Intercultural consultations: investigation of factors that deter non-English speaking women from attending their general practitioners for cervical screening

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Abstract

***Objectives*—To determine the factors that deter ethnic minority women living in east London from attending their general practitioner for cervical cytology screening.**

***Design*—Qualitative study by means of focus group discussions between October 1993 and March 1994.**

***Setting*—East London.**

***Subjects*—Non-health specific established community groups and specially convened groups of Bengali, Kurdish, Turkish, Urdu and Punjabi, and Chinese speaking women.**

***Main outcome measures*—The spontaneous views of non-English speaking women resident in east London on cervical screening, focusing on attitudes to screening, their experiences of the cervical cytology screening services as currently provided, and their knowledge and beliefs about cervical screening.**

***Results*—Some reported attitudinal barriers to cervical cytology screening such as fear of cancer were not deterrents. Administrative and language barriers were more important, as were inadequate surgery premises and concerns about sterility.**

***Conclusion*—Contrary to popular belief among general practitioners in east London, women from ethnic minorities are enthusiastic about cervical cytology screening once they understand the purpose of the test and the call and recall procedures. It is possible to consult with community groups in their own language through focus group discussions, working with bilingual health advocates who have had a short practical training in facilitating small group discussions. This form of user consultation could be carried out focusing on other aspects of health promotion.**

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Introduction

Reasons for women's non-attendance for cervical screening have been extensively studied both in the United Kingdom and elsewhere. Studies have focused on the attitudinal, emotional, and demographic factors and on the organisational aspects of the call and recall system.

An attitudinal belief that the cervical smear test is a test for cancer[1-3] and associations made with promiscuity in the popular media[4] have been considered to be powerful deterrents, as have misapprehensions about age and the need for regular testing.[1] The fear of pain[5] and the embarrassment, particularly when the test is carried out by a male doctor,[6-8] are also powerful deterrents. Most of these studies were conducted with English speaking women.

The emphasis the family practitioner lays on screening and the availability of a woman doctor encourage women to have a smear test, though women may be more interested in being screened by a sympathetic and familiar person such as their own doctor, regardless of sex.[9-11] Other general practice barriers to screening uptake include the timing of surgeries excluding women with work or family commitments, lack of child care provision, and inflexibility in rescheduling appointments.[5,10] Administrative factors that affect screening uptake mainly concern the call and recall system and poor communication of test results.[12-16]

This study sought to consult with women from different ethnic minority groups in their own language by using the methodology of focus groups.[17] The aim was to determine the factors which deter non-English speaking women from attending their general practitioner for cervical screening in the city and east London area.

Subjects and methods

Focus groups[17] are group discussions organised to explore a set of specific issues. The process allows for and actively exploits group interactions. The project worked with bilingual health advocates (not from a social science or psychology background) who had no previous experience of focus groups. Bengali, Turkish, Chinese, Vietnamese, Punjabi, and Urdu speaking advocates were seconded to the project to plan and run discussions and help to analyse the information. Training for focus group discussions was provided in a series of six workshops.

After pilot studies Bengali, Kurdish, Turkish, Punjabi, and Chinese and Vietnamese women were recruited through posters in community centres, personal invitation, and, in one case, through the practice nurse. Two health advocates attended each meeting, with one facilitating while the other took notes. At the outset permission to record the conversation and informed consent to participate were obtained from the women. A diagram of where each woman sat helped to identify who said what. At least one member of the research team attended each meeting as observer, independently noting the women's behaviour and the general atmosphere. The groups met in community centres, mosques, the local toy library, women's homes, and doctors' waiting rooms (after surgery), each meeting lasting about 90 minutes. A total of 11 focus groups were convened, each with six to 10 women.

Results

The women were generally open and communicative. The presence of observers, whom they met for the first time, did not seem negatively to influence group interaction. However, groups larger than eight led to

inhibitions about discussing intimate topics and the group tended to fragment. All the groups included children.

There were noticeable differences in the interaction between women from different ethnic backgrounds. The Bengali and Punjabi groups were more formal, each woman taking her "turn" to speak in social hierarchy. The Chinese women behaved respectfully towards the group organisers, while the Turkish and Kurdish groups were more spontaneous and informal. The observers' impressions of each ethnic group were consistent.

Most of the women had had their first smear taken at a postnatal examination, but some seemed to confuse smear tests with high vaginal swabs. All the groups referred to the cervical smear test as the "cancer test" and perceived positive benefits from having one. They seemed to be fatalistic about contracting cancer, saying that if you have it, then that is that, and it would be better if it were detected early so that something could be done.

Most women gained their information through women friends or relatives, the family planning clinic, the health advocate, or their doctor. Translated written material, often unobtainable, was difficult to understand.

The general anxieties about the pain and discomfort sometimes related to an unpleasant past experience or the misconception that pieces are cut from the womb with the speculum. Some women did not know that laboratory analysis was required and were reassured when the doctor said their internal examination was fine, not expecting to receive a results letter and believing that the general practitioner would call them back if there was any abnormality. Many were not aware that cervical screening had to be repeated at regular intervals.

Not all the women could recollect receiving a call or recall letter. Though some did not think that a letter in English would be a barrier, others said that they would simply ignore it if there was no one to translate. Many responded to a personal invitation from their family doctor. Several said that they did not receive a results letter, causing anxiety.

Though most groups associated cervical cancer with sexual activity, the germ theory seemed to be the prevailing explanation. Chinese women were particularly concerned about the standard of hygiene in the surgery, implying that infection could be acquired through unsterile equipment.

The Chinese, Bengali, and Punjabi groups preferred a woman doctor and to be accompanied by a familiar health advocate. The Turkish and Kurdish women were used to male doctors in their own country but said that given the choice they would prefer a woman doctor. At least one young woman said she respected and trusted her doctor (a man) and would definitely allow him to take a smear.

Most women said that they found it distracting to have children in the same room when having a smear test and suggested that facilities for children would be helpful.

Discussion

Our findings support previous research, in that failure of the call and recall system and unpleasant past experiences deter some non-English speaking women from having a smear test and that most prefer a woman doctor.[5-16] However, incorrect information about smear tests seemed to be common. To remedy this our advocates have written a family planning leaflet, initially in Turkish and subsequently in 12 other languages. These will be tested with women in focus groups.

Practice implications

- Ethnic minority women are enthusiastic about cervical cytology screening as an early diagnostic test for cancer once the purpose and procedures are understood
- Inadequate administration and language are potential barriers to screening uptake
- Concerns about surgery hygiene, sterility of equipment, and facilities for children deter ethnic minority women from attending their general practitioner for cervical screening
- Focus group discussions in the patients' own language are an effective way to consult with ethnic minority community groups to gather information for health promotion strategies

Contrary to the finding of other studies,[1-3] the belief that the cervical smear test is a test for cancer was perceived to be of positive benefit. The women preferred to call it a "cancer test." "Smear" test has an English meaning through colloquial use and does not have an equivalent in different languages. For example, in one leaflet it was translated as "fat" test.

All the women we consulted were enthusiastic about taking up cervical screening once they understood the nature of the test and the procedures for the call and recall programme. Thus the impression of east London general practitioners that "ethnic minority women are not interested in preventive services" was not borne out.[18] Language and the administrative system seem to be the barriers rather than the women's attitude.

There were concerns about surgery hygiene and sterility of equipment and a suggestion that child care facilities in the surgery would encourage the women to attend for cervical screening. In an inner city area where unsatisfactory premises are common this would be an aspect that the family health services authority could reasonably be expected to invest in, together with the issues about the availability of a familiar bilingual health advocate and women clinicians whether doctors or nurses.

The training sessions the health advocates received not only enabled them to play a major part in group facilitation but will in future enhance their ability to act as true advocates for their community. Taking on a proactive rather than reactive role, they are keen to extend this approach to other aspects of health promotion.

This method of consultation with ethnic minority women ensured that discussion groups could proceed in one language most of the time and the project team could elicit the information it needed. This in itself was an innovative approach.

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1 Schwartz M, Savage W, George J, Emohare L. Women's knowledge and experience of cervical screening: a failure of health education and medical organization. *Community Medicine* 1989;11:279-89.
2 Gregory S, McKie L. The smear test: women's views. *Nursing Standard* 1991;5:32-6.

3 Posner T, Vessey M. *Prevention of cervical cancer: the patient's view*. London: King Edward's Fund for London, 1988.
4 Nathoo V. Investigation of non-responders at a cervical cancer screening clinic in Manchester. *BMJ* 1988;296:1041-2.
5 Sansom CD, MacInerney J, Oliver V, Wakefield J. Differential response to recall in a cervical screening programme. *British Journal of Preventive and Social Medicine* 1975;29:40-7.
6 Bailie R, Petrie K. Women's attitudes to cervical smear testing. *N Z Med J* 1990;103:292-5.
7 Davison RL, Clements JE. Why don't they attend for a cytotest? A pilot study among a high-risk population. *The Medical Officer* 1971;1:329-31.
8 Cullum DE, Savory JN. Patient preference for cervical cytology. *BMJ* 1983;287:329-32.
9 Pierce M, Lundy S, Palanisamy A, Winning S, King J. Prospective randomised controlled trial of methods of call and recall for cervical cytology screening. *BMJ* 1989;299:160-2.
10 Elkind AK, Haran D, Eardley A, Spencer B. Reasons for non-attendance for computer-managed cervical screening: pilot interviews. *Soc Sci Med* 1988; 27:651-60.
11 McKie L, Gregory S, Garrett A, Bellerby I. *Patterns of take up and attitudes towards smear tests in the County of Cleveland (1989/1990)*. Stockton-on-Tees: Community Health Council (North Tees), 1990.
12 Bowling A, Jacobson B. Screening: the inadequacy of population registers. *BMJ* 1989;298:545-6.
13 Allman ST, Chamberlain J, Harman P. The national cervical cytology recall scheme: a report of a pilot study. *Health Trends* 1974;6:39-41.
14 Beardow R, Oerton J, Victor C. Evaluation of the cervical cytology screening programme in an inner city health district. *BMJ* 1989;299:98-100.
15 Ross SK. Cervical cytology screening and government policy. *BMJ* 1989;299: 101-4.
16 Shroff KJ, Corrigan AM, Bosher M, Edmonds MP, Sacks D, Coleman DV. Cervical screening in an inner city area: response to a call system in general practice. *BMJ* 1988;297:1317-8.
17 Kitzinger J. The methodology of focus groups: the importance of interaction between research participants. *Sociology of Health and Illness* 1994:16: 103-21.
18 Naish J. *General practitioners' view of cervical cytology screening in City and east London*. London: City and East London FHSA, 1992.

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Statistics Notes

Matching

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This is the ninth in a series of occasional notes on medical statistics

In many medical studies a group of cases, people with a disease under investigation, are compared with a group of controls, people who do not have the disease but who are thought to be comparable in other respects. This happens in epidemiological case-control studies, where a possible risk factor is compared between cases and controls to investigate the cause of the disease, and in clinical studies, where the characteristics of cases and controls are compared to investigate the nature of the disease. In both types of study cases and controls are sometimes matched. This means that for every case there is a control who has the same (or closely similar) values of the matching variables. Matching may be by sex, age to within five years, ethnic group, etc. Sometimes there are two or more such controls for each case.

We match to ensure that controls and cases are similar in variables which may be related to the variable which we are studying but are not of interest in themselves. For example, in many epidemiological case-control studies age is an important predictor of exposure to the risk factor under investigation. There are strong cohort effects in variables such as cigarette smoking and diet. If we do not take age into account we may get spurious differences between cases and controls because, for example, cases are older than controls. Matching ensures that any difference between cases and controls cannot be a result of differences in the matching variables. However, we cannot then examine the effects of the matching variables.

Sometimes matching is ignored in the analysis of the data. If the matching variables are important, this is inefficient. Matching variables, such as age and sex, may be strongly related to the variable of interest. If we allow for the matching in the analysis the variation due to these variables is removed. If we ignore the matching the variability which is related to the matching variables becomes part of the unexplained variation and may obscure important differences. For example, if we compare the mean blood pressure of subjects with a disease to that of their age matched controls, the variability in blood pressure which is associated with its increase with age will be part of the residual variance and will increase the standard error of the difference between the means. Instead, we should use the differences between individually matched cases and their controls. Appropriate simple methods include the paired t test for means, McNemar's test for proportions, and the sign test for ordinal data. Sometimes there is no suitable method of matched analysis, as in survival analysis. We can usually adjust for the matching variables, however.

It is desirable to adjust for matching when this was done to make the groups comparable for believed prognostic or confounding variables. This should be done even if in the sample the variable is not significantly prognostic or confounding. By contrast, matching is sometimes merely a convenient method of drawing the sample. For example, in studying cot deaths we might take as a control the next birth in the same hospital. This is sometimes referred to as cosmetic matching. We can ignore the matching in the analysis of such studies.

There are disadvantages to matching. If we match we can only use cases for whom we have matching controls. The more variables we match on the more difficult it may be to find such controls. Even to match on age, sex, and ethnic group we need a large population of potential controls from which to draw. A practical difficulty with matched pairs is that if we want to adjust for other, non-matched, variables the analysis required is more complex than ordinary multiple or logistic regression.

In a large study with many variables it is easier to take an unmatched control group and adjust in the analysis for the variables on which we would have matched, using ordinary regression methods. Matching is particularly useful in small studies, where we might not have sufficient subjects to adjust for several variables at once.

Some authors use "matched" to mean that the two groups are similar in the distribution of the matching variables, but not that there is individual matching of each case to his or her own control. Such studies should not be described as matched.

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