ETHNICITY: UK COLORECTAL CANCER SCREENING PILOT

FINAL REPORT
Appendices

The UK CRC Screening Pilot Evaluation (Ethnicity) Team, May 2004

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Appendix A1: Ethnic Composition Coventry and Warwickshire

Table A1.1: Ethnic composition and age breakdown of Coventry and Warwickshire as a whole, from 1991 Census of Population

Age	All ethnic groups	White	Minority ethnic groups	Black	Black Carib-bean	Black African	Black Other	South Asian	Indian	Pakis-tani	Bangla-deshi -	Chinese &Other	Chinese	Other Asian	Other	Born in Ireland
Population, 1991	778634	727219	51415	7322	4861	648	1813	37983	32209	4523	1251	6110	1552	1639	2919	21236
Percentage of population, 1991	100.0	93.4	6.6	0.9	0.6	0.1	0.2	4.9	4.1	0.6	0.2	0.8	0.2	0.2	0.4	2.7
Percentage in each age group, 1991																
0-15	20.2	19.4	32.1	29.9	18.9	26.1	60.8	31.8	30.0	40.3	46.0	37.1	19.3	26.1	52.8	2.3
16-24	13.0	12.7	17.9	16.6	16.0	16.8	18.3	17.9	17.7	19.4	19.3	19.3	25.1	20.7	15.4	3.1
25-44	28.5	28.4	29.8	27.2	29.1	42.6	16.8	30.2	31.5	23.5	19.7	31.0	40.2	37.3	22.5	22.8
45-64	22.5	23.0	16.4	21.6	29.6	12.8	3.3	16.3	16.7	14.6	13.7	10.3	12.6	13.6	7.3	47.2
65+	15.8	16.6	3.7	4.6	6.4	1.7	0.8	3.8	4.1	2.2	1.4	2.3	2.9	2.3	2.0	24.6
Over 50 in 1991	31.7	32.8	15.6	21.6	30.1	10.6	2.9	15.5	16.0	13.4	12.0	9.0	11.8	10.3	6.9	60.5
% born in the UK	92.6	95.6	10.5	73.4	51.9	37.7	90.8	14.2	48.9	50.8	42.6	88.0	26.2	30.9	72.4	25.3
Percent with a Limiting Long Term Illness, 1991	12.3	12.5	8.8	10.9	12.2	15.6	5.7	8.9	8.8	9.7	8.6	5.4	3.9	6.5	5.5	20.5
Estimated number of persons aged over 50 in 2001	354578	341296	13282	2149	1909	136	104	10055	8874	948	233	1078	330	379	369	17163
Percentage of those aged 50+ in each ethnic group, 2001	100.0	96.3	3.7	0.6	0.5	0.0	0.0	2.8	2.5	0.3	0.1	0.3	0.1	0.1	0.1	4.8

Table A1.2: Estimated Ethnic composition of people aged 50 and over by local authority districts in Coventry and Warwickshire, 2001

District	All aged 50 plus 1991	Percentage in each ethnic group				
		White	Born in Ireland	Black	South Asian	Chinese & Other
Coventry	128091	93.0	7.0	1.1	5.5	0.4
North Warwickshire	27338	21.3	0.1	0.0	0.0	0.0
Nuneaton	50927	38.9	0.8	0.1	0.7	0.1
Rugby	39299	29.8	0.9	0.3	0.5	0.1
Stratford-on-Avon	53685	41.8	0.1	0.0	0.0	0.1
Warwick	55232	41.7	1.5	0.2	1.1	0.2

Appendix A2: Defining Ethnicity and Ethnic Group

A2.1 BACKGROUND

In approaching the issue of ethnicity and diversity we need to be aware of a complex and contentious history in the evolution of ideas and terminology. Traditional anthropology defined four major human 'races', usually described as 'Caucasian' ('white' or European), 'Negroid' (Black or African), 'Mongoloid' (Asian, Chinese or Indic), and 'Australoid' (that is, the group of people described as 'Aboriginal' to Australia). These groups assumed that race was a bio-scientific concept explaining significant biological differences between populations. This concept of race is now firmly discredited by modern genetics. Over 99% of the genetic make up of human beings is common to all ethnic groups. Those differences that do exist between people and populations are minor and largely reflect superficial physical characteristics ('phenotypes') such as facial features, hair or skin colour. In this sense the division of people into 'races' reflects social decisions rather than having any real scientific justification, being based on fallacious genetic/biological associations rather than cultural ones. Culture is a complex social phenomenon and its definition problematic. It consists of the shared beliefs, values and attitudes that guide the behaviour of group members. The concept of 'ethnicity' is even more complex, but recognises that people identify themselves with a social grouping on cultural grounds including language, lifestyle, religion, food and origins. The basis of 'ethnicity' is thus often a tradition of common descent or intermarriage and shared culture or history. It is essential to recognise that, in a world of migration and mixing, cultures and societies are dynamic rather than fixed. The Table below compares the concepts of race, culture and ethnicity.

Table A2.1: Comparison of 'race', culture and ethnicity

Concept	Primary Characteristics	Origin	Associated perceptions
'Race'	Inherent, Biological, Physical, Nature/ Natural	Genetic – Descent	Permanent
Culture	Behavioural Expression of preferred lifestyle	Upbringing – Learned	Capable of being changed, Optional
Ethnicity/ Ethnic Group	Identity, Multi-faceted, 'Political'	Socially constructed – Internal or external – or legal	Situational, Negotiated

A2.2 ETHNIC MONITORING IN THE NHS

The UK Race Relations Act 1976 defined a 'racial group' as 'a group of persons defined by reference to colour, race, nationality or ethnic or national origins...' 'Ethnicity' and 'ethnic group' became more formally defined in UK law by a House of Lords decision (Mandla v Lee 1983) as relating to those with 'a long shared history and a distinct culture'. Other 'relevant' characteristics were 'a common geographic origin or descent from a small number of common ancestors; a common language; a common literature; a common religion and being a minority within a larger community'.

Since April 1996, the NHS has expected that all hospital trusts will record, and provide as part of the 'contract minimum data set' to health commissioners, data relating to the ethnic origin of all 'admitted patients'. This includes day cases as well those admitted to hospital for any form of treatment. The circular authorising this data collection (EL(94)77) was the product of extensive discussion and prior testing, and led to considerable controversy at the time of its introduction (Johnson & Gill 1995, Ranger 1994).

Ethnic monitoring requires the identification of individuals as belonging to one or more groups, defined in terms of their culture and origin (Gerrish 2000). Were it nothing more than this, it might be the sort of casual categorisation that could lead to discrimination and harm based on stereotype (Ahmad 1999). To be effective and useful, ethnic monitoring in the NHS and elsewhere should rely upon the individual concerned being given the opportunity to define their identity in terms that are meaningful to them - and hence, which reveal something about them which is of value to the care-giver. This may mean looking

for differences where they are not expected - including among the 'white majority' population - and that cannot be inferred from skin colour and appearance.

Since 1996, there has been a steady growth in the collection of ethnic monitoring data in hospital trusts, although rather fewer indications of its use. The NHS has also supported the development of ethnic monitoring procedures in primary care (Pringle and Rothera 1996) with several 'pilot sites' in West London (Brent & Harrow), the West Midlands, and Liverpool participating in this process.

The most common indicator of difference, or the size of 'minority' populations, in census data and other official records, has been *birthplace*. This information is recorded on most identity documents, and is used to analyse data such as that collected on death certificates. Unfortunately, it provides a poor indicator of cultural or 'ethnic' origin. At the time of the 1991 Census, over half the population in the 'Black' categories (54% Black Caribbean, 84% Black Other, and 36% Black African) were UK-born, as were half of those giving their ethnic group as Pakistani, 42% of 'Indians' and 37% of 'Bangladeshis'. It is now estimated that less than 40% of the black and minority ethnic population can be identified by birthplace, and increasingly few by the birthplace of their parents. In terms of ethnic health, birthplace data may therefore be of little or no value, even if still used in some epidemiological studies.

Information on ethnicity can be collected in a number of ways. One of the least threatening and most commonly used identifiers for front-level staff to ask is that of *language* i.e. 'mother tongue' or 'language most commonly used in the home' - which can be seen to relate directly to the needs of the client. Unless language is asked about, and recorded, providers may have no idea of the need for interpreting and translation services. Increasing numbers of refugees, and older people who settled in Britain after the war (from India, Italy or Poland, amongst other places), need such help.

Religion can also play an important part in providing care, especially for people in distress, and most hospital records do have a space for religion, although it is not always completed.

Nationality is probably one of the most problematic categories. Too often the notion of ethnic 'origin' is described as nationality. In ethnic monitoring, it is essential not to confuse the idea of identity with the question of the rights of the citizen to state-funded services. The official guidelines (Department of Health Manual of Guidance on the NHS Treatment of Overseas Visitors) make this quite clear.

Data on ethnic groups can be aggregated at various levels. However, publication of research reports such as the Fourth National Study of the Policy Studies Institute (Modood 1997) has emphasised the considerable differences that exist even within the meta-category (broad level of aggregation) of 'South Asian'. This and other studies (e.g. Johnson *et al* 2000) have shown that there are considerable differences in health status, as well as in expectations and priorities, between the recognisable sub-categories, such as 'Indian' (which in Britain may include Sikh Punjabis, Muslim Gujeratis and Hindus of various linguistic origin as well as other smaller groups), and the predominantly Muslim Bengali or Bangladeshi group whose health status is almost invariably shown to be less advantaged. For the most part, research to date has been confined to levels of analysis which are related not to the theoretical ideal, but to categories in use for administrative purposes, and linked to data (mostly meaning here the Census) against which some baseline for comparison can be established. Therefore, for research purposes and for ethnic monitoring, in general, the 'ethnic group' categories used to date have been those developed for use in the 1991 census.

A2.3 CENSUS CATEGORIES

The ethnic groups identified by the Office of National Statistics in the decennial UK Census are shown below. Table A2.2 presents the categories used in the 1991 census and those utilised in the Census in 2001. It may be that the 'ethnic group' labels used in the UK 1991 Census - 'Black-Caribbean', 'Asian-Pakistani' etc - are sufficient to identify the existence of discrimination on broad, racialised grounds. On the other hand, for planning services and allocating resources more detailed information is needed. The Office of National Statistics therefore agreed that the 2001 Census would ask for more detailed information on ethnic group. The most recent census questions therefore reflect changes such as a tendency for some people of African-Caribbean origins born in Britain to determine their own identity as 'Black British'. Also, while the 2001 Census used the term 'Ethnic Group', it made it clear that this is seen as a matter of 'cultural background'.

Table A2.2: Categories of ethnic group recorded in the UK Censuses of 1991 and 2001

1991	**2001**
White	White – British
	White – Irish
	White – Any other White background (please write in)
(Other...)	Mixed – White/Black Caribbean
	Mixed – White/Black African
	Mixed – White/Asian
	Any other mixed background (please write in)
Black- Caribbean	Black or Black British: Caribbean
Black- African	Black or Black British: African
Black- Other (Please describe)	Black or Black British: Any other background (please write in)
Indian	Asian or Asian British Indian
Pakistani	Asian or Asian British Pakistani
Bangladeshi	Asian or Asian British Bangladeshi
Asian- Other (Please describe)	Asian or Asian British Any other background: (please write in)
Chinese	Chinese or Other Ethnic group Chinese
Any Other Ethnic Group (Please describe).	Chinese or Other Ethnic group Any other: (please write in)

(Adapted from ONS forms: reproduced with permission)

The 2001 census also asked people about their religion (see Figure A2.1), although this question was not compulsory. Once available, this data will make it easier to produce projections of the numbers of people from the main religious groups, and to anticipate the needs they may bring to the health service for religious observance, diet and counselling.

Figure A2.1: Question 10 of the 2001 census

10: What is your religion?

- ♦ This question is voluntary
- ♦ (Tick) one box only

- ❑ None
- ❑ Christian (including Church of England, Catholic, Protestant and all other Christian denominations)
- ❑ Buddhist
- ❑ Hindu
- ❑ Jewish
- ❑ Muslim
- ❑ Sikh
- ❑ Any other religion (please write in)

(Cm 4253, 1999) and Census 2001 England Household Form page 6

A2.4 CONCLUSIONS

In conclusion, there are many ways of defining an 'ethnic minority' (Pringle *et al* 1997), and there has been considerable debate and controversy about the categories in use within the NHS (Bhopal 1991, Ahmad, Sheldon and Stuart 1996, Sheldon and Parker 1992, Aspinall 1995, McKenzie and Crowcroft 1994). The crucial point made by many authors is that the categorisation used must be 'fit for purpose' i.e. it must be relevant to the delivery of the service being considered and to the recognition of client need.

> The trouble with using nationality, birthplace, ethnic origin or language spoken at home as indicators of ethnic categories is that this implicitly assumes that such criteria all refer to the same clear-cut entities .... It is more effective to use different criteria to pursue different policy objectives ...
> (Vermeulen 1997: 12)

A2.5 REFERENCES

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Appendix A3: Ethnic Groups and Literacy levels

There is a limited amount of up-to-date information on the language capability and literacy of minority ethnic groups in UK. The majority of studies have explored the 'preferred' or 'home' language of South Asian populations, or relied on school-based data to estimate the number of languages spoken (and the size of child populations speaking another language at home) without being able to project from these back to true population estimates. Three major national surveys have collected data in recent years which provide the opportunity to make some estimates of language capacity and literacy. In all cases, these show that among older people, and especially within the population of Bangladeshi origin, there is limited ability either to understand (spoken) English or to read (any language), more especially among women. Even in the 'middle-age' group (data report grouped ages, so that we have to rely on those aged 30-49 about ten years ago as a proxy for the younger half of the 'at-risk population of our study), there are significant numbers who cannot be expected to read English.

Source: Rudat 1994 (Data collected 1991)

	Women 30-49	Women 50-74	Men 30-49	Men 50-74
'Speak English'	%	%	%	%
Indian	80	47	93	86
Pakistani	42	15	94	66
Bangladeshi	21	10	72	51
'Main Language: English'				
Indian	18	8	25	19
Pakistani	3	-	15	7
Bangladeshi	1	-	7	-
Main language spoken at Home: English				
Indian	29	5	31	24
Pakistani	12	-	17	22
Bangladeshi	4	-	6	1

	Women 30-49	Women 50-74	Men 30-49	Men 50-74
Read English	%	%	%	%
Indian	67	34	83	71
Pakistani	31	7	77	54
Bangladeshi	15	4	60	38
Read NO language				
Indian	4	25	2	6
Pakistani	31	68	7	16
Bangladeshi	24	52	3	19

These data show very clearly that there is much less likelihood of Asian women, especially older and Muslim women, being able to read any communications received, especially if they are in English. Men of Bangladeshi origin, especially in the older cohort, also have very low levels of familiarity with English, and low levels of literacy generally. A significant minority, even in those aged 40-60 (now) will be essentially illiterate in any language. While this may also be true for White families (for whom we do not have equivalent data) there is at the same time unlikely to be much alternative support from other family members, especially where children have moved away from home, or have not learned fluency in their parental languages.

Johnson et al 2000 (Data collected 1994)

	Women 30-49	Women 50-74	Men 30-49	Men 50-74
Able to read English	%	%	%	%
Indian	78	43	98	79
Pakistani	55	31	82	55
Bangladeshi	37	13	87	62

When asked about ‘languages best understood’, there were significant (and age-related) splits within the Pakistani and Bangladeshi population, as well as the Indian population breaking into groups of Gujerati, Punjabi and other major languages. The majority of Pakistani women reported that their preferred language was Punjabi (49%) followed by Urdu (18%), while the males of this ‘ethnic group’ were more likely to report preferring Urdu (39%) compared to Punjabi (23%). This may reflect exposure at school, since Urdu is the official language of instruction in Pakistan, and the script would be more familiar also to Pakistani people attending and learning ‘mother tongue’ classes in UK. Similarly, in Bangladesh, the official language is Bangla (Bengali) but the ‘home language’, Sylhetti, is not a written language and is not taught in UK schools. Consequently, over half of the ‘over-50s’ of Bangladeshi origin reported speaking Sylhetti: overall, the ‘language best understood’ among Bangladeshi women was Bangla (understood by 42% of men) but surprisingly, only 29% of women reported speaking Sylhetti, preferred by 41% of men. Very few reported that English was their ‘best understood’ language, although the

numbers stating this has risen among the younger age groups, some of whom now report that they cannot speak their parental languages, and would be unable to translate materials sent to them in English, if they contained any complicated terms.

Modood et al 1997 (Data collected 1994)

The 'Fourth National Study' of minority ethnic groups used a different (and for our purposes, less helpful) set of age group boundaries, and did not present data on literacy, although it is the only source of fluency in English for any groups other than the 'Indian-Pakistani-Bangladeshi' group. Their category 'African Asian', however, was not represented specifically in our study although it does equate to the (Mainly Gujerati) population of Leicester where focus groups were held.

	Women 25-44	Women 45-64	Men 25-44	Men 45-64
English spoken 'Fluently or well'	%	%	%	%
Indian	73	53	88	68
Pakistani	47	28	81	56
Bangladeshi	27	4	75	54
Chinese	82	47	82	50
African Asian	92	71	94	87

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Appendix A4: Minimum Datasets Extracted from Key Papers on Cancer Screening

Table A4.1: CRC screening uptake and barriers to recruitment and retention
Minimum dataset (MDS) summary information extracted from colorectal cancer screening articles

ID	Type of cancer	Country of study (Date)	Type of test(s) studied		Population(s) studied						Research carried out		
			1ST screen test#	Follow up test	Ethnic Group(s)	Gender/ Age	Religion	Non-Local Lang.	Comp-arator i.e. White	Socio-demogr Factors	Type of study	Key findings	Comments
46	Colorectal	USA (2001)	FOBt FS	Col	Hispanic; African Americans; Asian; White.	M/f	Not studied	Not studied	Yes	Not studied	Knowledge, beliefs, risk perception & barriers	Telephone survey. Only 19% believe are at risk; non-whites more likely to underestimate risk. Barriers: fear of finding cancer; pain of sigmoidoscopy; difficulties in accessing screening. Focus groups explored: knowledge of CRC & various screening tests; barriers to screening; recommendations by medical professionals and family; intentions to be screened; and influence of family history.	Telephone interview survey. 67 first degree relatives of CRC cases; Hispanic (10%), African American (19%), Asian (16%) and White. 7 focus groups (56 mixed-risk participants): African Americans, Hispanics and Chinese
48	Colorectal	USA (2000)	FOBt FS	Not studied	Mixed (not specified)	M/f	Not studied	Not studied	Yes (not in detail)	Not studied	Knowledge, beliefs, enabling factors & reinforcing factors	Exploration of (i) knowledge, attitudes; (ii) enabling factors/ barriers; (iii) reinforcing factors. Sub-groups defined by race reported to be generally similar. Overall, participants poorly informed re CRC & screening; little information from physicians/ media, negative attitudes to screening, fear of cancer.	14 mixed focus groups (10 – 11 participants) Authors suggest urgent need for public education campaigns, decision aids & targeted interventions.
79	Colorectal	USA (2000)	FS	Not studied	African Americans	F	Not studied	Not studied	Yes	Educ	Knowledge, beliefs & practices	Face-to-face interviews in women's homes. Measures: knowledge; beliefs; barriers; risk; worry; physician recommendation; stage of adoption. Logistic regression analysis. showed predictors of adherence to FS screening were perceiving fewer barriers and having a physician recommendation. Race, age, education not significantly related.	202 low income, African-American (77%) and white women 72% of women were non-adherent to FS screening guidelines
226	Colorectal	USA Hawaii (1994)	FOBt	Various	Chinese; Filipino; Hawaiian; Japanese; White.	M/f	Not studied	Not studied	Yes	Not studied	Screening uptake	Japanese, whites & Chinese more likely to return FOBt kits; Filipinos & Hawaiians less likely – 34.6% returned overall. Diagnosis – Filipinos least likely to undergo colonoscopy/ sigmoidoscopy follow up	Media campaign followed by free distribution via pharmacies 15,015 people received kits

# DRE = digital rectal examination Col = colonoscopy
FOBt = faecal occult blood test FS = flexible sigmoidoscopy

Table A4.1 (contd): CRC screening uptake and barriers to recruitment and retention
Minimum dataset (MDS) summary information extracted from colorectal cancer screening articles

ID	Type of cancer	Country of study (Date)	Type of test(s) studied		Population(s) studied						Research carried out		
			1ST screen test#	Follow up test	Ethnic Group(s)	Gender/ Age	Religion	Non-Local Lang.	Comp-arator i.e. White	Socio-demogr Factors	Type of study	Key findings	Comments
272	Colorectal	USA (1998)	FOBt FS	Not studied	African Americans; Hispanics	M/f Age	Not studied	Not studied	Yes	Income Educ	Screening uptake	Analysis of cancer screening uptake among 34,078 black, white and Hispanic Americans by income (<$20,000 vs ≥ $20,000) and education (<12 years vs ≥ 12 years). Social class is a more powerful explanatory variable in ethnic group disparities for younger (50-64) Americans; older (65-74) black Americans who were poor or less educated reported less screening than older white Americans of a similar social class..	Using National Health Interview Survey data, the evidence appears to indicate that for African Americans there remains an 'ethnic' effect, especially for older (>65 years) individuals.
321	Colorectal	USA (1998)	FOBt DRE	Not studied	Korean Americans	M/f Age	Not studied	Not studied	No	Educ	Knowledge & practices	Interview survey. 13.5% of men reported having a DRE, 10.6% a FOBt; figures for women were lower at 11.3% and 8.8% respectively. Overall, fewer than 6% reported having DRE or FOBt for *screening* purposes. Multiple regression shows: knowledge of cancer warning signs & length of residence in US α use of DRE; no variable α FOBt.	263 Koreans (104 men; 159 women) Two-stage probability sample.
355	Colorectal	Sweden (1995)	FOBt	Not studied	Immigrants	Not studied	Not studied	Not studied	Yes	Not studied	Screening uptake	Immigrants without Swedish citizenship: uptake lower in older (age 64) group; no difference for younger (age 50) group	34,144 subjects 15% immigrants; 3% older group; 12% younger
357	Colorectal	USA (1996)	DRE FOBt FS	Not studied	African Americans	M/f	Not studied	Not studied	No	Educ	Knowledge, beliefs, risk perception & practices	Telephone interview covering CRC screening, beliefs about CRC, perception & attribution of risk, and experience of CRC. Majority rated risk as below average or did not know. Individuals providing risk estimate were younger & held more accurate beliefs. Subjects reported higher levels of CRC screening than national norm, but medical audit failed to confirm this.	547 low-income, predominantly African Americans (80%), aged 50 and older Conclusion that educational effort needed to enhance knowledge/risk perception;. Also, self-report CRC screening data needs care.
359	Colorectal	USA (2000)	FOBt	Not studied	African Americans	M/f	Not studied	Not studied	No	Income Educ	Risk perception & screening intentions	Telephone interviews: perceived absolute & comparative risk; concerns about getting CRC; intention to adopt CRC screening; and FOBt screening. Baseline absolute risk did not predict screening intentions or FOBt on schedule (or absolute & comparative risk or concerns about CRC at follow up). Whether person was on schedule for FOBt at baseline did not predict FOBt on schedule at follow-up.	Two year follow-up of 435/547 low-income, predominantly African Americans (79%), aged 50 and older Authors suggest once again that educational effort is needed to enhance knowledge and risk perception.

Table A4.1 (contd): CRC screening uptake and barriers to recruitment and retention
Minimum dataset (MDS) summary information extracted from colorectal cancer screening articles

ID	Type of cancer	Country of study (Date)	Type of test(s) studied		Population(s) studied						Research carried out		
			1ST screen test#	Follow up test	Ethnic Group(s)	Gender/ Age	Religion	Non-Local Lang.	Comp-arator i.e. White	Socio-demogr Factors	Type of study	Key findings	Comments
482	Colorectal	USA (1997)	FOBt FS	Not studied	African Americans	F Age	Not studied	Not studied	Yes	Not studied	Knowledge, beliefs & practices	Survey of 300 low-income African American (AA) and white women. Variables related to screening for all women included receiving regular check-ups (breast cancer); beliefs (breast and colorectal cancer screening), and knowledge (cervical cancer). For AAs barriers to screening were significant for breast screening uptake and regular checkups for cervical screening ($p < 0.01$). High perceived risk of colorectal cancer related to recent FS only for white women ($p = 0.012$).	More AAs than white reported FOBt < 1 year (21% vs. 17%); more whites had flexible sigmoidoscopy < 5 years (31% vs. 24%). AAs' reported uptake of mammograms, clinical breast exam & pap smears also higher. Diffs not statistically significant when adjusted for ages.
485	Colorectal	USA (2000)	FOBt FS	Not studied	African Americans	F	Not studied	Not studied	No	Working status Health insurance	Knowledge, beliefs & practices	Interviews with random sample women in their own homes re FOBt and FS. Most important predictor for FS & FOBt was a physician recommendation ($P < 0.001$). Less than half women had "good" to "excellent" knowledge re CRC screening; most women had positive attitudes about FS and FOBt. Majority of women reported barriers to receiving these tests. 20% women reported FOBt < 1 year, 26% FS < 5 years, 7% both tests, and 64% neither test. 20% women reported FOBt < 1 year, 26% FS < 5 years, 7% both tests, and 64% neither test.	263 women 50 yrs plus in low-income housing communities in North Carolina. Authors conclude that interventions should focus both on provider and public education.
505	Colorectal	USA (1995)	FOBt	Not studied	African Americans	M/f Age	Not studied	Not studied	Yes	Income Educ	Screening uptake	Uptake of FOBt screening (provided free) among elderly African and white Americans. Power Fatalism Model used to measure fatalism. African Americans were found to have a higher fatalism score ($p<0.0001$); there was some indication that fatalism may be a factor in poor FOBt uptake.	Sample only 192 individuals.
638	Colorectal	USA (2001)	FOBt FS	Not studied	Chinese American	F	Not studied	Indirect	No	Not studied	Factors influencing screening uptake	Factors influencing FOBt & sigmoidoscopy screening use in Chinese American women 60 years and older. Questionnaire on common/cultural barriers to cancer screening; and acculturation (including language fluency). Logistic regression shows: greater acculturation α FOBt; and acculturation and physician recommendation α sigmoidoscopy.	100 participants, recruited from 7 senior centres (71% resp. rate) Recommend outreach efforts target women who are less acculturated.

Table A4.1 (contd): CRC screening uptake and barriers to recruitment and retention
Minimum dataset (MDS) summary information extracted from colorectal cancer screening articles

ID	Type of cancer	Country of study (Date)	Type of test(s) studied		Population(s) studied						Research carried out		
			1ST screen test#	Follow up test	Ethnic Group(s)	Gender/ Age	Religion	Non-Local Lang.	Comp-arator i.e. White	Socio-demogr Factors	Type of study	Key findings	Comments
689	Colorectal	Japan (1998)	FOBt	Col	Japanese	M/f Age	Not studied	Not studied	Not directly	Not studied	Screening uptake	Over 14 year period uptake fell from 81% to 59%. Uptake was higher for women than men; lower for young (<50) and very old (>80) subjects. Uptake figures reported are comparable to other populations e.g. Swedish, English & USA. Subjects with a previous –ve result had lower uptake ($p<0.01$).	FOBt screening programme over 14 year. Japanese village community. Population ca 2,150.
706	Colorectal	USA (2001)	FOBt FS	Not studied	Hispanic; Black; Asian; White.	M/f	Not studied	Not studied	No	Not studied	Knowledge, beliefs, barriers & practices	Telephone interview survey covering CRC screening behaviour, knowledge, beliefs, barriers to screening, and physician advice and social support. 54% could not name a CRC screening test; only 39% believed themselves at risk. Barriers: FOBt - stool samples & dietary restrictions; flexible sigmoidoscopy - enema prior to test. Screening status related to active physician encouragement to have FS	Convenience sample of 115 urban, predominantly minority men and women in New York; Hispanic (32%), Black non-Hispanic (24%), white non-Hispanic (15%), Asian (6%); Caribbean (12%).
726	Colorectal	USA (2001)	FOBt FS	Not studied	Chinese Americans	M/f Age	Not studied	Not studied	No	Educ.	Knowledge & practices	Interview survey in the individual's home. Respondents more likely to have never been screened with FOBt (85% vs 70% for general population). Knowledge of DRE, FOBt & Ca warning signs poor. Multiple regression shows: educational level α use of DRE; age α use of FOBt. Most common reason for not having FOBt (85%) was 'not sick'; next most frequent (5% FOBt) was 'doctor didn't recommend'.	644 Chinese (312 males, 332 females) Two-stage probability sample.

Table A4.2: UK cancer screening uptake and barriers to recruitment
Minimum dataset (MDS) summary information extracted from UK cancer screening articles

ID	Type of cancer	Country of study (Date)	Type of test(s) studied		Population(s) studied						Research carried out		
			1ST screen test#	Follow up test	Ethnic Group(s)	Gender/ Age	Religion	Non-Local Lang.	Comp-arator i.e. White	Socio-demogr Factors	Type of study	Key findings	Comments
63	Cervical & Breast	UK (1995)	Smear & Mamm	Not studied	Not specified (deprived inner-city London population)	F	Not studied	Not studied	No	Indirect	Comparative cervical & breast screening uptake	Comparison of uptake of breast and cervical screening in 156 practices in east London, a highly deprived inner city area. Uptake of breast screening consistently lower than uptake of cervical screening. Significant positive correlation between the two rates. Authors suggest low uptake possibly linked to high mobility of population.	Authors conclude more accurate addresses needed to improve uptake & extra payment for checking notification lists should be evaluated in inner city areas of high mobility.
67	Breast	UK (1993)	Mamm	Not studied	Asian	F	Not studied	Yes	Yes	Yes	Knowledge/ screening intentions beliefs/ barriers Risk perception/	Knowledge of breast cancer & screening varied significantly by language: 60.4% of English-speaking and 12.5% of non-English-speaking women were knowledgeable ($p<0.001$). Despite that, 80% or more intended to attend for screening, irrespective of neighbourhood, language, age, or social class. Authors suggest that difference in knowledge are due to indirect discrimination in dissemination of health information.	701 inner-city women in Leicester City were randomly sampled & stratified by neighbourhood and by women's "likely home language." Trained interviewers interviewed 79%. Paper reports preliminary analysis of 413 respondents.
72	Cervical	UK (1996)	Smear	Not studied	Mixed Lang (Black, Cantonese Hindu, Gujerati, Punjabi Somali Tamil etc)	F	Not studied	Yes	No	No	Knowledge, attitudes & experience of cervical screening	Reported that many women surveyed were unaware of screening service and held misconceptions about the smear test; and fear, embarrassment and previous negative experiences all inhibited initial or repeat attendance for screening. Concerns also reported about language, the need for advocacy, and racism.	Women & health advocates in East London. 172 women surveyed; 17 women in-depth interviews. 11 session facilitators interviewed individually, and 11 health advocates took part in 2 focus-groups.
74	Cervical	UK (1993)	Smear test	Not studied	'Asian'	F 50-64	Not studied	Not studied	Non-Asians	Not studied	Screening uptake	No difference in uptake found (uptake in Asians 61.5%, non-Asians 60.6%). Asian women less likely to have had a previous smear. Authors suggest that ethnicity does not seem to play an important part in the uptake of cervical smear testing in this population.	158 Asian and 158 non-Asian women from 4 Oldham general practices. Noted that the register contained a higher number of inaccurate addresses for Asian women.

# Mamm = mammography, breast screening
Smear = smear test, cervical screening

Table A4.2 (contd): UK cancer screening uptake and barriers to recruitment
Minimum dataset (MDS) summary information extracted from UK cancer screening articles

ID	Type of cancer	Country of study (Date)	Type of test(s) studied		Population(s) studied						Research carried out		
			1ST screen test#	Follow up test	Ethnic Group(s)	Gender/ Age	Religion	Non-Local Lang.	Comp-arator i.e. White	Socio-demogr Factors	Type of study	Key findings	Comments
103	Cervical	UK (1995)	Smear	Not studied	African-Caribbean Bangladeshi Indian Pakistani	F	Not studied	Yes	No	Not studied	Screening uptake & language used with GP	Survey collected data on frequency of surgery visits, language competence, and screening for cervical cancer. Language barriers identified for Asians (especially women). Cervical cancer screening rates: African-Caribbean women report higher uptake than Asian groups; over 50% of Bangladeshi women and over 33% of Pakistani women had not been screened at all.	MORI survey of African-Caribbeans, Indians, Pakistanis and Bangladeshis.
119	Cervical	UK (1999)	Smear	Not studied	Mixed Lang (Afr Caribb Arabic Bengali Cantonese Urdu Vietnamese	F	Not studied	Not studied	No	No	Factors contributing to low participation of minority ethnic women in cervical screening	Professional and lay perceptions: focus groups show divergence in perceptions, this contributed to negative experiences for both groups & poor communication. Majority of women did not understand purpose of screening or test procedure.	Poor communication has implications for informed consent and choice as well as uptake
214	Breast	UK (1998)	Mamm	Not studied	Mixed	F	Not studied	Not studied	No	Yes	Breast screening uptake	Uptake of screening for breast cancer by general practice. Variation in uptake during Round 1 was explained partly by deprivation score and by presence of 1+ female GP. In Round 2, effect of female GP diminished. No. hours worked by practice nurses had no effect on uptake.	Research conducted in south Lancashire
267	Breast	UK (1996)	Mamm	Not studied	Asian Black non-Asian White	F	Not studied	Yes	Yes	Yes	Review of incidence of breast cancer and uptake of screening.	Lowest incidence of breast cancer found in Chinese, Japanese and Arabic populations and women from the Indian subcontinent; 2-3 times lower than in UK. Studies measuring ethnic differences in uptake may be confounded by socio-economic factors. Inaccurate screening registers are one of most important reasons for non-attendance, compounded by extended visits to Indian subcontinent.	Further issue is poor awareness of ethnic naming systems.

Table A4.2 (contd): UK cancer screening uptake and barriers to recruitment
Minimum dataset (MDS) summary information extracted from UK cancer screening articles

ID	Type of cancer	Country of study (Date)	Type of test(s) studied		Population(s) studied						Research carried out		
			1ST screen test#	Follow up test	Ethnic Group(s)	Gender/ Age	Religion	Non-Local Lang.	Comp-arator i.e. White	Socio-demogr Factors	Type of study	Key findings	Comments
268	Breast	UK (1992)	Mamm	Not studied	Asian (Indian)	F	Not studied	Yes	No	Not studied	Reasons for non-attendance for screening	93 women with Asian names from an inner-city area of Manchester were followed up by link workers. Half were no longer at the address; one third of remainder were on extended visits to Asia. Both attitudinal and practical reasons were given for non-attendance. 34 women were offered an additional appointments (70% uptake). From the response of women contacted by the link workers, it would appear uptake could be increased through better health promotion materials.	The authors conclude that uptake figures may be unreliable for Asian women, with misleadingly low values resulting from the inaccuracy of screening registers.
363	Cervical	Smear (1996)	Not studied	Not studied	African Caribbean Indian Pakistani Bangladeshi	F	Not studied	Not studied	Yes	Not studied	Review, including screening uptake	Mortality from cervical cancer higher for African-Caribbeans & lower for women from India & African Commonwealth. Results of Health Education Authority survey of health and lifestyles: uptake rates differ (85% all women; 87% African-Caribbean; 70% Indian; 54% Pakistani; 40% Bangladeshi women).	Currently no routine ethnic monitoring of women attending for screening; author suggests this needs discussion. Also, query whether socio-economic status is a more important factor.
368	Breast	UK (1995)	Mamm	Not studied	Non-white	F	Not studied	Not studied	Yes	Yes	Variations in breast screening uptake vs patient and general practice characteristics	43,063 women eligible for first round breast cancer screening, 25,826 (60%) attended for a mammogram. Practice rates varied from 12.5% to 84.5%. Most highly correlated variable was percentage list inflation for practices (r = -0.69). Strong –ve correlations with social deprivation (r = -0.61), and with ethnicity (r = -0.60). Uptake significantly higher in computerised practices (59.5% v 53.9%). No significant difference for practices with/ without: a female GP; practice nurse; or practice manager. Authors conclude accurate age-sex registers most important in achieving high breast cancer screening rates.	131 practices in Merton, Sutton, and Wandsworth (covering parts of inner and outer London). Breast cancer screening rates were on average lower than cervical cancer screening rates (mean difference 14.5%) and were less strongly associated with practice characteristics.

Table A4.2 (contd): UK cancer screening uptake and barriers to recruitment
Minimum dataset (MDS) summary information extracted from UK cancer screening articles

ID	Type of cancer	Country of study (Date)	Type of test(s) studied		Population(s) studied						Research carried out		
			1ST screen test#	Follow up test	Ethnic Group(s)	Gender/ Age	Religion	Non-Local Lang.	Comp-arator i.e. White	Socio-demogr Factors	Type of study	Key findings	Comments
369	Cervical	UK (1994)	Smear	Not studied	'ethnic minority' % non-white population	F	Not studied	Not studied	Not directly	Not studied	Screening uptake vs patient and general practice characteristics	Practice uptake varied from 16.5% to 94.1%. Negatively correlated with the % practice population from ethnic minorities & with social deprivation (e.g. overcrowding, no car and unemployment). Rates higher in practices with a female partner, and in larger practices. Multiple regression identifies 5 significant factors: female partner; children under five; overcrowding; number aged 35-44 as a percentage of all women aged 25-64; and change of address in past year.	126 GP practices in Merton, Sutton and Wandsworth Cervical smear uptake rates 1987-92. The study concluded that over half the variation can be explained by patient and practice variables.
448	Cervical	UK (1994)	Smear	Not studied	Bengali Kurdish Turkish Punjabi Chinese Vietnamese	F	Not studied	Not studied	No	Not studied	Knowledge, beliefs, barriers, attitudes & experiences	Focus groups of Bengali, Kurdish, Turkish, Urdu and Punjabi, and Chinese speaking women. Previously reported barriers such as fear of cancer not reported to be deterrents. Administrative & language barriers more important, as were inadequate surgery premises and concerns about sterility.	Carried out in east London Authors conclude that ethnic minority women enthusiastic about cervical screening once they understand the purpose of the test and the call & recall procedures.
516	Breast	UK (1999)	Mamm	Not studied	Mixed	F	Not studied	Not studied	No	Not studied	Review of literature on breast screening and ethnic minority women	27 references, only 4 relate specifically to the UK (all included in our review) and a further 4 relate to the USA (included in our Bibliography); the remainder do not relate directly to breast screening in ethnic minorities. The main reasons for low uptake appear to be a lack of knowledge about screening services & lack of referral/ recommendations by healthcare professionals and physicians.	It is suggested that future initiatives should target appropriate education strategies for healthcare professionals on the needs of ethnic groups.
630	Cervical & Breast	UK (2001)	Smear & Mamm	Not studied	South Asian	F	Not studied	Not studied	Yes Non-Asian	Not studied	Cervical & breast screening uptake: pairwise comparison of South Asian & non-Asian women matched by date of birth and general practice.	67% of the 852 South Asians and 75% of the 15,623 non-Asians had acceptable cervical screening histories ($p<0.001$); considerable variations between practices. 53% of the 73 South Asians and 78% of the 3,255 non-Asians had acceptable breast screening histories ($p<0.01$); Asian women were largely concentrated in one practice.	South Asian women in Wakefield, compared with other city residents. Authors conclude that interventions needed to improve coverage for breast screening; need for interventions for cervical screening less clear.

Table A4.2 (contd): UK cancer screening uptake and barriers to recruitment
Minimum dataset (MDS) summary information extracted from UK cancer screening articles

ID	Type of cancer	Country of study (Date)	Type of test(s) studied		Population(s) studied						Research carried out		
			1ST screen test#	Follow up test	Ethnic Group(s)	Gender/ Age	Religion	Non-Local Lang.	Comp-arator i.e. White	Socio-demogr Factors	Type of study	Key findings	Comments
631	Breast	UK (1994)	Mamm	Not studied	White Black Asian	F	Not studied	Not studied	Yes	Yes	Study of predictors of first-round attendance for breast screening in inner London practices.	A total of 3291 women aged 50-64 years were interviewed/completed a questionnaire. Main predictors were: (i) *socio-demographic factors:* living in rented accommodation. Black women had higher than average uptake. (ii) *health behaviours:* cervical smear. (iii) *attitudes, beliefs, & intentions:* Women who reported a moderate amount of worry about breast cancer were more likely to attend than those at the two extremes.	Analysis of predictors was based on a subsample of 1,301, reflecting a response rate of 75% to interview and 36% to postal questionnaire.

Table A4.3: CRC screening - Interventions to improve uptake
Minimum dataset (MDS) summary information extracted from colorectal cancer screening articles

ID	Type of cancer	Country of study (Date)	Type of test(s) studied		Population(s) studied						Research carried out		
			1ST screen test#	Follow up test	Ethnic Group(s)	Gender/ Age	Religion	Non-Local Lang.	Comparisons made i.e. White	Socio-demogr Factors	Type of study	Key findings	Comments
49	Colorectal	USA (2001)	FOBt		African Americans	Not studied	Not studied	Not studied	Yes	Not studied	Review of literature on barriers to cancer screening and interventions for improving uptake	Review of literature relevant to strategies to overcome barriers to screening for colorectal cancer among African Americans. Barriers to cancer screening uptake identified: fear of cancer, fatalism, reliance on self-care, limited opportunities to access care, and inadequate provider-patient communication. Interventions (based on non-CRC screening): community-based approaches targeting the individual, community & health care system levels advocated.	Limited colorectal screening literature identified so other literatures (e.g. breast screening) applied to CRC screening.
149	Colorectal	USA (2001)	FOBt		African American; Hispanic.	Not studied	Not studied	Yes	No	Not studied	Review of literature on interventions for CRC screening	Review article. Does not specifically focus on ethnic minorities. For diverse populations CRC screening issues raised include language & dialect; appropriate use of interpreters; reading level of educational materials; and demographic profiles of physicians and nurses.	Any mention of diverse population findings related to other (i.e. non-CRC) forms of screening.
507	Colorectal	USA (1999)	FOBt		African American		Not studied	Not studied	No	Not studied	Intervention study (pre-test post-test design: educational video focused on fatalism)	Senior citizen centres were assigned randomly to intervention or control (American Cancer Society (ACS) standard video). Study design: repeated measures, pre-test/ post-test. Outcomes measured (post-test @ 7 days after intervention): cancer fatalism score; knowledge of CRC; participation in FOBt testing. Intervention group had greater decrease in cancer fatalism scores (p=0.003); greater increase in knowledge of CRC (p=0.044). No significant difference in rate of participation in FOBt; the majority of the intervention group (60%) and the control group (68%) participated in FOBt screening within 7 days.	Rural, socio-economically disadvantaged elders (average age 73). 70 individuals participated in the study (42 intervention and 28 control). Majority African American and female; no further details provided Authors conclude that more research is needed to determine if the positive outcomes of intervention can be maintained over time.

# DRE = digital rectal examination Col = colonoscopy
FOBt = faecal occult blood test FS = flexible sigmoidoscopy

Table A4.3 (contd): CRC screening - Interventions to improve uptake
Minimum dataset (MDS) summary information extracted from colorectal cancer screening articles

ID	Type of cancer	Country of study (Date)	Type of test(s) studied		Population(s) studied						Research carried out		
			1ST screen test#	Follow up test	Ethnic Group(s)	Gender/ Age	Religion	Non-Local Lang.	Comparisons made i.e. White	Socio-demogr Factors	Type of study	Key findings	Comments
691	Colorectal	USA (1994)	FOBt		African American	Older adults M/f	Not studied	Not studied	Yes	Not studied	Intervention study (pre-test post-test design: educational session including practice)	Adaptation for Ageing Changes with Practice (AACP) educational method compared with American Cancer Society (ACS) standard CRC educational programme & AAC without practice. Quasi-experimental, pre-test post-test design used. More of those taught by AACP method (94%) participated in FOBt screening than AAC method (41%) or traditional ACS method (65%). AACP had similar effect on different ethnic groups	135 subjects; 56% African Americans. AACP method includes demonstration & practice on how to collect the stool specimen, written material modified to low reading age, and various reminders re return date for FOBt card.

Table A4.4: UK cancer screening - Interventions to improve uptake
Minimum dataset (MDS) summary information extracted from UK cancer screening articles

ID	Type of cancer	Country of study (Date)	Type of test(s) studied		Population(s) studied						Research carried out		
			1ST screen test#	Follow up test	Ethnic Group(s)	Gender/ Age	Religion	Non-Local Lang.	Comparisons made i.e. White	Socio-demogr Factors	Type of study	Key findings	Comments
29	Breast	UK (1997)	Mamm	Not studied	Indian Pakistani Bangladeshi Black Chinese Other	F	Not studied	Not studied	Yes	Not studied	Intervention study (RCT; 2 hours training session for practice reception staff)	2,064 women (50-64 yrs) who had failed to attend for screening were contacted by receptionists. Attendance in intervention group significantly better than in control group (9% v 4%). Impact was highest in Indian women - 19% vs 5%. The authors conclude that this simple, low cost intervention is effective in modestly improving breast screening rates, and it could be effective as part of a multifaceted strategy in areas with low uptake rates.	Trial carried out in 37 practices in inner London (Newham). 31% of women were white, 17% Indian, 10% Pakistani, 14% black, 6% Bangladeshi, 1% Chinese, 4% other ethnic groups, & 16% not known.
41	Breast	UK (2001)	Mamm	Not studied	Mixed population	F	Not studied	Not studied	No	Not studied	Intervention study (Patient RCT: 2 interventions; GP letter vs flag in women's notes)	1,158 women were randomised: 289 control; 291 letter; 290 flag; 288 both interventions. Logistic regression adjusting for the other intervention and practice produced an odds ratio (OR) for attendance of 1.51 for the letter, and 1.39 for the flag. Health service costs per additional attendance were £35 (letter) and £65 (flag). The authors conclude that the letter is most cost-effective.	13 General practices with low uptake in the second round of screening (below 60%) in north west London and the West Midlands. GP letter includes translation sheet (14 languages). No data on different ethnic groups in the sample.
51	Breast	UK (1999)	Mamm	Not studied	Urdu Bengali Somali Arabic Gujerati	F	Not studied	Yes	Yes	Not studied	Non- randomised intervention study (pre-test post-test design: to identify interventions & hard to reach groups).	Interventions assessed were: identification of language groups; GP letter; translated leaflet; transport to screening centre; and language support by linkworkers. Of 369 women invited, 50.7% attended (cf 35.2% previous uptake). Uptake was highest amongst Urdu and Gujarati speaking groups and lowest for Bengali and Somali speakers.	3 general practices in inner city Cardiff with a low uptake in the previous round of breast screening, and with a high proportion of ethnic minority women on their lists.
176	Breast	UK (1996)	Mamm	Not studied	Mixed (incl Bengali Cantonese/ Vietnamese Somali)	F	Not studied	Not studied	No	Not studied	Intervention study (Observational study of personal approach from the GP surgery)	Practice receptionists trained to be able to contact women; draft letters provided in English, Cantonese and Bengali; breast screening mobile unit left on site for longer; health advocates (2 Bengali, Cantonese, Vietnamese & Somali) available to women. Uptake for practices participating in the scheme was 55%, and 31% for those who did not participate ($p<0.01$).	19 practices were invited; 2 practices had receptionists trained; 10 practices finally participated and 1,038 women were contacted and asked to make appointments to attend.

# Mamm = mammography, breast screening
Smear = smear test, cervical screening

Table A4.4 (contd): UK cancer screening - Interventions to improve uptake
Minimum dataset (MDS) summary information extracted from UK cancer screening articles

ID	Type of cancer	Country of study (Date)	Type of test(s) studied		Population(s) studied						Research carried out		
			1ST screen test#	Follow up test	Ethnic Group(s)	Gender/ Age	Religion	Non-Local Lang.	Comparisons made i.e. White	Socio-demogr Factors	Type of study	Key findings	Comments
266	Breast	UK (1994)	Mamm	Not studied	Asian (Indian)	F	Not studied	Not studied	No	Not studied	Intervention study (RCT: linkworker visit vs control)	Study population all women with Asian names from selected practices. Linkworkers could contact 59% of intervention group. No difference in uptake (49% intervention and 47% control). Attendance for screening was related to length of stay in UK. Authors conclude that intervention not successful	25% of women were permanently or temporarily not resident at the invitation address.
319	Cervical & breast	UK (1996)	Smear & Mamm	Not studied	African Caribbean Asian East European	F	Not studied	Not studied	Yes	Not studied	Intervention study (pre-test post-test design: Community development approach, piloted over 18 months (1991-93) in Bradford).	Study subjects 1,628 women; stratified sample of 1,000 women (670 South Asian, 163 African-Caribbean, 96 Eastern European and 71 other) interviewed at start of project & 6 months after intervention. Significant differences in baseline levels of knowledge; South Asian women had lowest levels of knowledge & also showed most significant improvements. Authors conclude that a community development approach to health promotion is particularly valuable, but a definitive evaluation is needed, including an economic evaluation.	2 Health Promotion Facilitators provided group sessions in the women's preferred languages; including health education about breast and cervical cancer & screening programmes & audio-visual material and specially designed teaching pack. This was augmented by a local publicity campaign.
367	Breast	UK (1997)	Mamm	Not studied	Mixed inner-city population	F	Not studied	Not studied	No	Not studied	Intervention study (Observational study of follow up letter to non-attenders)	Breast screening uptake increased by an average of 4.6% in the 40 intervention practices compared with 1.6% in the 53 control practices ($P < 0.0001$). Absolute increase was small (53.8% to 58.5%). Marginal cost per additional woman screened was £7 (c.f. average cost per woman screened £27). Authors conclude that reminder letters have limited role in inner city areas	93 general practices in South West London. 40 practices had screening uptake < 60% & were offered clerical support to check names/ addresses of non-attenders & send a reminder letter.
396	Cervical	UK (1991)	Smear	Not studied	Asian (Indian & east African)	F	Sikh Hindu Moslem	Gujarati, Punjabi, Urdu, Hindi Bengali	No	Not studied described	Intervention study (RCT: home visit + video; home visit + leaflet; postal leaflet vs control)	Main outcome was smear test 4 months post intervention. For the home visit groups, 37% of the women given a leaflet & 47% shown the video attended for cervical smears (difference not significant). Uptake was 11% for those posted a leaflet & 5% for controls. The authors conclude that home viewed videos may be particularly effective in hard to reach groups: e.g. Urdu speaking, Pakistani Moslems.	737 randomly selected Asian women in Leicester (aged 18-52) who were recorded as never having had a cervical smear test. Hindus had a higher uptake (49%) than Moslems (34%) or Sikhs (31%) [differences not statistically significant].

Table A4.4 (contd): UK cancer screening - Interventions to improve uptake
Minimum dataset (MDS) summary information extracted from UK cancer screening articles

ID	Type of cancer	Country of study (Date)	Type of test(s) studied		Population(s) studied						Research carried out		
			1ST screen test#	Follow up test	Ethnic Group(s)	Gender/ Age	Religion	Non-Local Lang.	Comparisons made i.e. White	Socio-demogr Factors	Type of study	Key findings	Comments
536	Breast	UK (2001)	Mamm	Not studied	Mixed population	F	Not studied	Not studied	No	Not studied	Intervention study (Cluster RCT: 2 interventions; GP letter vs flag in women's notes)	6,133 women invited for third round breast screening in the trial: 1,721 control; 1,818 letter; 1,232 flag; 1,362 both interventions. Interventions independently increased uptake in logistic regression model adjusted for clustering, with the flag (odds ratio (OR) 1.43) marginally more effective than the letter (OR 1.31). Health service costs per additional attendance were £26 (letter) and £41 (flag). The authors conclude that the letter was the more cost-effective.	24 General practices with low uptake in the second round of screening (below 60%) in north west London and the West Midlands. The GP letter accompanied by a translation sheet (14 languages). No data on different ethnic minority groups in the sample.
582	Breast	UK (1996)	Mamm	Not studied	Mixed population SE London	F	Not studied	Not studied	No	Not studied	Intervention study (RCT: personal GP letter vs nurse visit with education vs nurse visit without education)	RCT of 3 interventions. 799 women. 11.4% uptake following nurse visit with health education; 7.8% following nurse visit without health education; and 13.1% following GP letter. Differences between groups not statistically significant: The authors conclude that a personal letter from the GP is at least as effective as nurse home visits (with or without a health education intervention).	Study carried out in south east London. Women who had not attended first round screening registered with 27 GPs. Reported that delivering nurse based interventions proved difficult.
590	Breast	UK (1999)	Mamm	Not studied	Mixed	F	Not studied	Not studied	No	Not studied	Review of intervention studies to increase breast screening uptake	A total of 28 studies identified; 8 included ethnic minorities in the UK. All but one study (unpublished) found by our literature search. Most interventions were 'person directed'; these were more likely to be effective in boosting uptake, be simple in design, and to have been evaluated by a randomised trial design. However, it is reported that in inner city areas the best approach to raising uptake rates is likely to be multistrategy.	Unpublished descriptive, prospective study carried out in Berkshire and focused on Asians from one low uptake general practice. Bus transport and an interpreter increased uptake from 46% to 73%.

Appendix A5: Analyses of Routine Data

Table A5.1: Screening Status by Age, Gender and Ethnic Group (Up to March 1, 2002 with 3 months follow-up)										
Demographic/Ethnic Factor			Considered for Screening			Screening Status				
			Yes	Withdrawn	Total	Screened	Under Process	Declined Screening	Did not Respond	Total
Gender	Male	Count	66475	4510	70985	37960	5553	773	22189	66475
		%	93.65	6.35	100.00	57.10	8.35	1.16	33.38	100.00
	Female	Count	66517	2348	68865	43558	4416	1097	17446	66517
		%	96.59	3.41	100.00	65.48	6.64	1.65	26.23	100.00
Age	50-54	Count	39009	1954	40963	21841	3328	336	13504	39009
		%	95.23	4.77	100.00	55.99	8.53	0.86	34.62	100.00
	55-59	Count	38015	1805	39820	23170	2832	395	11618	38015
		%	95.47	4.53	100.00	60.95	7.45	1.04	30.56	100.00
	60-64	Count	29546	1573	31119	18893	2177	478	7998	29546
		%	94.95	5.05	100.00	63.94	7.37	1.62	27.07	100.00
	65-69	Count	26422	1526	27948	17614	1632	661	6515	26422
		%	94.54	5.46	100.00	66.66	6.18	2.50	24.66	100.00
Religion	Hindu-Gujerati	Count	760	35	795	307	164	15	274	760
		%	95.60	4.40	100.00	40.39	21.58	1.97	36.05	100.00
	Hindu-other	Count	597	34	631	253	116	6	222	597
		%	94.61	5.39	100.00	42.38	19.43	1.01	37.19	100.00
	Muslim	Count	1685	142	1827	505	278	9	893	1685
		%	92.23	7.77	100.00	29.97	16.50	0.53	53.00	100.00
	Sikh	Count	3408	159	3567	1098	867	38	1405	3408
		%	95.54	4.46	100.00	32.22	25.44	1.12	41.23	100.00
	Other Asian	Count	620	29	649	216	172	7	225	620
		%	95.53	4.47	100.00	34.84	27.74	1.13	36.29	100.00
	Non Asian	Count	125922	6459	132381	79139	8372	1795	36616	125922
		%	95.12	4.88	100.00	62.85	6.65	1.43	29.08	100.00
	Total	Count	132992	6858	139850	81518	9969	1870	39635	132992
		%	95.10	4.90	100.00	61.30	7.50	1.41	29.80	100.00

Table A5.2: Number of Kits Sent and Received Back by Age, Gender and Ethnic Group (Up to March 1, 2002 with 3 months follow-up)								
Number of Kits Sent								
Demographic/Ethnic Factor			0	1	2	3	4 +	Total
Gender	Male	Count	60	31020	31265	1274	2856	66475
		%	0.09	46.66	47.03	1.92	4.30	100.00
	Female	Count	103	36088	26669	1120	2537	66517
		%	0.15	54.25	40.09	1.68	3.81	100.00
Age	50-54	Count	36	17966	18761	581	1665	39009
		%	0.09	46.06	48.09	1.49	4.27	100.00
	55-59	Count	28	18743	17150	636	1458	38015
		%	0.07	49.30	45.11	1.67	3.84	100.00
	60-64	Count	43	15719	11953	600	1231	29546
		%	0.15	53.20	40.46	2.03	4.17	100.00
	65-69	Count	56	14680	10070	577	1039	26422
		%	0.21	55.56	38.11	2.18	3.93	100.00
Religion	Hindu-Gujerati	Count	1	323	363	21	52	760
		%	0.13	42.50	47.76	2.76	6.84	100.00
	Hindu-other	Count		234	298	9	56	597
		%	0	39.20	49.92	1.51	9.38	100.00
	Muslim	Count		537	654	28	466	1685
		%	0	31.87	38.81	1.66	27.66	100.00
	Sikh	Count	2	1138	1673	87	508	3408
		%	0.06	33.39	49.09	2.55	14.91	100.00
	Other Asian	Count		257	282	14	67	620
		%	0	41.45	45.48	2.26	10.81	100.00
	Non Asian	Count	160	64619	54664	2235	4244	125922
		%	0.13	51.32	43.41	1.77	3.37	100.00
	Total	Count	163	67108	57934	2394	5393	132992
		%	0.12	50.46	43.56	1.80	4.06	100.00
Number of Kits Received Back								
			0	1	2	3	4 +	Total
Gender	Male	Count	27859	35823	1208	1170	415	66475
		%	41.91	53.89	1.82	1.76	0.62	100.00
	Female	Count	22387	41508	1145	990	487	66517
		%	33.66	62.40	1.72	1.49	0.73	100.00
Age	50-54	Count	16827	20812	623	483	264	39009
		%	43.14	53.35	1.60	1.24	0.68	100.00
	55-59	Count	14535	22060	626	538	256	38015
		%	38.23	58.03	1.65	1.42	0.67	100.00
	60-64	Count	10355	17847	574	553	217	29546
		%	35.05	60.40	1.94	1.87	0.73	100.00
	65-69	Count	8529	16612	530	586	165	26422
		%	32.28	62.87	2.01	2.22	0.62	100.00
Religion	Hindu-Gujerati	Count	436	270	27	14	13	760
		%	57.37	35.53	3.55	1.84	1.71	100.00
	Hindu-other	Count	336	228	11	8	14	597
		%	56.28	38.19	1.84	1.34	2.35	100.00
	Muslim	Count	1148	430	36	17	54	1685
		%	68.13	25.52	2.14	1.01	3.20	100.00
	Sikh	Count	2230	940	92	59	87	3408
		%	65.43	27.58	2.70	1.73	2.55	100.00
	Other Asian	Count	395	183	21	7	14	620
		%	63.71	29.52	3.39	1.13	2.26	100.00
	Non Asian	Count	45701	75280	2166	2055	720	125922
		%	36.29	59.78	1.72	1.63	0.57	100.00
	Total	Count	50246	77331	2353	2160	902	132992
		%	37.78	58.15	1.77	1.62	0.68	100.00

Table A5.3: Screening Status by Gender and Religion/Language (Up to March 1, 2002 with 3 months follow-up)										
Gender	Religion/ Language		Considered for Screening			Screening Status				
			Yes	Withdrawn	Total	Screened	Under Process	Declined Screening	Did not Respond	Total
Males	Hindu-Gujerati	Count	365	25	390	157	74	8	126	365
		%	93.59	6.41	100.00	43.01	20.27	2.19	34.52	100.00
	Hindu-other	Count	309	24	333	123	70		116	309
		%	92.79	7.21	100.00	39.81	22.65		37.54	100.00
	Muslim	Count	916	108	1024	278	157	4	477	916
		%	89.45	10.55	100.00	30.35	17.14	0.44	52.07	100.00
	Sikh	Count	1671	124	1795	536	437	19	679	1671
		%	93.09	6.91	100.00	32.08	26.15	1.14	40.63	100.00
	Other Asian	Count	292	20	312	98	78	3	113	292
		%	93.59	6.41	100.00	33.56	26.71	1.03	38.70	100.00
	Non Asian	Count	62922	4209	67131	36768	4737	739	20678	62922
		%	93.73	6.27	100.00	58.43	7.53	1.17	32.86	100.00
	Total	Count	66475	4510	70985	37960	5553	773	22189	66475
		%	93.65	6.35	100.00	57.10	8.35	1.16	33.38	100.00
Females	Hindu-Gujerati	Count	395	10	405	150	90	7	148	395
		%	97.53	2.47	100.00	37.97	22.78	1.77	37.47	100.00
	Hindu-other	Count	288	10	298	130	46	6	106	288
		%	96.64	3.36	100.00	45.14	15.97	2.08	36.81	100.00
	Muslim	Count	769	34	803	227	121	5	416	769
		%	95.77	4.23	100.00	29.52	15.73	0.65	54.10	100.00
	Sikh	Count	1737	35	1772	562	430	19	726	1737
		%	98.02	1.98	100.00	32.35	24.76	1.09	41.80	100.00
	Other Asian	Count	328	9	337	118	94	4	112	328
		%	97.33	2.67	100.00	35.98	28.66	1.22	34.15	100.00
	Non Asian	Count	63000	2250	65250	42371	3635	1056	15938	63000
		%	96.55	3.45	100.00	67.26	5.77	1.68	25.30	100.00
	Total	Count	66517	2348	68865	43558	4416	1097	17446	66517
		%	96.59	3.41	100.00	65.48	6.64	1.65	26.23	100.00

Table A5.4: Response to Screening and Completion of Phase 1 of Screening by Demographic and Ethnic Factors									
Demographic/ Ethnic Factor		Responded to Screening (Returned at least one kit: both adequate and inadequate kits included) within 3 months of invitation				Completion of Phase 1 of Screening: initial adequate kit returned (negative, positive or weakly positive result) within 3 months of invitation			
		Number	Uptake (%)	Unadjusted OR (95% CI)	Adjusted OR (95% CI)	Number	Uptake (%)	Unadjusted OR (95% CI)	Adjusted OR (95% CI)
Gender	Male	38616	58.09	1 (-)	1 (-)	38363	57.71	1 (-)	1 (-)
	Female	44130	66.34	1.422 (1.391 – 1.454)	1.428 (1.396 - 1.462)	43853	65.93	1.418 (1.389 - 1.450)	1.424 (1.392 - 1.458)
Age	50-54	22182	56.86	1 (-)	1 (-)	22010	56.42	1 (-)	1 (-)
	55-59	23480	61.77	1.223 (1.190 – 1.258)	1.200 (1.165 - 1.236)	23333	61.38	1.227 (1.193 - 1.263)	1.201 (1.166 - 1.237)
	60-64	19191	64.95	1.382 (1.341 – 1.424)	1.424 (1.379 - 1.471)	19075	64.56	1.407 (1.364 - 1.451)	1.426 (1.380 - 1.473)
	65-69	17893	67.72	1.546 (1.498 - 1.595)	1.596 (1.542 - 1.651)	17798	67.36	1.594 (1.543 - 1.646)	1.560 (1.544 - 1.653)
Invitation Time	July-Sept 2000	3005	66.47	1 (-)	1 (-)	2988	66.09	1 (-)	1 (-)
	Oct-Dec 2000	13304	64.29	0.904 (0.847 - 0.965)	0.878 (0.819 - 0.941)	13239	63.97	0.911 (0.851 - 0.975)	0.881 (0.822 - 0.945)
	Jan-Mar 2001	16786	64.82	0.929 (0.871 - 0.990)*	0.931 (0.869 - 0.996)*	16695	64.47	0.931 (0.871 - 0.995)*	0.932 (0.870 - 0.998)*
	Apr-June 2001	17621	66.81	1.022 (0.958 - 1.089)@	0.983 (0.918 - 1.053)@	17530	66.47	1.017 (0.951 - 1.087)@	0.984 (0.919 - 1.053)@
	July-Sept 2001	17439	62.75	0.854 (0.802 - 0.910)	0.824 (0.769 - 0.882)	17329	62.35	0.850 (0.795 - 0.908)	0.823 (0.769 - 0.881)
	Oct-Dec 2001	10540	52.91	0.573 (0.537 - 0.611)	0.697 (0.650 - 0.747)	10425	52.33	0.563 (0.527 - 0.603)	0.695 (0.649 - 0.745)
	Jan-Mar 2002	4051	51.98	0.557 (0.518 - 0.599)	0.756 (0.698 - 0.817)	4010	51.45	0.544 (0.504 - 0.587)	0.757 (0.670 - 0.819)
Religion	Hindu-Gujerati	324	42.63	0.442 (0.383 - 0.509)	0.555 (0.478 - 0.644)	320	42.11	0.421 (0.364 - 0.486)	0.554 (0.477 - 0.643)
	Hindu-other	261	43.72	0.451 (0.384 - 0.523)	0.540 (0.457 - 0.638)	258	43.22	0.440 (0.374 - 0.518)	0.539 (0.455 - 0.637)
	Muslim	537	31.87	0.267 (0.241 - 0.295)	0.419 (0.376 - 0.467)	519	30.80	0.258 (0.232 - 0.286)	0.408 (0.366 - 0.455)
	Sikh	1178	34.57	0.314 (0.293 - 0.337)	0.404 (0.375 - 0.435)	1134	33.27	0.289 (0.269 - 0.310)	0.388 (0.360 - 0.419)
	Other Asian	225	36.29	0.335 (0.285 - 0.393)	0.446 (0.376 - 0.528)	222	35.81	0.323 (0.274 - 0.381)	0.446 (0.376 - 0.529)
	Non Asian	80221	63.71	1 (-)	1 (-)	79763	63.34	1 (-)	1 (-)
Deprivation	1 & 2	28939	69.02	1 (-)	1 (-)	28817	68.73	1 (-)	1 (-)
	3	25542	65.16	0.840 (0.815 - 0.865)	0.838 (0.813 - 0.863)	25427	64.87	0.840 (0.816 - 0.865)	0.839 (0.814 - 0.864)
	4	19073	57.98	0.619 (0.601 - 0.638)	0.652 (0.632 - 0.673)	18919	57.51	0.616 (0.560 - 0.635)	0.649 (0.630 - 0.670)
	5	4819	48.72	0.426 (0.408 - 0.446)	0.463 (0.443 - 0.485)	4757	48.09	0.422 (0.403 - 0.441)	0.459 (0.438 - 0.480)
	6 & 7	2184	38.92	0.286 (0.270 - 0.303)	0.374 (0.352 - 0.398)	2124	37.85	0.277 (0.262 - 0.294)	0.364 (0.342 - 0.387)
	Total	82746	62.22			82216	61.82		
Note:* indicates p<.05; ** indicates p<0.10; @ indicates not significant; all the remaining coefficients are significant at p<.01 level.									

Table A5.5: Completion of screening (FOBt test result available) by Demographic and Ethnic Factors									
Demographic/Ethnic Factor		Completion of screening (FOBt test result available within four months of invitation)				Completion of screening in responders (i.e. those who returned a kit)			
		Number	Uptake (%)	Unadjusted OR (95% CI)	Adjusted OR (95% CI)	Number	Uptake (%)	Unadjusted OR (95% CI)	Adjusted OR (95% CI)
Gender	Male	36483	58.40	1 (-)	1 (-)	36483	99.36	1 (-)	1 (-)
	Female	41723	66.52	1.415 (1.383 - 1.448)	1.422 (1.388 - 1.456)	41723	99.39	1.415 (1.383 - 1.448)	1.056 (0.881 - 1.267)@
Age	50-54	20798	57.29	1 (-)	1 (-)	20798	99.25	1 (-)	1 (-)
	55-59	22237	61.86	1.209 (1.173 - 1.245)	1.192 (1.156 - 1.230)	22237	99.41	1.209 (1.173 - 1.245)	1.179 (0.931 - 1.494)@
	60-64	18119	65.30	1.403 (1.358 - 1.449)	1.426 (1.379 - 1.474)	18119	99.40	1.403 (1.358 - 1.449)	1.272 (0.988 - 1.637)**
	65-69	17052	67.67	1.560 (1.508 - 1.613)	1.580 (1.526 - 1.636)	17052	99.48	1.560 (1.508 - 1.613)	1.399 (1.074 - 1.822)*
Invitation Time	July-Sept 2000	2988	66.09	1 (-)	1 (-)	2988	99.43	1 (-)	1 (-)
	Oct-Dec 2000	13239	63.97	0.911 (0.851 - 0.975)	0.881 (0.822 - 0.945)	13239	99.51	0.911 (0.851 - 0.975)	1.146 (0.669 - 1.963)@
	Jan-Mar 2001	16695	64.47	0.931 (0.871 - 0.995)*	0.932 (0.870 - 0.998)*	16695	99.46	0.931 (0.871 - 0.995)*	1.045 (0.620 - 1.760)@
	Apr-June 2001	17530	66.47	1.017 (0.951 - 1.087)@	0.984 (0.919 - 1.053)@	17530	99.48	1.017 (0.951 - 1.087)@	1.038 (0.616 - 1.748)@
	July-Sept 2001	17329	62.35	0.850 (0.795 - 0.908)	0.823 (0.769 - 0.881)	17329	99.37	0.850 (0.795 - 0.908)	0.893 (0.532 - 1.498)@
	Oct-Dec 2001	10425	52.33	0.563 (0.527 - 0.603)	0.693 (0.646 - 0.743)	10425	98.91	0.563 (0.527 - 0.603)	0.788 (0.468 - 1.327)@
	Jan-Mar 2002	0	NA			0	NA		
Religion	Hindu-Gujerati	261	45.39	0.473 (0.402 - 0.558)	0.592 (0.450 - 0.701)	261	98.86	0.473 (0.402 - 0.558)	0.697 (0.221 - 2.198)@
	Hindu-other	220	44.72	0.461 (0.386 - 0.550)	0.540 (0.450 - 0.649)	220	98.65	0.461 (0.386 - 0.550)	0.529 (0.168 - 1.672)@
	Muslim	458	32.10	0.269 (0.241 - 0.301)	0.417 (0.370 - 0.469)	458	96.62	0.269 (0.241 - 0.301)	0.308 (0.180 - 0.528)
	Sikh	953	34.60	0.301 (0.278 - 0.326)	0.397 (0.366 - 0.431)	953	96.17	0.301 (0.278 - 0.326)	0.217 (0.151 - 0.312)
	Other Asian	178	38.95	0.363 (0.301 - 0.439)	0.479 (0.395 - 0.582)	178	98.89	0.363 (0.301 - 0.439)	0.858 (0.210 - 3.504)@
	Non Asian	76136	63.72	1 (-)	1 (-)	76136	99.44	1 (-)	1 (-)
Deprivation	1 & 2	28118	68.81	1 (-)	1 (-)	28118	99.58	1 (-)	1 (-)
	3	24473	65.20	0.849 (0.824 - 0.875)	0.843 (0.818 - 0.869)	24473	99.55	0.934 (0.720 - 1.211)@	0.942 (0.725 - 1.223)@
	4	17482	57.95	0.625 (0.606 - 0.644)	0.650 (0.630 - 0.671)	17482	99.21	0.528 (0.413 - 0.675)	0.576 (0.449 - 0.739)
	5	4215	48.19	0.422 (0.402 - 0.442)	0.448 (0.427 - 0.470)	4215	98.71	0.322 (0.233 - 0.444)	0.359 (0.259 - 0.498)
	6 & 7	1768	39.61	0.297 (0.279 - 0.317)	0.373 (0.349 - 0.399)	1768	97.25	0.148 (0.106 - 0.207)	0.209 (0.145 - 0.300)
	Total	78206	62.47			78206	99.38		
Note:* indicates p<.05; ** indicates p<0.10; @ indicates not significant; all the remaining coefficients are significant at p<.01 level.									

Table A5.6: Screening Uptake Rate by Religion/Language Status of the Subject Cross-Classified by Religion/Language Status of the GP					
Subject-Religion/ Language	GP-Religion/ Language	Responder (Returned the Kit)		Completion of Screening Phase 1 (Negative, Positive & Weakly Positive)	
		Number	Uptake %	Number	Uptake %
Hindu-Gujerati	Hindu-Gujerati	54	32.14	53	31.55
	Hindu-Other	59	42.75	58	42.03
	Muslim	14	40.00	14	40.00
	Sikh	52	45.61	52	45.61
	Non-Asian	145	47.54	143	46.89
	Total	324	42.63	320	42.11
Hindu-Other	Hindu-Gujerati	28	32.18	28	32.18
	Hindu-Other	42	36.21	40	34.48
	Muslim	14	46.67	14	46.67
	Sikh	29	40.28	29	40.28
	Non-Asian	148	50.68	147	50.34
	Total	261	43.72	258	43.22
Muslim	Hindu-Gujerati	44	22.00	43	21.50
	Hindu-Other	107	28.38	106	28.12
	Muslim	63	22.83	59	21.38
	Sikh	51	29.82	49	28.65
	Non-Asian	272	41.15	262	39.64
	Total	537	31.87	519	30.80
Sikh	Hindu-Gujerati	236	31.98	231	31.30
	Hindu-Other	210	32.31	196	30.15
	Muslim	84	32.56	82	31.78
	Sikh	143	33.03	137	31.64
	Non-Asian	505	38.00	488	36.72
	Total	1178	34.57	1134	33.27
Other Asian	Hindu-Gujerati	38	27.14	37	26.43
	Hindu-Other	48	34.53	48	34.53
	Muslim	18	51.43	18	51.43
	Sikh	34	34.69	33	33.67
	Non-Asian	87	41.83	86	41.35
	Total	225	36.29	222	35.81
Non-Asian	Hindu-Gujerati	2264	56.67	2250	56.32
	Hindu-Other	6448	58.96	6390	58.43
	Muslim	2110	54.89	2091	54.40
	Sikh	4306	61.21	4266	60.64
	Non-Asian	65093	65.02	64766	64.69
	Total	80221	63.71	79763	63.34
All	Hindu-Gujerati	2664	50.00	2642	49.59
	Hindu-Other	6914	55.95	6838	55.34
	Muslim	2303	51.43	2278	50.87
	Sikh	4615	58.25	4566	57.63
	Non-Asian	66250	64.38	65892	64.03
	Total	82746	62.22	82216	61.82

Table A5.7: Geographical location of practices and GPs, and CRC screening uptake rates of Asian and Non-Asian populations in these locations														
Region	Location of Practice	Number of Practices			Number of Doctors			No. of Subjects (June 1, 2003)	No. of Subjects with ≥ 3 Months Follow-up			CRC Screening Uptake (% who return the kit)		
		Single	Group	All	Asian	Non-Asian	All		Asian	Non-Asian	All	Asian	Non-Asian	All
Coventry	**Coventry**	**22**	**46**	**68**	**60**	**111**	**171**	**63073**	**4411**	**37290**	**41701**	**32.69**	**62.01**	**58.91**
Rugby	**Rugby**	**0**	**12**	**12**	**5**	**40**	**45**	**19075**	**598**	**17428**	**18026**	**48.33**	**67.63**	**66.99**
South Warwickshire	**All**	**2**	**36**	**38**	**6**	**133**	**139**	**54170**	**1289**	**39591**	**40880**	**39.88**	**65.04**	**64.25**
	Alcester	0	3	3	2	4	6	1330	13	1257	1270	76.92	62.85	62.99
	Bidford on Avon	0	1	1		4	4	2630	17	2441	2458	58.82	64.93	64.89
	Harbury	0	1	1		3	3	1673	5	1591	1596	40.00	66.06	65.98
	Kenilworth	0	2	2		12	12	6290	46	5936	5982	47.83	70.86	70.68
	Kineton	0	1	1		2	2	813	6	756	762	16.67	55.82	55.51
	Leamington	0	9	9	2	33	35	14349	1062	12558	13620	38.61	64.09	62.11
	Shipston on Stour	0	1	1		7	7	2668		7	7		14.29	14.29
	Solihull	0	3	3		10	10	3680	9	1618	1627	44.44	65.02	64.90
	Southam	1	2	3		7	7	1474		13	13		46.15	46.15
	Stratford upon Avon	0	5	5		26	26	10057	25	6749	6774	44.00	64.90	64.82
	Studley	1	1	2		4	4	2083						
	Warwick	0	5	5	2	15	17	5963	98	5581	5679	39.80	61.96	61.58
	Wellesbourne	0	1	1		4	4	22	1	19	20	100.00	36.84	40.00
	Wolston	0	1	1		2	2	1138	7	1065	1072	57.14	69.86	69.78
North Warwickshire	**All**	**9**	**20**	**29**	**28**	**62**	**90**	**42592**	**772**	**31613**	**32385**	**36.27**	**61.88**	**61.27**
	Atherstone	1	1	2	3	5	8	3492	0	12	12		33.33	33.33
	Bedworth	3	3	6	8	9	17	8756	227	7398	7625	39.21	61.79	61.11
	Birmingham Coleshill	0	1	1		6	6	2605		1	1		0.00	0.00
	Bulkington	0	1	1		2	2	1125	7	1078	1085	57.14	66.33	66.27
	Kingsbury Birmingham	0	2	2		7	7	2486	16	2357	2373	50.00	66.06	65.95
	Nuneaton	5	10	15	15	26	41	19258	508	17085	17593	34.06	60.03	59.28
	Tamworth Birmingham	0	1	1	1	5	6	3309	11	3172	3183	27.27	62.33	62.21
	Water Orton	0	1	1	1	2	3	1561	3	510	513	100.00	94.51	94.54
All		**33**	**114**	**147**	**99**	**346**	**445**	**178910**	**7070**	**125922**	**132992**	**35.71**	**63.71**	**62.22**
Missing	(Moved-in & Finding a GP)							36						
Missing	(Without NHS ID)							359						
Grand Total								179305						

Table A5.8: Determinants of Uptake of Screening among Asian and Non-Asian Population							
Demographic/Ethnic/Geographical Factor		% Returned the Kit			Odds Ratio		
		Non-Asian	Asian	All	Non-Asian	Asian	All
Gender	Male	59.38	35.18	58.09	1	1	1
	Female	68.02	36.25	66.34	1.452	1.057@	1.428
Age	<55	58.48	32.29	56.86	1	1	1
	55-59	62.97	36.23	61.77	1.202	1.155*	1.199
	60-64	66.56	37.24	64.95	1.433	1.244	1.422
	>64	69.22	39.38	67.72	1.605	1.380	1.592
Invitation Time	July-Sept 2000	66.79	48.75	66.47	1	1	1
	Oct-Dec 2000	65.02	39.29	64.29	0.880	0.694@	0.876
	Jan-Mar 2001	65.15	47.11	64.82	0.923*	0.934@	0.925*
	Apr-June 2001	67.12	50.98	66.81	0.961@	1.038@	0.963@
	July-Sept 2001	63.76	40.18	62.75	0.797	0.775@	0.796
	Oct-Dec 2001	56.50	31.46	52.91	0.718	0.624*	0.719
	Jan-Mar 2002	56.90	28.79	51.98	0.792	0.617*	0.775
Religion of Subject	Hindu-Gujerati		42.63	42.63		1.186@	0.546
	Hindu-other		43.72	43.72		1.162@	0.541
	Muslim		31.87	31.87		0.855@	0.424
	Sikh		34.57	34.57		0.901@	0.414
	Other Asian		36.29	36.29		1	0.450
	Non Asian	63.71		63.71			1
Deprivation	1 & 2	69.53	46.79	69.02	1	1	1
	3	65.84	42.26	65.16	0.837	0.874@	0.838
	4	59.62	36.49	57.98	0.649	0.727	0.652
	5	50.55	32.40	48.72	0.451	0.653	0.461
	6 & 7	44.17	25.18	38.92	0.363	0.500	0.372
Religion of GP	Hindu-Gujerati	56.67	30.01	50.00	0.914*	0.770	0.880
	Hindu-other	58.96	32.82	55.95	0.952*	0.860**	0.942
	Muslim	54.89	30.44	51.43	0.814	0.861@	0.820
	Sikh	61.21	34.80	58.25	0.950*	0.889@	0.944*
	Non Asian	65.02	41.40	64.38	1	1	1
Type of Practice	Single handed	56.57	31.86	52.88	0.923	1.039@	0.948**
	Multiple	64.11	36.50	62.82	1	1	1
Location of Practice	Coventry	62.01	32.69	58.91	1	1	1
	Rugby	67.63	48.33	66.99	1.072	1.121@	1.083
	South Warwicks	65.04	39.88	64.25	0.903	0.970@	0.908
	North Warwicks	61.88	36.27	61.27	0.932	0.915@	0.936
All		63.71	35.71	62.22			
Number of Cases		125922	7070	132992			
Note:* indicates p<0.05; ** indicates p<0.10; @ indicates not significant; all the remaining, **unmarked coefficients are significant at p<0.01 level.**							

Table A5.9. Uptake of FOBt screening (split by gender and age) for Ethnicity Study sample and the Nottingham trial[1] (n,%)

	English Pilot [2]		Nottingham Trial †			
			Pilot and main study		Main study	
Age (years)	Men	Women	Men	Women	Men	Women
45-49						
50-54	-	-	471 (33.8)	575 (43.0)	37 (40.2)	49 (47.6)
55-59	10256 (52.2)	11926 (61.60	4119 (50.5)	4707 (58.6)	3631 (53.1)	4180 (62.1)
60-64	10914 (56.9)	12566 (66.7)	4192 (51.9)	4888 (59.2)	3760 (54.8)	4344 (62.0)
65-69	9052 (60.9)	10139 (69.0)	4100 (54.2)	4692 (57.7)	3727 (56.8)	4217 (60.7)
>70	8394 (65.6)	9499 (69.7)	3496 (54.0)	3967 (54.1)	3179 (56.8)	3634 (56.9)
	-	-	2422 (49.3)	3106 (47.4)	2226 (53.5)	2854 (50.9)
All	38616 (58.1)	44130 (66.3)	18800 (51.4)	21935 (55.3)	16560 (55.0)	19278 (58.8)
						16375 (60.5)

[1] Data from Final Report Main Evaluation; personal communication (S Moss) and Hardcastle et al, 1996
[2] Data are taken from a data download taken from the English Pilot site on 1/6/02; % returned kit

Appendix A6: Psychosocial Surveys

Table A6.1 Comparison of ethnic groups on measures of colorectal cancer risk factors.

	Hindu-Gujerati		Hindu-Other		Muslim		Sikh-Punjabi		White/European	
	Total N = 194		Total N = 87		Total N = 191		Total N = 311		Total N = 1170	
Proportion of people agreeing with each item.	**N**	**%[1]**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Exercise "Over a 7-day period during my leisure-time, I never/rarely engage in any regular activity long enough to work up a sweat.	66	37.3	29	36.3	65	38.2	111	40.2	441	39.9
Smoking "Yes, I am a smoker."	16	8.8 abc	8	10.0 de	24	13.5 afg	10	3.3 bdfh	282	24.7 cegh
Weight (assessed by BMI)										
Underweight	12	6.9	3	3.9	7	4.3	11	3.9	32	2.9
Desirable	65	37.6	40	51.9	64	39.8	127	45.0	401	36.8
Overweight/Obese	96	55.5 a	34	44.2 b	90	55.9	144	51.1 c	658	60.3 abc
Fibre Intake[2]										
Low	71	40.6	36	46.2	79	45.1	97	33.3	489	44.3
Moderate	46	26.3	19	24.4	42	24.0	74	25.4	363	32.9
High	58	33.1 a	23	29.5	54	30.9 bc	120	41.2 bd	253	22.9 acd
Fat Intake[2]										
Low	100	65.8 ab	31	49.2 c	81	52.9 a	155	65.1 cd	589	53.8 bd
Moderate	28	18.4	18	28.6	46	30.1	54	22.7	301	27.5
High	24	15.8	14	22.2	26	17.0	29	12.2	204	18.6
Family History										
"I know someone personally who has had bowel cancer."	29	15.6 ab	27	33.8 abc	30	16.9 bd	36	12.0 ce	419	36.8 bde
"A member of my family (a blood relative) has had bowel cancer."	9	4.9 ab	10	12.7 ac	10	5.7 d	14	4.7 ce	160	14.0 bde
Contraceptive Pill (% of Women only)	**N = 92**	**%**	**N = 42**	**%**	**N = 87**	**%**	**N = 167**	**%**	**N = 596**	**%**
Never/< 12 months	18	60.0 a	7	41.2 b	11	47.8 c	29	64.4 d	64	17.6
1-5 years	8	26.7	4	23.5	8	34.8	8	17.8	136	abcd
> than 5 years	4	13.3	6	35.3	4	17.4	8	17.8	163	37.5 44.9

[1] Figures indicate proportion endorsing each item.

[2] Fibre and fat intake was assessed by the DINE (Dietary Instrument for Nutrition Education- Roe, Strong, Whiteside, Neil, & Mant, 1994). The low fat category is designed to represent a fat intake of 83 g/day or less and the high fat category an intake greater than 122 g/day. The low fibre category is designed to correspond to a dietary fibre intake of 20 g/day or less, and the high fibre category to more than 30 g/day.

Table A6.2 Comparison of FOBt outcome groups on measures of colorectal cancer risk factors.

	Phase I Non-Responder		**Phase I Negative**	
	Total N = 155		**Total N = 628**	
Proportion of people agreeing with each item.	**N**	**%**	**N**	**%**
Exercise				
"Over a 7-day period during my leisure-time, I never/rarely engage in any regular activity long enough to work up a sweat.	68	49.6 a	203	35.9 a
Smoking				
"Yes, I am a smoker."	14	9.7	44	7.4
Weight (assessed by BMI)				
Underweight	7	5.3	26	4.6
Desirable	62	47.3	234	41.6
Overweight/Obese	62	47.3	302	53.7
Fibre Intake[2]				
Low	61	45.5	222	37.9
Moderate	33	18.2	148	25.3
High	40	29.9	215	36.8
Fat Intake[2]				
Low	69	60.0	298	60.7
Moderate	29	25.2	117	23.8
High	17	14.8	76	15.5
Family History				
"I know someone personally who has had bowel cancer."	8	5.4 a	114	19.2 a
"A member of my family (a blood relative) has had bowel cancer."	3	2.1 a	40	6.8 a
Contraceptive Pill (% of Women only)				
Never/< 12 months	10	62.5	55	55.6
1-5 years	5	31.3	23	23.2
> than 5 years	1	6.3	21	21.2

* % within a row sharing the same subscript differ significantly at $p < .05$

[2] Fibre and fat intake was assessed by the DINE (Dietary Instrument for Nutrition Education- Roe, Strong, Whiteside, Neil, & Mant, 1994). The low fat category is designed to represent a fat intake of 83 g/day or less and the high fat category an intake greater than 122 g/day. The low fibre category is designed to correspond to a dietary fibre intake of 20 g/day or less, and the high fibre category to more than 30 g/day.

Table A6.3 Comparison of FOBt outcome groups on specific items assessing perceived susceptibility to colorectal cancer.

	Phase I Non-Responder		Phase I Negative	
	N = 155		N = 628	
Proportion of people agreeing with each item.	**N**	**%**	**N**	**%**
"In comparison to other people my age, my chances of developing bowel cancer are high."	58	39.2	222	38.1
"I am at more of a risk of developing bowel cancer than other people my age."	68	48.2	279	48.4
"I think that my chances of developing bowel cancer are high."	32	22.1	122	20.9
"I feel personally at risk of developing bowel cancer."	52	34.4	224	37.8
"It is likely that I will develop bowel cancer."	48	32.4	160	28.0
"I agree that my chances of developing bowel cancer are very high."	48	32.2	156	26.9

Table A6.4 Comparison of ethnic groups on specific items assessing perceived susceptibility to colorectal cancer.

	Hindu-Gujerati		Hindu-Other		Muslim		Sikh-Punjabi	
	N = 194		N = 87		N = 191		N = 311	
Proportion of people agreeing with each item.	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
"In comparison to other people my age, my chances of developing bowel cancer are high."	64	35.2	27	33.3	75	42.4	114	39.3
"I am at more of a risk of developing bowel cancer than other people my age."	79	43.9 ab	37	46.8	102	59.0 a	152	53.3 b
"I think that my chances of developing bowel cancer are high."	36	19.6	16	19.5	41	23.4	61	21.2
"I feel personally at risk of developing bowel cancer."	73	39.2	33	39.8	56	30.9	114	38.9
"It is likely that I will develop bowel cancer."	55	30.9	19	23.5	54	31.2	80	27.9
"I agree that my chances of developing bowel cancer are very high."	48	26.	23	528.4	55	30.7	78	27.2

Table A6.5 Comparison of FOBt outcome groups on specific items assessing perceived severity of colorectal cancer

	Phase I Non-Responder		Phase I Negative	
	N = 155		N = 628	
Proportion of people agreeing with each item.	**N**	**%**	**N**	**%**
"I am certain that if I were to develop bowel cancer it would limit my community life."	105	69.5	439	72.1
"If I develop bowel cancer it is likely that my financial security would be at risk."	89	60.5	385	64.4
"I am certain that if I were to develop bowel cancer it would damage important relationships in my life."	75	49.7	333	55.0
"If I develop bowel cancer it is likely that I would have to stop living my life the way that I want to."	106	70.7	435	73.4
"If I develop bowel cancer I am certain that I would experience a lot of physical pain."	107	74.3	437	74.3
"If I develop bowel cancer I am certain that I would experience a lot of physical sickness."	99	69.7	427	73.0
"If I develop bowel cancer is it likely that I will die."	90	62.1	402	70.4
"If I develop bowel cancer, it could almost certainly cause my death."	79	55.6	344	59.5

Table A6.6 Comparison of ethnic groups on specific items assessing perceived severity of colorectal cancer.

	Hindu-Gujerati		Hindu-Other		Muslim		Sikh-Punjabi	
	N = 194		N = 87		N = 191		N = 311	
Proportion of people agreeing with each item.	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
"I am certain that if I were to develop bowel cancer it would limit my community life."	136	72.3	59	69.4	129	70.1	220	72.6
"If I develop bowel cancer it is likely that my finances would be at risk."	135	71.1 ab	55	67.1	105	58.0 a	179	61.3 b
"I am certain that if I were to develop bowel cancer it would damage important relationships in my life."	108	56.5	40	47.6	85	47.0 a	175	58.1 a
"If I develop bowel cancer it is likely that I would have to stop living my life the way that I want to."	133	71.1	63	78.8	133	74.3	212	71.4
"If I develop bowel cancer I am certain that I would experience a lot of physical pain."	144	78.7 a	64	78.0	133	74.7	203	70.3 a
"If I develop bowel cancer I am certain that I would experience a lot of physical sickness."	137	75.3	54	66.7	122	68.9	213	74.2
"If I develop bowel cancer, it is likely that I will die."	127	70.9	60	72.3	114	66.3	191	67.7
"If I develop bowel cancer, it could almost certainly cause my death."	96	53.0 a	44	55.7	103	59.5	180	62.7 a

* % within a row sharing the same subscript differ significantly at $p < .05$

Table A6.7 Comparison of FOBt outcome groups on specific items assessing the efficacy/benefits of performing FOBt.

	Phase I Non-Responder		Phase I Negative	
	N = 155		N = 628	
Proportion of people agreeing with each item.	**N**	**%**	**N**	**%**
"Doing an FOBt in the future would reduce my chances of dying from bowel cancer."	110	77.5	468	82.5
"Doing an FOBt in the future would help find any abnormalities I may have before they become cancerous."	121	86.4	499	90.9
"Doing an FOBt in the future would increase my chances of getting treatment earlier."	132	91.0	540	94.1
"Doing an FOBt in the future would help me avoid having to have drastic treatment if I had bowel cancer I didn't know about."	114	83.8 a	509	92.0 a
"Doing an FOBt in the future would put my mind at rest about bowel cancer."	120	83.3 a	518	92.2 a
"Doing an FOBt in the future would reduce any worries I might have about getting bowel cancer."	123	84.8	501	89.9
"Doing an FOBt in the future would increase my confidence about not getting bowel cancer."	121	84.6	481	86.0
"Doing an FOBt in the future would reduce any worries I might have about having any 'non-cancerous' abnormalities."	151	81.6	474	84.9

* % within a row sharing the same subscript differ significantly at $p < .05$

Table A6.8 Comparison of ethnic groups on specific items assessing the efficacy/benefits of performing an FOBt.

	Hindu-Gujerati		Hindu-Other		Muslim		Sikh-Punjabi	
	N = 194		N = 87		N = 191		N = 311	
Proportion of people agreeing with each item.	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
"Doing an FOBt in the future would reduce my chances of dying from bowel cancer."	129	73.7 abc	66	86.8 a	150	85.2 b	233	82.6 c
"Doing an FOBt in the future would help find any abnormalities I may have before they become cancerous."	153	89.5	70	92.1	153	90.0	244	89.7
"Doing an FOBt in the future would increase my chances of getting treatment earlier."	172	94.5	76	96.2	164	94.3	260	91.5
"Doing an FOBt in the future would help me avoid having to have drastic treatment if I had bowel cancer I didn't know about."	152	89.9	69	92.0	154	90.1	248	90.5
"Doing an FOBt in the future would put my mind at rest about bowel cancer."	159	89.8	70	90.9	158	90.3	251	90.6
"Doing an FOBt in the future would reduce any worries I might have about getting bowel cancer."	148	84.6 a	67	88.2	160	92.5 a	249	89.6
"Doing an FOBt in the future would increase my confidence about not getting bowel cancer."	137	79.7 a	67	88.2	156	90.2 a	242	86.1
"Doing an FOBt in the future would reduce any worries I might have about having any 'non-cancerous' abnormalities."	139	79.9 a	65	86.7	144	82.8	241	87.3 a

* % within a row sharing the same subscript differ significantly at $p < .05$

Table A6.9 Comparison of FOBt outcome groups on specific items assessing confidence in performing an FOBt.

	Phase I Non-Responder		Phase I Negative	
	N = 155		N = 628	
Proportion of people agreeing with each item.	**N**	**%**	**N**	**%**
"If I am invited to do an FOBt in the future, I could easily do it if I wanted to."	110	71.9 a	582	93.9 a
"If I am invited to do a bowel cancer screening test in the future, I have control over whether or not I do it."	123	82.0 a	570	92.8 a
"If I am invited to do an FOBt in the future, it is easy for me to do it."	89	58.9 a	549	89.0 a
"If I am invited to do an FOBt in the future, it is entirely up to me whether I do it or not."	135	91.8	556	93.3
"If I am invited to do an FOBt in the future, I am certain that I could do it."	107	70.4 a	550	90.0 a
"If I am invited to do an FOBt in the future, I am capable of doing it."	118	76.6 a	558	92.2 a
"If I am invited to do an FOBt in the future, I would feel very confident in my ability to do it."	106	70.2 a	544	90.8 a
"If I am invited to do an FOBt in the future, I believe that I would be able to do it."	114	76.0 a	553	92.2 a

* % within a row sharing the same subscript differ significantly at $p < .05$

Table A6.10 Comparison of ethnic groups on specific items assessing confidence in performing an FOBt.

	Hindu-Gujerati		Hindu-Other		Muslim		Sikh-Punjabi	
	N = 194		N = 87		N = 191		N = 311	
Proportion of people agreeing with each item.	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
"If I am invited to do an FOBt in the future, I could easily do it if I wanted to."	171	88.1	81	94.2 a	160	86.0 a	280	91.2
"If I am invited to do a bowel cancer screening test in the future, I have control over whether or not I do it."	16	87.9	779	94.0	172	93.0	275	90.2
"If I am invited to do an FOBt in the future, it is easy for me to do it."	156	81.3	77	89.5 a	148	79.1 a	257	84.8
"If I am invited to do an FOBt in the future, it is entirely up to me whether I do it or not."	173	92.5	73	90.1	168	91.3	277	95.2
"If I am invited to do an FOBt in the future, I am certain that I could do it."	161	85.2	76	90.5	157	83.5	263	87.1
"If I am asked to do an FOBt in the future, I am capable of doing it."	166	89.2	78	94.0	163	86.2	269	89.4
"If I am invited to do an FOBt in the future, I would feel very confident in my ability to do it."	161	86.6	78	94.0 a	150	82.0 a	261	87.6
"If I am invited to do an FOBt in the future, I believe that I would be able to do it."	168	90.3	76	91.6	154	83.7 a	269	90.6 a

* % within a row sharing the same subscript differ significantly at $p < .05$

Table A6.11 Comparison of FOBt outcome groups on specific items assessing difficulties in performing FOBt.

	Phase I Non-Responder		Phase I Negative	
	N = 155		N = 628	
Proportion of people agreeing with each item.	**N**	**%**	**N**	**%**
"Constipation is likely to stop me from doing an FOBt if I am asked to do one in the future."	62	46.6 a	183	33.2 a
"Physical disability is likely to stop me from doing an FOBt if I am asked to do one in the future."	53	38.4	188	34.2
"Visual impairment is likely to stop me from doing an FOBt if I am asked to do one in the future."	44	32.6	145	27.1
"Irregular bowel movements are likely to stop me from doing an FOBt if I am asked to do one in the future."	50	37.0 a	129	23.9 a
"Diarrhoea is likely to stop me from doing an FOBt if I am asked to do one in the future."	59	43.4	188	34.8
"Current treatment for bowel cancer is likely to stop me from doing an FOBt if I am asked to do one in the future."	36	29.5	142	28.2
"Other bowel disease is likely to stop me from doing an FOBt if I am asked to do one in the future."	37	29.1	122	24.0
"Other illness is likely to stop me from doing an FOBt if I am asked to do one in the future."	41	32.0 a	112	22.1 a
"Lack of time is likely to stop me from doing an FOBt if I am asked to do one in the future."	36	27.3 a	93	17.5 a
"Having no where to store the test is likely to stop me from doing an FOBt if I am asked to do one in the future."	46	34.8 a	103	19.5 a

* % within a row sharing the same subscript differ significantly at $p < .05$

Table A6.12 Comparison of ethnic groups on specific items assessing difficulties in performing an FOBt.

	Hindu-Gujerati		Hindu-Other		Muslim		Sikh-Punjabi	
	N = 194		N = 87		N = 191		N = 311	
Proportion of people agreeing with each item.	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
"Constipation is likely to stop me from doing an FOBt if I am asked to do one in the future."	66	37.5	23	29.9	58	35.4	98	36.7
"Physical disability is likely to stop me from doing an FOBt if I am asked to do one in the future."	73	41.5 ab	18	24.3 a	53	31.4 b	97	36.1
"Visual impairment is likely to stop me from doing an FOBt if I am asked to do one in the future."	55	32.5 a	13	17.8 ab	44	26.2	77	29.5 b
"Irregular bowel movements are likely to stop me from doing an FOBt if I am asked to do one in the future."	48	27.9	14	18.9	43	25.7	74	28.2
"Diarrhoea is likely to stop me from doing an FOBt if I am asked to do one in the future."	63	36.2	26	34.2	62	37.3	96	36.8
"Current treatment for bowel cancer is likely to stop me from doing an FOBt if I am asked to do one in the future."	57	35.4 ab	22	31.9	37	24.8 a	62	25.1 b
"Other bowel disease is likely to stop me from doing an FOBt if I am asked to do one in the future."	58	34.9 ab	17	24.6	35	22.6 a	49	20.0 b
"Other illness is likely to stop me from doing an FOBt if I am asked to do one in the future."	44	27.3	14	20.0	44	27.5	51	21.0
"Lack of time is likely to stop me from doing an FOBt if I am asked to do one in the future."	38	22.5	14	18.7	35	21.2	42	16.5
"Having no where to store the test is likely to stop me from doing an FOBt if I am asked to do one in the future."	45	26.5	11	15.1	39	24.1	54	21.1

* % within a row sharing the same subscript differ significantly at $p < .05$

Table A6.13 Comparison of FOBt outcome groups on specific items assessing the psychological costs of performing an FOBt.

	Phase I Non-Responder		Phase I Negative	
	N = 155		N = 628	
Proportion of people agreeing with each item.	**N**	**%**	**N**	**%**
"Doing an FOBt in the future would be an invasion of my privacy."	74	54.4 a	168	29.9 a
"Doing an FOBt in the future would be embarrassing."	92	66.7 a	204	36.5 a
"Doing an FOBt in the future would be disgusting."	78	58.2 a	182	33.5 a
"Doing an FOBt in the future would be unhygienic."	75	55.6 a	183	33.6 a
"Doing an FOBt in the future would lead to unpleasant treatment if abnormalities were present."	98	73.1 a	344	62.0 a
"Doing an FOBt in the future would lead to me having to go to hospital if abnormalities were present."	104	78.2	417	75.8
"Doing an FOBt in the future would lead to blood being found in my bowel motion if abnormalities were present."	95	72.5	389	70.3

* % within a row sharing the same subscript differ significantly at $p < .05$

Table A6.14 Comparison of ethnic groups on specific items assessing the psychological costs of performing an FOBt.

	Hindu- Gujerati		Hindu-Other		Muslim		Sikh-Punjabi	
	N = 194		N = 87		N = 191		N = 311	
Proportion of people agreeing with each item.	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
"Doing an FOBt in the future would be an invasion of my privacy."	65	37.8	24	32.0	58	33.3	95	34.4
"Doing an FOBt in the future would be embarrassing."	84	47.5	31	39.7	70	40.9	111	41.0
"Doing an FOBt in the future would be disgusting."	77	44.3 ab	23	30.7 a	55	32.9 b	105	40.1
"Doing an FOBt in the future would be unhygienic."	72	41.9 a	25	33.3	53	31.4 ab	108	54.1 b
"Doing an FOBt in the future would lead to unpleasant treatment if abnormalities were present."	111	63.1	51	68.9	112	66.7	168	62.0
"Doing an FOBt in the future would lead to me having to go to hospital if abnormalities were present."	130	74.7	65	85.5 a	124	73.4 a	202	76.5
"Doing an FOBt in the future would lead to blood being found in my bowel motion if abnormalities were present."	122	69.7	58	74.4	112	68.3	192	71.9

* % within a row sharing the same subscript differ significantly at $p < .05$

Table A6.15 Comparison of FOBt outcome groups on specific items assessing the social influences on performing an FOBt.

	Phase I Non-Responder		Phase I Negative	
	N = 155		N = 628	
Proportion of people agreeing with each item.	**N**	**%**	**N**	**%**
"My partner is likely to want me to do an FOBt in the future."	105	81.4 a	471	88.2 a
"My children are likely to want me to do an FOBt in the future."	99	74.4 a	446	85.6 a
"My doctor is likely to want me to do an FOBt in the future."	109	84.5	479	90.4
"My friends are likely to want me to do an FOBt in the future."	90	73.8	398	77.7
"My community leaders are likely to want me to do an FOBt in the future."	75	64.1	328	68.9

* % within a row sharing the same subscript differ significantly at $p < .05$

Table A6.16 Comparison of ethnic groups on specific items assessing social influences on performing an FOBt.

	Hindu-Gujerati		Hindu-Other		Muslim		Sikh-Punjabi	
	N = 194		N = 87		N = 191		N = 311	
Proportion of people agreeing with each item.	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
"My partner is likely to want me to do an FOBt in the future."	138	80.7 ab	63	90.0	143	89.9 a	232	88.2 b
"My children are likely to want me to do an FOBt in the future."	120	73.6 abc	64	91.4 a	134	85.4 b	227	86.0 c
"My doctor is likely to want me to do an FOBt in the future."	134	81.2 abc	67	93.1 a	148	91.4 b	239	91.9 c
"My friends are likely to want me to do an FOBt in the future."	103	66.0 abc	57	81.4 a	125	80.1 b	203	80.6 c
"My community leaders are likely to want me to do an FOBt in the future."	91	60.7 a	47	72.3	98	69.0	167	70.8 a

* % within a row sharing the same subscript differ significantly at $p < .05$

Table A6.17 Comparison of Asian and Non-Asian FOBt outcome groups on specific items assessing perceived susceptibility to colorectal cancer.

	Phase I Non-Respond – Ethnic Sample		Phase I Negative – Ethnic Sample		Phase I Non-Respond – White/European		Phase I Negative – White/European	
	N = 155		N = 628		N = 473		N = 697	
Proportion of people agreeing with each item.	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
"In comparison to other people my age, my chances of developing bowel cancer are high."	58	39.2 a	222	38.1 bc	250	57.2 abd	315	47.5 cd
"I am at more of a risk of developing bowel cancer than other people my age."	73	51.8 ab	297	51.6 cd	315	72.2 ac	432	67.7 bd
"I think that my chances of developing bowel cancer are high."	32	22.1 ab	122	20.9 cd	172	39.5 ac	223	34.0 bd
"I feel personally at risk of developing bowel cancer."	52	34.4	224	37.8	176	39.1	276	41.3
"It is likely that I will develop bowel cancer."	48	32.4	160	28.0 ab	142	35.4 a	203	33.6 b
"I agree that my chances of developing bowel cancer are very high."	48	32.3 a	156	26.9 bc	176	41.0 b	275	42.6 ac

* % within a row sharing the same subscript differ significantly at $p < .05$

Table A6.18 Comparison of Asian and Non-Asian FOBt outcome groups on specific items assessing perceived severity to colorectal cancer.

	Phase I Non-Respond – Ethnic Sample		Phase I Negative – Ethnic Sample		Phase I Non-Respond – White/European		Phase I Negative – White/European	
	N = 155		N = 628		N = 473		N = 697	
Proportion of people agreeing with each item.	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
"I am certain that if I were to develop bowel cancer it would limit my community/social life."	105	69.5 a	439	72.1 b	363	77.6 abc	488	71.1 c
"If I develop bowel cancer it is likely that my finances/financial security would be at risk."	89	60.5 a	385	64.4	321	69.3 ab	430	62.5 b
"I am certain that if I were to develop bowel cancer it would damage important relationships in my life."	75	49.7	333	55.0 a	259	55.7 b	336	49.1 ab
"If I develop bowel cancer it is likely that I would have to stop living my life the way that I want to."	106	70.7	435	73.4	355	76.8	507	74.9
"If I develop bowel cancer I am certain that I would experience a lot of physical pain."	107	74.3 a	437	74.3 bc	313	68.5 bd	385	57.9 acd
"If I develop bowel cancer I am certain that I would experience a lot of physical sickness."	99	69.7 a	427	73.0 bc	285	63.6 bd	359	54.9 acd
"If I develop bowel cancer, it is likely that I will die."	90	62.1 ab	402	70.4 c	358	80.1 acd	472	72.5 bd
"If I develop bowel cancer, it could almost certainly cause my death."	79	55.6	344	59.5 a	260	59.1	343	53.2 a

* % within a row sharing the same subscript differ significantly at $p < .05$

Table A6.19 Comparison of Asian and Non-Asian FOBt outcome groups on specific items assessing the efficacy/benefits of performing an FOBt.

	Phase I Non-Respond – Ethnic Sample		Phase I Negative – Ethnic Sample		Phase I Non-Respond – White/European		Phase I Negative – White/European	
	N = 155		N = 628		N = 473		N = 697	
Proportion of people agreeing with each item.	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
"Doing an FOBt in the future would reduce my chances of dying from bowel cancer."	110	77.5 ab	468	82.5 c	380	86.4 ad	592	90.4 bcd
"Doing an FOBt in the future would help find any abnormalities I may have before they become cancerous."	121	86.4 ab	499 cd	90.9	425	96.8 ac	647	96.4 bd
"Doing an FOBt in the future would increase my chances of getting treatment earlier."	132	91.0 a	540	94.1 b	412	93.8 c	653	98.0 abc
"Doing an FOBt in the future would help me avoid having to have drastic treatment if I had bowel cancer I didn't know about."	114	83.8 abc	509	92.0 ad	415	94.3 b	633	96.1 cd
"Doing an FOBt in the future would put my mind at rest about bowel cancer."	120	83.3 abc	518	92.2 ad	397	91.3 be	651	97.6 cde
"Doing an FOBt in the future would reduce any worries I might have about getting bowel cancer."	123	84.8 a	501	89.9 b	391	89.5 c	629	95.7 abc
"Doing an FOBt in the future would increase my confidence about not getting bowel cancer."	121	84.6 a	481	86.0 b	386	88.7 c	628	94.7 abc
"Doing an FOBt in the future would reduce any worries I might have about having any 'non-cancerous' abnormalities."	115	81.6 ab	474	84.9 c	384	88.3 ad	618	93.6 bcd

* % within a row sharing the same subscript differ significantly at $p < .05$

Table A6.20 Comparison of Asian and Non-Asian FOBt outcome groups on specific items assessing confidence in performing an FOBt.

	Phase I Non-Respond – Ethnic Sample		Phase I Negative – Ethnic Sample		Phase I Non-Respond – White/European		Phase I Negative – White/European	
	N = 155		N = 628		N = 473		N = 697	
Proportion of people agreeing with each item.	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
"If I am invited to do an FOBt in the future, I could easily do it if I wanted to."	110	71.9 ab	582	93.9 acd	370	79.1 ce	686	99.3 bde
"If I am invited to do a bowel cancer screening test in the future, I have control over whether or not I do it."	123	82.0 abc	570	92.8 ad	440	94.0 be	677	98.0 cde
"If I am invited to do an FOBt in the future, it is easy for me to do it."	89	58.9 abc	549	89.0 ade	326	69.9 bdf	679	98.0 cef
"If I am invited to do an FOBt in the future, it is entirely up to me whether I do it or not."	135	91.8 ab	556	93.3 cd	447	97.8 ac	659	98.4 bd
"If I am invited to do an FOBt in the future, I am certain that I could do it."	107	70.4 ab	550	90.0 acd	333	71.6 ce	665	96.4 bde
"If I am invited to do an FOBt in the future, I am capable of doing it."	118	76.6 abc	558	92.2 ade	394	85.3 bdf	659	96.3 cef
"If I am invited to do an FOBt in the future, I would feel very confident in my ability to do it."	106	70.2 ab	544	90.8 acd	351	76.0 ce	663	98.4 bde
"If I am invited to do an FOBt in the future, I believe that I would be able to do it."	114	76.0 ab	553	92.2 acd	366	80.1 ce	654	97.3 bde

* % within a row sharing the same subscript differ significantly at $p < .05$

Table A6.21 Comparison of Asian and Non-Asian FOBt outcome groups on specific items assessing difficulties in performing an FOBt.

	Phase I Non-Respond – Ethnic Sample		Phase I Negative – Ethnic Sample		Phase I Non-Respond – White/European		Phase I Negative – White/European	
	N = 155		N = 628		N = 473		N = 697	
Proportion of people agreeing with each item.	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
"Constipation is likely to stop me from doing an FOBt if I am asked to do one in the future."	62	46.6 abc	183	33.2 ad	124	29.9 be	120	18.5 cde
"Physical disability is likely to stop me from doing an FOBt if I am asked to do one in the future."	53	38.4 ab	188	34.2 cd	95	23.2 ace	113	17.1 bde
"Visual impairment is likely to stop me from doing an FOBt if I am asked to do one in the future."	44	32.6 ab	145	27.1 cd	64	15.9 ac	97	14.7 bd
"Irregular bowel movements are likely to stop me from doing an FOBt if I am asked to do one in the future."	50	37.0 abc	129	23.9 ad	98	23.7 be	63	9.4 cde
"Diarrhoea is likely to stop me from doing an FOBt if I am asked to do one in the future."	59	43.4 ab	188	34.8 c	122	30.0 ad	142	21.8 bcd
"Current treatment for bowel cancer is likely to stop me from doing an FOBt if I am asked to do one in the future."	36	29.5	142	28.2	98	25.1	149	23.2
"Other bowel disease is likely to stop me from doing an FOBt if I am asked to do one in the future."	37	29.1 a	122	24.0 b	89	22.6 c	87	13.6 abc
"Other illness is likely to stop me from doing an FOBt if I am asked to do one in the future."	41	32.0 abc	112	22.1 ad	78	19.6 be	55	8.5 cde
"Lack of time is likely to stop me from doing an FOBt if I am asked to do one in the future."	36	27.3 ab	93	17.5 acd	95	23.5	20 ce	3.0 bde
"Having no where to store the test is likely to stop me from doing an FOBt if I am asked to do one in the future."	46	34.8 abc	103	19.5 ad	75	18.5 be	23	3.5 cde

* % within a row sharing the same subscript differ significantly at $p < .05$

Table A6.22 Comparison of Asian and Non-Asian FOBt outcome groups on specific items assessing the psychological costs of performing an FOBt.

	Phase I Non-Respond – Ethnic Sample		Phase I Negative – Ethnic Sample		Phase I Non-Respond – White/European		Phase I Negative – White/European	
	N = 155		N = 628		N = 473		N = 697	
Proportion of people agreeing with each item.	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
"Doing an FOBt in the future would be an invasion of my privacy."	74	54.4 abc	168	29.9 ad	145	34.0 be	70	10.8 cde
"Doing an FOBt in the future would be embarrassing."	92	66.7 abc	204	36.5 ade	216	50.0 bdf	118	18.4 cef
"Doing an FOBt in the future would be disgusting."	98	73.1 ab	344	62.0 ac	311	74.2 cd	387	61.3 bd
"Doing an FOBt in the future would be unhygienic."	78	58.2 abc	182	33.5 ad	149	35.9 be	94	14.9 cde
"Doing an FOBt in the future would lead to unpleasant treatment if abnormalities were present."	75	55.6 abc	183	33.6 ad	121	29.5 be	80	12.7 cde
"Doing an FOBt in the future would lead to me having to go to hospital if abnormalities were present."	104	78.2	417	75.8 ab	363	85.0 a	527	80.8 b
"Doing an FOBt in the future would lead to blood being found in my bowel motion if abnormalities were present."	95	75.2	389	70.3 a	327	77.3 a	476	74.0

* % within a row sharing the same subscript differ significantly at $p < .05$

Table A6.23 Comparison of Asian and Non-Asian FOBt outcome groups on specific items assessing the social influences on of performing an FOBt.

	Phase I Non-Respond – Ethnic Sample		Phase I Negative – Ethnic Sample		Phase I Non-Respond – White/European		Phase I Negative – White/European	
	N = 155		N = 628		N = 473		N = 697	
Proportion of people agreeing with each item.	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
"My partner is likely to want me to do an FOBt in the future."	105	81.4 ab	471	88.2 acd	313	82.6 ce	555	96.7 bde
"My children are likely to want me to do an FOBt in the future."	99	74.4 abc	446	85.6 ad	320	84.7 be	546	94.6 cde
"My doctor is likely to want me to do an FOBt in the future."	109	84.5 a	479	90.4 b	354	89.4 c	601	96.8 abc
"My friends are likely to want me to do an FOBt in the future."	90	73.8 a	398	77.7 c	314 d	81.1	542	88.7 acd
"My community leaders are likely to want me to do an FOBt in the future."	75	64.1	328	68.9	-	-	-	-

* % within a row sharing the same subscript differ significantly at $p < .05$

Table A6.24 Comparison of Asian and Non-Asian FOBt outcome groups on specific items assessing future intentions to perform an FOBt.

	Phase I Non-Respond – Ethnic Sample		Phase I Negative – Ethnic Sample		Phase I Non-Respond – White/European		Phase I Negative – White/European	
	N = 155		N = 628		N = 473		N = 697	
Proportion of people agreeing with each item.	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
"If I am invited to do an FOBt in the future, I intend to do it."	114	75.5 ab	571	92.1 acd	333	72.1 ce	682	98.4 bde
"If I am invited to do an FOBt in the future, I will try to do the test."	127	82.5 ab	578	93.2 acd	364	77.9 ce	675	98.3 bde
"If I am invited to do an FOBt in the future, I would be willing to do it."	115	78.8 ab	541	89.9 acd	344	75.6 ce	651	96.7 bde
"If I am invited to do an FOBt in the future, it is likely that I will do the test."	112	74.7 ab	553	89.8 acd	336	72.4 ce	662	96.1 bde

* % within a row sharing the same subscript differ significantly at $p < .05$

Table A6.25 Invitees overall evaluation of screening for bowel cancer by ethnic group.

	Hindu-Gujerati		Hindu-Other		Muslim		Sikh-Punjabi		White/European		Total
	N = 194		N = 87		N = 191		N = 311		N = 1170		
Proportion of people agreeing with each item.	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**
Yes, FOBt should be offered	162	90.5	80	97.6	166	91.7	281	96.6	1101	95.8	1790
No, FOBt should not be offered	17	9.5 abc	2	2.4 a	15	8.3 de	10	3.4 bd	34	4.2 ce	78
Total	179	9.6	82	4.4	181	9.7	291	15.6	1135	60.7	1868

* % within a row sharing the same subscript differ significantly at $p < .05$

Table A6.26 Psychological distress up to 24 months after first FOBt screening invitation.

	HADS Depression			HADS Anxiety			STAI -Anxiety			STAI-Anger		
	N	Mean	Sd	N	Mean	Sd	N	Mean	Sd	N	Mean	Sd
All Questionnaire Respondents	705	5.03	3.74	707	6.68	4.34	498	35.92	11.54	575	9.12	3.96
Group												
Phase I Non-Responder	138	6.43 a	3.95	143	7.66 a	4.31	92	39.14 a	11.80	105	9.34	3.75
Phase I Negative	567	4.69 a	3.60	564	6.43 a	4.31	406	35.19 a	11.37	470	9.07	4.01
Ethnic Group												
Hindu- Gujerati	180	5.00	3.74	179	6.62	4.29	57	36.36	11.28	146	9.61 a	3.95
Hindu- Other	80	4.01 a	3.28	80	5.50 a	3.86	133	34.43	12.06	67	9.04	4.14
Muslim	169	4.65	3.63	169	6.08 b	4.22	125	33.49 a	10.87	139	8.07 ab	3.07
Sikh-Punjabi	276	5.58 a	3.84	279	7.41 ab	4.45	183	37.73 a	11.75	223	9.48 b	4.30
Gender												
Female	345	5.52 a	3.95	347	7.40 a	4.51	227	37.03 a	12.16	266	9.51 a	4.34
Male	360	4.56 a	3.46	360	5.98 a	4.05	271	35.00 a	10.94	309	8.79 a	3.59
Deprivation Category												
Depcat ½	86	4.38 a	3.75	87	6.39	4.38	64	34.56	12.30	71	8.66	3.58
Depcat 3	82	4.62	3.12	86	6.76	3.83	64	34.45	10.32	71	8.39	3.41
Depcat 4	182	4.47 b	3.57	184	5.92 a	4.24	129	34.61	11.16	149	8.93	3.63
Depcat 5	106	5.00	3.65	106	6.76	4.40	82	37.84	12.10	92	9.48	4.23
Depcat 6/7	236	5.87 ab	4.02	232	7.30 a	4.49	150	37.24	11.39	183	9.53	4.30
Population Norms												
Female	-	-	-	-	-	-	106	32.02	8.67	-	-	-
Male	-	-	-	-	-	-	382	34.51	10.34	-	-	-
(*Spielberger et al., 1983)*												
Comparison With Main Study Groups	**N =**	**Mean**	**Sd**	**N =**	**Mean**	**Sd**	**N =**	**Mean**	**Sd**	**N =**	**Mean**	**Sd**
Phase I Non-Responder (Asian)	**1953**	6.43 abc	3.95	**1953**	7.66 abc	4.31	**1953**	39.14 abc	11.80	**1953**	9.34 ab	3.75
Phase I Negative (Asian)	138	4.69 ad	3.60	143	6.43 a	4.31	92	35.19 a	11.37	105	9.07 cd	4.01
Phase I Non-Responder (White/European)	567	4.09 bde	3.48	564	6.53 b	4.43	406	33.22 b	10.52	470	7.61 ac	2.93
Phase I Negative (White/European)	454	3.77 ce	3.18	455	6.36 c	4.15	352	33.31 c	10.72	402	7.22 bd	2.31
	655			652			534			598		
Breast Cancer Screening Studies												
1) 8-10 weeks post breast screening – clear result	102	2.54	2.97	102	2.93	2.75	-	-	-	-	-	-
8-10 weeks post breast screening – false positive result	65	2.80	3.93	66	4.29	3.68	-	-	-	-	-	-
Control group – women aged 50-69 yet to be screened	226	3.13	3.10	226	4.27	3.54	-	-	-	-	-	-
(*Scaf-Klomp et al., 1997)*												
2) 6 weeks post breast screening – clear result	104	4.23	-	-	-	-	103	4.43	-	-	-	-
6 weeks post breast screening – false positive 1	202	4.25	-	-	-	-	202	4.32	-	-	-	-
6 weeks post breast screening – false positive 1	49	3.82	-	-	-	-	49	4.27	-	-	-	-
(*Bull & Campbell, 1991)*												

* Means within a column sharing the same subscript differ significantly at $p < .05$

Appendix A7: Focus Groups

A7 Focus Group Responses

As a general rule, there was (at least theoretical) support and even enthusiasm for the principle of screening among most minority ethnic communities. Few people, once the principle had been explained, thought that there was, or should be, a problem with completing the test. Many suggested that 'doing it at home' was a more convenient and acceptable method than having to report to a hospital. However, at the same time, it was clear that many members of minority groups would not respond to postal invitations unless prior warning had been given and community-relevant sources had alerted them to the value of the activity. Low levels of literacy meant low awareness or reliance on others (such as children) to advise about postal material, and some said that their children protected them against intrusive surveys and the like. We did not find the anticipated level of resistance to FOBt screening on the grounds of hygiene or religion, although there were some questions about 'storage'.

It became apparent during the course of reviewing the focus group transcripts that, in general, there were fewer differences between the 'ethnic groups' involved than between groups which contained someone who was relatively well-educated or had been affected by a family member (or personal) experience of cancer, and those which were less well informed. Clearly, there were points at which 'ethnic-specific' culturally linked responses were made, but as a general rule, there was a considerable degree of consistency between the groups in the way they discussed the issues. We have therefore presented the results according to the themes of the discussions.

At the start, reactions tended to be fairly general, and almost formulaic: 'All diseases are no good. May God save everyone from any disease' (Leics. Urdu Females). As discussion developed, and confidence grew, more knowledge was revealed and sometimes experience (or information about relatives) was shared, leading to deeper discussion. It was also, in nearly every case, an opportunity for education and most of the groups asked the facilitators questions, and were grateful for the distribution of leaflets and (in some groups) a short presentation about the disease. Interestingly, at times members of the group began to evince a consensus and to seek to educate or convince 'recalcitrant' (or 'less progressive') colleagues and to argue in favour of the screening programme. This courtesy bias is a well-known feature of such discussions, especially working with members of South Asian and Far-Eastern cultures, but hopefully reflects a genuine belief within the communities in the benefits of modern medical practice, and is a possible way forward in enhancing future response to invitations to screening. It also illustrates clearly the likelihood that inaction is a probable response in the absence of active support, rather than outright refusal.

A7.1 Knowledge (and fear) of cancer and bowel disease in general

In nearly every community there was some prior knowledge about 'cancer', and agreement that this was a fearsome and probably inexorable disease with fatal consequences, which had many forms and could attack different parts of the body. There were many obvious misunderstandings – some of which might be seen to reflect real experiences – such as the observation that 'cancer of the blood' can 'destroy the beard and hair', presumably based on knowing of people who had lost hair following chemotherapy. Some groups described the way in which cancer happened in some detail, albeit phrased in ways which made sense to themselves: others described the fear of cancer as being in many ways similar, and as dangerous:

> 'Cancer is very dangerous, the patient has to endure a lot of difficulties (LUF1)
>
> 'The word cancer – this we are very afraid. If anyone has cancer he would be afraid to tell anyone else that he has cancer (LHM)
> 'that is a dangerous thing, anuff people that thing lick down (CAM)
>
> 'The name cancer itself is an issue of fear. Once if you have cancer it spread like the roots of bamboo, once it spread in the vein how come people survive? It is not possible for doctor to save people (BBMa)

Indeed, an early reaction was that the patient with cancer was in God's hands, and that death was possibly inevitable:

> 'The name cancer is frightening. I believe that 100% people read '*inna lillahi wa inna ilaihi raziun'* – on hearing the name cancer, it makes the body shaken (BBMb) [The Arabic phrase means 'Verily we belong to Allah and unto him is our return', and is routinely recited when hearing of the death of a Muslim or any other sad event]
>
> One person mentioned a saying in Bengali: 'Who have cancer, he have no answer' (BBMa)

However, a few people were able in some of our groups to challenge the consensus, and it is evident that knowledge is spreading and attitudes changing:

> 'It's a terminal illness that is incurable (#1)' … 'I don't think so. That is how we used to think – you know, it was like if you had cancer you were the untouchables and you were going to die. Nowadays that is not the case. (#2 – health care advice worker)' … 'And also at what stage it is discovered … (#3 – former nurse)' (LHF)

That said, it was clear that the majority were aware that there is a natural history of cancer, which implies at least that an early recognition and detection may lead to better outcomes. In this sense, cancer is seen as having similarities with infectious diseases, and as having the possibility of appearing in any part of the body and spreading through it:

> 'The place become a wound – from infection a place becomes wound and then it spread. It develop gradually and it is connected with blood; once it becomes in touch with blood then it is serious – cancer grab the blood and reduced peoples blood … Cancer carry a disease and tumour melt and spread (BBMa)

> 'A kind of wound, the place becomes rotted. It cannot be cured by the medicine. This can be in the peoples throat, in the intestine, in the liver, in the anus or any part of skin. It can be inside the bone. It can be in the blood (BBMb)

There was clearly a consensus that cancer was a hard thing to discuss, and some discussion as to whether there was a word for it in their own languages: one (Punjabi) group thought that there was not, while another offered 'nasoor' (Urdu) or 'mogli phora' (Punjabi). The English word was probably at least as familiar, although there was much less awareness of other technical terms. The most common description or reference was to a 'lump' or 'boil', and one Vietnamese respondent said 'cancer means having a lump in your bowel' – although the general impression was that few people knew of bowel or colorectal cancer: blood, breast (especially among women), liver and lung cancers were more commonly mentioned. Again, among the Vietnamese, a group member said that there were two types of cancer: benign and malignant, although it was not clear that the significance of these terms was understood. As discussion developed, many people recounted friends or family who had suffered from finding a 'lump' and then (usually) had died.

> '(My) sister in law had breast cancer then she developed lump in her arm, it burst and she died – (member wanted to know) if it was linked to cancer (LUF1) [*In this case, the facilitator replied that 'as I have no medical knowledge I cannot say but it may be possible that she had secondaries'*].

> It had (Name) the other day, and dem cut out some of the side of im belly, is a bad thing (CAM)

> 'My own daughter I have lost through cancer, 25 years ago. She had a tumour only when she was 4. She was in this country for just one year – we came from Uganda … it still upsets me even today (LHM)

There was virtually no knowledge of, or reference to, other forms of bowel disease, at least at the earlier stages of the discussion groups. This was to change as the meetings developed as a result of information sharing and relaxing among group members.

> I didn't bother before, I had a friend who found out that he had something similar called 'colietis', and it was detected early because of this (*the FOBt Screening Programme in Coventry*) (CAF1)

> 'My dad has bowel cancer. He is not the sort of person who likes going to the doctor. He can take a lot of pain and he would have to die before he would go to see the doctor… (LHF)

Many of the discussion groups at this point began to recount tales of friends of family members who had adverse experiences of cancer, usually then commenting on the (poor) response of the doctors they had used, but making the point in the process that they were aware that earlier recognition and action might have led to better outcomes:

> '(my) 40-year-old nephew complained of chest pain, had rash, when really bad his arm was bloated and nails were bleeding … it was cancer (LUF1)

'(My) wife died of cancer. Was diagnosed late and she was not told everything – feel very bitter about this. Before, they used to tell the family and not the patient. My wife really suffered – the doctors did not tell us anything for at least 4-6 months. We used to go tot he hospital for all different tests but never told us why. When she was really bad we approached them and said 'why are you not telling us? Why don't you tell us privately if that is the case?' They used to put a camera inside her. My wife used to complain of pains, still doctors not telling us. In the end we went privately to BUPA. They just felt my wife and told us straight away that she had cancer. Then they carried out tests 3-4 times and diagnosed bowel cancer that had advanced and spread to the lungs – she had advanced so much she had only 6-7 weeks to live (LPM)

'The GP always suggests that it is due to old age and gives medicine or tells them to rest … but no diagnostic tests first line. This is the example of my father .. and how the locum GP treated him. … It was only when our own GP came back that the matter was sorted … (LHF)

'(My) Grand-daughter had cancer. White cells were not being produced. Her temperature had risen for a whole month. My daughter in law had to nag the doctors for a reason … and after further tests she was diagnosed cancer. After that treatment started and now she is perfectly well. There is treatment but provided it is caught at the right time (LPM)

'After my wife was diagnosed privately they said we will treat her on the NHS. All this time wasted, 7-8 months, they could have started treatment and she could have got better (LPM)

'But this particular man had been complaining of 'gas' to his GP for at least 3 months. GP did not do anything about it. In the meantime cancer does not wait. He does not get hospitalised. Even when they do get hospitalised, for one week nothing appeared to have been done .. after a week they introduced a 'camera' from the mouth and then they did a biopsy. It was then that they knew what this man had. And within 4-5 days he died (LGM).

Two conclusions may be drawn from these parts of the discussion – since although earlier there had been many statements about the inevitability of death from cancer, it was also clear that there were some expectations that doctors should be more pro-active and respond to descriptions of symptoms, to explore diagnoses and possible interventions – and that people had heard of cases where at least some forms of cancer had been 'caught' and cured. These included some stories drawn from the media.

'I watched on TV specialist talking about the benefit of exercise and diet for the prevention of cancer (LUF2)

'One lady knows of a girl with a brain tumour, she was taken to America for treatment and is still alive (LUF2)

'My sister had a scare but it was clear in the end. She had a lump removed from under her arm (CAF)

The majority of group members drew their knowledge from UK (or North American) sources, but a few did refer to the sub-continent or east Africa, and a small number were relatively recent migrants, who thought that levels of knowledge (or possibly, levels of disease) were lower in India/Pakistan/Bangladesh. That said, there are clearly rising levels of awareness and probably some impact of campaigns in those countries, particularly in respect of oral cancers:

'I have come from India and have recently arrived here. In India we have not heard about this. We have heard about throat cancer and tongue cancer in India but not bowel. This is the first time I have heard about this (LGF)

'I also come from India. I know that cancer occurs but much more than that I don't know … except that it can occur at any time and affect any part of the body including blood (LGF)

In Africa, cancer was called something else. It was visible on the surface of the skin. The skin turned a different texture and mimicked an infection. They used leeches to treat it. (LGM)

'We have heard of old people dying back in Bangladesh due to bleeding through their back passage, we called it blood dysentery (BBF)

> ‘Two of my brothers had suffered from cancer, we took him (one) to a hospital in Dhaka – they told us “It is too late, if you could come early then we could do some treatment, he got no time now … another brother had cancer and was told to refer him to Mirzapur in India, he had two operation (BBMa)

It is probably important, at least for the older generation, to link any public education of Asian communities in UK to such ‘homeland’ stories, since in previous research (Johnson & Verma 1998) we have been told that such diseases were ‘not part of our history’ and unknown in the homeland – therefore (by implication) not relevant to ‘our’ people. This may, of curse, be an attitude that creates an unhealthy passivity among both lay people in the community and possibly among some doctors, who do not associate members of minority communities with such disease patterns – especially perhaps if they themselves came from the sub-continent:

> ‘Due to the low rate of this disease they (doctors) do not take action in early, considering it is not dangerous. As a result of this attitude, the disease goes worse (BBMb)

Members of Asian discussion groups were not always complimentary about their own (Asian) GPs, although the normal feeling expressed was that they would not do something that would offend, or be against the advice of, their own doctor. Equally, it was clear that they felt that sometimes, doctors would connive at, or be complicit with, their own fear and dislike of discussing such an unlucky or 'tabu' subject:

> ‘Cancer is a serious disease that affects all parts of the body. Doctors do not ask or probe too much about the family history of cancer or personal histories as it may cause psychological harm to the patient. Some GPs come from India and are reluctant to send patients to the LRI because they do not want to appear incompetent. ... There are so many factors a GP has to consider. Hospital consultants are specialists but the GP has to consider the patient as a whole and sometimes a precise diagnosis particularly for something like cancer can be very difficult and influenced by a lot of factors. (LPM)
> ‘The elderly member of the family (the mother) had been admitted to (the Hospice). The whole family was ‘scared’ that the elderly relative would find out about her condition – this had been kept a secret from her … The family members requested the doctor not to tell their mother of her condition – cancer … They thought if their mother found out she would not be able to bear it. The doctor said ‘I respect your wish and will not tell her but at the same time I cannot lie to my patient. If your mum asks me, I will tell her’ … However, one of the medical team was told by the patient that although she did not know what she had, she was dying. She did not want to know what of … she was apprehensive about telling her family that she was not worried about dying because she did not want them to feel unhappy … (Voluntary chaplain, member of Hindu female group)

However, it was also clear in this study, as in others, that most Asian families prefer to be registered with an Asian GP who can provide language and culturally sensitive care, and reduce the problems of using (or needing) an interpreter – and that, as a rule, they felt comfortable in discussing ‘sensitive’ subjects with them. This was not, however, always true of the other support workers, in particular receptionist staff.

A7.2 Attitude towards screening/ learning about disease risks and personal health status

As began to emerge during the earlier discussion of broad prompts regarding general levels of knowledge and fears about cancer and other bowel disease, the notion of preventability and early intervention was certainly known and approved of in all groups. There was, despite some reference to the hand or will of God, no belief that 'fate' was inexorable or should not be changed by personal action.

> 'We all are agreeing that they should try to catch the disease in early stage (BBMb)

> 'No disease can come by one day, it developed by years but took five years to develop and to catch it … If you are in touch with doctor, in co-operation with doctor, it can be caught in early stage through screening and tests, and it is an advantage to treat (BBMa)

> 'Prevention is better than cure (all participants) (LGF)

> Its important to know what's happening with your body, but I agree its not a good way to do it (CAF)

> 'I think screening is very useful and beneficial (LGF)

> 'Some people believe that illness comes from Allah, this attitude is wrong. Allah has given the medicine same as the illness and science have developed treatment. Some people feels that one day Allah will give the disease and I will go to doctor, I do not need to do check-ups early; this attitude makes us suffer, it makes delay to get the disease caught. Religion should not be an issue in this situation (BBMb)

That said, there was some discussion among certain groups who did not see the point in learning about a disease if there was no hope of intervention. Some differentiated between conditions such as diabetes (which was relatively commonly known, being a major health concern for Asian populations) and cancer. However, especially among the women who had been exposed to the possibility (and experience) of mammography or cervical screening, (and among men who had been offered blood pressure monitoring) there was a generally positive attitude:

> 'If I were to be offered a test to see if I was prone cancer I would be very afraid. It would worry me. I would not be afraid to be tested for diabetes but I would be for cancer. It would worry me a lot (LGF)

> ' I think testing is very essential but I can see why people would be concerned about it … If you do not have the test you can worry about it and get depressed and stressed. Even if you are not ill you can get ill due to the stress of not knowing. Cancer is such a thing that you can get very frightened … What if I get it in the future (LGF)

> 'We have had breast screening and cervical smear tests; at first it was worrying as to why we should have it done – Do we have the illness? Will it be a female doctor doing the tests? – Sometimes after the tests it is worrying waiting for the results but (now) it feels like a routine (BBF)

> 'There are so many people having check-ups for breast cancer. I do not feel frightened of having a check. I have had a mammogram three times (LGF)

As in the 'native' UK population, there is some variation and no great consistency – screening can clearly raise worry levels as well as having the potential to reassure, as four consecutive statements made in a Bengali discussion group illustrate:

- It (screening/learning about risks and personal health status) is very good; it gives the knowledge that it can be in future
- Check-up is good, it gives peace of mind, he (someone) will not feel worried
- The worry will go away
- Some people may feel frightened that he will have to go to hospital and stay

Similarly, a Punjabi group produced two statements which appear to be diametrically opposite and which might affect how individuals respond:

- ‘Cancer, in my knowledge, has a “root”. Once cancerous cells are removed, the “root” will always remain and cannot be removed, hence the cancer can reoccur (LPM - #3)
- ‘If you can get it at an early stage then you cannot get it again (LPM - #1)

There was also, clearly, some sophistication in understanding that screening was not a ‘once for all’ event, but only part of a longer-term health maintenance plan, and with its own shortcomings as well as the potential to avert future disaster:

> ‘We go for various check-ups like blood pressure, heart disease, we may be referred for future test in hospital, after test the result may be fine but this may be this year and this may not same in next year. It is good to do screening (BBMa)
>
> Sometime like the smear test it may have to repeated as you can’t always get clear results – it’s a long and lengthy process who will always be there for you (BBF)
>
> If the doctors can help us to understand, give us better information and accept that we know something about our own bodies then it is better to know (CAF).
>
> ‘If my doctor suggests I have the test, and there are so many types of cancer many of which cannot be tested for, then I would have it. The disease is such that it can strike at any time. Once you have had the test you can be assured that either you have it or are prone to it or not. If I think that I have the test and if I have cancer, what will I do? At least I know. It has been detected and something can be done about it. This country has so many facilities and science is so far advanced something can be done about it. It is not worth getting depressed about - one has to have a positive attitude to this. (LGF).
> ‘13 years ago I was admitted for suspected breast cancer, I was with 13 other women but thank God I was found negative, but ten women were found positive (LUF2)

Equally, it appears that, through a process of personal experience and testimony shared between friends, there is growing awareness of the diseases and the potential for early detection, and the role of the individual in performing self-care checks:

> ‘All I know is that is that when I rub myself in the bathe on the chest - if I feel a lump - this is cancer. I learnt this from a friend of mine who detected it this way. I think it is very important for everybody when they bathe, especially women for the skin on the chest to be smooth. If they find a lump – then can treat it straight away (LPF)
>
> To tell you the truth I go to my Doctor twice per year for a general check-over and he has to give me the works, feel my balls, everything, because if anything is wrong I want to know about it. … in fact in 2001 I found a lump in my chest, went to the Doctor and then sent to the Specialist and had it surgically removed. It was caught early enough (CAM)

Even among the men, it was clear that knowledge of their wives’ experiences (and opportunities) affected their attitude towards the possibilities:

> ‘Majority mentioned that it is good to take part and do the testing. Someone mention the smear test, Breast cancer, and that this is compulsory (sic). *Group agreed that if the test is free then it is good opportunity (BBMa)*

Overall, we may see that screening and advance information about health risks was regarded as a helpful aid to personal health maintenance, and that a positive attitude to participation was expressed by virtually all groups (with individuals inevitably differing), although this could be affected by levels of awareness of risk or, perhaps more importantly, the possibility of successful intervention.

> ‘If we are too frightened of this - we shall be dead! If we have a disease it is good to know and get treatment if there is a treatment (LPM).

We may illustrate the overall view in relation to screening, by reference to a discussion among Gujerati (Hindu) men in Leicester about the more familiar topic of diabetes, a condition which has a particularly high prevalence among this community. It was clear that screening could be a means of reducing worry, although

the potential for stress arising from an adverse result was also recognised, as something that they were prepared to accept in order to get expert help and avoid later worse outcomes.

The facilitator directly introduced the question, as a means of stimulating the discussion about the broad principles:

> *Does anybody else feel that if you did not have the disease but you knew that somebody else did (e.g. diabetes) that you would want to know more about the condition?*
> I would definitely like to learn more about it (5)
> It would definitely help. We could take more precautions (2)
> I always test my blood for sugar. I do not have diabetes but I still have a test.(1)
> *(Why?)*
> I know that if I detect sugar in my blood, I can catch it early enough to do something about it.(1)
>
> *Would it worry you if the test detected sugar?*
> I know I have not got it - 101%. I know that I am not going to get it either. But I will still test to satisfy myself (1).
> Diabetes is something that if you tell somebody 'you have got diabetes' - it would worry them a lot. Particularly if you tell an 'asymptomatic diabetic' that they have got 'diabetes' - their diabetes increases due to increased stress. So it is better to tell them how to help themselves rather than harp on about the fact that they have got an incurable disease. It is much better to give this sort of positive news and ideas on its management, what to do about the condition rather then worrying them and making the disease worse. (3). (*All participants agreed.*)
>
> Many people do not go to the doctor because they do not want to hear the bad news so it is better to have awareness raised but raised in a positive, non-alarming manner (3).
> *What other things should have awareness raised in this manner?*
> Cholesterol, asthma. We know these diseases are harmful and dangerous. (3,5,7)
>
> *(Facilitator's Comment: Some participants go regularly for a yearly check-up, some go only as needed (field observation). Most participants wanted to learn only on a 'need to know' basis).*
>
> (LGM)

The issue of diabetes, and the experience (which is common among many South Asian communities) of being involved in research, has clearly had an effect, and might be built upon in promoting future screening activity in relation to 'new' diseases such as cancer:

> 'I would do it now I have been explained it. I have taken part in previous test to do with diabetes … My GP recommended me to do the test. My GP wanted to a test to assess the risk of me getting it in 10 years time or so. They wanted as many Asian people as possible to give blood samples and the samples sent to Oxford. The results came back to the GP. I was clear but had still to watch my diet … I believe prevention is better than cure. I am master of my own body and if I don't loo after it no-one else is going to. So taking part in an exercise like this there's no harm in it (LHM).

A7.3 Specific knowledge of Bowel Cancer – term 'Colorectal'; implications.

Although a few people had indeed themselves had, or been screened for, bowel cancer there was almost no knowledge about the disease or its implications, although some 'guessing' and as the discussion developed, rather more people did refer to bowel or colorectal cancer. However, at the start, virtually no-one recognised the term 'colorectal' and bowel or intestinal cancer was one of the least-commonly mentioned in the early discussions about the nature of cancer. Our fieldworkers had to give a short presentation to most of the groups and explain the disease (with diagrams) – this was much appreciated, although some group members were quite shocked:

> Sounds like a dirty disease which happens to people of bad nature for doing bad things … If it is a real illness, how can you speak to anyone about it, it's too embarrassing … The symptoms sound as if you are suffering

> from upset stomach or gastric … Any illness at our age is hard to cope with, why do we find things out so late, how long has this disease been around? (BBF)

Once people had begun to discuss it, however, there was clearly some 'memory-jogging' effect, such that examples were proffered as fitting into the pattern that was emerging:

> 'End part of our inside pipe is big, it is called colon in English. King Hussain of Jordan has suffered from cancer (BBMa)

> 'Some seh diet, some seh not enough fibre, I always believe everyone has the potential to develop it. / I support that, because I am sure I read somewhere that something like 3 out of 5 guys can get it (CAM)

> 'My son is 31 and I think he needs to do this … I have seen blood in his toilet. He has been 2-3 times to the GP and asked to send stool samples. He is currently suffering from diarrhoea but no blood. I think this test at home would be a good idea for him (LHM)

The majority of discussion about bowel disease, however, was focused on piles and anal problems, which were clearly something that (at least among the men) it was felt could be discussed quite freely and frankly in their groups:

> 'We are not aware … about bowel but Piles for which blood discharge through our anus (BBMa)

> 'Like Piles develop like a tumour then it ripe and melt. Doctors cut it, after a few days it develops again, doctors cut it again (BBMa)

> Only one person claimed that he had heard about the bowel cancer: he explained that 'a person (he knew) died suffering from bowel cancer. It occurred in the anus, did not realise (it was) as a bowel cancer, therefore time passed and it gone worse, could not treat in hospital' (BBMb)

> No we don't know a lot about it but it could be related to piles or haemorrhoids. People will try to get treatment for this - get better for a while but if it cancer - it can advance. (LPM)

A few people suggested that bleeding and constipation might also be a sign of cancer, but it is possible that this was a 'learned' response, and being offered as an idea developed in the context. A few of the women's groups had members who knew individuals who had a

stomach cancer, which was seen as similar. There was however a great deal of sharing and 'teaching' among the groups, so that in one, a care worker who joined the discussion late explained:

> 'This (bowel cancer) does not come suddenly as a big thing. It starts with some symptoms, if someone go to doctors early stage to control it then patient will be benefited and at the same time others will be benefited (BBMb).

> 'With colorectal it is when they have a bout of diarrhoea or constipation, sometimes stomach ache and loss of appetite. Loss of weight comes later. The things we used to say was bouts of constipation and diarrhoea … what we as people tend to do is to take medicine for the constipation and then if we get diarrhoea it is a side effect of the medication, you see (former nurse) (LHF)

In one of the women's groups in Leicester, with minority Khatri (Muslim) women (LMF), there was a surprising level of awareness, which appeared to be traceable to two women, one of whom had actually taken three bottles of stool sample to her GP's surgery for testing – so that both constipation and diarrhoea as well as 'blood in stools' were mentioned as possible symptoms, and the term 'stool' explained as a synonym for faeces. The woman did not explain why she had done this, however.

Levels of knowledge were, however, slightly higher in Coventry/Warwickshire, where it was apparent that several people had received information connected to the national FOBt screening programme. Otherwise, there was a low level of awareness, although one person in Leicester (only) mentioned the implication of treatment:

> 'I would be apprehensive about bowel disease because I only hear of colostomies and operations (LGF).

Among the Vietnamese and Cantonese population, there seemed to be a higher level of awareness or knowledge about digestive tract problems, although these were very low in specificity and seemed to reflect a more general concern with bowel movements, or a confusion with constipation (which they may associate with cancer being seen as a blockage or lump):

> 'all respondents (said they) had heard of Bowel cancer or 'colorectal' cancer before but did not know what the symptoms were. Some thought it could be that they would not be able to urinate or go to stool properly. The others said it would mean that they would have to go to the toilet to pass frequently, or would have to spend a long time in the toilet but could not open their bowels. They also said that the cause ' could be the foods they ate … not washed or cooked properly or contained dangerous chemicals … when asked about treatment, most respondents said they did not have a clue; however one member mentioned that the doctor would have to put a tube into their mouth to evacuate their bowels (LVC)

A7.4 Knowledge about possibility of screening for Bowel cancer – FOBt, Colonoscopy

With the exception of the one woman in Leicester, knowledge of any means of screening or examining for signs of bowel disease was confined to discussion of individuals who had had a 'camera' introduced into their anus or mouth, or a barium test, to look for causes of disease once they had been referred with other symptoms. Most groups, eventually, turned out to know of one such example, although this was not always associated with Bowel disease, or indeed, necessarily with cancer, and certainly was not a form of pro-active symptom-less screening.

> 'My husband died of bowel cancer 10 years ago. I used to go to hospital with him and know what they were doing and what they were checking etc. He had a stomach ulcer that burst and when they endoscoped, they not only found a stomach ulcer but also a tumour in his bowel. His main symptom was of blood in his vomit. (LGF)

Similarly, in one of the Bengali groups in Birmingham, one person (out of sixteen) had a test and had been treated, while another claimed that his friend had had this test whereupon another person said that he was (also) 'aware' of this kind of test'. In the light of earlier comments, it is unclear how far this revealing process was a function of growing confidence as the discussion group proceeded, and how far it was a form of 'not wishing to fall behind' in awareness; a form of peer pressure to conform.

That said, there was in our discussion groups a full and apparently relaxed discussion about some of the investigations which individuals had undergone, which were described in terms which seemed to cause little surprise or difficulty:

> After a week they introduced a 'camera' from the mouth and then they did a biopsy. (LGM)

> I was admitted to the hospital some time ago. I had to have 4-5 X-rays before they told me I had gall stones. It was very inconvenient.(LGF)

> He had a stomach ulcer that burst and when they endoscoped, they not only found a stomach ulcer but also a tumour in his bowel (LGF) (Note: this was the only person in the study who seemed familiar with the term 'endoscopy', but there were numerous references to 'the camera')

> I have chest and other problems also. These tests you are talking out I have done (i.e. stool samples) as well as urine samples. There are 'balloons' they put inside of me and test me. I have got blood pressure and diabetes. (LPF)

It is clear (see below for a discussion of this effect) that the setting and the nature of the discussion encouraged this sort of revealing – but from other remarks, it is unlikely that some of these things would have been said in an open, mixed, or more formal setting.

> *(Probe:) Do you know anybody who has had bowel cancer?*
> No (unanimous): Nobody talks about cancer even in a group discussion. (LPM)

At the end of nearly all the sessions held in Leicester and Birmingham there was a significant demand, or at least enthusiasm, to take part in future trials :

> Because you don't know how this affects you, why it was sent to you, how genuine it is, there is so much junk mail these days I would be sceptical about this to be honest, but having spoken to someone from the NHS and who is knowledgeable about this (our fieldworker) I would do it. I would now also recommend it to other people (Temple president)

> *Fourteen women have expressed that they are willing to take part in the test and would encourage friends of their own age to do so* (Fieldworker's note: BBF)

A7.5 Possible reasons for avoiding/ not taking part in screening:

Once the FOBt procedure had been described to the members of the focus groups, they were asked explicitly whether there were any aspects of the process which might lead them to refuse to take part, or why else they 'might not respond to a letter inviting them to take part'. Interestingly, the general response seemed to be that while they might not have done so, before having had the explanation and learning about the disease through the earlier discussion, the members were more inclined to respond positively after the description of the process, than hitherto. That said, there were members of the groups who expressed some worries, and one or two who had aesthetic concerns, as well as a few who if not fatalistic, were unconcerned about their health, having experienced few if any scares. Others regarded the taking part in such a communal activity as mass screening as part of their duty to the community as a whole – a very distinctive reaction, which resonates with certain core values among most of the minority ethnic groups:

> I do not want anything done (6). If you are well-why do all these things? *Field observation - throughout demo she looked 'disgusted'.*
> Oh No - we do not have any blood in stools.(6 and 8) *(Explanation that FOB looks for blood that cannot be seen).* Now that the test has been explained – what do you think ? The test should be done (all except #6) (LPF)
> *If you got a letter through the post – will you take part?*
> Yes, after you explained (all) – Who knows, I might have this disease (#3) – Maybe we need to help doctors and we can do this test (#1) – if this research can help others we will take part (#4) – (LPM)

> When we get a letter for breast screening asking us go, so we go (LUF2)

Others, however (perhaps the majority) suggested that they would not be interested in taking part unless they had some idea of the overall or personal importance and value of taking part – reinforcing the need for a general awareness-raising programme before any future screening:

> I have seen that our community is very reluctant to participate in programmes – 80% will not return the sample because they do not see it relevant to them personally (LUF1)

> *Participant no. 6 probed:* There is nothing wrong with me - no Blood Pressure, diabetes or anything. So I cannot comment on this screening process as I have never fallen ill. I have never fallen ill or have visited the doctor. (77 years old). I have only been for a 'flu jab. I have started to have piles recently but nothing to go to the doctor about. So if I was told about screening I would not understand it or have a need to understand this. If anybody talked to me about illness or how to treat them or manage them, I would get extremely worried. Because I have never experienced an illness, I would not know what you are talking about and I would get anxious. So I tend not to get involved in conversations regarding illness as it does not interest me. (laughter from participants). I have had a cataract operation though. (LGM)

> If the test is posted with explanation and prior knowledge of benefit to the individual we will do it, after all it is for our benefit (LUF2)

Most, including the men, were not worried about the possibility of having to handle their waste matter, although one did make a remark about this, and was immediately 'jumped on' by other members of the group, discussing the cleaning of toilets! Another woman expressed religious scruples over handling waste

matter, but it was explained to her by the others in the group that she could have a bath to cleanse herself. Similarly, one woman (LUF1) mentioned concern about the smell during storage over the span of the test, as another (Bengali) woman asked 'Where can I store the card, it is dirty thing to do, will it smell?' and one (who had taken stool samples to her GP for some test) remarked that she 'could not face food for several days afterwards' (LMF). There were also comments about the problem of doing this in a family home with other members of the extended family (including those of the opposite sex) around, and some felt that they were not properly qualified to do a clinical test:

> I do not feel I am qualified to do this. It is not that I would feel dirty looking at that, but I would like to see why I am doing it and what needs to be done … I would feel more comfortable if a nurse did it (LHF)

A major problem expressed by many group members, however, was about literacy: while some could read Asian languages, and it was felt important that letters and leaflets be translated, the impact of written communications even among those who could read, was said to be low:

> I would definitely do it but I prefer explanations verbally (1,2 and 7)
> There should be leaflets and messages in all languages (Gujerati, Punjabi and Hindi) to explain the importance of the test.(2)
> Even if they were in Gujerati, many of our people do not read Gujerati. Many older people find it difficult to read leaflets.(1)
> If I had a leaflet in Gujerati and it was adequately explained, I would try to do the test after reading it properly. (5)
> But if it was explained to me and if I had the chance to talk about it with my friends then I would be more interested (1, 3 and 4)
> We would still prefer a verbal explanation as it would 'sit better in our mind'
>
> LGM

Post is clearly an issue in some Asian households – as well as the problem of unsolicited (formal) post being confused with 'junk mail' referred to earlier, children and husbands may also exercise some control or protect their family from unwanted mail, particularly if literacy is an issue:

> 'It seems men are still in control of how much information women should be aware of – when asked why, group's answer was 'Possibly they don't want us to become "modern" (*in other words have power*)' (*Facilitator's comment*: BBF)

> 'Sometimes it is very difficulty to attend for appointments especially tests as we often do not know we have an appointment especially for routine check ups as the husbands often open the letters and throw them away or children read the letters to us and say "oh it's nothing" (BBF)

> 'I wouldn't even bother to read it if it came through the post. I would think of it as just a marketing agency gimmick. If this comes from the local (health authority) I think I would say yes, but I would need prior information about it (LHM)

There were a few other reasons put forward for not being certain that the individual would take part, again indicating perhaps the connectedness of Asian family cultures or at least the importance of approaching matters across all the family:

> I would only do the test if I had my husband's approval (LUF1)

> Nurse can do mine – she does all my tests. My daughter is also a nurse so she will see to this for me (LPF)

As a rule, however, for those who had grasped the point of the test, there was no feeling of any barrier:

> No problem with doing this test, after all it is for my diagnosis, I would not have a problem with carrying out this test (LUF1)

> It is very good that this screening programme will be rolled out, it will catch – I am very pleased to hear that such a programme will happen, then at least the disease can be caught early and prevent more misery for some individuals (LUF1)

A7.6 Explore possible reactions to getting test results (How might you feel…)

A concern explored in some detail in the main survey psychosocial questionnaire was the possible reaction of participants to receiving adverse diagnoses. This could affect the likelihood of completing the tests, if fear

of knowing was too great. The general view among minority ethnic participants was that this was only to be expected, and it was better to know, and to face up to fears, than to live in ignorance. A Vietnamese community worker quoted a traditional saying that 'when you start to ride on a tiger, you must fight with him to the end'. The most important factor was the availability of some form of treatment, and a belief that earlier intervention would raise chances. This did, however, depend on the confidence that people had in their doctors or local hospitals – and this was not universal.

> I think we have done ourselves a good deed if we do this test. Also, your life will be extended if we do this test. I think this is a good thing. (LPF)
>
> Life is in God's hands anyway. But if these tests come through the post, we will now do them. (midwife)
>
> *(probe): When results come to GP - how would you feel?*
> I would be anxious (midwife). *General nodding all round.*
>
> *If the result was positive, how would you feel?*
> The GP has to do the treatment - so you rely on him. (midwife).
>
> *Would you be grateful that you caught the illness by doing the test*
> Yes we would be grateful and that we would thank you two ladies that you made us aware of this and you demonstrated the test to us. (1). *General agreement*
>
> LPF

> If we start treatment early, we might get better. I have seen on TV positive outcomes from cancer. There was a serial on TV where the heroine had cancer. Her husband left her because of it. She was devastated. Nobody there to help her. She got to grips with her situation after a couple of weeks. She consulted books on ayurvedic medicines, and started this treatment. All her hair fell out - this is what happens in cancer. She also took drugs given to her from hospital. Her in-laws did not want her. She went back home. This was on TV and was very informative. She was looked after by her Mum and she grew back her hair. She went to America to her sister. The serial shows her now in America working with her sister. The heroine gave an important message. I get up in the morning, see the sun and live for today. That heroine had so much confidence and strength and went through all the cancer treatment and despite leaving her husband. We can learn from such programmes and messages. If we can learn to be strong and believe like this heroine, it can give a lot of courage. So when I get frightened, I gain a lot of strength watching these serials which show real-life situations with positive outcomes (LGF)

This last observation contains many important messages, including the role and impact of 'soaps' and TV among the Asian community.

When members of the family (or individuals) had undergone unfortunate (or adverse) experiences in hospital, they may be less likely to regard learning about a problem and seeking intervention in a less favourable light – so any screening programme will need to be accompanied by confidence-building measures in respect of the possibility for intervention and recovery:

> My brother had an operation for his piles and now it is 'numb' around that area. He does not feel anything. The doctors have messed him up. He cannot feel the sensation of defecation, now doctors are saying they cannot operate. So how much can you rely on the GP's diagnosis? (LPF)
> I am afraid of what will happen if the tests are positive, I am old who will care for me if they know I have this disease (BBF)
> I would not trust just the GP's opinion if I had something wrong or I had stomach problems. I would like to get it thoroughly checked as I had my pregnancy misdiagnosed by the GP. I ended up having kidney problems. So I would need to be absolutely sure before being told I had bowel disease (LGF)

Even so, there seemed to be determination to persist in seeking help, and recognition that not all doctors were the same – even to the point where it was hard to see the same person twice, in some surgeries!

> 'I'm unwell!' That's why I have been called in. Its good to know because we can start treatment early. You live on hope. (LPM: 1, 2 and 3)

Another member of this group revealed that he had been diagnosed with a throat cancer, and treated, several years earlier. This led to a more focused discussion about his feelings at the time, and appears to bear out the general expressions above:

> *When you first found out that he had throat cancer - how did you or your family feel?* We were glad we found out and that my life is saved. Do whatever you like –I said this to the doctors. Now I am not worried. (LPM)

Similar expressions of confidence were expressed among the women's groups, notably among those who had been discussing their own response to breast and cervical smear screening programmes, from experience:

> It's good to do the test, it will detect any abnormalities early.
>
> Test results should be sent to us, whether negative or positive.
>
> Further investigations are part and parcel of such test.
>
> (There are) No problems with undergoing further tests/investigations following suspect sample.
>
> (It is) Seen as beneficial to individuals own health. (LUF1)

There was general agreement that this (waiting for, and receiving, test results) could be stressful, but equally, this was not thought to be a reason to avoid taking part – once people started to think about the issue. This might be argued to be a 'positive' aspect of "fatalism" or at least, of a belief in a higher purpose and meaning to life.

> *Is there anything about the test you feel would do harm?*
> None at all (*all participants*)
>
> *How would you react if you got a call from your GP about your test result?*
> I would have to know whether it was 'yes' or 'no' (1)
> I would feel a little worried initially but I would want to know the result. (2)
> We should be positive about the result of the test because we know it is for our own good. We would get a bit worried-but the outcome is for our own good.
> *(All participants nodding)*
>
> *How would you react if your test was positive for FOB?*
> We would have to get it treated - like it or not (1**)**
>
> *Lots of probes needed - Would you be relieved that you knew or stressed?*
> *What are your views on the feelings of receiving a positive result?*
> I would feel relieved that we caught it early (2)
> I would know how to go forward and plan (1)
> We need to learn how to cope positively (3)
> The more worried you get, the more the tension in the household. I'll tell you something, if you keep on worrying about something like cancer without knowing what to do about it, it will keep on increasing and growing. I have gone through 4 heart attacks. If I keep on worrying about what is going to happen to me , I would have been dead a long time ago. I do not keep this in my mind. I always tell myself to eat, drink and be happy and I am still alive (1)
> I agree (2,3 and 7)
> Why should a positive result worry me? What will happen will happen.(4)
> We have to know because we have to make an effort to get better (3)
>
> (LGM)

A7.7 General question on fears and information needs

It is worth noting that throughout the discussions, and following a specific prompt at the end of the interview session about 'fears and information needs', most groups expanded on a number of related issues, and their attitude towards ill-health and the ageing process.

Attitudes towards cancer, self-care, screening and death were clearly mediated by these general perspectives and the awareness that as one gets older, many alternatives for ill-health present themselves, along with the loss of key faculties such as mobility and sight. At the same time, attitudes towards health and involvement in health care also change, generally towards a more 'mature' attitude and acceptance that bad things will happen, but that health can be preserved or maintained by compliance with health professionals advice, rather than saying that deterioration was inevitable:

> The older you get, you become more aware and cautious, whereas when we were young we were less cautious and reckless. That's why if there is anything wrong with me I have to know (CAM)

> Loss of organ function and this leads to heart failure is worrying in older people. If there is a change in diet this can lead to gastric problems. Arthritis is going to be there as one grows older despite exercise and good diet, but in small bouts. All tissues and organs will grow weak at some time (LGF)

Equally, as described above, there is growing awareness, and familiarity with the value, of screening procedures such as those for diabetes, breast and cervical cancer, and possibly also a growing recognition that cancer is a disease that does affect the minority populations (as is also growing among clinicians: Smith *et al* 2003).

A7.8 OTHER ISSUES:

(i) Gender

In most cases we arranged to conduct focus groups in single-sex settings, since experience has suggested that many such sensitive issues are best discussed in this way: men and women will generally not talk frankly about matters such as sex and elimination in front of the 'opposite' sex. In the process, however, we did obtain some interesting points raised in discussion, which seemed to justify this approach. Men (and women) are clearly aware of the others' health problems, but in many cultures it is not thought appropriate for this to be made clear. In protected settings, it became clear for example that men knew about female cancers, and the screening programmes associated with these, and that they approved of, and would encourage their wives or other female members of the family to attend. This also provided a model with which they were familiar and comfortable, and hence an example of good practice that might make them more likely to comply with similar invitations to themselves.

> '… bowel cancer should receive the same kind of status as breast cancer screening 'for the ladies' (SPM)

The following discussion, from a Gujerati women's group in Leicester, is illustrative:

> Bowel cancer affects mainly men doesn't it? It is the men who need to be convinced. Our men are just not interested in these things. You'll see when you call them from downstairs. Whenever we have open sessions on health topics - there is a full house of ladies but men just do not appear to be interested. (1)
>
> Ladies seem more interested in health issues than men *(all participants)*
> Only a few men interested and it's the same ones all the time. *(all participants)*
> Men are babies! (3)
> They whinge about everything. Their pain threshold is very low. *(all participants)*
> Very difficult to persuade the menfolk to come to health fairs. They do not listen to ladies. You have to push them to go for blood tests. Men will not be persuaded to do this test. *(all participants)*
> Men are not willing to accept facts and they tend to brush things under the carpet. They do not tend to listen to ladies. (3)
>
> (LGF)

Male respondents (in Coventry and Warwickshire) also supported this view, and it was evidently not confined to the Asian groups:

> 'I think they (Asians) are hiding and shy … Indian and Asian men are shy about all health matters, particularly bowel and prostate. Unless they are dragged to the doctor they will ignore their health problems (CGM)

> ‘All participants were very positive about the screening programme but felt more awareness raising … was needed. Most agreed that deep rooted taboos about discussing cancer or any disease linked to, as one participant put it, the ‘private parts’ of the body, were very prevalent (SPM).
>
> You see what happens is that a lot of West Indian men don't ask dem Doctor questions … West Indian men on a whole dem don’t visit Doctor (CAM)

This may, indeed, be a ‘male’, rather than an ‘ethnic’ characteristic!

(ii) Religion

While we had anticipated some explanations for non-compliance, or other attitudes related to screening, to have been expressed in terms of religion, as is normally the case with minority ethnic group discussions about health, this was very rarely the case. We did ask, explicitly, if there were any religious or cultural scruples, and many group discussions took place in religious settings (i.e. associated with a Gurdhwara or Mosque) while the facilitator for two groups was a recognised Maulana (Islamic priest). No formal religious objections were raised to any of the procedures, and the general consensus was that religion involved an obligation on the believer to take advantage of modern medical science to preserve God-given health. We have obtained a copy of a formal fatwa which assures Muslim believers that they are able to fulfil their religious duties of prayer in a state of ritual cleanliness even with a stoma, and another relating to analgesia, but have not found any other formal statements of relevance. It is very clear that the stereotype of ‘fatalism’ and any belief that health outcomes are purely in the hands of God or fate, were not world-views subscribed to by any members of our discussion groups, even if they saw ultimate control in those hands, as two quotes from Muslim groups illustrate:

> ‘Some people believe that illness comes from Allah, this attitude is wrong. Allah has given the medicine same as the illness and science have developed treatment. Some people feels that one day Allah will give the disease and I will go to doctor, I do not need to do check-ups early; this attitude makes us suffer, it makes delay to get the disease caught. Religion should not be an issue in this situation (BBMb)
>
> Life is in God’s hands anyway. But if these tests come through the post, we will now do them. (LUF: midwife)

There is a high level of sophistication in many communities, and a tradition in Islam as in Judaism, of debating religious concerns and their relevance to everyday life, so that in several groups when one member produced a worry, others put forward their own understandings, and in general, more respected members of the groups intervened to reassure those who were unsure that religion was about living a fuller life, rather than about restriction on it:

> ‘It is against our religion to have certain tests done, smear tests cause you to lose your virginity [*Explained that this was not true, also it is only done on women who have had intercourse*] .. No tests for medical reasons are against the Islamic religion… If it is for medicinal purpose it will be allowed in our religion (*majority agreed: in total 4 women were not so convinced*) (BBF)

In another group, a care worker described in some detail the story of a patient who had been admitted to a hospice:

> The senior doctor spent a lot of time and care for her. There were fears about religious scruples about a catheter/ colostomy bag coming in the way of religious worship. A patient with this felt that she could not go to worship if she had these devices or appliances. She felt that she was ‘dirty’. Cannot go anything for God. How could she live and what was the point of living if she could not do this? This was a fear. So a priest was called and he explained that God looks at the person’s heart and soul and this is clean. So what was bothering her that because her worship would not be recognised and she couldn’t do any more, this was fear. This fear was dispelled by the priest with a simple but effective trusting explanation.

Appendix A8: Bibliography: Literature Identified on Cancer Screening & Ethnicity

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Appendix A9: Minimum Datasets Extracted from all Bibliographic References

ID	Type of cancer	Country of study	Type of test(s) studied		Population(s) studied						Research carried out		
			1ST screen test#	Follow up test	Gender	Ethnic Group(s)	Religion	Non-English Lang.	White Comp-arator	Socio-demogr Factors	Type of study	Key findings	Comments
EG	Breast Cervical Breast & cervical Prostate Colorectal General	USA UK Australia Norway	BSE CBE Mamm Smear FOBT Flex sig	Y/N	M/F	Black; Hispanic/ Latina; Mexican; Chinese; Asian American; American Indian; Vietnamese Korean; Caribbean; S Asian	Moslem	Y/N	Y/N	Y/N	Epidemiological (e.g. mortality rates; stage Ca detection) Screening uptake Beliefs/ attitudes ** Factors influencing uptake ** Intervention study (type of intervention)	No difference Reported difference: Black ↓ than Whites Black ↑ than Whites Reported difference decreasing No difference Reported difference: Black ↓ than Whites Black ↑ than Whites Key differences in beliefs = Knowledge ↓ than Whites Qualitative identification barriers/incentives Quantitative analysis of factors (barriers) Quantitative analysis of factors (incentives) Description of intervention implemented Evaluation of intervention via RCT/ case control/ before & after/ Q survey	Corrected for sociodem factors Corrected for sociodem factors Fatalism/ ??

Summary data extracted from all articles meeting the primary inclusion criteria for the literature review

Minimum datasets (MDS) extracted from all bibliographic references

ID	Type of cancer	Country of study	Type of test(s) studied		Population(s) studied						Research carried out		
			1ST screen test#	Follow up test	Gender	Ethnic Group(s)	Religion	Non-English Lang.	White Comp-arator	Socio-demogr Factors	Type of study	Key findings	Comments
1	B	UK			F						Raising Community Awareness		
2		UK									Raising community awareness		
3		UK									Conference report, overview studies		
4		USA											
5											Methodology		Name-based ethnicity identification
6					F								
7	B & C	USA	Mam, Pap		F	Hisp					Sample survey	Poverty & low education reduce uptake	
8	B	USA	Mam		F						Consensus conference and LitRev		
9	B	USA	Mam		F						Consensus conference and LitRev		
10	B	USA	Mam		F						Consensus conference and LitRev		
11	B		Mam		F							Minority women have later follow-ups after abnormal mammogram screening	
12	Co										?	Barriers to CRC screening in minorities	
13												Poor uptake among minorities	
14		USA			F	AfA							
15	Pr	USA	DRE, PSA	Y	M	AfA			Y		Survey/New service	AfA low levels of knowledge – free screening raised most knowledge	

ID	Type of cancer	Country of study	Type of test(s) studied		Population(s) studied						Research carried out		
			1ST screen test#	Follow up test	Gender	Ethnic Group(s)	Religion	Non-English Lang.	White Comp-arator	Socio-demogr Factors	Type of study	Key findings	Comments
16	B & C	HK	Mam, Pap BSE		F	Ch				Y	Survey of users	Health conscious people use services; misconceptions over role of doctors and nurses	
17	Endo, Ova		Pelvic Exam		F	?					? Observation/Survey	Obesity affects screening examination	
18	B	USA	BSE		F	AfA					Survey and Intervention Training	Intensive training increases self-efficacy	
19	B		Mam		F						?		
20	Pr	USA	DRE PSA		M	AfA				Y	Nonrandom survey	Poor knowledge correlates with low use, low education and income	
21	Co	Fin	Genetic	Y	MF					Y	Prosp. Intervention	Counselling and education given to high-risk individuals. Employment status predicts use	
22	B	USA	Mam	Y	F	AfA, Hisp					Interviews	Low levels of knowledge	
23	B	Africa			F						Review		
24	B & C	USA	?	Y	F	AfA					Intervention – nurse outreach * free screen	Intervention successful in raising uptake	
25	Co	USA	?			AfA			Y		Physician and Patient Education and convenience ample survey	Effects of low knowledge or belief in efficacy of follow-up affects likelihood of take-up	
26	Pr	USA	PSA			AfA				Y	Random surveys	Low uptake and knowledge	
27	B	USA			F	AfA					Theory		
28	Co	UK	FS			Pop					RCT		
29	B	UK	?		F	I B P Black			Y		RCT Intervention training of reception staff	Effective in raising uptake	
30	B & C	USA			F	Hisp					LitRev		
31	Co	UK				-					Descriptive		
32	B	UK	BSE Mam		F	-					Descriptive		
33	All	UK									Policy		
34	Co	USA	FOB FS Colo								Methodology – survey to determine self-reported behaviour accuracy	People do remember what they have done – self report accurate	
35	Lung	USA				Black			Y		Epidemiology?	Black patents under-represented	
36	C	UK	Smear		F	Lesbians					Descriptive, epidemiology	Abnormal results found – lesbians are at risk too	
37	B	UK			F						Review		

ID	Type of cancer	Country of study	Type of test(s) studied		Population(s) studied						Research carried out		
			1ST screen test#	Follow up test	Gender	Ethnic Group(s)	Religion	Non-English Lang.	White Comp-arator	Socio-demogr Factors	Type of study	Key findings	Comments
38	B	USA	BSE Mam		F	SEA, Hisp					Intervention – nursing students in community clinics		
39	C	RSA			F	Black/ Coloured			Y		Epidemiology		
40	B & C	USA	Mam Pap		F	Hisp					Survey & Focus Group and professionals	Education of professionals may help	
41	B	UK			F						RCT of recall systems	Letters raise attendance	
42	B	UK			F						RCT of invitation letter/ plus questionnaire	No effect (adverse or positive)	
43	B & C	USA	Mam Pap		F	Hawaiian					Survey		
44	Pr	USA	DRE PSA		M	AfA			Y		Educational intervention & Survey	Low knowledge & uptake by AfA; prefer private screen to mass; radio most effective medium	
45	B	USA	Mam		F	'minority'					Sample record review	Use of specialty clinics (??)	
46	Co	USA	Sig			AfA, Ch Hisp			Y		Interviews with relatives of cases, focus Groups	Different reasons for non-takeup	
47	B	USA	Mam		F	AfA, Latina/Hisp			Y		Expt showing different videos	Different strategies work for AfA & Latina/whites (style of message)	
48	Co	USA				AfA			Y		Focus Groups	People talked comfortably in FGs but have low knowledge/awareness	
49	Co	USA				AfA					Review		
50	C	?	Smears								Psychol study of effects of smear test	It may be traumatic (?? Ethnic??)	
51	B	UK (Wales)			F	Asian Somali		Urdu Guj			Intervention – translated info and letter, etc	Language support and translated infor raised uptake, not free transport. Bengali & Somali remained hardest to reach	
52	Oral										Survey of smokers	??ethnic??	
53	Pr	USA				Black			Y		Survey of identified cases	Low literacy affects screening uptake	
54	C	USA	Pap								Epid survey	Low uptake among low income multiethnic populations	
55	B		Mam		F	'color'					Intervention – motivational interviewing	Interactive intervention works	
56	B	UK			F						Letter		

ID	Type of cancer	Country of study	Type of test(s) studied		Population(s) studied						Research carried out		
			1ST screen test#	Follow up test	Gender	Ethnic Group(s)	Religion	Non-English Lang.	White Comp-arator	Socio-demogr Factors	Type of study	Key findings	Comments
57	B	USA			F	AfA			Y		Record based epidemiology	Role of help-seeking behaviour	
58	B & C	USA	Pap mam CBE		F	Viet					Intervention trial of community education	Trained Viet lay health workers raise uptake	
59	B	USA			F	Black			Y		Review		
60	B	UK			F						Record review	???ethnic??	
61	All										Review		
62	Pr	USA			M	AfA					Intervention – lay education via churches	Effective in raising knowledge and self-efficacy	
63	B	UK			F						Letter	Accurate addresses improve outcomes	
64	C	NL	Smear		F						Record review	GPs better at getting high risk people to uptake than specialised paramedicals	
65	B	USA			F	AfA					Focus Groups	Black women saw Breast C as white disease, and stigma – prefer black role models etc	
66	B	USA	Mam BSE CBE		F	Black			Y		Intervention & Surveys	Income and race affect referrals; Medicare funding raised use	
67	B	UK			F	'non-English speakers'		Y	Y		Survey	Indirect discrimination affects information access	
68	B	Can	BSE		F	S Asian					Discussion		
69	C	Can	Pap		F	S Asian FirstNation			Y		Case Study qualitative interviews	Gender-sensitivity essential also cultural	
70	B	USA			F	AfA					Psych survey	Extreme mis-rating of risks	
71	B & C	USA			F	Black Hispanic			Y		Methodology – utility of national health survey and ecological data for designing studies		
72	C	UK			F						Survey & FGs on Knowledge etc	Lack of knowledge and fear, previous adverse experiences, racism	
73	All	USA			F	AfA			Y		Epidemiology from records data	AfA highest risk of death	
74	C	UK	Smear		F	'Asian'			Y	Y	Response to invitation to attend for smear	No difference found between groups in response but Asian had less previous smears, and more wrong addresses	
75	B	USA	Mam		F	AfA			Y		Survey of beliefs	Complex differences in self efficacy, fears and knowledge etc	
76	Pr	USA			M	Black					Review		

ID	Type of cancer	Country of study	Type of test(s) studied		Population(s) studied						Research carried out		
			1ST screen test#	Follow up test	Gender	Ethnic Group(s)	Religion	Non-English Lang.	White Comp-arator	Socio-demogr Factors	Type of study	Key findings	Comments
77	B	USA	Mam		F						Epidemiology from record data and National Survey information		
78	B	USA			F						Review		
79	Co	USA	FS		F	AfA					Sample survey	Stages of change study	
80		USA			F						Review		
81	B	UK	MRI		F						Research protocol		
82	B	USA			F	Black					Review	Leininger model for care design	
83	Pr	USA	PSA		M						Review	Descriptive blah	
84	B	USA	Mam		F						Survey – social marketing inquiry into 'barriers'	??? ethnic??	
85	Pr	USA	DRE PSA		M	AfA			Y		Intervention – workplace education and offer of free exam	Workplace education raised uptake	
86	C	USA	Pap		F	Mexican					Survey	Need for basic education	
87	C	USA	Pap`		F						RCT of reminders by / to doctors	Little impact	
88	B	USA	Mam		F	Native American					Lay peer education outreach intervention	Increased uptake	
89		USA				Native American (Indian and Alaskan)					Review		
90	B & C	USA	Mam pap BSE		F						Interviews with clinic users	??? ethnic	
91		USA			F	?							
92	Lung	EU	PET								Prospective screen	Highly technical – PET 'works'	
93	B	USA	Mam		F	Hisp					Record based analysis	Education and income and insurance predict	
94	C	UK									Journalistic		
95		USA									Methodology – assessing use of EORTC QoL questionnaire		
96	C	Can	Pap		F	First nation					Intervention – community-based outreach	Raised uptake	
97	C		Pap CBE		F	Black			Y		Survey	Racial differences	

ID	Type of cancer	Country of study	Type of test(s) studied		Population(s) studied						Research carried out		
			1ST screen test#	Follow up test	Gender	Ethnic Group(s)	Religion	Non-English Lang.	White Comp-arator	Socio-demogr Factors	Type of study	Key findings	Comments
98	C	UK Scotland	Smear		F	?					HV motivational interview	Personal approach works	
99	Co		FOBt								Review	Nurses role….	
100	B	Can	Genetic		F						Survey	? ethnic	
101	C	USA	Pap		F	Cambodian					Survey and ethnography	Need for outreach and culturally sensitive information	
102	B & C Co	USA	Pap BSE Sig		F	Mex / Latina					Survey of knowledge	Knowledge links to self-efficacy	
103	C	UK	?			African-Caribbean I P B					Primary care Survey	Ethnic inequalities	
104	Pr	USA	PSA								Prospective methodological study	Highly technical	
105	B & C	USA	Pap Mam CBE		F						Screening of volunteers in another trial for compliance	?? ethnic ??	
106	Pr	USA	PSA		M	Black			Y		Prospective Methodological study of screened men	Highly technical	
107	B	USA	Mam & BSE		F	AfA					Convenience survey of psychol. Variables	Need for more education	
108	B	USA	Mam & BSE		F	AfA					Methodological development of scale	Culturally sensitive instrument developed (?)	
109	B	USA	Mam		F	Afa					Methodological check on self-reported status	Unreliable in 40%+ cases	
110	B	USA	Mam	Y	F	AfA					Intervention to measure effect of tailored personal care	?	
111	B	HK	Mam		F	Chinese					Epidemiology		
112	B	HK	FNA (fine needle aspiration		F	Chinese					Methodology	Effective	
113	C	NZ	Smears		F	-					Survey of smear takers on techniques	?? ethnic	
114	? (BOOK)												
115	? BOOK												

ID	Type of cancer	Country of study	Type of test(s) studied		Population(s) studied						Research carried out		
			1ST screen test#	Follow up test	Gender	Ethnic Group(s)	Religion	Non-English Lang.	White Comp-arator	Socio-demogr Factors	Type of study	Key findings	Comments
116	B & C	USA			F	Black Hispanic					Registry data epidemiology	Later picking up	
117	?										Three highly technical case studies		
118	C	Africa									Provision of screening services		
119	C	UK	Smear								Focus groups	Misperceptions	
120	B	USA	Mam		F	Black			Y	Y	Survey	SES effects explain racial differences in referral	
121	Co	?	Gene								Survey of Relatives of colon cancer patients	? ethnic	
122	B	UK Scotland			F						Survey of service users about uptake campaign	Users liked the adverts ?? ethnic	
123	B	USA	Mam CBE BSE		F	Black			Y	Y	National survey data	Physician referral and socio-econ effects	
124	B	?	Mam CBE		F	Tamil					Focus groups and survey of clinicians	Cultural and knowledge barriers	
125	Pr	USA			M	AfA			Y		Case notes review	AfA men present younger with more advanced disease – more research needed	
126	Co	USA	FS			??					Case reviews epidemiology	Age seems to be an issue ?? ethnic	
127	B	USA			F	??					? Discussion		
128	B & C	USA	Mam Pap BSE		F	Cajun			Y		Phone survey	Cajun cultural differences	
129	B & C	USA			F	(Native) Am Indian (Houma)					Descriptive		
130	B & C	USA	Mam pap		F	Am Indian Alaskan Native					Case notes review	Underserved	
131	B & C	USA	Mam CBE Pap		F	'Asian' Pacific Islander					Case notes review	Underserved	
132	B	USA	Mam		F	?					Survey of referred patients	Fear of immigration authorities deters	
133	B	USA			F	?					Descriptive of intervention		
134		USA	Gene			?					Review	?? ethnic	

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135	B	USA	Mam		F	AfA					Survey of referred patients	Various factors affect uptake including nurse or Dr referral (Nurses better)	
136		USA				AfA Native Am 'Asian' Pacific Is Hisp			Y		Descriptive	(Book chapter)	
137	B & C	USA	CBE Pap mam BSE Pelvic E			AfA					Outcomes from intervention (Descriptive)		
138	B	USA	Mam			AfA					Random survey	Age, exposure to media, education, insurance	
139	B	?	Mam			'Learning disabled'					Postal survey	Underserved	
140	C	USA	Pap			Black Hisp					Intervention via churches	Found unscreened cases	
141	Pr	USA	PSA DRE		M	Black			Y		Survey of screening attenders	Racial differences	
142	B	?	?		F								
143	C	USA	Pap		F	Black					Intervention – community education programme snf pre-post survey	Awareness rose slightly	
144	C	USA			F	Native Am					Describes development of intervention – lay peer educators		
145	C	USA	Pap		F	NativeAm (Cherokee)					RCT Intervention – peer education pre-post survey	Raised knowledge and uptake	
146	C	USA	Pap		F	NativeAm (Lumbee)					RCT Community education intervention	Education raised uptake and knowledge – higher identification with native culture also associated with higher knowledge	
147	B	USA	Mam		F	AfA			Y		Follow-up of referred cases for compliance	Age, race, insurance status	
148	?	USA	?		M & F	Black 'Asian' Hisp AmIndian			Y	Y	Risk factor surveillance study data	Ethnic differences	
149	Co	?									Review	Risk assessment varies	

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150	Pr	USA	Gene		M	? mixed			Y		Focus groups		
151	B & C	USA	Pap Mam	Y	F	?					Intervention –same day' screening for walk-in centres	Raised uptake	
152	B	NZ			F						Case Records review		
153	B	USA	BSE		F	AfA			Y		Case Control review of first degree relatives	Relatives self examine more, esp AfA, often excessively	
154	B & C	USA	Pap		F	AfA			Y		Reanalysis of national survey data (1985)	Differences	
155	B	USA	Mam		F	Hawaiian Jap			Y		Epidemiology		
156	B Ova	USA	Gene		F	AfA Jewish Lesbian			Y		Focus groups	Differences not highlighted, similarities found	
157	B	USA			F	AfA					Descriptive of lay health educator intervention		
158	B	UK ?			F	??					Random survey	Women over 65 might be interested	
159	Skin	UK ?	?			??				Y	Feasibility Study – random sample survey	?? ethnic	
160	B	USA	??		F	Black			Y		Survival analysis of diagnosed clients from case notes	Blacks more likely to die	
161	C	USA	Pap		F	Pacific is			Y		Case notes analysis	PI patients (and Asians?) higher rates, fewer smears	
162	C	UK ?			F	?					Descriptive		
163	All	NZ	?			Maori			Y		Descriptive		
164	B	USA	Mam		F	Black					Intervention Lay Education programme & Focus Groups	Describes developments	
165	B	USA	Mam		F	Black					Describes lay educators network intervention		
166	B	USA	Mam		F	AfA					Describes lay educators network intervention: Focus Groups		

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167	B & C	USA	?		F	Latina Chinese Viet AfA				Y	Describes development of screening intervention – survey data	Ch & Viet lower levels of screening and knowledge	
168	B	USA	Mam	Y	F	AfA					Intervention of community-based education through churches	raised uptake	
169	B	USA	Mam	Y	F	AfA					Intervention of community-based education through churches	Raised uptake	
170	Neuro	Jap	Biochem	Y							Evaluation of epidemiological data – feasibility	Technical methodological	
171	Pr	USA	PSA		M	Black					Registry and records data	Black rates below white but ? catching up	
172	B	UK	MRI		F	??					Review of uptake of trials	Poor uptake among high-risk groups ??ethnic	
173	B	USA	??		F	Black					Convenience sample survey through churches of psychosocial predictors		
174	B	USA	??		F	Latina Afa			Y		Focus group narratives		
175	B	USA	BSE Mam		F	AfA Lat/Hisp			Y		Community-based surveys	Perceptions of barriers include economic capacity and previous experience of prejudice	
176	B	UK	Mam		F	??					Describes intervention (Receptionist training and reminders)	Raised uptake	
177	B	UK			F	?					Review of routine data on uptake	?? ethnic	
178	Pr	USA			M	AfA					Survey of beliefs		
179	B	??	(treat)		F	?					Clinical discussion of treatment options and need for genetic data		

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180	B & C	USA	Mam & Pap		F	Hisp					Survey of uptake and knowledge	High uptake reported, low knowledge or compliance	
181	B & C	USA	Mam & Pap	Y	F	'Minority'			Y		Intervention of outreach health education- record review	Effective	
182	?	USA	Mam		F	??					Descriptive?		
183	B	USA	Mam		F	Black					Depth interviews with participants in intervention lay health advisors	Counselling felt to be helpful and comfortable	
184	B	USA	Mam		F	Black			Y		Intervention Controlled Trial – Community Education	Black women gained less but uptake generally increased	
185	C	RSA	Pap		F	??					Epidemiology		
186	B & C	USA	Pap Mam CBE		F	Obesity, non-white			Y		Population Survey	Obesity limits uptake esp among whites	
187	B	USA	Mam		F	Afa					Intervention – free screening via beauty salons – descriptive protocol	No outcomes described	
188	B Ova	UK	Gene			??					Survey of respondents to genetic counselling	?? ethnic	
189	Pr	USA	PSA		M	??					Survey of physicians	Variable attitudes affect referrals	
190	C	USA	?	Y	F	Not stated					Analysis of case record data	Women of color and others need more follow-up	
191	B	USA	CBE Mam		F	??					Phone interviews survey	Physician style affects response	
192	B	USA	Mam		F	Hisp Black			Y	Y	Probability sample survey	Income and education explain more	
193	B	USA	Mam		F	?					Survey of church members	Seems church members attend better	
194	B	USA	?	Y	F	AfA					Intervention of counselling (RCT) may affect levels of concern	No data on uptake	
195	All	USA	All			Korean					Knowledge survey in USA and Korea	Descriptive	

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196	B & C	USA	BSE and CBE/ Pelvic e		F	AfA Hisp AmerInd			Y		Survey of psychosocial etc	Ethnic variations	
197	B & C	USA	?		F	Latino					Describes intervention outreach programme		
198	B	USA	BSE CBE Mam		F	?					Survey of clinicians own practice for self	Ethnicity did not affect behaviour in this group	
199	Co	USA	FS or FOBt			?					Cost-Effectiveness Modelling study	(no ethnicity)	
200	B	USA	Mam		F	AfA			Y		Reanalysis of health behaviour survey data on smoking etc	Interaction of race, smoking, alcohol and screening behaviour	
201	B & C	USA	Biopsy		F	Black					Exploratory 'lay advocate' intervention	'Patient Navigators' raised follow-up biopsies – unclear of ethnic effect	
202	Skin	USA	SSE		?	?					Descriptive survey of patients	Low rates of self-examination among users of worksite cancer screening service	
203	Skin	USA	SSE		F	AfA Hisp			Y		Survey of behaviour and Beliefs	Worksite screening service users	
204	B	USA	BSE		F	AfA Hisp			Y		Survey of behaviour and Beliefs	Worksite screening service users	
205	B	USA	Mam		F	?				Age	KAB survey of users of educational outreach programme	No age differences suggests older women underestimate risks	
206	B	USA	Mam BSE CBE		F	Hisp					Compliance survey of psychiatric clinic users	Educated Hispanics with active doctors do more than low income others	
207	B	USA	BSE CBE Mam		F	Latino (Mex, P Rican)					Survey of KAB		
208	C	USA	Pap		F	Native American			Y		Health belief and record-based survey	No difference; nurse practitioner value	
209	B	USA	Mam		F	?			Y		Mail survey		
210	B	USA	Mam		F	Hisp Black			Y		Telephone survey of KAB		
211	Kidney	USA	BioChem		?	?					Blood tests of hypertension patients		
212	B	UK	?		F	?					Record-based	No ethnicity results	

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213	Co	UK	FOBT								Protocol for the national Colorectal screen programme	No ethnicity: gives sensitivity etc data	
214	B	UK	?		F	?				Y	Record data	Deprivation affects uptake, by practice (as also female GP presence) No ethnicity	
215	Pr	USA	DRE PSA		M	AfA					Survey in attenders at clinics in churches	Fear of Cancer links to dislike of DRE but not clinic attending!	
216	B	USA	Mam		F	Latino					Screening of Latino factory employees	Plus education	
217	Pr	Pak	PSA		M	Pakistani					?	Needs to establish community baseline standards	
218	C	UK	?		F	?					Record-based review	East Anglia registry – no ethnicity	
219	B	USA	?		F	AfA					Descriptive nurse-led project		
220	C	Aust	Pap Smear		F	Aboriginal					Descriptive	Community-based outreach clinic – results good	
221	B & C	USA	Pap Mam CBE		F	Am Ind					Phone survey	General health beliefs and knowledge of health education inc CHD etc	
222	B	USA	Mam		F	Am Ind					Random survey	Low self-reported uptake	
223	B	USA	Mam		F	Black			Y		Phone survey – HMO members, Health Belief Model	Blacks are different	
224	Co	USA	Gene		?	Jap Hawaii			Y		Mail survey of first-degree relatives	Hawaiians more concerned, Japanese more at risk	
225	B	USA	Mam		F	Black Hisp					Phone follow-up of abnormal results	Low income effects	
226	Co	USA	FOBT			(Hawaii)					Describes intervention and outcomes		
227	?	UK	?									Useless Nursing Times article, no abstract	
228	B	Can	Mam		F	?					Record-based study	Age effects. ?? ethnicity?	
229	B & C	USA				?					Review/ advice		
230	B	USA	Mam		F	AfA					Dietary study – veg/fruit eaters	Veg/fruit eaters get screened, low incomes don't do either	
231	B & C	USA	Mam BSE Pap		F	AfA Hisp NatAm					Review		
232	B & C	USA	?	Y	F	Hawaiian					Intervention study – community based education	It works	

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233	Pr	?	?		M	?					Survey of trial participants re informed consent	?? ethnicity	
234	All	USA	??			AfA NatAm APIs Hisp					Book chapter		
235	B	UK	?			?					Protocol of quality assurance initiative	Mentions ethnic groups ?? what	
236	B	UK	?			?					Describes nurse HP activity in Tower Hamlets	(not research)	
237	B & C	USA	?			AfA					Describes academic/practice initiative	Protocol for research and how it is a good thing – not much on outcomes	
238	B & C	USA	Mam CBE BSE Pap		F	AfA					Describes explanatory models (? Qualitative?		
239	?	China	Bio			Chinese					Lab based comparison of sera and H Pylori		
240	C	Can	Pap		F	S Asian					Survey of knowledge and uptake	Low	
241	C	USA	Pap		F	Hisp					Follow-up survey of abnormal smears		
242	C	USA	Pap		F	Hisp					Follow up survey of abnormal smears		
243	Head & Neck	?	?								Survey of screen attenders about smoking/tobacco		
244	B	?			F	Asian					Letter		
245	B	USA	Mam		F	Korean					Survey of church members		
246	?	Aust	?			?					Describes health education programme		
247	C	USA	Pap		F	Black, Hisp					Reanalysis of national survey data		
248	C	USA	Pap		F	AfA Hisp			Y		Review		
249	B	USA	Mam		F	?					Review	(with only two references)	
250	?	?	?								Book chapter	EEC Occupational health review	

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251	Familial	UK	Gene								Short review about genetic screening		
252	Co	UK	FOBT			?					Intervention inviting Blood Donors to take part	No ethnic data presented, followed up with no better data from investigators	
253	Co	UK	FOBT			?					Workplace based health promotion offer of screening	No ethnicity	
254	Liver	UK	?			Migrants					Registry data on mortality by birthplace		
255	Oral	?	?								Risk behaviour in attenders at free screening clinic		
256	Pr	USA	?			Blacks					Review (short)		
257	B	Norway	Gene		F						Cost-effectiveness study from surveillance data		
258	B	UK	?		F	?					GP-based invitation letters	No ethnicity	
259	B & C	USA	?		F						Press release about national programme		
260	C	USA	Pap		F	AfA etc					National survey data		
261	C	RSA	CCT Visual		F	Black (South African)					All clinic attenders offered visual and Cervical cytology checks		
262	B	USA	Mam		F	AfA Hisp			Y		National survey data		
263	B & C	USA	CBE Pap		F	AfA Chinese Latina			Y		Outreach intervention study	Baseline data	
264	B & C	USA	?		F	Viet Latina					Lay-health worker outreach		
265	C	Can	Pap		F	First Nation					Multi-method design and evaluation	Primary care providers roles critical	
266	B	UK	?		F	Asian					Linkworker visits to ‘Asian names’	25% non-resident at registered address – ineffective	
267	B	UK	?		F	Asian					?Review and RCT of linkworkers	Did not raise uptake	

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268	B	UK	?		F	Asian					Follow-up of non-attenders (Manchester)	Half addresses wrong, one in three away in India	
269	C	USA	Pap		F	AfA					Small focus groups study of adolescents		
270	C	USA	?		F	Am Ind					Community health education intervention	'formal evaluation awaited'	
271	All	USA	All		F	AfA					Review of cultural barriers		
272	All	USA	All			Black Hisp			Y	Social Class	Reanalysis of National health Interview Survey		
273	C	USA	Pap		F	Black					Registry data		
274	B	?	?								Letter		
275	B	USA	Mam		F	AfA			Y		Survey – health Belief Models & Locus of Control		
276	?	USA	?			Hawaiian					Focus Groups with cancer survivors		
277	B	USA	Mam		F	'race'					Record based study and survey		
278	All	?	Gene								Review		
279	Oral	USA									Focus groups of dentists	? ethnicity	
280	B C Co	USA	Mam Pap FlexSig Guiac		F	?					National Women's Health Observational (?Panel) study		
281	B	USA	?		F	Latina					Ethnography & telephone survey		
282	C	USA	Pap		F	Latina					Phone survey & Ethnographic data		
283	All	USA	All			Hawaiian PacIsles					Review		
284	All	USA	Gene								Discussion paper		
285	B	USA	Mam		F	AfA					Interview survey		
286	B	Can	Mam		F	Carib					Survey of GPs		
287	B	?	?			?					Discussion of health belief model		

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288	C	USA	Smear		F	Black			Y		Follow-up compliance of abnormal smears		
289	All	USA	?			Asian Amer					Review		
290	C	NZ	Smear		F	Pacific					Qualitative interviews		
291	B & C	USA	CBE Mam Pap		F	Viet					Intervention community (media) education + phone survey		
292	C	USA	Pap		F	Black Hisp					Convenience Sample survey		
293	Skin	USA	SSE			?					Educational intervention for self-exam	'irrespective of ethnicity' (not stated)	
294	?	USA	?		F	AfA					Describes 'strategic plan'		
295	?	UK	?			?					Systematic review	HTA monograph - ??? ethnicity	
296	?	USA	?			AfA					Focus Groups		
297	B	USA	?		F	Hisp					Intervention of education via interactive computer-based soap opera	Increased knowledge and beliefs	
298	B & C	Aust	BSE & pap		F	Thai					Cross-sectional survey		
299	B	USA	Mam								Survey of primary care physicians		
300	C	?	Smear		F						Survey (matched pair) on preferences for nurse/doctor male/female		
301	?	Spain	?		F						Validation of a measure of affect	? what doing here?	
302	B	USA	Gene		F	AfA Euro NatAm Jewish					Offer of counselling to family at risk members		

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303	C	India	C Cytol/ Visual		F						Search for other determinants of risk among screened women in India	Very statistical review of records	
304	B	?	Biochem		F						Laboratory based study		
305	All	?	?								Review	Discusses ethnicity	
306	B & C	USA	?		F	Asian Am Pis			Y		Re-analysis of NHIS survey data	' to the authors knowledge this is the first … (!!!)	
307	C	USA	Pap		F	B Hisp			Y		Cross-sectional survey of adolescents attending clinic		
308	B & C	USA	Map & Pap		F						Mental health screening	? ethnicity?	
309	C	Can	?		F	?					Review of literature about role of physicians		
310	?	RSA	?								Disability study in south Africa ?		
311	All	USA	?			Am Ind Alaskan Native					Lit review (9 refs)		
312	C	Aus	Pap		F	Pacific Is, Chinese, German, Greek, Moslem (sic)	Only Muslim (it seems)				Focus Groups	No link to 'transtheoretical model' (stages of change)	
313	B	USA	Mam		F	Medicare			Y	Medicare	NHIS data reanalysis		
314	B	UK Wales	?		F	Language		Urdu Gujerati Bengali Somali			Intervention study via GPs and translation	Translation and GP endorsement work, free transport not	
315	?	?	Gene/ Biol?								Discussion of risk bio-markers		
316	B & C	USA	?		F	Cambodian					Intervention following focus groups – various outreach strategies	Raised uptake well	

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317	B	?	Mam		F						Follow-up tracking data after abnormal mammography	? ethnicity???	
318	B	USA	?		F						Review		
319	B & C	UK	?		F	S Asian African-Caribbean E Euro			'Other?'		Health promotion community development intervention and education and follow-up interviews	'need for a definitive study' – no clear follow-up outcome measures on uptake (self-reported only)	
320	B	?USA	99mTc sestamibi imaging		F						Lab based test of patients with suspected abnormalities		
321	Co	USA	DRE FOBT		M & F	Korean					Questionnaire survey on KAB	Low awareness	
322	C	USA	Pap		F	Korean					Questionnaire survey	Low awareness and use – knowledge = having had a smear.	
323	All	UK	?								Editorial review	Intro to special issue of BJ Cancer	
324	-										Medical student text		
325	Ova Endomet	UK	Ultrasound		F	?					Describes ongoing study	Ethnic group mentioned	
326	C	USA	Pap		F	?					Survey of care providers		
327	?	?	?								Waffly review		
328	C	?	?		F					Older women	Control trial of education	Education increased uptake in older women ?? ethnicity?	
329	?	USA	Phone call pre-screening								Diagnosed cancer patients		
330	B & C	USA	CBE Pap		F	Am Ind					Nurse-led clinic intervention		
331	B	Aust	Mam		F	-					Record review - ? ethnicity		
332	C	RSA	HPV, Pap Visual		F	?					Multi-method screening – sensitivity analysis	No ethnicity – H Papilloma virus DNA test is effective, easier and cheaper	
333	B & C	?	?		F	Black					Follow-up to raise compliance and referral rates		
334	?	USA	?								?		

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335	C	UK	Smear		F	'minority'					NHS – no abstract		
336	C	USA	Pap		F	Alaskan native					Random population survey		
337	?	USA	?			Hispanic					Focus groups discussion of risk factors including agricultural chemcals KAB		
338	B	UK	?								News item		
339	B	USA	Mam	Y	F	AfA			Y		Motivational telephone interviewing and follow-up		
340	B	USA	Mam	Y	F	Hisp					Series of cross-sectional surveys	Key effects of insurance and physician recommendation	
341	B & C	USA	Pap		F	'race'					Long discursive review and description of national programme (news?)		
342	Skin	?									Discussion paper about melanoma risk factors		
343	B	USA	Mam		F	B Hisp					Breast Screening project record review		
344	V	USA	?		F	Korean					Focus Group HBM interviews		
345	B C Co	USA				Chinese Am					Survey of care providers		
346	B	USA	Mam		F	?					Systematic review (it appears)		
347	B Ova	USA	Gene		F	AfA			Y		Randomised trial with education and counselling	Counselling helped raise AfA rates, not whites (Caucasian)	
348	?	USA	Trials			?					Survey of diagnosed patients – questionnaire -	'Questionnaire to determine factors that influence whether people participate in cancer control trials' (sic?)	'No AfA were accrued'
349	?	USA	Trials								Survey of diagnosed patients – questionnaire -	'Questionnaire to determine factors that influence whether people participate in cancer control trials' (sic?)	'No AfA were accrued'

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350	C	Aus	Smear		F	Arab		Arabic			Survey of Arabic speaking women attending Arabic speaking GPs	Lower than hoped-for levels of knowledge etc	
351	C	USA	Pap		F	Latina					Ethnographic and survey interviews		
352	B	USA	Mam		F	Asian			Other		Mobile screening offered to mobile older women at feeding stations	Uptake improved among older Asian transient women (must be rare!)	
353	C	USA	Pap		F	?					Mission statement about national literacy programme		
354	C	USA	Pap		F	?					Survey of women attending clinics	Literacy issue and baseline survey, survey of physicians assessments	
355	Co	Scand	FOBT			? non-migrant/ migrant					Record review and follow-up questionnaire	Non attenders had worse health, more negative attitudes!!!	
356	Co	Scand	FOBT			?					Survey of worry levels in FOBT invitees		
357	Co	USA	DRE FOBT F Sig			AfA					Survey of clinic attenders -	Audit did not confirm self-reported uptake	
358	B	USA	Gene		F	AfA					Interviews of family members and non-family members (method unclear)	Family History does raise concern about risk	
359	Co	USA	FOBT	Y		AfA					Follow-up study to earlier paper	Risk awareness poor; little relationship between baseline data and outcomes. Need education	
360	?	USA	CT & radio imaging			?					Case study	Very laboratory	
361	B	USA	Mam		F	Chinese					Describes intervention one-day demonstration clinic		
362	B	Israel	BSE Mam		F	'migrant'					Telephone Survey of clinic attenders – to establish rates & characteristics	Immigrant, low education, unmarried women need physician reminder/ education	

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363	C	UK	?		F	Caribb, Indian sub, African					Review article		
364	B Ova Colon	Can	Gene			?					Discussion	?? ethnicity	
365	C	USA	Pap		F	Cambodian		Khmer			Describes development of motivational video		
366	B & C	USA	Cerv Cyt, Mam		F	Am Ind (Sioux)					Record based review of diabetic and other patients	Found no difference – doctors missing chances for opportunistic screening	
367	B	UK	?		F	??					Observational study of effect of reminder letters and cost effectiveness	?? ethnicity – says that in inner city 'limited role/effectiveness'	
368	B	UK	?		F	'non-white'					Ecological (record-based) study by characteristics of practices not patients	'estimated proportion' of 'non-white' patients negatively correlated with uptake	
369	B	UK	?		F	'minorities'					Ecological (record-based) study by characteristics of practices not patients	Estimated percentage of minorities correlated negatively with uptake	
370	B	UK	?		F	'ethnic'					Ecological (record-based) study by characteristics of practices not patients		
371	B & C	USA	CBE Pap		F	Black					Re-analysis of national health interview survey data	Black showed greatest increases 1973-1985	
372	C	Aust	Pap		F	'migrant'					Comparison of self-reported behaviour in health survey and rates of observed registry data		
373	B & C	USA	Mam & Pap		F	Black				Y	Describes outcomes (case finding) of public clinic screen	Poor compliance with follow-up	

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374	B & C	USA	Mam & Pap		F	Black				Y	Baseline cross-sectional random survey and follow-up from records	Offering in primary care works, especially to those with several illnesses	
375	B	USA	Mam		F	AfA Hisp			Y	Y	Review of data on cases diagnosed using ecological data		
376	B & C	USA	? nurse		F	?					Cost-effectiveness of offering screening to patients in public A&E clinic	Cost-effective for Cervical, not for breast, given small numbers reached	
377	B & C	USA	Mam CBE Pap		F	Black (US Carib Haiti) and Hisp (Columb Domin, PR, Ecuador)					Quota telephone survey	Age effects	
378	B & C	USA	BSE Pap		F	Asian			Y		Survey of young students and psych barriers	'open-ness about sexuality a significant factor' – i.e. acculturation	
379	Ear	?	Bio								Lab-based study of single case		
380	B C Co Pro	USA	?			AfA	'AfA Churches'				Outreach techniques through churches – uptake judged by survey of sample	The message is heeded when delivered via the church	
381	B & C	USA	Mam & Pap		F	NatAm					Controlled Trial Impact of lay advisors in outpatient clinics	Particularly effective among low income and Native American groups	
382	C	UK	?								Discussion of models of barriers	?? ethnicity	
383	C	Can	Pap		F	?					Prison-based screening – registry data	No relation with inmate ethnicity (not described further in abstract)	
384	Skin	Aust	-								Random survey of GP patients for KAB on skin cancer	??? no ethnicity	
385	B & C	USA (Alaska)	?								Describes setting up of state service and outcomes	?? ethnicity	
386	C	USA	Pap								Editorial	Rhetoric arguing for state funding	

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387	B & C	USA	?		F	Hawaii Native					Description of Culturally competent community-based programme	Participatory action research	
388	B	USA	Mam		F	Filipina		Tagalog			Convenience sample survey – KAB		
389	B	USA	Mam		F	Filipina Korean				Y	Interview survey with convenience sample on uptake and barriers e.g. income, residence		
390	Co B & C	USA	Pap Mam BloodStool, Sig / Colonosc		F	Filipina & Korean					Convenience sample survey of uptake	Percentage of life spent in USA affects likelihood	
391	Co B & C	USA	Pap Mam BloodStool, Sig / Colonosc		F	Filipina & Korean					Convenience sample survey of uptake	Percentage of life spent in USA affects likelihood	
392	B	USA	?		F	-				Y	Effect of relocating Screening unit – records survey (postcode data)	Socio-demography more significant than distance	
393	B	Can	Mam		F	?					National survey data	?? ethnicity	
394	B	USA	Mam		F	AfA			Y		Repeated (panel) surveys of uptake	Only decent predictor of behaviour is past behaviour – which does correlate with age, poverty, minority	
395	B	USA	Mam		F	Afa					Survey and 'fatalism' inventory	Age race income may affect fatalism which does correlate with uptake but not when controlled for other variables (!)	
396	C	USA	Pap		F						Qualitative interviews with sample from clinics, about KAB and understanding of risks around HPV, warts, pap smears	Poor knowledge	
397	Skin	USA	-								Evaluation of education for nurses	Module raised levels of efficacy – nurses need more education	

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398	B	USA	Mam		F	?					Describes Early Detection programme for the medically under-served and outcomes		
399	Pr	USA	DRE		M	B Hisp			Y		Phone survey KAB and uptake	B and H had much lower levels of DRE	
400	B	USA	Mam		F	AfA					Randon KAB survey	Low knowledge but high uptake of screening and deny common barriers affected – Health Belief Model ineffective predictor	
401	C	USA	Pap		F	Black Hisp					Review article		
402	?	Ireland	?		M	Irish					Pilot study – random allocation to four different screening programmes/ health education	Minor but significant short-term changes	
403	Co	USA	Sig Colonos Barium En			AfA			Y		Medicare record data analysed	Race gender and socio-economic disparity in use of screening technologies	
404	B & C	USA	CBE Mam Pap		F	Viet		Y			Interview survey	Education (low) affects knowledge etc	
405	B	USA	?		F	Hisp (Mex)					Review and reflection		
406	B	USA	Mam		F	Tamil					Interviews and health belief model as theoretical analysis framework		
407	B	USA	Mam		F	AfA					Data method unclear		
408	Ova Br	USA	Ultrasound, Serum Gene		F	?					Cross-sectional survey of high-risk familial clinic users	?? ethnicity	
409	B	Scotland UK	?		F	?					RCT of tailored reminder letter	No effect of changing content of letter!	
410	Skin	UK	Derm			? 'skin type?					Postal survey and invitation to screening clinic	Low skin awareness and knowledge, underreported risk	
411	B	USA	?		F	B Hisp			Y		Cancer Registry data reanalysis		
412	Pr	USA	?		M	B			Y		Cancer registry type data		

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413	?	?	?		F						Guidelines	??	
414	B	USA	Mam		F	B Hisp		Spanish	Y		Telephone survey KABP	Reliance on physician information	
415	B	UK	?		F			Y (non-E)			Project report		
416	B & C	USA	Mam & Pap		F	Hisp, Black, other			Y		National survey data	Hispanic and other ethnic equal low uptake	
417	C	USA	Smear		F	Black			Y		Medical record follow-up	Community education had effects	
418	B	USA	Mam CBE BSE		F	AfA					Random sample survey K & uptake		
419	B	Israel	CBE Mam BSE		F	Russian migrants					Sample survey	Low uptake despite knowledge - ?? marginalisation affects attitude even among pre-migration screeners	
420	B Ova	USA	Gene		F	AfA			Y		KAB survey of first-degree relatives		
421	?	USA	?		M	AfA					Survey of KAB using health beliefs framework	Early warning signs and seriousness of cancer	
422	B	USA	CBE Mam		F	Samoan					Random survey KAB * uptake	Dismal screening rates in this indigenous population require attention to physician communication	
423	Co	USA	?			Black	Church				No abstract		
424	C	NZ	Pap		F	?		NESB			Postcode data on uptake rates after radio publicity	Role of ethnic media	
425	C	USA	Pap		F						Discussion of treatments		
426	B	Tobago	CBE Mam		F	African descent					Population sample survey of KABP – descriptive	Difficulty of travel to Trinidad for smear!	
427	Bowel	India	?			?					Descriptive epidemiology and discussion of trends		
428	Digestive	India	?			?					Descriptive epidemiology and discussion		
429	B	USA	-		F	AfA					Analysis of printed educational materials	Printed materials do not adequately provide information to AfA women	

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430	C	USA	Pap & liquid cytology		F	Black			Y		Cost-effectiveness modelling	Liquid-based cytology most cost-effective in high-risk groups	
431	C	USA	?		F	Hisp		Spanish			Survey of service users KABP	Low knowledge and high rates of misperceptions – eg. surgery and bruises cause spread of cancer – avoid lumpectomy	
432	-	Japan	Blood test								Discussion of Japanese Eugenic law		
433	B	USA	Mam		F						Discussion		
434	B	USA	?		F	AfA					Review article		
435	Pr	USA	DRE PSA		M	Black					Review article		
436	B	UK	?		F	?					Routine data analysed, discussion of implications of raising age limits	??? ethnicity	
437	?	USA	?		F	Black			Y		Phone survey of non-responders to invitation to enter trials -	Reasons why black women do not take part in trials – mistrust of white establishment	
438	B	USA	Mam		F	AfA					Describes development of training programme for mammographers including cultural competence issues	Positive evaluation	
439	?	Can	?			?					Focus groups of older people	'various ethno-cultural groups included'	
440	Pr	USA	?		M	AfA					Phone survey on KABP and med history	High knowledge of raised risk, willing to be screened	
441	Pr	USA	?		M	AfA					Phone survey on KABP and med history	High willingness to be screened	
442	Pr	USA			M	AfA					Phone survey on KABP and med history: RCT of invitation letter	High knowledge of raised risk, willing to be screened – tailored invitation with education raised attendance	
443	Pr	USA	Blood (PSA) DRE		M	AfA					Phone survey on KABP and med history	High knowledge of raised risk, willing to be screened	

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444	Pr	USA			M	AfA					Phone survey on KABP and med history	High knowledge of raised risk, willing to be screened	
445	All	China	?			Chinese					Survey of factory workers knowledge and attitudes	Low and need to be raised	
446	C	UK Scotland	GPs		F	?					Cost-effectiveness study	??? ethnicity	
447	Oral	Japan	Mucosal			Japanese					Description of incidence from screening pilot	Also data on smoking and drinking	
448	C	UK	Cytol		F	Bengali Kurdish Turkish Urdu Punjabu & Chinese		As ethnicity			Focus Group study of perceptions of barriers to uptake	Attitudinal barriers less important than structural – administrative and language – women enthusiastic once purpose and procedures explained in own language	
449	Liver	Japan	Gene								Case study – highly technical lab based data		
450	Ova	UK, Can USA	Gene		F	?					Case control study of tubal ligation risks	?? ethnicity	
451	B	HK (China)	BSE		F	Chinese					Cross-sectional survey of cancer cases	Poor response rate	
452	B	USA	CBE Mam		F	Viet					Intervention study of community education	Low impact on behaviour	
453	C	Ireland	Smear		F	Irish				Y	KABP survey of urban women and GUM clinic attenders	Socio-econ effects on knowledge and uptake	
454	B	USA	Mam		F	Black					Describes nurse-led intervention		
455	Pr	NL	PSA DRE ultrasound		M	?					Survey of attenders and non-attenders	?? ethnicity	
456	Co	?	FOBT	Y		'Asian-African' ?					Follow-up survey of attenders and non-attenders etc	Refusers were more likely to be of 'African-Asian (sic) descent, smoke, drink coffee and use less tea or dairy – refusers have worse outcomes	

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457	Pr	USA	PSA DRE		M	AfA			Y		Descriptive survey of convenience sample – using 'Cues to Participation … theory and exposure to media	Hearing about screening helped, especially from a health care provider, to raise uptake – not from family or friends	
458	B & C	USA	Mam & Pelvic exam		F	Disability					National survey of women with physical disabilities data	Race significant effect for pelvic but not mammogram use	
459	B & C	USA	Pap BSE CBE Mam		F	Black, Caribbean B Haitian B P Rican Dominican Columbian Ecuadorian (Hisps)		Spanish			Structured phone interview re continuity of care		
460	B C Co	USA	Pap CBE Mam FOBT		F	AfA			Y	Y	Phone survey of KABP and patient satisfaction	Role of HMOs and insurance status	
461	B	USA	Mam		F	Black			Y		Breast Cancer Screening programme and survey data	Black lower report of uptake, doctor recommendation crucial	
462	B	USA	Mam		F	Black			Y	Y	Survey of compliance and econ/soc factors, physician recommendation and education	Factors affect doctors reported recommendation, which affects use	
463	B	USA	Mam	Y	F	Black Hisp			Y		Intervention RCT of mailing re Medicare cover for screening	Mailings raised uptake in B and Hisps	
464	B	USA	?		F	Black					Discussion, Leininger and Health Belief Models		
465	All	USA	?			AfA Hisp API NatAm Native Alaskan Hawaiian					Review		

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466	?	USA	?			AfA					Survey of involvement in cancer screening activity of nurses		
467	C	UK	Smear		F	?					Post-smear interviews on psychosocial effects	Sheina Orbell – pain and embarrassment affect more than fear; social class effects	
468	C	UK	Smear	Y	F	?					Follow-up study using medical records and earlier psychosocial data	S Orbell – choice motivation poor correlation with action	
469	C	USA	Pap		F	?					Discussion of lab based methods to estimate uptake		
470	B	USA	BSE Mam		F	Hisp					Survey of mental health clinic patients	Physician recommendation matters – Psych can do this	
471	B	USA	Mam Pap		F	Yes but not stated in abstract				Y	National survey data from surveillance system self-reports	Ethnicity and education not associated but other related factors (income, insurance etc) do.	
472	B	USA	Mam		F	AfA					Qualitative interviews after false positive results		
473	Co	USA	FOBT Home / Office Sig Colonosc			AfA Latino					RCT of screening methods	Patients were non-compliant in home based FOBT but compliance better in office and follow-up	
474	C	Aust	Pap		F	Pacific Ils, Chinese, German, Greek, Moslem (sic)	(Muslim women as group)				Qualitative & Focus group interviews analysed by the Transtheoretical Model of Behavioural Change (6 stage)	No evidence of ethnic differences in terms of the model but preference for own language and female practitioner	
475	B	USA	Mam		F	Black			Y		Medicare record data	Previous behaviour predicts future, more for black and older – get the first one done	
476	Ova	UK	Ultrason	Y	F	??					Feasibility of screening at Breast Screen centre – descriptive, part of multi-centre trial	Pilot	
477	B	USA	Mam		F	Am Ind					Discussion		

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478	?	USA	?			Multi-		Spanish Cantonese Mandarin Vietnamese			Critical reanalysis of data from surveys plus focus groups etc	Critique of quality of data in multi-ethnic surveys –casts doubt on data quality and results	
479	B	USA	Mam		F	AfA					Describes development and evaluation of a photo-essay	Seems to overcome problems of literacy etc	
480	?	USA	?			Afa					Review of methods to increase inclusion of AFA in cancer trials	It can be done	
481	B & C	USA	Mam & Pap		F	?					Follow-up to check validity of self-reported screening	?? ethnicity	
482	B C Co	USA	Mam Pap BSE FOBT FlexSig		F	AfA			Y	Income	KABP survey	Income most effective effector	
483	B & C	USA	Mam Pap	Y	F	AfA					Monitor clinic record data against educational interventions and computer tracking	Improved results	
484	B & C	USA	Mam Pap	Y	F	AfA					Monitor clinic record data against educational interventions and computer tracking, survey data, control city data cross-sectional survey	Improved results	
485	Co	USA	FOBT Flex Sig		F	AfA					Random sample home survey KABP	Poor knowledge, good attitude, reported barriers	
486	Ova	UK	Gene/ serum		F	African, Asian			Y		Baseline data from laboratory tests on post-menopausal women	Lower CA125 levels in Af & Asian women	

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487	B	USA	Mam		F	Black Hisp			Y		Review of literature and data extrapolated from national survey using the model of Transtheoretical (6 stage) change	Race and ethnicity interact with socio-demographic factors	
488	B & C	USA	Mam CBE Pap		F	Black			Y		National Health Survey data	Further barriers to mam screening	
489	Oral	UK	Dental			Bangladeshi					Interviews – paan and tobacco use	Low take-up of dental care' language problems, tobacco chewing women	
490	C	USA	Pap		F	Latino (Mexican, P Rican)					Convenience survey interviews	Mexicans and older less regular screening	
491	?	USA	?			Asian					Describes development and evaluation of educational programme through Asian convenience stores	More research is needed	
492	B & C Co	USA	Pap Mam CBE DRE FOBT Sig			Latino			Y		Random telephone surveys	Latino 'a relatively minor predictor' of use but there are differences that need to be taken into account	
493	C	UK	Smear		F	?					Review – not very detailed	??? ethnicity	
494	B & C	USA	?		F	Native Am Alaskan native					Describes educational programme for nurses	Training associated with higher levels of uptake	
495	B & C	USA	Mam Pap		F	Vietnamese					Survey of knowledge and behaviour	Pressing need for educational interventions, low knowledge and misperceptions	
496	B	USA	Mam		F	Black Hisp			Y		National Survey data for two years – trends	Decreased differences – better education	
497	B & C	USA	Mam & Pap		F	Hisp					Reanalysis of NHIS data – commentary		
498	B	USA	Mam CBE BSE		F	AfA					Quota sample survey		

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499	B	USA	?		F	AfA					Focus Group discussions	Breast Cancer is seldom discussed … misperceptions and fatalism – educational level matters	
500	B	USA	?		F	AfA					Qualitative – hermeneutic phenomenological	Need for holism	
501	B & C	USA	-		F	Viet Cambodian		Y			Qualitative telephone interviews on knowledge	Over 70% did not know what cancer was – need for language and cultural sensitivity in information based on levels of knowledge	
502	Pr	USA	?		M	AfA					Discussion based on Health Belief Model		
503	Pr	USA	-		M	Black			Y		Tumour registry data survival analysis		
504	C	USA	Pap		F	AfA Latina					Questionnaire survey based on Theory of Planned Behaviour	TPB did not survive encounter with ethnic groups	
505	Co	USA	FOBT		F	AfA					Fatalism study – questionnaire survey non random	Fatalism strong and explained low FOBT	
506	?	USA	-			AfA					Review stressing role of fatalism	Author is pushing fatalism in Black populations as explanation	
507	Co	USA	FOBT			AfA					Control trial using video education to combat Fatalism	Video ‘telling Gods will’ decreased fatalism and raised uptake	
508	Co	USA	?		F	AfA					Survey using standardised questionnaires to establish fatalism and KAB	More evidence of fatalism among older poorer AfA rural women in day centres	
509	B	USA	Mam		F	Black			Y		Medicare records data analysis	Medicare reimbursement for screening raised uptake	
510	B	USA	Pap		F	‘ethnicity’					National risk behaviour data from telephone survey	Complex mathematical modelling – ethnicity not directly linked to risk taking BUT.	
511	B	USA	-		F	Mexican					Grounded theory study using focus groups	Traditional cultural beliefs may be barriers to screening	
512	C	UK	Smear		F	-					Registry data analysis	Screening has little impact on death rates but may protect from litigation	
513	?	UK	?			?					Discussion about ethics and policy and information	??? ethnicity (nil)	

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514	Pr	USA	?		M	?					Follow-up pilot study of screened males – motivation and info needs	Rural men differ from urban – wives or doctors information in country, media in town	
515	B	UK	?		F	'ethnic minority'					Review of literature		
516	B	UK	?		F	'ethnic minority'					Review of literature	Repeat of 515	
517	B	USA	Mam CBE		F	?					Discussion about the role of cultural explanatory models	?	
518	B	USA	?		F	Asian	Islam				Review of Islamic teaching and relevance to attitudes towards Screening	Need to place info in religious and socio-cultural context	Get it!
519	B	USA	Mam		F	?				Y	Randon phone survey of smoking behaviour and mammography	Smokers less likely to be screened	
520	?	USA	?			Hispanic					Discussion paper		
521	B & C	USA	Pap Mam		F	?					Describes development and implementation of intervention through lay education and referral process	Use of role modelling	Looks interesting but no evaluation of outcome
522	B	USA	Gene		F	AfA			Y		Survey of patients waiting for services – KABP	Differing dimensions of informed consent identified	
523	B	USA	BSE		F	Middle-East Asian	Islamic				Exploratory descriptive KAB study	Champions BSE tool – low levels of knowledge among 'Middle-Eastern Asian women at mosques'	
524	?All	UK	?			Chinese Turk Arab Greek					Literature review and discussion		
525	B & C	USA	Mam & Pap		F	Hisp Mexican, P Rican, Cuban, Central Am					Questionnaire survey on knowledge of screening guidelines KABP	Attitudes were not predictive of reported behaviour – ethno-regional differences emerged	

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526	All	USA	?			?					Focus Groups on barriers for rural people	??? ethnicity	
527	Liver	?	-								Laboratory analysis of ayurvedic herbal cures	??	
528	B & C	USA	Mam Pap CBE		F	?					Describes the design of the National health Information Survey and role of community clinics	CHCs raise minority participation	
529	B Ova	Norway	Gene		F	?					Family members survey with standardised instruments e.g. HADS GHQ Hopelessness	??? ethnicity	
530	B	USA	Mam		F	??					Literature review on role of HMOs	USA based – role of Medicare etc	
531	B & C	Israel	BSE Mam Gynae exam		F	Russian migrants					Survey of migrant women of Russian origin	Post migration changes in screening behaviour	
532	B & C	Israel	BSE Mam Gynae exam		F	Russian migrants					Literature review	Low self efficacy	
533	B & C	USA	Mam & Pap CBE		F	Hisp (Columbian Dominican P Rican Ecuadorian Black – US, Carib, Haiti					Telephone survey of quota sample on use of screening and predictor demography	Age effects and having carer – healthy older women (and unhealthy younger ones) more likely to be screened	
534	Co	USA	Colonoscopy			-					Discussion argues against reliance on FOBT and shows that Endoscopic raises detection rates	? review?	

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535	B	USA	Mam		F	?					Cost-effectiveness study of workplace-based intervention	??? ethnicity	
536	B	UK	?		F	?					RCT and cost effectiveness study of interventions to invite women –	Letters cheaper ??? ethnicity	
537	B	USA	All		F	?					Registry data to examine treatment of early detected low income women	No bias detected	
538	B	USA	Mam Pap CBE		F	?					?survey? or clinical review of patients at low income health centre	??? ethnicity	
539	B	USA	Mam		F	?					Telephone survey of Blue Cross women KABP	Confusion about consensus guidelines	
540	?	USA	?								Broad literature review or editorial		
541	C	USA	Pap		F	Am Indian					Random household survey of uptake	Low – lack of access and knowledge	
542	B	USA	Mam CBE		F	Am Indian					Random household survey of uptake	Low access and uptake	
543	?	USA	? Risks		F	Am Indian					Random Household survey of risky behaviours etc	High levels of need for prevention	
544	B	USA	Mam		F	Black					Mobile outreach intervention and sample survey	Unclear design but functional barriers identified	
545	B	USA	CBE Mam		F	Black			Y		Multi-strategy intervention and follow-up? Risk factors and behaviour survey	No differences found between AfA and whites in this one once recruited	
546	?	USA	?		F	Lesbian					National survey of lesbian health behaviour	??? ethnicity	
547	?	USA	?			Afa					Literature review on innovative strategies		
548	Pr	USA	?		M	AfA					Focus Group discussions		

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549	B	USA	Mam		F	?					Cross-sectional survey of participants in Florida project	More need correlates with more barriers and lower motivation	
550	All	USA	All			AfA Hisp				Y	Registry data on stage and outcome against Medicare cover		
551	B	USA	Mam	Y	F	?					Retrospective follow-up of abnormal screened mammograms with report on compliance and advice given	Need for better communication of results	
552	B	USA	Mam		F	Black Hisp Asian			Y		Health Belief Model survey of hospital employees		
553	B	Can	Mam		F	?					Ecological data analysis ? from records	??? ethnicity	
554	B	USA	?		F	AfA					First degree relative study – no abstract		
555	B	USA	Mam		F	Race			Y		Health belief Model random survey sample	Race / ethnic no impact ?	
556	B & C	UK	?		F	?					Letter?	Relation to childhood immunisation?	
557	B	USA	?	Y	F	Asian		Y			Intervention study of lay health educators in grocery stores	Baseline and follow-up survey - effective	
558	B	USA	?		F	Chinese					KABP survey?		
559	B	USA	BSE Mam		F	Asian Indian					KABP survey	Inadequate knowledge -	
560	B	USA	Mam		F	Vietnamese					KABP survey	Low knowledge	
561	B	USA	?		F	??					Case Study discussion	?? ethnicity	
562	C	Spain	Pap		F	Migrant				Y	City Health Survey	Migration puts you at risk of low socio-econ status equals poor health access	
563	Liver	USA	Ultra-sound			?					Literature review based cost-effectiveness		

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564	B	USA	Mam		F	AfA			Y		Age and reasons for not getting screened ? survey data	Unclear data collection	
565	B	USA	Mam		F	AfA			Y		Record-based study	AfA women more likely than whites over life to have Mam in Missouri (!)	
566	B	USA	Mam		F	?					Survey of women given 'free screen' ticket (?intervention)		
567	C	Bali	Pap		F		Hindu Muslim				Record-based study		
568	C	Germany	Pap		F	??					Describes uptake data from national records and German policy etc		
569	B	USA	?			Black			Y		Medicare record data	Blacks less likely to get screening – various other health risks also covered	
570	B	USA	Mam		F	AfA Latina			Y		RCT of video-messages to explore effect of cultural and message targeting	Loss-framed multi-cultural affected Anglo and Latina better but not AFA women	
571	B	USA	Mam		F	AfA			Y		Record based study on quality of service	No racial difference proven	
572	C	USA	Pap		F	Vietnamese		Vietnamese			Survey (non-random) of attenders at Viet churches KABP	Low awareness of risk	
573	C	USA	?			Black			Y		Record data on mortality risks	Multiple disease study – excess among Blacks not explained by incidence	
574	P	USA	PSA		M	Black			Y		Record based study	Age effects	
575	?	USA	?			AfA					Discussion		
576	B & C Pr Co	USA	?			AfA			Y	Y	KABP survey	Differences including fatalism and access and etiologic myths among Black population mistrusting white services	
577	C	Singapore	Pap		F	Chinese					Uptake and socio-demographic survey in Malaysia	?? unclear if Malay women or other ethnic groups	
578	C	Singapore	Pap		F	?					Random Household survey of knowledge and intentions KABP	Perceived barriers and susceptibility effects	

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579	B	Singapore	Mam		F	Chinese Indian Malay					Survey of attenders and non-attenders KABP	Strongest factor affecting behaviour was spouse encouragement	
580	C	Singapore	Pap		F	?					KABP screening survey	?	
581	B	USA	Mam		F	Black Hisp			Y		Random phone survey interviews	Most effective was if doctor had discussed	
582	B	UK	?		F	?					RCT of health education, nurse visit, GP letter on screening uptake	Letter from GP seems to work. ??ethnicity – but in LSL Camberwell area so should be	
583	All	USA	All			?					Knowledge survey among doctors in an under-served community – educational visit intervention	Raised awareness ??? ethnicity	
584	Pr	USA	?		M	AfA					Sample survey of perceived barriers and attitudes	Embarrassment seems high	
585	B	UK	?		F	?					Descriptive		
586	Co	Israel	FOBT Colonoscopy			?					Epidemiological survey of first-degree relatives	?? ethnicity	
587	Co	USA	Sig			AfA Chinese			Y		Telephone interviews with first degree relatives	AfA distrust doctors; Chinese prefer ‘eastern’ medicines	
588	C	USA	Mam CBE Pap Clin Exam			AfA			Y		Data from major regional probability surveys on risk etc	Links to other health risks etc	
589	B	USA	Mam	Y	F	Black					Intervention study of letter reminder	Low impact even though letter recalled	
590	B	UK	?		F	?/					Literature review	?? ethnicity	
591	B & C	USA	Mam BSE Pap		F	Hisp					KABP survey	Cost and lack of worry reasons for non-compliance	
592	B & C	USA	Mam Pap BSE		F	Hisp					KABP survey	Income and being taught BSE raised …	

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593	B	USA	Mam		F	Black					Intervention RCT messages tailored as reminders followed up by telephone survey	Works for low income black women	
594	B	USA	Mam		F	AfA					Focus groups on acceptability of mobile services	Need advance knowledge, assurance of privacy, link to primary care centres not shopping	
595	B	USA	Mam		F	?					Theory-led educational intervention described		
596	B	USA	Mam		F	AfA					KABP interview survey – linked to Stages of Change model		
597	B	Aust	Mam CBE BSE		F	?ethnicity			Y		National health survey data	'ethnicity significantly associated' (no detail in abstract)	
598	C	USA	Pap		F	Am Indian					?unclear source	Worse health status and access	
599	Pr	USA	?			?					Literature review	Major review but very dependent on biological research showing ? molecular differences between ethnic groups	
600	B	USA	Mam		F	?					Medicare record data	??? ethnicity	
601	B	USA	BSE CBE Mam		F	AfA					?	Reports difference arising from ethnicity and style of recommending doctor – no design described	
602	B	USA	Gene		F	Ashkenazi (Jewish)			?		Psychological profiles of women coming for tests	Predictors of distress	
603	Lung	Japan	X-ray Sputum								Case control retrospective survival study	??? ethnic	
604	C	USA	Pap		F	Am Indian					Survey to develop traditional behaviour scale	Unsuccessful – no relation to behaviour	
605	B	USA	Mam		F	?	Church attendance				Telephone interview KABP	Church members attend more but no reason found	
606	?	USA	?			AfA					No abstract		

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607	Pr Lung Co Ova	USA	All			Black					Describes design of study to establish differences in the PLCO trial		
608	Co	Aust	Gene			?					Case study of extended family members	?? ethnicity	
609	B	UK Scotland	?		F	-					Postal survey and interviews of attendees to determine reasons for (non) attendance	Distance and accessibility. ???ethnicity	
610	B	UK	?		F	?					RCT of fixed vs free appointment time in reminder letter	Fixed works better ??? ethnicity (even tho in Coventry Warwick & Solihull) 1997	
611	Pr	USA	PSA DRE		M	AfA			Y		Risk assessment survey – telephone survey -	Physician advice crucial, also race	
612	Focus on Learning Disability	UK	Mam, Smear			? LDs ?					Survey of GP views on management of health needs of people with learning Disability	Cautious attitude towards screening among these users	
613	B	UK	?								Letter	??? ethnicity	
614	?	USA	?		F	Alaskan Native					Case study and discussion	Description	
615	Pr	USA	?		M	AfA					No abstract - ?editorial		
616	B	Singapore	Mam		F	Chinese					Focus groups and theoretical model – fatalism, costs, misinformation and motivators		
617	B & C	USA	Mam Pap CBE BSE		F	?					Discussion ? review plus reused community survey data		
618	B	Singapore	?		F	Asian (sic)					Survey data (poorly described method)		

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619	B	USA	?		F	?					RCT of educational intervention (multimedia / written) and KABT before and after survey	All improved, younger women learned most	
620	C	USA	Pap		F	Am Indian					Focus group and grounded theory ethnography	Highlights aspects of Native Indian culture	
621	C	USA	Pap		F	Am Indian					Discusses importance of qualitative research		
622	B & Ova	USA	Gene		F	??					Interviews with family members	??? ethnicity	
623	B & C	USA	?		F	Mexican AfA					Impact study of role model stories and volunteer peer health educators	Unclear what control rates were	
624	B & C	USA	Pap & Mam		F	Hisp		Spanish		Y	Acculturalisation scale and Uptake survey	Various scales of Hispanic cultural values and English proficiency predict behaviour	
625	?	USA	Mam & Flex Sig			Black					Discussion and description of the problems of running a mobile service		
626	C	USA	Pap		F	See note					Retrospective analysis of medical insurance records	Non-adherents were 'other than non-Hispanic white' (i.e. were other …)	
627	B & C	USA	Mam & Pap CBE		F	AfA					Household interview survey KABP and uptake	Knowledge levels varied and explain more than beliefs	
628	B & C	USA	Pap CBE Mam		F	AfA					RCT of educational intervention	LHWs affect mammography in low income inner city black women	
629	B & C	USA	Pap CBE Mam		F	AfA					RCT of educational intervention	Describes the study – low participation rate noted	
630	B & C	UK	?		F	South Asian					Pairwise analysis of record data	Asians under-represented in Breast screening, slightly worse cervical history (not sig)	Should have been ordered
631	B	UK	?		F	Black			Y		Prospective study – survey before invitation to screen	Recommends that properly conducted RCTs be conducted…	
632	Endo	?	Ultrasound		F	?					Discussion of Literature review	Mentions ethnicity – no detail	

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633	?	?	?			Chinese					HADS and other pain and depression scales in cancer sufferers	Not about screening	
634	?	USA?	?			Lao, Hmong, Vietnamese Cambodian					Medical records – not about cancer? Physical disability and mental health	Neurological and war-related trauma found in refugees (surprise) – no mention of cancer in abstract	
635	Oral	Malaysia	?			Malay Indian					Health belief Model KABP interview of screened workers	Link to Betel habit	
636	B & C	USA	BSE Pap		F	Asian			Y		Survey of cultural factors in participation in screening among young women	Lacks detail on method	
637	B	USA	Mam CBE BSE		F	Chinese					Questionnaire survey of recruits KABP	Cultural factors have high salience on beginning screening	
638	Co	USA	FOBT Sig		F	Chinese					Questionnaire survey of older women	Underuse of screening but not sure why	
639	B	USA	Mam		F	?					Multi-ethnic focus groups	Fears of radiation, discomfort etc – and effect of previous experience of mammogram but this does NOT affect likelihood of another mammogram (!)	
640	B	USA	Mam		F	?					Multi-ethnic focus groups	Duplicate of 639	
641	B	USA	BSE CBE Mam		F	Guam (Chamorro)					KABP survey		
642	B	USA	BSE CBE Mam		F	Hmong					Interview survey of uptake		
643	B & C	USA	?		F	AfA					Describes the setting up of the Forsyth County educational intervention		
644	?	USA	?			AfA Hisp	Spirituality focus				Discussion Literature review on spirituality		
645	C	Aust	Pap		F	Migrant				Y	Data extracted from national health status surveys	??? ethnicity (Mentions migrant status)	

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646	C	Aust	Pap		F	Migrant		Y		Y	Data extracted from national health status surveys	??? ethnicity (Mentions migrant status and origins in various countries inc. S Europe, SEAsia MiddleEast Greece etc	
647	B	USA	Mam		F	'Racial'			Y		Interviews with primary care clinic users	Wide variety of issues and beliefs discussed	
648	C	USA	Pap		F	Cambodian					Survey of residents on beliefs and uptake	Some culturally specific issues (karma, female doctor)	
649	C	USA	Pap		F	Chinese		Y			RCT of invitations (plus educational input) multi-media vs letter	Outreach better than letter better than usual care	
650	B	USA	Mam		F	AfA					Focus groups in natural settings	Various outcomes – cost a matter of priorities, doctors for cure not prevention	
651	Co	USA	Flex Sig			Asian Black Latino			Y		Care records on registry data reviewed to establish if ethnicity affects viability / sensitivity of Flex Sig as diagnostic procedure	FS better at detecting CRC in Asians (and Latinos) than Whites (Blacks even worse)	Significant issue
652	B	USA	Gene		F	?					Discussion	??? ethnicity	
653	B	USA	Mam		F	Multiethnic					Health Belief Model random sample interview	Asserts ethnicity (no detail) had no impact	
654	B	USA	CBE Mam		F	?					Age only factor affecting follow-up		
655	Co	Aust	FOBT Sig			??					Random telephone interview of knowledge and attitudes -	Low knowledge but little resistance. ???ethnicity	
656	B	UK	?			African Caribbean					? no abstract		
657	Pr	USA	DRE PSA			AfA			Y		Intervention Trial – various educational interventions	Some worked better than others, whites did best	
658	B	UK Wales	?			??					Before and After study of new booking system for mobile screening	??? ethnicity	
659	?	USA	?		F	Vietnamese					No abstract		

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660	B	USA	CBE Mam		F	Cambodian					Cross-sectional household survey		
661	B	UK?	?		F						RCT of invitation with GP letter	??? ethnicity	
662	C	UK	?		F						Letter ?		
663	C	Hong Kong	?		F	Chinese					No abstract		
664	C	Hong Kong	Pap		F	Chinese					Interview plus focus groups on if nurse acceptable (rather than doctor)	No white control but greater confidence in nurses expressed	
665	C	Hong Kong	?		F	Chinese					No abstract		
666	C	Hong Kong	Pap		F	Chinese					Interview plus focus groups on if nurse acceptable (rather than doctor)	No white control but greater confidence in nurses expressed	
667	C	Hong Kong	Pap		F	Chinese					Discussion of health education aspects of study and methodology		
668	Gastric	?	H Pylori		?	?					Literature Review article		
669	?	USA	?		M	AfA					Discussion		
670	B	USA	?		F		Muslim				Focus groups	Importance of ensuring screening is seen to be consistent with Islamic principles	Important to read
671	B	USA	?		F	AfA					Method unclear		
672	All	USA	?			AfA					Describes educational provision to support nurses working with African Americans		
673	B	UK	Forrest		F	?					Prospective study with survey before invitation to attend	Predictive influences include belief that 'salient others' want (her) to attend ??? ethnicity	
674	B	USA	Mam		F	AfA Hisp Asian					Population sample survey – uptake and reasons	Expense and lack of insurance, after 'not important enough to do' – Hispanic low rates	
675	B	NL	Mam		F	?					National health Interview Survey data	??? ethnicity	

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676	-	USA	- (mental health)			Mexican, AfA			Y		Mental health Allen Cognitive Levels ACL assessment for schizophrenia –	Not cancer	
677	B & C	USA	?		F	?					No abstract		
678	Co	UK	FOBT Flex Sig			?					RCT of tests	Uptake of FS higher – FOBT missed cases	??? ethnicity
679	B	USA	Mam		F	Black Hisp			Y		Major survey of attenders to establish perceived risk factors		
680	Co	USA	?		M	AfA			Y		Developmental work on a scoring system for beliefs and attitudes, mostly done with white male workers – small confirmatory study with AfA and women groups	Scale needs to be evaluated among other (ethnic/ gender) groups	
681	B	USA	Radio-pharma		F	?					Lab trials of new test	?? ethnicity	
682	B	USA	Gene								Discussion of ethical issues	?? ethnicity	
683	B	USA	Mam		F	?					Prospective record tracking study	?? ethnicity	
684	Gastric	Japan	?			?					Organisational study with ecological data and survey of administrators	?	
685	B	USA	Mam		F	Black					Method unclear – suggests women associate breast cancer with bruises from domestic violence	Notes that Faith (Gods will) motivates health-seeking behaviour not fatalism	
686	Skin	?	?								Interviews with hospital employees workplace screening about fears and risks		

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687	B	USA	Mam		F	Black					Telephone interviews using Health Belief Model into KABP	Black and white have different explanatory models, blacks underestimate risk – but no difference in uptake	
688	B & C	USA	Pap Mam		F	Obesity (!)					National health Interview Survey data	??? ethnicity but obese women less likely to be screened	
689	Co	Japan	FOBT			Japanese					Long-term record-based study	Compliance deteriorated over time	
690	Pr	USA	Gene		M	AfA					Pilot survey to test levels of interest among AfA men	Strong intention to test expressed but confusion over screening tests	
691	Co	USA	FOBT			AfA			Y		Describes teaching method for older people in quasi-experimental test – post-test study on age effects	Improved uptake - NB use of peanut butter in some sites (not separately analysed?)	
692	Co	USA	FOBT		M	AfA					RCT of peer education on uptake	Peer education and client navigators raise uptake	
693	Pr	USA	DRE PSA		M	AfA					Survey of self-reported urinary symptoms	Need to repeat that Prostate cancer does NOT have urinary symptoms	
694	Pr	USA	PSA DRE		M	AfA			Y		Quasi-Experimental design with pre-test knowledge questionnaire survey	More knowledge predicted participation	
695	Pr	USA	PSA DRE		M	AfA					Descriptive study offering educational programme and free screening through different routes	Mass screening at state fairgrounds, the standard method, ineffective for AfA – Work sites and NAACP sites worked will as did churches; most cancers found at housing projects – outreach needed	
696	B	USA	?		F	?					Tracking record data analysis	Highlights risk groups for extra rescreening	
697	Gastric	USA	?			Latino					Literature review	Comprehensive risk assessment of many diseases – not just cancer	
698	Skin	USA	SSE			?					Test-retest and RCT education input	Education raised knowledge cost-effectively	
699	Lung B & C	USA	Pap Risk assess			Am Indian Sioux					Risk assessment study	Various recommendations	

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700	C	NZ	Smear		F	ONLY whites invited to take part: (Caucasian)					in-depth interviews	Pilot	
701	B & C	USA	Pap Mam CBE		F	AfA					Record-based study	Serious shortfalls found	
702	Pr	USA	PSA		M	Black			Y		Retrospective case control record based study	PSA seems to be same across black and white men	
703	B	USA	Mam CBE		F	AfA					Focus groups	Distrust of clinics, prefer 'their own'	
704	B	USA	?		F	Mexican					Focus groups	Shame/ cultural prohibition on touching or exposing breast inhibits uptake	
705	B	UK	?								Report on national NHS activity	No abstract	
706	Co	?	FOBT Sig								Telephone survey about KAB and barriers	Misconceptions and lack of knowledge common	
707	Ova	UK	?			?					Letter		
708	Ova endometrial	UK	Ultrasound		F	'non-caucasian' (sic)			Y`		Survey via GPs	Non-Caucasians more willing to be screened – feasibility study, indeterminate results	
709	B	?	?								Clinical Trial – record based review?	Design unclear	
710	All	USA	All								Literature review		
711	Liver	USA Hawaii	?			Asian					Retrospective record-based study	Suggestive of a role for screening	
712	C	RSA	smear		F	Black					Anthropological study of three language groups	Traditional views of the womb, promiscuity and sexual health confused with cancer	
713	C	RSA	Pap HPV direct clinical observation colposcopy		F	Black					Cross-sectional observational study comparing results of different screening techniques and detection rates	HPV may have its uses	
714	Liver	Japan	-								Case study		
715	All	Japan	-			Japanese					Literature and policy review		

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716	C	USA	Pap			AfA Latina					Review and case study description of impact of video shown in waiting room	Informal evaluation (!)	
717	C	USA	Pap			AfA Latina		Spanish			Quasi-Experimental evaluation of technique described above (716)	Suggests that culturally sensitive videos led to higher rates in weeks when shown	
718	B & C	USA	Mam pap CBE			AfA					Describes computer-based reminder system for doctors implementation and outcomes	Did raise compliance but not enough – low activity level by physicians in low-income areas	
719	B	USA	CBE Mam		F	Vietnamese					Telephone survey KABP	Income, length of residence, age etc all affected (low) rates of uptake	
720	B	USA	CBE Mam		F	Cambodian					Telephone survey KABP		
721	B	USA	Mam		F	AfA			Y		Record-based survival analysis	Ethnic differences in stage at diagnosis are critical for survival differences	
722	-	USA	-								Tai Chi, exercise and Blood pressure RCT	Not cancer -	
723	C	Can	Pap		F	Aboriginal (Canadian)			Y		Data linkage of records	Urgent need for pap screening in aboriginal populations	
724	C	UK	Smear		F	-					Random survey	??? ethnicity (probably not tested)	
725	B & C	USA	CBE BSE Pap Mam		F	Chinese		Mandarin and Cantonese			Random Survey Interviews KABP using NHIS translated	Spoken English fluency correlated with knowledge and uptake	
726	Co	USA	DRE FOBT			Chinese		Chinese			Random Survey Interviews KABP using NHIS translated	Education link to use of DRE, age to FOBT – lack of regular source of health care	
727	B	USA	?		F	Chinese					Describes problems of drawing up survey frame list of Chinese women for study		
728	?	USA	?			?					Older people survey using Ware's HPQ and participation in cancer screening studies	Ethnicity mentioned but no detail given	

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729	?	USA	?			?					Older people survey using Ware's HPQ and participation in cancer screening studies	Ethnicity mentioned but no detail given	
730	-	Denmark	Hypnosis study								Danish adaptation of Harvard Group scale of Hypnotic susceptibility	Not cancer!	
731	B & C	USA	Pap Mam CBE		F	Hisp Mexican P Rican Cuban Other					Reanalysis of NHIS national sample survey data	Differences within category Hispanic	
732	All	USA	-			Hisp AfA		Spanish			Sample survey of home care attendants	Various 'cancer and disease myths'	
733	B	USA	Mam CBE		F	Hisp					Pre and post intervention study – intervention ? educational not described in abstract		
734	C	Aust	Pap		F	?					Letter		
735	B	USA	Mam		F	Black Hisp					Registry data evaluation		
736	B	USA	Mam		F	?					Describes intervention and admin record data		
737	B	USA	Mam		F	AfA					Baseline survey data KABP	Women who had a mammogram recently were different in many ways – including being in more social networks	

# BSE = breast self examination
CBE = clinician breast examination
Mamm = mammography
Flex sig = flexible sigmoidoscopy
FOBT = faecal occult blood test

** - Describe whether these relate to:
- specific knowledge
- personal belief about susceptibility
- belief about cancer itself
- beliefs about screening

Also – highlight any papers/ instruments used to measure anxiety

APPENDIX 10: Predicted UK CRC Screening Uptake Rates by Unitary Authority

Table A10.1: Predicted uptake rates by Unitary Authority for England

Unitary authority	unemployment rate	percent muslim	percent non-muslim asian	% 50-64 year olds female	%50-64 year olds aged 60-64	Predicted uptake rate
064 ENGLAND	5.0	3.4	2.2	50.6	27.9	58.1
A NORTH EAST	7.4	1.2	0.5	50.6	29.2	57.8
00EH Darlington UA	6.1	0.6	0.6	50.5	28.9	58.7
00EB Hartlepool UA	9.2	0.5	0.3	50.5	30.1	56.9
00EC Middlesbrough UA	10.6	4.6	0.8	50.6	29.6	54.7
00EE Redcar and Cleveland UA	8.7	0.5	0.2	50.1	29.7	57.1
00EF Stockton-on-Tees UA	7.8	1.5	0.5	50.1	28.1	57.0
20 Durham	6.2	0.2	0.3	50.6	28.9	58.8
20UB Chester-le-Street	4.8	0.2	0.3	50.7	29.1	59.8
20UD Derwentside	6.3	0.1	0.2	50.2	29.1	58.7
20UE Durham	4.9	0.7	0.7	50.2	27.8	59.1
20UF Easington	7.9	0.2	0.3	51.3	30.3	58.3
20UG Sedgefield	6.5	0.1	0.2	50.7	28.5	58.6
20UH Teesdale	4.1	0.1	0.2	50.2	28.9	60.1
20UJ Wear Valley	7.6	0.1	0.3	50.3	28.5	57.7
35 Northumberland	5.9	0.2	0.3	50.7	27.9	58.8
35UB Alnwick	5.7	0.1	0.2	50.9	29.2	59.4
35UC Berwick-upon-Tweed	5.6	0.0	0.2	51.4	29.9	59.8
35UD Blyth Valley	6.7	0.3	0.2	50.7	25.9	57.9
35UE Castle Morpeth	4.6	0.4	0.8	50.2	29.0	59.5
35UF Tynedale	4.2	0.1	0.3	50.5	27.3	59.8
35UG Wansbeck	7.7	0.3	0.4	50.8	28.7	57.8
2D Tyne and Wear (Met County)	7.8	1.5	0.7	50.7	29.8	57.5
00CH Gateshead	6.6	0.6	0.3	50.8	30.5	58.8
00CJ Newcastle upon Tyne	8.0	3.9	1.5	50.4	29.7	56.4
00CK North Tyneside	6.4	0.6	0.5	50.8	28.9	58.7
00CL South Tyneside	10.3	1.2	0.6	50.0	30.6	55.8
00CM Sunderland	7.9	0.8	0.4	51.0	29.5	57.8
B NORTH WEST	5.7	3.3	0.7	50.5	28.6	58.1
00EX Blackburn with Darwen UA	6.7	21.2	0.6	49.7	27.8	52.2
00EY Blackpool UA	6.7	0.5	0.4	50.2	30.9	58.7
00ET Halton UA	7.1	0.1	0.2	50.2	26.2	57.5
00EU Warrington UA	4.2	0.6	0.5	50.6	28.3	59.8
13 Cheshire	3.7	0.4	0.4	50.4	27.9	60.1
13UB Chester	3.6	0.6	0.5	50.3	28.6	60.2
13UC Congleton	3.2	0.2	0.3	50.4	26.5	60.2
13UD Crewe and Nantwich	4.2	0.4	0.3	49.5	27.8	59.4
13UE Ellesmere Port and Neston	4.8	0.3	0.3	51.2	30.3	60.3
13UG Macclesfield	2.9	0.5	0.5	50.8	27.9	60.7
13UH Vale Royal	4.1	0.2	0.3	50.1	26.9	59.6

Table A10.1: Predicted uptake rates by Unitary Authority for England

Unitary authority	unemployment rate	percent muslim	percent non-muslim asian	% 50-64 year olds female	%50-64 year olds aged 60-64	Predicted uptake rate
16 Cumbria	5.2	0.2	0.2	49.9	29.1	59.3
16UB Allerdale	5.9	0.1	0.1	50.1	28.6	58.8
16UC Barrow-in-Furness	7.0	0.3	0.2	49.1	29.4	57.8
16UD Carlisle	5.2	0.3	0.2	50.5	29.1	59.5
16UE Copeland	8.0	0.2	0.2	49.2	29.5	57.2
16UF Eden	2.9	0.1	0.2	49.6	28.6	60.6
16UG South Lakeland	3.0	0.1	0.4	50.4	29.2	61.0
2A Greater Manchester (Met County)	5.5	5.4	1.1	50.3	28.3	57.4
00BL Bolton	5.3	7.6	2.3	50.0	27.5	56.4
00BM Bury	4.1	4.0	0.7	50.5	27.4	58.8
00BN Manchester	9.0	10.1	1.9	50.5	30.2	54.1
00BP Oldham	5.7	11.8	0.8	50.7	28.5	55.9
00BQ Rochdale	6.1	10.1	0.4	50.0	27.0	55.6
00BR Salford	6.1	1.3	0.7	50.2	29.4	58.4
00BS Stockport	3.6	1.9	0.8	50.5	28.5	59.9
00BT Tameside	4.9	2.7	1.7	50.0	27.8	58.2
00BU Trafford	3.9	3.5	1.3	51.1	28.4	59.3
00BW Wigan	4.9	0.4	0.3	49.8	27.5	59.0
30 Lancashire	4.5	3.7	0.8	50.3	28.2	58.7
30UD Burnley	4.9	7.1	0.5	50.0	27.1	57.2
30UE Chorley	3.8	0.7	0.4	48.8	25.9	58.9
30UF Fylde	3.1	0.3	0.3	51.4	29.5	61.3
30UG Hyndburn	5.0	7.7	0.2	49.7	28.8	57.3
30UH Lancaster	5.8	0.6	0.5	51.2	28.8	59.1
30UJ Pendle	5.6	14.5	0.3	49.6	27.1	54.6
30UK Preston	5.4	8.9	3.6	49.2	28.9	55.7
30UL Ribble Valley	2.3	0.6	0.3	50.2	27.7	60.9
30UM Rossendale	4.2	3.1	0.3	49.0	25.5	58.0
30UN South Ribble	3.1	0.3	0.6	50.4	27.6	60.4
30UP West Lancashire	4.9	0.2	0.4	51.0	28.7	59.8
30UQ Wyre	4.1	0.2	0.4	51.8	31.5	61.3
2B Merseyside (Met County)	8.4	0.7	0.4	51.3	29.9	57.7
00BX Knowsley	10.3	0.2	0.2	51.6	31.3	57.0
00BY Liverpool	11.0	1.5	0.7	50.9	30.6	55.7
00BZ St. Helens	6.7	0.2	0.3	50.8	28.9	58.5
00CA Sefton	6.4	0.3	0.4	52.5	30.9	59.9
00CB Wirral	6.9	0.3	0.4	51.1	28.4	58.4
D YORKSHIRE AND THE HUMBER	5.7	4.1	0.9	50.5	28.4	57.8
00FB East Riding of Yorkshire UA	4.6	0.3	0.4	50.7	28.1	59.7
00FA Kingston upon Hull; City of UA	10.1	0.9	0.4	49.2	29.3	55.5

Table A10.1: Predicted uptake rates by Unitary Authority for England

Unitary authority	unemployment rate	percent muslim	percent non-muslim asian	% 50-64 year olds female	%50-64 year olds aged 60-64	Predicted uptake rate
00FC North East Lincolnshire UA	8.4	0.5	0.4	50.0	29.3	57.1
00FD North Lincolnshire UA	5.5	1.2	0.7	49.9	28.1	58.4
00FF York UA	3.7	0.6	0.5	51.4	28.2	60.6
36 North Yorkshire	3.4	0.2	0.3	50.5	28.2	60.5
36UB Craven	2.8	0.7	0.3	50.5	27.8	60.7
36UC Hambleton	2.9	0.1	0.2	50.6	28.5	61.0
36UD Harrogate	2.6	0.2	0.3	50.5	28.4	61.1
36UE Richmondshire	3.4	0.1	1.0	50.6	28.6	60.5
36UF Ryedale	3.1	0.1	0.2	49.9	29.2	60.8
36UG Scarborough	5.7	0.2	0.2	51.4	29.4	59.6
36UH Selby	3.5	0.1	0.2	49.4	25.3	59.4
2C South Yorkshire (Met County)	6.6	2.7	0.5	50.6	28.8	57.8
00CC Barnsley	6.5	0.3	0.2	50.2	28.3	58.3
00CE Doncaster	6.8	0.8	0.6	51.0	28.5	58.3
00CF Rotherham	6.2	2.4	0.3	50.4	28.5	58.1
00CG Sheffield	6.6	5.0	0.7	50.6	29.4	57.2
2F West Yorkshire (Met County)	5.6	7.8	1.5	50.5	28.0	56.7
00CX Bradford	6.9	17.5	2.3	50.5	28.7	53.2
00CY Calderdale	5.5	5.8	0.5	49.7	26.7	56.9
00CZ Kirklees	5.1	10.9	1.2	50.3	26.8	55.9
00DA Leeds	5.0	3.3	2.0	51.0	28.8	58.4
00DB Wakefield	5.5	1.2	0.4	50.0	27.8	58.5
E EAST MIDLANDS	4.9	1.8	2.8	50.1	27.4	58.1
00FK Derby UA	6.2	4.9	4.4	50.0	28.9	56.3
00FN Leicester UA	7.9	11.9	20.6	50.9	29.3	49.4
00FY Nottingham UA	9.1	5.1	2.8	49.7	29.5	54.7
00FP Rutland UA	2.8	0.3	0.3	50.4	28.2	60.8
17 Derbyshire	4.7	0.2	0.5	49.7	26.9	58.9
17UB Amber Valley	4.5	0.1	0.3	49.5	26.2	58.9
17UC Bolsover	6.6	0.1	0.3	49.4	28.0	57.9
17UD Chesterfield	7.0	0.4	0.3	50.7	27.3	57.9
17UF Derbyshire Dales	3.1	0.2	0.2	49.8	26.9	60.1
17UG Erewash	4.7	0.2	0.7	49.4	26.8	58.8
17UH High Peak	3.8	0.2	0.3	49.2	26.6	59.4
17UJ North East Derbyshire	5.0	0.2	0.3	50.1	27.5	59.1
17UK South Derbyshire	3.3	0.2	1.7	49.5	25.8	59.3
31 Leicestershire	3.3	0.9	3.2	50.0	26.5	59.0
31UB Blaby	2.8	0.4	3.6	51.1	27.3	60.0
31UC Charnwood	3.9	1.7	5.1	49.8	26.3	57.8
31UD Harborough	2.4	0.2	1.0	49.4	26.1	60.1
31UE Hinckley and Bosworth	3.4	0.3	0.9	49.9	25.7	59.5

Table A10.1: Predicted uptake rates by Unitary Authority for England

Unitary authority	unemployment rate	percent muslim	percent non-muslim asian	% 50-64 year olds female	%50-64 year olds aged 60-64	Predicted uptake rate
31UG Melton	3.3	0.1	0.5	49.1	26.4	59.6
31UH North West Leicestershire	3.5	0.1	0.4	49.5	25.9	59.6
31UJ Oadby and Wigston	3.7	3.0	11.1	51.2	29.6	57.3
32 Lincolnshire	4.4	0.3	0.3	50.8	28.8	60.1
32UB Boston	4.3	0.5	0.4	50.3	29.3	60.0
32UC East Lindsey	5.1	0.2	0.3	51.3	30.6	60.2
32UD Lincoln	6.4	0.5	0.5	50.4	28.0	58.3
32UE North Kesteven	3.6	0.2	0.2	51.4	29.3	61.0
32UF South Holland	3.4	0.2	0.3	51.5	30.3	61.4
32UG South Kesteven	3.5	0.3	0.4	50.3	26.2	59.9
32UH West Lindsey	4.9	0.1	0.3	49.9	27.8	59.2
34 Northamptonshire	3.9	1.0	1.5	49.8	25.7	58.8
34UB Corby	6.0	0.2	0.5	50.8	30.0	59.2
34UC Daventry	3.2	0.3	0.6	49.4	24.7	59.3
34UD East Northamptonshire	3.4	0.1	0.5	49.2	25.3	59.3
34UE Kettering	3.5	0.5	1.6	50.0	25.2	59.1
34UF Northampton	4.3	2.3	2.0	49.8	25.7	58.1
34UG South Northamptonshire	2.3	0.2	0.4	49.3	24.1	59.8
34UH Wellingborough	4.5	1.0	4.2	50.5	26.3	58.1
37 Nottinghamshire	5.0	0.5	0.8	50.1	27.3	58.9
37UB Ashfield	6.5	0.1	0.3	49.8	27.8	58.0
37UC Bassetlaw	6.3	0.4	0.3	50.0	27.4	58.2
37UD Broxtowe	3.9	0.9	1.6	50.3	27.3	59.4
37UE Gedling	4.1	0.7	1.0	50.3	27.3	59.4
37UF Mansfield	7.0	0.3	0.5	50.1	28.2	57.8
37UG Newark and Sherwood	4.7	0.2	0.3	50.0	27.5	59.3
37UJ Rushcliffe	3.1	1.0	1.6	50.1	26.1	59.5
F WEST MIDLANDS	5.7	4.4	3.5	50.1	28.4	56.9
00GA Herefordshire; County of UA	4.0	0.1	0.3	50.1	28.6	60.1
00GL Stoke-on-Trent UA	6.5	3.5	0.6	49.8	27.7	57.1
00GF Telford and Wrekin UA	4.8	1.4	2.0	49.9	27.0	58.3
39 Shropshire	3.6	0.2	0.3	50.8	28.5	60.6
39UB Bridgnorth	3.0	0.1	0.2	49.6	28.4	60.5
39UC North Shropshire	3.6	0.2	0.2	50.3	28.2	60.3
39UD Oswestry	4.7	0.2	0.3	51.8	28.4	60.2
39UE Shrewsbury and Atcham	3.5	0.3	0.4	51.2	28.3	60.7
39UF South Shropshire	3.6	0.2	0.3	51.2	29.7	61.0
41 Staffordshire	4.0	0.8	0.6	49.8	27.5	59.4
41UB Cannock Chase	4.6	0.2	0.4	49.7	27.1	59.1

Table A10.1: Predicted uptake rates by Unitary Authority for England

Unitary authority	unemployment rate	percent muslim	percent non-muslim asian	% 50-64 year olds female	%50-64 year olds aged 60-64	Predicted uptake rate
41UC East Staffordshire	4.5	4.3	0.5	50.3	28.0	58.5
41UD Lichfield	3.5	0.3	0.6	50.2	27.7	60.1
41UE Newcastle-under-Lyme	4.3	0.6	0.5	50.0	28.0	59.5
41UF South Staffordshire	3.5	0.2	0.9	49.6	28.2	59.9
41UG Stafford	3.8	0.4	0.7	50.4	27.6	59.9
41UH Staffordshire Moorlands	3.3	0.1	0.2	49.4	27.3	60.0
41UK Tamworth	4.9	0.2	0.5	48.5	25.0	57.9
44 Warwickshire	3.6	0.7	2.4	50.1	27.1	59.3
44UB North Warwickshire	3.7	0.1	0.5	49.6	26.4	59.5
44UC Nuneaton and Bedworth	4.3	1.7	2.4	50.4	26.7	58.6
44UD Rugby	3.7	0.7	3.0	49.8	27.2	58.9
44UE Stratford-on-Avon	2.8	0.2	0.4	50.5	27.8	60.8
44UF Warwick	3.5	0.5	4.6	49.8	26.9	58.6
2E West Midlands (Met County)	7.7	8.1	6.3	50.4	29.6	54.2
00CN Birmingham	9.5	15.6	5.7	50.5	29.8	51.3
00CQ Coventry	6.3	4.2	8.1	50.7	29.8	55.9
00CR Dudley	5.9	2.6	1.7	49.8	29.2	57.7
00CS Sandwell	8.5	5.0	9.7	49.7	30.5	53.5
00CT Solihull	4.3	0.9	2.0	50.8	26.4	59.0
00CU Walsall	6.9	5.8	5.1	50.4	30.6	55.9
00CW Wolverhampton	8.6	1.9	12.9	50.3	30.3	53.6
47 Worcestershire	3.7	0.9	0.4	49.7	26.7	59.4
47UB Bromsgrove	3.0	0.3	0.7	49.9	27.3	60.2
47UC Malvern Hills	2.9	0.2	0.4	50.8	28.2	60.9
47UD Redditch	4.9	2.6	0.6	48.5	22.9	56.9
47UE Worcester	3.8	2.0	0.5	50.0	27.1	59.3
47UF Wychavon	3.2	0.2	0.3	49.4	27.0	60.0
47UG Wyre Forest	4.4	0.6	0.4	49.5	26.9	59.0
G EAST	3.8	1.6	1.1	50.5	27.4	59.5
00KA Luton UA	5.7	15.8	4.1	49.2	28.7	53.4
00JA Peterborough UA	4.8	6.3	1.7	50.4	27.1	57.3
00KF Southend-on-Sea UA	5.5	1.3	1.0	51.3	27.3	58.8
00KG Thurrock UA	4.8	1.1	1.5	49.8	25.2	58.1
09 Bedfordshire	3.5	1.6	2.1	49.5	26.4	58.8
09UD Bedford	4.5	3.6	4.2	50.0	26.8	57.3
09UC Mid Bedfordshire	2.5	0.3	0.6	49.1	25.6	59.8
09UE South Bedfordshire	3.3	0.3	0.9	49.5	26.6	59.6
12 Cambridgeshire	3.0	0.9	1.0	49.9	26.5	59.8
12UB Cambridge	3.8	2.7	2.7	51.2	27.4	59.1
12UC East Cambridgeshire	3.1	0.2	0.5	49.5	27.2	60.1
12UD Fenland	4.1	0.3	0.4	50.1	28.8	60.0

Table A10.1: Predicted uptake rates by Unitary Authority for England

Unitary authority	unemployment rate	percent muslim	percent non-muslim asian	% 50-64 year olds female	%50-64 year olds aged 60-64	Predicted uptake rate
12UE Huntingdonshire	2.7	0.7	0.5	49.4	25.5	59.8
12UG South Cambridgeshire	2.2	0.5	0.8	49.9	25.3	60.3
22 Essex	3.6	0.6	0.7	51.1	27.1	60.1
22UB Basildon	4.5	0.6	0.8	51.7	26.9	59.7
22UC Braintree	3.2	0.3	0.4	49.8	25.0	59.6
22UD Brentwood	2.7	0.6	1.1	51.6	27.9	61.0
22UE Castle Point	3.6	0.3	0.4	51.4	26.8	60.4
22UF Chelmsford	2.9	0.7	0.7	50.5	25.9	60.1
22UG Colchester	3.4	0.8	1.0	51.2	25.9	60.0
22UH Epping Forest	3.8	1.3	1.9	50.8	26.3	59.3
22UJ Harlow	4.7	1.4	0.9	52.3	28.7	60.0
22UK Maldon	3.1	0.3	0.3	50.6	25.8	60.2
22UL Rochford	3.0	0.2	0.4	51.3	27.7	61.0
22UN Tendring	5.0	0.3	0.3	52.0	32.2	60.9
22UQ Uttlesford	2.4	0.5	0.4	49.7	25.4	60.1
26 Hertfordshire	3.0	1.8	1.8	50.5	26.8	59.7
26UB Broxbourne	3.3	1.3	0.8	51.2	27.8	60.3
26UC Dacorum	3.1	1.3	1.1	50.3	26.0	59.6
26UD East Hertfordshire	2.2	0.6	0.8	50.1	25.6	60.4
26UE Hertsmere	3.3	1.5	2.7	50.6	26.0	59.2
26UF North Hertfordshire	2.9	0.8	3.1	50.6	27.2	59.8
26UG St. Albans	2.4	2.8	1.2	50.0	26.4	59.7
26UH Stevenage	3.9	1.2	1.3	51.5	28.0	60.0
26UJ Three Rivers	3.0	1.6	3.3	50.6	26.2	59.2
26UK Watford	3.3	6.6	2.8	49.8	27.3	57.7
26UL Welwyn Hatfield	3.0	1.2	1.8	50.7	28.4	60.2
33 Norfolk	4.5	0.3	0.4	50.6	29.0	60.0
33UB Breckland	4.0	0.2	0.2	50.3	29.1	60.3
33UC Broadland	2.8	0.2	0.3	50.7	28.8	61.1
33UD Great Yarmouth	8.3	0.3	0.3	50.1	28.6	57.1
33UE King's Lynn and West Norfolk	4.0	0.2	0.4	51.1	30.2	60.8
33UF North Norfolk	4.2	0.1	0.2	51.1	30.3	60.7
33UG Norwich	6.4	0.8	0.9	51.0	28.1	58.4
33UH South Norfolk	3.0	0.2	0.4	50.2	27.8	60.5
42 Suffolk	3.9	0.4	0.4	50.5	28.0	60.0
42UB Babergh	3.2	0.2	0.3	50.3	26.7	60.3
42UC Forest Heath	3.0	0.3	0.3	50.4	27.6	60.6
42UD Ipswich	5.1	1.4	0.9	49.9	28.0	58.6
42UE Mid Suffolk	2.9	0.1	0.2	49.4	27.4	60.3
42UF St. Edmundsbury	3.0	0.3	0.3	51.0	28.0	60.9
42UG Suffolk Coastal	3.2	0.3	0.4	51.0	28.2	60.8
42UH Waveney	6.2	0.2	0.3	51.0	29.2	59.1
H LONDON	6.5	9.3	6.9	51.6	27.8	54.7

Table A10.1: Predicted uptake rates by Unitary Authority for England

Unitary authority	unemployment rate	percent muslim	percent non-muslim asian	% 50-64 year olds female	%50-64 year olds aged 60-64	Predicted uptake rate
1B Inner London	8.4	12.9	3.8	51.8	28.6	53.4
00AG Camden	7.6	12.9	3.4	51.7	26.2	53.5
00AA City of London	4.8	6.1	2.6	40.8	21.0	51.8
00AM Hackney	11.2	15.6	3.2	51.3	28.8	50.9
00AN Hammersmith and Fulham	7.2	7.5	2.2	51.4	29.4	56.2
00AP Haringey	8.9	12.8	3.9	52.7	28.8	53.6
00AU Islington	8.9	9.0	2.6	52.1	27.9	54.5
00AW Kensington and Chelsea	7.1	9.3	2.6	52.8	26.5	55.6
00AY Lambeth	8.5	6.0	2.6	52.2	29.4	55.8
00AZ Lewisham	8.2	5.1	3.3	52.0	28.5	55.9
00BB Newham	11.4	26.7	11.4	50.9	29.8	45.6
00BE Southwark	9.4	7.6	2.7	51.7	29.5	54.7
00BG Tower Hamlets	11.2	39.3	2.3	50.8	32.5	45.5
00BJ Wandsworth	5.2	5.7	3.5	52.4	29.2	58.0
00BK Westminster	6.7	12.9	3.8	50.8	26.9	53.8
1C Outer London	5.2	7.0	8.8	51.5	27.4	55.5
00AB Barking and Dagenham	7.2	4.8	2.7	50.6	27.1	56.0
00AC Barnet	5.0	6.8	9.0	52.6	26.7	55.9
00AD Bexley	4.2	1.5	2.9	51.7	27.9	59.4
00AE Brent	7.6	13.3	20.3	51.8	30.6	49.9
00AF Bromley	3.8	1.8	1.8	51.8	26.8	59.7
00AH Croydon	5.5	5.8	6.5	51.5	26.8	56.1
00AJ Ealing	5.8	11.1	18.6	50.7	28.8	51.4
00AK Enfield	6.3	10.5	4.5	51.8	28.6	55.4
00AL Greenwich	8.3	4.7	5.6	50.6	28.1	54.6
00AQ Harrow	4.5	7.7	22.8	52.3	27.9	52.5
00AR Havering	3.8	0.9	1.5	51.8	27.5	60.1
00AS Hillingdon	3.9	5.0	10.3	51.3	28.1	56.6
00AT Hounslow	4.7	9.9	18.2	50.8	27.9	52.4
00AX Kingston upon Thames	3.4	4.2	5.4	50.7	24.6	57.3
00BA Merton	4.5	6.3	6.2	51.4	27.0	56.7
00BC Redbridge	5.5	12.9	14.8	50.9	26.2	51.6
00BD Richmond upon Thames	3.6	2.5	3.0	50.9	23.7	58.3
00BF Sutton	3.5	2.5	2.8	51.3	26.4	59.1
00BH Waltham Forest	7.3	16.5	3.1	51.7	28.5	53.4
J SOUTH EAST	3.3	1.5	1.4	50.5	27.1	59.7
00MA Bracknell Forest UA	2.6	0.7	1.6	49.7	24.9	59.5
00ML Brighton and Hove UA	5.4	1.6	1.5	49.9	28.7	58.4
00MW Isle of Wight UA	5.8	0.3	0.3	50.6	28.7	59.0
00LC Medway UA	5.0	1.1	2.3	50.2	26.4	58.2

Table A10.1: Predicted uptake rates by Unitary Authority for England

Unitary authority	unemployment rate	percent muslim	percent non-muslim asian	% 50-64 year olds female	%50-64 year olds aged 60-64	Predicted uptake rate
00MG Milton Keynes UA	3.9	2.5	2.2	49.0	23.2	57.3
00MR Portsmouth UA	4.6	2.3	1.1	49.6	28.1	58.6
00MC Reading UA	3.5	4.4	2.2	49.5	27.6	58.3
00MD Slough UA	4.8	14.5	15.0	47.6	26.7	50.4
00MS Southampton UA	4.5	2.1	2.5	49.0	27.2	57.9
00MB West Berkshire UA	2.2	0.4	0.6	49.3	25.1	60.0
00ME Windsor and Maidenhead UA	2.8	2.6	2.7	50.5	26.9	59.3
00MF Wokingham UA	2.1	1.4	2.2	50.0	25.3	59.7
11 Buckinghamshire	2.8	3.9	1.3	50.2	26.5	59.2
11UB Aylesbury Vale	2.7	2.9	0.8	49.7	25.0	59.1
11UC Chiltern	2.5	2.0	0.9	50.4	26.8	60.2
11UE South Bucks	2.8	1.2	3.4	50.8	28.6	60.1
11UF Wycombe	3.0	7.0	1.2	50.3	26.8	58.4
21 East Sussex	3.9	0.7	0.5	51.8	28.8	60.6
21UC Eastbourne	4.6	1.1	0.7	52.1	30.2	60.5
21UD Hastings	6.4	0.8	0.7	50.1	26.8	57.7
21UF Lewes	3.4	0.5	0.5	51.9	28.5	61.0
21UG Rother	3.9	0.7	0.4	52.8	31.0	61.6
21UH Wealden	2.5	0.4	0.3	51.8	27.8	61.5
24 Hampshire	2.7	0.4	0.6	50.5	26.9	60.6
24UB Basingstoke and Deane	2.6	0.6	0.9	49.5	25.1	59.7
24UC East Hampshire	2.5	0.3	0.4	50.9	26.3	60.8
24UD Eastleigh	2.2	0.3	1.1	49.8	26.5	60.5
24UE Fareham	2.4	0.4	0.4	51.1	27.6	61.2
24UF Gosport	3.8	0.3	0.3	50.5	27.5	60.0
24UG Hart	2.1	0.4	0.7	50.3	25.8	60.7
24UH Havant	4.1	0.3	0.4	51.7	29.2	60.7
24UJ New Forest	2.9	0.2	0.2	51.7	28.8	61.5
24UL Rushmoor	2.6	0.8	1.2	48.9	25.7	59.4
24UN Test Valley	2.1	0.3	0.7	50.3	25.7	60.6
24UP Winchester	2.3	0.4	0.6	50.1	26.3	60.6
29 Kent	4.2	0.5	1.3	50.7	27.7	59.6
29UB Ashford	3.5	0.6	0.5	50.1	26.8	59.8
29UC Canterbury	4.3	0.7	0.9	52.0	28.6	60.3
29UD Dartford	3.6	0.8	2.3	50.3	28.3	59.6
29UE Dover	5.1	0.3	0.4	50.5	28.1	59.3
29UG Gravesham	5.1	0.9	8.1	51.3	28.0	57.4
29UH Maidstone	3.1	0.6	0.9	50.0	26.7	60.0
29UK Sevenoaks	2.8	0.4	0.5	50.7	26.9	60.6
29UL Shepway	5.1	0.4	1.4	50.8	29.2	59.4
29UM Swale	5.2	0.4	0.5	50.1	26.9	58.7
29UN Thanet	7.2	0.5	0.6	51.6	29.0	58.5

Table A10.1: Predicted uptake rates by Unitary Authority for England

Unitary authority	unemployment rate	percent muslim	percent non-muslim asian	% 50-64 year olds female	%50-64 year olds aged 60-64	Predicted uptake rate
29UP Tonbridge and Malling	2.7	0.3	0.4	50.7	27.2	60.8
29UQ Tunbridge Wells	2.7	0.6	0.5	50.2	26.8	60.4
38 Oxfordshire	2.6	1.4	0.8	50.3	26.9	60.2
38UB Cherwell	2.5	1.3	0.7	49.9	26.3	60.1
38UC Oxford	3.7	4.2	2.0	50.7	28.1	58.9
38UD South Oxfordshire	2.3	0.4	0.5	50.5	27.0	60.9
38UE Vale of White Horse	2.2	0.5	0.5	49.9	26.6	60.6
38UF West Oxfordshire	2.0	0.2	0.3	50.6	26.7	61.1
43 Surrey	2.4	1.4	1.3	50.6	26.5	60.2
43UB Elmbridge	2.8	1.4	1.7	51.0	25.8	59.9
43UC Epsom and Ewell	2.5	2.1	2.7	50.8	25.9	59.6
43UD Guildford	2.3	0.9	1.0	51.0	26.6	60.7
43UE Mole Valley	2.3	0.6	0.7	50.9	27.3	61.0
43UF Reigate and Banstead	2.4	1.4	1.2	50.5	25.6	60.1
43UG Runnymede	2.4	1.1	1.4	49.8	27.1	60.1
43UH Spelthorne	2.7	1.0	2.2	50.1	29.0	60.3
43UJ Surrey Heath	2.2	1.3	1.4	49.9	26.3	60.1
43UK Tandridge	2.4	0.6	0.8	50.3	25.8	60.4
43UL Waverley	2.3	0.6	0.5	51.1	26.1	60.9
43UM Woking	2.5	5.4	1.2	49.9	26.2	58.8
45 West Sussex	2.8	1.1	1.1	51.5	27.9	60.8
45UB Adur	3.0	0.8	0.6	52.2	28.8	61.4
45UC Arun	3.4	0.4	0.3	51.9	30.7	61.6
45UD Chichester	2.8	0.3	0.4	52.3	29.4	61.9
45UE Crawley	3.1	4.8	4.6	50.5	26.1	57.9
45UF Horsham	2.2	0.4	0.5	50.8	26.2	60.9
45UG Mid Sussex	2.2	0.7	0.6	51.2	25.5	60.8
45UH Worthing	3.1	0.8	0.7	51.4	28.7	61.0
K SOUTH WEST	3.8	0.5	0.5	50.7	28.1	60.1
00HA Bath and North East Somerset	2.9	0.4	0.6	51.0	27.5	60.7
00HN Bournemouth UA	4.6	1.0	0.6	50.5	28.6	59.5
00HB Bristol; City of UA	4.6	2.2	1.6	49.7	27.8	58.4
00HC North Somerset UA	3.1	0.3	0.3	50.8	27.4	60.6
00HG Plymouth UA	5.0	0.4	0.3	51.0	28.1	59.6
00HP Poole UA	3.3	0.4	0.4	50.9	28.3	60.7
00HD South Gloucestershire UA	2.5	0.4	0.6	50.1	27.3	60.6
00HX Swindon UA	3.3	1.1	1.5	49.9	27.8	59.7
00HH Torbay UA	6.5	0.3	0.3	51.4	29.8	59.1
15 Cornwall and the Isles of Scilly	5.2	0.1	0.3	50.8	28.2	59.5
15UB Caradon	4.0	0.2	0.2	50.9	26.8	60.0
15UC Carrick	4.9	0.2	0.4	51.6	28.2	59.9

Table A10.1: Predicted uptake rates by Unitary Authority for England

Unitary authority	unemployment rate	percent muslim	percent non-muslim asian	% 50-64 year olds female	%50-64 year olds aged 60-64	Predicted uptake rate
15UD Kerrier	5.7	0.1	0.2	50.4	28.6	59.0
15UE North Cornwall	4.8	0.0	0.2	50.8	29.1	59.9
15UF Penwith	7.0	0.2	0.4	50.9	27.5	58.1
15UG Restormel	5.1	0.2	0.2	50.5	28.6	59.5
15UH Isles of Scilly	1.4	-	0.4	49.4	26.9	-
18 Devon	3.9	0.2	0.3	51.0	28.7	60.5
18UB East Devon	3.2	0.1	0.2	52.2	31.1	62.0
18UC Exeter	3.9	0.8	0.6	50.4	28.1	59.9
18UD Mid Devon	3.4	0.1	0.3	50.0	28.0	60.3
18UE North Devon	5.0	0.2	0.3	50.9	28.5	59.7
18UG South Hams	3.5	0.1	0.5	51.2	27.4	60.5
18UH Teignbridge	3.5	0.1	0.3	51.4	28.2	60.8
18UK Torridge	5.7	0.1	0.3	49.8	28.8	58.9
18UL West Devon	3.7	0.2	0.2	50.3	27.8	60.2
19 Dorset	3.1	0.2	0.3	51.9	29.2	61.4
19UC Christchurch	3.5	0.2	0.3	53.3	32.4	62.5
19UD East Dorset	2.6	0.2	0.3	52.6	29.0	62.2
19UE North Dorset	2.7	0.2	0.5	51.6	28.3	61.4
19UG Purbeck	2.9	0.2	0.4	51.3	27.9	61.1
19UH West Dorset	3.0	0.2	0.4	52.0	29.8	61.7
19UJ Weymouth and Portland	4.5	0.3	0.3	50.1	27.9	59.5
23 Gloucestershire	3.7	0.7	0.6	50.0	27.4	59.8
23UB Cheltenham	3.8	0.5	1.2	50.2	28.0	59.8
23UC Cotswold	2.5	0.1	0.3	49.9	26.7	60.6
23UD Forest of Dean	4.3	0.1	0.3	49.4	27.7	59.3
23UE Gloucester	4.8	2.5	0.7	50.1	27.4	58.5
23UF Stroud	3.4	0.2	0.3	49.9	26.6	59.9
23UG Tewkesbury	2.8	0.2	0.4	50.4	28.0	60.8
40 Somerset	3.6	0.2	0.3	50.6	27.9	60.4
40UB Mendip	3.7	0.2	0.4	50.1	26.7	59.8
40UC Sedgemoor	4.1	0.2	0.3	50.3	28.0	59.9
40UD South Somerset	3.1	0.1	0.3	50.9	28.0	60.9
40UE Taunton Deane	3.6	0.3	0.4	51.0	27.2	60.3
40UF West Somerset	4.8	0.1	0.4	51.2	31.9	60.6
46 Wiltshire	2.7	0.3	0.4	50.5	27.5	60.8
46UB Kennet	2.8	0.2	0.3	50.4	27.4	60.7
46UC North Wiltshire	2.5	0.3	0.5	49.7	26.5	60.4
46UD Salisbury	2.5	0.3	0.4	51.2	28.5	61.4
46UF West Wiltshire	3.2	0.4	0.4	50.5	27.8	60.5

Table A10.2: Predicted uptake rates by Unitary Authority in Wales

Unitary authority	unemployment rate	percent muslim	percent non-muslim asian	% 50-64 year olds female	%50-64 year olds aged 60-64	Predicted uptake rate
220 WALES/CYMRU	5.7	0.8	0.5	50.6	28.4	58.8
00PL Blaenau Gwent/Blaenau Gwent	8.4	0.2	0.3	49.3	28.4	56.7
00PB Bridgend/Pen-y-bont ar Ogwr	5.7	0.2	0.4	50.9	28.8	59.2
00PK Caerphilly/Caerffili	6.0	0.1	0.2	50.4	27.9	58.6
00PT Cardiff/Caerdydd	4.9	4.0	1.5	50.8	27.6	58.1
00NU Carmarthenshire/Sir Gaerfyrddin	5.7	0.2	0.3	50.4	28.5	58.9
00NQ Ceredigion/Sir Ceredigion	5.0	0.4	0.5	50.3	28.8	59.4
00NE Conwy/Conwy	6.1	0.3	0.3	51.8	31.0	59.8
00NG Denbighshire/Sir Ddinbych	5.5	0.3	0.4	50.7	29.3	59.4
00NJ Flintshire/Sir y Fflint	4.4	0.1	0.2	50.5	27.9	59.8
00NC Gwynedd/Gwynedd	6.8	0.3	0.4	50.7	29.5	58.5
00NA Isle of Anglesey/Sir Ynys Mon	7.9	0.1	0.2	51.2	29.0	58.0
00PH Merthyr Tydfil/Merthyr Tudful	7.4	0.3	0.4	50.2	29.0	57.8
00PP Monmouthshire/Sir Fynwy	4.0	0.2	0.4	50.4	27.3	59.9
00NZ Neath Port Talbot/Castell-nedd Port Talbot	7.0	0.3	0.3	50.7	28.7	58.3
00PR Newport/Casnewydd	6.2	2.8	0.4	50.5	28.3	57.9
00NS Pembrokeshire/Sir Benfro	6.5	0.2	0.3	51.1	29.6	59.0
00NN Powys/Powys	4.0	0.1	0.5	50.4	28.0	60.0
00PF Rhondda; Cynon; Taff/Rhondda; Cynon; Taf	6.2	0.3	0.3	50.0	28.0	58.3
00NX Swansea/Abertawe	6.2	1.0	0.5	51.7	28.9	59.0
00PM Torfaen/Tor-faen	5.6	0.2	0.3	49.9	27.4	58.6
00PD The Vale of Glamorgan/Bro Morgannwg	5.0	0.4	0.5	50.6	27.6	59.2
00NL Wrexham/Wrecsam	5.1	0.3	0.3	49.6	27.2	58.8

Table A10.3: Predicted uptake rates by Unitary Authority in Scotland

Unitary authority	unemployment rate	percent muslim	Percent non-muslim asian	% 50-64 year olds female	%50-64 year olds aged 60-64	Predicted uptake rate
SCOTLAND	6.1	0.9	0.4	51.2	29.0	58.9
Aberdeen City	4.0	0.9	0.6	50.1	28.2	59.7
Aberdeenshire	3.6	0.1	0.2	49.0	26.3	59.4
Angus	5.7	0.2	0.1	51.0	28.2	59.2
Argyll & Bute	6.0	0.1	0.2	51.1	30.3	59.5
Clackmannanshire	6.6	0.4	0.1	51.1	27.0	58.4
Dumfries & Galloway	6.5	0.1	0.3	50.9	30.2	59.0
Dundee City	8.9	2.1	0.6	51.1	31.0	57.1
East Ayrshire	8.6	0.2	0.1	51.1	28.8	57.4
East Dunbartonshire	4.0	0.7	1.4	52.3	29.2	60.6
East Lothian	4.0	0.2	0.1	51.2	28.8	60.6
East Renfrewshire	3.7	2.3	0.9	52.1	28.4	60.3
Edinburgh, City of	4.3	1.6	0.8	51.8	28.2	60.0
Eilean Siar	7.7	0.2	0.2	48.2	30.8	57.3
Falkirk	5.7	0.6	0.1	51.2	29.3	59.4
Fife	6.8	0.5	0.2	51.4	27.9	58.5
Glasgow City	9.8	3.3	0.9	51.2	31.5	56.2
Highland	6.3	0.2	0.2	50.4	28.5	58.6
Inverclyde	7.5	0.2	0.2	51.4	29.4	58.4
Midlothian	3.7	0.4	0.1	51.6	27.6	60.6
Moray	5.1	0.2	0.2	50.8	29.2	59.7
North Ayrshire	9.3	0.1	0.3	51.5	29.3	57.3
North Lanarkshire	7.2	0.6	0.2	51.9	29.5	58.8
Orkney Islands	4.3	0.0	0.2	50.1	29.6	60.1
Perth & Kinross	4.1	0.2	0.2	51.2	28.6	60.4
Renfrewshire	5.7	0.4	0.3	51.9	29.1	59.7
Scottish Borders	4.5	0.1	0.2	51.3	29.2	60.4
Shetland Islands	3.2	0.3	0.3	47.2	26.0	58.8
South Ayrshire	6.9	0.1	0.2	51.5	29.3	58.9
South Lanarkshire	5.9	0.4	0.2	51.9	29.5	59.7
Stirling	4.6	0.4	0.3	51.1	28.7	60.0
West Dunbartonshire	8.6	0.2	0.2	51.9	28.6	57.7
West Lothian	5.1	0.6	0.2	51.0	27.4	59.3

Table A10.4: Predicted uptake rates by Unitary Authority in Northern Ireland

Unitary authority	unemployment rate	percent muslim	Percent non-muslim asian	% 50-64 year olds female	%50-64 year olds aged 60-64	Predicted uptake rate
Northern Ireland	6.6	0.1	0.1	51.1	28.2	58.7
Antrim	4.4	0.1	0.1	50.6	26.7	59.6
Ards	4.8	0.1	0.0	50.7	25.9	59.3
Armagh	5.8	0.0	0.0	50.3	27.9	58.9
Ballymena	4.6	0.1	0.1	51.2	28.4	60.1
Ballymoney	5.8	0.0	0.1	50.3	28.8	59.1
Banbridge	4.2	0.0	0.0	51.2	27.9	60.3
Belfast	9.5	0.1	0.2	52.3	30.3	57.7
Carrickfergus	5.1	0.1	0.1	51.0	28.1	59.7
Castlereagh	3.8	0.1	0.1	52.5	30.0	61.5
Coleraine	6.7	0.0	0.2	51.6	30.3	59.3
Cookstown	5.9	0.0	0.0	50.8	27.3	58.9
Craigavon	5.6	0.2	0.1	51.5	28.3	59.5
Derry	11.9	0.0	0.2	50.7	27.6	54.8
Down	5.7	0.0	0.0	50.0	27.7	58.8
Dungannon	5.9	0.0	0.1	50.7	28.4	59.1
Fermanagh	8.2	0.0	0.0	49.2	27.2	56.6
Larne	5.7	0.0	0.0	50.6	28.4	59.1
Limavady	8.2	0.0	0.0	49.9	27.3	57.0
Lisburn	4.9	0.0	0.1	51.5	27.3	59.8
Magherafelt	5.0	0.0	0.1	50.8	27.3	59.5
Moyle	8.2	0.0	0.0	50.1	29.9	57.7
Newry and Mourne	8.1	0.0	0.0	50.4	28.1	57.4
Newtownabbey	4.6	0.1	0.1	51.7	28.8	60.4
North Down	4.7	0.1	0.0	51.5	25.3	59.5
Omagh	7.6	0.0	0.1	49.8	27.7	57.4
Strabane	10.1	0.0	0.1	50.1	28.5	56.0