



# **‘IT ONLY TAKES A MINUTE GIRL’**

## INSIGHTS INTO WOMEN’S PERCEPTIONS OF CERVICAL SCREENING IN BLACKPOOL

AUGUST 2009

MARY LYONS   DAVID NEARY   JANE HARRIS   KIRSTY JORDAN  
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## ACKNOWLEDGEMENTS

A great many people have helped in the development and production of this report.

We would particularly like to thank;

The young women of Blackpool who attended the focus groups and opened their lives to us

Lynn Donkin and colleagues from NHS Blackpool for their support and practical assistance.

Lee Tisdall for design ideas and support

Keith Osborn, Neil Chadborn and Paolo Luria for ideas and support

MRUK for assistance with recruitment



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## KEY MESSAGES

- 1) Young women in Blackpool value family life and their daily social interactions highly. They feel that it is their duty to keep fit and healthy for the sake of their families. Good health is largely something that they feel they have little control over and is not valued as highly as family and friends. Facebook provides an important form of social interaction that could be usefully used as an innovative part of a social marketing strategy. Being able to step off and enjoy some 'me-time' is also very important.
- 2) Many of the young women from deprived areas of Blackpool who do not attend for cervical smears in a timely fashion are young mothers with caring responsibilities.
- 3) Ignorance, embarrassment and fear are significant barriers to attending for a smear. Women lack knowledge about cervical cancer; what a smear is for; what it feels like to have a smear; and how the results should be interpreted.
- 4) Previous negative experiences not only influence the individual but also create a ripple effect, colouring the views of many others.
- 5) The most important practical barriers to going for a smear include:
  - a) The invitation letter that is regarded as unwieldy, impersonal and uninformative and could be supplemented by or replaced with a smaller card, either postcard or credit card sized. Frequent reminders would be welcome.
  - b) Current services are not flexible enough.
- 6) The social marketing strategy will need substantial and long term commitment and should include:
  - a) Information tailored to a range of needs and situations, including the development of a local web site and Facebook group. Simple videos using 'real women' can be highly influential.
  - b) Testing of strap lines and nudges, preferably delivering positive messages and possibly with some humour for use by a wide variety of media.
  - c) Service redesign, to examine the whole client journey with a view to introducing more flexible, warm, friendly services offered in a wider range of settings. Women like the convenience of the walk-in centre and the sexual health clinics. They do not mind waiting to be seen at these flexible service centres.
  - d) A training plan for any service changes, especially to facilitate staff making better use of contact opportunities, not only to give 'nudges' and information but also to continuously monitor and evaluate the service.
- 7) Although the development of a social marketing strategy presents NHS Blackpool with an exciting opportunity to make a difference by achieving a sustained increase in the coverage for cervical smears among women from deprived backgrounds, there are potential threats. Possibly the most important risk is that the service is advertised, but not adequately monitored, evaluated and continuously improved, so does not live up to expectations.



# EXECUTIVE SUMMARY

## BACKGROUND AND INTRODUCTION

This report is stage one of a larger project to increase coverage of cervical cancer screening in Blackpool. About 22 percent of young women aged 25 to 29 years (994 women) and 10 percent of women aged 30 to 34 years (389 women) living in the area covered by NHS Blackpool have never attended for a cervical smear test and many of these young women come from deprived backgrounds. For any screening programme to work efficiently and equitably, good coverage is essential, and the fact that women from disadvantaged neighbourhoods appear to be more reluctant to attend for screening will serve to increase health inequalities in the area. NHS Blackpool has therefore decided to embark on a social marketing programme in an attempt to improve cervical screening rates, especially in the groups where coverage is known to be low. This first insight stage of the project will inform the social marketing or a second development stage.

Since an independent review by the National Consumer Council in 2006 established its effectiveness, the use of a social marketing approach to encourage healthy behaviour has become a key feature of government policy and is now widespread.

Social marketing uses traditional marketing strategies such as explicitly seeking to understand what consumers want, and then tailoring service developments to meet identified needs. Good marketing makes the customer feel that if they buy the product, they will also buy into the valued benefit associated with it. Social marketing, when customised, developed and delivered to and with disadvantaged communities has achieved a lot. Success however, is dependent on gaining a true understanding of the motives, needs and lives of those in the target group, developing new or revised communication materials, testing these and then improving services to better meet needs.

Individuals working in health promotion have been trying with varying degrees of success to 'sell' good health for many years. These messages work well amongst people who value and want good health and are prepared to forego pleasure today, to enhance healthy life chances in the future. The ability to defer gratification in this way is a characteristic of the educated more affluent sector of the population. However, health promotion messages have been less successful amongst people living in deprivation who do not share the same values.



## RESEARCH AIMS AND OBJECTIVES

### AIM

The aim of this project is to find out what young women aged 25 to 34 years living in the Blackpool area value and want.

### OBJECTIVES

- Conduct a thorough literature review around factors that encourage, and barriers that prevent women attending for cervical smears. The literature review will include an exploration of recent research and initiatives carried out by PCTs who share a similar demographic to Blackpool to identify good practice.
- Determine what young women living in a deprived area of Blackpool value and want by conducting a series of focus groups.
- Synthesise the information from objectives 1 and 2 to develop recommendations for the design of a social marketing programme to improve cervical smear attendance in young women in Blackpool.

## LITERATURE REVIEW

An extensive literature review was conducted, based on research and studies from around the world.

The chapter was split into two main sections. In the first, literature about health beliefs and behaviour change was explored. This included traditional models as well as some more recent theoretical developments. Factors known to act as barriers and motivators to women attending for cervical smears were extracted. In the second, evidence from successful social marketing campaigns, particularly for promoting cervical smears were reviewed.

### HEALTH BELIEFS AND BEHAVIOUR CHANGE

Health beliefs are important determinants of behaviour. Essentially people only change their behaviour because they believe that in some way or other it will create a benefit either for themselves or their family. Reference to various models can help unpick the stages that people go through prior to changing their behaviour, and help to identify what services can do and where they can effectively intervene to help people move towards the 'desired' behaviour.

Some more recent research has built on the older theories and created more useable guidelines or principles.

Tom Coates (University of California, USA) has pulled together ideas from a wide variety of theories and suggested that there are a few basic factors that are needed to support and sustain behaviour change. These can be used as a checklist to ensure that campaigns maximise the potential for success.

- information regarding the need to change
- motivation to change behaviour
- skills to initiate and sustain new behaviour
  - ♦ technical skills
  - ♦ social skills
- feeling that change is possible
- supportive changes in community norms
- policy structure changes to support educational efforts and behaviour changes

American economists Richard Thaler and Cass Sunstein have developed 'nudge' theory based on a libertarian paternalist approach (Thaler and Sunstein, 2009). According to this theory, people will change their behaviour incrementally if they are given small nudges in the 'right' direction. These nudges may simply be a question posed by a health professional or a poster providing some positive facts. Both approaches suggest that changing community norms is important, so for example instead of highlighting that coverage data suggest that 25 percent of eligible women in Blackpool do not go for a smear, turn this around and reinforce the fact that 75 percent do go for a smear. Both resonate well with government policy expressed in the White Paper 'Choosing health: making healthy choices easier' (2004).

According to the literature, lack of knowledge and fear are the main factors which affect participation in screening including:

- lack of knowledge of cervical cancer and risk factors
- fear of embarrassment and / or pain
- lack of understanding of the screening procedure
- low level of awareness of the benefits of screening

Other more practical issues also play a part and can include:

- never received the invitation (Neilson & Jones, 2001)
- inaccuracy of target list
- style of letter, illiteracy, poor English skills (Neilson & Jones, 2001)

- unsuitability for screening, e.g. previous hysterectomy (Neilson & Jones, 2001)
- experience from previous testing as reason for non-attendance, e.g. dislike of a male doctor (Neilson & Jones, 2001)
- an assumption of sexual surveillance which suggests that cervical screening may be viewed as a method of monitoring the sexual activity of women (Bush 2000)

In their review of social marketing campaigns Stead and colleagues (2009) found a number of key points that characterised successful social marketing initiatives that can be used as a checklist to ensure best practice:

1. Changing attitudes, behaviour and policy requires a long-term commitment with long-lasting organisational and financial support.
2. Many social and public health issues are a challenge for society as a whole, not just a group of individuals. Adopting a perspective that facilitates policy change as well as individual behaviour change encourages broad ownership of a problem and collective responsibility for tackling it.
3. Reframing a problem can be effective. For example, the ban on smoking in public places was achieved because the problem moved away from 'victim blaming' towards a public health issue – the protection of workers.
4. Offerings showing humour, empathy and positive messages can engage people's emotions as effectively as fear-based messages.
5. They often involve multiple approaches including upstream changes to policy and services as well as awareness-raising, education, legislation and continued support for behaviour change.
6. Changing behaviour often means changing social norms because changing the way the public sees a problem can increase buy-in and encourages greater self-reflection.
7. They are built on understanding the target group's attitudes, values and needs.
8. They analyse and address the 'competition' to the desired behaviour or policy change.

The National Social Marketing Centre (NSMC), a strategic partnership between the Department of Health and Consumer Focus, present a series of international, evaluated case studies displaying social marketing techniques which have achieved real behavioural change in a health care setting (National Social Marketing Centre 2009). Each of these case studies meets the social marketing benchmark criteria and can thus be viewed as examples of best practice.

In one case study from New Zealand, with the strap line 'Don't just SAY they matter', cervical smear uptake among Pacific island and Maori women was significantly

increased. The campaign was based on the finding that the women valued getting together with friends for food and to socialise. Health professionals worked with community leaders to initiate 'Tupperware' like parties, where the women all brought some food and they sat, chatted and ate together at a friend's house. The female nurse then went to the house and set up to take smears in one of the bedrooms. Women then took turns to go in for their smears. There is no doubt that the success of this campaign revolved around not only the publicity and media, but also the willingness of professionals to completely revise the way they ran the service and go into women's homes during evenings or weekends to take the smears.

"What's pants but can save your life" was the first cervical screening initiative in the UK to link social behaviour research with audience segmentation and data trends. It was aimed at 25-29 year old women in the West Midlands with particular emphasis on those who fail to attend screening during these years. By the end of the first quarter, there was a 16 percent increase in the target group and a 4 percent increase across all age groups (National Social Marketing Centre). A mixture of humour and the honest acknowledgement that having a cervical smear is 'pants' seemed to create the right message for these women.

## RESEARCH METHODOLOGY

This research was based on a synthesis of an extensive literature review, combined with findings from four focus groups conducted in Blackpool. Having gained ethical committee approval, women from deprived areas of Blackpool were recruited by a marketing company and invited to come and discuss what they want and value in life, and to give their opinions about what sort of social marketing campaign they think might work.

All women were recruited from relatively deprived areas, and were residents of Blackpool. All focus groups took place in The Solaris Centre, Blackpool.

Focus group 1, Tuesday afternoon 28<sup>th</sup> April, Global room. This group consisted of young women who had never had a smear test and who had children.

Focus group 2, Tuesday evening 28<sup>th</sup> April, Global room. This group consisted of young women who had attended for a smear test and had children.

Focus group 3, Wednesday evening 29<sup>th</sup> April, Earth room. This group consisted of young women who did not have children and consisted of those who had attended as well as a few of those who had never attended for a smear test.

Focus group 4, Wednesday evening 13<sup>th</sup> May, Global room. This group consisted of women who had never had a smear, or who had a smear more than five years ago, so were overdue.

A protocol was developed for the focus groups to ensure that the information required would be obtained (see Appendix 1). The protocol was pilot tested using LJMU students

in order to allow the researchers to modify and improve the process before undertaking any of the focus groups.

During the focus groups, a series of short exercises was employed to generate discussion about what women want and value and what sort of activities they engage in, followed by debate around some current health information and social marketing campaigns.

The qualitative data generated from the focus groups was coded and analysed. Although this group was not selected to be completely representative of women from the target group, there is no reason to suppose that the women who attended were biased in any way, so data from the exercises were analysed quantitatively to reveal a hierarchy of what women most valued in life and what sort of activities they had undertaken during the previous twelve months

## FINDINGS

Most women in the target age groups, and living in the more deprived parts of Blackpool are typically young mothers with one or more children. Many are not in paid employment.

For young women in Blackpool the key insights from the focus groups were:

- family life comes first – Women were prepared to sacrifice a great deal of time and effort to achieve the goal of a happy family life.
- freedom for ‘me-time’ is needed – Women needed to have a part of their life that was just for them.
- friends and Facebook matter – It was particularly interesting to note how meeting up at home or going out for a drink and talking to friends on the telephone is being supplemented or even surpassed by the use of Facebook. Social networking through Facebook allows women to be sociable even when they are at home with their children and is an activity that provided a lifeline for several participants.
- feeling safe and secure is important – this predominantly revolves around personal safety when they went out and about in Blackpool due to the presence of tourists who were often intoxicated. Feeling secure was linked to having a happy family life and having a home where children can feel safe.

These key findings represent important elements in the lives of young women in Blackpool and provide potential building blocks for the social marketing strategy.

Good health is valued, but is not regarded as something that the women have much control over. Participants attending the focus groups tended to have a fatalistic attitude to health and illness, although most agreed that it was important to try and keep healthy, mainly for the sake of the children or other family members who relied on them.

Living a long and healthy life was not a priority for most Blackpool women who attended the focus groups, suggesting that promoting or 'selling' health per se, will be ineffective.

Although women felt trapped in Blackpool, nearly all had ambitions and said that it was important to have something to aspire to in life. Several women displayed determination and resilience and were already acting on their aspirations for example by undertaking courses to position themselves better in the labour market.

#### BARRIERS AND MOTIVATING FACTORS

Probably the most important individual barrier to going for a smear identified during this research was fear, and the most important motivating factors were knowledge and education.

More specifically, the barriers revealed were:

- feelings of fatalism and health beliefs held
- lack of confidence
- fear of pain or embarrassment (including the possibility of a male health care professional taking the smear)
- lack of knowledge about what it feels like to have a cervical smear
- lack of knowledge about cervical cancer and its treatment
- lack of understanding about cervical smear results
- fear of the test outcome
- low level of awareness of the benefits of cervical screening
- lack of understanding about why there is an age limit
- unattractive, uninformative invitation letter (looks like a utility bill)
- inconvenient times for appointments
- previous negative experience, especially where there was a perceived lack of respect / empathy from health care professionals

The quantitative data indicated that the women in this target group have considerable contact with health related services, possibly as part of their parenting role. A remarkable 90 percent of women had had their blood pressure measured and 83 percent had visited their general practitioner and 73 percent had been to the walk-in centre during the preceding 12 months. Each interaction with a health care provider is a possible opportunity to provide some simple positive messages or 'nudges' about going for a smear that is currently not being utilised.

## CONCLUSIONS AND RECOMMENDATIONS

The conclusions and recommendations are divided into two interlinked sections. The first relates to the social marketing strategy and campaign, the second refers to the associated service redesign that will be needed if the social marketing campaign is to be successful.

### MESSAGES, MEDIA AND METHODS MIX FOR SOCIAL MARKETING

The social marketing strategy must be built around the insights discovered. Any ideas mentioned below will need to be tested to find out whether they actually do have resonance, particularly with the target groups of women or staff providing the service.

Some of the core benefits that may be tested further;

**Cervical screening is important because I am important, I am worth it**

**Cervical screening may be a bit uncomfortable, and embarrassing, but worth it to stay fit and healthy**

**Cervical screening provides reassurance for a small amount of discomfort**

**Take some time out for yourself – go for a smear**

Cervical screening needs to be positioned as a service that enables women to get on and live their lives. It is important because they are important and also because they are important to their children. As a core concept it needs to be seen as being worthwhile because 'I'm too important not to have a smear test'.

We recommend that NHS Blackpool:

- **tests a range of strap lines and nudges to see which resonate best with local women, using positive messages wherever possible and including some ideas that are humorous**
- **displays these through a wide mix of media and other service opportunities**
- **creates a website (and possibly a phone line) to provide more information about cervical smears and cervical cancer, including what the results of smears mean. This may include short videos from professionals to cover the details of the procedure and interpretation of the result; but also from women similar to themselves to let others know what it feels like to have a smear. This could be used with both serious and light hearted drama to reinforce the message**
- **includes information on the web site about services and where women can go for a smear**
- **sets up and moderates a facebook group**



## SERVICE ISSUES

Possibly the most significant threat to the success of a social marketing strategy is that as a result of the communication element of the campaign, uptake increases, but services do not then live up to expectations. The communication strategy and service re-design with associated staff training must go hand in hand. Adequate resources will be needed to develop and maintain both the communication strategy and the accompanying service redesign.

In relation to making services more flexible, we recommend that NHS Blackpool:

- **explores the possibility of making the NHS walk-in centre more flexible, by offering the facility to come in for a smear at anytime the centre is open**
- **opens up sexual health services and well woman clinics, so that women can drop in for a smear without making an appointment**
- **considers offering smears at children's centres, women's homes (as in the 'Don't just say they matter' campaign) or other venues**

A single bad cervical smear experience can have a significant ripple effect and greater impact than a large number of routine or 'normal' encounters so cannot be underestimated. In order to create a warm friendly service for all, we recommend that NHS Blackpool:

- **attempts to overcome perceptions of poor treatment that women may have experienced or heard about in the past, by reviewing the whole service experience. This will include the invitation letter or card, the making of appointments, the greeting at reception, how the service is delivered and very importantly how the service encounter is closed. 'Service warmth' is important in creating the perception of a high quality service and is essential to overcome any previous negative experience of medical services (Mudie and Pirrie 2006)**
- **reflects on how best to create a positive service experience for any young woman who has plucked up the courage to request a smear, even though she may not be within the recommended age group. This would be especially important for women who are nearly 25 years of age. Certainly better education is required here as well and would alleviate many of the problems. This may be regarded as an interim measure, until an education campaign has been implemented so that women understand why they are being refused**
- **re-designs contact letters /cards so that they both invite and encourage women to attend for cervical screening. Additional credit-card sized reminders containing a suitable social marketing message should be developed for wider distribution and be integrated with other parts of the campaign, most notably a website**

- **puts information about the sex of the person carrying out the test on the invitation letter**
- **explores ways to use the various stages of a women's journey through the cervical screening process to provide information and reassurance, and receive feedback that can be used to evaluate and improve the programme**
- **explores how interactions with other services can be better allied to the cervical screening programme**
- **considers giving women nudges and opportunities to discuss cervical screening as a routine part of contraceptive prescribing and monitoring**

One of the most important barriers identified to going for a cervical smear was inadequate knowledge, not only about the smear test itself, but also how the result is interpreted, and about cervical cancer. In order to prevent this lack of knowledge in the first place and to improve the level of understanding about cervical smears and cervical cancer in the population as a whole, we recommend that as well as developing the website and other materials, NHS Blackpool:

- **lobbies for the new PSHE curriculum to include adequate and in depth sessions on cervical cancer and cervical smears**
- **considers developing educational materials about smear tests as part of the HPV vaccination programme in schools emphasising the benefits provided by screening in detecting changes that can lead to cervical cancer**

Staff are at the core of any service and an essential element in the success of any redesign. Since staff are going to be asked to do things differently, they will need training. We recommend that NHS Blackpool:

- **considers the staff education and training implications as an integral part of any social marketing strategy they develop**

Any strategy that is implemented needs to be continuously monitored and evaluated. We recommend that NHS Blackpool:

- **develops an evaluation strategy as part of the social marketing strategy**
- **considers how people feel about the invitation and how they are communicated with at all stages in the cervical smear journey**
- **tests what people feel about being contacted by phone to book a smear appointment if they don't respond to the letter or to discuss any issues or concerns that may be putting women off**

## BACKGROUND

This report is stage one of a larger project to increase coverage of cervical cancer screening in Blackpool. About 22 percent of young women aged 25 to 29 years (994 women) and 10 percent of women aged 30 to 34 years (389 women) living in the area covered by NHS Blackpool have never attended for a cervical smear test and many of these young women come from deprived backgrounds. For any screening programme to work efficiently and equitably, good coverage is essential, and the fact that women from disadvantaged neighbourhoods appear to be more reluctant to attend for screening will serve to increase health inequalities in the area. NHS Blackpool has therefore decided to embark on a social marketing programme in an attempt to improve cervical screening rates, especially in the groups where coverage is known to be low. This first insight stage of the project will inform the social marketing or second development stage.

Low cervical screening coverage among this group of women is not inevitable and can be addressed. To achieve success and develop an appropriate strategy, public health professionals need insight into women's views on what is important in their lives, as well as an understanding of what they think about health and cervical screening. This new knowledge will inform a social marketing campaign to 'nudge' women to go for cervical screening *and* inform the service changes needed to facilitate improved cervical screening coverage.

## INTRODUCTION

### SOCIAL MARKETING

The term social marketing was first coined by Kotler and Zaltman in 1971 to refer to the application of marketing to the solution of social and health problems. Marketing has been remarkably successful in encouraging people to buy products such as new cars, Coca-Cola, and designer clothes and trainers, and it can also encourage people to adopt behaviours that will enhance their own - and their fellow citizens' lives. Many social and health problems are preventable and are linked to individual behaviour. The most dramatic example of this is tobacco use, which kills at least one in two smokers. Social marketing provides a mechanism for tackling such problems by encouraging people to adopt healthier lifestyles.

The concept is not new and even in 1951, Wiebe suggested that the more a social behavioural change campaign mimicked that of a commercial marketing campaign, the greater the likelihood of its success. However, there are some important differences between social and commercial marketing.

Specifically, in social marketing:

- the products tend to be more complex
- demand is more varied
- target groups are more challenging to reach
- consumer involvement is more intense
- the competition is more subtle and varied

Since an independent review by the National Consumer Council in 2006 established its effectiveness, the use of a social marketing approach to encourage healthy behaviour has become a key feature of government policy and is now widespread.

Social marketing uses traditional marketing strategies such as explicitly seeking to understand what consumers want, and then tailoring service developments to meet identified needs. In traditional commercial marketing, a happy family image or sex is often used to sell products. The key to good marketing is finding something that the customer wants or values and then working out what customers might be prepared to offer in exchange. The commercial market trader links a car with an attractive lifestyle, or something that the customer wants or values. This increases demand for the product and money is exchanged for an item that is wanted and both parties feel satisfied. The successful trader manages to link what is essentially a mundane product such as soap powder with something that the customer values. Good marketing makes the customer feel that if they buy the product, they will also buy in to the valued benefit associated with it.

Individuals working in health promotion have been trying with varying degrees of success to 'sell' good health for many years. Members of the public have been urged to stop smoking, use condoms, wash their hands or drink less alcohol because it is good for their own or other citizen's health. The product being sold in these examples is good health. These messages work well amongst people who value and want good health and are prepared to forego pleasure today, to enhance healthy life chances in the future. The ability to defer gratification in this way is a characteristic linked to the educated middle class sector of the population, and indeed many health promotion campaigns have been successful among these groups of people. However, they have been less successful amongst people living in deprivation who do not share these values.

Campaigns encouraging young people to stop smoking – because it is good for health, do not appear to work as well as those suggesting that a person who does not smoke is more attractive or has fresh breath. Essentially stopping smoking is being sold, not because it is good for future health, but because it provides something, such as being attractive, that young people value more highly here and now. A social marketing campaign relies on having insight into what the customer values and wants; what they might be prepared to forego to 'buy' this and then linking it to the product or service on offer. Social marketing, when customised, developed with and delivered to

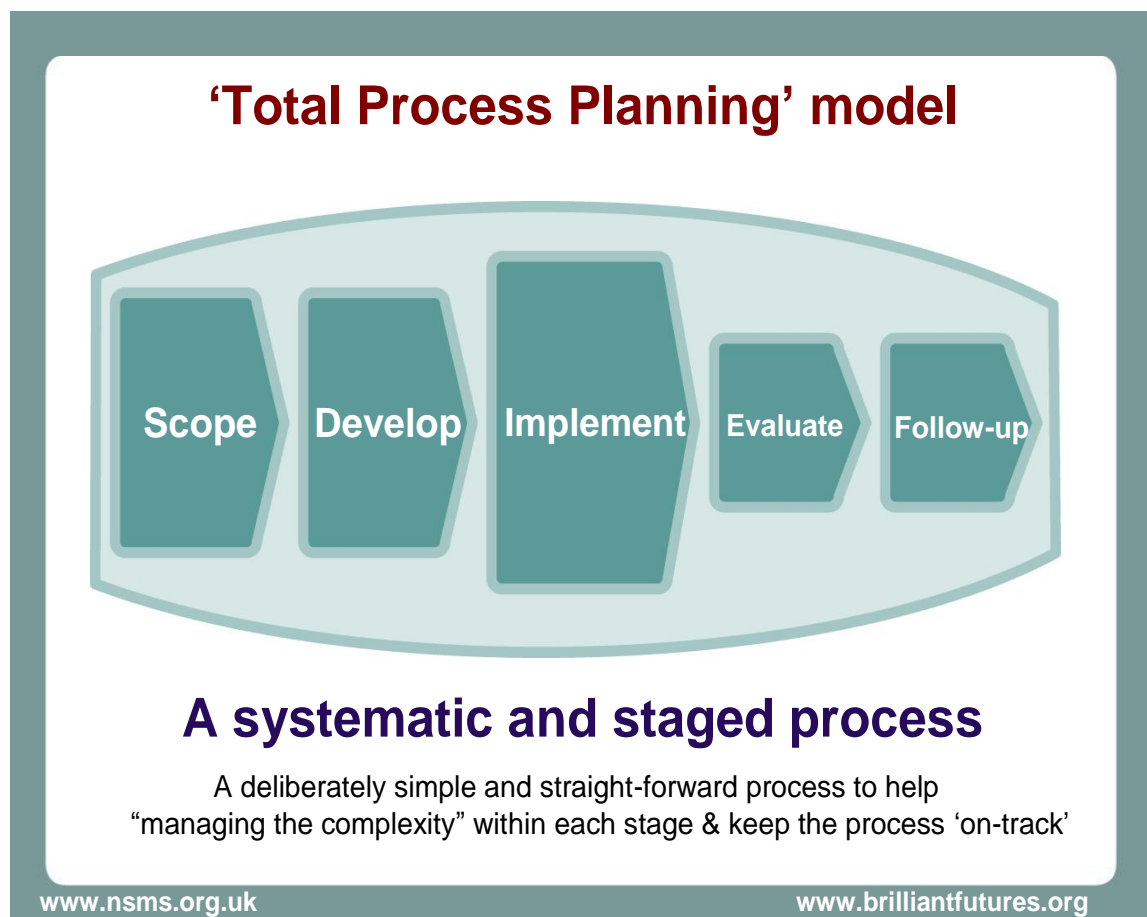
disadvantaged communities has achieved a lot. Success however, is dependent on gaining a true understanding of the motives, needs and lives of the people living in the local communities.

According to the brief from NHS Blackpool, the individuals not attending for cervical smear tests tend to be those in the younger age groups, living in the most deprived quintile of the population. It is not surprising to note that they have not responded well to traditional forms of health promotion.

#### TOTAL PROCESS PLANNING MODEL

A standard process planning model has been developed by the National Social Marketing Centre (NSMC) to describe the various stages used in the development of a social marketing strategy.

FIGURE 1 TOTAL PROCESS PLANNING MODEL



Source: National Social Marketing Centre

This research is designed to gain insight into what young women in Blackpool value and want, and to explore the patient journey to discover the main barriers and factors that motivate young women in Blackpool to attend for cervical smears. The information discovered during this scoping stage will then be used by NHS Blackpool to inform the development stage.

## CERVICAL SCREENING COVERAGE AND CERVICAL CANCER

The pattern of cervical screening in Blackpool is similar to the national picture in terms of declining coverage and differences in uptake by socio-economic status. In a written answer to a Parliamentary question tabled in September 2008, the estimated percentage of women in Blackpool who had been adequately tested in the previous five years had declined from 79.4 percent in 2003 to 75 percent in 2007. The number adequately tested in Blackpool fell by nearly 1,500 women from 28,053 in 2003 to 26,620 in 2007 (Parliamentary written answer, 2008). Blackpool's 75 percent level of coverage does not compare well with other local primary care organisations at the regional or English national level. Blackpool's cervical screening coverage is below the 80 percent national target and is ranked twentieth out of twenty-four primary care trusts in the north west region.

TABLE 1: CERVICAL SCREENING COVERAGE 2007-08

PRIMARY CARE ORGANISATION	CERVICAL SCREENING COVERAGE (%) *
Liverpool	72.3
Manchester	74.0
<b>Blackpool</b>	<b>75.0</b>
North west	79.0
England	79.2
North Lancashire	79.2
Central and Eastern Cheshire	83.2
* Percentage of women less than 5 years since last adequate test for women aged 25-64 in 2007-08	

(Source: Adapted from Cervical Screening Programme 2007-08, The Health and Social Care Information Centre, 2008b)

Using the national indices of multiple deprivation (IMD) to divide the local female population eligible for cervical screening (women aged 25-64) into fifths (quintiles), clear differences in screening coverage between women living in the most and least deprived areas of Blackpool become apparent. In Blackpool, there are 14,914 women eligible for screening living in the most deprived areas. Of these, only 66 percent have had a cervical smear in the last three years. Some 9.6 percent (1431 women) have never been for a smear test; and a further 15.2 percent (2267 women) have not been screened for more than five years. In contrast, there are 2,445 women living in areas of Blackpool that are in the two most affluent quintiles and of these, 75.2 percent (1838 women) have had a cervical smear in the last three years and only 4.1 percent (101 women) had never been screened. In the younger age groups, 22.7 percent of 25-29 year olds and 10 percent of 30-34 year olds have never attended for cervical screening.

Geodemographic analysis shows that there are areas, such as the relatively deprived wards of Claremont and Warbreck, where cervical screening coverage is particularly low.<sup>1</sup> Mosaic (Experian) segmentation indicates that two of the more deprived geodemographic groups have significantly higher proportions of women eligible for screening compared to more affluent groups. These two are described as 'close knit inner city manufacturing communities' (Group D) and also 'low income families living in estate based social housing' (Group G). The former group contains the largest number of eligible women in Blackpool.

Group D contains a number of subgroups, the most significant of which are D25 and D24. The former is characterised by low income families living in small Victorian terraces where rates of both alcohol and drug abuse is higher than in other areas, and a high proportion of children may be eligible for free school meals. The latter is characterised by resort areas containing hostels and refuges, suggesting more transient populations. There may also be issues relating to alcohol and mental health problems, and occupations are often in the catering and hotel industries.

Examples of housing in more deprived areas of Blackpool



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<sup>1</sup> Data provided by NHS Blackpool





There are well-established links nationally between socio-economic deprivation and the incidence and mortality rates for cervical cancer, with higher rates for both in the more deprived areas and lower rates in the more affluent. The incidence of cervical cancer is more than three times higher among women from deprived communities and survival rates at one and five years are five percent higher for women from prosperous areas (ONS, 2005). It is important to emphasise that differences in mortality rates relate more to the level of deprivation than the success or otherwise of the screening programme. Cervical screening is an effective method of detecting cellular changes that can lead to cervical cancer and survival is strongly influenced by the stage at which the disease is diagnosed (CRUK, 2009). Consequently differences in the uptake of smear tests will have a greater effect on mortality rates for women from socially disadvantaged backgrounds because they are more likely to develop cervical cancer than those from more affluent areas. To reduce this health inequality and achieve equity in outcome, targets for screening need to be considerably higher than the national average among women from deprived backgrounds.

## RESEARCH AIMS AND OBJECTIVES

This research examines what young women living in deprived areas of Blackpool value and want from their lives. What aspirations do they have for the future? What activities do they enjoy? What relationships do they value? The research also explores what young women think about health and lifestyle behaviours, how they view the provision of health care services; where they get health information from; what they think and feel about cervical screening; and what they think NHS Blackpool could do to encourage young women to go for a smear test. This information will subsequently be used to improve services; and a better understanding of women's lives will help NHS Blackpool identify levers that can be used in the design of a social marketing programme to influence behaviour and encourage attendance for cervical smear tests in phase two.

### AIM

The aim of this project is to find out what young women aged 25 to 34 years living in the Blackpool area value and want.

### OBJECTIVES

- Conduct a thorough literature review around factors that encourage, and barriers that prevent women attending for cervical smears. The literature review will include an exploration of recent research and initiatives carried out by PCTs who share a similar demographic to Blackpool to identify good practice.
- Determine what young women living in a deprived area of Blackpool value and want by conducting a series of focus groups.
- Synthesise the information from objectives 1 and 2 to develop recommendations for the design of a social marketing programme to improve cervical smear attendance in young women in Blackpool.

## LITERATURE REVIEW

Globally there are estimated to be 500,000 women diagnosed with cervical cancer every year with approximately 80 percent of cases in the developed world and nearly 275,000 deaths around the world (Globocan, 2002). In the United Kingdom in 2006 some 2,873 women were diagnosed with cervical cancer and in 2007 there were 941 deaths although, thankfully, incidence and mortality rates have been on a downward trend for the last 15 years (CRUK, 2009). Since its inception in 1988, the NHS cervical screening programme has screened approximately 64 million women, detected more than 400,000 significant cervical abnormalities and saves an estimated 4,500 lives every year (NHS CSP Annual Review, 2008). Cervical screening programmes face numerous challenges. Incomplete uptake is a common issue that has been tackled through the use of a wide variety of mass media campaigns, health promotion initiatives and awareness raising programmes at the local community and national levels. The effectiveness of these initiatives has been extensively researched and often yields similar findings from around the world.

## HEALTH BELIEFS AND SOCIAL DEPRIVATION

Health beliefs of individuals determine their choice of action or non-action. It is commonly assumed that women from deprived urban areas are more likely to hold negative or fatalistic beliefs about their health and therefore less likely to participate in screening services, but this rather simplistic assumption needs to be explored in more depth (Leavey, 2000). Numerous studies have consistently shown that preventive services are more likely to be taken up by individuals with higher socio-economic status (McCaffery et al., 2002). Levels of education, occupation, income, the passivity of fatalism, the culture of poverty, and the greater congruence of higher social class patients' values with those of the medical profession all play a part.

Health beliefs have an important role in explaining health behaviour (Leavey, 2000). Lower uptake of screening services among the most socially deprived is, at least in part, a consequence of poverty or lack of material resources, but individuals from diverse sectors of the population attach different values to the possible outcomes of screening and these are worthy of further investigation. Crockett et al. (2007:17) suggest that "those who are more or less socially disadvantaged may place a different value on early diagnosis." Those who have a high level of material resources are aware that they can use these to ameliorate the impact of a diagnosis of a serious illness. For individuals who are more deprived, such a diagnosis may bring the prospect of increasing poverty and uncertainty and they might prefer to delay knowledge of an illness for as long as possible (Levin and Schiller 1999). Individuals and groups subscribe to very different notions of health and exhibit diverse health behaviours (Leavey, 2000).

It has been argued that a person's beliefs about health are influenced by their cultural, social background, and experiences of health and illness. Kasl and Cobb (1996) defined health behaviour as "any activity undertaken by a person believing themselves to be healthy for the purpose of preventing disease or detecting it at an asymptomatic stage". Although they defined health behaviour in terms of the intention of the individual, most researchers have interpreted this in terms of medically approved practices and the use of health services designed to prevent disease. There is evidence to support the view that people from lower socio-economic groups have different health beliefs from those with higher socio-economic status. Pill and Stott (1983) looked at the concept of illness causation among a sample of working-class mothers, and noted that the majority of the women believed germs to be the main cause of illness. The women who regarded the cause of illness as external to the individual were less likely to feel responsibility or guilt for being ill. Those who felt the individual had some responsibility for illness were more likely to be home owners and have higher education levels. Their feeling of control in their lives may account for their greater sense of responsibility for their own health. These beliefs clearly need to be taken into account if health promotion is to be more effective, which is why one of the most important pillars of social marketing is an exploration of the target groups' beliefs and values.

## BEHAVIOUR CHANGE

The underlying principles of behaviour change may not necessarily be formally recognised as theories, but a good understanding of them and the elements needed to enact and sustain behaviour change is important, since social marketing is in essence all about behaviour change. The two most commonly cited older models together with some more recent ideas will serve to underpin later recommendations for action.

### HEALTH BELIEF MODEL

This was developed by psychologists in the 1950s to explain the lack of participation in health screening and prevention programmes. The key variables used in the health belief model are:

- perceived threat: Consists of two parts, perceived susceptibility indicating the subjective perception of the risk of contracting the disease or problem; and perceived severity of a health condition, based on feelings surrounding the seriousness of contracting the disease and leaving it untreated. Jade Goody's story can change this, especially among women who perceive her to be like them
- perceived benefit: The believed effectiveness of strategies designed to reduce the threat of illness
- perceived barriers: The potential negative consequences that may result from taking particular health actions, including physical, psychological and financial demands
- cues to action: Events, either bodily, e.g. physical symptoms or environmental that motivate people to take action. The 'Jade Goody effect' would be a good example of a cue to action
- other variables: Anything, such as socio-economic segmentation, or geography that affects perceptions and influences health behaviour
- self efficacy: The belief in being able to successfully undertake the behaviour, in this case attending a smear test appointment

The health belief model can be used to understand and explain why some do and other women do not attend for a smear test when invited. However, the model has been criticised because it fails to explore social norms, which are thought to be important in determining behaviour; and its abstract nature with emphasis on the rationality of people's behaviour probably makes it more useful as a framework rather than a true model (Gillam 1991).

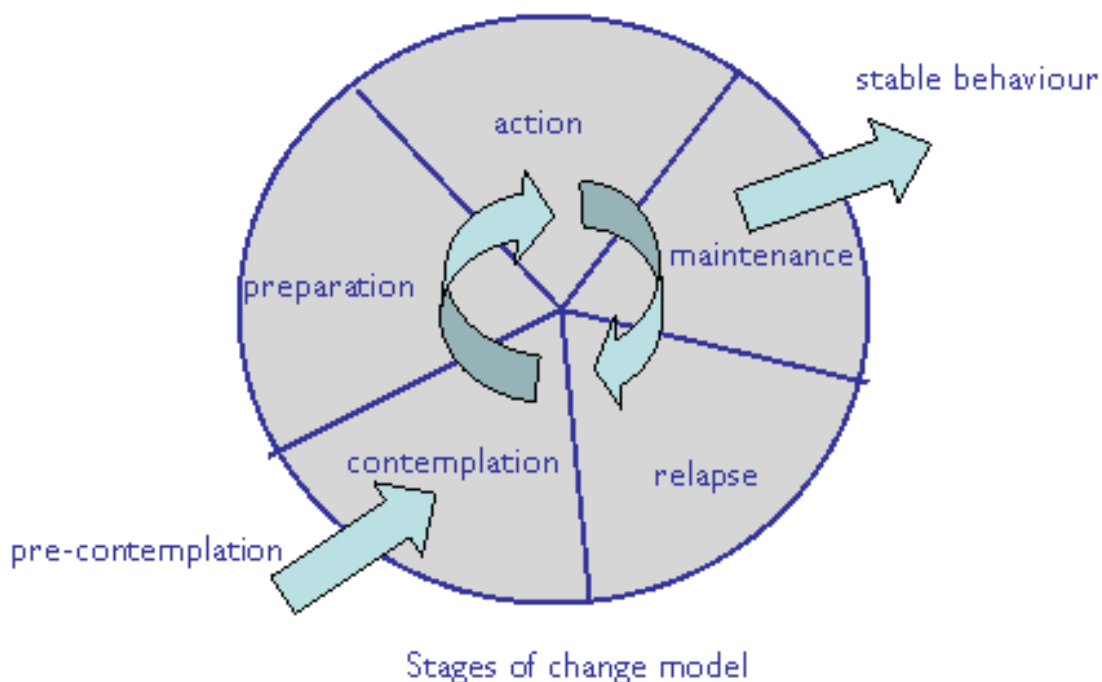
### THE TRANSTHEORETICAL OR STAGES OF CHANGE MODEL

This is the most frequently cited model, and was first described in 1982, and later developed to incorporate the following clearly defined stages by Prochaska, DiClemente and Norcross in 1992.

The model suggests that when people engage in a new health behaviour, they travel along on a continuum of behaviour change, and that it is important to understand where along the continuum anyone exists, so that advice and education can be tailored to their needs at the time.

There were originally four stages, but five or six are now recognised. The stages were originally considered to be linear, but are now thought to be more cyclical, with people moving around the cycle several times before sustainable behaviour change is achieved.

FIGURE 2 STAGES OF CHANGE



In relation to cervical screening they could be described as:

**Pre-contemplation:** A woman is not engaging with the screening programme and has no intention of changing her behaviour. At this stage, consciousness raising, using information and education, possibly through drama or other media is needed.

**Contemplation:** A woman acknowledges that she should be going for screening. During this stage, affirmation from the professional of the importance of screening is needed.

**Preparation for action:** At this stage, a woman feels that she can go for screening and may try to make an appointment. Professionals can help by providing continuous encouragement. Any negative experience can easily send a woman back to the pre-contemplation stage.

**Action:** A woman attends her appointment and has her smear. Provided this is a relatively positive experience, she can move onto the next stage. Professionals can help

by providing praise, and making sure that every woman attending is treated well and with respect.

Maintenance: At this stage, women need encouragement to confirm that they have succeeded and have overcome barriers and will continue to do so in future.

This model has also been criticised because it focuses too much on the individual, without assessing the important role of external environmental influences.

#### THE COATES APPROACH

There are several other ideas, theories and models that can be drawn on to help explain and understand behaviour changes.

Tom Coates (University of California, USA) has been very successful in researching, designing and evaluating behaviour change interventions in relation to sexual behaviour. Although most of his work relates to HIV prevention, there are important lessons that can be learned from his work, including attending for a cervical smear, because any sexual health activity is more covert and less openly talked about than other health behaviours. Coates has pulled together ideas from a wide variety of theories and suggested that there are a few basic factors that are needed to support and sustain behaviour change. These can be used as a checklist to ensure that campaigns maximise the potential for success.

- information regarding the need to change
- motivation to change behaviour
- skills to initiate and sustain new behaviour
  - ♦ technical skills
  - ♦ social skills
- feeling that change is possible
- supportive changes in community norms
- policy structure changes to support educational efforts and behaviour changes

Firstly, people need information, so in relation to cervical smears, women need to know why they should be going for a smear, what's involved and what the results might mean. One of the most important motivators for achieving sustained behaviour change in the sexual health field is a change in social norms, which creates a feeling that change is possible. Nobody likes to feel different, and the belief (whether true or not) that 'everyone else' has had a smear, can act as a strong motivating force.

Other factors include the means to achieve the desired behaviour change, which in this case would include removing many of the current barriers, such as the lack of flexibility around appointment times.

## LIBERTARIAN PATERNALISM AND NUDGE THEORY

The recent, highly influential and increasingly popular work of American economists Richard Thaler and Cass Sunstein has prompted the development of 'nudge' theory based on a libertarian paternalist approach (Thaler and Sunstein, 2009). Libertarian paternalism contends that people should be free to do what they choose to do; but that it is legitimate for people's behaviour to be influenced in what might be considered a positive health direction to make their lives longer, healthier and better (i.e. paternalism steering people's choices in ways that will improve their lives). This influencing process is performed by choice architects, these are individuals or groups who organise the context in which people make decisions, and whether they intend to do so or not, influence people's behaviour. This approach gives people a nudge and makes it easier for them to make healthy choices that will improve their lives, whilst acknowledging their freedom not to do so. This theory resonates well with government policy expressed in the White Paper 'Choosing health: making healthy choices easier' (2004). By deciding to work on improving cervical smear coverage rates, commissioning this work and acting on the recommendations NHS Blackpool is acting as a choice architect.

Nudge theory is a particularly useful approach to consider when researching cervical screening coverage because although having a smear test is what the paternalist would want women to do, they are free to choose not to attend. There are barriers that inhibit attendance that also need to be considered. A social marketing approach, in essence, aims to induce people to change their behaviour through a series of small nudges.

We all make choices that we later regret because our judgments are determined by both our reflective and automatic systems of thought, and there is often conflict between the two. The reflective system is more controlled, requires effort, is deductive, relatively slow, and requires self-awareness and rule-following; while the automatic system is uncontrolled, effortless, associative, fast, unconscious and skilled. In terms of popular culture, Spock from Star Trek is a prime example of the reflective system while Homer Simpson represents the automatic approach to thought and decision-making. These two fictional characters are polar opposites representing 'black and white' when the reality is much more 'grey' because we all use a mixture of these two systems of thought when we make decisions. Therefore the challenge for choice architects is to make healthy choices easier so that people can rely on their automatic systems without getting into terrible trouble.

When making decisions we often use three 'rules of thumb' (heuristics) that can lead to systematic biases when faced with making decisions. The first rule is 'anchoring and adjustment' which means that when we don't know the answer to a question, or when we are unsure of the outcome of a decision then we start with an anchor point that we do know and then adjust our response in whatever direction we think is appropriate. We all have different knowledge and anchors, but they do influence our response when asked a question or when faced with a decision.

The second rule of thumb is accessibility and salience, which refers to what information we have access to and how relevant we think it is. We assess the likelihood of risks by



considering how readily examples come to mind. If people can easily think of relevant examples they are far more likely to be frightened and concerned than if they cannot. The recent death of Jade Goody from cervical cancer provides a relevant example, and appears to have led to an increase in demand for smear tests. Personal experience leads to an inflated perception of the danger associated with risk that is not justified by statistical reality. Our experiences, whether good or bad in the past make us more likely to think that history will repeat itself. In relation to cervical screening, a bad personal experience of a smear test is likely to strongly influence an individual's decision about whether to return for another test. Women are also more likely to share negative experiences of smear tests and this can influence the decisions of other women to attend. However, because smear tests are a 'dread event' for many women they are less likely to share a routine (non-negative) experience with friends.

The third heuristic is representativeness, which refers to how well we relate similarities and stereotypes that we grasp to situations that we don't fully understand. This rule of thumb can lead to mistaken perceptions of risks, patterns and the outcomes of decisions. We may see a pattern in random events that are determined by chance. For example if a coin is tossed and comes up heads three times then we may think there is something unusual or odd about the coin, when this is simply a random outcome. Since we often want to see a pattern in random events this tendency can detrimentally affect our decision-making.

Research by psychologists has consistently shown that we tend to be over-optimistic and over-confident and hence engage in risk taking behaviour because we underestimate the likelihood of events happening to us. For example, gay men systematically underestimate the chance that they will contract HIV Aids while smokers can be aware of the statistical risks of smoking, indeed some even exaggerate them, but most believe that they are less likely to be diagnosed with lung cancer and heart disease than most non-smokers or even other smokers. Although there is a lack of research evidence, it is possible that a similar set of beliefs is held by young women with regard to cervical screening given that most are likely to be in a state of good health. We also experience social influences and peer pressures that make us want to conform with whatever the majority of the population thinks or does in relation to an issue. As Thaler and Sunstein note:

"If choice architects want to shift behaviour and to do so with a nudge, they might simply inform people what other people are doing. Sometimes the practices of others are surprising, and hence people are much affected by learning what they are." (Thaler & Sunstein, 2009: 71)

A successful example of this nudge approach was a campaign to reduce binge drinking among college students at Harvard and Montana Universities. Most students believed that alcohol consumption was far more pervasive on campus than it actually was. A survey found that 44 percent of students engaged in binge drinking in the two weeks preceding the survey, and many were engaging in this activity in order to conform. When the data were turned around and a series of posters appeared on campus

informing students that most students (81 percent) have four or fewer alcoholic drinks each week and that most teenagers (70 percent) are tobacco free there followed a statistically significant decrease in both alcohol and tobacco consumption. If a simple nudge can change the negative health behaviours of college students on campus then increasing the coverage of cervical screening among women in Blackpool is eminently feasible.

Choice architects can also use 'channel factors' to nudge people to change their behaviour. These can include something as simple as asking people about their intentions leading to a change in people's behaviour. For example, if people are asked how often they expect to floss their teeth in the next week, they tend to floss more regularly. How an issue is framed and the type of message that is used to encourage appropriate behaviour can have a considerable effect on people. Another example of these tendencies in operation was observed at a three day rock festival in the height of the summer when the health risks of dehydration were a concern. The organisers (choice architects) used an electronic display board providing information about the festival schedule to show two additional messages, "Drink more water" and "You sweat in the heat: you lose water." These messages successfully appealed to our sense of not wanting to lose something that we already have, while also suggesting that people were already acting appropriately but needed to drink more water than they were already doing.

Nudges can appear to be relatively weak mechanisms for influencing people's behaviour but they can be very effective if appropriately fashioned. There are likely to be a variety of nudges that could be used to encourage women in Blackpool to go for a smear test but they need to be built upon an understanding of the literature on cervical screening, the views of young women in the target population and an appreciation of the behavioural psychology of decision-making among this group.

## **BARRIERS TO PARTICIPATION IN CERVICAL SCREENING**

Despite the implementation of a national screening programme inviting all women aged between 25 and 64 years who are registered with a general practitioner for cervical smears, a significant number of women do not attend. Over the last ten years the percentage of eligible women in England who have been screened at least once in the previous five years has fallen from 82.6 percent in 1998 to 79.2 percent in 2008 (The Health and Social Care Information Centre, 2008a). Women marginalised, either by poverty, lack of education, language, race, or disability appear to be at highest risk of not attending. Approximately 92 percent of women dying from cervical cancer have never been tested (Neilson & Jones 2001), so a good understanding of the reasons why women do not come for screening and exploration of their motives for attending is important for the improvement of screening services.

## ATTITUDES AND KNOWLEDGE

Unfounded and uninformed beliefs are commonly cited barriers to women taking part in screening programmes (Neilson & Jones 2001). Factors which affect participation in screening include:

- lack of knowledge of cervical cancer and risk factors
- fear of embarrassment and / or pain
- lack of understanding of the screening procedure
- low level of awareness of the benefits of screening

Several studies have shown widespread misunderstandings about both cervical screening and cervical cancer. This varies with age but is important, because it can affect perceived vulnerability. The women in King's study (2002) perceived their risk of cervical cancer to be low, with younger women more likely to attribute cervical cancer to promiscuity or the contraceptive pill. The perception that cervical cancer can have serious consequences, coupled with fear of detection appears to inhibit attendance for screening (King, 2002). Fears about cervical cancer and cervical abnormalities must be differentiated from fears about cervical smear testing itself. Both are common factors given for non-attendance.

Many studies highlight that the degree and accuracy of women's knowledge of cervical cancer and of the screening programme are inadequate. Baileff (2000) found that negative attitudes held by women ultimately prevent them from participating in the screening programme. Sutton and Rutherford (2005) found that anticipated embarrassment and attitudes to screening, such as only attending if symptoms are present, were significant predictors of uptake. Phillips et al. (2005) concluded that women are only partially aware of the risk factors associated with cervical cancer and those women who are more likely to hold incorrect perceptions are predominantly those from lower socio economic groups, yet it is women from this group who are at higher risk of cervical cancer.

Low levels of knowledge and understanding of the screening process are often associated with feelings of anxiety. Even among relatively well educated women, awareness and knowledge of cervical cancer is poor, and this contributes to the anxiety and stress associated with the test (Manchanda & Budden 2004). It is fundamental to the improvement of screening services that negative attitudes held by women are dispelled. Being better informed and educated about cancer and screening helps to reduce anxiety and improves compliance (Manchanda & Budden, 2004). A clear understanding of these feelings from the women's perspective can help to inform an effective information/education programme.

## LITERACY AND HEALTH LITERACY

Health literacy is defined as the ability to read and understand medical terminology, comprehend and act on health information. Health illiteracy is linked to lower cervical screening rates (Sharp et al., 2002), and is an important aspect of cervical screening behaviour. Women with literacy difficulties face exclusion from the screening programme because of difficulties in reading and understanding invitation letters from health care providers as well as not being able to understand cervical smear educational material. A persistent lack of literacy skills makes these women more vulnerable to exclusion from the cervical screening programme and other forms of health care provision.

Research from the United States has shown that people with low health literacy have poor understanding about their health, compared to people with adequate health literacy (Williams et al., 2003). There is however limited information on levels of health literacy in the United Kingdom. The recent skills for life survey revealed that '46 percent of participants scored at literacy levels below that required for achieving their full potential, with 3 percent at the lowest level, being functionally literate' (Williams et al., 2003). In 2008 the National Social Marketing Centre was commissioned to review and update knowledge on health literacy. They found that: 'The extensive knowledge about functional health literacy and readability of different types of media used in the clinical context does not appear to be applied to the public health context' (NSMC 2008).

## WOMEN FROM ETHNIC MINORITY GROUPS

Studies indicate that attendance for cervical screening among women from ethnic minority groups is low. Women from South Asian backgrounds are less likely to participate in the screening programme (Fylan, 1998). Cultural beliefs and religious principles, language barriers and an essential lack of understanding are important aspects in understanding why women do not go for a smear test. However, there are comparatively few women from ethnic minorities in Blackpool so this was not regarded as a significant issue in explaining the low level of screening coverage in the area.

## WOMEN WITH PHYSICAL / LEARNING DISABILITIES

Studies show that women with disabilities do not receive the same standard of preventative health care as the general female population. Biswas et al. (2005) demonstrated that out of 160 women with learning disabilities only 16 percent had been screened. Women with physical disabilities are often seen as 'asexual' (Scullion, 1999) and as a result they can be excluded from cervical screening advice and services. Women living in the more deprived areas [of Blackpool] are more likely to have a disability and less likely to attend for cervical screening (Elwan, 1999). The literature indicates the need for local policies to be inclusive so that vulnerable populations do not face exclusion from screening programmes and health care services.

## SEX OF SMEAR TAKER, OTHER PRACTICALITIES AND APPOINTMENT TIMES

Women often cite practical reasons for non-attendance for cervical screening, such as family commitments, work obligations, illness, menstruation, transport problems (Gillam, 1991). Numerous ways of encouraging uptake have been identified such as

appropriately worded invitations, educational materials, flexible appointments and personalised approaches (Eardley et al. 1985).

However, the importance of these is contentious and few differences in number and type of practical issues between non-attendees and attendees have been found, suggesting that some of these may be being used by non-attendees as an excuse, rather than being a genuine barrier. Leavey (2000) found that women from deprived areas of Liverpool seldom offered practical obstacles as a reason for non-attendance. Much more important factors were embarrassment over the test, anxiety over the result and negative relationships with health care professionals.

However, practical issues undoubtedly can act as barriers, and are worthy of exploration and discussion. Reasons given for women not participating in screening programmes have emerged from numerous studies (such as Neilson & Jones 2001, Leavey 2000 and Bush 2000) include;

- never received the invitation
- inaccuracy of target list
- style of letter, illiteracy, poor English skills
- unsuitability for screening, e.g. previous hysterectomy
- experience from previous testing as reason for non-attendance, e.g. dislike male doctor
- attitudes of fear and fatalism
- an assumption of sexual surveillance which suggests that cervical screening may be viewed as a method of monitoring the sexual activity of women

The sex of the smear taker and inconvenient appointment times are most often cited as important barriers to attendance. Women are more likely to attend for cervical screening if the practitioner is female. This relates to issues of embarrassment and a perception that a female practitioner will be more understanding of women's feelings and be more responsive to the needs of female patients. Walsh (2006) found that male smear takers and unsuitable appointment times were significant barriers to the success of a screening programme. Fylan (1998) and Gannon & Dowling (2008) also cite these as factors which result in non compliance. Gannon & Dowling (2008) and Forbes et al. (2002) suggest that to reveal the sex of the smear taker in the invitation letter may help to improve uptake. Christie et al. (2005) conducted a pilot study in Queensland and found that of 100 hundred women attending a family planning centre for a routine appointment with a doctor or registered nurse, there was greater support for the registered nurses (who are more likely to be female) to take their smears.

## STRATEGIES TO IMPROVE PARTICIPATION

Olowokure et al. (2006) suggest that there is a failure within the health service to accommodate the increasing number of women in employment who have childcare and work commitments. The provision of evening and weekend appointments and raising awareness that a female practitioner will be carrying out the smear are effective strategies to increase participation.

Many studies have looked at the reasons for non-attendance but few have asked what prompts attendance. A survey conducted in Tower Hamlets (2004) gives some indications when 27 percent of women suggested 'more publicity' and 15 percent indicated that 'encouragement by health professionals' were factors in their decision to attend for a smear test.

In general, the less power individuals exercise over their own lives the less likely they are to comply with official health recommendations. A further factor influencing health behaviour is the availability of social support and social networks. According to Gillam (1991: 512) studies of general health behaviour and the use of breast screening facilities have shown that those women who are socially well integrated are more likely to participate in preventive health programmes than those who are less well integrated.

### EDUCATION

Effective education and communication are particularly valuable tools for enhancing and improving perception of the benefits of cervical screening and encouraging women to take part in cervical screening programmes. A lack of knowledge about what is involved in the procedure is an important barrier, but one that is amenable to rectification by education (Perry, 2001).

The literature on this issue is clear and indicates that women who have been exposed to adequate health education about the benefits of cervical screening demonstrate a greater knowledge and understanding of cervical cancer and as a result are more likely to have had a cervical smear test performed. Fylan (1998) contends that the primary reason why many women do not partake in the cervical screening programme is a lack of knowledge about the test and its indications. Clearly, appropriate education can enhance the uptake of screening services. However, the effectiveness of approaches differs and any intervention designed to increase the uptake of cervical screening must be modified to the intended audience. Base-line knowledge, perceptions, cultural norms, and attitudes towards health all need to be taken into account (Germar 2004, p2). Women need clear information on the procedures, benefits and risks of cervical screening (Cervical Check, 2008). Given that participation rates are low for marginalised and socially disadvantaged women, it is important to tailor and target information for these particular audiences through appropriate education and social marketing campaigns.

### COMMUNICATION AND INVITATION LETTERS

Forbes et al. (2002) suggest that appropriate invitation letters and educational interventions are the two most effective methods of increasing screening uptake.

Invitation letters are an important aspect of communication, and a good letter provides a cost effective way of increasing uptake. The style and approach of the letter is important. If the letter clarifies the benefits of the test and mentions the sex of the smear taker, this can increase uptake. Some studies have suggested that women who have not previously had a test are more likely to accept an invitation if they are offered a specific appointment (Austoker, 1994). This was also noted by Forbes (2002) who suggested that there is some evidence that contrary to popular belief about choice, invitation letters with fixed appointments were more effective than those with open appointments or where women had to ring to make an appointment. This is obviously contentious, since these findings appear to contradict those of other studies such as Neilson & Jones (2001) and Olowokure et al. (2006) who found that women said the appointment times given in their letters were inconvenient and preferred a more a flexible appointment system. Olowokure et al. (2006) found that women from deprived areas preferred to have late morning appointments, whereas younger women and women from more affluent areas preferred late evening and Saturdays. Sending women regular and frequent invitation letters and reminders may be effective in reducing some of the socioeconomic differences in screening uptake found between affluent and deprived areas (Sutton & Rutherford 2005, p.571).

This brief review has explored some of the main barriers to the cervical screening programme and effective strategies to overcome them. Low socioeconomic status and a lack of knowledge contribute to levels of fear and anxiety in women which can lead to non participation. This review found that provision of female smear takers and a more flexible appointment system, along with increased education and suitably designed letters of invitation may help to remove fears and make screening accessible to more women. Consideration of the beliefs of women is important, since this ultimately determines women's decisions to take action over their health or not. A good understanding of what women value and how they perceive their own health is therefore indispensable for the development of successful campaigns to promote screening programmes (Neilson & Jones 2001, p571).

## GOOD PRACTICE IN SOCIAL MARKETING FOR CERVICAL SCREENING

Young women do not want to feel that they are being 'nagged' by public health messages, but they do want facts and information about cervical screening and their overall health. In their review of social marketing campaigns Stead and colleagues (2009) found a number of key points that characterised successful initiatives:

1. Changing attitudes, behaviour and policy requires a long-term commitment with long-lasting organisational and financial support.
2. Many social and public health issues are a challenge for society as a whole, not just a group of individuals. Adopting a perspective that facilitates policy change as well as individual behaviour change encourages broad ownership of a problem and collective responsibility for tackling it.

3. Reframing a problem can be effective. For example, the ban on smoking in public places was achieved because the problem moved away from 'victim blaming' towards a public health issue – the protection of workers.
4. Offerings showing humour, empathy and positive messages can engage people's emotions as effectively as fear-based messages.
5. They often involve multiple approaches including upstream changes to policy and services as well as awareness-raising, education, legislation and continued support for behaviour change.
6. Changing behaviour often means changing social norms because changing the way the public sees a problem can increase buy-in and encourages greater self-reflection.
7. They are built on understanding the target group's attitudes, values and needs.
8. They analyse and address the 'competition' to the desired behaviour or policy change

The National Social Marketing Centre (NSMC), a strategic partnership between the Department of Health and Consumer Focus, present a series of international, evaluated case studies displaying social marketing techniques which have achieved real behavioural change in a health care setting (National Social Marketing Centre 2009). Each of these case studies meets the social marketing benchmark criteria and can thus be viewed as examples of best practice. The social marketing benchmark criteria were developed in order to create a consistent approach and provide a base for commissioning agencies undertaking social marketing.



## SOCIAL MARKETING NATIONAL BENCHMARK CRITERIA

1. **Customer orientation** – develops a “broad and robust” understanding of the target audience by using market research to identify their needs and characteristics and drawing on multiple public and consumer data sources to inform an understanding of people’s everyday lives.
2. **Behaviour** – focus on developing measurable behavioural goals as a result of a strong behavioural analysis.
3. **Theory** – based on behavioural theory and draws from an integrated theory network.
4. **Insight** – based on developing an insight into what moves and motivates the customer
5. **Exchange** – gives a full insight into what the customer has to give to achieve the benefits proposed.
6. **Competition** - completes a full analysis to understand what competes for the audience’s time and attention.
7. **Segmentation** – tailored directly to specific audience segments rather than relying on blanket approaches.
8. **Methods mix** - identifies an appropriate mix of methods.

(Adapted from French, Blair Stevens 2006)

Out of the thirty five case studies of best practice which are showcased, two are programmes designed to increase cervical screening uptake amongst specific groups of women. The first, entitled “Don’t just SAY they matter”, is a national social marketing campaign which was developed in New Zealand to encourage women from Maori and Pacific ethnic communities to attend cervical smear appointments. The second; “What’s pants but could save your life?” is a three year regional programme developed to increase uptake for cervical screening amongst 25-29 year old women in the West Midlands with particular focus on non-attendees.

“**Don’t just SAY they matter**” is a two phase programme which was launched in 2007 to run until 2010 (National Screening Unit). The primary audience for the project was Maori and Pacific island women who had not had a cervical smear test within the last three years. The project aimed to increase attendance by creating an understanding of cervical screening and enhancing the service in order to support uptake. The project was launched by Prime Minister Helen Clark at the National Museum of New Zealand. After 12 months, a 3.3 percent increase in screening coverage was seen nationally with

a 6.8 percent rise in Maori communities and a 12.7 percent rise in Pacific communities (National Social Marketing Centre [online]).

The programme used a combination of interviews and surveys within Maori and Pacific communities; interviews with health workers and professionals; and a telephone survey of key audiences to develop a robust understanding of awareness and attitudes to issues relating to cervical cancer. From this research, key 'actionable insights' were identified to underpin the development of the programme. The research revealed that women from these groups generally had a lack of knowledge about the cervical screening process and were embarrassed to talk about it amongst their peers. The idea of staying healthy for one's family was a key priority. Humour was also revealed to be a good way to approach sensitive subjects. Amongst the two groups of women it was found that Maori women felt individual responsibility for their health while Pacific women felt a collective responsibility and liked the idea of being able to go together. Informed by these insights, materials were therefore developed which were direct and positive and focused on community and family supporting women to stay healthy.

The programme was developed around a set of clear behavioural goals; to increase awareness and understanding about cervical cancer and the benefits of screening; to increase discussion; and to increase the number of women attending screening and calling the 0800 advice number. The programme focused solely on Maori and Pacific women as there were fears that an all inclusive project would only serve to worsen inequalities.

From this research, three main barriers were identified: the difficulty and inconvenience of accessing clinics, the cost (in New Zealand; women are required to pay a surcharge when going for a smear) and the embarrassment surrounding going for a smear and raising this as a topic of conversation. A mixture of methods which included promotional and awareness raising activities and a reconfiguration of service provision were developed to overcome these barriers and positively change behaviour. The opening hours of screening clinics were extended to meet demand and create a more convenient and accessible service. Practices changed their services to allow for those attending to 'get together with the women you care about and go for your smear' (National Cervical Screening Programme, 2007). Services were extended to include smear parties; a concept quite similar to a 'Tupperware party', where groups of Pacific women were encouraged to gather together; usually in a private home, and have their smear. The parties were low cost and sociable events which encouraged women to overcome the embarrassment surrounding cervical screening and talk about the topic with their peers.

Advertising campaigns combined real life stories ("If Lilian hadn't had her smear test she wouldn't be alive to share her story"), ethnic-specific media using Maori and Pacific faces and language ("Do it for you and your whanau") and humour to generate conversation about smears and to reassure women that the process was quick, painless, professional and beneficial (National Cervical Screening Programme, 2007). An award winning film director of Samoan descent was hired to make the television advertising campaign and it was shot on 35mm film; the high production values giving the underlying message that

the subject was an important one which was worth investing in. Women attending for a smear in September 2008 were also given a small gift of a bottle of hand lotion which aside from its intrinsic value also served as affirmation; saying 'well done' to women for choosing to attend for their smear.

**“What’s pants but can save your life”** was the first cervical screening initiative in the UK to link social behaviour research with audience segmentation and data trends. It was aimed at 25-29 year old women with particular emphasis on those who fail to attend screening during these years. By the end of the first quarter, there was a 16 percent increase in the target group and a 4 percent increase across all age groups (National Social Marketing Centre [online]).

The campaign combined a comprehensive review of literature and existing cervical screening programmes, a review of coverage data, and focus groups with local women. From this research several insights communicated; that cervical screening is 'pants', not painful enough to be 'nasty' but important and not frequent enough to be necessarily routine. Cervical cancer was poorly understood and improvements to the service were required.

From these insights, a series of clear behavioural goals were set. The project would increase and sustain cervical screening rates in women aged between 25 and 29 in the West Midlands, raise screening coverage above the national minimum of 80 percent and increase overall screening coverage in the region. The research identified that women in this 25 to 29 age band who did not attend for their first smear were unlikely to take up opportunities to attend later in life and so the decision was made to target this age band specifically and work was done with local media organisations to find key touch points for women of this age.

Three barriers to attendance were identified from the research; the test is uncomfortable and embarrassing and women cannot see the benefit, screening services are inconvenient and difficult to access and for young women screening was not a priority because 'young people don't get cancer'. In response, a social marketing strategy was developed which combined awareness raising, communication and improved service provision.

'Pants' was a colloquial term which had been used frequently by young women attending the focus groups and this was adapted as the campaign brand using images of underwear and the headline 'What's pants but can save your life?'. The advertising campaign combined humour with honest messaging acknowledging the embarrassment and discomfort associated with screening but at the same time emphasising the benefits. The advertisements used national statistics to calculate the number of lives saved daily in the region ('Free cervical screening saves the life of one woman in our region every day') to address the belief that 'young people don't get cancer' (NHS, 2008). This was further reinforced by a project website which provided further factual information about cervical cancer and screening (NHS, 2008 [online]).

The promotional activity was communicated through buses and bus shelters, trains and strategically placed posters in a range of venues including clothing shops, gyms, cinemas and toilets in large offices. In addition a leaflet was included with all invitations for cervical screening in the region and small pants shaped cards were given to customers at selected supermarkets and lingerie stores. A two week campaign was run on 'Heart fm' and in local press prior to the project launch.

A range of other events was organised by individual primary care trusts (PCTs) in order to communicate the facts about cervical cancer and screening. These included laboratory technicians showing slides of cervical cytology in local supermarkets, training days at local Sure Start centres and 'The Cervical Monologues'; a health in theatre event which shared the stories and experiences of real women to explore love, life and sexuality and demystify the screening process.

In conjunction with this, service provision was altered in order to address the barrier of inconvenience and inaccessibility. The opening hours of screening centres were extended and new locations across the region were developed. A comprehensive list of screening facilities was then published on the website.

The two case studies above provide a detailed look into social marketing best practice combining both intervention and full marketing methods to achieve real behavioural change. To supplement these case studies from the National Social Marketing Centre a further review of the literature was undertaken to identify other existing cervical screening programmes. This included a review of grey literature from primary care trust (PCT) and other NHS related websites. From this review two further social marketing campaigns were identified both based in London in the UK.

The first programme which ran in 2001 across London targeted women aged between 40 and 64 years who had never been for a cervical smear test. The campaign used a mixture of publicity including personalised contact with women through their health authority, a month long poster campaign on London buses, billboards, posters in health care facilities and broadcast media as well as a press photo shoot with a television celebrity. A series of credit card sized reminders were also developed delivering simple information about cervical cancer which were then distributed via general practitioner practices. The programme resulted in an increase in attendance in nine out of ten local health authorities with an overall increase of 0.42 percent. Women screened for the first time within this group were found to be three times more likely to have an abnormality than the UK average for their age group indicating the benefits of targeting specific groups of women who have not previously been screened (Millet et al., 2005).

A second project, the Edmonton cervical screening access project was set up in 2005. The project was aimed at increasing uptake amongst women who had been identified as not attending smears because of male smear takers. There was a particular focus on ethnic groups, where cultural and religious values often meant that women were more comfortable with female healthcare practitioners (Enfield PCT, 2005). The project worked closely with women in local community and black and ethnic minority groups to try and improve the information and advice given about cervical cancer. A new cervical

screening poster was developed which emphasised the diverse population of screening age women in Enfield. Training sessions were run for community leaders to help them promote and raise awareness of the importance of cervical screening in the community. Service provision was improved by the creation of a new smear clinic which worked alongside local general practitioner practices and community groups to increase access and capacity and provide choice to all women (Enfield PCT, 2008). As a result, all practices in the area achieved an increased level of coverage with overall increase being greatest in the Edmonton area.

The literature review also identified several smaller projects developed by individual primary care trusts. These activities tended to focus on awareness raising and promotion rather than changes in service provision. Evaluation of these activities was not readily available so the success of such projects could not be established. Since their focus also tends to be on single isolated events, these activities do not meet the benchmark criteria for social marketing. However, the brief review below provides a useful insight into smaller scale activity at the primary care trust level, which could be used to inform the development of a social marketing campaign.

A significant number of primary care trusts have undertaken some sort of awareness-raising activity with the aim of increasing uptake for cervical smears. By far the most popular, was “Cervical Screening Awareness Weeks” (Bradford and Airedale PCT, 2007; North Tyneside PCT, 2007; Oldham PCT, 2007; Blackburn with Darwen PCT, 2009; Leicester, Leicestershire and Rutland PCT, 2009) which involved health care staff holding stalls at a mixture of pharmacies, Boots stores and sexual health clinics to highlight the importance of attending cervical screening appointments with ‘goody bags’ given to women attending.

Aside from these events, awareness raising specifically focused on cervical cancer tended to be restricted to promotional posters and postcards (Derby PCT, 2009; Enfield PCT, 2005; Newham PCT, 2003). These awareness raising events tended to be short lived and prompted by a specific rise in demand for screening. Derby primary care trust cites the diagnosis of Big Brother celebrity Jade Goody as the reason for a new postcard scheme which sent out thousands of postcards to women between 25-35 years old. This trend mirrors an earlier case from Croydon primary care trust, where a series of awareness raising activities was undertaken after the death of Alma in Coronation Street from cervical cancer which prompted a 35 percent increase in attendance (Croydon PCT, 2001).

Frequently, cervical cancer awareness raising events were held as part of wider women’s health events. In conjunction with the social marketing benchmark criteria; these campaigns acknowledge that other health issues and messages compete for women’s time. For example, cervical screening workshops being held alongside workshops on other issues including breast cancer, contraception and general health and wellbeing (Blackburn with Darwen PCT, 2009). Tower Hamlets primary care trust held ‘A walk in the park’; an event organised in partnership with charitable organisation Jo’s Trust and community centre health leaders which presented cervical cancer

alongside women's fitness. The day was centred around a sponsored walk to raise money for a cervical cancer charity and prior to the walk women took part in a tai-chi warm up session and listened to a talk from a local general practitioner about the importance of attending smear appointments (Tower Hamlets PCT, 2008). Other promotional events included a 30 second film on the importance of attending cervical smears, filmed using local women and shown to shoppers in a south east Essex shopping centre. The film was broadcast alongside two other short films on chlamydia screening and stop smoking services (South East Essex PCT, 2006). All of these events focused on incorporating cervical cancer into a wider dialogue of women's health and fitness.

These real life examples of cervical cancer social marketing campaigns illustrate that successful behavioural change can be achieved through service redesign coupled with an appropriate mixture of methods based on a comprehensive understanding of what motivates women to take action.

## RESEARCH METHODOLOGY

The statistics already available clearly indicate that in many of the deprived areas of Blackpool between a quarter and a third of women have either never attended, or it is more than five years since they went for a smear. A more qualitative approach to the exploration of this topic was used to facilitate a deeper understanding of why women do not attend for cervical smears and examine how a social marketing campaign could be used to encourage young women to go for a smear test.

It was decided to use a series of four focus groups as the main method to generate debate and generate data about what women want out of life and what they feel is important as well as to check whether the purported rationale for non attendance suggested from the literature holds true in these specific groups of women. From previous experience of this type of work, it was felt that four groups would generate sufficient data to allow fulfilment of the aim of the project within the time scale, although the facility to recruit additional groups was available if it proved necessary.

Since this research involved the development of new knowledge, and used members of the public as a source of information, University ethical committee approval was needed. No field work was undertaken until LJMU ethical committee approval had been granted.

### FOCUS GROUPS

A market research company, MRUK, was used to recruit participants for the focus groups and a protocol for recruitment was agreed with the company. The literature suggested that the factors that affect a woman's decision to attend for a focus group vary considerably, but include social standing, deprivation, education, age and whether or not they have children. MRUK were supplied with a list of postcodes to recruit from. The postcodes covered areas where women from Mosaic group D lived. Geodemographics<sup>2</sup> identify areas with multiple characteristics of interest and were used rather than the index of multiple deprivation, to identify the most suitable recruitment areas.

Women aged 25 to 32 years, mainly living in the prescribed postcodes were recruited to one of four focus groups. The plan was for the first group to consist of women who had children, but had never had a smear, the second was women with children, who had attended for a smear (at least once), the third group consisted of women who had attended for a smear and who did not have children and the fourth was women who did not have children and had never attended for a smear. We felt that it was important to include women who had been for a smear as well as those who had not, so that differences between the groups could be more clearly ascertained. We particularly wanted to explore why some women had managed to overcome the barriers to attending for a smear, yet others had not. There is a moral pressure to participate in screening programmes, and women who do not, may experience feelings of guilt, embarrassment

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<sup>2</sup> For more information on geodemographics see APHO technical briefing 5: Geodemographic segmentation at [www.apho.org.uk/resource/item.aspx?RID=67914](http://www.apho.org.uk/resource/item.aspx?RID=67914)

or inferiority which may be exacerbated in the presence of women who have participated. We felt that on balance it was best to keep these two groups separate as far as practically possible, so that those who had never been for a smear would not be intimidated by those who had. There was also a risk that women who had been for a smear could use the focus group to discuss extremely negative experiences, which could serve to frighten and further deter any women present who had not yet plucked up enough courage to attend.

The venue for the focus groups was the Solaris Centre in Blackpool, a relatively central venue on the south end of the sea front, close to several of Blackpool's more deprived areas. This is an eco-friendly building that houses several small ecological businesses, as well as leasing out rooms that can be used for community activities. The rooms contained tables and chairs and each had a data projector or digital screen connected to a computer. We planned to run the focus groups over two days at the end of April, holding one group in the afternoon and the other in the early evening. Appropriate refreshments were provided in every group session, and taxis were offered to anyone suggesting that this would be a barrier to attending.

**FIGURE 3 THE SOLARIS CENTRE, BLACKPOOL**





Four focus groups took place, one in the afternoon and three in the evening.<sup>3</sup>

A protocol was developed for the focus groups to ensure that the information required would be obtained (see Appendix 2). The protocol was pilot tested using LJMU students in order to allow the researchers to modify and improve the process before undertaking any of the focus groups. Three researchers (Macintosh, Jordan and Lyons) were focus group facilitators playing an active role in capturing the data while three members of the team (Neary, Harris and Carlin) were non-participant observers, taking notes, providing refreshments and looking after babies.

**FIGURE 4 FOCUS GROUP VENUE IN THE SOLARIS CENTRE**



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<sup>3</sup> MRUK had difficulty recruiting to the afternoon sessions so in the end the first two groups ran to schedule. The third group scheduled for the second afternoon was postponed and what should have been the fourth group took place but contained some women who had never had a smear as well as the majority who had. A further round of recruitment by MRUK produced a fourth focus group that ran one evening more than a week after the initial three groups and consisted of young women aged 26 to 34 who had either never had a smear or had not had one for more than five years. We had originally planned for this fourth group to be for women who did not have children but after holding three focus groups and facing difficulties in recruitment, it was decided to relax this criterion as it could prove to be a barrier to recruitment and did not appear to be as important a factor as we had first thought and so consequently the fourth group largely consisted of mothers

Women were first welcomed and all signed a consent form to agree to take part and for the session to be recorded on video. Participants were then invited to complete the first activity, which consisted of ranking statements about life in general, according to relative importance to them. As well as the prepared statements, the groups each had three cards that could be used to add additional factors. (See Appendix 3 for content of cards and results of this exercise). This exercise worked well and the discussion that surrounded the ranking of the statements was revealing.

The second exercise was a 'Q sort' activity that involved asking the women to rank a series of statements about health, illness and personal health behaviour derived from previous research (Blaxter, 2004).

This exercise provided some simple descriptive statistics for the group and, more importantly, provided a means of introducing and exploring the health beliefs that are an important influence on health behaviour.

Although this exercise was undertaken individually, women were encouraged to discuss issues with their neighbours. The first time this exercise ran, participants were asked to consider sixteen statements about their health and rank them sequentially from 'agree completely' to 'disagree completely'. This proved very difficult and in subsequent groups, we only asked women to complete the two extreme ends and nominate the three statements they agreed and disagreed with most.

The third exercise was a health bingo 'game' containing a range of healthy and other less healthy activities. The facilitator randomly called out the activities and participants were invited to cross this off their cards if they had engaged in this activity during the preceding twelve months (see Appendix 4). This was a fun and relatively easy way to gather some basic data about recent health related behaviours.

These exercises served to break the ice and provided a framework for subsequent activities. A structured discussion was conducted around public health campaigns (Appendix 5).

A variety of approaches were adopted to explore the attitudes and experiences of participants towards cervical screening, information that was available to women and how they might be nudged towards attending for cervical screening. These included discussions of personal views and experiences of smear tests, showing videos discussing cervical screening from possible sources on the internet, the tragic story of Jade Goody and the associated media coverage and whether a successful social marketing campaign for cervical screening in the West Midlands had any resonance with young women in Blackpool.

Participants were invited to comment on which videos and campaigns if any they thought were good, and which if any they had ever acted upon. Jade Goody's situation was brought up and participants were asked what they thought about this. The group finished with a discussion about what could be done to encourage participants to attend

for cervical smears. Clear ideas emerged from all groups about simple improvements that would make the service more accessible.

Every participant was given store vouchers worth £25.00 in value as reimbursement for their time. In an attempt to reduce the risk of bias, the audio-video data from each focus group were reviewed, coded and thematically analysed by at least two people and a senior public health researcher with experience in qualitative data analysis reviewed every one. Recordings were also analysed by an independent senior academic who discussed the emerging interpretation with the team. This insured a reasonable degree of validity. Themes emerged about what young women want and value; and factors that motivated women to attend as well as those that can be considered barriers were determined.

# QUANTITATIVE FINDINGS

CHART 1 – Q SORT STATEMENTS THAT PARTICIPANTS DISAGREE WITH OR STRONGLY DISAGREE WITH.

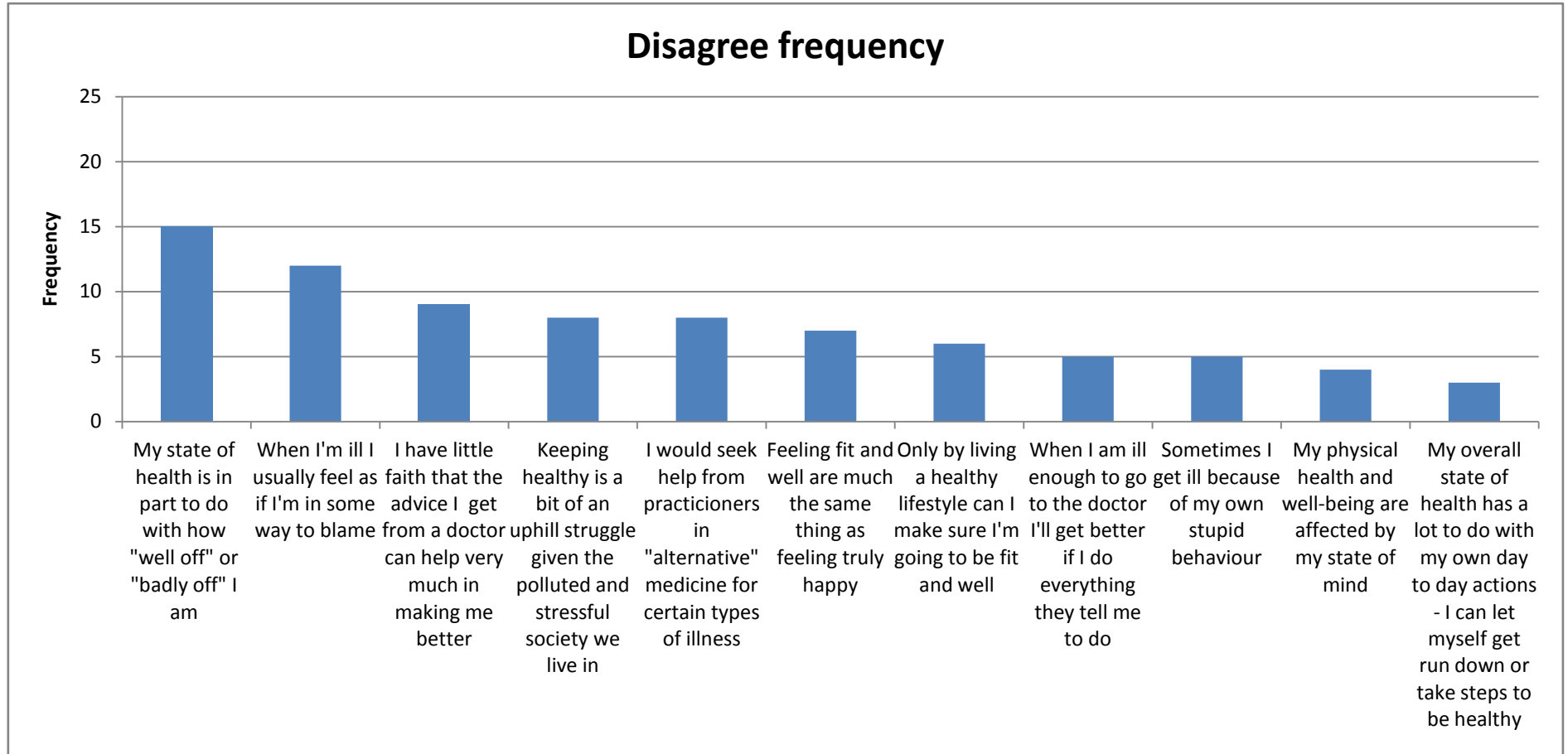


CHART 2 – Q SORT STATEMENTS THAT PARTICIPANTS AGREE WITH OR STRONGLY AGREE WITH.

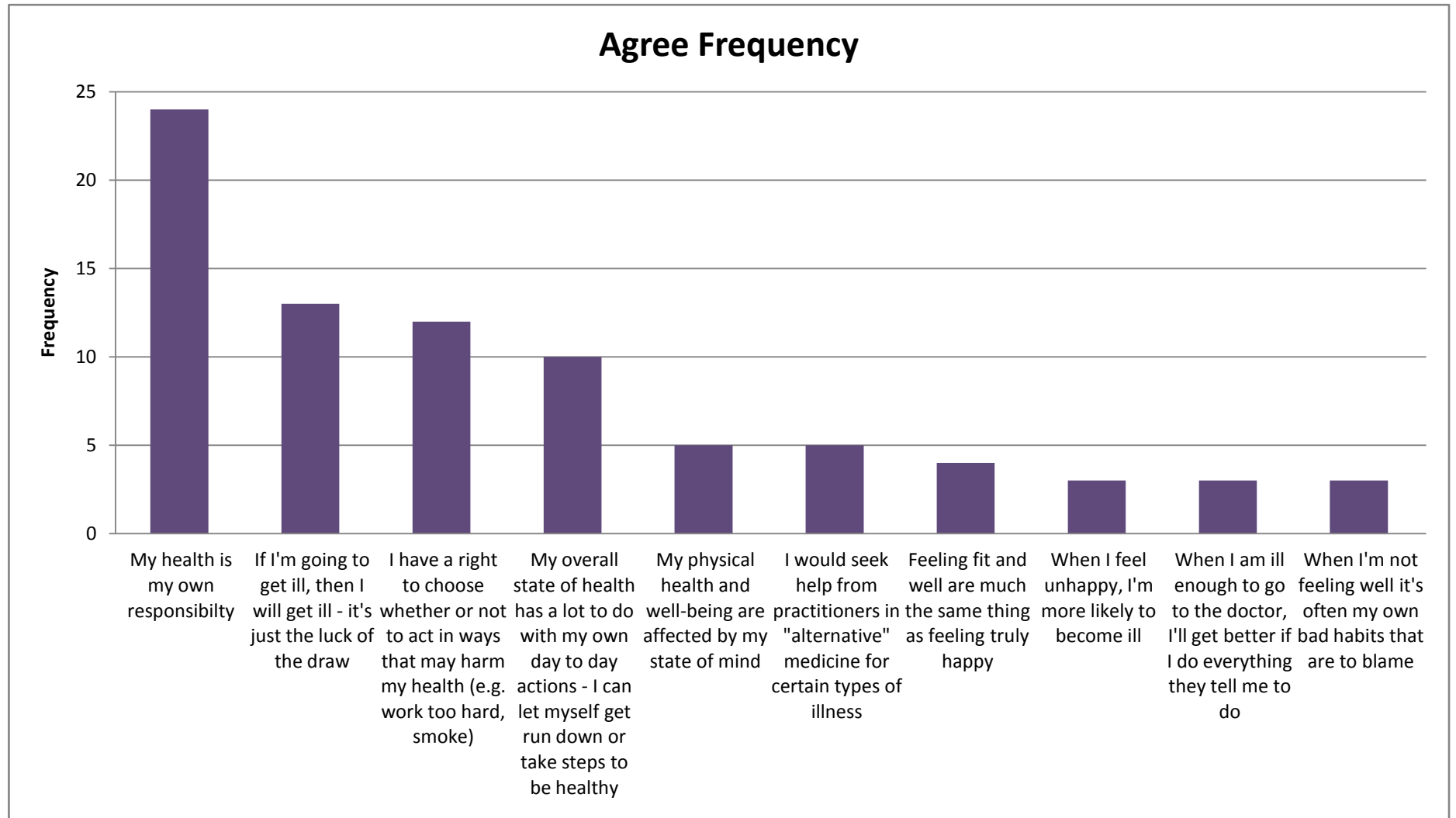


CHART 3 - MOST COMMONLY ENGAGED IN HEALTH ACTIVITIES, FROM HEALTH BINGO

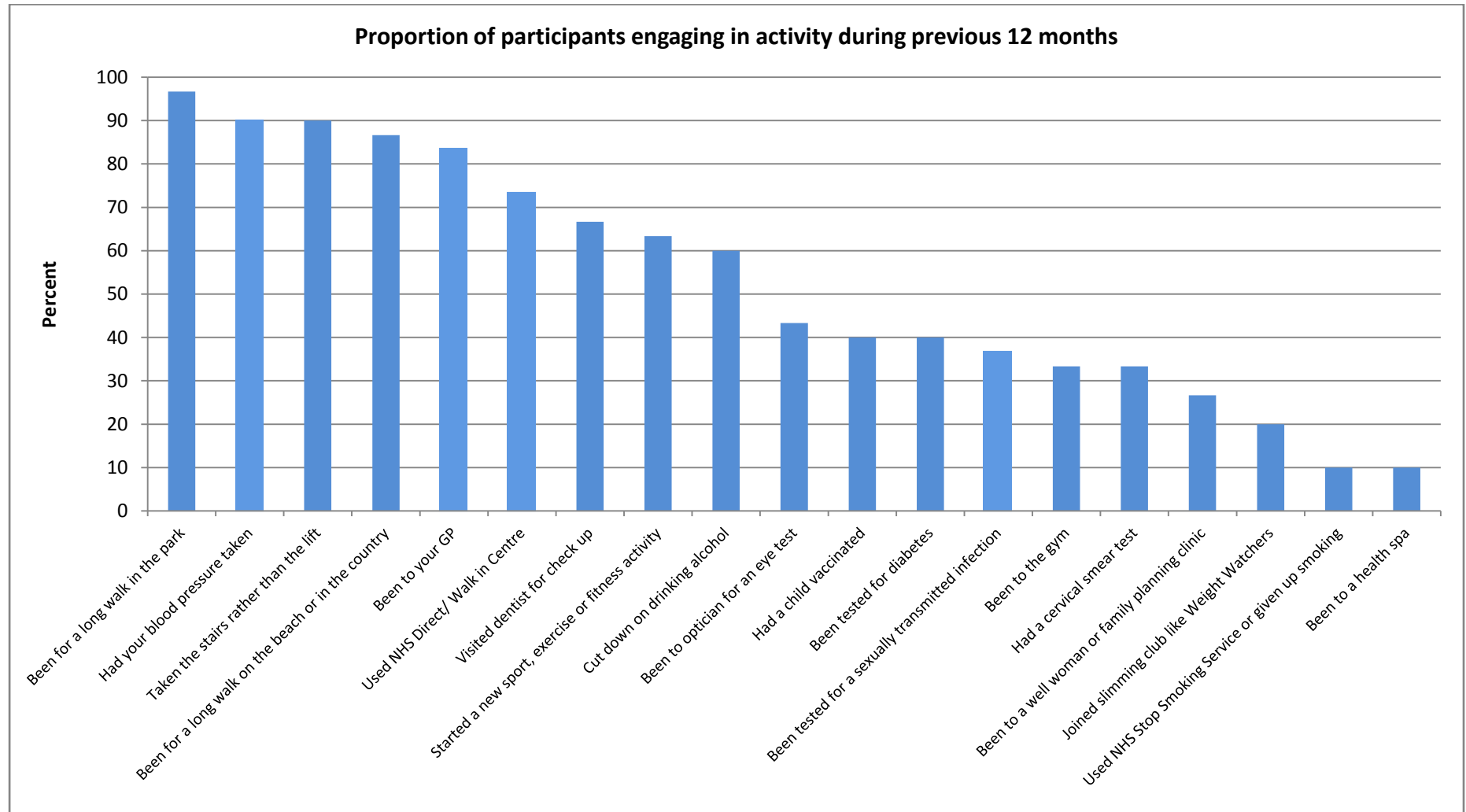
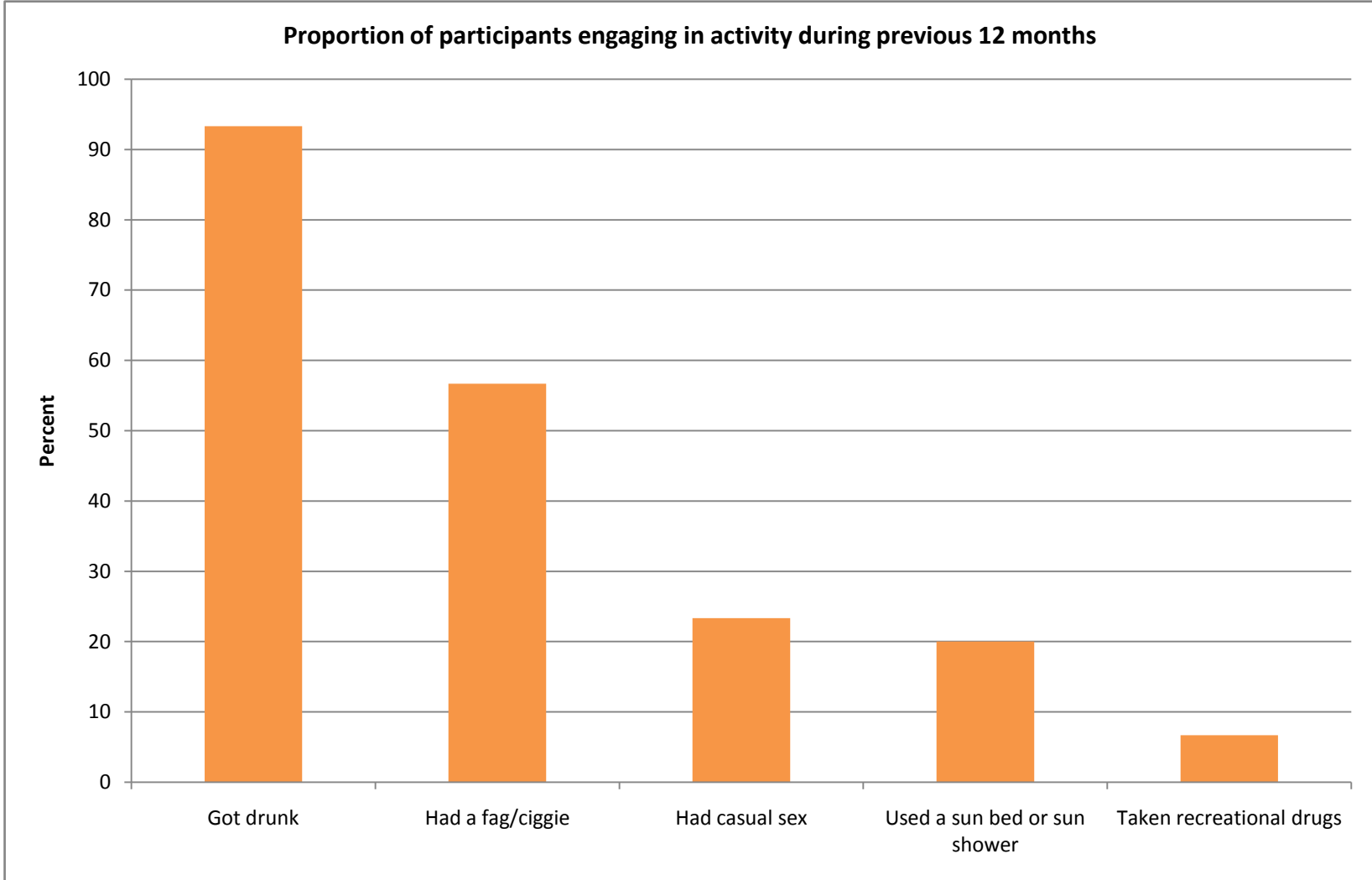


CHART 4 - MOST COMMONLY ENGAGED IN NEGATIVE HEALTH ACTIVITIES, FROM 'HEALTH BINGO'



## COMMENTARY ON Q SORT AND HEALTH BINGO FINDINGS

One of the most interesting features of Chart 1 above was that the women who participated in the focus groups disagreed most strongly with the statement that 'My state of health is in part to do with how "well off" or "badly off" I am'. This is in stark contrast with the intelligence, including that relating to cervical cancer, which suggests that poverty is indeed strongly linked to and is one of the best predictors of poor health.

Participants also express a fascinating degree of 'fatalism'. They disagreed quite strongly with the notion that blame could be attached to illness and felt that getting ill was just the 'luck of the draw'. Yet, somewhat incongruously, they felt very strongly that their health was their own responsibility.

Whilst there were plenty of complaints aired about general practitioners and what happens when trying to book an appointment, there was a surprisingly high degree of faith in the advice received from doctors. These statements were backed up by supportive accounts of the importance of believing in professionals. However, those who had not been for a smear test did appear to hold more negative attitudes towards their general practitioner.

There was quite a high level of disagreement about whether factors such as pollution or stress impacted on health.

Considering that the focus groups consisted of healthy young women, it was surprising to note that 83 percent had visited their general practitioner and 73 percent had been to the walk-in centre during the previous year, indicating a relatively heavy use of services. Each visit provides an opportunity for health professionals to build a rapport with young women that can be used to identify whether women have not attended for a smear test recently and provide care and support to address barriers and encourage take up.



## FOCUS GROUP FINDINGS

All women were recruited from relatively deprived areas, and were residents of Blackpool. All Focus groups took place in The Solaris Centre, Blackpool.

Focus group 1, Tuesday afternoon 28<sup>th</sup> April, Global room. This group consisted of young women who had never had a smear test, and who had children.

Focus group 2, Tuesday evening 28<sup>th</sup> April, Global room. This group consisted of young women who had attended for a smear test and had children.

Focus group 3, Wednesday evening 29<sup>th</sup> April, Earth room. This group consisted of young women who did not have children and who had attended as well as a few of those who had never attended for a smear test.

Focus group 4, Wednesday evening 13<sup>th</sup> May, Global room. This group consisted of women who had never had a smear; or who had a smear more than five years ago, so were overdue.

The findings present a thematic exploration of the main points of the research. Writing up qualitative research findings is not a precise exercise and terms such as majority and minority or few and many are used to describe views expressed either in a particular focus group or across the sample as a whole. These terms are not precisely descriptive of the views of focus group participants – people were not asked to hold up their hand if they agreed or disagreed with a particular point of view – but are subject to interpretation and agreement by the research team who viewed and listened to the focus group data.

Each member of the research team separately analysed at least one of the focus groups and engaged in discussions with other members of the team and with the main author of this section (Neary) who analysed all the groups. There was widespread consensus among the research team about the themes and findings from the focus groups although minor differences in emphasis are inevitable with such a process.

There is always a need to be cautious when generalising to a wider group in qualitative research but it is very rare for a sample of this size to be completely atypical of the wider population. There are likely to be differences in emphasis on issues, as there are between any two people, between the sample selected for this research and the population as a whole. There may be hundreds of different reasons why young women choose not to attend for cervical screening and a similar number of factors could nudge them into going to be tested and this research has only highlighted the most important issues for this group of women. However, there should be no doubt there are valuable insights from these focus groups that need to be understood and acted upon so that cervical screening coverage can be improved and the deaths of young women due to cervical cancer can be reduced.

## WHAT DO YOUNG WOMEN IN BLACKPOOL VALUE AS IMPORTANT IN THEIR LIVES?

The first part of the focus group sought to explore the elements of what could constitute a 'good life' and how young women in Blackpool interpreted the statements in their everyday lives. The process of sorting the statements served to break the ice and quickly led to interesting discussion. Although there was generally a high degree of consensus about the rank order of the statements within the groups it is necessary to acknowledge that there were differences of opinion between participants. However, the points of views that were expressed by participants during the discussions were of great importance in revealing what women valued and wanted in their lives.

FIGURE 5 GOOD LIFE STATEMENTS



## FAMILIES, RELATIONSHIPS AND 'ME-TIME'

'Having a happy family life' was a statement that many participants felt was an important part of living a good life, and produced some lively debate about what it constituted and its importance. For many respondents 'having a happy family life' was associated with having a stable family life that provided a suitable environment for children and adults to enjoy. This was particularly evident among the groups with children whose social world invariably revolved around the lives of their offspring, but it was also important (but less so) to women who were not mothers. For many young mothers, the overwhelming importance of the development, health and welfare of their children was clearly evident to such an extent that the individual needs of the participants often appeared to be secondary. The statement 'being in a happy relationship' was regarded with some ambivalence, particularly by women who were in lone-parent households, but was generally interpreted in the context of living a happy family life for the sake of their children. The short quotes below illustrate this widely and strongly held sentiment among young mothers.

*"You've already got your kids so it doesn't matter if you're in a happy relationship. I think the kids should always come first when you're in a relationship ... your kids are your priority, they're always the number one priority."*

The importance of health not only as a resource for them, but for good parenting came across very clearly.

Although families were of great importance there were many women, particularly mothers of young children, who felt the need to add to the statements that were provided for this discussion. Their views were summarised as 'me-time' - something that gave them a break from their caring responsibilities – and included behaviour such as smoking cigarettes. Smoking was acknowledged to be a negative health behaviour but was seemingly always undertaken outside the house and away from their children and was regarded as essential to keeping them 'sane'. A consistent research finding is that, while mothers were aware of the health risks to them and their children, they experienced smoking as a vital resource for caring for their children in circumstances marked by chronic disadvantage. This is consistent with the work of Graham 1993, Greaves 1996 and Stead, MacAskill, MacKintosh, Reece & Eadie 2001.

Other 'me-time' behaviours were perhaps more obviously positive such as engaging with education, socialising with friends or taking part in leisure activities.

The descriptions of life as 'incredibly boring' with 'nothing left in Blackpool anymore' were commonplace. The importance of setting themselves goals and grabbing opportunities to allow the women to achieve their potential came across very strongly.

## FRIENDS AND FACEBOOK

Having an extended social network of friends was something that was highly valued by participants. The discussion was prompted by the statement 'having a good social life with friends' and led to conversations about the importance of having a good social network to support participants in their daily lives as well as having 'nights out on the town.' It was very interesting to note that the first focus group, which consisted of young women who had children but had not been for cervical screening and who were generally not in paid employment, reported that having children and little money restricted their ability to have a 'normal' social life, but that they made up for this by spending a great deal of time using the internet. Facebook, the social networking site, was cited as a 'safe' activity that participants in this focus group and their friends in Blackpool spent a great deal of time engaging with, and was something that was highly valued and enthusiastically supported. This initial finding prompted the researchers to explore this topic with other subsequent groups and a great many of the young women in the sample used Facebook for a variety of reasons. Facebook allows communication with a large social network of friends and helps with the organisation of more conventional face-to-face social activities and provides an interesting insight into the lives of some young women in Blackpool as the quotes below shows.

*"You don't have to go out to have a good social life. I've got my computer and Facebook. I'm never off that ... I think it's important because you can catch up with people even if you're in your own home, you can still talk to people over the internet and you can still socialise even if you don't go out ... I've got friends in Norway and Australia ... It doesn't stop you from having a social life, if anything it gives you more of a social life because you can meet up with people..."*

*"You need to have friends to vent otherwise you just stew and you just rot ... Getting a few friends round for a brew or whatever is important but you don't necessarily have to [meet up] but you do need the mental contact from other people ... If you just want to vent your anger then you can just chat away online and you know that they're there ... There's always somebody there to talk to ... Even if they don't know you as a person and you don't really know them it's just somebody that you can reach out to and tell them that this is what's going on and they can talk back to you...It's like speaking to a counsellor that you don't know basically ..."*

*"There's loads of groups on Facebook that you can join like Blackpool parents and things like 'Stop Smoking' are on Facebook and you can join the groups and discuss things ... One of my friends has joined that group about having the age for cervical smears lowered and that's a group that I've joined up to as well. It's just somewhere we can meet up and talk and give our points of view like we're doing here today ... It's easier to talk to people who you can't see because they're not going to judge you, so if you say something private and confidential then they're not going to turn up and say something because they don't know who you are or"*

*where you live ... I need a social life to keep me going otherwise I'd just go bang."*

*"Being anonymous is also quite important ... [Facebook] allows you to say anything and they can't judge you."*

A social network of friends is a factor that has universal appeal to young women and the widespread use of the internet, particularly Facebook, for organising social arrangements and seeking support, indicates that this medium could be imaginatively used to reach young women in Blackpool who are reluctant to attend appointments for cervical screening.

#### FRUSTRATIONS AND FEARS ABOUT PERSONAL SAFETY AND SECURITY:

It was notable how many women felt personally threatened by the often drunken behaviour of people, usually tourists, in and around the central areas of Blackpool. Most participants appeared to be reluctant to venture into certain parts of the town in the evenings, in some cases even in the afternoons, and this was regarded as a negative part of living in Blackpool. The duality of Blackpool – the tourist-oriented centre that was felt to be *'kept nice and posh and cleaned'* in contrast with the residents experience of estates that were *'trashed'* and parks that were sometimes not safe – was something that several participants felt particularly strongly about, and which also served to make socialising on the internet more attractive. As one frustrated young woman said: *"...nothing works in Blackpool. Everything is defunct or in the dark ages. If you're not a druggie or an alcoholic then you don't get anything."* This view was supported by other members of the focus group and the wider frustrations and perceived latent threats to their personal safety and security were widely shared sentiments across the sample.



## VIEWS ABOUT HEALTH, ILLNESS AND LIFESTYLE

The Q sort statement that had the strongest resonance with participants was the view that 'my health is my responsibility' which was picked out by the majority of respondents across all of the focus groups. This appeared to be a generally held view across the sample and was shared by women who took divergent positions on other issues such as the merits of following the advice of doctors or whether they felt guilty about becoming ill. This personal responsibility stance was a strongly held view that was barely challenged by any of the other participants in the focus groups.

There was a clear difference of opinion in relation to the medical profession between those who had not had a cervical smear and those who had attended for screening. The young women who had not had a cervical smear voiced more complaints and held negative opinions about doctors and clinical settings compared with those who had attended for screening. For example, women who had not been for a cervical smear voiced support for the view aired by one participant that their general practitioner was "...*rubbish because they never tell you anything...*" and viewed receptionists particularly negatively because of concerns about confidentiality. In contrast, women who had been for a cervical smear appeared to be more likely to support the view that an important part of taking personal responsibility for their health was to comply with the advice of their general practitioner:

*"...that doesn't mean living a healthy lifestyle, it means getting yourself to the doctor when there's anything wrong with you ... What's the point in going to the doctors if you're not going to listen to what they say?"*

This difference of opinion and attitude towards the medical profession also extended to other clinical settings which were often spoken about negatively by women who had not had a smear test.

In order to explore young women's health behaviour a game of 'health bingo' was devised with the intention of generating discussion about and ascertaining the lifestyle of women and whether they had made any changes in their lives over the last 12 months. The health behaviours used were largely positive, for example going to the gym or visiting the dentist for a check-up, but there were also several negative health behaviours such as smoking or using recreational drugs. The most prevalent negative behaviours were getting drunk (more than 90 percent of participants had done this in the previous twelve months) and cigarette smoking (nearly 60 percent). The most prevalent positive health behaviours related to leading a physically active life and included long walks in the park or on the beach or taking the stairs rather than the lift (all about 90 percent in the previous twelve months). Rather surprisingly, some 90 percent had had their blood pressure taken; 80 percent had visited their general practitioner and more than 70 percent had used the NHS walk-in centre. The details of the health bingo are in Appendix 4, and general results are above, but playing the game encouraged some pertinent comments from participants that further showed a wariness of the medical profession that could serve to hamper efforts to increase cervical screening coverage among this group.

## AWARENESS AND ATTITUDES TOWARDS PUBLIC HEALTH CAMPAIGNS

In order to understand how the young women might respond to a local social marketing campaign on cervical screening, participants were asked to identify any public health campaigns that they were aware of or had an impact on them. The five-a-day campaign was widely recognised, and a frequently expressed opinion was that it was difficult to actually consume five portions of fruit and vegetables each day given the cost of healthy food. There was generally good awareness of a variety of public health campaigns ranging from Pablo the drugs mule dog; reducing speed in cars by using the haunting image of a dead child to follow a man through his daily life; the importance of making sure that meat was properly cooked on a barbecue; through to a variety of stop smoking adverts. However, there was some confusion between public health campaigns and a current advertising campaign for a cleaning product that featured a baby holding an uncooked chicken drumstick and a fundraising campaign for a well-known cancer charity. Both of the latter were cited as 'public health campaigns' that had had an impact upon participants. While these adverts undoubtedly contained important public health messages – the importance of food hygiene and the progress made in treatments that have increased cancer survival rates over the last two decades – they were not part of a co-ordinated public health campaign that provided advice or services. The most commonly held view expressed by women in the focus groups was that public health campaigns provided useful information, but generally had not resulted in them changing their behaviour. The exceptions were a campaign to improve sexual health by using condoms to reduce sexually transmitted infections and the stop smoking campaigns that had led to changes in their smoking behaviour around their children.

In order to prompt further responses and discussion, the women in the focus groups were shown an advertisement ([http://www.youtube.com/watch?v=ZcqB\\_dL462Y](http://www.youtube.com/watch?v=ZcqB_dL462Y)) from Change4Life and a recent and relatively controversial stop smoking advertisement (<http://www.youtube.com/watch?v=P7L4LVfHCSE>) featuring a child who was worried about her mother's smoking. The majority of respondents were aware of the national high-profile Change4Life campaign and many respondents had seen this advert on their TV screens. However, it was generally met with disparaging comments for not being realistic, by using morph-like plasticine figures to spread the 'eat better, move more, live longer' message at the heart of the campaign. The adverts were regarded as being primarily aimed at children who might then pester their parents. Women felt that there were considerable costs and difficulties associated with eating healthily and living an active lifestyle for relatively poor people in Blackpool. *"Anything good and healthy ... the price has gone through the roof."* The stop smoking advert was regarded as being powerful because it used children to exert pressure on the smoking habits of parents but was also disliked because it could be a cause of concern and worry for children. As one mother commented: *"...it is a bit sad that they're sort of scaring the children whose parents do smoke."*

Participants were generally open to the use of 'shock' tactics such as the images that are now displayed on the side of cigarette packets or that show the pain inflicted as a consequence of individual behaviour, such as speed reduction campaigns that graphically connect the consequences of road traffic accidents or drinking and driving

with painful feelings of conscience and regret. Shock tactics clearly had an impact on people's awareness of public health messages although they reportedly did not necessarily lead to the intended changes in people's behaviour. For example, it was acknowledged by all that smoking was a risk to health but there was considerable support for the view that if it was something that the individual enjoyed, then they should be free to engage in this damaging behaviour and that people gave up smoking because they wanted to rather than as a result of public health campaigns.

Participants generally thought that public health campaigns needed to be realistic in order to be effective. The animated images of fat pulsing round the body of a plasticine figure were particularly ridiculed when real life images and stories were considered much more likely to have an impact on people's behaviour. The notion that an obese child could be bullied in the school playground was much more likely to motivate mothers to feed children 'me-size' meals than the Change4Life advert.

The young women generally knew that they should engage in 'good' or positive health behaviours such as eating healthily, drinking in moderation or going for a cervical smear test. Public health campaigns that 'nagged' people not to do something that was potentially damaging to their health, such as stopping smoking, were regarded as being unlikely to be effective although more positive messages might work.

#### FEELINGS OF FEAR AND EMBARRASSMENT ARE MAJOR BARRIERS

The young women in the focus groups frequently discussed their feelings when it came to cervical screening and the decision to attend or miss appointments, indicating the relative importance of 'emotional' rather than 'rational' factors in reaching their individual decisions. Common fears included accounts of upsetting experiences that they personally or their friends had endured when they had been for a smear test. These experiences usually occurred in their general practitioner surgeries but also in the local district general hospital and had clearly left a strong impression on the women personally or by proxy. One woman who was overdue and not had a smear test for more than five years offered these views;

*"They don't make you feel comfortable ... They don't talk to you beforehand, it's just in and get it over with quickly ... They took me into a small room, the instruments were clanging around and I had my little child with me and he was screaming ... I know I should have it done because it detects what it needs to but I don't like the thought of just lying there..."*

Women who had been for a smear test generally did not do so happily but had been able to overcome their fears and attend their appointment, although it was often with great reluctance and anxiety.

*"It's like going to the dentist ... it's just something that you have to get checked ... it's something that you want to know about and get sorted ... I think a lot of people find it embarrassing and intrusive and so you don't want to go and if you've never had one before but then you have one and it isn't great but you think it's got to happen."*



Fears that having a smear test would hurt and be painful were also mentioned by young women as an important factor in their decision whether or not to attend their appointment. Women who had not been for a smear test said that they wanted to know *'what it felt like'* rather than receive excessive quantities of clinical information. Although several participants had been for cervical screening it was clear that the occasional negative experience was far more effective in damaging the prospects of women going for a smear test than several less traumatic or even positive experiences were in encouraging women to attend. It is plausible to contend that one bad experience of going for a smear test may deter numerous women whereas many acceptable experiences may reassure very few or none. Participants suggested that reassurances that practitioners will make every effort to ensure that the procedure does not hurt, particularly coming from ordinary women who have been for a smear test, will help to encourage women to go for cervical screening and need to be part of a social marketing campaign and, more importantly, an integral part of daily practice.

#### FEMALE HEALTH CARE PROFESSIONALS AND RESPECT

There was a widespread preference for smear tests to be conducted by female health care professionals, usually identified as female nurses compared to male general practitioners, and this view was shared by women who had been for a smear along with those who had not been for their test. In part this preference was driven by bad experiences at the hands of male doctors, with several examples being offered by participants who were drawing support from other young women in the group. One woman recalled her experience with a male doctor:

*"I found he was much more rude and didn't really care about me as a person. He didn't knock, he walked in through the door, threw back the curtain and with his student stood behind him and the door open he just did it..."*

Another respondent was firmly of the opinion that male doctors were less likely than female health care professionals to guide women through the process in an empathetic fashion.

*"I don't think they [male doctors] understand the same way, they don't get it. I mean obviously they know they're dealing with a personal area but they can't give you the same bedside manner because they've never had it done themselves..."*

There was a feeling expressed by many that women were not always treated with sufficient *'respect'* and were often *"talked at as though we're stupid"*.

This stood in stark contrast to the experience of a couple of women who had, in effect, been persuaded by the nurses at their practice surgeries to have a smear test, having previously declined the invitation to attend for their scheduled appointment. As one of the women put it: *"She knows me and it was a bit more friendly ..."* This preference for female health care professionals was regarded as particularly important for young women or those who were particularly reluctant to attend their screening appointment.

When one group was asked if it mattered whether it was a male or female who performed the procedure, one mother who had regularly attended her smear test appointments drew widespread support for her view:

*“It mattered before I had children but once you’ve had kids, loads of people have had a look at you, but at 16 I would have wanted a woman. If you had a choice you’d prefer a woman...”*

This is not to say that male doctors cannot perform smear tests appropriately and empathetically or that female health care practitioners do not inflict physical discomfort but that young women in Blackpool clearly expressed a consistent preference for a (female) nurse led service.

#### FLEXIBLE SERVICES

An important factor for young women who had not been for a smear test was the practical difficulties they experienced in attending their scheduled appointment. These difficulties included; being at the ‘*wrong time of the month*’ or the demands of work and the ubiquitous ‘*something always happens so I can’t go.*’ Whether these difficulties are reasons or excuses, they were raised by a majority of young women who felt the pressure of a lack of time in their daily lives. Going to their screening appointment was something that was often seen as inconvenient and time-consuming as well as being an event to dread. The solution that numerous young women who had not been for a smear test proposed and strongly supported was the provision of flexible services at the NHS walk-in centre.

*“Make it more accessible so that people are more likely to go and have it done because for people with kids it’s too restrictive because you can’t always get to an appointment. You need a place where you can just go and have it done like the walk-in centre and don’t make it such a scary issue by telling people what it could be – it’s not just that [cervical cancer] it could be all these other things...”*

*“If we could go somewhere like the walk-in centre, a place that everybody knows and everybody can get to because the buses run through town. If I could just go there and even if there’s a queue of 10 people I’d be willing to sit and wait knowing that I’m going to be seen...”*

The NHS walk-in centre appeared to be held in high regard, particularly by young women who had a less than perfect relationship with their general practitioner, possibly because it was less intimidating and largely run by female nurses. Twenty two out of the thirty young women attending the focus groups had used the walk-in centre in the last 12 months and there were no complaints about the services provided there compared to numerous complaints about their general practitioners and the receptionists in local surgeries. This is not to suggest that the walk-in centre is perfect nor without fault but compared to the available alternative venues it was the preferred site for many young women.

Participants felt that the flexibility in the provision could also be extended to evening clinics to allow women who worked greater opportunity to access services. At least one young woman who had attended a local sexual health clinic had asked about having a cervical smear test, but had been told [possibly incorrectly] that it wasn't a service that they provided and consequently she remained outside the coverage of the screening programme.

FIGURE 6 NHS BLACKPOOL WALK IN CENTRE



It was particularly interesting to note that there was widespread support for the extension of cervical screening to cover young women in the 20-24 age range even though there was some awareness that the clinical evidence did not support this position. A national opinion poll conducted in the period since Jade Goody was diagnosed with cervical cancer and her premature death found that 80 percent of the 2,000 men and women polled supported lowering the smear test age from 25 to 20 (Metro, 11/5/09). Although their experiences were unlikely to be representative of the wider population, one participant had first been invited for a smear test at the age of 21 and when she returned three years later for her next test, was understandably quite perturbed to be rather abruptly told that she was too young and didn't need one. Another participant recalled how she had built up the courage and rung her doctor a couple of years ago to ask for a smear test but was told that because of her age she needed to have a reason why he should perform the procedure. Consequently she had never been for a smear test and made it clear that she was unlikely to go to her general practitioner for one in the future. There was widespread support for the view that cervical screening should be available to young women as soon as they become sexually active and certainly once they have given birth to a child. There was generally strong support for the cervical screening

programme in principle although all participants acknowledged that it was easy to build on fears and put people off attending for a smear test in practice. As one woman who had been for several smear tests said: *"I'm still scared now, I don't think anybody likes it."* An important insight from the focus groups was that young women's decisions about cervical screening can be finely balanced. Some women manage to overcome their fears and go for a smear test but other women are unable to cross the threshold and bring themselves to attend even though they say that they want to go for a test.

#### 'FOREVER JADE?'

The death of reality TV celebrity Jade Goody at the age of 27 in March 2009 raised the profile of cervical screening and cancer in the public consciousness (Guardian 22/3/2009). Jade's diagnosis in 2008 is widely reported to have increased the uptake of cervical screening. This has now been labelled the 'Jade effect' (Guardian 17/2/2009 & 13/3/2009). This tragic story provided an obvious avenue to guide conversations on screening and the behaviour of young women towards their own health and to explore the extent of the Jade effect among a group of young women in Blackpool.

The impact of the story of Jade Goody was somewhat mixed with very high levels of awareness of her story, a great deal of empathy for her and her young children with several women citing her as justification for the extension of cervical screening coverage to younger women. For example, one woman who had not been for a smear test was of the opinion:

*"When I was younger, I was really determined to go and have one done and obviously with this Jade Goody thing going on, it's made everybody focus on why we need to go and have it done. So it's really opened it up to a lot of young people who want to have it done but can't have it."*

Another participant shared the popular public perception that cost was an important factor in the decision to raise the minimum screening age from 20 to 25 years:

*"If Jade had gone when she was younger, it might have made a difference because those two years could have been crucial, they might have caught it. I mean it can't be that expensive can it?"*

The 'Jade effect' had prompted at least a couple of participants to go for a smear test because they were the same age as Jade and her death had helped them overcome their fears and change their perception that they were 'invincible'. Another woman who had not been for a smear test in more than 10 years following a deeply traumatic experience first time around was firmly of the opinion that she would never go again: *"I'm just so put off by it. I just feel that it's [cervical cancer] not going to happen to me. But that's what Jade thought isn't it?"* A young woman who had not been for a cervical smear test acknowledged that she had been touched by Jade's story because of her young children being without their mother: *"The thought of me not being here for them is extremely scary..."* When asked if she had done anything about going for a smear test her reply was that she hadn't yet, but she had come to the focus group to find out more about it and at the end of the focus group she and her neighbour resolved to go to the

walk-in centre together to have a smear test. It was acknowledged that the 'Jade effect' was a potentially powerful influence on the behaviour of young women.

As one participant candidly acknowledged comparing Jade's story to the NHS Choices film:

*"This sounds really awful but they really should be taking advantage of Jade's death because everybody knows about it and using that to the benefit of young women with young children and something like that is so much more likely to make you go for a smear test [than the NHS Choices clip]."*

Using Jade's diagnosis and death to encourage women to go for a smear test might be effective at a national level but her premature death appeared to have limited resonance with some of the young women in this sample. Indeed, there was very little indication that the 'Jade effect' would significantly increase the uptake of cervical screening among young women in Blackpool. However, caution needs to be exercised when drawing conclusions about the 'Jade effect' from this sample of young women, who may not be representative. It is probable that Blackpool has experienced an increase in cervical screening demand since Jade's death.

#### FACTS CAN HELP TO OVERCOME FEARS AND NUDGE WOMEN TOWARDS A SMEAR TEST

As well as wanting to know more about what it 'feels like', many young women wanted more factual information about the screening procedure and the risks and symptoms of cervical cancer to help them make a decision about going for a smear test. Encouragingly there was some knowledge about the link between cervical cancer and the human papilloma virus (HPV), almost certainly related to the recent introduction of the HPV vaccination programme. As one young woman who had never been for a smear test said:

*"My reason [for not having a smear test] is that I don't know what they do. I'd like to find out and make sure that I am all right but it's what they actually do to you, the procedure, what actually happens, that's why I won't go."*

Another participant who had never had a smear test wanted to know precisely what was involved in having a smear test and had used the internet to search for material. In anticipation of this course of action, the research team showed a widely viewed information film on cervical screening available from the NHS Choices website (<http://www.nhs.uk/video/Pages/medialibrary.aspx?Tag=Cancer>). The three minute video features a male gynaecological oncologist explaining cervical cancer from symptoms through diagnosis to treatment in clinical language. The clip is available on YouTube where it has been viewed nearly 70,000 times since it was first posted less than a year ago. Although clearly intended to be a medical information film rather than part of a social marketing campaign, it is reasonable to assume that young women who wanted to find out more about going for cervical screening could easily find this video. When this film was shown, it was negatively received by all the groups, with women

finding it 'too clinical' and 'boring' with the consultant lacking 'communication skills'. Fortunately, none of the women in the groups had seen this film but it was apparent that it was not likely to encourage any of them to go for a smear test. A second three minute video from Cancer Research UK on cervical screening featuring a female nurse (<http://www.youtube.com/watch?v=61PhqmtsK7g>) was also shown to explore the reactions of participants. This film was received much more optimistically than the NHS film because it contained positive messages about how smear tests can catch cervical cancer at an early stage, and the greater likelihood of it then being treated successfully. The statistic that cervical cancer is the second most common cancer among women under the age of 35 struck a chord with one group of women because it was "...*something that everybody can understand.*" These videos, along with reactions to other public health adverts and other comments from participants, suggest that young women in Blackpool may be receptive to an appropriate short film posted on the internet as part of a wider social marketing campaign using positive messaging about the benefits of catching the disease early.

Factual information about screening and cervical cancer that stuck in people's minds was only part of the solution that young women wanted to see NHS Blackpool develop. There was strong support across the groups for much better education in schools about smear tests as part of the HPV vaccination programme and the wider personal, social, health and economic (PSHE) education in secondary schools. Education on the importance of cervical screening, amongst other things, to women's health was widely felt to be something that they had not experienced during their time at school and it was something that they wanted their daughters to have. As one woman said "*sex education at school was how to use tampons ... I don't know what a smear test is really for ... what does 'cell changes' mean?*"

#### WHAT CAN NHS BLACKPOOL DO TO ENCOURAGE WOMEN TO HAVE A CERVICAL SMEAR?

The focus groups were asked what steps NHS Blackpool could take to encourage young women to have a cervical smear test. All participants were supportive of NHS Blackpool actively encouraging women to go for a smear test and provided a wide variety of ideas on how this might be achieved. As one participant said: "There's nothing to be embarrassed about and I think that we need to get past it by advertising it [the smear test]..."

As mentioned earlier, the provision of more flexible services, particularly through the walk-in centre, was considered of paramount importance to the young women. Enabling easier access to cervical screening was essential, because although all of the young women knew that they should go for a smear test, many found it difficult to overcome their fears or to attend their scheduled appointment for a variety of practical reasons.

Several women in the final focus group mentioned that they had found the local health trainers to be very helpful and suggested that they could be used to encourage women to attend for cervical screening. There was a feeling that unlike the doctors and nurses at the local practice, health trainers had time to sit and talk and explain things. Another

group suggested that health visitors could take a more active role in encouraging young mothers to go for their smear tests.

All groups were supportive of the use of 'shock' tactics to draw people in and get public health messages across although many said that such an approach might not lead them to changing their health behaviour. Everybody knew that smoking was bad for their health but public health campaigns had succeeded in nudging them only to smoke outside their homes and away from their children. As one participant contended: "*They [NHS Blackpool] need to make it clear that the consequences of not having one are so risky that you just need to go for one...*"

One group supported the use of unusual but memorable images to attract people's attention. Another group emphasised that they wanted the provision of a few key facts about the link between HPV and cervical cancer. As one young woman said: "*Some facts in an advert could be really useful because you can think that you are all right and quite healthy but if you're sexually active then there's every chance you will have it [HPV].*" There was a general consensus that shock tactics, or whatever was used as a hook to grab their attention, needed to be followed up by signposting or easy access to more in depth information. The women wanted to have facts about cervical screening and cancer so that they could make an informed decision about going for a smear test rather than simply being told what to do because it was good for them. As one participant said: "*You don't want people going on and on at you. You just need them to tell you what it's all about.*"

There was widespread support for the use of local radio stations to get health messages across to young women. Radio jingles for double glazing companies or car showrooms were adverts that stuck in people's minds (even if they didn't want them to!) so some 'catchy' musical jingle that could be associated with cervical screening or women's health in general could increase awareness among young women. There was also support for the idea of NHS Blackpool using the internet to provide more information about cervical screening and cancer.

More negatively, there was considerable antipathy towards the impersonal letter that women received when being invited for their smear test. It was felt that it was very easy to ignore this letter because it was "*like a bill or junk mail*" rather than something that was important to their health. Participants said that they would like their letters to be more 'friendly' and to explain why having a smear test matters. Recall letters that included leaflets about cervical cancer induced considerable anxiety and worry among those women who had received them. The results letter '*scared me to death*' even though the woman agreed that the letter was at pains to point out that an abnormal smear did not necessarily mean that she had cancer. It is difficult to see how this might best be overcome, since participants who had experienced this situation reported that it was the fear that motivated them to attend for a repeat smear or further follow up.

## REACTION TO THE NHS 'PANTS' SOCIAL MARKETING CAMPAIGN

Participants in the focus groups were shown a short presentation summarising the NHS Pants social marketing campaign and told how it used posters, radio adverts and the local press to get the message across, and that whilst having a smear tests might be 'pants' it could save their life.

The campaign had been developed by NHS Walsall and the West Midlands Cervical Screening Quality Assurance Reference Centre in order to increase cervical screening coverage among young women in the 25-29 age range. The campaign was needed because although the incidence of cervical cancer in the West Midlands had nearly halved in the 20 years since the introduction of the NHS Cervical Screening Programme there was still a significant difference between the rates of cervical cancer in women from the most and the least deprived areas. Women from the most deprived areas were more likely to be diagnosed with cervical cancer and less likely to have been for a smear test (Chief Medical Officer's Annual Report 2007:76).

The reaction of the focus groups to the NHS Pants presentation was somewhat mixed with a majority of participants responding positively agreeing that it would get their attention and was 'not too in your face' in getting the message across. It was generally thought that such an approach, based on humour and empathy, could be used locally in Blackpool. However, such a campaign was not considered to be sufficient by several respondents unless it was linked to the provision of flexible screening services and education about cervical cancer and the HPV vaccine. A minority of participants responded negatively to the NHS Pants presentation because they thought it lacked impact and detail. However, participants were only exposed to a few of the key messages and images when they might have been expecting a You Tube video and it is unlikely that any social marketing campaign can please the entire target group all of the time.



## DISCUSSION

Blackpool is an interesting and in many ways unique setting. Much of Blackpool's wealth still comes from tourism and there appears to be some conflict between the need to compete with cheap foreign holidays and attract tourists, yet retain something of its former glory. Much of the housing stock indicates previously high levels of wealth, although most of the large grand houses have now been converted into several smaller flats. There are high levels of poverty in the area and significant health inequalities are present. Certainly the women we spoke to felt that the various authorities in Blackpool were more concerned with the tourists than caring about those living in more deprived areas of the town. Where else would such a traditional civic building be found in such close proximity to 'Funny girls'?

**FIGURE 7 BLACKPOOL LIBRARY WITH 'FUNNY GIRLS' IN THE BACKGROUND**



## VALUES AND BELIEFS

This group of young women clearly saw health as a resource for daily life, and felt that it was important (or even a duty) to keep healthy, not just for yourself, but for the family. However good health was considered less important than family life, or social relations and it was interesting to note that 'I have a right to choose whether or not to act in ways that may harm my health' was the third most popular comment selected from the Q-sort activity overall.

There was quite a difference of opinion about whether being poor affected the ability to keep healthy but the majority view was that although they did have some control over their own health, luck played the greatest part, and was not affected by behaviour. As is often the case when discussing the importance of healthy behaviours, numerous examples were cited about individuals who bucked the trend, either by falling ill after living an exemplary life, or alternatively living a long and healthy life despite breaking all the 'health' rules. It was interesting to note that living a long and healthy life was not high on the agenda for most Blackpool women who attended the focus groups, suggesting that promoting or 'selling' health per se, will be ineffective.

There is clearly scope for using the responsibilities that young women, particularly young mothers, feel towards their families to inform the social marketing campaign to increase the coverage of cervical screening. However, while having a happy family life revolving around children is clearly important to mothers it does not have a universal appeal to all young women.

This mixture of views suggests that although women value good health, they feel that they have little control over it. Attitudes characterised by individual responsibility, fatalism about health outcomes and the importance of the freedom to act as they want even if this damages their health will prove a challenge for any social marketing campaign. Of the categorical labels that can be applied to the Q-sort responses, the young women in the focus groups were most readily associated with one described as 'robust individualism'. (Blaxter, 2004: chapter 3). Robust individualists are likely to believe that individual freedom is very important to a good life including engaging in behaviours that may harm their health

## YOUNG WOMEN'S LIVES

Data from NHS Blackpool and the index of multiple deprivation indicate that deprived groups contain the highest proportion of both non-attendees and teen parents. These results are not necessarily linked, and care needs to be taken to avoid the ecological fallacy, but when combined with the fact that MRUK had difficulty finding participants who have not had a smear and did not have children, it does suggest that the majority of non-attendees are women with young children, which may be of value when attempting to understand women's lives and develop appropriate social marketing materials. It would be useful if this theory could be tested by cross referencing a sample of records.

Although the original brief stated that the target group was women living in the most disadvantaged areas of Blackpool; through undertaking this research it has become apparent that there are a number of subgroups in Blackpool with different behavioural drivers. The values of disadvantaged women who have children are different from those who do not and the positioning of why screening is important will also differ as a consequence. Clearly there are also differences in perception between those who have used the service and those who have not. If resources are limited, it would probably be most effective to target the women with children, since they appear to represent the largest group.

Most of the women with young children have substantial caring responsibilities and had found it very difficult (or impossible) to enter the world of work in a local economy that is reliant on the seasonal tourist trade and service industries. It was apparent that many of the participants had not planned to have their children and consequently they often felt trapped by life and disenfranchised by their situation in Blackpool. Nevertheless, many demonstrated ambition and resilience, and felt that it was important to have personal goals and to grasp opportunities to achieve them for the benefit of themselves, their children and families. Going out to socialise in town was not an option that most had any interest in. The feeling that there was very little for people like themselves was strong; and that the authorities only valued tourists or those with money came across convincingly.

The significance of 'Facebook' as a social outlet was very interesting and somewhat unexpected. Facebook was particularly important for the single mothers, trapped at home on low incomes, and participants clearly valued the safe extended network provided by the internet. Several women reported being involved with special interest groups on Facebook, and there were very few women who did not have regular access to the internet.

## TIME OUT

Young women also valued having some 'me-time' that gave them a break from their responsibilities and involved activities ranging from smoking a cigarette in peace and quiet through to taking a college course or meeting up with friends for a cup of coffee and a chat.

'Me-time' was universally acknowledged as important and highly valued. Women felt exhausted by their daily routines and they reported that being able to stop and do something different for a while contributed to the maintenance of their sanity. Taking some 'me-time' provides Blackpool women with renewed energy, and helps them regain a sense of control.

## BARRIERS AND MOTIVATORS

Probably the most important individual barrier identified during this research was fear, and the most important motivating factor was knowledge and education.

The main barriers identified during the focus groups were;

- feelings of fatalism and health beliefs held
- lack of confidence
- fear of pain or embarrassment (including the possibility of a male health care professional taking the smear)
- lack of knowledge about what it feels like to have a cervical smear
- lack of knowledge about cervical cancer and its treatment
- lack of understanding about cervical smear results
- fear of the test outcome
- low level of awareness of the benefits of cervical screening
- lack of understanding about why there is an age limit
- unattractive, uninformative invitation letter (looks like a utility bill)
- inconvenient times for appointments
- previous negative experience, especially where there was a perceived lack of respect /empathy from health care professionals

## SERVICE ISSUES

Many of the barriers to young women from deprived areas attending for cervical smears are service related and most come with remediable solutions. Whilst this study discovered some new, unique and interesting details about young women in Blackpool, the findings, especially about service related barriers and motivators were consistent with the literature that already exists on this topic.

The potential for poor service design to affect women's decisions to return for smear tests has been highlighted in this research. Perceptions of poor service can discourage women from ever attending particularly if they have experienced other negative encounters with medical professionals. A poorly designed service can also make communication campaigns less effective, if the service is positioned positively yet fails to live up to expectation. For this reason service design is just as important as communications in delivering sustained behaviour change. In designing services a

number of dimensions of quality have been identified which customers rely on to inform their judgements and are worthy of consideration in relation to cervical screening:

- reliability, the ability to perform the promised service dependably and accurately
- responsiveness and willingness to help clients and provide prompt service
- assurance of employees knowledge and courtesy and ability to inspire trust
- tangibles, the appearance of physical facilities, equipment and written materials (Zeithaml, Bitner and Gremler 2006)

## THE STRATEGY

Although many participants were supportive of the use of 'shock tactics' to get an important message across, this negative approach is not always appropriate because shock tactics rely on fear to promote behaviour change. Given that going for a smear test is already a 'dread event' for many women the wisdom of adding to this by using more fear to change behaviour seems questionable. There are very mixed views about the advisability of using a parent's responsibility to care for children to invoke guilt, because although this can be a very powerful motivating factor it can induce strong negative emotions. Using children as part of a social marketing campaign is likely to have resonance among mothers by playing on their maternal responsibilities, and providing reassurance that they will be around to care for their children but will have less appeal to other women. Several cases reported in the literature have suggested that positive messages are actually more powerful.

Behaviour change theory suggests that people are more likely to change their risk-taking behaviour depending on how seriously they perceive the risk, their susceptibility to it and the ease of taking action to reduce the hazard. The mix of methods used in the 'Pants' campaign included changes to service provision such as extended opening times and the widespread dissemination of promotional material (posters and leaflets) featuring the pants logo across surgeries, chemists, major supermarket chains and other places such as hairdressers and beauty salons that young women visited. Messages were delivered by a local radio campaign, press releases to local newspapers, a dedicated website ([www.pants.nhs.uk](http://www.pants.nhs.uk)) and credit card sized cut outs in the shape of pants displaying key messages. The integration of the campaign material with established direct mail sent to women inviting them for cervical screening also helped (National Social Marketing Centre, 2009). Although it was not the intention of the focus group; after exploring the issues, many who had not been for a smear test, or were overdue, clearly faced the incongruity of their actions and resolved to go for a test. Attending the focus group had 'nudged' the participants along through the stages of change, from a state of pre-contemplation to preparation for action.

## CONCLUSIONS AND RECOMMENDATIONS

The purpose of this report is to provide insight into the lives of women in Blackpool, their perceptions and experience of cervical screening and potential levers of influence.

The social marketing approach of basing public services around the needs and lives of people and differentiating what is offered to meet these needs is now a driving force in the shaping of public services. This is embodied in Ambitions for Health, where the government supports the need for customer focus to be at the heart of policy and also in the competences underpinning the World Class Commissioning Framework. In addressing cervical screening in Blackpool a strategic approach as well as some short term tactical action is needed, and the insights gained from this study will inform both.

## INSIGHTS

Young women from deprived areas of Blackpool, particularly those with children, value family life very highly. For them, 'being there' for your children is very important. The need to keep fit and healthy for the sake of the family appears to be one of the strongest motivating factors that could be used to inform a social marketing strategy. It was interesting to note that the lives of the women who had attended for cervical smears more clearly revolved positively around families. Their social life and friends formed around their children and other young parents. Among these women, children were generally planned and wanted.

Living in Blackpool can be boring, frustrating and is not always very safe, so socialising with friends and having time for yourself is very important. The need to have something that you are striving towards seems to help women keep their spirits lifted, and maybe offers hope of escape from current 'boring' lives. In relation to a social marketing campaign, it might be worth testing whether having a smear could be positioned as an achievement, or something to aim for, that benefits a woman and her family.

Women in Blackpool have good internet skills and possibly one of the most interesting findings is the significance of 'Facebook' as a social outlet, particularly for young women with child care responsibilities who have never had a smear. The data suggest that this group is very typical of those that need to be targeted by a social marketing strategy, so this is an important conclusion. Women expressed feelings of being trapped by their poverty and family circumstances and Facebook clearly provides an easy way to escape and socialise. It was particularly interesting to note how meeting up at home or to go out for a drink and talking to friends on the telephone was being supplemented or even surpassed by the use of Facebook. Social networking through Facebook allowed women to be sociable even when they were at home with their children and was an activity that was a lifeline for some participants

Choice gives people power, and although women clearly valued health as a resource, they were quite fatalistic and did not feel that they had much control over their health. So it is not surprising that they strongly defended their right to choose to behave in a way that might damage their health. This insight provides a clear indication that promoting cervical smears because they improve your chances of living a long healthy life will have little resonance with these women.

## WHAT DO YOUNG WOMEN IN BLACKPOOL WANT AND VALUE MOST IN LIFE?

For young women in Blackpool the key insights from the focus groups were:

- family life comes first – Women were prepared to sacrifice a great deal of time and effort to achieve this goal
- freedom for ‘me-time’ is needed – Women needed to have a part of their life that was just for them
- friends and Facebook matter
- feeling safe and secure is important – this predominantly revolves around personal safety when they went out and about in Blackpool due to the presence of tourists who were often intoxicated. Feeling secure was linked to having a happy family life and having a home where children can feel safe

These key findings represent important elements of the lives of young women in Blackpool and provide potential building blocks for the social marketing strategy.

## SOCIAL MARKETING STRATEGY

A recently (May 2009) published Joseph Rowntree Foundation (JRF) report strongly recommends that any social market ‘campaign’ is viewed as part of a long term commitment to an overall strategy to improve services. The evidence from this report suggests that to change social norms, a sustained effort is needed. ‘One off’ campaigns or incidents, such as anything linked to Jade Goody’s death may increase coverage in the short term, but unless activity is maintained, they are unlikely to achieve sustainable change. Young women are likely to be receptive to an appropriately designed social marketing campaign that nudges them to change their behaviour particularly in this period when the ‘Jade effect’ is still strong.

To design an appropriate strategy, it is important to gain insight into the various incentives and rewards, as well as the barriers and blocks that shape both the problematic and the desired behaviour.

FIGURE 8 DIAGRAM TO SHOW DETERMINANTS OF BEHAVIOUR



#### TERMS OF EXCHANGE AND COMPETITION

Any social marketing campaign needs to understand the competition for women's time and use the information provided from these focus groups about insights into what women want and value to discover what they will be prepared to exchange in order to benefit from a change in behaviour. Since women appear to value safety and security as well as family life, the benefits from participating in cervical screening could be framed in terms of the smear test providing peace of mind for women, their children and families. The death of Jade Goody certainly raised some anxiety and fears among young women and should make the terms of the exchange considerably easier because the eligible population is likely to be more susceptible to an appropriate nudge when the memory of this tragic premature death is still so vivid. Women who had not attended for a smear test often cited inconvenience or time pressures and the difficulties they experienced in attending appointments as reason for non attendance. Time is clearly precious, and



when women are able to relax and have 'me-time', they prefer their own company or spending time with a partner or close friend. According to a recent (2008) MORI survey the top five activities that women engage in are reading a book or magazine, surfing the internet, watching TV or listening to music. These activities might best be described as 'passive competition' but it might be possible to refer to them in a social marketing campaign. For example by shaping the service to offer a valued benefit, for example centres where smear tests are held offering relaxing music, internet access and interesting magazines to read.

#### MESSAGES, MEDIA AND METHODS MIX FOR SOCIAL MARKETING

The social marketing strategy must be built around the insights discovered. Any ideas mentioned below will need to be tested to find out whether they actually do have resonance, particularly with the target groups of women or staff providing the service.

Some of the core benefits that may be tested further;

<p><b>Cervical screening is important because I am important</b></p> <p><b>Cervical screening may be a bit uncomfortable, and embarrassing, but worth it to stay fit and healthy</b></p> <p><b>Cervical screening provides reassurance for a small amount of discomfort</b></p> <p><b>Take some time out for yourself – go for a smear</b></p>
--

Cervical screening needs to be positioned as a service that enables women to get on and live their lives. It is important because they are important and also because they are important to their children. As a core product concept it needs to be seen as being worthwhile because 'I'm too important not to have a smear test'.

The core media for any social marketing campaign is likely to be poster-based billboards and public transport sites (taxis, buses, trams and stops) in order to raise awareness and send positive messages to the target population of young women. It is anticipated that this could also be accompanied by a short advertisement on local radio stations with a similar focus.

A strap line ideally in the form of a positive message will be needed. Something that stresses that smear tests are brief such as 'It only takes a minute, girl', might be worth testing out.

Encouraging facts that normalise going for a smear need to be collected and can be used to help shape community norms. For example, 'In the UK 75 percent of women go

for a smear test – and the vast majority (89.5 percent) of results are all clear’ (The Health and Social Care Information Centre, 2008a) provides a simple message about personal safety. Put more simply ‘Nine out of ten who go for a smear, get the all clear.’

Blackpool women expressed an unambiguous need for ‘me-time’, and this could also form the basis for some positive messages inferring that taking time out to go for your smear is a positive ‘me-time’ activity. ‘It’s all about you’ could be a suitable strap line worth testing to emphasise that women’s well being is at the centre of the cervical screening programme and the social marketing campaign.

The latest ‘Fairy liquid’ advertisement, attempts to suggest that using this washing-up liquid is a responsible thing to do for your family, akin to bringing up children properly. We know that women value family life very highly, so maybe a similar message could be used for cervical smears?

Finding more opportunities to deliver simple nudges like posing the question of whether women have been for a smear test may also be helpful because we change our behaviour when prompted. If people are asked how often they expect to floss their teeth in the next week then they floss more, if people are asked whether they intend to consume fatty foods in the next week then they consume less (Thaler and Sunstein, 2008: 76). Although the question is asked impersonally, a poster could have the same nudge effect:

“Have you been for a smear test recently? 75 percent of women in Blackpool have been for a smear test in the last few years. They know where they stand. Do you? It only takes a minute. To find out more about the cervical smear test call NHS Blackpool on 01XXX XXXXXX or go to [www.websitename.nhs.uk](http://www.websitename.nhs.uk)”

This research has identified that having a smear is as much an emotional as a rational decision, so more emotive messages will also be needed; possibly stressing that having a smear is important is because ‘you are important’.

There is considerable scope for NHS Blackpool to provide more information about local services and to promote cervical screening through a website. Traditional media outlets such as posters and local radio can be used to guide women to the website. See [www.pants.nhs.uk](http://www.pants.nhs.uk) for a good example. The website could include times and places when screening was available, reassurances about the procedure and that female medical staff would be available to perform the smear test. The site could link to other NHS websites such as the newly established screening portal ([www.screening.nhs.uk/cervicalcancer-england](http://www.screening.nhs.uk/cervicalcancer-england)), and the cervical screening programme’s own website ([www.cancerscreening.nhs.uk/cervical](http://www.cancerscreening.nhs.uk/cervical)). The cervical cancer charity, Jo’s Trust ([www.jotrust.co.uk/about\\_cervical\\_cancer/screening.cfm](http://www.jotrust.co.uk/about_cervical_cancer/screening.cfm)) provides excellent advice on cervical screening. Although it was surprising to note how knowledgeable most young women in Blackpool were about the internet and how to access various websites, an internet access divide still exists, so the web cannot be used on its own, and probably ought to be backed up with other materials.

This work suggests that a simple video featuring a local female nurse briefly outlining why the screening programme is in place, what happens when women attend a clinic, how the results are disclosed and what they mean to women would be welcome. In addition to the reassuring presence of a female health care professional, serious consideration should be given to using 'ordinary' young women from Blackpool to share their personal experiences about having a smear test. This would cover what women thought and felt about being called for cervical screening, what it felt like when they actually had the smear test and how reassured they feel knowing more about their risk of cancer once it is all over. The core message of these stories from 'real women' would be that although the smear test is not a pleasant experience it was performed with due professional consideration, respect for their feelings and was over with quickly. Hence the 'It only takes a minute girl' message.

It would be advisable here to unpick who should appear in communications materials. If NHS staff are used, how should they look to convey an image of warm friendly caring, people? What should they be saying to reassure? How much clinical information should be given and at what point?

The Facebook insight cannot be ignored, so an imperative for NHS Blackpool is to pilot a Facebook group. The use of social networking in this way is new and has not been adequately researched, but the popularity of the activity is overwhelming. Facebook provides an easy and inexpensive way to contact a lot of local women from the target groups. The reach of social networking sites across the population continues to rapidly grow, particularly among young women, and should easily attract membership if it is linked to the cervical screening website. Groups are very popular on Facebook, and many are joined purely to allow people to display a belief they have for a particular cause or to voice their feelings for a common cause. Advantage could be taken of this facility by NHS Blackpool to set up their own group to encourage women to go for a smear, and maybe provide a facility for 'Facebook buddies' to come in together to provide mutual support.

Women who are making their decision whether to go for a smear test could post questions that could be answered by other members of the group and/or by a moderator from NHS Blackpool. Women who have been for a smear test in Blackpool could be encouraged to join this Facebook group to share their own experiences of cervical smears, as well as disclose any queries or thoughts they have about the screening process and provide feedback both to other women and to NHS Blackpool about the quality of their experience. Good feedback would provide reassurance to other women who are making a decision about whether to go for a smear test, while negative feedback would provide NHS Blackpool with the opportunity to address poor quality experiences. Women want to know more about what cervical screening involves and value the anonymity of Facebook so a regular short session each week when a health care professional responds to concerns and questions to alleviate fears or correct any misguided / misinformed comments about cervical screening could be an additional feature of this forum.

However, there would need to be careful consideration given to the operation of such a forum in terms of moderation of comments but it could provide an innovative strand to the process of social marketing for cervical screening.

We recommend that NHS Blackpool:

- tests and then uses a range of strap lines and nudges to see which resonate best with local women. Use positive messages wherever possible and include some ideas that are humorous
- displays these through a wide mix of media and other service opportunities
- creates a website (and possibly a phone line) to provide more information about cervical smears and cervical cancer, including what results of smears mean. This may include short videos from professionals, but also from ordinary women to let others know what it feels like to have a smear, together with both serious and light hearted drama
- includes information on the web site about services and where women can go for a smear
- sets up and moderates a 'Facebook' group

## SERVICE ISSUES

Elements of service design whose importance could be tested further;

**Cervical screening is provided in a warm, friendly service environment**

**Cervical screening is provided at times and places that are convenient for the women who are our clients / customers**

**Enough appropriate information is provided about cervical screening and cervical cancer**

In testing the service design it is necessary to unpick what people understand by the term 'warm and friendly services', perhaps by drawing on non health examples to illustrate what they mean and how these characteristics may transfer to the health service. Children's centres could be explored as a suitable venue for taking smears, but if this is not feasible, at a minimum, they could be used as an outlet for the dissemination of information about cervical screening.

Both the literature review and the focus groups indicate the importance of discussion as a good means of raising awareness and encouraging women to attend screening, sometimes with the support of a close friend, so finding opportunities to prime such discussions may be useful.

It may be worth testing other concepts such as offering incentives or organising social gatherings to encourage women to have smears. (As in the 'Don't just say they matter' campaign).

Social marketing campaigns and commitment to service change and improvement need to be sustained in order to be successful. Jeff French, Director of the National Social Marketing Centre said that having found out what people want, it is crucial to the success of any social marketing campaign that directors are willing to amend their services to meet population needs identified (personal communication). Social marketing has to be accompanied by the provision of flexible, female-friendly services in order to produce a sustainable increase in cervical screening coverage.

Differences in attitudes towards health care professionals, between women who had not been for a smear compared to those who had were also apparent. For those who do not have a good relationship with their local practice, it may prove to be unrealistic and an insurmountable barrier to ask women to go to their general practitioner for a smear test. The development of flexible services at a variety of other locations would seem to be an essential component of any strategy.

The need for facilities to be more easily accessible was clearly evident with the NHS walk-in centre as the preferred option. At the moment, times for having a smear are restricted which negates the concept of flexibility that the 'drop-in' centre could provide. Sexual health services were also identified as having greater flexibility and accessibility and being a place where women felt welcome. Some participants were aware that they could use this facility, but they felt that it was only possible if they were attending for another reason, and did not think that they could go there just for a smear. Many of the women who attended the focus groups used children's centres and valued them as warm friendly places offering a positive service.

We recommend that NHS Blackpool:

- explores the possibility of making the drop-in centre more flexible, by offering the facility to come in for a smear at anytime
- opens up sexual health services and other well woman clinics, so that women can drop in for a smear without making an appointment
- considers offering smears at children's centres, women's homes (as in the 'Don't just say they matter campaign) or other venues

Many of these women live life day by day, and rarely plan ahead. The ability to seize the moment and attend for a smear at a convenient time can only serve to increase uptake.

Some women who had never been for a smear had requested one at a younger age and been refused. The women remembered this as a very negative incident, and although they were now within the target age group had been so put off by this earlier experience, they clearly had no intention of attending for a smear in the future. There is no sudden change in a woman's cervix when she reaches the age of 25, so to some extent this cut

off point is arbitrary. There was virtually complete misunderstanding of the rationale for 'refusing' to undertake smears on women less than 25 years of age.

The concept of 'moments of truth' is very important in service satisfaction. These are points that can make or break how a customer perceives the service (Zeithaml, Bitner and Gremler, 2006). Several examples from the focus groups illustrated how negative service encounters had affected women's decisions not to have a smear test. It also underlines the importance of having a means of monitoring the customer experience as described in the customer journey diagram (Figure 10) to pick up good and bad 'moments of truth.'

We recommend that NHS Blackpool:

- reflects on the negative effects of refusing a young woman who has plucked up the courage to request a smear, and may never attend again as a consequence of the refusal, with the problems of allowing any sexually active woman to have a smear who has come forward; even though she may not be within the recommended age group. This would be especially important for women who are near to 25 years of age. Certainly better education is required here as well and would alleviate many of the problems
- attempts to overcome perceptions of poor treatment that women may have experienced or heard about in the past, by reviewing the whole service experience. This will include the invitation letter or card, the making of appointments, the greeting at reception, how the service is delivered and very importantly how the service encounter is closed. 'Service warmth' is important in creating the perception of a high quality service and is essential to overcome any previous negative experience of medical services (Mudie and Pirrie 2006)

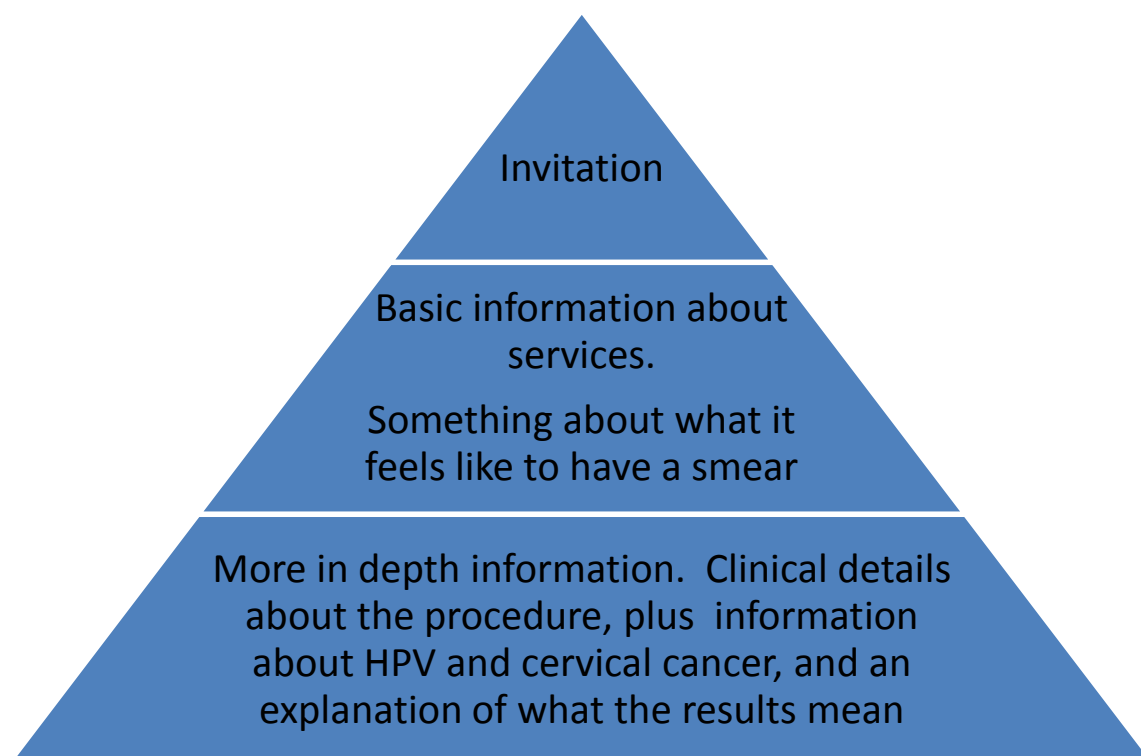
#### THE LETTER AND OTHER INFORMATION

The current invitation letter has serious flaws and is regarded as unwieldy, impersonal and uninformative.

Contacting women to invite them for cervical screening is a critical first step and whatever is used needs to be carefully designed and actively encourage women to go for a smear test.

The clear message coming across from all groups was that there is a lack of clarity about what a cervical smear is for, and how the results should be interpreted. Women did not understand what some of the commonly used terms like 'pre-cancerous' or 'changes' meant. Women expressed the need for a hierarchy of information at different levels. (Figure 9). They want something to grab their attention, or a 'hook' to make them interested, followed by something more detailed. Women who had never had a smear spoke of the need to know what it 'felt' like. Above all, they would like to hear this from a 'normal' person, someone like themselves that they can relate to, explaining less about the process and more about the personal experience. For those who are really interested, they also expressed a desire to know where to go to find out more.

FIGURE 9 INFORMATION PYRAMID



These issues are linked, and women suggested that a small attractive card, possibly postcard or credit card size be used as the primary invitation or as a reminder. Women want something that is not overtly embarrassing that they can stick onto the fridge door or put into a purse or handbag. The “Pants” research suggested that the use of pink and floral or similar imagery should be avoided because it tends to falsely imply that cervical cancer is attractive or it gives the impression that cervical screening should not be talked about seriously but rather covered up with something pleasant (NSMC, 2008). Ideally, the card should not be overly obtrusive. More frequent, but simple gentle reminders would also be welcome.

Women want the card to point to somewhere that they can go to for more information, possibly a specific website or a phone number. This second tier of information on the website could include details of where they can go and what times services are open and available.

Clinical information about what happens is less important than being able to speak to someone about what it ‘feels like’ to have a smear. Again, this may be achievable through a website; a Facebook group led by NHS trained volunteers, or a phone-line.

There is obviously a need to correct some of the misunderstandings about why the age for the initial smear has changed and what the results of the smear actually mean. The participants felt that it was an indictment of our education system that girls leave school without understanding what cervical smears are for, what the results mean and the

disadvantages of screening women aged under 25 years. The logical long term recommendation would therefore be for the NHS to lobby for these topics to be included as essential components of the core curriculum. In April this year (2009) Ed Balls, Secretary of State for Children, Schools and Families, outlined plans to make personal, social, health and economic (PSHE) education a compulsory part of the curriculum at both primary and secondary school by 2011. This would seem like a golden opportunity to get population health issues into the compulsory school curriculum.

However in the shorter term, it may be helpful to develop web-based or other materials about cervical screening and to train community nurses or possibly other volunteers to go into secondary schools to deliver these sessions as part of the current personal, social, health and economic (PSHE) curriculum.

We recommend that NHS Blackpool:

- lobbies for the new PSHE curriculum to include sessions on cervical cancer and cervical smears
- re-designs contact letters /cards so that they both invite and encourage women to attend for cervical screening. Additional credit-card sized reminders containing a suitable social marketing message should be developed for distribution and be integrated with other parts of the campaign, most notably a website
- puts information about the sex of the person carrying out the test on the invitation letter
- considers developing educational materials about smear tests as part of the HPV vaccination programme in schools emphasising the benefits of screening in detecting changes that can lead to cervical cancer



## SERVICE DESIGN

This is about setting the environmental and physical context of the service. It considers the customer journey and all points of contact where there is opportunity to influence behaviour and provide a positive experience. A diagram of what the customer journey may look like is given in Figure 10 overleaf

## OPPORTUNISTIC INTERACTION

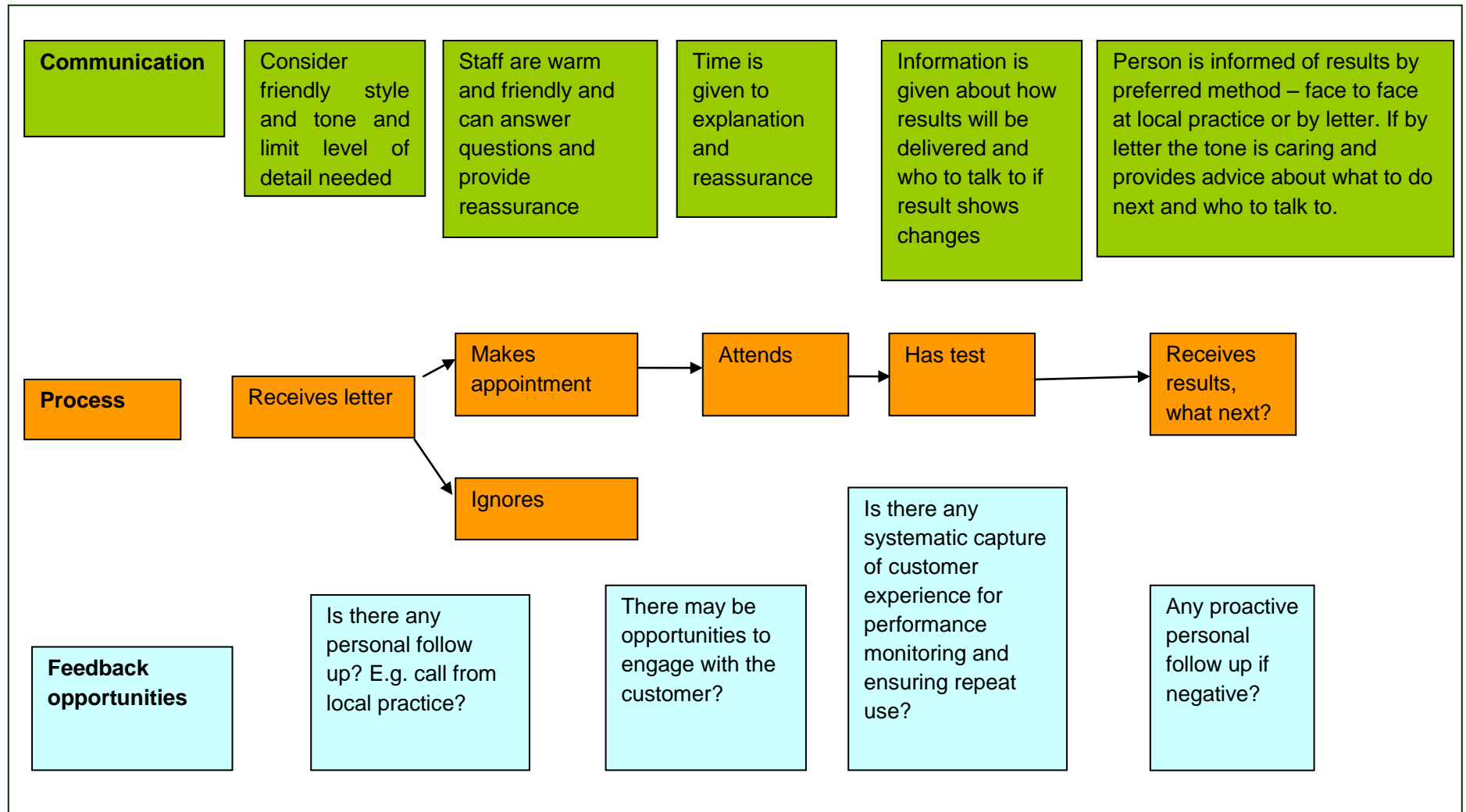
At various points along the woman's journey, there are opportunities for communication, to inform and also times where the woman can give feedback that can be captured for continuous quality improvement purposes.

In re-designing the service, opportunistic points of contact need to be considered as they represent a chance to change the choice architecture. For example many young women, both with and without children, may be using the contraceptive pill or other form of contraception that necessitates regular blood pressure checks. This research indicated that they are relatively heavy users of services. A large number of the young women in our focus groups had been to the dentist or general practitioner, and 90 percent had received a blood pressure check in the past year. Each time this happens a valuable point of contact with services takes place and provides an opportunity to discuss cervical screening and provide one to one information in a tailored way. Re-design of the cervical screening process should not take place in isolation and needs to involve other services to achieve maximum uptake.

We recommend that NHS Blackpool

- explores ways to use the various stages of a women's journey through the cervical screening process to provide information and reassurance, and receive feedback that can be used to evaluate and improve the programme
- as part of the redesign of services, explores how interactions with other services can be better allied to the cervical screening programme

FIGURE 10 THE JOURNEY THROUGH THE SERVICE



## STAFF EDUCATION AND TRAINING

Many an excellent plan has failed because people have been expected to change the way they do things without adequate explanation or education. Training of staff is an essential element in ensuring the consistent delivery of a high quality service of sufficiently high standard that will encourage women to come back.

We recommend that NHS Blackpool;

- considers the staff education and training implications as an integral part of any social marketing strategy they develop

## EVALUATION

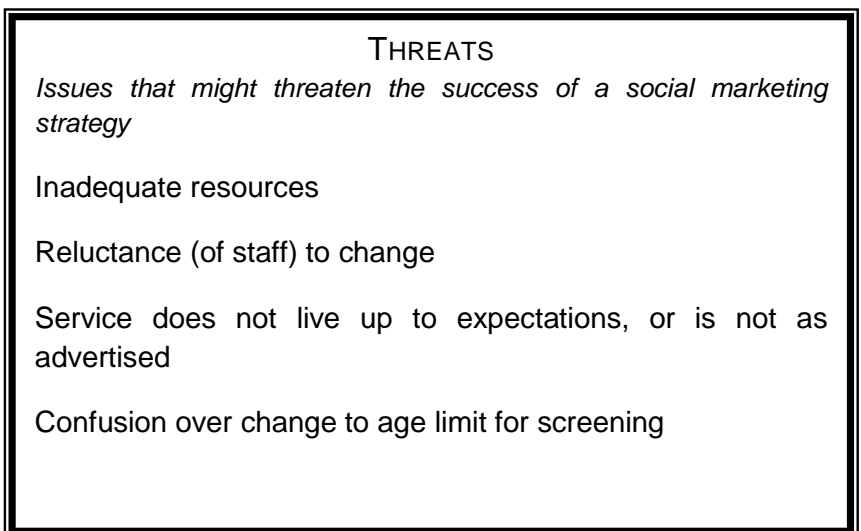
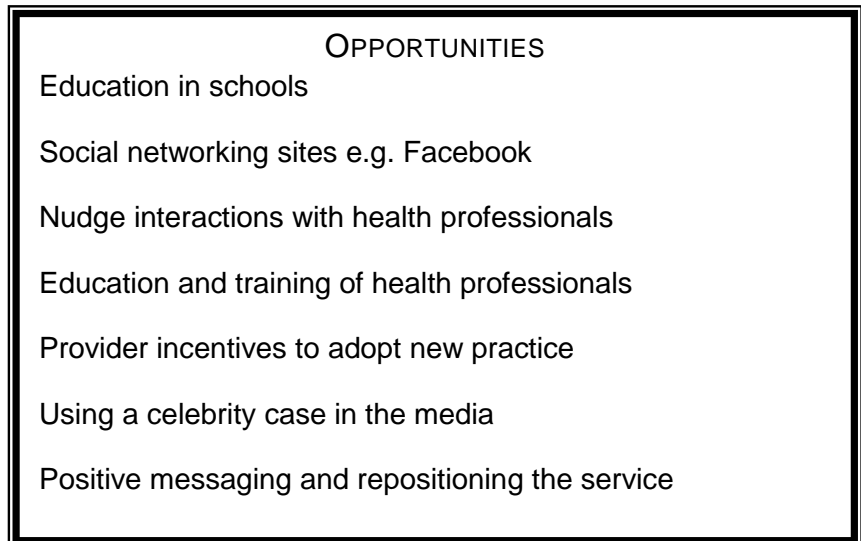
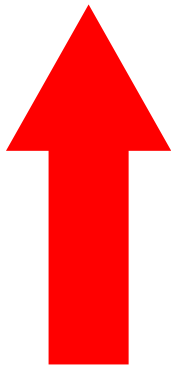
Any strategy that is implemented needs to be continuously monitored and evaluated.

We recommend that NHS Blackpool;

- develops an evaluation strategy as part of the social marketing strategy
- considers how people feel about the invitation and how they are communicated with
- tests what people feel about being contacted by phone to book a smear appointment if they don't respond to the letter or to discuss any issues or concerns that may be putting women off
- considers giving women an opportunity to discuss cervical screening as a routine part of contraceptive prescribing and monitoring. This may require training for staff of all types to ensure they have the appropriate interpersonal skills to do this.

## OPPORTUNITIES AND THREATS

The development of a new social marketing programme and accompanying redesign of services offers many exciting opportunities to make a difference, but a few threats that may need to be considered and addressed to ensure success.



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## APPENDIX 1 FOCUS GROUP TOPIC GUIDE

Scripted initial introduction from J & K

Topic 1: Lives and aspirations (c. 25-30 minutes)

[Scripted introduction for this section from J/K]

“We’d like to start off by finding out about your views of ‘living a good life.’ What does that mean to you?”

[Present a couple of statements on A4 and facilitate discussion – “*Which of these two statements do you think are more important to you?*” There must also be scope for a couple of additional statements to be generated from participants (don’t just spring this on them at the end!)]

[Additional prompts as you see fit – the stock prompt of ‘**Why do you say that?**’

To prompt wider group discussion ‘Is that something you would agree with? / What do other people think about that?’

Remember to guide this discussion so that it will focus on the local area – ‘**So what does that mean for young women in Blackpool?**’]

[Really try to explore what women say – Take your time!]

Topic 2: Health – thoughts and actions

[Scripted introduction from K/J (including brief explanation of why Q-sort is being done – people think about this in different ways and we want to see how young women in Blackpool think about health)]

[Q-sort exercise to be done in pairs after demonstration by K/J including reading out some of the statements and circulating among the pairs to assist & encourage women to ask questions while they are filling in grid correctly!]

[After the task has been completed, ask for views on the statements and explore if there is any one/two statements that people feel strongly about: ‘**Did any of the statements really strike a chord with anybody?**’ EXPLORE if they did]

Health Bingo – [play it as bingo]

[After the game, ask for views on the statements on the card – are there any behaviours that people feel strongly about?]

### Topic 3: Public Health Campaigns (scripted intro)

“We get a lot of information and messages on health. Are there any public health campaigns that you’ve noticed or have had an impact on your lifestyle?”

[Prompt verbally with: 5-a-day for eating fruit and vegetables, NHS Stop Smoking services, Know Your Units for alcohol]

“Have these campaigns/messages had any impact on them? Why/Why not?” [Explore]

[Introduce and play Change4Life advert/PH leaflet]

“What do you think about these adverts?”

“How do these sorts of messages compare with other advertising campaigns?”

“What other advertising campaigns have had an impact on you? Why?”

“What do you think are the best ways of providing public health information?”

[Explore until short break. Prompts for discussion:

What do you think about using shock tactics? (Fag packets)

Are you more likely to follow the advice if the message is positive? (i.e. Change4Life’s Eat Better, Move More, Live Longer motto)

How do you feel about advice that tells you not to do things you enjoy but are bad for your health (i.e. Know your units for drinking alcohol or Stop Smoking advice)

### PART 2: Topics 4 & 5: Cervical screening/Jade and Your Health Your Say

Introduction by J/K – including “We’d like you to think about what the NHS *in Blackpool* could do to encourage young women to go for a smear test and jot any ideas that you have down or raise them during this part of the focus group” [Planting seed for social marketing]

“Cervical screening and cancer have been in the news a lot recently. What do you think about going for a smear test?”

[When Jade is brought up then explore what they think of her behaviour] [**Explore feelings of embarrassment, fear, anxiety etc.**]

[Then for those who have attended a smear test: likely to be mixed groups so just going to have to do our best...]

Thinking about your first screen, how did you feel before the screening?

Where did people have the screening done?

How easy was it having the smear test? Did people have to travel, take time off work?

How did they feel after the screening?

What made you feel like this? [Explore particularly the negative feelings?]

How did you feel you were treated by the staff?

Did they make you feel at ease? Did they explain what they were going to do?

How quickly did people receive their results? If the result was not clear did people feel they could get good advice and discuss how they felt?

Having been for a smear test are you likely to continue going for a smear test in the future?

What would make it more likely that you would go for a smear test?

**What could the NHS do to encourage you to attend?** [Will come back to this later but it grows the seed...]

For those who have not attended a smear test:

How do you feel about having a cervical smear test?

[Explore feelings of embarrassment, fear and so on]

Do you know what the smear test involves and what it's for?

Has anybody been invited for a smear test but decided not to go? Why was this?

Has anybody asked for a smear test? Why was this?

Are you likely to go for a smear test when you're invited? Why/Why not?

What would make it more likely that you would go for a smear test?

What could the NHS do to encourage you to attend?

Part 6: Do you think this sort of approach might work in Blackpool?

[Play NHS Choices and/or Mid-Wales clip of nurse in front of curtains to show how bad the traditional NHS approach can be] So what did you think? [Explore (negative) reactions...]

[Play NHS Essex and CRUK clips] Explore (more positive?) reactions...

“There has been a campaign in the West Midlands that acknowledges that having a cervical smear isn't pleasant but that it could save your life and it's known as the pants campaign – what do you think of this sort of approach?”

[Show power point slides and explain how the Pants campaign featured advertising on buses, local radio and press to raise awareness; **and**, changes to practice opening times so that it was easier for women to go for a test at lunch time or after work]

Do you think this sort of approach could work in Blackpool? [Explore any views]

End with any final questions or comments?

Thanks for their time; distribution of vouchers; and inform participants that there is an NHS professional available to answer any questions that they may have about cervical screening



## APPENDIX 2

### FOCUS GROUP 1

#### PRIORITIES

- Having a happy family life
- To have goals [they appeared to be ambitious and motivated – one was a would be entrepreneur]
- Having ‘me-time’
- Living a long and healthy life
- Facebook (virtual social life) – very high use of internet including Skype
- Having a good social life with friends
- Having a good job
- Having children
- Being in a happy relationship
- Going on holiday in the sun
- Owning own home

### FOCUS GROUP 2

#### PRIORITIES

- Having a happy family life
- Having children
- Safe environment for children
- Feeling secure
- Being in a happy relationship
- Living a long and healthy life
- Owning your own home
- Having a good social life
- Good job
- Facebook [not as important but still used quite a bit]
- Going on holiday in the sun

### FOCUS GROUP 3

#### PRIORITIES

- Independent women (many did not respond to prompt on relationships)
- Having a good social life
- Feeling safe and secure
- Long and healthy life
- Having a good job
- Having a happy family life
- Helping others
- Being in a happy relationship
- Having children
- Owning own home

Going on holiday in the sun

## FOCUS GROUP 4

### PRIORITIES

Support Network

Living a long and healthy life

Having children

Having a happy family life

Me time

Education

Being in a happy relationship

Having a good job (interesting, well paid)

Going on holiday in the sun

Owning your own home



## Q SORT STATEMENTS

When I'm ill enough to go to the doctor I'll get better if I do everything they tell me to do

I have little faith the advice I get from a doctor can help very much in making me healthier

When I'm ill I usually feel as if I'm in some way to blame

When I feel unhappy, I'm more likely to become ill

My state of health is in part to do with how 'well off' or 'badly off' I am

If I'm going to get ill, then I will get ill – it's just the luck of the draw

When I'm not feeling well it's often my own bad habits that are to blame

My physical health and well-being are affected by my state of mind

Feeling fit and well are much the same thing as feeling truly happy

My health is my own responsibility

I have a right to choose whether or not to act in ways that may harm my health (e.g. work too hard, smoke)

Only by living a healthy lifestyle can I make sure I'm going to be fit and well

Keeping healthy is a bit of an uphill struggle given the polluted and stressful society we live in

Sometimes I get ill because of my own stupid behaviour

I would seek help from practitioners in 'alternative' medicine for certain types of illness

My overall state of health has a lot to do with my own day to day actions – I can let myself get run down or take steps to be healthy

# Eyes Down for Health Bingo

In the last 12 months have you done any of the following activities?

2. Visited dentist for check-up	11. Been for a long walk in the park	21. Had casual sex	32. Been to the gym	41. Been to a health spa	50. Been for a long walk on the beach or in the country	62. Cut down on drinking alcohol	71. Taken recreational drugs	81. Had your blood pressure taken
5. Used NHS Direct/ Walk in Centre	13. Had a child vaccinated	23. Started a new sport, exercise or fitness activity	33. Had a fag/ciggie	44. Used a sun bed or sun shower	51. Been to a Well-Woman or Family Planning Clinic	63. Not drunk any alcohol	74. Been to your GP	84. Been tested for diabetes
8. Joined slimming club like Weight Watchers	18. Been tested for a sexually transmitted infection	29. Had medical advice for a foreign holiday	37. Used NHS Stop Smoking service or given up smoking	47. Had acupuncture	52. Got drunk	64. Had a cervical smear test	77. Been to optician for an eye test	88. Taken the stairs rather than the lift

## HEALTH BINGO STATEMENTS

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44. Used a sun bed or sun shower
47. Had acupuncture
50. Been for a long walk on the beach or in the country
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52. Got drunk
62. Cut down on drinking alcohol
63. Not drunk any alcohol
64. Had a cervical smear test
71. Taken recreational drugs
74. Been to your GP
77. Been to optician for eye test
81. Had your blood pressure taken

84. Been tested for diabetes

88. Taken the stairs rather than the lift

## APPENDIX 5

### PUBLIC HEALTH ADVERTISEMENTS SHOWN TO FOCUS GROUPS

Change4Life (2009), Department of Health.

Available at: [http://www.youtube.com/watch?v=ZcqB\\_dL462Y](http://www.youtube.com/watch?v=ZcqB_dL462Y)

'Scared' (2008), NHS Stop Smoking Services

Available at: <http://www.youtube.com/watch?v=P7L4LVfHCSE>

Cervical Cancer (2008), NHS Choices

Available at: <http://www.nhs.uk/video/Pages/medialibrary.aspx?Tag=Cancer>

Screening Matters – Cervical Screening (2007), Cancer Research UK

Available at: <http://www.youtube.com/watch?v=61PhqmtsK7g>



**Published by**

Centre for Public Health  
Research Directorate  
Faculty of Health and Applied Social Sciences  
Liverpool John Moores University  
Kingsway House  
Hatton Garden  
Liverpool  
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© August 2009

ISBN: 978-1-906591-79-3 (web)

