

Appendix 6:

Box 1 - Individual barriers to uptake of screening

Language barriers[1-5]; low literacy[4, 5]; time limitations[1, 4]; perceived time and cost[6]; negative perceptions and beliefs[2-4, 7-9]; perceived test accuracy[4]; low perceived benefit of screening[10-12]; low perceived cancer risk[2, 4, 13]; low priority[4]; fear of test and outcome[1, 4, 6, 8-10, 12, 14-19]; procrastination[1]; fatalism[5, 11, 13]; belief that screening is unnecessary without symptoms [13, 15, 20]; distrust[2, 4, 5, 16]; confidence in traditional medicine[2, 8]; cultural beliefs[1-3, 21]; false beliefs[1, 11, 22]; shame[5, 23]; embarrassment[1, 4-6, 15, 19, 24]; anticipated pain and discomfort[13, 15, 16, 18, 24]; disgust[8]; stigma[9, 13, 16, 21]; threats to modesty[5, 6, 13, 16]; spiritual beliefs[5]; issues with disclosure[9, 21]; patriarchal beliefs[5]; masculinity[3]; vulnerability[24]; lack of acculturation[20, 25]; and undocumented status[16]. In particular, the inequity of screening participation was highlighted and the likelihood of attending or being screened was influenced by the following factors: age[2, 4, 26] [27]; gender[4, 27, 28]; comorbidities[28]; education[25-29]; income[25, 26]; race and ethnicity[4, 18, 27, 28, 30]; socioeconomic status[4, 11, 28]; rural[28]; and home situation[18, 26, 27]. Overuse of screening was linked to higher education and different perceptions of risk[31].

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