PHE5CSP: Social and Cultural Perspectives in Public Health

Assessment 2

Why is cancer screening not effective in many communities?

Introduction

The topic of cancer screening is now being looked at by the medical community. Current trends generally favour fewer routine tests rather than more. These guidelines are based on recently discovered evidence that, unfortunately, raises the possibility that expanding screening may not always reduce cancer-related death and that some screening may even be harmful (Wu et al., 2019). Clinical studies have shown that cancer screening does, in fact, save lives, especially when it comes to common malignancies like cervical, gastrointestinal, lung, and breast cancer. Sometimes, though, the size of the benefit is misunderstood. For instance, between the ages of 50 and 59, more than 1,300 women must get mammograms in order to save one life. This essay will provide a comprehensive overview of the importance of cancer screening and will focus on a critical analysis of issues of cancer screening in many communities (Wu et al., 2019).

Discussion

During a cancer screening, a person's body is examined for malignant tumours or cancer even if they show no symptoms of the illness being screened for. Early detection of an aberration in the process of cancer development is the goal. A precancerous lesion can be managed or surgically removed if a cancer screening test finds it. A patient has a better chance of receiving successful therapy if a test identifies cancer at an early stage, such as stage I or stage II before it has spread (Henderson et al., 2020). For example, the 5-year rate of relative survival for those with colon or rectum-only colorectal cancer is 90%. According to the World Health Organization (WHO), there might be "11 million new cases of cancer there year by 2030 an increase of 80% from 2008". Cancer, which is expected to overtake all other causes of mortality by the end of the twenty-first century, is the most significant impediment to nations' efforts to extend life expectancy. One strategy to lower mortality is early cancer detection. However, screening that

searches for disease indications in asymptomatic people occurs far less frequently in low- and middle-income nations than in high-income ones, where treatments like mammograms and cervical screens are commonplace. One factor contributing to the gap is a lack of infrastructure (Henderson et al., 2020). Other factors include the scarcity of hospitals in rural areas, the high cost of treatment, a lack of qualified medical professionals, poor quality hospital instruments, and patient resistance to testing. The need for improved screening programmes is increased by the scarcity of technologies capable of treating advanced malignancies.

In low- and middle-income (LMIC) countries, cancer is usually not found until it has gotten to an advanced stage when treatment is more difficult. Measures are being done, such as the creation of screening programmes, to find cancers sooner. In certain places, new strategies and technologies are reshaping society (Ampofo et al., 2020). There are still challenges, such as cultural barriers, logistical challenges, and the moral dilemma of whether to screen those who would not be able to access treatment. But as the effect of cancer grows, doctors are paying more attention to these problems. In LMICs, the primary priorities have historically been malaria and other dangerous diseases like pneumonia.

Screening practices differ from those in affluent nations in environments with limited resources. Smear testing is the primary screening method used in high-income countries. Cervical cells must be removed from these for laboratory analysis. The tests, however, need well-funded medical institutions and are pricey and difficult. In LMICs, the VIA test is a more practical substitute (visual inspection with acetic acid) (Ampofo et al., 2020). This simple treatment includes putting a vinegar mixture on the cervix and checking to see if the membrane becomes white rather than waiting days to see results. Treatment can start right soon using

methods that are specific to LMICs. High-income nations frequently use the refrigerant gas-based cryotherapy technique to get rid of aberrant cells.

Women in urban regions were more likely to overscreen for each of these malignancies than those in rural ones. However, this was not the case for males. Residents in rural regions occasionally struggle to receive medical attention because there are so few clinics and other medical services there. While this might lessen overscreening, some patients might not be able to receive the appropriate screening tests when they require them (Chen et al., 2019). It is not yet known precisely who among the proportion of older people who are in good health and have a long life expectancy may benefit from ongoing observation. In response to new research, medical groups and expert groups often modify their screening guidelines using the most recent models and data. Even if many primary caregivers might not be informed of the most recent assessment as a result, this may lead to suggestions for who should be evaluated and how regularly to do so being unclear and looking at odds (Chen et al., 2019).

These tests may be carried out differently by various medical professionals and healthcare systems, and they may also be compensated differently based on the insurance provider. For instance, current studies show that breast cancer incidence rates were greater among "White women over 60 and Black women under 45", respectively. The "U.S. Preventive Services Task Force (USPSTF)" and several other medical groups urge mammography screenings to start at age 50 for anybody at average risk, without regard to race (Iragorri, & Spackman, 2018). This ignores the fact that breast cancer often affects Black women more quickly and younger. When looking at cancer diagnosis and screening through the lens of health justice, researchers must take into account the compelling data relating to the disproportionate frequency of "breast cancer among Black women under 40".

Cervical cancer has similar inequalities. In 2018, the "USPSTF and the American Cancer Society (ACS) recommended that women between the ages of 21 and 65 have Pap screenings every three years". Every three (ACS) to five (USPSTF) years, women between the ages of 30 and 65 should get a Pap test combined with a hrHPV test, which checks for the condition of elevated human papillomavirus, a significant risk factor for cervical cancer. In light of the reduced prevalence of cervical cancer in younger women, it was advised that "hrHPV testing begin at age 25 rather than 21" (Iragorri, & Spackman, 2018). Some medical experts are concerned about this because they believe that variations in screening accessibility are to blame for variations in cervical cancer rates and death. More Black women compared to any other race or ethnicity pass away from cervical cancer, with Hispanic women experiencing the disease at a rate that is 32% greater than that of White women. It may be less efficient to avoid cancers in high-risk locations by limiting screening alternatives (Iragorri, & Spackman, 2018).

According to the revised guidelines, the ideal age for the initial screening has increased; thus, if insurers alter payments to reflect this shift, screening percentages in the most underserved communities may decrease even more (Liu et al., 2019). The most recent, accurate screening methods for breast and cervical cancer are more expensive and less often available. In rural and poor areas, there is a larger likelihood that the most latest technology will spread gradually. The addition of HPV testing to the Pap test has been shown in randomised clinical studies to enhance detection, decrease false positives, and decrease mortality when compared to Pap smears alone. Screening recommendations have long made this suggestion. But there are few options for HPV testing in regions with a disproportionately high incidence of cervical cancer, morbidity, and mortality. Three-dimensional mammograms are another breakthrough that has been made more

accessible to people who need them, despite the fact that doctors maintain that traditional mammograms are still the global standard for all patients (Liu et al., 2019).

More Americans than ever before have had access to health insurance in the ten years because the "Affordable Care Act was implemented in 2010". According to ACS research, increased government coverage has considerably improved access to cancer screening by lowering many out-of-pocket expenses (Giampietro et al., 2020). In the United States, men who resided in states that had extended Medicaid saw fewer high PSA levels, a sign that they were getting checked out more frequently than men who did not. A paper that was issued by the "Journal of Cancer in July 2020" gave an example of this. At least in one instance, insurance seems to be directly related to higher screening results. Today, socioeconomic health issues are increasingly shown to be directly responsible for cancer disparities in the fields of epidemiology, sociology, and medicine. These factors include people's working and living surroundings, which affect the risks and outcomes of their health (Giampietro et al., 2020). Physicians and other health professionals are beginning to see the need for targeted and planned social activities to assist the most impacted people.

Around the nation, institutions of higher learning and healthcare systems are developing interdisciplinary health equality programmes to ensure that the most disadvantaged individuals receive crucial cancer screening tests (Ferrari et al., 2021). The first step in achieving health equality is to figure out how to increase cancer screening knowledge, accessibility, and acceptance among individuals for whom screening is recommended. Patients from racial and ethnic minorities may also share information with one another through culturally relevant community education to improve health literacy and make people aware of cancer and screening and treatment among racial and ethnic minorities. Making sure that everybody has access to

excellent medical care is also crucial (Ferrari et al., 2021). More specialised screening procedures must be developed for each racial and ethnic minority group, as well. Research is currently being done on this subject.

Numerous studies have demonstrated that it is possible to significantly raise colorectal cancer screening rates for all races and ethnic groups by actively contacting adult women who are not screened (Vhuromu et al., 2018). This can be done by mailing these adults information about cancer risk and a stool test or by implementing patient navigation programmes that offer patients individualised support to help them get over obstacles in their personal and health care system and to promote understanding and prompt treatment. The cancer control programme introduced in Delaware in 2003 illustrates how patient navigation may be beneficial in lowering disparities in colorectal cancer screening and outcomes. Cancer screening rates alone won't be enough to address inequality in cancer health. People need to make sure that those who undergo screening tests and show an abnormality receive further screening and care as soon as feasible (Vhuromu et al., 2018). Delayed follow-up might result in a diagnosis at a later stage, which reduces the patient's chance of receiving a successful cure.

The demographic groups who delay or never pursue follow-up care when a cancer screening program indicates an abnormality are disproportionately those that have disparities in other markers of cancer burden. For instance, follow-up is least likely when a cervical cancer screening shows an abnormality among women who are African American, who are of low socioeconomic status, or who do not have private insurance. Despite the fact that cancer rates have dramatically fallen over the previous few years, not all groups have seen comparable drops (Liu et al., 2019). As more researchers have begun to focus on this issue, there is mounting evidence that the cancer burden is substantially greater in rural parts of the United States. Even if

some illnesses, such as lung, gastrointestinal, and cervical cancer, which may be prevented with regular screenings, are more prevalent in rural regions, the bulk of malignancies is similarly prevalent there. Additionally, rural areas had higher overall cancer death rates than metropolitan areas. The American Cancer Society (ACS) released a strong recommendation that average-risk women aged 45 and older have regular mammography screenings in 2015, in addition to a qualified suggestion that women in the age range of 40 to 44 have the chance to start screening before turning 45. A "strong" recommendation means that most people are expected to opt to utilise the intervention since there is broad consensus that its advantages exceed its drawbacks (Liu et al., 2019). On the other hand, a proposal that is "qualified" shows a consensus that there is beneficial evidence but less clarification regarding the benefits to hazards ratio or considering the preferences and values of the patient for the intervention.

For women between the ages of 45 and 54, as well as those between both the ages of 40 and 44 who choose to start screening before turning 45, the "American Cancer Society (ACS)" suggests annual screening (Chang et al., 2019). Women over 55 are advised to switch to biannual screening, and they are free to remain with annual screening if they want. As long as their general health is strong and they have a life expectancy of ten years or more, women should maintain screening mammography. Potential screening downsides include the anxiety that may be connected to each false-positive result and the requirement for further testing after a referral for an abnormal mammogram. While the estimated and observed frequency of these negative consequences varies numerically, the influence, significance, and severity of these are felt differently by individual women (Chang et al., 2019).

Given the disparity in the global burden of disease between women aged 40 to 44 and those aged 45 to 54, it was difficult to predict whether most women would choose to begin

screening at age 40 or wait until age 45 (Giampietro et al., 2020). As a result, a qualified

suggestion for the option to choose to start monitoring between the ages of 40 and 44 was made.

In the age groups when breast cancer screening is explicitly advised or is a feasible alternative,

the American Cancer Society (ACS) states that the advantages of screening exceed the risks.

Nevertheless, some researchers have looked at registry data and reached the conclusion that

improvements in contemporary therapy, not an early diagnosis, are principally responsible for

reported decreases in the breast cancer death rate. Despite the fact that both individual research

and comprehensive evaluations of the available data continue to show conclusive proof of

mammography's efficacy (Ferrari et al., 2021). The common study designs that led to this

discovery have received criticism primarily for their subpar methodology. Since they do worse

academically, minorities with low earnings are more likely to experience inequality. Lower

educational status is associated with worse cancer screening use. Low levels of education are

associated with fewer medical system exposures and, as a result, lower percentages of cancer

screening.

Conclusion

Understanding the link between perceived neighbourhood problems and cancer screening

uptake is important because attitudes like these may be more difficult to change through

initiatives that just aim to change attitudes and enhance information rather than the environment.

More research on the impact of geographic obstacles on cancer prevention practices may be

helpful for developing cancer prevention programmes targeted at low-income people (Thomson

et al., 2019). Public policy requires more funding for initiatives that increase people's health

insurance coverage. By increasing their access to health insurance, low-income individuals may

have easier access to cancer prevention programmes. Important components that assist the

acceptance of cancer screening are outlined in this summary. It demonstrates the value of the patient-provider relationship in promoting informed uptake and expands our knowledge of how fear and risk are experienced and handled when deciding whether to go to a screening. A further study utilising quantitative approaches should examine the prevalence of the mentioned barriers in different categories. To improve the feeling of individualised care, increase trust in the healthcare system, and reduce excessively high feelings of fear and perceived risk, interventions may be attempted (Thomson et al., 2019). Cancer screening invites will change in the future because of the development of new screening methods and the rising popularity of concepts like informed decision and risk stratification.

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