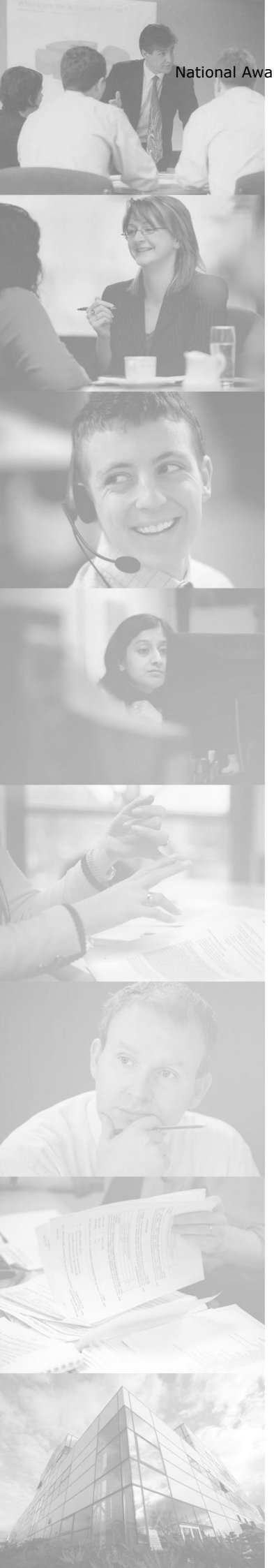
UK Data Archive Study Number 6643 -
National Awareness and Early Diagnosis Initiative: Cancer Awareness Measure, Lambeth, 2009-2010



# Research Report

## Cancer Awareness in Lambeth

### Prepared for: Lambeth PCT and South East London Cancer Network

bmg research

# Cancer Awareness in Lambeth

**Prepared for: Lambeth PCT and South East London Cancer Network**

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# 1 Key findings

## 1.1 Knowledge of warning signs

The CAM shows that while knowledge of a lump as a warning sign of cancer is high among respondents (88% c.f. 94% [1]national survey), knowledge relating to persistent coughs, unexplained bleeding, change in bowel and bladder habits and change in the appearance of a mole (79% c.f. 94% national survey) is lower than the findings of the national study.

It is difficult to interpret low knowledge of change in bowel and bladder habits as these do not apply to one particular cancer site, and it is therefore difficult to design interventions to tackle this. However, the PCT may consider it appropriate to focus interventions on improving awareness of other warning signs, in particular, persistent cough, hoarseness, and on sores that do not heal.

Analysis by demographics suggests that knowledge of the warning signs of cancer is lower among the economically inactive and in non-white respondents. It is difficult to identify which of these factors is the most important determinant of knowledge because of the strong relationship between being non-white and socioeconomic deprivation.

## 1.2 Barriers

When the results are compared to those of the national survey, it is found that respondents to the Lambeth CAM highlighted fewer barriers than the national results. The top three barriers experienced by respondents to the Lambeth CAM are being worried about what the doctor might find (29%) finding it difficult to make an appointment with the doctor (20%) and being too scared (18%), the top three barriers from the national survey were finding it difficult to make an appointment (41%), being worried about wasting the doctor's time (38%) and being worried about what the doctor might find (37%).

## 1.3 Knowledge of risk factors

In a number of instances the knowledge of the risk factors of cancer was higher among Lambeth residents than the national survey. Knowledge of risk factors such as smoking, passive smoking, sunburn, family history, being overweight and age were relatively high.

However, more than half (54%) of respondents were unsure if infection with HPV affect a person's chance of getting cancer. The PCT may consider it appropriate to focus interventions on raising awareness of this risk factor cancer, as all girls age 12-13 years will be offered HPV immunisation.

Knowledge of risk factors associated with diet is much lower with few respondents agreeing that eating less than five portions of fruit and vegetables a day and doing less

[1] Robb KA, Stubbings S, Ramirez A, Macleod U, Austoker J, Waller J et al. Public awareness of cancer in Britain. British Journal of Cancer 2009; 101:s18-s23.

than 30 minutes of moderate physical activity five times a week cn affect a person's chance of getting cancer. Interventions should focus on increasing knowledge around these risk factors.

## 1.4 Knowledge of lifetime risk

It is clear from the survey results that a large proportion of respondent underestimate how many people out of 100 are likely to develop cancer at some point in their life. Approximately one in three people (33%) are likely to develop cancer at some point in their life; however more than a third (35%) of respondents believe that one in five or fewer people are likely to develop cancer. Approaching two fifths (37%) of respondents thought 21-40 people out of 100 will develop cancer at some point in their life, while 14% thought that as many as 41-60 people out of 100 will be affected.

## 1.5 Knowledge of common cancers

The results from the survey indicate that while the top three cancers in men; prostate, lung and bowel, were correctly identified as being the most commonly occurring cancers in men, that awareness of the most commonly occurring cancers in women is lower.

It appears that respondents are overestimating the frequency of cervical cancer (52% respondents identified as first, second or third), which is in part due to the high profile publicity that has recently surrounded this condition, and while this is a positive step in terms of increasing awareness and early diagnosis of this cancer, it may be overshadowing cancers from which women are more at risk.

Along with breast cancer, the most commonly occurring cancers in women are lung and bowel, but while lung was correctly identified as the third most commonly occurring cancer in women, bowel cancer was only identified by a total of 17% of respondents. This suggests that women are not seeing themselves at high risk of these cancers and therefore may be less likely to recognise the warning signs and seek an early diagnosis.

## 1.6 Knowledge of NHS Cancer screening programmes

A high proportion of respondents have not heard of any of the NHS screening programmes, suggesting that interventions regarding increasing awareness of these programmes may be necessary. Awareness was highest for the Cervical Cancer screening programme (46%) followed by the Breast Cancer screening programme (43%) However, only 16% of respondents think there is a screening programme for Bowel Cancer.

When the results for the breast cancer and cervical cancer screening programmes are considered for female respondents only it was found that awareness of the breast cancer screening programme is significantly higher among older female respondents and white female respondents compared to those from a Black/Black British or Chinese/other background.

There were also significant difference between the main and Black African boost sample with regard to awareness of the screening programmes. Respondents in the

main sample are significantly more likely to be aware of the breast cancer screening programme (44% c.f. 25%), cervical cancer screening programme (47% c.f. 28%) and bowel cancer screening programme (16% c.f. 11%) compared to the Black African Boost sample. This suggests that interventions to increase the awareness amongst the Black African community in Lambeth are required.

# 2 Introduction

## 2.1 Background

This report summarises the results of a survey of cancer awareness in Lambeth carried out by BMG in 2009/2010 on behalf of Lambeth PCT and the South East London Cancer Network (SELCN).

The survey was carried out using the Cancer Research UK Cancer Awareness Measure, a validated instrument developed by University College London, King's College London and University of Oxford. It is used to assess level of awareness and anticipated help-seeking behaviour amongst the public in relation to cancer.

The questionnaire included questions relating to:

- Knowledge of the warning signs and symptoms of cancer;
- Anticipated delays before contacting a doctor;
- Barriers to seeking medical advice;
- Knowledge of risk factors of cancer;
- Knowledge of lifetime risk of cancer;
- Knowledge of most common cancers; and
- Knowledge of NHS screening programmes.

## 2.2 Survey Method

A total of 2,298 interviews were conducted face-to-face with residents using CAPI (Computer Aided Personal Interviewing) technology. The sample included a boost sample of 261 Black African residents, as the SELCN were particularly interested in the levels of awareness and perception of cancer amongst this ethnic community.

Interviews took place between October 2009 and January 2010. During interviewing, quotas were set for ward, age, and ethnicity and deprivation quintile to ensure the sample represented as closely as possible the population of Lambeth. Upon completion of the interview respondents were provided with an information sheet which gave them the answers to the questions contained within the interview as well as providing details of support services should they require further information or wish to discuss anything that the survey had highlighted. The interviews lasted an average of 15 minutes.

### 2.2.1 Sampling

The target population for the survey was the adult population (18+) of the London Borough of Lambeth. The survey was conducted via a household face-to-face methodology, using a stratified random sample obtained from the Royal Mail's Postcode Address File (PAF). The sample was selected by stratifying SOAs according to their deprivation quintile and then selecting every 'nth' address within the selected SOAs. Fixed interviewing targets were set by ward in proportion to the resident population. In addition, responses were also monitored by age and ethnicity to ensure the survey was representative of the resident population. A boost sample of Black

African residents was also completed. All quotas were based on the latest population projections provided by Lambeth PCT, including the GLA population projections for 2007. Interviews were conducted weekdays, weekends and evenings to ensure a representative sample. All sampled households were visited up to a further three times if the initial knock did not illicit a response. To further ensure the randomness of the sample, respondents were selected using the birthday rule, whereby the interview was conducted with the person aged over 18 years who has had their birthday most recently.

A total of 5076 households were approached giving a response rate of 45%. This includes 513 households who refused to take part and 2309 households from which a response could not be achieved after four attempts. Further to this, 12 households were unable to complete the survey because of language problems.

### 2.2.2 Questionnaire design

The CAM is a validated questionnaire and as such is standardised to ensure consistency and comparability of data. However, upon review of the questionnaire some issues were raised by BMG with Cancer Research UK, who designed the validated questionnaire, and minor changes to its design were approved. These changes did not affect any of the questions asked or reduce the data comparability with surveys conducted in other areas.

## 2.3 Data

In total, 2,298 interviews were completed with respondents aged 18+ years. The sample size of 2,298 is subject to a maximum standard error of ±2.0% at the 95% confidence level on an observed statistic of 50%. Thus, for the quantitative survey, we can be 95% confident that responses are representative of those that would be given by the total population of Lambeth, if a census had been conducted, to within ±2.0% of the percentages reported.

This means that if the total population of Lambeth had completed the survey and a statistic of 50% was observed, we can be 95% confident that the response lies between 48% and 52%.

### 2.3.1 Weighting

To ensure that the results are representative of the population, the data has been weighted at a ward level by gender, age, ward and ethnicity to match the 2001 Census data. Weighting is a statistical technique used to counteract the deviations that occur in survey samples against the population as a whole. In this case, weighting by ward, age, ethnicity and gender has been used to ensure that the sample used here corresponds to the overall population of Lambeth.

At its most basic level, this means that if a national survey of 1,000 people is made up of 550 men and 450 women, then the survey is unrepresentative of the UK population as 51% is female. Therefore weighting would be applied to give the responses from female respondents slightly more weight (in this case each female respondent would be equivalent to 1.133 people) to give them a representative impact on the final results. Conversely, men would be weighted to each count as 0.891 so that their responses were not over represented in the final data.

## 2.4 Reporting

Throughout this report the word significant is used to describe differences in the data. This indicates where the data has been tested for statistical significance. This testing identifies 'real differences' (i.e. differences that would occur if we were able to interview all residents in the borough rather than just a sample). However, as already noted the actual percentages reported in the data may vary by ±2.0% at the 95% confidence level on an observed statistic of 50%.

Figures and tables are used throughout the report to assist explanation and analysis. Although occasional anomalies appear due to 'rounding' differences, these are never more than +/-1%. These occur where rating scales have been added to calculate proportions of respondents who are satisfied at all (i.e. either very or fairly satisfied).

On receipt of each completed questionnaire, BMG coded the verbatim (open-ended) questions, input and then analysed the data. Throughout this report there is analysis at both a total and sub sample level, e.g. gender, ethnicity, age and quintile of deprivation of area of residence. The quintiles of deprivation used for this analysis were calculated based on:

- the index of multiple deprivation ranked by SOA area according to census 2001 for Lambeth;
- Lambeth IMD data (rather than England or South East London);
- Quintile 1 represents the least deprived SOAs in Lambeth and quintile 5 the most deprived SOAs.

For more detailed analysis, refer to the separate cross tabulated data report.

The data results reported have been based on weighted data, however, for comparative reasons the data tables also include the unweighted data results in brackets.

## 2.5 Respondent profile

The following table outlines the profile of respondents who participated in the survey. Further demographic analysis has been provided in Appendix 2. As shown in table 1 and 2 the sample obtained had a distribution of demographic factors that closely resembles that of Census 2001, with a few exceptions. The survey sample has a slight over representation of the 25-44 age group and respondents are more likely to be economically inactive than would be expected by the key census demographics.

**Table 1 Profile of survey respondents**

| | Unweighted % | Unweighted sample base | Census 2001 |
|---|---|---|---|
| **Gender** | | | |
| **Male** | 48% | 1082 | 49% |
| **Female** | 52% | 1216 | 51% |
| **Age** | | | |
| **18-24** | 12% | 281 | 11% |
| **25-44** | 47% | 1082 | 56% |
| **45-64** | 25% | 566 | 21% |
| **65+** | 12% | 282 | 12% |
| **Ethnicity** | | | |
| **White** | 63% | 1260 | 62% |
| **Mixed** | 6% | 132 | 5% |
| **Black / Black British** | 22% | 696 | 26% |
| **Asian / Asian British** | 3% | 76 | 5% |
| **Chinese / Other** | 6% | 114 | 2% |
| **Marital Status** | | | |
| **Single / Separated / Divorced / Widowed** | 55% | 1261 | 77% (Doesn't take into account those living with partner – classed as single) |
| **Married / Living with Partner / Civil Partnership** | 44% | 968 | 23% |
| **Prefer not to say** | 1% | 49 | - |
| **Education** | | | |
| **More than O Levels** | 55% | 1267 | 51% |
| **O levels or less** | 39% | 896 | 44% |
| **Other** | 3% | 69 | 5% |
| **Prefer not to say** | 1% | 46 | - |

**Table 2 Profile of survey respondents (continued)**

| | | | |
|---|---|---|---|
| **Household tenure** | | | |
| **Owner Occupier / Leaseholder** | 34% | 714 | 38% |
| **Renting** | 59% | 1419 | 61% |
| **Other** | 3% | 73 | 1% |
| **Prefer not to say** | 4% | 72 | - |
| **Economic Activity** | | | |
| **Economically active** | 57% | 1267 | 71% |
| **Economically inactive** | 42% | 964 | 29% |
| **Prefer not to say** | 1% | 47 | - |

# 3 Findings

## 3.1 Introduction

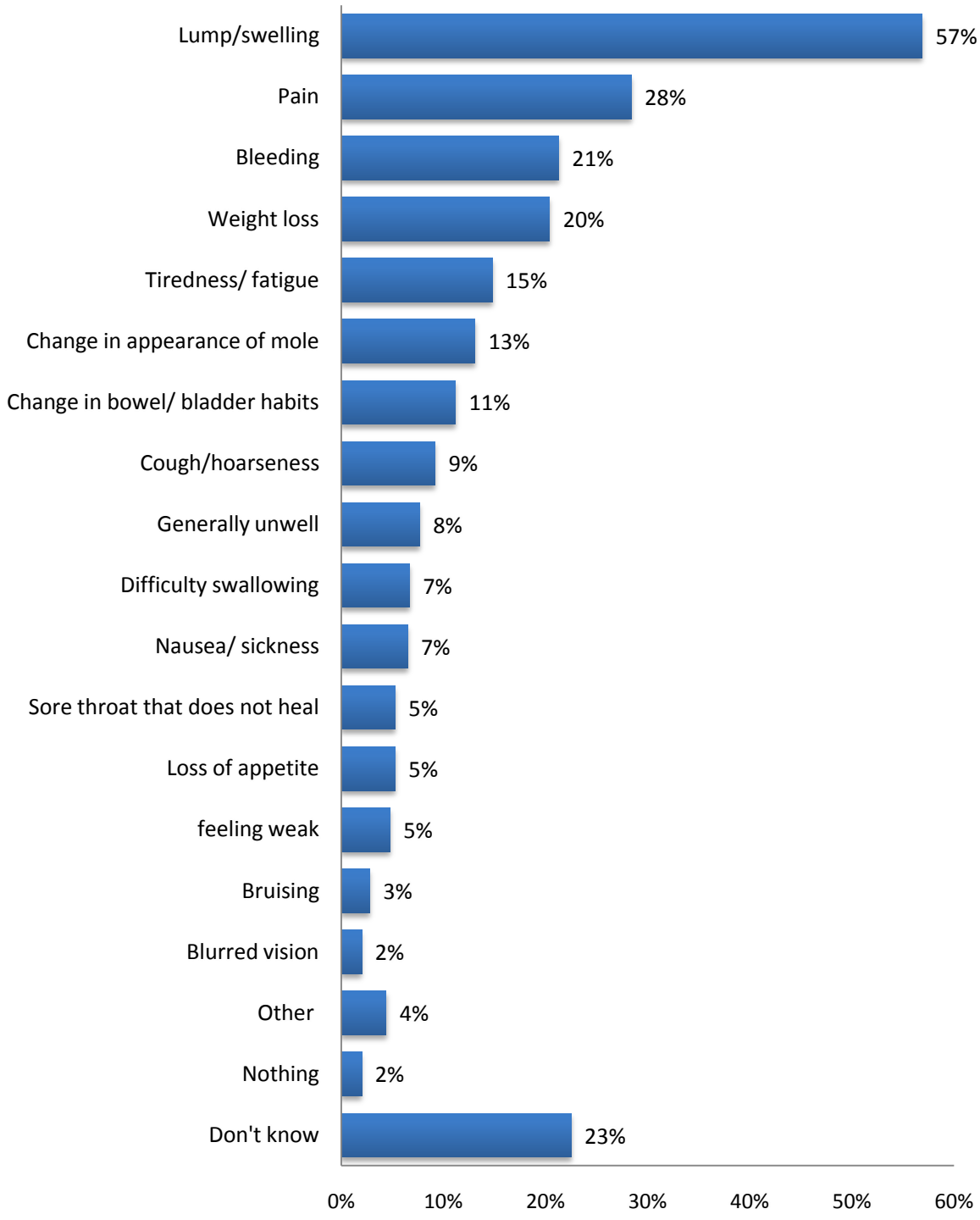
The following section provides the findings from the CAM survey. The data has been presented on all respondents, and any significant variations in the data by ward, ethnicity, age or gender have been highlighted.

## 3.2 Recall of warning signs of cancer

Respondents were asked to name as many warning signs of cancer as they could think of. Interviewers were instructed to give respondents time to think about their response and to keep asking if they could think of anything else until the respondent could think of no more warning signs. Some respondents were able to name as many as 13 individual warning signs of cancer.

The symptom most often given by respondents was a lump/swelling (56%), followed by pain (28%) and bleeding (21%). Respondents are least likely to state that blurred vision or bruising would be a warning sign for cancer (2% and 3% respectively).

**Figure 1: Responses to: "There are many warning signs and symptoms of cancer. Please name as many as you can think of" (All respondents)**




Unweighted base: 2298

## 3.3 Recognition of warning signs of cancer

Respondents were then read a list of symptoms, such as unexplained lump or swelling, or unexplained pain, and asked if they thought they were a warning sign of cancer.

**Table 3: Responses to closed questions about warning signs of cancer (All respondents)**

| | Yes | No | Don't know |
|---|---|---|---|
| **Do you think an unexplained lump or swelling could be a sign of cancer?** | 88% (87%) | 7% (7%) | 6% (6%) |
| **Do you think persistent unexplained pain could be a sign of cancer?** | 75% (74%) | 15% (15%) | 11% (11%) |
| **Do you think unexplained bleeding could be a sign of cancer?** | 75% (75%) | 14% (13%) | 11% (12%) |
| **Do you think a persistent cough or hoarseness could be a sign of cancer?** | 62% (60%) | 24% (24%) | 15% (16%) |
| **Do you think a persistent change in bowel or bladder habits could be a sign of cancer?** | 77% (76%) | 13% (13%) | 10% (12%) |
| **Do you think persistent difficulty swallowing could be a sign of cancer?** | 61% (60%) | 22% (23%) | 16% (17%) |
| **Do you think a change in the appearance of a mole could be a sign of cancer?** | 79% (77%) | 10% (11%) | 11% (12%) |
| **Do you think a sore that does not heal could be a sign of cancer?** | 60% (60%) | 22% (21%) | 18% (19%) |

### 3.3.1 Unexplained lump or swelling

The majority (88%) of respondents think that an unexplained lump or swelling could be a sign of cancer, while one in 14 (7%) do not and a further 6% said they don't know. There are some significant variations by demographics with the following groups significantly more likely to think that an unexplained lump or swelling is a sign of cancer:

- Respondents aged 25-44 years and 45-64 years (90%), compared to older (82%) and younger (83%) respondents;
- White respondents (91%) compared to other ethnic groups; and
- Economically active (91%) respondents compared to economically inactive respondents (84%).

### 3.3.2 Unexplained pain

Three quarters (75%) of respondents think that an unexplained pain could be a sign of cancer while one in seven (15%) said they do not think it is a symptom and one in nine (11%) said they do not know.

As with an unexplained lump, the following groups are significantly more likely to think that an unexplained pain is a sign of cancer:

- Respondents aged 25-44 years and 45-64 years (78%), compared to older (67%) and younger (64%) respondents;
- White respondents (80%) compared to other ethnic groups;
- Economically active (79%) respondents compared to economically inactive respondents (69%); and
- Respondents in quintiles 1-4 (74%, 81%, 76% and 72%) compared to those in quintile 5 (65%).

### 3.3.3 Unexplained bleeding

Three quarters (75%) of respondents think that unexplained bleeding could be a sign of cancer while one in seven (14%) said they do not think it is a symptom and one in nine (11%) said they do not know.

As with an unexplained pain, the following groups are significantly more likely to think that unexplained bleeding is a sign of cancer:

- Respondents aged 45-64 years (81%), compared to those aged 25-44 years (76%) and older (74%) and younger (64%) respondents;
- White respondents (80%) compared to other ethnic groups;
- Economically active (78%) respondents compared to economically inactive respondents (71%); and
- Respondents in quintiles 1-4 (76%, 78%, 76% and 75%) compared to those in quintile 5 (66%).

### 3.3.4 Persistent cough or hoarseness

More than three fifths (62%) of respondents think that a persistent cough or hoarseness could be a sign of cancer, while almost a quarter (24%) do not and a further 15% said they don't know.

Respondents in Clapham Common (75%), Herne Hill (78%) and Ferndale (75%) are significantly more likely to believe that a persistent cough or hoarseness is a sign of cancer than residents in other wards.

Respondents in Prince's ward are significantly more likely than those living in other wards to think that a persistent cough is not a sign of cancer (38%), while those in Larkhall are most likely to say they don't know (28%).

The following groups are significantly more likely to think that a persistent cough or hoarseness is a sign of cancer:

- Females (64%) compared to males (59%);
- Respondents aged 45-64 years (68%), compared to those aged 25-44 years (62%) and older (64%) respondents;
- White respondents (67%) compared to other ethnic groups;
- Respondents who are Married / Living with a partner / Civil Partnership (65%) compared to those who are single/divorced/widowed (60%);
- Economically active (65%) respondents compared to economically inactive respondents (58%); and
- Respondents in quintiles 1-4 (64%, 65%, 60% and 63%) compared to those in quintile 5 (53%).

### 3.3.5 Change in bowel or bladder habits

More than three quarters (77%) of respondents think that a change in bowel or bladder habits can be a sign of cancer. Residents in Tulse Hill (89%), Thurlow Park (85%), Herne Hill (86%) and Clapham Common (88%) are significantly more likely to think that a change in bowel and bladder habits can be a sign of cancer.

The following groups are significantly more likely to think that a change in bowel and bladed habits is a sign of cancer:

- Respondents aged 25-44 years (78%), 45-64 years (68%), and 65+ (78%) compared to younger respondents (64%);
- White respondents (83%) compared to other ethnic groups;
- Economically active (81%) respondents compared to economically inactive respondents (71%); and
- Respondents in quintiles 1-4 (79%, 82%, 79% and 77%) compared to those in quintile 5 (64%).

### 3.3.6 Persistent difficulty with swallowing

Three fifths (61%) of respondents thought that persistent difficulty swallowing could be a sign of cancer. Respondents in Larkhall and Oval were significantly *less* likely to think persistent difficulty swallowing is a sign of cancer.

The following groups are significantly more likely to think that persistent difficulty with swallowing is a sign of cancer:

- Respondents aged 25-44 years (62%), 45-64 years (67%), and 65+ (66%) compared to younger respondents (49%);
- White respondents (66%) compared to other ethnic groups; and

- Economically active (64%) respondents compared to economically inactive respondents (59%); and
- Respondents in quintiles 1, 2 and 4 (65%, 66% and 61%) compared to those in quintile 3 and 5 (59% and 53%).

### 3.3.7 Change in the appearance of a mole

More than three quarters (79%) of respondents think that a change in the appearance of a mole can be a sign of cancer. Residents in Clapham Common (97%) are significantly more likely to think that a change in the appearance of a mole can be a sign of cancer.

The following groups are significantly more likely to think that the change in the appearance of a mole is a sign of cancer:

- Respondents aged 25-44 years (80%), 45-64 years (84%) compared to younger (69%) and older (75%) respondent;
- White respondents (85%) compared to other ethnic groups;
- Economically active (84%) respondents compared to economically inactive respondents (73%); and
- Respondents in quintiles 1-4 (81%, 82%, 84% and 76%) compared to those in quintile 5 (67%).

### 3.3.8 A sore that does not heal

Three fifths (60%) of respondents think that a sore that does not heal can be a sign of cancer. Residents in Ferndale (67%), Herne Hill (83%) and Clapham Common (69%) are significantly more likely to think that a sore that does not heal can be a sign of cancer.

The following groups are significantly more likely to think that a sore that does not heal is a sign of cancer:

- Respondents aged 25-44 years (58%), 45-64 years (69%), and 65+ (63%) compared to younger respondents (50%);
- White respondents (64%) compared to other ethnic groups;
- Economically active (63%) respondents compared to economically inactive respondents (57%); and
- Respondents in quintiles 1-4 (61%, 66%, 61% and 58%) compared to those in quintile 5 (50%).

### 3.3.9 Unexplained weight loss

Three quarters (75%) of respondents think that unexplained weight loss can be a sign of cancer. Residents in Clapham Common (97%), Herne Hill (88%) and Oval (87%) are significantly more likely to think that unexplained weight loss can be a sign of cancer compared to respondents in other wards.

The following groups are significantly more likely to think that unexplained weight loss is a sign of cancer:

- Respondents aged 25-44 years (75%), 45-64 years (83%) and 65+ (76%) compared to younger respondents (65%);
- White respondents (80%) compared to other ethnic groups;
- Economically active (77%) respondents compared to economically inactive respondents (74%); and
- Respondents in quintiles 1-4 (78%, 78%, 75% and 74%) compared to those in quintile 5 (68%).

## 3.4 Contacting the doctor

### 3.4.1 Anticipated delays before contacting the doctor

Respondents were presented with a range of symptoms and asked if they were to have any of these symptoms how long it would be before they contacted their doctor to make an appointment.

For symptoms such as an unexplained lump or swelling (57%), unexplained bleeding (68%) or a symptom they thought might be cancer (61%) the majority of respondents said they would contact their doctor in 1-3 days.

For all other symptoms the largest proportion of respondents said they would contact their doctor to make an appointment within 1-3 days. Few respondents said they would wait longer than 1 month before contacting their doctor for any of these symptoms, although there are a small number of respondents who said they would never contact their doctor.

The results suggest that respondents living in quintiles 3,4 and 5 (68%, 65% and 62% respectively) are significantly more likely to make an appointment within 1-3 days of noticing a symptom they think might be cancer than those living in quintiles 1 and 2 58% and 53% respectively).

**Table 4: If had unexplained symptoms, how soon would you go to the doctor (All respondents)**

| | 1-3 days | 4-6 days | 1 week | 2 weeks | 1 month | 6 weeks | 3 months | 6 months | 12 months | Never | Don't know | Prefer not to say |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Unexplained lump or swelling** | 57% (59%) | 12% (12%) | 13% (13%) | 8% (7%) | 5% (5%) | 1% (1%) | 1% (1%) | *% (*%) | *% (*%) | 1% (*%) | 2% (1%) | - |
| **Unexplained pain** | 43% (45%) | 17% (18%) | 20% (19%) | 11% (10%) | 5% (4%) | 1% (1%) | 1% (1%) | *% | *% (*%) | *% (*%) | 1% (1%) | - (*%) |
| **Unexplained bleeding** | 68% (69%) | 12% (12%) | 11% (11%) | 5% (4%) | 1% (1%) | 1% (*%) | *% (*%) | *% (*%) | *% (*%) | *% (*%) | 1% (1%) | - |
| **Persistent cough or hoarseness** | 32% (34%) | 13% (13%) | 22% (23%) | 16% (15%) | 9% (8%) | 3% (2%) | 1% (1%) | *% (*%) | *% (*%) | 2% (1%) | 2% (2%) | *% (*%) |
| **Change in bowel or bladder habits** | 40% (42%) | 16% (15%) | 19% (19%) | 14% (13%) | 6% (5%) | 2% (2%) | 1% (1%) | *% (*%) | *% (*%) | 1% (1%) | 2% (1%) | *% (*%) |
| **Difficulty swallowing** | 47% (49%) | 17% (17%) | 20% (20%) | 9% (8%) | 3% (3%) | 1% (1%) | *% (*%) | - | - | 1% (1%) | 2% (1%) | *% (*%) |
| **Change in the appearance of a mole** | 48% (50%) | 15% (15%) | 15% (16%) | 10% (9%) | 5% (5%) | 1% (1%) | 1% (1%) | *% (*%) | *% (*%) | 1% (1%) | 2% (2%) | *% (*%) |
| **Sore that did not heal** | 36% (38%) | 17% (18%) | 22% (22%) | 13% (12%) | 6% (6%) | 1% (1%) | 1% (1%) | *% (*%) | *% (*%) | 1% (1%) | *% (1%) | 2% (*%) |
| **Unexplained weight loss** | 34% (37%) | 10% (10%) | 14% (14%) | 12% (12%) | 16% (15%) | 5% (4%) | 3% (3%) | 1% (1%) | *% (*%) | 2% (2%) | 2% (2%) | *% (*%) |
| **A symptom that you thought might be a sign of cancer** | 61% (63%) | 12% (12%) | 15% (14%) | 6% (6%) | 3% (3%) | 1% (1%) | *% (*%) | *% (*%) | - | *% (*%) | 2% (1%) | *% (*%) |

**Unweighted sample bases vary** ***% denotes less than 0.5%**

### 3.4.2 Reasons for delaying a visit to the doctor

It was explained to respondents that sometimes people are put off going to see their doctor, even when they have a symptom that they think could be serious. They were then shown a list of reasons and asked to state which, if any, would put them off going to see their doctor.

**Table 5: Reason for delaying going to the doctor (All respondents)**

| | Yes often | Yes sometimes | No | Don't know |
|---|---|---|---|---|
| **Emotional barriers** | | | | |
| **I would be worried about what the doctor might find?** | 7% (7%) | 22% (22%) | 70% (71%) | *% (*%) |
| **I would be too scared?** | 3% (3%) | 15% (14%) | 82% (83%) | *% (*%) |
| **I wouldn't feel confident talking about my symptom with the doctor?** | 2% (2%) | 5% (5%) | 93% (93%) | *% (*%) |
| **I would be too embarrassed?** | 2% (2%) | 9% (9%) | 89% (89%) | *% (*%) |
| **Practical barriers** | | | | |
| **I would be too busy to make time to go to the doctor?** | 3% (3%) | 14% (13%) | 82% (83%) | *% (*%) |
| **I have too many other things to worry about?** | 2% (2%) | 12% (11%) | 86% (86%) | *% (*%) |
| **It would be difficult for me to arrange transport to the doctor's surgery?** | 1% (1%) | 4% (4%) | 95% (95%) | *% (*%) |
| **Service barriers** | | | | |
| **It would be difficult to make an appointment with my doctor?** | 6% (5%) | 14% (15%) | 79% (79%) | 1% (1%) |
| **I would be worried about wasting the doctor's time?** | 3% (2%) | 12% (11%) | 85% (86%) | *% (*%) |
| **My doctor would be difficult to talk to?** | 2% (2%) | 7% (7%) | 89% (90%) | 1% (1%) |
| **Is there any other reason not already mentioned for delaying?** | - | 2% (2%) | 98% (98%) | - |
| **Unweighted sample bases vary** | | | | ***% denotes less than 0.5%** |

In all instances the majority of respondents said that none of the reasons put them off going to see their doctor. The highest proportion of respondents said they would worried about what their doctor might find (29%) or would find it difficult to make an appointment to see their doctor (20%). Approaching a fifth of respondents also said they often or sometimes would be too scared to go to their doctor's (18%) or would be too busy (17%).

One in seven respondents said they would often or sometimes worry about wasting the doctor's time (15%) or have too many other things to worry about (14%).

### 3.4.3 Reasons for delaying a visit to the doctor by ethnicity

When the reasons for delaying a visit to the doctor are analysed by ethnicity (BME and White respondents) they indicate that White respondents are more likely to encounter barriers to visiting their doctor. White respondents were significantly more likely to say would be worried about what their doctor might find (8% yes often), find it difficult to make an appointment to see their doctor (8% yes often), be worried about wasting the doctor's time (4% often, 14% sometimes), be too busy to make time to go to the doctor (4% often) and have too many other things to worry about (3% often).

As shown in Table 5, BME respondents appear to encounter few barriers to visiting their doctor compared to white respondents and where barriers are experienced they tend to be emotional rather than practical or service barriers.

## Table 6 Reasons for delaying a visit to the doctor by ethnicity

| | White | | | | BME | | | |
|---|---|---|---|---|---|---|---|---|
| | Yes often | Yes sometimes | No | Don't know | Yes often | Yes sometimes | No | Don't |
| **Emotional barriers** | | | | | | | | |
| **I would be worried about what the doctor might find?** | 8% (9%) | 23% (22%) | 68% (69%) | 1% (1%) | 5% (6%) | 22% (22%) | 72% (72%) | *% (*%) |
| **I would be too scared?** | 3% (3%) | 15% (15%) | 82% (82%) | *% (*%) | 2% (2%) | 14% (14%) | 83% (84%) | *% (*%) |
| **I wouldn't feel confident talking about my symptom with the doctor?** | 2% (2%) | 6% (5%) | 92% (92%) | 1% (1%) | 2% (2%) | 5% (5%) | 93% (93%) | *% (*%) |
| **I would be too embarrassed?** | 2% (2%) | 9% (9%) | 89% (89%) | *% (*%) | 2% (2%) | 9% (9%) | 89% (89%) | *% (*%) |
| **Practical barriers** | | | | | | | | |
| **I would be too busy to make time to go to the doctor?** | 4% (4%) | 16% (15%) | 79% (80%) | 1% (1%) | 2% (2%) | 13% (12%) | 84% (85%) | *% (*%) |
| **I have too many other things to worry about?** | 3% (3%) | 12% (12%) | 84% (85%) | *% (*%) | 2% (2%) | 11% (11%) | 87% (87%) | *% (*%) |
| **It would be difficult for me to arrange transport to the doctor's surgery?** | 1% (2%) | 4% (4%) | 94% (94%) | *% (*%) | 1% (1%) | 3% (4%) | 96% (95%) | *% (*%) |
| **Service barriers** | | | | | | | | |
| **It would be difficult to make an appointment with my doctor?** | 8% (8%) | 16% (16%) | 75% (75%) | 2% (1%) | 4% (3%) | 13% (14%) | 82% (82%) | 1% (1%) |
| **I would be worried about wasting the doctor's time?** | 4% (3%) | 14% (14%) | 82% (82%) | *% (*%) | 2% (2%) | 10% (9%) | 89% (89%) | 0% (0%) |
| **My doctor would be difficult to talk to?** | 2% (2%) | 8% (7%) | 88% (88%) | 2% (2%) | 2% (2%) | 7% (7%) | 91% (91%) | *% (*%) |

Unweighted sample bases vary

*% denotes less than 5%

### 3.4.4 Reasons for delaying a visit to the doctor by deprivation quintile

When the reasons for delaying a visit to the doctor are analysed by deprivation quintile they indicate that there are a range of barriers experienced by respondents, with those living in quintile 2 perhaps experiencing the most barriers. Respondents in quintiles 2, 3, 4 and 5 are significantly more likely to say would be worried about what their doctor might find (28%, 30%, 30% and 35% yes often/sometimes) compared to those living in quintile 1 (24% yes often/sometimes).

Respondents in quintiles 2, 3 and 5 are also significantly more like to say they have too many other things to worry about (14%, 18% and 16%) compared to those in quintiles 1 and 3.

Those living in quintile 2 are also significantly more likely than respondents in the other quintiles to say they are too busy to see their doctor (22%) would find it difficult to make an appointment (23%) and would be too embarrassed (13%).

**Table 7 Reasons for delaying a visit to the doctor by deprivation quintile (Those responding yes often and yes sometimes)**

| | 1 | | 2 | | 3 | | 4 | | 5 | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Yes often | Yes sometimes | Yes often | Yes sometimes | Yes often | Yes sometimes | Yes often | Yes sometimes | Yes often | Yes sometimes |
| **Emotional barriers** | | | | | | | | | | |
| **I would be worried about what the doctor might find?** | 8% (9%) | 16% (16%) | 6% (6%) | 22% (22%) | 6% (6%) | 24% (24%) | 6% (6%) | 24% (23%) | 8% (8%) | 27% (26%) |
| **I would be too scared?** | 2% (2%) | 15% (15%) | 3% (3%) | 13% (13%) | 3% (2%) | 16% (15%) | 3% (2%) | 14% (13%) | 3% (3%) | 16% (15%) |
| **I wouldn't feel confident talking about my symptom with the doctor?** | 1% (1%) | 3% (3%) | 1% (1%) | 7% (7%) | 2% (2%) | 6% (6%) | 3% (2%) | 4% (4%) | 1% (1%) | 6% (6%) |
| **I would be too embarrassed?** | 1% (1%) | 6% (6%) | 1% (1%) | 12% (12%) | 3% (3%) | 8% (8%) | 2% (2%) | 7% (7%) | 2% (1%) | 10% (10%) |
| **Practical barriers** | | | | | | | | | | |
| **I would be too busy to make time to go to the doctor?** | 4% (4%) | 13% (12%) | 2% (2%) | 20% (19%) | 5% (4%) | 14% (13%) | 2% (2%) | 10% (10%) | 4% (3%) | 14% (12%) |
| **I have too many other things to worry about?** | 3% (3%) | 11% (10%) | 2% (2%) | 12% (12%) | 3% (3%) | 15% (13%) | 2% (2%) | 8% (8%) | 2% (2%) | 14% (12%) |
| **It would be difficult for me to arrange transport to the doctor's surgery?** | 0% (0%) | 2% (2%) | 1% (1%) | 5% (5%) | 2% (2%) | 3% (3%) | 2% (2%) | 3% (3%) | 2% (1%) | 5% (5%) |
| **Service barriers** | | | | | | | | | | |
| **It would be difficult to make an appointment with my doctor?** | 6% (6%) | 14% (14%) | 8% (7%) | 15% (16%) | 6% (5%) | 14% (14%) | 4% (4%) | 13% (14%) | 4% (3%) | 15% (16%) |
| **I would be worried about wasting the doctor's time?** | 2% (2%) | 12% (12%) | 2% (2%) | 13% (12%) | 2% (2%) | 15% (14%) | 3% (3%) | 9% (9%) | 4% (3%) | 11% (10%) |

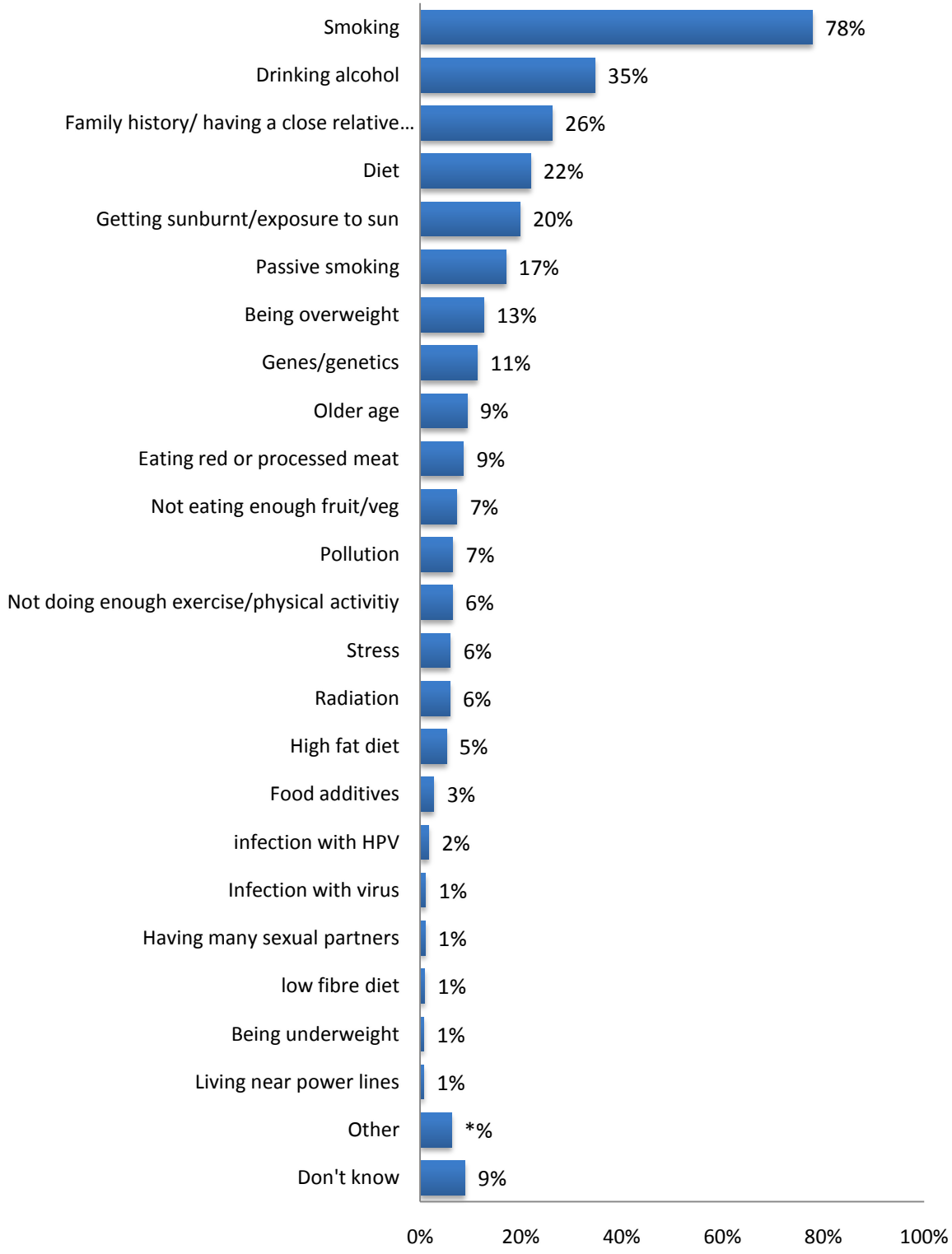
| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **My doctor would be difficult to talk to?** | 2%<br>(2%) | 6%<br>(6%) | 2%<br>(1%) | 8%<br>(8%) | 1%<br>(2%) | 7%<br>(7%) | 2%<br>(2%) | 8%<br>(7%) | 3%<br>(2%) | 8%<br>(8%) |
| **Unweighted sample bases vary** | *% | | | | | | | | | |

## 3.5 Chances of getting cancer

### 3.5.1 Recall of risk factors for cancer

Initially, respondents were asked what things they think affect a person's chance of getting cancer. Interviewers were instructed to give respondents time to think about their response and to keep asking if they could think of anything else until the respondent could think of no more risk factors. The biggest risk factor highlighted by respondents is smoking (78%), followed by drinking alcohol (35%).

**Figure 2: Responses to open question: "What things do you think affect a person's chance of getting cancer" (All respondents)**




Unweighted base: 2298

### 3.5.2 Recognition of risk factors for cancer

Respondents were shown a list of factors and asked to what extent they agree or disagree that they increased a person's chance of getting cancer. For each factor the net agreement score has been calculated by subtracting the percentage of respondents strongly disagree/disagree from those that strongly agree/agree. As Table 4 shows the majority of respondents agree that smoking any cigarettes at all increases a person's risk of getting cancer (+90%), while just over three quarters (+76%) agree that exposure to another person's cigarette smoke increases the chances of getting cancer.

More than three fifths of respondents (+62%) believe that getting sunburnt once as a child increases a person's chance of getting cancer and more than half believe that having a close family member with cancer increases a person chance of developing the disease (+53%).

However, respondents were more likely to disagree that eating less than five portions of fruit and vegetables per day (net agree -1%) and doing less than 30 minutes of physical activity five times a week (net agree -4%) increases a person's chance of getting cancer.

**Table 8: Responses to closed question: "What things do you think affect a person's chance of getting cancer" (All respondents)**

| | Strongly disagree | Disagree | Not sure | Agree | Strongly agree | Net Agree Scores |
|---|---|---|---|---|---|---|
| **Smoking any cigarettes at all** | *% (*%) | 3% (3%) | 4% (3%) | 49% (50%) | 44% (43%) | **90% (90%)** |
| **Exposure to another person's cigarette smoke** | 1% (1%) | 6% (6%) | 10% (9%) | 57% (57%) | 26% (27%) | **76% (77%)** |
| **Getting sunburnt more than once as a child?** | 2% (1%) | 8% (7%) | 17% (18%) | 49% (50%) | 23% (22%) | **62% (64%)** |
| **Having a close relative with cancer?** | 2% (2%) | 13% (12%) | 16% (17%) | 51% (51%) | 17% (17%) | **53% (54%)** |
| **Being overweight** | 2% (2%) | 14% (14%) | 25% (25%) | 47% (47%) | 12% (12%) | **43% (43%)** |
| **Being over 70 years old?** | 2% (2%) | 17% (17%) | 26% (27%) | 44% (43%) | 10% (11%) | **35% (35%)** |
| **Eating red or processed meat once a day or more** | 2% (2%) | 19% (18%) | 29% (29%) | 38% (39%) | 12% (12%) | **29% (32%)** |
| **Infection with HPV?** | 1% (1%) | 7% (7%) | 54% (55%) | 31% (31%) | 6% (6%) | **29% (29%)** |
| **Drinking more than 1 unit of alcohol a day** | 3% (3%) | 22% (21%) | 27% (27%) | 43% (44%) | 5% (5%) | **23% (25%)** |
| **Eating less than 5 portions of fruit and vegetables a day** | 4% (4%) | 30% (29%) | 32% (33%) | 31% (31%) | 2% (3%) | **-1% (+1%)** |
| **Doing less than 30 minutes of moderate physical activity 5 times a week?** | 5% (4%) | 30% (30%) | 34% (35%) | 29% (28%) | 2% (2%) | **-4% (-4%)** |

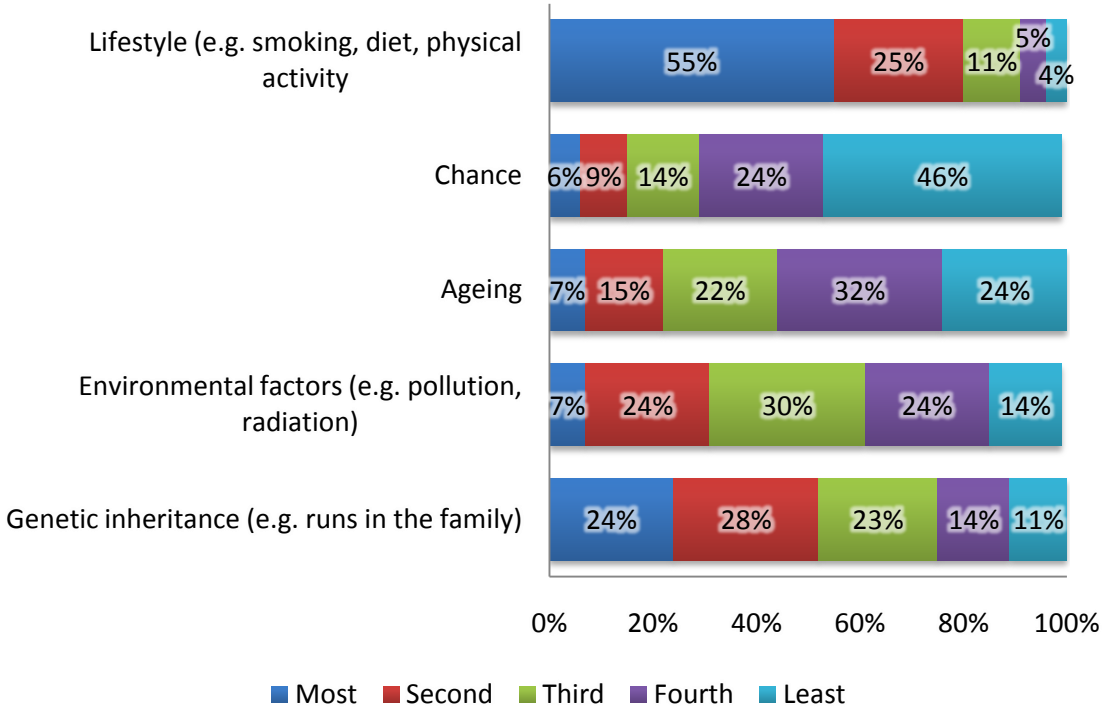
When asked how much they thought a range of factors contributed to cancer in the UK, the majority (55%) thought that lifestyle, such as smoking, diet and physical activity was the factor that most contributed to cancer, while a quarter (25%) thought it was the second most contributory factor.

Genetic inheritance was also seen to be a contributory factor with 24% of respondents thinking it had the largest contribution, 25% thinking it was the second most contributing factor and 23% believing genetics to be the third most contributing factor.

While environmental factors such as pollution and radiation were not considered by respondents to have the most contribution to cancer in the UK, almost a quarter (24%) thought environmental factors was the second most contributing factor, while 30% thought the environment was the third most contributing factor.

Chance was seen to be the least contributing factor to cancer in the UK (46%).

**Figure 3: How much do the following contribute to cancer in the UK (All respondents)**



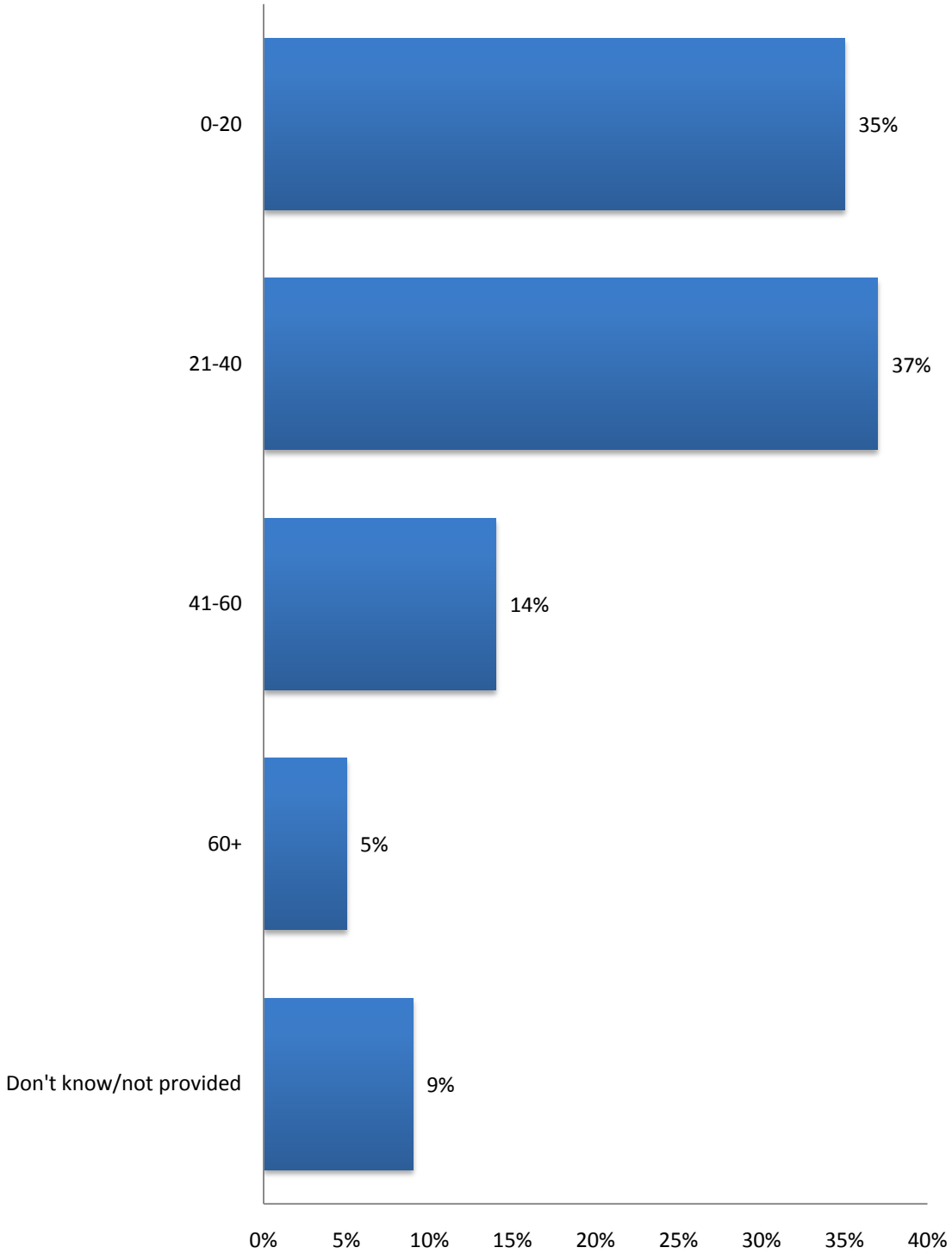

Unweighted base vary

### 3.5.3 Knowledge of lifetime risk of cancer

Respondents were shown a picture of 100 individuals and asked to estimate how many of the 100 will develop cancer at some point in their lives. The largest proportion of respondents (37%) thought that between 21 and 40 percent of people will develop cancer at some point in the life. More than a third (35%) of respondents thought that between 1 and 20 people will develop cancer, while a further 14% thought that between 41 to 60 people would develop cancer during their lives.

The actual numbers of people who will develop cancer at some point in their life is approximately one in three; with the results from this survey suggesting that many people are underestimating their chances of developing cancer.

**Figure 4: Out of 100 people, how many do you think will develop cancer at some point in their life (All respondents)**




Unweighted base: 2298

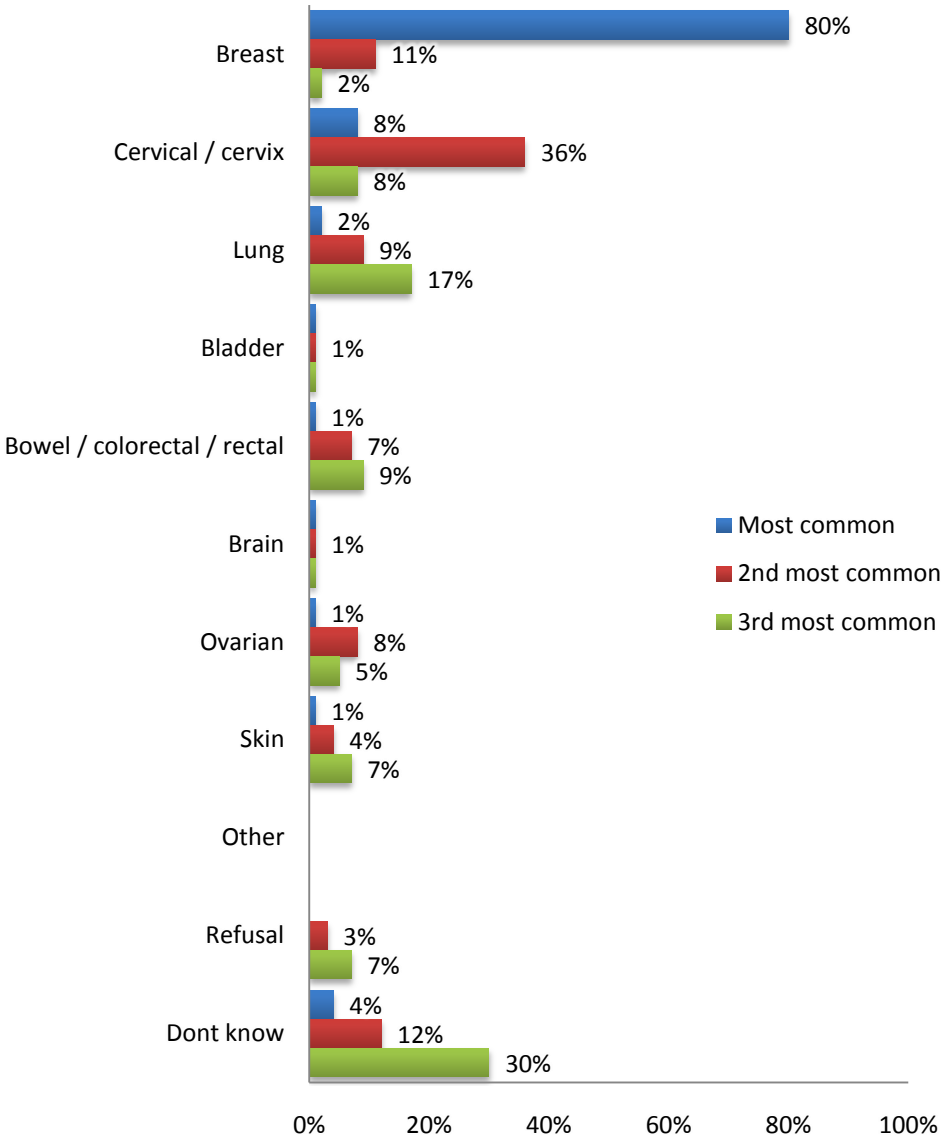
## 3.6 Knowledge of the most common cancers

### 3.6.1 Most common cancers in women

Respondents were asked to name the top three cancers in women. As figure 5 shows the majority (80%) of respondents thought the most common cancer in women was breast cancer, followed by cervical cancer (36%) and thirdly lung cancer (17%). Only 1% of respondents thought that ovarian cancer is the most common cancer in women, while 8% thought it was the second most common cancer and 5% the third most common cancer.

Small numbers of respondents (<0.5%) did mention other forms of cancer, but for clarity they have not been included on the chart.

**Figure 5: The most common cancer in women (All respondents)**

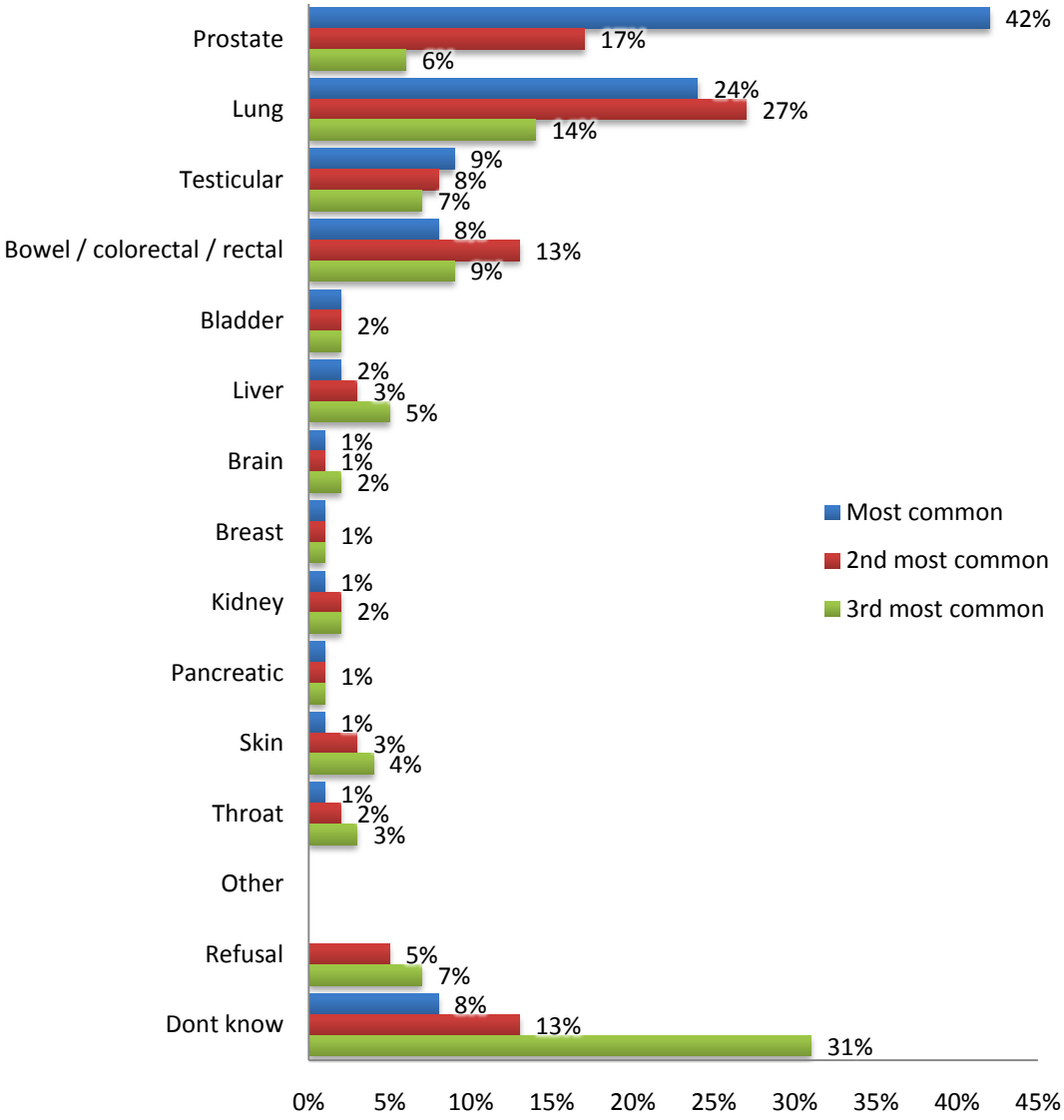



Unweighted bases = 2,298

### 3.6.2 Most common cancers in men

Respondents were asked which they thought were the three most common forms of cancer in men. The highest proportion of respondents thought that the most common form of cancer in men was prostate cancer (42%) followed by almost a quarter who thought lung cancer was the most common cancer in men (24%).

**Figure 6: The most common cancer in men (All respondents)**




Unweighted bases = 2,298

The second most common cancers in men were thought to be:

- Lung (27%);
- Prostate (17%); and
- Bowel / colorectal / rectal (13%)

The third most common cancers in men were thought to be:

- Lung (14%);
- Bowel / colorectal / rectal (9%); and
- Testicular (7%).

## 3.7 Knowledge of NHS screening programmes

Respondents were asked if NHS screening programmes exist for breast cancer, cervical cancer and bowel cancer.

In all instances fewer than half of respondents were aware of the screening programmes. Respondents were most aware of the cervical cancer screening programme (46%) followed by the breast cancer screening programme (43%). In both cases more than a third of respondents said they didn't know if these programmes were available.

Awareness of the bowel screening programme was much lower amongst respondents with only 16% saying they are aware of the programme, a third (32%) don't think the programme is available and more than half (52%) stated they don't know. This suggested an area in which increased awareness raising and education is required.

**Table 9: NHS cancer screening programme (All respondents)**

| | Yes | No | Don't know |
|---|---|---|---|
| **Is there an NHS breast cancer screening programme?** | 43% (43%) | 22% (22%) | 35% (35%) |
| **Is there an NHS cervical cancer screening programme (smear tests)?** | 46% (46%) | 18% (18%) | 36% (36%) |
| **Is there an NHS bowel cancer screening programme?** | 16% (16%) | 32% (32%) | 52% (52%) |
| **Sample bases vary** | | | |

When the results are considered by ward they show some significant variations. Awareness of each of the programmes is significantly higher in Clapham Common, Oval and Thurlow Park, while awareness of each of the programmes is significantly lower in Coldharbour, St Leonard's and Stockwell.

The following demographic groups were significantly more likely to say there is a **breast cancer screening programme**:

- Females (50%) compared to males (35%);
- Respondents aged 45-64 years (56%) and 65+ (53%) compared to younger respondents;
- Non BME respondents (53%) compared to BME respondents (35%);
- Married / co-habiting / Civil partnership respondents (50%) compared to single / separated / divorced respondents (39%);
- Economically active (46%) compared to economically inactive respondents (39%);

- Respondents living in quintile 1 (50%) compared to those living in quintiles 2, 3, 4 and 5 (41%, 46%, 44%, 31%);
- Respondents in the main sample (44%) compared to respondents in the Black African boost (25%).

Further demographic variations are shown in Table 9. The shaded boxes show statistically significant results.

**Table 10 Knowledge of breast cancer screening programme**

| | Yes | No | Don't know | Net knowledge |
|---|---|---|---|---|
| **Male** | 35% (34%) | 23% (23%) | 42% (43%) | +12% (+11%) |
| **Female** | 50% (51%) | 21% (22%) | 28% (27%) | +29% (+29%) |
| **18-24** | 23% (22%) | 29% (29%) | 48% (49%) | -6% (-7%) |
| **25-44** | 41% (39%) | 24% (26%) | 35% (35%) | +17% (+13%) |
| **45-64** | 56% (56%) | 16% (16%) | 28% (28%) | +40% (+40%) |
| **65+** | 53% (52%) | 16% (17%) | 31% (30%) | +37% (+35%) |
| **BME** | 35% (35%) | 26% (26%) | 39% (39%) | +9% (+9%) |
| **Non-BME** | 53% (54%) | 18% (17%) | 30% (28%) | +35% (+37%) |
| **Single/separated/divorced/widowed** | 39% (39%) | 23% (24%) | 38% (37%) | +16% (+15%) |
| **Married/living with partner/civil partnership** | 50% (49%) | 21% (20%) | 29% (30%) | +29% (+29%) |
| **Economically active** | 46% (47%) | 21% (21%) | 33% (32%) | +25% (+26%) |
| **Economically inactive** | 39% (39%) | 23% (24%) | 37% (37%) | +16% (+15%) |
| **More than 0 levels** | 48% (48%) | 21% (21%) | 31% (31%) | +27% (+27%) |
| **O levels or less** | 37% (38%) | 23% (23%) | 40% (39%) | +14% (+15%) |

| | | | | |
|---|---|---|---|---|
| **Other** | 47%<br>(45%) | 32%<br>(35%) | 21%<br>(20%) | +15%<br>(+10%) |
| **Main sample** | 44%<br>(45%) | 22%<br>(22%) | 34%<br>(33%) | +22%<br>(+23%) |
| **Black African** | 25%<br>(28%) | 25%<br>(25%) | 49%<br>(48%) | 0%<br>(+3%) |
| **Quintile 1** | 50%<br>(52%) | 15%<br>(14%) | 34%<br>(34%) | +35%<br>(+38%) |
| **Quintile 2** | 41%<br>(42%) | 24%<br>(24%) | 35%<br>(34%) | +17%<br>(16%) |
| **Quintile 3** | 46%<br>(45%) | 23%<br>(24%) | 31%<br>(31%) | +23%<br>(+21%) |
| **Quintile 4** | 44%<br>(45%) | 18%<br>(18%) | 38%<br>(38%) | +26%<br>(+27%) |
| **Quintile 5** | 31%<br>(30%) | 32%<br>(32%) | 37%<br>(38%) | -1%<br>(-2%) |

The following demographic groups were significantly more likely to say there is a **cervical cancer screening programme**:

- Females (57%) compared to males (35%);
- Respondents aged 45-64 years (52%), 65+ (45%) and 25-44 years (49%) compared to younger respondents (30%);
- Non BME respondents (55%) compared to BME respondents (39%);
- Married / co-habiting / civil partnership respondents (53%) compared to single / separated / divorced respondents (42%);
- Economically active (51%) compared to economically inactive respondents (40%);
- Respondents living in quintile 1, 2, 3 and 4 (48%, 49%, 50%, 48%) compared to those living in quintile 5 (33%)
- Respondents in the main sample (47%) compared to respondents in the Black African boost (28%).

Further demographic variations are shown in Table 10. The shaded boxes show statistically significant results.

**Table 11 Knowledge of cervical screening programme**

| | Yes | No | Don't know | Net knowledge |
|---|---|---|---|---|
| **Male** | 35% (33%) | 20% (21%) | 45% (46%) | +15% (+12%) |
| **Female** | 57% (57%) | 15% (16%) | 28% (27%) | +42% (+41%) |
| **18-24** | 30% (28%) | 23% (24%) | 47% (48%) | +7% (+4%) |
| **25-44** | 49% (48%) | 17% (19%) | 34% (34%) | +32% (+31%) |
| **45-64** | 52% (52%) | 16% (15%) | 33% (33%) | +36% (+37%) |
| **65+** | 45% (46%) | 17% (18%) | 38% (37%) | +28% (+28%) |
| **BME** | 39% (38%) | 21% (22%) | 40% (40%) | +18% (+16%) |
| **Non-BME** | 55% (56%) | 14% (14%) | 31% (31%) | +41% (+42%) |
| **Single/separated/divorced/ widowed** | 42% (41%) | 20% (21%) | 38% (37%) | +22% (+23%) |
| **Married/living with partner/civil partnership** | 53% (52%) | 15% (15%) | 32% (33%) | +38% (+37%) |
| **Economically active** | 51% (51%) | 15% (16%) | 33% (33%) | +36% (+35%) |
| **Economically inactive** | 40% (40%) | 20% (21%) | 39% (39%) | +20% (+19%) |
| **More than 0 levels** | 54% (54%) | 15% (15%) | 31% (31%) | +39% (+39%) |
| **O levels or less** | 35% (36%) | 20% (21%) | 44% (44%) | +15% (+15%) |
| **Other** | 52% (51%) | 29% (30%) | 19% (19%) | +23% (+21%) |
| **Main sample** | 47% (48%) | 17% (18%) | 36% (34%) | +30% (+30%) |
| **Black African** | 28% | 24% | 48% | +4% |

| | | | | |
|---|---|---|---|---|
| | (28%) | (24%) | (49%) | (+4%) |
| **Quintile 1** | 48%<br>(50%) | 12%<br>(11%) | 39%<br>(39%) | +36%<br>(+39%) |
| **Quintile 2** | 49%<br>(49%) | 17%<br>(17%) | 34%<br>(34%) | +32%<br>(+32%) |
| **Quintile 3** | 50%<br>(49%) | 18%<br>(19%) | 32%<br>(32%) | +32%<br>(+30%) |
| **Quintile 4** | 48%<br>(48%) | 15%<br>(14%) | 37%<br>(38%) | +33%<br>(+34%) |
| **Quintile 5** | 33%<br>(31%) | 28%<br>(29%) | 39%<br>(40%) | +5%<br>(+2%) |

The following demographic groups were significantly more likely to say there is a **bowel cancer screening programme**:

- Females (18%) compared to males (14%);
- Respondents aged 45-64 years (21%), 65+ (27%) and 25-44 years (13%) compared to younger respondents (8%);
- Non BME respondents (20%) compared to BME respondents (12%);
- Respondents living in quintile 1, 2, 3 and 4 (15%, 18%, 18%, 18%) compared to those living in quintile 5 (9%)
- Respondents in the main sample (16%) compared to respondents in the Black African boost (11%).

**Table 12 Knowledge of bowel cancer screening programme**

| | Yes | No | Don't know | Net knowledge |
|---|---|---|---|---|
| **Male** | 14% (14%) | 30% (30%) | 55% (55%) | -16% (-16%) |
| **Female** | 18% (18%) | 33% (34%) | 49% (48%) | -15% (-16%) |
| **18-24** | 8% (8%) | 32% (32%) | 60% (60%) | -24% (-24%) |
| **25-44** | 13% (13%) | 34% (35%) | 52% (51%) | -21% (-22%) |
| **45-64** | 21% (20%) | 30% (30%) | 49% (50%) | -9% (-10%) |
| **65+** | 27% (27%) | 27% (28%) | 46% (45%) | 0% (-1%) |
| **BME** | 12% (12%) | 31% (32%) | 56% (56%) | -19% (-20%) |
| **Non-BME** | 20% (21%) | 33% (32%) | 47% (46%) | -13% (-11%) |
| **Single/separated/divorced/widowed** | 16% (16%) | 32% (33%) | 52% (52%) | -16% (-17%) |
| **Married/living with partner/civil partnership** | 17% (18%) | 33% (32%) | 50% (50%) | -16% (-14%) |
| **Economically active** | 16% (16%) | 32% (32%) | 52% (51%) | -16% (-16%) |
| **Economically inactive** | 17% (17%) | 31% (31%) | 52% (52%) | -14% (-14%) |
| **More than 0 levels** | 18% (18%) | 33% (33%) | 49% (48%) | -15% (-15%) |
| **O levels or less** | 14% (14%) | 28% (29%) | 58% (57%) | -14% (-15%) |
| **Other** | 20% (14%) | 47% (51%) | 33% (35%) | -27% (-37%) |
| **Main sample** | 16% (17%) | 32% (33%) | 52% (51%) | -16% (-16%) |
| **Black African** | 11% (10%) | 31% (30%) | 58% (60%) | -20% (-20%) |
| **Quintile 1** | 15% | 26% | 59% | -11% |

| | | | | |
|---|---|---|---|---|
| | (15%) | (26%) | (59%) | (-11%) |
| **Quintile 2** | 18%<br>(19%) | 36%<br>(36%) | 46%<br>(45%) | -18%<br>(-17%) |
| **Quintile 3** | 18%<br>(18%) | 31%<br>(33%) | 51%<br>(49%) | -13%<br>(-15%) |
| **Quintile 4** | 18%<br>(19%) | 26%<br>(26%) | 56%<br>(56%) | -8%<br>(-7%) |
| **Quintile 5** | 9%<br>(8%) | 40%<br>(39%) | 51%<br>(52%) | -31%<br>(-31%) |

### 3.7.1 Women's awareness of the breast and cervical cancer screening programmes

To further understand the levels of awareness of these screening programmes among respondents further analysis was undertaken.

When the results are considered for female respondents only the data indicates that awareness of the breast cancer screening programme is significantly lower among younger women and those from BME backgrounds.

**Table 13 Knowledge of the breast cancer screening programme (Female respondents)**

| | Yes | No | Don't know | Net knowledge |
|---|---|---|---|---|
| **Female** | 50% (51%) | 21% (22%) | 28% (27%) | +29% (+29%) |
| **18-24** | 31% (31%) | 25% (29%) | 43% (40%) | +6% (+2%) |
| **25-44** | 45% (43%) | 25% (28%) | 30% (29%) | +20% (+15%) |
| **45-64** | 70% (68%) | 13% (13%) | 17% (19%) | +57% (+55%) |
| **65+** | 63% (64%) | 14% (15%) | 23% (21%) | +49% (+49%) |
| **White** | 59% (62%) | 19% (18%) | 22% (21%) | +40% (+44%) |
| **BME** | 44% (44%) | 23% (25%) | 32% (31%) | +21% (+19%) |
| **Quintile 1** | 58% (61%) | 13% (13%) | 28% (26%) | +45% (+48%) |
| **Quintile 2** | 45% (47%) | 25% (23%) | 31% (29%) | +20% (+24%) |
| **Quintile 3** | 52% (53%) | 24% (25%) | 24% (23%) | +28% (+28%) |
| **Quintile 4** | 57% (59%) | 15% (14%) | 28% (27%) | +42% (+45%) |
| **Quintile 5** | 37% (36%) | 32% (34%) | 31% (30%) | +5% (+5%) |

Similarly, the results for awareness of the cervical cancer screening programme show that awareness is significantly higher among white and older female respondents. The data also

indicates that respondents living in deprivation quintile 4 are also significantly more likely to be aware of the cervical screening programme, while those living

**Table 14 Knowledge of the cervical cancer screening programme (Female respondents)**

| | Yes | No | Don't know | Net knowledge |
|---|---|---|---|---|
| **Female** | 57% (57%) | 15% (16%) | 28% (28%) | +42% (+41%) |
| **18-24** | 45% (46%) | 20% (21%) | 36% (33%) | +25% (+25%) |
| **25-44** | 60% (59%) | 14% (16%) | 26% (25%) | +46% (+43%) |
| **45-64** | 64% (63%) | 12% (12%) | 23% (25%) | +42% (+41%) |
| **65+** | 53% (56%) | 15% (15%) | 32% (29%) | +38% (+41%) |
| **White** | 65% (66%) | 13% (13%) | 22% (21%) | +52% (+53%) |
| **BME** | 52% (51%) | 16% (18%) | 32% (31%) | +36% (+33%) |
| **Quintile 1** | 56% (59%) | 10% (9%) | 34% (32%) | +46% (+50%) |
| **Quintile 2** | 60% (62%) | 14% (13%) | 26% (26%) | +46% (+49%) |
| **Quintile 3** | 63% (63%) | 14% (15%) | 23% (23%) | +49% (+48%) |
| **Quintile 4** | 63% (64%) | 12% (11%) | 26% (26%) | +51% (+53%) |
| **Quintile 5** | 42% (39%) | 27% (29%) | 31% (32%) | +15% (+10%) |

### 3.7.2 Ages for screening

Respondents who said there was a screening programme for breast, cervical and bowel cancer were asked at what age the women or people are first invited to be screened.

The highest proportion of respondents who said there is a breast cancer screening programme said that women were invited to be screened at the age of 50 (25%), while one in ten (10%) thought women were invited when they reached 40 years of age. Respondents' answers ranged from 10 years to 75 years.

The highest proportion of respondents who said there is a cervical cancer screening programme said that women were invited to be screened at the age of 25 (16%), while 13% thought women were invited when they reached 18 years of age. Respondents' answers ranged from 12 years to 70 years.

The highest proportion of respondents who said there is a bowel cancer screening programme said that people were invited to be screened at the age of 60 (20%), while 11% thought people were invited when they reached 50 years of age. Respondents' answers ranged from 16 years to 77 year

## 3.8 Personal experience

To determine the impact on personal experience of awareness regarding types of cancer and the associated risk factors respondents were asked if they, a close family member or friend had had cancer.

The largest proportion (43%) of respondents had experienced cancer through a close family member, while a quarter (24%) said another family member had had cancer. More than a quarter (27%) said a close friend had had cancer, while 18% were aware of other friends having cancer. Few respondents said that they had had cancer (4%) or that their partner had had cancer (3%).

**Table 15: Have you or your family or close friends had cancer (All respondents)**

| | Yes | No | Prefer not to say | Not sure |
|---|---|---|---|---|
| **You** | 4%<br>(4%) | 95%<br>(95%) | 1%<br>(1%) | *%<br>(*%) |
| **Partner** | 3%<br>(3%) | 90%<br>(90%) | 6%<br>(7%) | *%<br>(*%) |
| **Close family member** | 43%<br>(40%) | 56%<br>(58%) | 1%<br>(1%) | *%<br>(*%) |
| **Other family member** | 24%<br>(23%) | 74%<br>(75%) | 1%<br>(1%) | 1%<br>(1%) |
| **Close friend** | 27%<br>(26%) | 71%<br>(72%) | 1%<br>(2%) | *%<br>(*%) |
| **Other friend** | 18%<br>(18%) | 79%<br>(80%) | 2%<br>(2%) | 1%<br>(1%) |
| **Unweighted sample bases vary** | | | | ***% denotes less than 0.5%** |

# 4 Appendices

## 4.1 Appendix 1 – Weighting[2]

Almost all the major British social surveys require weighting. If data requiring weighting are not weighted the resulting estimates will be biased if they are interpreted as estimates for the wider population (as opposed to estimates relating to the achieved sample). In almost all social science analysis, one is interested in the characteristics of the wider population (for example a local authority area and its constituent parts such as wards) rather than the achieved sample. For example, the Lambeth CAM is designed to provide estimates of attitudinal data for the adult population, but due to both differential selection probabilities (interviewing and one adult per household, and a set number of respondents per ward), one cannot interpret the achieved sample of the CAM as providing unbiased estimates of the social attitudes of the adult population of Lambeth. To generate estimates that are unbiased estimates of the adult population, one has to weight the CAM data.

The issue of weighting applies to simple descriptive statistics, such as income, or the proportion that say they are aware of a particular risk factor as well as to more complex methods such as multivariate analysis.

The effects of weighting are specific to each and every variable in the dataset. Some characteristics might be more common among the under-represented class(es) of respondent, others might be less common. Weight will ensure that under-represented characteristics will appear more common in the data, while those that are over represented will appear less common. If the characteristics vary at random with respect to the weighting variable, the weighted and unweighted parameter estimates will be the same. Similarly, when examining relationships via regression or other techniques, the relationship between two variables might be stronger or weaker among under-represented groups. If the former, the resulting parameter estimates (e.g. regression coefficients) will be larger once the data are weighted, if the latter they will be smaller.

In the case of the Lambeth CAM weightings have been applied to the data in line with Census 2001. Although this data is almost 10 years old it has been used in this instance as it was the most complete data set for providing a detailed break down of ethnicity by ward. Other more up-to-date datasets were considered such as the GLA population projections, but these only provided demographic details to borough level which was insufficient for the weighting required on the CAM survey.

[2] Adapted from Crockett A et al Weighting the Social Surveys , ESDS Government, October 2008

## 4.2 Appendix 2 - Further demographic data tables

**Table 16 Age and ethnicity**

| Age | Total | BME | Non-BME |
|---|---|---|---|
| **18-24** | 12% (12%) | 15% (16%) | 8% (8%) |
| **25-44** | 53% (47%) | 55% (49%) | 51% (44%) |
| **45-64** | 20% (25%) | 18% (22%) | 24% (28%) |
| **65+** | 12% (12%) | 9% (9%) | 15% (17%) |
| **Prefer not to say** | 3% (4%) | 4% (4%) | 3% (3%) |

**Table 17 Age and deprivation quintile**

| Age | Total | Quintile 1 | Quintile 2 | Quintile 3 | Quintile 4 | Quintile 5 |
|---|---|---|---|---|---|---|
| **18-24** | 11% (12%) | 8% (9%) | 10% (11%) | 13% (12%) | 15% (15%) | 13% (14%) |
| **25-44** | 53% (47%) | 46% (41%) | 60% (53%) | 52% (47%) | 48% (43%) | 57% (50%) |
| **45-64** | 21% (25%) | 25% (29%) | 18% (22%) | 20% (24%) | 22% (27%) | 17% (23%) |
| **65+** | 12% (13%) | 18% (18%) | 9% (10%) | 13% (14%) | 10% (11%) | 10% (10%) |
| **Prefer not to say** | 3% (3%) | 4% (4%) | 3% (4%) | 3% (3%) | 4% (4%) | 3% (3%) |

**Table 18 Ethnicity by deprivation quintile**

| Age | Total | Quintile 1 | Quintile 2 | Quintile 3 | Quintile 4 | Quintile 5 |
|---|---|---|---|---|---|---|
| **White** | 63% (57%) | 68% (66%) | 70% (66%) | 70% (63%) | 57% (50%) | 40% (29%) |
| **Mixed** | 6% (5%) | 5% (5%) | 5% (5%) | 5% (5%) | 4% (4%) | 10% (8%) |
| **Asian** | 4% (3%) | 6% (8%) | 3% (3%) | 3% (3%) | 3% (3%) | 4% (4%) |
| **Black** | 21% (28%) | 15% (17%) | 15% (21%) | 19% (24%) | 28% (36%) | 42% (57%) |
| **Chinese / Other** | 5% (5%) | 5% (5%) | 7% (7%) | 5% (5%) | 5% (5%) | 4% (4%) |
| **Prefer not to say** | 1% (1%) | 1% (1%) | 1% (1%) | *% (*%) | 1% (1%) | *% (*%) |

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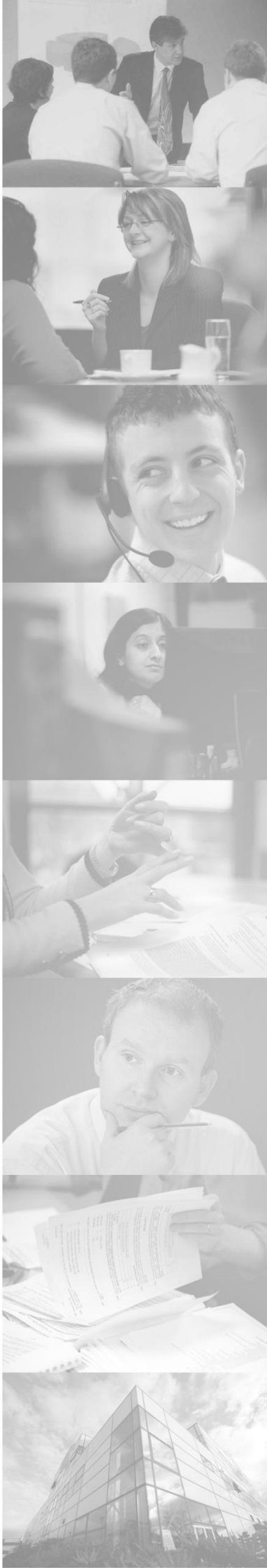
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