

«Review»

ACTUAL CONDITION OF CERVICAL CANCER SCREENING AND HEALTH EDUCATION PROGRAM TO ENHANCE SCREENING RATE

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Abstract: Cervical cancer is one of the cancers that may be prevented by cancer screening. While screening rate has been enhanced and the prevalence of the disease has been controlled in countries with developed screening environment, prevalence in Japan has been increasing. It has been 5 years since the start of the free screening ticket program to enhance screening rate in young women who have high risk of cervical cancer. However, the performance of cervical cancer screening during the past 5 years is far below the screening rates in other countries or the target screening rate set by the Ministry of Health, Labour and Welfare.

Under such a circumstance, this paper seeks to clarify the factors involved in the low screening rate in young women by comparing measures against cervical cancer in Japan with those in other countries, which are designed in the light of health promotion. The paper also presents the results of a survey related to cervical cancer screening and a health education program performed in B-City in A-Prefecture using screening participation models.

Aiming at the enhancement of cervical cancer screening rate, the paper proposes strategies for providing effective health education not only to nurture knowledge and behavior but also to improve health consciousness.

Key words : cervical cancer, cancer screening system, screening, health locus of control (HLC)

I . Introduction

Cervical cancer is called *mother killer* because it can destroy the life or health of women of childbearing potential. WHO reports (2007) that about 500,000 women develop cervical cancer annually worldwide and that more than half of this population is from developing countries with poor cervical screening service. Zur Hausen (2002) discovered that the major cause of cervical cancer is chronic infection of cervical epithelial cells with human papillomavirus (HPV) and that it is developed through precancerous stages termed cervical intraepithelial neoplasia (CIN). It can take

10 years or longer for cervical cancer to develop after infection. Primary prevention with HPV vaccination and early detection of CIN by routine screening are the most effective for preventing the disease (WHO, 2007).

Population-based cervical cancer screening program has been implemented in Japan. In recent years, however, a decreasing trend is observed in screening rate in Japan (Hasegawa, 2006), which is lower than not only that in the UK (79%), Netherlands (70%), or Korea (65%), countries that have adopted the cancer registration system and the organized screening system, but also that in any other member countries of the OECD (2009). In

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particular, the screening rate in young women in their 20s is as low as 10% (Comprehensive Survey of Living Conditions, 2010). Meanwhile, the prevalence of cervical cancer has been increased in Japan to 14.1 (persons per 100,000 women; hereinafter the same shall apply), which is higher compared to the prevalence in the USA (7.8), UK (9.3), and the global average (12.4). Therefore, the low screening rate in young women is pointed out as a causal factor for the increase in prevalence of cervical cancer in Japan.

In order to promote screening, it is essential to enhance health education activities including the improvement of screening environment (Matsuura, 2009). In countries with higher screening rates, screening environment has been upgraded and recommendation of screening and health education have been effectively performed in schools and communities in the light of health promotion. In Japan, it remains unclear whether there is sufficient cancer screening environment or whether screening programs is appropriately supported.

II. Necessary Factors to Promote Cervical Cancer Screening

Screening Program Improvement and Effective Encouragement of Screening

Cervical cancer screening plays an important role in prophylaxis against cervical cancer. In Japan, population-based screening started to be performed in 1961, and the incidence of cervical cancer, which had been 12%, was decreased to 3% in the 1980s. After the cancer screening program became funded by general budget in 1988, however, testing details and costs, etc., began to vary from one municipality to another, causing a decrease in screening rate. At present, cervical cancer is ranked the highest among cancers in women in their 20s and the average age of associated death is becoming lower. In comparison with data from the 1980s, the incidence of cervical cancer has been increased from 0.2% to 1.2% in women in their early 20s and from 2.0% to

6.3% in women in their late 20s.

Cancer Control Act was enacted in 2007 and uterus cancer screening was institutionalized in 2008 based on the Health Promotion Act (Moriyama, 2009). According to a survey conducted by the Japan Cancer Society, however, only 575 (31.7%) out of 1,818 municipalities implement this program in accordance with the national guidelines. As a program to promote cancer screening, a new system was established in 2009, enabling every woman aged 20 years or older to receive tickets for free cancer screening every 5 years. In fiscal 2013, this system was implemented in a total of 3,820,000 women to promote cancer screening rate in women.

Because such cervical cancer screening service is implemented in individual municipalities, however, a nationwide cancer registration system has not been established. As a result, it is difficult to know the actual status of screening exactly or to evaluate the effectiveness of this national program. It will be necessary to understand the actual status of screening accurately by establishing the cancer registration system and to enhance screening rate in addition to the improvement of the cervical cancer screening system and promotional programs.

Step-by-Step Health Education to Promote Cervical Cancer Screening

Young women in Japan are said to have low interest in their own health as well as in cancer prevention. According to the Comprehensive Survey of Living Conditions 2010, the screening rate in women aged 20 to 29 years is lower compared to that in other age groups. The results of an awareness survey demonstrated that few young women have a correct understanding of the purpose and method of cervical cancer screening or the need of routine screening. Reasons why women do not undergo screening is shown in table 1.

In the "Guideline for health education focused on prevention of cancer and for cancer screening," the Ministry of Health, Labour and Welfare (hereinafter

Table 1 Health locus of control

Factor		Example of subscale item
Internal		I will protect my health by myself.
External	Professional	I owe my health to advances in medicine.
	Family	My health is supported by my family members and people around me.
	Chance	Things that affect my health happen to me by chance.
	Supernatural	Thanks to God, I am healthy.

This term is used as an index of prediction of health behavior or intervention effect. The JHLC scale (Horike, 1991) (hereinafter called HLC) is used in this research. This scale consists of 5 subscales with 25 items which include external health locus of control reflecting Japanese health views and culture.

referred to as MHLW) states that health education should help women to obtain accurate knowledge in cervical cancer and to understand the relationship between the disease and sexual activity. The results of the above surveys, however, show their insufficient understanding of cancer prevention. In fact, some researchers such as Sasagawa (2008), Onuki (2009), and Aklimunnessa K (2006) have reported that young women may feel embarrassed or ashamed of being examined for cervical cancer or may have prejudice against persons involved in HPV infection. Under such a circumstance, there is a pressing need to enhance education related to gynecological examination including cervical cancer screening.

Due to their limited experience of not only screening but also ordinary medical care, most young women are likely to be confident about their own health and have little opportunity to think about upgrading their health view. In Japan, health education in school started to be implemented in the 1920s and developed as a comprehensive school health program after the enactment of School Health Act in 1958. However, Japanese health education is still slow in adopting the concept of health promotion from the viewpoint of public health (Minagawa, 1999). The National Institute for Educational Policy Research has compared conventional health education in Japan and that in other countries and advocates the inclusion of the idea of health promotion in school health education. Health promotion is an integrated concept including conventional health education,

which provides organizational, financial, and environmental support to help people maintain or enhance their health (Green L, 1983). WHO says that new health education to be performed in the light of health promotion should be free from conventional specialist-led dependent methods and should encourage people's voluntary and subjective participation in health activities and that it is important to establish an environment in which ideal health habits will be maintained (WHO, 1986).

In many countries, health education is continuously provided as a school health activity based on the respective governments' policies and standards to nurture public interest in health including cultural background and sense of values (Wallerstein N, 1994), (Takeda, 2001), (RA Spasoff, 2006). Since 1990s, health promotion network centered on health promotion schools has been expanded in the EU, US, South America, and Asia. Health education related to cervical cancer prevention has been promoted together with cancer prevention policy in each country. Particularly in countries in which HPV vaccination is implemented as primary prevention, girls learn the pathological condition of cervical cancer and the importance of receiving cancer screening from early teen, around the age of the first menstruation.

The concept of health promotion has been adopted in school education since 2009, and specialists such as Kotake (2011) and Suketomo (2013) have implemented educational activities related to cancer prevention. On the other hand, it is speculated that many girls reach adulthood qualified for cancer

screening without learning relevant information or behavior in the course of their development. In Japan, by reference to other countries, it is needed to implement step-by-step health education and to promote women's knowledge and interest in cervical cancer prevention methods.

Multifaceted Support from the Viewpoint of Health Promotion

In the USA where opportunistic screening system has been practiced, there are many related advertisements and campaigns targeted at teenagers. They are advised to have their first cervical cancer screening within 3 years of the start of sexual activity or age 21. In the UK where organized screen system has been practiced, women of certain ages are invited to have cervical screening tests by local healthcare organizations and are re-invited if failing to answer the initial invitation (Fukumoto, 2001) (Kito, 2009).

Family education also plays an important role in making women have screening tests on a regular basis. In Europe and the US, many girls at the stage of menarche see a family doctor (such as general practitioner) with their mothers. By creating the first opportunity for girls to have cervical cancer screening through collaboration with school, home, and community, the beneficial effect of health education is supposed to be enhanced (Swift C, 1987). In countries with high screening rate, cervical screening tests are allowed to be performed not only by a physician but also by a nurse or a midwife so that young women are able to have examination without feeling fear or shame.

What is needed now in Japan is to establish and operate primary care supported by the continuous involvement of healthcare system, presence of a family doctor, and a trusting relationship with healthcare professionals. Multifaceted support, such as collaboration between educational and healthcare organizations, is likely to enhance young women's awareness of health value, which can increase

cervical cancer screening rate.

III. Establishment of Health Education Program to Enhance Screening Rate

Modeling of Screening Participation and Investigation of Evaluation Methods

Individual factors including health consciousness and other factors such as local healthcare system, cultural background, and degree of health are interrelated in a complex manner to motivate women to have cervical cancer screening. The conceptual diagram for screening participation and health view is shown below. Conceptual diagram of screening and health views is shown in **fig 1**.

Next, the details of health education and evaluation indexes for the results of education were investigated based on preceding studies. As a result, it was found out that the model of "subjective definition of health (or self-assessed health status)," in which a relationship between objective health status and screening is reported, and "health locus of control (hereinafter referred to as HLC)" proposed by Rotter (1966) are effective as evaluation indexes. These models are not only effective for training the internality of the target population but also usable for health promotion-based programs such as improvement of external support or environmental conditions (Kanda, 2000), (Wallston BS, 1976, 1997, 2004), (Lefcourt HM, 1991)

Based on the HLC model, Horike (1991) in Japan developed the Japanese version of HLC scale, which has been widely used (Hori, 2001). The HLC scale has been regarded as an effective concept or assessment scale usable for predicting coping behaviors of young women in Japan or assessment of health education. Health locus of control (factor and example of subscale item) is shown in **table 2**.

Based on these preceding studies, screening status in the target area was surveyed, and a health education program was developed and implemented for the promotion of screening rate. This study was conducted after obtaining approval from the Ethics

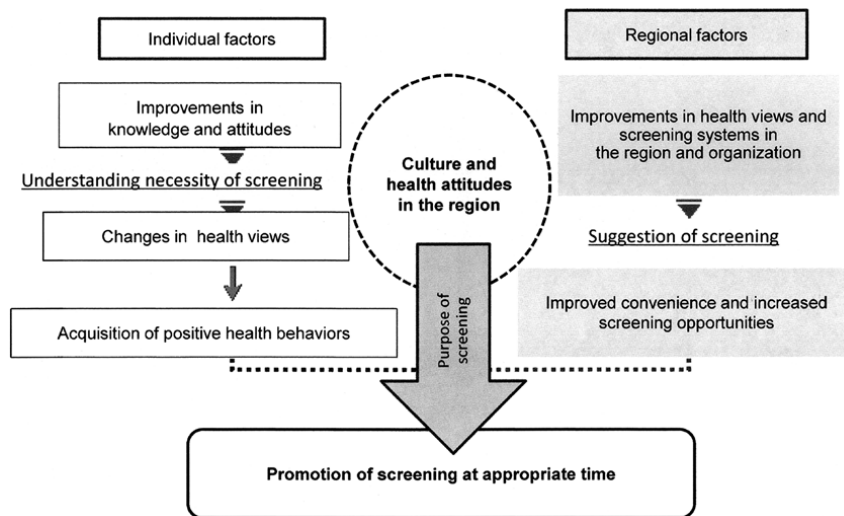


Fig 1 Conceptual diagram of screening and health views

Table 2 Reasons why women do not undergo screening

Reasons	All ages	20s
Screening is possible at any time	34.2	21.9
I have no time for screening	22.9	25.8
Screening costs money	19.6	29.1
Screening is not needed because I am healthy	9.4	15.1
I did not know about screening	4.5	13.0

National Livelihood Survey (2010)

Committee of Hirosaki University Graduate School of Medicine (Approval Numbers: 2010-037 and 2011-173).

Outline of the Target Area for the Survey and Performance of Cervical Cancer Screening

1. Outline of the Target Area for the Survey

B-City in A-Prefecture has a population of approximately 180,000. According to the population census in 2006, the employment rate accounted for 59.4% of the productive-age population in the city and the proportion of women had been increasing year by year (B-City population census, 2006). According to the Annual Prefectural Statistical Report on Healthcare 2008, the ratio of young population in B-City was 10% (A-Prefecture: 8.6%, national mean: 7.2%) and the total fertility rate in B-City was 1.19 (A-Prefecture: 1.34, national mean:

1.31). The health promotion program for women in B-City has been established with a focus on healthcare policy based on the Health Promotion Act and the municipal next generation development plan. Since 2010, the health promotion program has been implemented with cooperation of the Health Promotion Department, Child Support Department, Health and Physical Education Department, and Educational Research Institute, etc., in a longitudinal manner.

2. Cancer Screening System and Performance

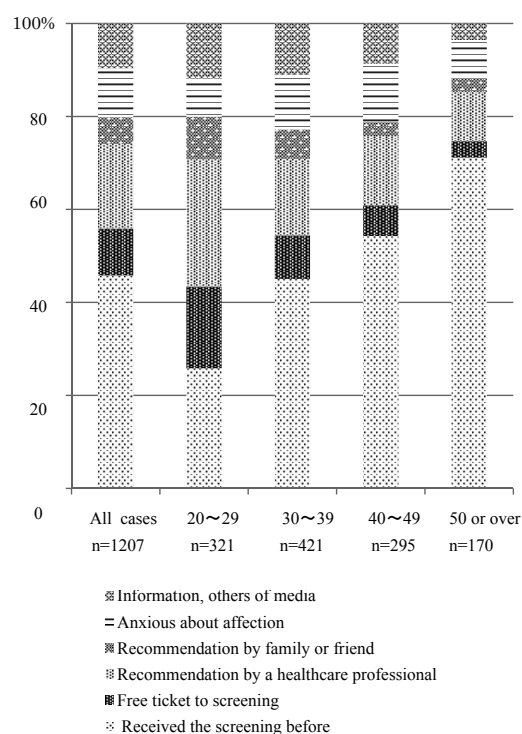
According to the health-statistics annual report of the prefecture of the fiscal year in 2008. The causes of death in B-City, cancer, cardiac disease, and cerebrovascular disorder account for 31.6%, 15.0%, and 11.2%, respectively. As shown, cancer is the highest cause of death. As cancer prevention measures based on the Health Promotion Act,

B-City implements population-based screening tests for stomach, lung, colorectal, prostate, and breast cancers. Cervical cancer screening is performed under the name of “uterus cancer screening.” The screening sites are the Medical Association Examination Center and designated medical institutions. The eligible population for cervical cancer screening is women aged 20 years or older, and women aged 40 years or older are qualified for receiving screening at community-based screening sites (using the mobile cancer screening bus). The cancer screening program for women with an even age is subsidized. The actual cost is 700 yen, and women with national insurance are required to pay 350 yen and those who have corporate health insurance pay 630 yen. In the fiscal year when this study was performed, 6,842 (designated medical institutions: 4,267, mobile cancer screening: 2,575) out of 47,939 eligible women had cervical cancer screening, and the screening rate was 14.9% (national mean: 18.8%, A-Prefecture: 26.5%) . Based on the results of the screening, 99 women needed to undergo a detailed examination (required for those who were assessed as Class III or higher stage).

Actual Status of Cervical Cancer Screening

1. Survey Method and Results

The objectives of the study were explained orally and in writing to women aged 20 years or older, who visited designated medical institutions in B-City for cervical cancer screening, before the conduct of a questionnaire survey. An analysis was made in terms of the responses to the questionnaires from 1,207 women (valid response rate: 93.4%) who had provided informed consent. Their age ranged from 20 to 76 years old (mean: 37.2 years), and 78.7% of them had a job while 22.3% of them were housewives, students, or others. More than 80% of them had experienced cervical cancer screening, and the number of those who had screening on a regular basis was higher with the increase in age. As screening types, population-based screening



(Matsuo, 2013)

Fig 2 Motivation for Screening

accounted for 34.2%, workplace screening accounted for 34.8%, self-pay screening accounted for 20.3%, and screening received concomitantly with medical examination accounted for 10.7%. The number of women who had screening for the first time was significantly high in the age 20-29 group, and the number of women who had screening on an irregular basis was significantly high in the age 30-39 group (Matsuo, 2011, 2014). Motivation for screening is shown in fig 2.

As motives for screening, the answer, “I have received screening before,” was ranked the highest (46.6%). The number of women who chose this answer became higher with the increase in age. In the age 20-29 group, the answers, “receipt of a ticket for free screening” and “recommendation from healthcare professionals/family members,” were significantly higher. As reasons for not having screening in the age 20-29 group, the percentage of women who chose the answer, “troublesome,” was significantly lower compared to the other age groups, and the percentage of women who chose the answer, “having no family doctor” or “high co-

payment," was also high. In an analysis of HLC, 91.8% of the women responded "healthy or relatively healthy." In a comparison of HLC subscale scores, the score for internal HLC (hereinafter referred to as I-HLC) was high and it was positively associated with professional HLC (hereinafter referred to as Pr-HLC), super natural HLC (hereinafter referred to as S-HLC), and family HLC (hereinafter referred to as F-HLC) scores (0.36, 0.27, and 1.6, respectively).

2. Characteristics of the Subjects Regarding Screening and Health Consciousness

It was speculated that most of the survey subjects were motivated to receive screening after their experience in screening or recommendations from healthcare professionals and that their motivation became higher with the advancement in age to an extent that they started to have screening on a regular basis. In the UK, screening rate was reported to be increased by about 10% after re-encouraging women who had not received screening to have it (Quinn M, 1999). Considering that one of the main motives for screening was recommendations from other people, obtainment of information of the beneficial effects of screening from other women with experience in screening probably encouraged the subjects to receive screening, improving the screening rate. Regarding health consciousness of the subjects, their high I-HLC score suggested that they received screening feeling that "I will protect my health by myself" (Yamada, 1995).

This survey demonstrated that young women do not always have a negative perception of cervical cancer screening and that their lack of relevant knowledge or experience prevents them from receiving screening. These results suggested that, in order to increase screening rate and promote the establishment of regular screening habit, it is important to enhance women's own sense of health control that cervical cancer is preventable in addition to the provision of specific education about the method and details of screening. Provision of

specific information such as the date, method, and sites of screening also seems necessary to enable women to undergo screening promptly once they decide to do so (Greimel, 1997) (Mateji, 2008).

Development of Health Education Program Using HLC

1. Outline of the Health Education Program

Based on the results of the survey, a health education program was developed to provide knowledge and behavior needed for receiving cervical cancer screening and to enhance health consciousness. The program was designed as a workshop on demand that was to be held at the sites of activities of the target population and was entitled "Learn and Receive Cervical Cancer Screening!".

The workshop consisted of 2 parts. The first part was entitled "Cervical Cancer and Screening," in which the evidence-based effects of cervical cancer prevention measures were presented. The second part was entitled "Make Your Own Screening Plan." In this part, the participants were encouraged to make their own screening plan including method, site, and date for screening with reference to newsletters of the City and to prepare a postcard by which screening would be recommended to themselves.

In order to compare the effects of subjective screening plans and individual recommendations of screening, the participants were assigned either to the intervention group or the control group according to their registration numbers. After the health education workshop, the postcards with information of screening plan, which had been collected by the researchers, were sent only to the intervention group prior to their planned screening dates to recommend screening to them individually. Health consultation was also provided to participants who desired to have it after the workshop. This program was evaluated using a questionnaire form immediately before and after the workshop as well as 3 months after the workshop. Plan for health education program in table

Table 3 Plan for the Health Education Program

1. Objectives:	To support the subjects to receive screening according to their own life styles by promoting their understanding of cervical cancer and the importance of screening and enhancing their sense of health control.
2. Goals:	(1) The subjects understand the mechanism of cervical cancer and screening method and become motivated to receive screening. (2) The subjects become interested in receiving cervical cancer screening and become capable to make their own plan for screening. (3) The subjects receive screening based on their screening plan.
3. Subjects:	200 women aged 20 to 39 years who live in B-City or the surrounding area
4. Date:	August 2010 to September 2011
5. Site:	Companies or educational institutions, etc., in B-City
6. Materials and Survey Form	Material (1) Material 1: "Women's Health Handbook (slides)" produced by the Ministry of Health, Labour and Welfare. (2) Material 2: Flow chart of gynecological examination (interview, ocular inspection, palpation, and internal examination). (3) Material 3: List of screening sites, times, and costs. Preparation of a postcard for screening recommendation: an official postcard and a confidential label

Table 4 Health Education Procedure

Instruction	
Introduction	Explanation of this study and the acquisition of subject consent to participate in the study Distribution of documents
Part 1	<u>1. Health education using materials</u> (1) Statistical data of cervical cancer (2) Pathological condition of cervical cancer (3) Cervical cancer screening: Primary screening and detailed examination; screening types (4) Screening procedure (interview, ocular inspection, palpation, and internal examination) Cervical cytology method, notification of result (detailed examination)
	<u>2. Screening plan</u> (1) Screening sites and appropriate screening times (2) Explanation of screening sites in B-City (using newsletters of B-City) (3) Preparation of screening plan
Summary	3. Explanation of the longitudinal survey: explanation of the survey performed after 3 months 4. To the intervention group only: Presentation of examples of screening plan and postcard for screening recommendation; Preparation of a postcard for screening recommendation. Collection of postcards with confidential labels
	5. Completion of the questionnaire form; questions about screening; etc.

3, health education procedure is shown in **table 4**.

2. Results of the Health Education and Discussion

Health workshop was held on demand 10 times in various sites in B-City (Matsuo, 2013). The valid responses from 142 subjects (mean age: 27.0 years), responses from 53 subjects (intervention group:

27, control group: 26), for whom the longitudinal survey was performed until 3 months after the workshop, were analyzed. Their knowledge in cervical cancer was increased after the provision of the health education program compared to before the program. Seventeen (32.1%) of the 53 subjects actually received cervical cancer screening. To be

Table 5 Intervention and screening

	Number of women (%)	
	Underwent screening	Did not undergo screening
Intervention group n=26	10 (38.5)	16 (61.5)
Control group n=27	7 (25.9)	20 (74.1)

(Matsuo, 2013)

more specific, 11 (42.3%) of 26 subjects aged 20 to 29 years and 5 (22.7%) of 22 subjects aged 30 to 39 years underwent screening. Ten (37.1%) of 27 subjects in the intervention group, which was involved in the preparation of screening plan and individual screening recommendation via a postcard, and 7 (26.9%) of 26 subjects in the control group received screening. Concerning screening type, 14 subjects (63.3%) underwent population-based screening. Intervention and screening is shown in **table 5**.

Concerning health consciousness, the score of Pr-HLC, a subscale of HLC, was significantly increased 3 months after the health education program (19.9 ± 4.1) compared to the score before the program (18.1 ± 3.7). Although this health education program was performed in 200 participants, the number of valid responses obtained for the longitudinal survey was smaller. However, the health education program was likely to help the subjects to understand the specific methods and details of cervical cancer screening and to undergo screening. The screening rate in the subjects exceeded the mean national screening rate as well as the mean prefectural screening rate. The intervention group showed a higher screening rate compared to the control group, though not significantly, suggesting the effect of the intervention.

Of the HLC parameters, the score of Pr-HLC, "I owe my health to advances in medicine," was significantly increased 3 months after the program. This can be interpreted that the health education program by healthcare professionals enhanced the subjects' sense of health control in addition to their

internal health view, "I will protect my health by myself." As shown above, the efficacy of the health education program by healthcare professionals was suggested (Matsuo, 2013).

Measures to Promote Cancer Screening Rate

Based on the results of the study, this chapter will present how to pursue the idea of health promotion using health education program. To be more specific, start time of health education, choice of providers of health education, and development of supportive environment will be discussed by reference to preceding literature such as by Pender (1997) and Glanz K (2008).

Health education associated with cervical cancer should start to be provided to girls before they become sixth graders, at which HPV vaccination is started, and be continued in a stepwise manner according to the degree of their development. Besides individual health consciousness, the health view of people around them should also be enhanced by appropriate measures. Health education programs for school children should be designed in a way that allows them to participate in it with their parents, and programs for older girls and women should be performed in collaboration with their senior high schools, universities, or workplaces (Israel BA, 1994) (Dnny T, 2006) (Konno, 2011) (Suketomo, 2012).

It is also important to perform health education by healthcare professionals. In such occasions, healthcare professionals should maintain an equal relationship with participants. By taking part in

activities of target populations on a continuous basis and communicating with them to enhance their sense of health control, healthcare professionals must seek to establish mutual understanding and trusting relationship with target populations. In some preceding studies, HLC in healthcare professionals, who were providers of health education, had an effect on the HLC in those who received such education (Mitsubayashi M ,2000). Therefore, providers of health education should learn not only specialized knowledge and education methods but also the nature of their own HLC to achieve effective education.

Support for young women tends to be understood as support for those who have not yet received screening. However, it is also important to support women who receive screening on an irregular basis. Placing priority on work or child-care, etc, such women may neglect their own health control (Suzuki, 2010) (Monsonogo J, 2012). Irregular cancer screening can increase the risk of developing cancer. To complement the undeveloped cancer registration system, health education should be provided repeatedly to all women regardless of their experience of screening. At the same time, user-friendly screening methods must be developed (Hutagami, 2007). It will be helpful if an information query system is developed for target populations to confirm screening sites, methods, or other relevant information.

IV. Conclusion

This paper has discussed preceding studies and literature in Japan and overseas in terms of Japanese cancer screening environment. Because of a lack of official cancer registration system to know the screening status of target populations, it has been difficult in Japan to clarify the effect of screening recommendation or to encourage those who have not received screening to receive it. Due to insufficient support for girls to enhance their view of cervical cancer prevention, most of them

have little opportunity to gain relevant knowledge, behavior, or health consciousness before reaching adulthood.

In countries with health education performed based on the concept of health promotion, screening environment has been developed and young women are supported from educational institutions, families, and medical institutions in terms of cervical cancer screening. Women in these countries are able to gain knowledge, behavior, and health consciousness about cervical cancer, which are needed to cope with their increasing risk of developing the disease as they grow. Also in our health education program, a positive change was observed in knowledge and behavior related to cervical cancer and the screening rate 3 months after the workshop (58.8% for the intervention group and 41.2% for the control group) exceeded the national mean, proving its effectiveness.

Taking account of the above, this paper proposes that the provision of health education programs by healthcare professionals should be promoted to complement the undeveloped cancer registration system in Japan. It is sincerely hoped that the popularization of such programs will enhance young women's knowledge, behavior, and health consciousness related to cervical cancer and increase screening rate in Japan.

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子宮頸がん検診受診行動の実態と 受診率向上に向けた健康教育プログラムの展望

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要旨：子宮頸がんは、がん検診受診により予防が可能ながんの一つである。検診受診環境が整備された諸外国では、検診受診率が向上し罹患率は抑えられているが、日本の罹患率は増加傾向にある。罹患リスクの高い若年女性の検診受診率の向上を目的として、無料クーポン配布制度が実施され5年が経過した。しかしこの間の受診実績は、諸外国の検診受診率や厚生労働省の目標値に及ばず低迷している。

そこで本稿は、ヘルスプロモーションの視点に立った諸外国のがん対策と日本の現況を比較し、若年女性の検診受診率低迷の要因を明らかにする。次に、検診受診行動モデルを用いて、著者らがA県B市にて実施した子宮頸がん検診受診行動の実態調査と健康教育プログラムの結果を示す。

検診受診率向上に向けて、知識・態度の付与に加え、健康意識へ働きかける健康教育の方策を提言する。

キーワード：子宮頸がん、がん検診制度、検診受診行動、主観的健康統制感

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