

Health Perceptions and Attitudes Toward Cancer Screenings Among Individuals Attending Family Health Centers: A Cross-Sectional Research

Dilek YILDIRIM*, Ferda AKYÜZ ÖZDEMİR**, İbrahim Halil BOYACI***

Abstract

Aim: This study aimed to investigate the effect of individuals' health perceptions on their attitudes toward cancer screening and to examine the relationship between these two variables.

Method: We implemented a descriptive, cross-sectional, and correlational design. The sample consisted of 351 adults who applied to a family health center in Muğla, Turkey, between January and August 2025. Data were collected using a Personal Information Form, the Health Perception Scale, and the Attitude Scale for Cancer Screening. Statistical analyses included descriptive tests, independent samples t-tests, Pearson correlation, and regression analysis.

Results: The mean age of participants was 43.4±13.9 years, and 60.1% had never undergone cancer screening. The average scores were 38.17±8.21 on the Health Perception Scale and 74.64±15.89 on the Attitude Scale for Cancer Screening. A significant positive correlation was found between health perception and attitudes toward cancer screening ($r=0.350$, $p<0.001$). Regression analysis demonstrated that health perception explained 12.3% of the variance in screening attitudes. Participants with knowledge about cancer or screening methods had significantly higher health perception scores ($p<0.05$). No significant differences were observed in screening attitudes by gender, age, or chronic disease status.

Conclusion: The findings indicate that health perception is a key determinant of attitudes toward cancer screening. Interventions that strengthen health literacy, enhance awareness, and reduce psychosocial barriers could increase participation in screening programs. Educational initiatives and support interventions delivered through family health centers may play an essential role in promoting early detection and improving community health outcomes.

Keywords: Health perception, cancer screening, attitude, family health center, nursing.

Özgün Araştırma Makalesi (Original Research Article)

Geliş / Received: 25.09.2025 **Kabul / Accepted:** 30.07.2026

DOI: <https://doi.org/10.38079/igusabder.1790889>

* Assoc. Prof., Istanbul Aydın University, Faculty of Health Sciences, Department of Nursing, Istanbul, Türkiye.

E-mail: dilekyildirim@aydin.edu.tr [ORCID https://orcid.org/0000-0002-6228-0007](https://orcid.org/0000-0002-6228-0007)

** Asst. Prof., Muğla Sıtkı Koçman University, Fethiye Faculty of Health Sciences, Department of Internal Medicine Nursing, Muğla, Türkiye. E-mail: ferdaakyuz@mu.edu.tr [ORCID https://orcid.org/0000-0001-9109-3692](https://orcid.org/0000-0001-9109-3692)

*** Republic of Türkiye, Ministry of Health, Fethiye District Health Directorate - Fethiye Family Health Center No. 3, Fethiye Family Medicine Unit No. 21, Muğla, Türkiye. E-mail: kardox73@gmail.com [ORCID https://orcid.org/0009-0009-8061-9025](https://orcid.org/0009-0009-8061-9025)

ETHICAL STATEMENT: Ethical approval for the study was obtained from the Ethics Committee of Istanbul Aydın University (Date-form number: 25.12.2024; 136/2024). Informed consent was obtained from all participants.

Aile Sağlığı Merkezine Başvuran Bireylerin Sağlık Algıları ve Kansere Taramalarına Yönelik Tutumları

Öz

Amaç: Bu araştırma, bireylerin sağlık algılarının kanser taramalarına yönelik tutumları üzerindeki etkisini ve bu iki değişken arasındaki ilişkinin belirlenmesi amacıyla yapılmıştır.

Yöntem: Tanımlayıcı, kesitsel ve ilişki arayıcı tipteki araştırma Ocak–Ağustos 2025 tarihleri arasında Muğla’da bir aile sağlığı merkezine başvuran 351 kişi ile yürütülmüştür. Veriler, Kişisel Bilgi Formu, Sağlık Algısı Ölçeği ve Kansere Taramasına Yönelik Tutum Ölçeği kullanılarak toplanmıştır.

Bulgular: Katılımcıların yaş ortalaması $43,42 \pm 13,90$ ’dır. Katılımcıların %60,1’i daha önce hiç kanser taraması yaptırmamıştır. Sağlık algısı ve kanser taramasına yönelik tutum arasında pozitif yönlü anlamlı bir ilişki saptanmıştır ($r=0,350$; $p < 0,001$). Regresyon analizine göre sağlık algısı, tutum puanlarındaki varyansın %12,3’ünü açıklamaktadır. Kansere konusunda bilgi sahibi olan bireylerin sağlık algısı puanları anlamlı düzeyde daha yüksektir ($p=0,021$).

Sonuç: Bulgular, sağlık algısının kanser taramasına yönelik tutumları olumlu yönde etkilediğini göstermektedir. Aile sağlığı merkezlerinde uygulanacak eğitim programları, farkındalık çalışmaları ve psikososyal destek müdahaleleri, kanser tarama programlarına katılımı artırmada önemli katkı sağlayabilir.

Anahtar Sözcükler: Sağlık algısı, kanser taraması, tutum, aile sağlığı merkezi, hemşirelik.

Introduction

The health perceptions and attitudes toward cancer screening of individuals applying to Family Health Centers stand out as a significant public health concern. Cancer is one of the leading causes of morbidity and mortality worldwide and constitutes a major burden on healthcare systems, societies, and economies. The increasing incidence and mortality rates of cancer make it a critical public health priority that requires effective prevention and early detection strategies. Health perception represents a fundamental determinant in how individuals evaluate their own health status and in shaping their attitudes toward healthcare services¹. These perceptions can have a direct impact on both the accessibility of healthcare services and the regularity of their use by individuals². Cancer screening services, in particular, play a pivotal role in the early detection of disease. Therefore, given that attitudes toward these services are closely linked to individuals’ health perceptions^{3,4}. For instance, implementing public campaigns aimed at educating the community about the importance of cancer screenings, raising awareness, and facilitating access to such services are seen as a critical strategy⁵.

Family Health Centers serve as key healthcare providers addressing a wide range of individual health needs. These centers also enable the provision of screening services for serious health conditions such as cancer⁶. Given the high global burden of cancer, primary care settings such as Family Health Centers play a crucial role in reducing cancer-related morbidity and mortality through early diagnosis and timely intervention. It is reported that the psychosocial needs of patients, especially those related to cancer diagnosis, have the potential to directly affect their general health status and quality of

life. Numerous studies have indicated that the psychosocial challenges experienced by cancer patients emerge as a significant risk factor throughout the course of treatment^{7,8}. Therefore, it is important to emphasize that health perception is closely associated not only with physical health but also with psychosocial well-being⁹.

Attitudes toward cancer screening are among the key factors influencing individuals' participation in screening services. Research has shown that these attitudes are directly associated with the overall health perceptions of the community¹⁰. Despite the proven effectiveness of screening programs in reducing cancer-related mortality, participation rates remain suboptimal in many populations, which further underscores the importance of understanding the factors that influence these attitudes. For example, studies conducted in countries such as Korea demonstrate an increasing tendency among individuals to adopt a positive attitude toward screening services^{11,12}. These attitudes are closely linked not only to the accessibility of healthcare services but also to individuals' levels of health education. Consequently, factors influencing women's participation in specific screening programs, such as breast cancer screening, include both their health perceptions and the availability of psychosocial support^{13,14}.

Efforts to enhance health perceptions in society and to expand access to screening services are also supported by government policies. Various health organizations conduct campaigns to inform the public about the importance of health screenings and implement initiatives aimed at strengthening social trust to increase the effectiveness of these campaigns¹⁵. Addressing cancer as a societal issue requires coordinated actions at individual, community, and policy levels. In addition, barriers to accessing cancer screening services should be taken into account. In particular, limited access for individuals living in rural areas further exacerbates health inequalities^{12,16}. This situation leads to variability in cancer screening attitudes across different segments of the population, thereby representing a dynamic that broadly influences the healthcare system¹⁷.

The health perceptions and attitudes toward cancer screening among individuals attending Family Health Centers involve the interaction of multiple health-related variables. This interplay not only facilitates participation in cancer screening services but also highlights the impact of health perception on public health¹⁸. Therefore, studies conducted in this area will make a significant contribution to a better understanding of individuals' health perceptions and attitudes toward screening^{19,20}. Raising awareness on these issues within the community is essential for fostering healthier individuals and, consequently, healthier societies.

In conclusion, individuals' health perceptions and attitudes toward cancer screening represent complex dynamics that influence public health. Considering these factors in healthcare delivery is critical for enhancing the efficiency of the health system and improving community health. In this context, efforts to promote health education and raise societal awareness can strengthen preventive health services and facilitate the implementation of more effective screening programs. From this perspective, the present

study was conducted to determine the health perceptions and attitudes toward cancer screening among individuals attending Family Health Centers.

Material and Methods

Design

This study was conducted using a descriptive, cross-sectional, and correlational design. It was completed between January 2025 and August 2025 with the participation of 351 individuals to determine the health perceptions and attitudes toward cancer screening among those attending Family Health Centers. The study was reported in accordance with 'the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) statement'.

Population and Sampling

The study population consisted of adult individuals receiving treatment and follow-up at a Family Health Center in Muğla. Participants were recruited exclusively from this center. A non-probability sampling method, specifically the snowball sampling technique, was employed within the study setting. Initially, eligible participants who attended the Family Health Center were invited to participate in the study. These participants were then asked to recommend other individuals from the same center who met the inclusion criteria, allowing the sample to expand through a chain-referral process. Individuals aged 18 years and older, willing to participate in the study, and without any communication difficulties were included. Those with previously diagnosed psychiatric disorders were excluded. A post hoc power analysis was conducted using G*Power (version 3.1.9.7) to evaluate the statistical power of the study sample. The significance level (α) was set at 0.05. Assuming a medium effect size ($d=0.50$), the total sample size of 351 patients yielded a statistical power of greater than 95%.

Data Collection

Data for the study were collected between January and August 2025 from adult individuals receiving treatment and follow-up at a Family Health Center in Muğla. Participants were informed about the study objectives in the patient room, and verbal consent was subsequently obtained. They were assured that they could withdraw from the study at any time and that all collected data would be kept confidential. Data were gathered using a Personal Information Form, the Health Perception Scale, and the Attitude Scale for Cancer Screening. The administration took approximately 20–25 minutes, allowing participants sufficient time to respond carefully to the questions, thereby supporting the validity and reliability of the collected data. At the end of the data collection process, participants received thanks for their contribution to the study.

Instruments

The study's data were collected using a personal information form, the health perception scale and the attitude scale for cancer screening.

Personal Information Form

The form assessed participants' socio-demographic characteristics (marital status, gender, place of residence, age, education level), health history (smoking and alcohol use, presence of chronic diseases, personal history of cancer, and occurrence of cancer among first-, second-, or third-degree relatives), as well as their knowledge about cancer and attitudes toward cancer screening (awareness of cancer, being informed about cancer screenings, and history of undergoing screening). The form consisted of a total of 16 questions. This form was developed by the researchers based on information available in the literature^{2,7,21}.

Attitude Scale for Cancer Screening

The Attitude Scale for Cancer Screening was developed by Yıldırım, Öztürk, and colleagues (2020), Which its has confirmed validity and reliability for the Turkish language²². The scale consists of 24 items and a single dimension, using a five-point Likert-type response format. Items are scored on a scale from 1 to 5 as follows: '5: Strongly agree, 4: Agree somewhat, 3: Neither agree nor disagree, 2: Disagree somewhat, 1: Strongly disagree.' The administration of the scale should be conducted in such a way that the researcher observes the participant while the participant independently reads and responds to the items. With an appropriate sample and administration method, the scale can be used whenever measurement of attitudes toward cancer screening is required. The total score ranges from 24 to 120, with no predefined cut-off point. Scores closer to 24 indicate a more negative attitude toward cancer screening, whereas scores approaching 120 reflect a more positive attitude. In the validity and reliability study, the scale demonstrated a Cronbach's alpha of 0.95²². In this study, it was found as 0.88.

Health Perception Scale

The Health Perception Scale was developed by Diamond and colleagues in 2007²³. Its Turkish validity and reliability were established by Kadioğlu and Yıldız in 2012²⁴. Health Perception Scale: The Health Perception Scale consists of 15 items and four subdimensions (Certainty, Locus of Control, Self-Awareness, and Importance of Health) and uses a five-point Likert-type response format. Possible scores on the scale range from 15 to 75. A high score indicates a high perception of health, while a low score indicates a low perception of health. The original validity and reliability study of the scale showed a Cronbach's alpha value of 0.77²⁴, for this study, it was found as 0.78.

Data Analysis

Data obtained from the study were analyzed using SPSS 26.0. Normal distribution of the data was determined using the Kolmogorov-Smirnov test. Descriptive statistics were used in the study, independent sample t-tests were used to examine differences between groups, and Pearson correlation analyses were used to assess the relationship between health perception and attitudes toward cancer screening. Correlation tests were used to determine the relationship between variables.

Ethical Approval

The study was conducted with the approval of the Non-Interventional Clinical Research Ethics Committee of Istanbul Aydın University (Date: December 25, 2024; Decision No: 136/2024). During data collection, personally identifiable information such as names and surnames was not recorded, and all data were analyzed anonymously. The research was carried out in accordance with the ethical principles outlined in the 'Declaration of Helsinki'.

Results

The mean age of the participants was 43.42 ± 13.90 years. The majority of the participants were female (59.8%). Most individuals reported having an income equal to their expenses (62.1%). In terms of educational level, the largest proportion had a university degree or higher (35.3%). Regarding occupational status, workers constituted the largest group (26.8%).

A considerable majority of participants did not engage in regular exercise (78.6%). Similarly, most participants reported not smoking (65.2%) and not consuming alcohol (81.8%) (Table 1).

Table 1. Socio-Demographic Characteristics of Patients (n=351)

Characteristics	Mean	SD
Age (Years)	43.421	13.908
	n	%
Gender		
Female	210	59.8
Male	141	40.2
Economic Status		
Income < expenses	102	29.1
Income = expenses	218	62.1
Income > expenses	31	8.9
Occupation		
Civil Servant	54	15.4
Retired	78	22.2
Worker	94	26.8
Housewife	69	19.7
Student	12	3.4
Unemployed	44	12.6

Education Level		
Literate	12	3.4
Primary School	66	18.8
Middle School	48	13.7
High School	101	28.8
University or above	124	35.3
Alcohol Consumption		
Yes	64	18.2
No	287	81.8
Smoking		
Yes	122	34.8
No	229	65.2
Regular Exercise Status		
Yes	75	21.4
No	276	78.6

Of the participants, 40.2% had a diagnosed chronic disease, compared to 59.8% did not have any chronic conditions. Regarding types of chronic diseases, the breakdown showed 9.4% hypertension, 4.6% thyroid disorders, 10.3% asthma, 9.1% diabetes mellitus, 6.8% heart disease, 1.4% COPD, 2.8% psychiatric disorders, and 10.6% a cancer diagnosis. More than half of the participants reported not having a family member or someone in their social circle diagnosed with cancer (56.4%). A majority stated that they were informed about cancer (67.5%); however, most participants reported a lack of knowledge regarding cancer screening (57.6%). A considerable proportion of participants had never undergone any cancer screening (60.1%). Among screening methods, mammography (12.9%) and Pap smear (10.5%) were the most commonly reported. Health professionals were identified as the primary source of cancer-related information (37.9%), followed by relatives or close social circles (18.8%) (Table 2).

Table 2. Diagnosis and Treatment Characteristics of Patients (n=351)

Characteristics	Mean n	SD %
Chronic Disease Status		
Yes	141	40.2
No	210	59.8
Chronic Disease Diagnosis*		
Hypertension	33	9.4
Thyroid Diseases	16	4.6
Asthma	36	10.3
Diabetes Mellitus	32	9.1
Heart Diseases	24	6.8
COPD	5	1.4
Psychiatric Diseases	10	2.8
Cancer	37	10.6
Having a family member or social circle diagnosed with cancer		
Yes	153	43.6
No	198	56.4

Being Informed About Cancer Diagnosis		
Yes	237	67.5
No	114	32.5
Cancer Screening Information		
Yes	149	42.4
No	202	57.6
Cancer Screening Information		
Yes	140	39.9
No	211	60.1
Cancer Screenings Performed*		
Breast Ultrasound	15	4.3
Colonoscopy	15	4.3
Pap Smear	37	10.5
HPV Screening	5	1.5
Mammography	45	12.9
Fecal Occult Blood Test	26	7.4
Cancer Information Sources*		
Healthcare Professionals (Doctors, Nurses)	133	37.9
Social Media	65	18.5
Relatives	66	18.8
I am a healthcare professional myself	13	3.7
Internet	41	11.7

* **Marked more than once.**

The mean score of the participants on the Attitude Scale for Cancer Screening was 74.64 ± 15.89 . The total mean score on the Health Perception Scale was 38.17 ± 8.21 . Regarding the subdimensions of the Health Perception Scale, the mean scores were as follows: Locus of Control, 15.20 ± 5.33 ; Self-Awareness, 6.47 ± 1.99 ; Certainty, 10.75 ± 3.46 ; and Importance of Health, 5.74 ± 1.83 (Table 3).

Table 3. Patients' Health Perception Scale and Attitude Scale for Cancer Screening (n=351)

Scales	Mean	SD	Min-Max
Attitude Scale for Cancer Screening	74.64	15.89	24-120
Health Perception Scale	38.17	8.21	15-58
Control Center Subscale	15.20	5.33	5-25
Self-Awareness Subscale	6.47	1.99	3-12
Certainty Subscale	10.75	3.46	4-20
Importance of Health Subscale	5.74	1.83	3-12

When examining the relationships between scale scores in the study, a significant positive correlation was found between the total scores of the Attitude Scale for Cancer

Screening and the Health Perception Scale ($r=0.350$, $p<0.001$). Significant positive correlations were also observed between attitudes toward cancer screening and the subdimensions of the Health Perception Scale: Locus of Control ($r=0.285$, $p=0.001$), Self-Awareness ($r=0.177$, $p=0.001$), Certainty ($r=0.205$, $p<0.001$), and Importance of Health ($r=0.160$, $p=0.003$). The total score of the Health Perception Scale demonstrated strong and significant correlations with all its subdimensions (Locus of Control $r=0.844$; Self-Awareness $r=0.331$; Certainty $r=0.702$; Importance of Health $r=0.336$; all $p<0.001$). Additionally, the subdimensions exhibited significant correlations with each other at varying levels. On the other hand, no statistically significant relationship was found between age and any of the scale scores ($p>0.05$) (Table 4).

Table 4. Correlation analysis results (n=351)

		1.	2.	3.	4.	5.	6.
1. Attitude Scale for Cancer Screening	r	1					
	p						
2. Health Perception Scale	r	0.350	1				
	p	<0.001					
3. Control Center Subscale	r	.285	.844	1			
	p	.001	<0.001				
4. Self-Awareness Subscale	r	.177	.331	-.008	1		
	p	.001	<0.001	.885			
5. Certainty Subscale	r	.205	.702	.434	.024	1	
	p	<0.001	<0.001	<0.001	.653		
6. Importance of Health Subscale	r	.160	.336	.058	.368	-.036	1
	p	.003	<0.001	.275	<0.001	.505	
7. Age (years)	r	.011	-.044	-.072	-.079	.090	-.070
	p	.841	.442	.187	.143	.098	.197

* $p<0.05$ ** $p<0.01$; Pearson correlation test.

When participants' scale scores were examined according to certain socio-demographic and health characteristics, no significant differences were found between genders for the Health Perception Scale (female: 38.43 ± 7.79 , male: 37.77 ± 8.84 ; $p=0.458$) or the Attitude Scale for Cancer Screening (female: 74.68 ± 8.71 , male: 74.52 ± 13.53 ; $p=0.868$). Mean scores of both scales were similar between individuals with and without chronic diseases ($p>0.05$). Although participants with a family or social contact diagnosed with cancer had higher health perception scores (39.03 ± 7.38), this difference was not statistically significant ($p=0.089$). Participants who reported having knowledge about cancer had significantly higher health perception scores (38.91 ± 8.21) compared to those without such knowledge (36.75 ± 7.98 ; $p=0.021$). Similarly, participants knowledgeable about cancer screenings had higher health perception scores (39.41 ± 7.96) than those without knowledge, and this difference was statistically significant ($p=0.015$). In contrast, no significant differences were observed in attitudes toward cancer screening based on these variables ($p>0.05$), (Table 5).

Table 5. Mean Scores of Health Perception and Attitudes for Cancer Screening According to Certain Participant Characteristics (n=351)

Characteristics		Health Perception Scale	Attitude Scale for Cancer Screening Scale
		Mean±SD	Mean±SD
Gender			
	Female	38.438±7.792	74.682±8.717
	Male	37.771±8.840	74.522±13.530
t		.743	.166
p		.458	.868
Chronic Disease Status	Yes	38.446±7.884	73.595±14.692
	No	38.000±8.437	75.347±16.654
t		.499	-1.012
p		.618	.312
Having a family member or social circle diagnosed with cancer	Yes	39.033±7.384	75.666±13.678
	No	37.520±8.777	73.762±17.433
t		1.703	1.105
p		.089	.270
Being Informed About Cancer Diagnosis	Yes	38.915±8.215	75.063±15.345
	No	36.752±7.982	73.938±17.006
t		2.324	.619
p		0.021	0.536
Cancer Screening Information	Yes	39.416±7.969	73.718±14.290
	No	37.255±8.323	75.125±16.772
t		2.443	-0.825
p		0.015	.410

t=t-Test.

According to the regression analysis results presented in Table 6, the total score of the Health Perception Scale significantly predicted the total score of the Attitude Scale for Cancer Screening ($R = 0.350$, $R^2 = 0.123$, Adjusted $R^2 = 0.120$, $F = 48.808$, $p < 0.001$). These findings indicate that an increase in individuals' health perception is associated with the development of more positive attitudes toward cancer screening. Approximately 12.3% of the variance in attitude scores toward cancer screening is explained by health perception. Examination of the regression coefficients revealed that health perception has a positive and significant effect on attitude ($\beta = 0.350$, $p < 0.001$). Additionally, the Durbin-Watson statistic was 1.998, indicating that there was no autocorrelation problem in the model (Table 6).

Table 6. The Effect of Individuals' Health Perception on Their Attitudes for Cancer Screening (n=351)

	B	Standard Error	Standard Beta (β)	t	p	95.0% CI	
Constant	48.754	3.790		12.862	.000	41.299	56.208
Health Perception Scale Total Score	.678	.097	.350	6.986	.000	.487	.869
Dependent Variable: Attitude Scale for Cancer Screening Scale Total Score							
R=0.350, R ² =0.123, Adjusted R ² =0.120, F=48.808, p<0.001, Durbin Watson=1.998 (1.5-2.5)							

Discussion

This study examined the relationship between health perception and attitudes toward cancer screening among individuals attending a family health center and found that health perception significantly predicted screening attitudes. The findings indicate that higher levels of health perception are associated with more positive attitudes toward cancer screening. Regression analysis revealed that approximately 12% of the variance in cancer screening attitudes could be explained by health perception, highlighting it as a notable determinant of screening behavior. Recent studies support these findings. For example, a systematic review conducted in Ethiopia by Yirsaw et al. (2024) demonstrated that women with higher perceived risk, based on the Health Belief Model, were approximately 3.8 times more likely to participate in cervical cancer screening²¹. This indicates that individuals' health perception serves as a strong determinant of screening behaviors. Similarly, a study conducted in the United States by Asare et al. (2024) demonstrated that knowledge, awareness, and health perception play a significant role in participation in cervical cancer screening¹¹. These findings are consistent with the results of our study and indicate that health perception plays a key role not only at the particular level but also at the societal level in promoting screening behaviors. Recent evidence further suggests that interventions targeting perceived susceptibility and perceived benefits significantly improve screening uptake, reinforcing the central role of health perception in preventive health behaviors. Another noteworthy finding of our research was that individuals who had knowledge about cancer demonstrated significantly higher health perception scores. This suggests that knowledge enhances health perception and positively contributes to screening behaviors, a result that is also supported by the existing literature. Asare et al. (2024) emphasized that knowledge and awareness are fundamental determinants of participation in cervical cancer screening and highlighted that health literacy is a critical factor influencing screening uptake¹¹. Therefore, it can be suggested that programs aimed at improving health literacy may also enhance individuals' health perception and encourage participation in screening programs. In line with recent public health approaches, improving health literacy has been identified as a key strategy to reduce disparities in cancer screening participation.

It was noteworthy that a significant proportion of participants (60.1%) had never undergone any cancer screening. Benavidez et al. (2021) reported that only half of

women in the United States met the screening criteria recommended by the USPSTF⁷. This indicates that low participation in cancer screening is not unique to Turkey, but is a global concern. The low screening rates observed in our study may be attributed to factors such as lack of knowledge, insufficient awareness, barriers to accessing healthcare services, and time management challenges. In a systematic review, Yirsaw et al. (2022) highlighted that fear, anxiety, embarrassment, and concern about diagnosis are among the factors negatively affecting screening participation, suggesting that engagement in screening is influenced not only by cognitive but also by emotional processes²¹. Recent studies also emphasize structural barriers such as accessibility of services and appointment systems as critical determinants of screening participation^{25,26}.

In our study, no significant relationship was found between socio-demographic variables and screening attitudes. This finding suggests that attitudes toward cancer screening are influenced not only by demographic factors such as age, gender, or education, but more substantially by health perception, knowledge levels, and psychosocial factors. Similarly, a review by Calderon et al. (2022) demonstrated that key determinants shaping screening behaviors include health perception, health beliefs, social support, and emotional barriers²⁷. This finding indicates that health policies should not focus solely on specific demographic groups, but rather develop comprehensive strategies aimed at enhancing health perception across the entire population and reducing psychosocial barriers.

In our study, the most frequently consulted source of information by participants was healthcare professionals (37.9%). This finding highlights the critical role of healthcare workers in disseminating information and raising awareness within the community. Similarly, the literature indicates that guidance and education provided by healthcare professionals positively influence individuals' screening behaviors. Deatrack et al. (2022) emphasized that systematic risk assessments offered by healthcare providers to families not only enhance knowledge levels but also strengthen participation in screening programs¹⁴. Accordingly, providing continuous in-service training on cancer screening for healthcare professionals working in family health centers would facilitate individuals' access to reliable information and is expected to increase participation rates. Moreover, patient-provider communication has been identified as one of the most influential factors in improving adherence to preventive screening recommendations.

Among the strengths of this study is the simultaneous assessment of health perception and attitudes toward cancer screening within the same sample. This approach provides a comprehensive perspective on the relationship between health perception and screening behaviors. Additionally, the inclusion of participants from diverse socio-demographic backgrounds enhances the variability of the results, thereby increasing the study's value.

Limitations

The limitations of the study should also be considered. First, the cross-sectional design of the study does not allow for establishing a causal relationship between health

perception and screening attitudes. Additionally, conducting the research with only individuals attending a single family center in Muğla limits the generalizability of the findings to the broader population of Turkey. The self-reported nature of the data collection may also introduce risks of recall bias and social desirability bias.

Conclusion

In conclusion, this study demonstrates that health perception has a significant effect on attitudes toward cancer screening. The findings suggest that interventions aimed at strengthening health perception, increasing individuals' knowledge, and reducing psychosocial barriers could enhance participation in cancer screening. Therefore, comprehensive educational programs, community awareness campaigns, and psychosocial support interventions implemented at family health centers may play a critical role in improving the effectiveness of cancer screening programs. Future research using larger samples and longitudinal designs across different regions will provide a more detailed understanding of changes in health perception over time and their effects on screening behaviors.

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