

The barriers to colorectal cancer screening tests among adults attending Seremban health clinic in Negeri Sembilan, Malaysia

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ABSTRACT

Introduction: Colorectal cancer (CRC) is the second most common cancer in Malaysia, with most cases diagnosed at late stages, leading to poor survival. Stool-based screening methods, like the immunological faecal occult blood test (iFOBT), can reduce CRC mortality, but national uptake remains below 3%. This study explores barriers to CRC screening and their association with sociodemographic factors among adults aged 50 and above attending Seremban Health Clinic.

Materials and Methods: A cross-sectional study was conducted in March 2025 at Seremban Health Clinic, Negeri Sembilan, involving 400 adults aged 50 and above. Participants were selected through purposive sampling and completed a self-administered questionnaire adapted from the Scottish Bowel Screening Programme. Data analysis was performed using IBM SPSS version 28.0, with statistical methods including multiple linear regression.

Results: The most frequently reported barriers included low self-efficacy, unfamiliarity with screening procedures, emotional concerns, and negative perceptions of screening. Age, gender, education level, employment status, and previous experience on cancer screening were found to have significant associations with barriers to cancer screening. Respondent's belief in early detection, a sense of health responsibility, and encouragement from healthcare providers and family were identified as facilitators to cancer screening. Prior screening experience was linked to fewer barriers.

Conclusion: Findings indicate the need for targeted interventions to improve awareness, confidence, and attitudes toward screening.

KEYWORDS:

Barriers, Colorectal cancer, Screening, Malaysia

INTRODUCTION

Colorectal cancer (CRC) is the second most common cancer in Malaysia represented for 14.1% of all newly diagnosed

cancer cases from 2017 to 2021, increasing from 13.5% between 2012 and 2016.^{1,2} In Malaysia, which is multiethnic country CRC is a great burden as most CRC patients are detected at a late stage such as stage 4 or 5, with a 5-year relative survival rate lower than that of developed Asian countries.³ Moreover, due to a lack of cancer awareness and other barriers to screening, nearly 80% of cancer patients requested treatment when they were already in the late stages.^{4,5}

Stool-based tests, such as the guaiac Faecal Occult Blood Test (gFOBT) and the immunological faecal occult blood test (iFOBT), are suggested for CRC screening in asymptomatic individuals. It has been suggested that iFOBT screening could reduce CRC mortality by as much as 70%.⁶ In 2014, the Ministry of Health (MOH) launched a nationwide CRC screening program utilising iFOBT kits. This screening is available at public health clinics through an opportunistic approach. It is currently offered to all asymptomatic males and females aged 50 to 75 who visit the clinics. Patients receive a stool container and are asked to return a stool sample to the health clinic for analysis at the laboratory. Patients who receive positive results are referred to the nearest public hospital for a colonoscopy.⁶

Since its introduction, there has been a gradual increase in screening rates; however, the CRC screening uptake in the target population is still less than 3%, which is at a sub-optimal level.^{7,8}

A cross-sectional study in 44 health clinics in West Malaysia found extremely low knowledge and attitude towards CRC screening in the moderate risk group.⁴ In addition, research by Yusoff et al. in 2012 found that only 7% of almost 2000 healthy respondents knew about CRC screening.⁹ The main barriers to screening participation identified were embarrassment and anxiety, reflecting psychological obstacles.⁹ Another study done in Malaysia's Klang Valley found low awareness of CRC among urban Malaysians, with many unable to recall its warning signs.¹⁰

A key outcome from another Malaysian study showed increased public awareness of the significance of CRC

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screening, where 91.3% of respondents agreed that screening tests can detect cancer early, while 86.3% agreed that late detection leads to a lower survival rate.¹¹

Moreover, some recent research conducted in Al-Baha, Saudi Arabia, and Southern Italy showed low adherence to and awareness of CRC screening. 20.3% of Italians were aware of all screening tests, and 29.2% had completed FOBT; education and medical advice were important contributing factors. 49.7% of Al-Baha residents were aware that CRC could be identified early, but only 2.8% had undergone screening, indicating the necessity for focused education.¹²⁻¹³

Prior studies reveal persistently low CRC screening rates nationwide, with an uptake below 3% among the target population. Factors such as fear, embarrassment, lack of awareness, and inadequate health counselling have consistently contributed to low participation rates in CRC screening.^{9,14} Recent qualitative studies have identified specific barriers and facilitators, such as trust in healthcare providers and the need for culturally adapted screening instructions, suggesting that enhanced education and trust-building measures could play vital roles in increasing screening uptake.^{6,8} In addition, recent behavioural research on CRC screening has highlighted the importance of self-efficacy, perceived benefits of screening, social support, and culturally appropriate communication in influencing screening participation.^{6,8}

To better understand the factors influencing CRC screening participation, behavioral science frameworks have increasingly been used to examine screening uptake. The Integrated Screening Action Model (I-SAM) is a screening-specific framework that recognizes screening behavior as being influenced by multiple interacting factors, including self-efficacy, beliefs about screening effectiveness, practical and emotional barriers, social influences, and existing health conditions.¹⁵ By categorizing barriers and facilitators into distinct behavioral domains, I-SAM provides a structured approach for understanding determinants of screening participation and identifying potential targets for intervention. As the questionnaire used in this study was developed based on the I-SAM framework, this model was adopted to guide the assessment and interpretation of barriers and facilitators to CRC screening.

Despite these insights, there remains a need for a localized understanding of how socio-demographic factors impact screening barriers. The objectives of this study also aim to provide a comprehensive understanding of barriers to access CRC screening, specifically adults attending Seremban Health Clinic.

MATERIALS AND METHODS

This cross-sectional study was conducted at Seremban Health Clinic in March 2025 among Adults (aged 50 and above) who attended Seremban health clinic, Malaysia. Our exclusion criteria include people below the age of 50, non-Malaysians, population diagnosed with colorectal cancer, mental illnesses, or who are blind, deaf, and/or dumb, and medical doctors were excluded from the study. The questionnaire was

adapted from a survey used in a cross-sectional study conducted among the participants of the Scottish Bowel Screening Programme in 2022.¹⁵

Simple random sampling was used for data collection. The population size for adults aged 50 and above in Seremban is approximately 138,000 as of 2023.¹⁶ Based on a rate of 70.9% of urban respondents with awareness of at least one CRC symptom,¹⁰ and a 95% confidence level, the sample size required was 317 using the OpenEpi calculator. Considering an 80% response rate, the modified sample size was $317 / 0.80 = 396.25$ (~ 397). Therefore, a total of 400 individuals were targeted.

We used purposive sampling to recruit the required number of individuals who presented for CRC screening at Seremban Clinic. Eligible respondents were approached consecutively and invited to participate until the target sample of 400 was reached. Recruitment occurred during routine clinic hours over the study period, with refusals and reasons recorded and replaced by the next eligible patient.

Questionnaire validation

The questionnaire was adapted from the previous study.¹⁵ The questionnaire was culturally adapted to ensure clarity and relevance in the Malaysian context. It was translated into Malay, English, and Tamil using a forward-backward translation procedure. Forward translations were carried out by bilingual experts, followed by back-translation into the original language by independent translators. Any discrepancies were reviewed and resolved to ensure equivalence in meaning across all versions. Face validity was assessed through expert review and pilot testing among 30 respondents to confirm the clarity and appropriateness of the items. Internal consistency reliability, assessed from the pilot study, showed strong reliability for the barrier items (Cronbach's alpha=0.918).

Statistical Analysis

Statistical analysis was done using IBM SPSS version 28.0. Responses to each barrier item were measured using a 5-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). Barrier items were grouped into seven thematic domains according to the Integrated Screening Action Model (I-SAM) as done by the questionnaire's developer.¹⁵ For barriers, the domains comprised low self-efficacy, low perceived screening test efficacy, practical barriers, emotional barriers, fatalism, lack of social support, and comorbidities. For each domain, a mean domain score was calculated by averaging the scores of all items within that domain, with higher scores indicating stronger perceived barriers. Multiple linear regression analyses were performed to identify sociodemographic predictors for each barrier domain. Statistical significance was set at $p < 0.05$ for all tests.

Ethical considerations

The Ministry of Health Malaysia (MOH) has provided ethical approval for this study on 31 December 2024 with NMRR ID-24-02972-LNE. All personal information provided by participants was kept strictly confidential, and patient identities were anonymized in the final report. Informed consent was obtained from all participants prior to data

Table I: Barrier's domains based on mean Likert scores

Barrier Domain	Mean	Standard deviation
Low self-efficacy	2.914	1.047
Low perceived screening test efficacy	2.509	0.894
Practical barriers	2.385	0.833
Emotional barriers	2.305	0.857
Fatalism	2.297	0.903
Lack of social support	1.991	0.624
Comorbidities	1.938	0.736

collection. The research was carried out in accordance with the principles outlined in the Declaration of Helsinki.

RESULTS

In this study, a total of 400 participants completed the questionnaire. Most participants involved in this study ranged between 60-69 years of age and were females. The predominant ethnicity was Chinese (45.8%), followed by Indians (39.3%), preceding Malays (14.5%). More than half of them had completed secondary education and were retired at the time. For those who had undergone screening previously, government hospitals have been the choice of institution. Although around 85% of the participants had not undergone screening tests for colorectal cancer previously, it is evident that the majority believed the screening test to be easy and were willing to undergo the test if deemed required. The primary reasons for refusing CRC screening were shown in Figure 1, ranked from highest to lowest mean score of individual questionnaire item. The main reasons reported by the respondents were being unsure about where to get the test (3.030 ± 1.228), unfamiliarity with the test (2.760 ± 1.208), being worried about the test results (2.840 ± 1.391), being unsure how to take the stool sample (2.760 ± 1.208), perceiving that the test was not necessary (2.72 ± 1.306), anxiety about screening (2.690 ± 1.328), and insufficient staff to test (2.680 ± 1.087).

Barriers were further categorized into 8 thematic domains according to I-SAM, as shown in Table I. The strongest barrier category to CRC screening was low self-efficacy, followed by low perceived screening test efficacy and practical barriers. The lowest-scoring barrier domains lack of social support and comorbidities.

Multiple linear regression analyses were performed to examine the association between sociodemographic factors and different domains of barriers to CRC screening in Tables II and III. Overall, the sociodemographic variables accounted for 6% to 16% of the variation observed across the different CRC screening barrier domains. The assumptions of multiple linear regression were assessed before interpreting the model. The normality of the regression residuals was assessed using the Shapiro-Wilk test and normal P-P plot. Although the Shapiro-Wilk test was statistically significant ($p < 0.001$), indicating some deviation from normality, the points on the normal P-P plot closely followed the diagonal line, suggesting that the deviation was not substantial. The independence of residuals was assessed using the Durbin-Watson statistic, which ranged from 1.20 to 1.40 across the different barrier domains. Given the cross-sectional study

design, with one observation contributed by each participant, independence was primarily supported by the study design. Homoscedasticity was assessed by examining a scatterplot of standardized residuals against standardized predicted values. Multicollinearity was assessed using tolerance and variance inflation factor (VIF) values; all predictors had tolerance values > 0.20 and VIF values < 5 , indicating no evidence of problematic multicollinearity.

The Enter method was used, whereby sociodemographic variables (age, gender, ethnicity, education, employment, previous cancer screening) identified a priori were entered into the regression model simultaneously. Variables were selected based on their relevance to CRC screening behaviour and barriers, rather than on statistical significance during variable selection.

For each categorical variable, one category was designated as the reference category, and the remaining categories were compared with this reference category. The reference categories were selected based on their conceptual relevance. Female was used as the reference category for sex, while primary education was used for education, Indian for ethnicity, unemployed for employment status, and no previous experience for history of cancer screening. Age was entered into the model as a continuous variable, with a median age of 65 years (IQR=14 years).

The findings showed that comorbidities were not significantly associated with any of the barrier domains. Gender emerged as a significant predictor for all barrier domains except perceived screening test efficacy.

Compared with females, males reported significantly lower practical barrier scores ($B = -0.199$, $p = 0.021$), emotional barrier scores ($B = -0.257$, $p < 0.001$), low self-efficacy scores ($B = -0.407$, $p < 0.001$), fatalism scores ($B = -0.312$, $p = 0.001$), and perceived lack of social support scores ($B = -0.165$, $p = 0.011$). These findings indicate that females experienced greater practical and emotional barriers, lower self-efficacy, higher levels of fatalism, and a greater perceived lack of social support toward CRC screening than males.

Previous cancer screening experience was significantly associated with lower barrier scores across several domains. Participants who had undergone cancer screening previously reported lower practical barriers ($B = -0.039$, $p = 0.001$), lower levels of low self-efficacy ($B = -0.889$, $p < 0.001$), lower fatalistic beliefs ($B = -0.304$, $p = 0.014$), lower perceived barriers related to screening test efficacy ($B = -0.469$, $p < 0.001$), and lower perceived lack of social support ($B = -0.228$, $p = 0.008$).

Table II: Sociodemographic factors associated with practical, emotional barriers, and low self-efficacy

Variable	Practical barriers		Emotional barriers		Low self-efficacy	
	B (95% CI)	p-value	B (95% CI)	p-value	B (95% CI)	p-value
Constant	4.103[3.251,4.955]	<0.001	4.100[3.244,4.956]	<0.001	5.088[4.065,6.110]	<0.001
Age	-0.013[-0.023, -0.004]	0.006*	-0.010[-0.020, -0.001]	0.032*	-0.006[-0.018,0.005]	0.228
Gender	-0.199[-0.368,-0.030]	0.021*	-0.257[-0.611, -0.271]	<0.001**	-0.407[-0.609,-0.206]	<0.001**
Ethnicity	0.053[-0.064,0.170]	0.373	0.910[-0.027,0.209]	0.13	0.113[-0.028,0.253]	0.115
Education	-0.062[-0.183,0.060]	0.318	-0.130[-0.252, -0.007]	0.038*	-0.099[-0.245,0.047]	0.182
Employment	-0.041 [-0.186,0.104]	0.583	-0.074[-0.219,0.720]	0.321	-0.063[-0.237,0.110]	0.473
Previous Cancer screening	-0.390[-0.613,-0.167]	0.001**	-0.189[-0.414,0.35]	0.098	-0.889[-1.157,-0.621]	<0.001**
R square	0.075		0.117		0.159	
F statistic	5.293		8.605		12.244	
Df(regression,residual)	6,391		6,391		6,391	
Model p-value	<0.001		<0.001		<0.001	

*Significant at 0.05, ** significant at 0.01, B: unstandardized coefficient, β: standardized coefficient, CI: confidence interval, P: probability, Df: Degree of freedom

Table III: Sociodemographic factors associated with fatalism, low perceived screening test efficacy, and lack of social support

Variable	Fatalism		Low perceived screening test efficacy		Lack of social support	
	B (95% CI)	p-value	B (95% CI)	p-value	B (95% CI)	p-value
Constant	2.838[1.918,3.758]	<0.001	3.666[2.744,4.588]	<0.001	3.202[2.565,3.838]	<0.001
Age	0.009[-0.001,0.019]	0.082	-0.001[-0.012,0.009]	0.787	-0.006[-0.013,0.001]	0.108
Gender	-0.312[-0.495, -0.13]	0.001**	0.038[-0.145,0.221]	0.684	-0.165[-0.291,-0.038]	0.011*
Ethnicity	0.042[-0.084,0.169]	0.512	-0.045[-0.171,0.082]	0.489	0.047[-0.041,0.134]	0.296
Education	-0.186[-0.317,0.055]	0.006*	-0.013[-0.144,0.119]	0.848	-0.082[-0.173,0.009]	0.076
Employment	-0.008[-0.164,0.149]	0.923	-0.225[-0.382,-0.069]	0.005*	-0.119[-0.227,-0.011]	0.032*
Previous Cancer screening	-0.304[-0.545,0.063]	0.014*	-0.469[-0.711,-0.227]	<0.001**	-0.228[-0.395,-0.061]	0.008*
R square	0.081		0.061		0.076	
F statistic	5.774		4.254		5.328	
Df (regression,residual)	6,391		6,391		6,391	
Model p-value	<0.001		<0.001		<0.001	

*Significant at 0.05, ** significant at 0.01, B: unstandardized coefficient, β: standardized coefficient, CI: confidence interval, P: probability, Df: Degree of freedom

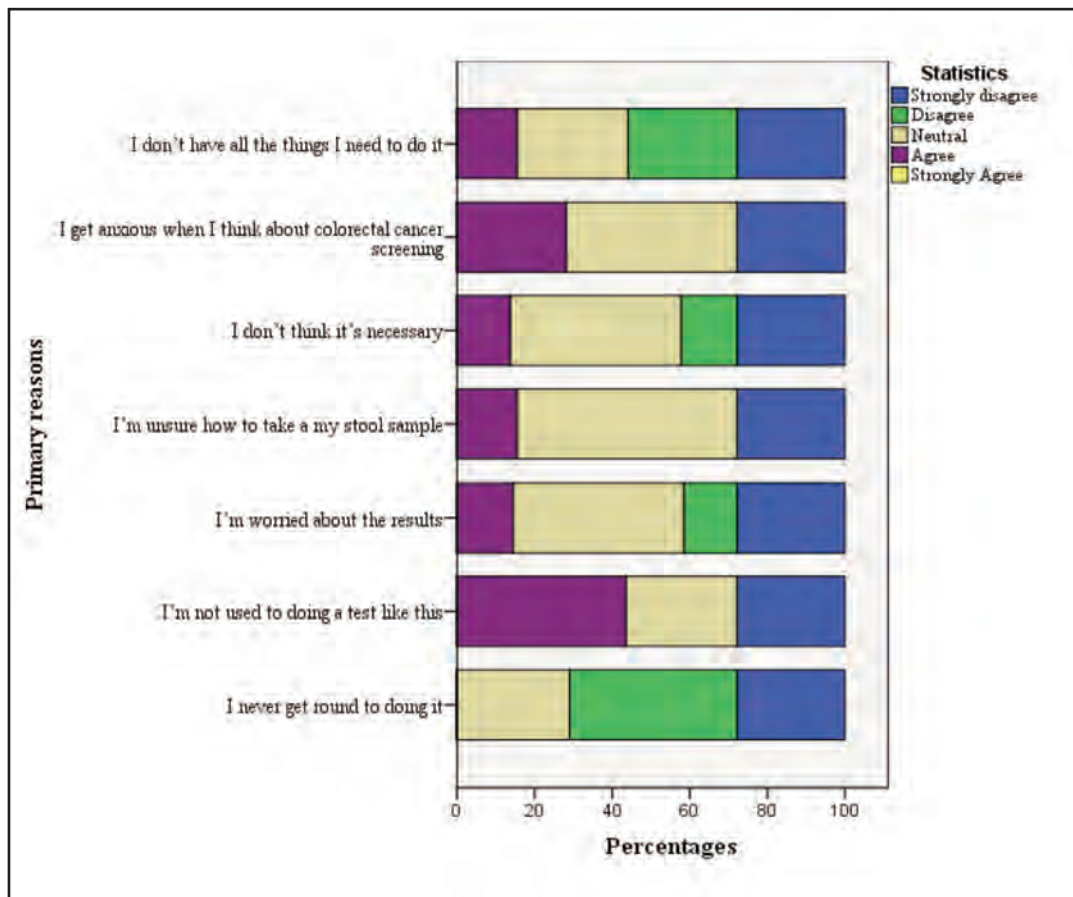


Fig. 1: Primary reasons for refusing CRC screening

compared with those who had never been screened. Previous screening experience was associated with greater familiarity and confidence regarding the screening process, less negative beliefs, greater perceived social support and fewer perceived barriers to CRC screening.

Age was a significant predictor of both practical barriers ($B=-0.199$, $p=0.006$) and emotional barriers ($B=-0.013$, $p=0.006$). These findings indicate that older participants perceived fewer practical and emotional barriers to CRC screening compared with younger participants.

Education was also significantly associated with emotional barriers ($B=-0.130$, $p=0.038$) and fatalism ($B=-0.186$, $p=0.006$). These findings suggest that higher education was associated with lower emotional barriers and lower fatalism, characteristics that have previously been linked with greater CRC screening participation.

Employment status was a significant predictor of perceived screening test efficacy ($B=-0.225$, $p=0.005$) and perceived lack of social support ($B=-0.119$, $p=0.032$). Compared with unemployed individuals, those who were employed or retired reported more favorable perceptions of screening effectiveness and perceived greater social support for CRC screening.

The findings suggest that being male, older age, higher educational attainment, employment, and previous cancer screening experience were associated with more favorable attitudes toward CRC screening and a greater likelihood of screening uptake.

DISCUSSION

This study highlighted those psychological and informational factors are more significant obstacles than logistical or systemic issues in undergoing CRC screening. Low self-efficacy emerged as the dominant barrier category, suggesting that individuals lack confidence in their ability to correctly perform or understand the CRC screening procedure. Additionally, a gap in understanding the importance of early detection underscores the importance of patient empowerment and education in public health strategies for CRC screening. These results align with previous research demonstrating that knowledge gaps, fear of results, and the belief that screening is unnecessary are critical determinants of CRC screening behaviour.⁷ Therefore, addressing a patient's confidence in performing the screening test and the perceived value of the test may have a more profound impact on improving screening uptake than solely focusing on access or cost-related interventions.

There are several other deterrents beyond the seven categories identified by participants. Long waiting times can contribute

to the reluctance to participate, while logistical challenges like transportation and language barriers add another layer of difficulty. A study that explored the barriers to CRC screening in semi-rural Malaysia reported that the most common barriers to CRC screening at clinics were long waiting times and a lack of transport.⁶ These findings are of considerable importance as they offer a comprehensive understanding of the factors that may hinder certain patients from accessing critical screening services. Addressing these barriers could help improve participation rates in CRC screening, which could lead to earlier detection and better health outcomes.

Fatalism, which is a belief system characterized by a perception that serious illnesses like colorectal cancer are predetermined or a natural part of aging, has been perceived significantly in the oldest age group (80 years and above). This sense of inevitability can diminish motivation to undergo the screening test.¹⁷ Together with the complex interplay of factors such as the influence of cultural beliefs in healthcare and varying perceptions of illness that create ethnic disparities in screening barriers, a multifaceted and culturally sensitive approach to shift this perception and emphasize the value of preventive care is required while respecting their individual autonomy, life experiences, and cultural beliefs. This finding may be interpreted through the Health Belief Model (HBM), which suggests that individuals are more likely to engage in preventive health behaviours when they perceive themselves to be susceptible to a disease, recognise its potential severity, and believe that screening can provide meaningful benefits. Recent studies have demonstrated significant associations between HBM constructs, fatalistic beliefs, and CRC screening behaviours, including among Malaysian populations.¹⁸⁻¹⁹ Fatalistic beliefs may reduce perceived benefits and self-efficacy, leading individuals to view screening as unnecessary or ineffective. Therefore, culturally sensitive educational interventions that emphasise the preventable and treatable nature of CRC when detected early may help address these misconceptions. Educational interventions based on HBM principles have been shown to improve CRC screening behaviours.¹⁹ Engagement of community leaders, religious leaders, and culturally tailored health promotion activities may further enhance acceptance of CRC screening across diverse populations.^{6,19}

The doctor-patient relationship may also play an important role in improving CRC screening uptake. In the Malaysian healthcare setting, patients often rely heavily on healthcare providers when making decisions regarding preventive health measures. Consequently, recommendations from doctors may serve as an important cue to action and help overcome uncertainty, misconceptions, and low confidence regarding screening.^{8,18} Opportunistic counselling and proactive recommendations for iFOBT during clinic visits may therefore represent practical strategies for increasing participation in CRC screening programmes.

The findings indicated that male gender, older age, higher educational attainment, employment, and a previous history of cancer screening were associated with lower barriers and a greater likelihood of CRC screening uptake.

Public health narratives that have historically focused more on female-specific cancers, such as breast and reproductive cancers, might lead to comparatively lower awareness of other cancers among women, or the perceived burden of undergoing multiple screening tests may discourage them from participating in low-prioritized cancer screening.²⁰ Although the current study found that male gender was associated with a greater likelihood of CRC screening uptake, more than half of male patients continue to present to healthcare facilities at a late stage of the disease. Despite CRC being one of the most common cancers among Malaysian men, awareness and participation in screening remain suboptimal. This suggests that while men in the study reported fewer barriers to screening, overall awareness and timely screening uptake among the broader male population may still be inadequate.²¹

Furthermore, individuals with lower educational attainment and consequently lower health literacy, as well as unemployed individuals, may have limited access to health information, support systems, and preventive healthcare services. As a result, they may have fewer opportunities to attend regular medical check-ups, receive vaccinations, or participate in cancer screening programmes. Research suggests that people who are not working may also have lower health literacy and less engagement with healthcare systems, which can affect their confidence in navigating screening processes.²² Thus, community-based education, peer support groups, and personalized reminders should be used to improve screening rates in these groups.

Employment status may influence attitudes toward screening and access to supportive social networks that facilitate screening participation. In Malaysia, government employees, particularly those aged 40 years and above, may have greater access to CRC screening through annual health check-ups provided at government health facilities.²³ Similarly, retirees from lower-income households (B40 group) may be eligible for subsidized or free health screening programmes under government healthcare initiatives.²⁴ These opportunities may increase awareness of CRC screening and reduce barriers to participation.

Notably, people who had done the screening test before reported fewer barriers overall. This finding is consistent with a study among the Saudi population, where participants who had not undergone any previous CRC screening reported more barriers compared to those who had previously screened.¹³ Participants with previous screening experience also reported greater confidence in their ability to complete the test and were less worried about the results or the process. Therefore, based on previous evidence, providing clear information and adequate support when individuals are first invited to participate in CRC screening may help improve their screening experience and encourage future participation. While the present study focused on barriers related to participation in CRC screening, the effectiveness of screening programmes also depends on timely diagnostic follow-up after a positive screening result. Barriers such as limited colonoscopy availability, prolonged waiting times, and incomplete follow-up may affect the overall effectiveness of CRC screening programmes, particularly in opportunistic

public sector settings. These factors were beyond the scope of the present study and warrant further investigation in future research evaluating the entire CRC screening pathway.

The significance of perceived test efficacy in shaping health behaviour is emphasised in our study, in line with earlier research that emphasises the part perceived benefits play in screening uptake.²⁵ Internal motivation and expectations of favourable results are also important factors that influence CRC screening participation.²⁵

The process of identifying these barriers among clinic-attending patients was predicated on the assumption that they were aware of the availability of screening tests and knew where to access them. Implementing a more proactive strategy, such as establishing information booths or using visual content on social media platforms, may be more effective in increasing awareness and promoting screening uptake among the older population. The fundamental challenge underpinning the effort to enhance CRC screening uptake by the targeted population is the widespread lack of awareness about the risk factors of CRC and the fact that it can remain asymptomatic until advanced stages. In Malaysia, March is designated as “CRC Awareness Month” to implement focused and coordinated educational campaigns, aligned with the national strategic plan, aimed at increasing public awareness and encouraging early screening. There is limited research on colorectal cancer screening in Malaysia, so the findings from this study offer important insights that could help improve screening rates across various population groups. This, in turn, supports national initiatives aimed at lowering colorectal cancer mortality.

LIMITATIONS

Since this is a cross-sectional study, the results cannot establish cause-and-effect relationships, nor can they track changes in behavior over time. In addition, this study was conducted at a single health clinic in Seremban. Participants were recruited exclusively from clinic attendees, who may be more health-conscious and more engaged with healthcare services than the general population. The use of purposive sampling and a single-centre study design may limit the generalizability of the findings to the broader population. In addition, the study may underestimate barriers experienced by individuals who are less likely to access or attend healthcare facilities.

CONCLUSION

This study highlights that psychological and informational barrier, such as fear, low confidence, and lack of knowledge, are the primary obstacles to CRC screening among adults aged 50 and above attending Seremban Health Clinic. The findings underscore the importance of proactive and sustained efforts to increase awareness, correct misconceptions, and normalize CRC screening as a routine part of preventive healthcare. Ultimately, fostering a culture of early detection through informed and confident participation is essential in reducing the burden of colorectal cancer in Malaysia.

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