Postprint: Current Status and Influencing Factors of Intention for Stroke High-Risk Screening Among Community Residents in Guangdong Province

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Abstract

Background The high-risk stroke screening program is a health initiative being vigorously promoted in China; however, in practice, residents' participation rate has been found to be low, seriously affecting screening efficacy. Screening intention is an important predictor of screening behavior, yet research on residents' screening intention and its influencing factors is scarce. Objective To investigate the current status of community residents' intention to undergo high-risk stroke screening and to explore the factors influencing this intention. Methods From March to May 2022, a convenience sample of 648 residents from Guangdong Province was surveyed using a questionnaire that included a general information form, Stroke High-Risk Screening Intention Scale, Stroke Health Knowledge Scale, Community Medical Service Trust Scale, and Perceived Social Support Scale. Statistical analyses including descriptive analysis, t-test, one-way ANOVA, and multiple linear regression analysis were conducted. Results A total of 600 valid questionnaires were collected (92.6%). The mean score for residents' high-risk stroke screening intention was (101.30$±$14.98), indicating a relatively high level. Specifically, 352 residents (58.67%) demonstrated high screening intention, while 248 residents (41.33%) showed moderate or low intention. Multiple linear regression analysis revealed that gender, presence of hypertension, presence of hyperlipidemia, whether the community had previously conducted high-risk stroke screening, perceived lifetime risk of stroke, perceived social support score, community medical service trust score, and stroke health knowledge level score were significant influencing factors of residents' screening intention ($P<0.05$). Conclusion It is recommended that communities focus particular attention on male residents with lower screening intention, strengthen health education on stroke knowledge especially regarding risk factors, and help

residents develop a scientific understanding of their personal stroke risk and the importance of high-risk screening. At the national level, investment in screening equipment and medical facilities should be increased, healthcare workforce development should be prioritized, and communities' capacity for high-risk stroke screening should be effectively enhanced to strengthen residents' trust in community medical services. Additionally, the facilitating role of social support on screening intention should be emphasized, societal-level publicity should be expanded, an atmosphere of universal participation in screening should be cultivated, and residents' intention to participate in high-risk stroke screening should be effectively improved.

Full Text

Preamble

Title: Residents' Intention Status and Influencing Factors for Stroke High-risk Screening in Guangdong

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Abstract

Background: The stroke high-risk screening project is a major health initiative being vigorously promoted in China. However, actual implementation has revealed low resident participation rates, which seriously affects screening efficacy. Screening intention is an important predictor of screening behavior, yet few studies have examined residents' screening intention and its influencing factors.

Objective: To evaluate community residents' intention regarding stroke high-risk screening and explore the factors influencing this intention.

Methods: From March to May 2022, 648 residents of Guangdong were conveniently sampled for a questionnaire survey covering general information, stroke high-risk screening intention scale, stroke health knowledge scale, community

medical service trust scale, and perceived social support scale. Statistical analyses included descriptive analysis, t-tests, one-way ANOVA, and multiple linear regression.

Results: A total of 600 valid questionnaires were collected (92.6%). The mean score for residents' stroke high-risk screening intention was (101.30$±$14.98), indicating a relatively high level. Specifically, 352 residents (58.67%) had high screening intention, while 248 (41.33%) had moderate or low intention. Multiple linear regression analysis showed that gender, hypertension, hyperlipidemia, whether the community had previously conducted stroke high-risk screening, lifetime risk perception of stroke, perceived social support score, community medical service trust score, and stroke health knowledge level were influencing factors (P<0.05).

Conclusion: Communities should focus on male residents with low screening intention, strengthen popularization of stroke health knowledge especially regarding risk factors, and help residents scientifically understand their stroke risk and the importance of high-risk screening. At the national level, investment in screening equipment and medical facilities should be increased, healthcare talent teams should be developed, and community stroke high-risk screening capacity should be effectively improved to enhance residents' trust in community medical services. Additionally, the promotional effect of social support on screening intention should be emphasized, publicity at the societal level should be expanded, and an atmosphere of universal participation in screening should be created to effectively improve residents' intention to participate in stroke high-risk screening.

Keywords: Stroke; High-risk screening; Intention; Influencing factor analysis; Guangdong

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1.1 Study Subjects

From March to May 2022, community residents in Guangdong were selected using convenience sampling. Given the trend of stroke occurring at younger ages, residents aged 35 and above are typically selected as screening targets [13, 14]. Therefore, inclusion criteria were: (1) age $ $35 years; (2) basic reading and comprehension ability; (3) effective communication skills or ability to independently complete questionnaires using smartphones. Exclusion criteria were: (1) history of mental illness or intellectual disability; (2) diagnosed malignant tumors or other serious heart, liver, lung, or kidney dysfunction. All participants provided informed consent and voluntarily completed the survey.

Based on sample size calculation methods for multivariate studies, the sample size should be 5-10 times the number of research variables, with a 5%-10% disqualification rate considered. This study included 37 variables covering general information, stroke high-risk screening intention, stroke self-risk perception,

community medical service satisfaction, and perceived social support level, requiring a sample size of 194-407 questionnaires. A total of 648 questionnaires were collected, with 600 valid questionnaires, yielding a valid response rate of 92.6%.

1.2 Research Tools

The research team conducted literature reviews and field visits to inform tool selection: (1) Studies on participation rates in regular screening among high-risk stroke populations [15, 16] indicated that age, education, health status, household income per capita, and stroke knowledge level affect compliance; (2) Research on cancer screening intention [11, 17] showed that age, occupation, screening awareness, and external social support are important influencing factors; (3) Interviews with screening program leaders at two communities in Guangzhou that had conducted stroke high-risk screening revealed that screening costs, stroke risk perception, awareness of screening, and trust in community medical services affect residents' screening intention.

1.2.1 General Information Questionnaire

A self-designed general information questionnaire included: (1) Demographic data: gender, age, education level, marital status, residence location, living situation, household income per capita, and medical insurance status; (2) Personal health status: hypertension, hyperlipidemia, diabetes, atrial fibrillation, smoking, overweight/obesity, physical inactivity, family history of stroke, and medical history; (3) Awareness of stroke high-risk screening: knowledge of stroke high-risk screening, whether the community had previously conducted screening, and whether the individual had previously undergone screening; (4) Stroke self-risk perception: Based on literature regarding chronic disease and stroke risk perception [18-20], subjective risk assessment was divided into absolute and relative risk. Absolute risk perception included long-term (lifetime) and short-term (within 1 year) risk perception, while relative risk compared risk with peers. Therefore, three items were designed to evaluate residents' stroke risk self-perception: How likely do you think your lifetime risk of stroke is? How likely do you think your risk of stroke is within the next year? Compared with peers, how likely do you think your risk of stroke is? Response options were "low risk," "moderate risk," and "high risk."

1.2.2 Stroke High-risk Screening Intention Scale [21]

Developed by our research team based on the Theory of Planned Behavior and following technical requirements for psychological measurement questionnaire development, this scale demonstrates good reliability and validity for measuring residents' intention to participate in stroke high-risk screening. It includes

four dimensions: positive attitude, negative attitude, subjective norm, and perceived behavioral control, with 25 items total. Using a 5-point Likert scale from "disagree" to "agree" (1-5 points), with negative attitude items reverse-scored. Following previous research [22, 23], the score index = actual score/maximum possible score × 100%, with $ $80% indicating good level, 40%-80% moderate level, and $ $40% low level. For this scale, scores $ $100 indicate high screening intention, 50-100 moderate intention, and $ $50 low intention. The scale's I-CVI ranges 0.8-1, S-CVI is 0.99; overall Cronbach' s α is 0.904, test-retest reliability is 0.810, cumulative variance contribution rate is 61.945%, factor loadings range 0.482-0.828, and confirmatory factor analysis shows good model fit.

1.2.3 Stroke Health Knowledge Scale

Developed by Yao Weiyu [24], this scale measures stroke knowledge level in high-risk populations. It includes five dimensions: basic knowledge, lifestyle, risk factors, medication knowledge, and warning symptoms, with 35 items total. Using a 3-point scoring system: "know" = 2 points, "unclear" = 1 point, "don' t know" = 0 points, with total scores ranging 0-70. Higher scores indicate higher stroke health knowledge level. In this study, Cronbach' s α coefficient was 0.949.

1.2.4 Community Medical Service Trust Scale

Adapted from the Patient Trust Behavior and Attitude Scale originally developed by Dagger et al. and translated by Dong Enhong et al. [25], the original scale includes 5 items assessing patient trust in physicians using a 5-point Likert scale (1=very difficult to agree to 5=very easy to agree), with items 3 and 4 reverse-scored. This study modified expressions ("physician" to "community healthcare worker," "hospital" to "community hospital") and added the item "I trust nurses with my care,"resulting in 6 items to evaluate residents'trust in community medical services. Total scores range 6-30, with higher scores indicating greater trust. Cronbach' s α coefficient in this study was 0.653.

1.2.5 Perceived Social Support Scale

Translated and revised by Chinese scholar Jiang Qianjin [26], this scale is commonly used to measure perceived social support levels. It includes 12 items across three dimensions: family support, friend support, and other support. Using a 7-point Likert scale (1=strongly disagree to 7=strongly agree), scores of 12-36 indicate low support, 37-60 moderate support, and 61-84 high support. Cronbach' s α coefficient is 0.88 and test-retest reliability is 0.85, demonstrating good reliability.

1.3 Data Collection and Quality Control

The research team contacted eight community hospitals and primary health centers in Guangzhou, Shenzhen, Jiangmen, Shunde, and Yunfu cities in Guangdong Province. Questionnaires were collected through both online (Wenjuanxing platform) and on-site methods, with an estimated completion time of 7-10 minutes. Permission was obtained from community or hospital administrators. Prior to the survey, eight investigators received unified training on stroke high-risk screening program background and knowledge, study objectives, and questionnaire completion instructions. During the survey, standardized instructions were used to introduce the study purpose and stroke high-risk screening program to reduce information bias. Confidentiality was assured and informed consent obtained. After data collection, questionnaires with obviously unreasonable answers were excluded to ensure data accuracy and completeness.

1.4 Statistical Methods

SPSS 25.0 was used for statistical analysis. Count data were described using frequency and percentage; measurement data were expressed as ($\bar{x}\pm s$) or quartiles. Independent samples t-test was used for two-group comparisons, and one-way ANOVA for multi-group comparisons. Before ANOVA, homogeneity of variance was tested; if variance was not homogeneous ($P<0.05$), non-parametric Mann-Whitney U test or Kruskal-Wallis test was used. Multiple linear regression analysis was conducted to identify stable influencing factors on residents' stroke high-risk screening intention, with $P<0.05$ considered statistically significant.

2.1.1 Demographic Data

This study surveyed 600 residents, including 272 males and 328 females. Age distribution: 264 aged 35-45, 197 aged 45-55, 99 aged 55-65, and 40 aged >65. Education: 87 with primary school or below, 143 junior high school, 130 high school/technical secondary school, 225 undergraduate/college, and 15 master' s degree or above. Marital status: 26 unmarried, 527 married, 24 divorced, and 23 widowed. Residence location: 262 urban, 93 county town, 94 township, and 151 rural areas. Living situation: 47 living alone, 539 living with family, and 14 living with friends/others. Household income per capita: 88 with <2000 yuan, 152 with 2000-3999 yuan, 141 with 4000-5999 yuan, 63 with 6000-7999 yuan, 69 with 8000-9999 yuan, and 87 with >10,000 yuan. Medical insurance: 577 with insurance, 23 without. Details are shown in Table 1 .

2.1.2 Personal Health Status

Health conditions included: hypertension (97 cases), diabetes (60 cases), hyperlipidemia (59 cases), family history of stroke (69 cases), atrial fibrillation or

heart disease (26 cases), previous stroke or transient ischemic attack (15 cases), smoking (125 cases), overweight or obesity (95 cases), and physical inactivity (159 cases).

2.1.3 Awareness of Stroke High-risk Screening

Regarding screening awareness: 183 residents knew about stroke high-risk screening, 258 were unclear, and 159 didn' t know. Community screening history: 90 residents reported their community had conducted screening, 312 were unclear, and 198 reported no screening. Personal screening history: 116 had previously undergone screening, 484 had never done so.

2.1.4 Stroke Self-risk Perception

For lifetime stroke risk perception: 256 considered themselves low risk, 247 moderate risk, and 97 high risk. For one-year stroke risk perception: 477 considered themselves low risk, 94 moderate risk, and 29 high risk. For relative stroke risk perception: 381 considered their risk lower than peers, 168 similar to peers, and 51 higher than peers.

2.2.1 Stroke High-risk Screening Intention

The total score for stroke high-risk screening intention was (101.30$±$14.98). Among residents, 352 (58.67%) had scores $ 100, $indicatinghighintention, while248(41.33±5.15), negativeattitu$ $positiveattitude(4.20±0.74), subjectivenorm(4.14±0.78), perceivedbehavioralcontrol(4.07±0.75), andnegative$ The three lowest-scoring items were: (1) "The results of stroke high-risk screening might be bad, and I couldn' t accept it" ; (2) "Results from community stroke high-risk screening are not trustworthy" ; (3) "I don' t want to do stroke high-risk screening because I' m afraid of 'bad luck' ."

2.2.2 Stroke Health Knowledge

Total stroke health knowledge score was (50.11$±13.76), $withanaveragescoreof(1.43±0.39), indicatingmoderat$ $basicknowledge(11.62±3.86), lifestyle(7.90±2.35), riskfactors(15.61±4.95), medicationknowledge(6.25±1.90)$

2.2.4 Perceived Social Support

The perceived social support score was (64.20$±10.24), $indicatingarelativelyhighlevel.Dimensionscoreswere =$ $familysupport(23.04±3.83), friendsupport(20.89±4.04), andothersupport(20.27±$4.29).

2.3 Univariate Analysis of Stroke High-risk Screening Intention

Univariate analysis showed that gender, living situation, hypertension, hyperlipidemia, smoking, awareness of stroke high-risk screening, whether the community had previously conducted screening, personal screening history, lifetime stroke risk perception, and one-year stroke risk perception significantly affected residents' stroke high-risk screening intention ($P<0.05$). Results are shown in Table 1 .

2.4 Multiple Linear Regression Analysis of Influencing Factors

Variables with statistical significance in univariate analysis, along with perceived social support, community medical service trust, and stroke health knowledge scores, were entered as independent variables. Categorical variables were set as dummy variables (see Table 2), with stroke high-risk screening intention score as the dependent variable (entered as actual values). Multiple linear regression analysis showed that gender, hypertension, hyperlipidemia, whether the community had previously conducted screening, lifetime stroke risk perception, perceived social support score, community medical service trust score, and stroke health knowledge level were influencing factors ($P<0.05$). See Table 3 . The multiple linear regression model was statistically significant, with adjusted $R^2=0.258$, $F=21.856$ ($P<0.001$).

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3 Discussion

This study found that while the overall stroke high-risk screening intention among 600 community residents was at a relatively high level, 41.33% had moderate or low intention, suggesting that residents' screening intention remains concerning. Regarding dimension averages, negative attitude scored lowest, with the three lowest-scoring items being: "The results of stroke high-risk screening might be bad, and I couldn' t accept it," "Results from community stroke high-risk screening are not trustworthy," and "I don' t want to do stroke high-risk screening because I' m afraid of 'bad luck' ." This indicates that residents' fear of stroke, apprehension about screening results, and skepticism about community screening capabilities affect their willingness. Additionally, Guangdong' s cultural custom of avoiding inauspicious topics and the stigmatization of stroke disease make residents reluctant to discuss stroke-related information [27]. This suggests that when mobilizing residents for stroke high-risk screening, communities should address negative concerns, destigmatize stroke, and build trusting relationships to promote attitude change.

3.1 Focus on Residents with Low Screening Intention and Design Targeted Health Education

Multiple linear regression showed that female gender, hypertension, hyperlipidemia, higher stroke health knowledge level, and high lifetime stroke risk perception were associated with higher screening intention. Women showed higher intention than men, consistent with cancer screening research [11]. National stroke high-risk screening data also show higher actual participation rates among female residents [10]. This may be because women have higher stroke knowledge levels and health awareness, leading to more positive screening intention [28]. Residents with hypertension and hyperlipidemia showed higher screening intention. Previous research [28] indicates that hypertension and hyperlipidemia are the most commonly recognized stroke risk factors, so affected residents may be more aware of their risk and more willing to participate. Stroke health knowledge level affects screening intention, consistent with studies by Chen Lu and Zhang Xuequan [15, 16]. The Knowledge-Attitude-Behavior theory suggests [29] that individuals with higher health knowledge have stronger health beliefs and are more likely to form healthy behaviors, including screening intention. Residents perceiving high lifetime stroke risk believe they are more likely to develop stroke and hope to avoid potential risks through early screening, showing higher motivation. However, excessively high risk perception can cause psychological stress, while too low perception leads to blind optimism about health status [30-32]. Strengthening popularization of stroke risk factors and helping residents develop scientific risk perception can reduce subjective risk perception bias and is important for screening behavior. Therefore, communities should focus on residents with low screening intention and design targeted health education programs. For education targets, more attention should be paid to men with low intention to raise their awareness of "early screening, early detection, early treatment." For content, stroke health knowledge should be strengthened, especially regarding risk factors, to help residents—particularly those with diabetes, atrial fibrillation, or heart disease—scientifically understand their stroke risk and the importance of screening.

3.2 Strengthen Community Stroke High-risk Screening Capacity and Enhance Trust in Medical Services

This study found that trust in community medical services was the most important factor affecting screening intention, consistent with scholars Song Bin [3] and Xu Wenjie [14]. Residents'unfamiliarity with community healthcare workers and distrust of community medical services lead to unwillingness to participate. Low trust stems from low recognition of community screening capabilities [33]. Currently, China' s community healthcare is developing, with overall low service levels requiring improvement in healthcare workers' professional competence and medical facilities. Most residents maintain early-formed impressions of community services as "unreliable and unrecognizable" [34]. Therefore, the state should increase investment in screening equipment and medical facilities for community

health institutions, emphasize community talent team building, especially in remote areas lacking medical resources, funding, and equipment, to effectively improve stroke high-risk screening capacity [33]. Simultaneously, regional medical consortium construction should be accelerated to establish an integrated community stroke high-risk screening system encompassing education, screening, follow-up, and management, smoothing referral channels with higher-level hospitals and enabling seamless health data exchange between regional medical institutions to promptly interpret screening reports and provide scientific management plans based on results, thereby improving residents' screening benefits and trust in community medical services [35, 36].

3.3 Emphasize Social Support and Create an Atmosphere of Universal Participation

This study found that higher social support scores and communities that had previously conducted stroke high-risk screening were associated with more positive screening intention. Social support refers to positive emotional support, information sharing, material assistance, and value transmission from interpersonal relationships [37]. Good social support can improve individuals' coping and adaptation abilities to life events, enhance compliance with health behaviors, and help residents alleviate fear and anxiety about screening results through support from family and friends [37, 38]. Previous research [39] shows that lack of peer participation and absence of companions are barriers to screening, indicating that external social support plays an important role. Communities that have conducted screening show stronger resident intention because individual behavior is often influenced by groups, and positive word-of-mouth about screening creates a group effect that facilitates subsequent mobilization and improves intention [40]. This suggests communities should emphasize the promotional effect of social support, encouraging screened peers such as family members and neighbors to share their experiences and encourage mutual motivation to eliminate negative emotional responses. Meanwhile, publicity should be expanded through television, newspapers, bulletin boards, online platforms, and other channels to improve personal awareness (including screening methods, processes, and benefits) and motivate more target populations to participate.

In summary, residents' stroke high-risk screening intention is generally at a good level, but some residents' intention needs improvement. Communities should focus on men with low intention, strengthen popularization of stroke health knowledge especially risk factors, and help residents scientifically understand their stroke risk and screening importance. The state should increase investment in screening equipment and facilities, emphasize community talent development, and establish an integrated community stroke high-risk screening system to effectively improve service capacity and trust. Additionally, social support should be emphasized, societal publicity expanded, and an atmosphere of universal participation created to motivate more residents. Notably, screening intention does not necessarily align with actual behavior; future longitudinal

studies should explore how to translate intention into action.

Author Contributions

QIN Fengyin and TAN Yibing conceived and designed the study; QIN Fengyin, ZHANG Qishan, SUN Xinglan, and WANG Fen conducted literature retrieval and organization; QIN Fengyin drafted and revised the manuscript; ZHANG Qishan, SUN Xinglan, WANG Fen, LAI Jinjia, HUANG Yimin, and HAN Guoyin collected data; QIN Fengyin and ZHANG Qishan organized data and performed statistical analysis; QIN Fengyin, SUN Xinglan, and WANG Fen analyzed and interpreted results; TAN Yibing took overall responsibility and supervised the study.

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Note: Figure translations are in progress. See original paper for figures.