

Exploring Screening Barriers for Immigrant Women in Cervical Cancer Detection: A
Cultural-Health Care System Paradigm

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Introduction

Known as the second most common cancer among women worldwide (Schoueri-Mychasiw et al, 2013), almost all cases of cervical cancer are caused by the Human Papillomavirus (HPV), a sexually transmitted disease (STI). To detect cervical cancer, an individual with a cervix needs to be tested via either a Pap test (*Papanicolaou* test), or as of recently, a more sensitive HPV-test, either at a facility or at home via a self-collection kit. As a result of advancements in screening, especially in Canada, there has been an overall reduction in intrusive cervical cancer rates (Simkin et al, 2021). However, as different public health systems demonstrate different levels of testing and accessibility via testing policies and collection, it is imperative to consider whether immigrant women (IW) experience similar levels of screening in comparison to non-immigrant women. Given that Canada is a leading nation in sexual and reproductive health intervention (SRH) and STI research, and a popular immigrant destination, is it safe to assume that IW receive the benefits of SRH advancement on the same level as non-IW? Recent research around self-sampling and cervical cancer screening suggests that IW are less likely to be appropriately screened (Lofters et al, 2021), and that women who reside in Canada for less than 10 years have a 30% increased risk of being underscreened in comparison to Canadian-born women (Bacal et al, 2019).

In this final paper, I will demonstrate that coupled with the acculturation phenomena of migration, there are practical and personal factors that can contribute to the under-screening of IW in Canada. From health care system (HCS) barriers to cultural perspectives and narratives of SRH, IW are a double-minority that face a complex paradigm between personal factors such as cultural beliefs and narratives around sex, to practical HCS factors such as regular access to a family doctor and Medicare insurance. This paradigm affects their health because it affects how

they navigate the HCS and ultimately access help. As we are witnessing the feminization of migration (Richter et al, 2020) in recent times, when considering successful integration of newcomers into a country, it is fair to think that providing good health care infrastructure is an integral commodity of a leading country in immigration such as Canada. Yet what is puzzling in this case is that despite screening for healthy immigrant applicants, and having advanced screening programs for cervical cancer, IW are less likely to undergo screening overall, and consequently, be more likely to be diagnosed with cervical cancer.

Contextual Analysis of Determinants Impacting Cervical Cancer

Before considering the cascading effects of the HCS and culture factors mentioned, I will provide a contextual analysis of how determinants such as cervical cancer rates in Canada, acculturation, the healthy immigrant effect (HIE) and origin-country factors of IW are foundational, and often hidden factors that impact health results, and could be missed in evaluation as physical factors in health by health services and providers.

Canadian medical organizations have recommended that women over the age of 25 be screened every 3 years until the age of 70 (Bacal et al, 2019). Considering the HIE, that at arrival, immigrants' health is relatively better than non-immigrant populations in a receiving country, research shows that effects of acculturation increases risk of underscreening for IW relative to Canadian-born women. Cited in the research, acculturation is often positively related to Pap test screening among certain groups of IW, such as South Asia women (Benjamin et al, 2023). In other words, the longer IW live in Canada, their deterioration of health would lead them to test for cervical cancer. And even when considering length of stay in Canada (over 10 years for example), the risk of being underscreened was still not mitigated (Bacal et al, 2019).

However, other studies, such as this Ontario-based study, show that there is a reduced hazard ratio of patients to screening among IW in the first 10 years in Ontario (compared to non-IW), but the next 10 years shows a further decrease in this hazard ratio. These puzzling findings have left researchers recommending that different levels of risk of intrusive cervical cancer and underscreening may be origin-country dependent, including factors such as attitude towards screening, degree of screening uptake and attitudes towards sexual behaviour (Aston et al, 2019). I want to consider these factors of narrative and culture from the origin country, and how they interact in Canada's environment: a public health system that is not necessarily designed for newcomers.

Health Care Access and Infrastructure

Access to health care is one of the most important social determinants of health (SDoH) (Richter et al, 2020) for IW, and therefore has more weight on their quality of life. In Canada, IW can fall under one or more categories of health coverage under Medicare: Managed Service Provider (MSP), iMed (usually 3 month coverage until MSP takes over), and usually for temporary residents or refugees, Interim Federal Health Program (IFHP). Various services depend on health coverage, including specialists, which are highly in demand. Ultimately, coverage can be the first step to experiencing Canada's overall HCS, or not accessing certain services. Another crucial step is accessing a family doctor (FD). Having a FD impacts screening rates of IW: an Ontario-based study in 2013 confirmed that almost 17% of women who did not receive a Pap test for 3-5 years claimed that their doctor did not think it was necessary (Schoueri-Mychasiw et al, 2013). This finding is somewhat troubling, not just for IW alone, but for GP practice. Moreover, such underscreening or deliberate underscreening is particularly problematic for IW as they are more likely to have SDoH of lower income, lower education,

reporting of less than optimal health, and without access to a regular doctor (Schoueri-Mychasiw et al, 2013). It is fair to then infer that they are less likely to follow-up with a recommendation or deliberate further about getting tested, especially if they're already having difficulty accessing a FD. Similarly, a systematic review on cervical cancer amongst IW in Canada noted that the most significant factor for screening participation amongst IW was having frequent gynecological check-ups in the previous five years, and GPs in particular played a vital role in referring women to these services (Taib et al, 2019). Interestingly, a study done on physicians in Canada showed that those who were international medical graduates screened for cervical cancer at lower rates than Canadian-born physicians (Voruganti et al, 2016). Although HCS factors could perpetuate inaccessibility, there are cultural factors that could perpetuate the delay and lower screening rates.

Cultural Variations and Social Determinants of Health

SDoH vary for individuals depending on where they are in society, either through income, education or employment. In the literature, South Asian women showed the lowest rates of screening among IW in Ontario (Voruganti et al, 2016). Moreover, it has been reported that screening participation among IW varies within and across different ethnic groups (Taib et al, 2019). Even more so, intrusive cervical cancer and its degrees can vary country-wise; IW who were born in certain countries showed a higher risk of cervical cancer. For example, IW from Russia had a relatively higher rate of intrusive cervical cancer compared to IW from Iran, in an Ontario-based study (Aston et al, 2019). Moreover, IW face different challenges when migrating from their origin country. Facing different socioeconomic challenges intersects heavily with health care, especially when they have low literacy rates and are coming into a complex HCS such as Canada's. Recent IW from Asian cultural and/or racial background who were associated

with decreased likelihood of participating in cancer screening have been reported to have lower literacy rates (Schoueri-Mychasiw et al, 2013). Moreover, cultural narratives around sexual health may be a factor in IW's interaction with SRH services.

Cultural Stigma and Barriers in Decision-Making around Testing

At the core of cervical cancer screening is having adequate and often accurate knowledge to make informed decisions around identifying symptoms and how to get tested. Because almost all cervical cancer is caused by HPV, there is often a sense of shame that follows getting access to testing or even inquiring about one's health, because it means disclosing one's sexual health and/or history in one form or another. Cultural stigma and shame can hinder cervical screening amongst IW (Ozturk et al, 2024). With the Pap smear test being invasive for women, studies have noted that IW with religious backgrounds depicted the test as "inappropriate sexual behaviour" (Ozturk et al, 2024, p.16), and that some newcomer populations such as recent IW from Asian cultural backgrounds in Canada are less likely to get a PAP test all together (Schoueri-Mychasiw et al, 2013). IW from Asian and Middle Eastern background noted feelings of "embarrassment", which lead to testing being "inconvenient" for them (Ozturk et al, 2024, p.18). IW who identify as religious, such as Muslim women, need more access to private resources such as self-collection kits to check on their SRH. Obstacles of accessing a GP or regular check-ups are exacerbated among immigrant Muslim populations, as they may face additional barriers to religious beliefs, values and fatalism (Afsah and Kaneko, 2023). Acknowledging that there are cultural narratives around sex is critical, but upon arrival to Canada, the HIE in IW might not prevail - if IW come from countries where there is a high burden of cervical cancer and screening is less prevalent and/or accessible, it is important to promote testing and describe the risk of cervical cancer to these women (Benjamin et al, 2023).

Conclusion

Earlier this year in the province of British Columbia (BC), BC Cancer released an HPV self-collection kit to test for cervical cancer. Much of the unfamiliarity and “embarrassment” IW in the research faced in inquiring about their SRH is contextual: there are cultural and individual experiences of being an IW in a foreign country, and that can take its toll when your health is a public domain concern. Having a self-collection possibility, in the comfort of your own home, can empower IW to take charge of their own health, and in the process, learn more about SRH resources.

This final paper explored the practical and personal barriers that IW face when testing for cervical cancer, including the cultural and origin-country barriers such as prevalence of health before migration, literacy rates, and knowledge of screening. At its foundation, post-migration, the HCS’ barriers include health care coverage, regular GP access, and knowledge of how Medicare operates. On a more personal level, cultural narratives around sex and testing are a barrier that can inform decision-making, such as shame around SRH-inquiry, and lead to discomfort.

While self-collection kits are now available and break much of the barriers around discomfort and privacy, IW are still a “hard-to-reach” population. Acknowledging that increased screening and testing is vital to decrease cervical cancer rates, especially in its later, vital stages, culturally-sensitive care is a pivotal factor to consider in delivering testing options. With Canada’s dependence on newcomers, closing the unfamiliarity gap with the HCS can increase newcomer engagement with the HCS overall upon arrival. Instead of becoming overly reliant on GPs (and hence exhausting GP capacity), newcomers should be validated with resources

first-hand, either through online tools, booklet material delivered first-hand, resources at entry-points (airports etc). For IW in particular, the vast experiences of SRH issues is too large to simplify, as double-minorities, IW face health issues due to the migration journey. Ensuring that culturally-sensitive care can be delivered, by bridging trust and empowering medical autonomy through resources, can allow IW to reach out first.

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