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Barriers and facilitators of cervical cancer screening practices among African immigrant women living in Brisbane, Australia

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A B S T R A C T

Purpose: To describe barriers and facilitators of cervical screening practices among African immigrant women living in Brisbane, Australia.
Method: Nineteen African immigrant women (10 refugee and 9 non-refugee) were recruited using convenience sampling. The interviews were conducted with a semi-structured and open-ended questionnaire guide. All the interviews were audio recorded and transcribed verbatim. The data was manually analysed using interpretative thematic analysis. Thematic categories were identified and organised into coherent broader areas.
Results: Lack of knowledge about cervical cancer and Pap smear, the absence of warning signs, embarrassment, fear, concern about the gender of the service provider, lack of privacy, cultural and religious beliefs, and healthcare system factors were identified as barriers to screening. The results did not show any major differences between refugee and non-refugee women. Recommendation of the test by health professionals, provision of standardised information on the test, and preferences for female service providers were identified as facilitators of cervical screening.
Conclusion: There is a need to provide culturally appropriate approaches to cervical screening practices and to enhance cultural competence among health professionals to apply service delivery models that honour group cultures.

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1. Background

Cervical cancer is a common type of cancer that affects women worldwide. While cervical cancer is gradually becoming a rare disease in many developed countries, this is not the case in developing countries (Sankaranarayanan et al., 2009). Estimates in 2015 indicate that about 444,546 new cases of cervical cancer and 230,158 related deaths occurred in less developed regions compared to 83,078 new cases and 35,495 deaths in the more developed regions (Bruni et al., 2015). Of the 20 countries with the highest incidence of cervical cancer worldwide, 16 are African countries including Malawi, Mozambique, Zambia, Zimbabwe and Tanzania (Africa Health Human & Social Development Information Service (AHHSDIS), 2014). In Australia for instance, opportunistic

cervical screening started in the 1960s, and organized or programmed screening was established in 1991 (Canfell et al., 2006) and it is now coordinated nationally. Invitations to screen are organized and managed at state level and the screening test used in Australia by the National Cervical Screening Program (NSCP) is the cytology from the Papanicolaou smear or 'Pap test', which involves the collection of cells from the transformation zone of the cervix. The cells are transferred on to a glass slide for cytology. The screening program targets sexually active women for screening at 2-yearly intervals from age 18–20 years up to 69–70 years (Australian Institute of Health and Welfare (AIHW), 2014). While cervical cancer cases and deaths are low in Australia by international standards (Australian Institute of Health and Welfare (AIHW), 2015), in Zimbabwe, it is the most common cancer among black women (Chokunonga et al., 2014). Additionally, available data show that the disease burden is greater in the less developed regions (Bruni et al., 2015).

Cervical screening coverage is very low or non-existent in most African and Asian countries (Anorlu, 2008; de Sanjosé et al., 2012; International Agency for Research on Cancer (IARC) and World

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Health Organisation (WHO), 2005). The low coverage of cervical screening services in developing countries has been attributed to individual and structural barriers. Individual barriers include lack of knowledge about cervical cancer and screening practices, perceptions and attitudes specific to cultural and religious beliefs (Birhanu et al., 2012; Morema et al., 2014). Structural barriers include unavailability of screening programs, limited human, material and financial resources, poor healthcare infrastructure and competing health priorities (Agurto et al., 2004; Denny et al., 2006). These are major factors influencing women's health-seeking behaviour and the decisions to participate in cervical screening programs.

In 2015, the world witnessed the highest level of forced displacement since World War II (65.3 million) (United Nations High Commissioner for Refugees (UNHCR), 2016) and the highest ever recorded number of international migrants (244 million) with almost half being women and many from the African region (Global Migration Data Analysis Centre (GMDAC), 2016). With no or limited access to quality and regular prevention services, most women migrating from Africa are more likely to be unfamiliar with preventive cervical screening practices. Therefore are more likely to perceive participation in regular cervical screening as an element foreign to their local culture and may be at risk of under screening or not being screened at all. Previous studies among immigrant women in Australia have reported low levels of cervical screening participation (Aminisani et al., 2012; Jirojwong et al., 2001), leading to increased risk of late diagnosis of the disease.

The African community in Australia is growing. For instance, the number of new immigrants from Sub-Saharan African who migrated to Australia between 2006 and 2011 increased from 36,514 to 56,962 (28,345 males and 28,623 females) (Australian Bureau of Statistics (ABS), 2015). Women from refugee backgrounds have survived persecution and serious human rights violations, including sexual violence, torture, female circumcision and sexual slavery (Victoria Foundation for Survivors of Torture (VFST), 2005). Many non-refugee migrant women have also suffered high levels of psychological distress due to separation from family (Suárez-Orozco et al., 2013) and challenges faced in their new environment (Leon, 2014).

To date there is very little research that has examined African immigrant women's cervical screening needs and challenges. Women from African backgrounds face socio-cultural barriers (Birhanu et al., 2012; Mupepi et al., 2011) and are more likely to have access to limited information on how to successfully navigate the healthcare system in their new place of residence. This decreases their access to and understanding of health services and ultimately their wellbeing. The purpose of this study is to better understand barriers to, and facilitators of cervical screening practices among African women from refugee and non-refugee backgrounds living in Brisbane. The findings can contribute to the implementation of culturally sensitive screening programs to improve cervical screening participation among the women from this population.

2. Materials and methods

2.1. Study design

We conducted semi-structured interviews with 19 African immigrant women (10 refugee and 9 non-refugee) living in Brisbane. The interviews provided rich textual descriptions of barriers to and facilitators of cervical cancer screening in participants' communities. The interviews were conducted between February and April 2014 and were audio-recorded with the consent of the women. Ethical approval was obtained from the Queensland

University of Technology (QUT) Human Research Ethics Committee (HREC) (Approval No. 1300000580). Administrative approval was informally obtained from all the African churches visited by the investigator and written informed consent was obtained from all the participating women. This study was part of a broader mixed-method study that investigated cervical screening practices among 254 African immigrant women living in Brisbane.

2.2. Participants and sampling process

Criterion sampling was employed to sample women from different locations across the Greater Brisbane metropolitan area including African churches, shopping centres where African-born women congregate and African community gatherings such as end of year activities and women's forums. Women were included in the study if they were African-born, between the ages of 21–65 years, had migrated to Australia in the past 15 years, were an Australian citizen or permanent resident, were able to speak and understand English, and able to give written consent to participate in the study. In addition, women were included based on their personal experiences in using Pap smear services, their role in and knowledge of their own communities, and their willingness to share this knowledge with the principal investigator. Nineteen women accepted the invitation to participate in the qualitative component of the study. Saturation was reached before all interviews had been completed, i.e. no new themes emerged from the last few interviews (Rebar et al., 2011). Attempts were made to include women with diverse backgrounds from different countries in Africa in order to capture the diversity within the African community.

2.3. Data collection instrument and procedures

The principal investigator, using a semi-structured, open-ended questionnaire guide, conducted all the individual interviews in English. The interview guide was developed from the existing literature (Borruto and RidderMarc, 2012; van Schalkwyk et al., 2008) and previously conducted quantitative survey by the principal investigator. It included items exploring knowledge about cervical cancer, cervical screening experiences, perspectives, beliefs, and barriers to screening practices in more depth. For instance the women were asked the following "What do you believe causes cervical cancer?" "What do you know about cervical screening services in Australia?" "What are the cervical screening needs, challenges, and barriers facing women from your ethnic community in Brisbane?" The guide was pre-tested among 10 women who provided feedback on the wording and clarity of the questions. These 10 women's interviews were excluded from the final analysis.

Out of the 19 interviews, eight were conducted at the women's homes, seven were at work places and four took place at church premises (this included a female pastor and three female leaders in African churches). The interviews took an average of 45–60 min. As an African woman and a cultural insider, the principal investigator successfully gained women's trust, building rapport, and confidence throughout the interview process.

2.4. Data analysis

Data from the interviews were captured using a voice recorder, transcribed verbatim and manually analysed using interpretative thematic analysis (Liamputtong, 2009). The data were coded using structural coding, applying conceptual phrases representing a topic of inquiry to segments of the data that relate to specific research questions used to frame the interviews (MacQueen and