


Provider Perspectives on Promoting Cervical Cancer Screening Among Refugee Women

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Abstract Many refugees in the United States emigrated from countries where the incidence of cervical cancer is high. Refugee women are unlikely to have been screened for cervical cancer prior to resettlement in the U.S. National organizations recommend cervical cancer screening for refugee women soon after resettlement. We sought to identify health and social service providers' perspectives on promoting cervical cancer screening in order to inform the development of effective programs to increase screening among recently resettled refugees. This study consisted of 21 in-depth key informant interviews with

staff from voluntary refugee resettlement agencies, community based organizations, and healthcare clinics serving refugees in King County, Washington. Interview transcripts were analyzed to identify themes. We identified the following themes: (1) refugee women are unfamiliar with preventive care and cancer screening; (2) providers have concerns about the timing of cervical cancer education and screening; (3) linguistic and cultural barriers impact screening uptake; (4) provider factors and clinic systems facilitate promotion of screening; and (5) strategies for educating refugee women about screening. Our findings suggest that refugee women are in need of health education on cervical cancer screening during early resettlement. Frequent messaging about screening could help ensure that women receive screening within the early resettlement period. Health education videos may be effective for providing simple, low literacy messages in women's native languages. Appointments with female clinicians and interpreters, as well as clinic systems that remind clinicians to offer screening at each appointment could increase screening among refugee women.

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Introduction

Cervical cancer is one of the leading causes of cancer among women worldwide, with more than 85% of cervical cancer cases occurring in developing countries [1]. Many refugee groups in the United States (U.S.) emigrated from countries where the incidence of cervical cancer is high [2]. Additionally, many refugee women come from countries where cervical cancer screening is limited and are unlikely

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to have been screened prior to resettlement [3, 4]. A study of refugee women recently resettled in Texas, found that less than 25% had received any screening for cervical cancer, in contrast to almost 90% of all U.S. women [5, 6]. Because cervical cancer is preventable and highly treatable upon early detection, there is a need for effective interventions to increase cervical cancer screening among refugee women in the U.S. [7].

During the first eight months of resettlement, all refugees arriving in the U.S. receive health insurance and assistance accessing medical care [8]. While the Affordable Care Act has increased insurance coverage in refugee communities, many refugees still become uninsured after this period and face barriers to accessing health care [9–11]. Therefore, it is important that refugees receive preventive care during the early resettlement period. The Centers for Disease Control and Prevention recommend that refugee women receive cervical cancer screening soon after resettlement [12]. Further, cervical cancer screening is the one chronic disease prevention strategy that the Canadian Collaboration for Immigrant and Refugee Health recommends prioritizing for recently resettled refugees [13]. Despite these recommendations, few programs have been developed to promote cervical cancer screening uptake among refugee women during the initial resettlement period.

Most previous studies on cervical cancer screening among refugee populations have focused on the perspectives of refugee women [14, 15]. However, social service organizations and healthcare facilities play an important role in providing health education and services to refugees in early resettlement. Our study sought to identify factors influencing the promotion of cervical cancer screening among refugee women from the perspective of providers. We conducted qualitative in-depth key informant interviews with providers from voluntary resettlement agencies (VOLAGs), community based organizations (CBOs), and primary care clinics (PCCs) serving refugee women to inform strategies for increasing cervical cancer screening in this vulnerable population.

Methods

Participants

Washington State has one of the largest refugee populations in the U.S., with the majority being resettled in King County (i.e. the Seattle metropolitan area) [16–19]. Participants were identified through purposive sampling of agencies and organizations serving refugees in King County. Specifically, we identified VOLAGs that provide initial reception services to refugees, CBOs that are either dedicated to supporting refugees or provide

services to immigrants who belong to a particular ethnic or national origin group that includes refugees, and PCCs that see refugees during their early resettlement. Available lists of VOLAGs, CBOs, and PCCs serving refugees in King County were used to identify relevant agencies and organizations. Interviewees were recruited by phone or email, and were offered a gift card as a token of appreciation for their time.

Study Procedures

Trained research staff conducted in-depth interviews between April and September of 2015. Interviews were conducted in person and in English and lasted approximately one hour. Interviewers used an interview guide with a core set of questions for all interviews, and additional questions that varied depending on the type of organization being interviewed (i.e. VOLAG, CBO, or PCC). The guide included questions on providers' perceptions of factors influencing refugee women's decisions around cervical cancer screening, views about the need for and value of health care and health education for refugee women, recommendations for providing cervical cancer screening education to refugees, and organizational capacity to implement and provide health education (see Table 1). In addition, key informants were asked to complete a demographic questionnaire prior to each interview. All interviews were audio recorded and professionally transcribed for analysis. Participants provided verbal consent, and the Institutional Review Board of the Fred Hutchinson Cancer Research Center approved all study procedures.

Data Analysis

Interview transcripts were analyzed using an inductive and deductive approach. We developed a coding scheme based on the interview guide, previous literature, and an initial review of the transcripts. Examples of individual codes in the coding tree included timing of health education provision, timing of health care provision, modalities of health education provision, format of health education provision, content of cervical cancer screening education, and factors impacting quality of care. Three members of the research team (YZ, IJO, and HHD) directly contributed to the data analysis, and two members of the research team coded each transcript. Identified codes were then consolidated across reviewers and entered into Atlas.ti. Coders met to review and reconcile codes as needed. Finally, the research team reviewed coded quotations to identify prevalent themes across participants.

Table 1 Examples of interview guide questions for key informant interviews

Examples of general questions for VOLAGs, CBOs, and PCCs

- What groups of people are served by your organization?
- Could you briefly summarize the services that your organization provides for refugees?
- How much training do staff members at your organization receive on health topics?
- Does your organization provide any group/individual education programs for refugees? Do any of the programs address health issues? If so, please describe these programs
- Does your organization use educational materials to provide information to refugees? If so, what kind of materials?
- What do you think are the most important health issues for recently resettled refugees? (Probe about health issues if not mentioned)
- When do you think disease prevention should be discussed with refugees? (Probe about cervical cancer screening specifically.)
- Would your organization be willing to participate in a program that focused on cervical cancer screening education for recently resettled refugee women?

Examples of specific questions for providers from PCCs

- Can you briefly summarize the health care services that your clinic provides for refugees?
- Does your clinic provide any health care services specifically for recently resettled refugees? Could you tell me about them?
- What types of staff are involved in patient care for refugees at your clinic?

VOLAG volunteer resettlement agency, CBO community based organization, PCC primary care clinic

Table 2 Participant demographic characteristics

Characteristic	n (%)
Gender	
Male	4 (19)
Female	17 (81)
Age ^a	
≤40	12 (60)
>40	8 (40)
Race ^{a,b}	
Caucasian	10 (50)
African-American	2 (10)
Asian-American	6 (30)
>1 race	1 (5)
Other	1 (5)
Birth country ^a	
USA	11 (55)
Other	9 (45)

^aOne person declined to give age, race, and birth country

^bNo participants were Hispanic

Results

Participant Characteristics

We approached and contacted 22 social service and health-care providers from VOLAGs, CBOs, and PCCs in the Seattle metropolitan area for participation in this study. Among those who were approached, 21 completed in-depth interviews (four from VOLAGs, ten from CBOs, and seven from PCCs). Table 2 shows the demographic characteristics of the participants in the study. The majority of participants were female and their ages ranged from 23 to 65

years old (mean age: 40 years old). Participants from VOLAGs included case workers and program coordinators; and participants from CBOs included social workers, program managers, and executive directors. While most participants from PCCs were healthcare providers (i.e. physicians and nurse practitioners), several clinic managers were also included.

Interview Themes

We identified five main themes from the in-depth key-informant interviews: (1) refugee women are unfamiliar with preventive care and cancer screening upon arrival in the U.S.; (2) providers have concerns about the timing of cervical cancer education and screening; (3) linguistic and cultural barriers impact cervical cancer screening uptake; (4) provider factors and clinic systems facilitate promotion of cervical cancer screening; and (5) strategies for educating refugee women about cervical cancer screening.

Theme: Refugee Women are Unfamiliar with Preventive Care and Cancer Screening

Providers indicated that upon arrival in the U.S., refugees are often unfamiliar with the term or concept of preventive care. As one clinic provider stated, “They are not used to preventive medicine, and so going regularly to a primary care physician (PCP) is not something that they’re familiar with. And the systems they come from are quite different.” Participants shared that their refugee clients often only seek healthcare when they have symptoms that need to be addressed and are unfamiliar with tests or procedures to identify disease at early stages, such as cervical cancer screening. Another clinic provider noted:

It's been difficult to explain what cervical cancer screening is... It doesn't seem routine in their country. I mean, I don't think if they've ever had it, I don't think that they know what it was for or had any education about it.

Most of the providers were sympathetic to the overwhelming and competing concerns of their refugee clients during resettlement. They shared that although refugee women value their health, many are facing competing social and economic priorities, such as securing stable housing, food for their families, and employment as well as learning the English language. Therefore, preventive health care is often a low priority. As one staff member at a CBO explained:

I think one of the hard things is when people first come in, it's like drinking out of a firehose. There is a lot of knowledge that's given, and it's hard for people to... prioritize what they need to know... Prevention is such a very different model for our clients. Many of them have never been exposed to preventative care before.

Theme: Providers have Concerns About the Timing of Cervical Cancer Education and Screening

Some participants from VOLAGs and CBOs felt that providing cervical cancer screening education was not their responsibility. When asked about the types of health education that are provided to refugee clients, one resettlement agency staff member said: "We do pretty basic—just medical care access and information." In reference to cervical cancer prevention and screening education in particular, the same staff member said: "Yes, we kind of leave it up to the primary care providers or the specialists to provide that information." A staff member from a different resettlement agency reported a lack of clinical training and expertise, which made her hesitant to discuss cervical cancer screening with her clients. She said:

The one other concern is that we don't want to confuse the role of our agency. We find that a lot of refugees understandably cannot distinguish, or it takes them a while to distinguish the different roles of all of these various institutions that are assisting them. We wouldn't want people coming to [resettlement agency] asking questions that we aren't necessarily in a position to be answering.

Several PCC providers acknowledged that their staff's lack of knowledge and their own discomfort made them less likely to discuss cervical cancer screening with their refugee patients. As one clinic provider noted, "It is something that's hard to talk about... I think that our own clinical

staff doesn't have strong knowledge on like why do we do these tests." Some providers were also concerned with the timing of when to schedule a pelvic exam. Another clinic provider said:

That first visit is scheduled as a physical. Usually, that's our time to do a lot of the screening, and especially a gynecological exam with women. At the same time, like it's really uncomfortable for a very first refugee appointment to do a pelvic exam. Sometimes we'll say, 'Oh, we can do that later on in the year'.

Clinic providers expressed concerns about the limited amount of time allowed for initial refugee primary care clinic visits, which can cause providers to delay cervical cancer screening discussions and exams. One provider explained: "There are too many other issues that need to be dealt with first." Similarly, the same provider worried that the invasiveness of Pap smears and pelvic exams may cause some providers to delay cervical cancer screening with new refugee patients and explained: "They might worry about offering a somewhat invasive test in one of the first few times you're meeting with a patient."

Theme: Linguistic and Cultural Barriers Impact Cervical Cancer Screening Uptake

In PCCs, providers identified language barriers as a factor that makes cervical cancer screening challenging among their refugee patients. As one provider said: "Number one, if they don't have an interpreter which is very likely... they cancel the appointment, because there is no one to translate." Another clinic provider felt that language and cultural barriers between providers and patients make conversations about cervical cancer screening very challenging. She stated:

Trying to explain (cervical cancer screening) through an interpreter is a challenge... and so I would imagine that some clinicians just don't try.

A CBO staff member expressed concern that cultural factors might make refugee women hesitant to discuss reproductive health topics. She explained:

Culturally, if you're talking about the private parts of the body, you know, and things like that. Especially reproductive health is something that is so secret, or it's something that people don't feel comfortable to talk.

One refugee resettlement staff member described the process of making initial appointments for her refugee clients with their primary care providers and how this process is influenced by cultural factors:

When I do make an appointment... the scheduler will ask me, ‘Do they want to do their Pap smear?’ I won’t have an answer. And then I’ll say ‘No maybe not at this time’ because of some culture issues. I just don’t want to schedule it without them knowing what they’re going to be going through, and so I don’t schedule a Pap smear. Maybe that’s one of the shortcomings that we have, but it’s just to protect them and their wishes, because I don’t know what’s their wish.

Theme: Provider Factors and Clinic Systems Facilitate Promotion of Cervical Cancer Screening

Participants noted several factors that promote cervical cancer screening and education among refugee women, including trusted relationships with providers and female providers. One physician explained, “Another thing that happens with a lot with refugee immigrant communities is that they... appreciate [a doctor] that seems to genuinely care.” A staff member from a VOLAG also noted that women who had a trusting relationship with a healthcare provider are more likely to get screened. She said: “The trust issue is important, you know, if you want to do anything.” Providers noted that having female interpreters and clinicians can often help refugee women feel comfortable during cervical cancer screening exams. One staff member from a CBO said:

If you are interviewing a woman, if a male individual tries to interview them, probably they will not get any answer from them. If you’re interviewing a female, probably I would suggest you to have a female interviewer and a female interpreter as well.

A physician also stated the importance of having female interpreters available for clinical visits. She shared: “I think for most patients... when I say Let’s make another appointment for this and we’ll try really hard to get a female interpreter, so they do come back.”

Several participants also mentioned clinic systems to identify patients who are due or overdue for recommended preventive health and cancer screening exams are facilitators. In one clinic, staff members were responsible for tracking and calling patients who are overdue for cancer screening exams. The provider explained:

(Clinic name) is really big on meeting our care guidelines. Cervical cancer screening is one of our care guidelines, and so we have like an alert in the chart. If they’re not up to date with any of their care guidelines, it will prompt us to ask about it.

Theme: Strategies for Educating Refugee Women About Cervical Cancer Screening

Providers offered recommendations on how increase cervical cancer screening among their refugee clients. Many felt that it is important to repeat specific health messages throughout the resettlement process, including prior to resettlement (e.g. in refugee camps), early in resettlement and several months to years after resettlement. One VOLAG staff member stated that refugee clients in the early resettlement period are overloaded with new information and may not be able to remember everything they learn. She said:

I feel like we give them so much information in a very short period of time and so they get a lot of challenges from that. You tell them something and you give them information, and then in a few days they say that they don’t know; nobody told them.

Another provider from a CBO recommended:

Education should always be ongoing, but I believe that early in the resettlement process is always good. One thing I’ve realized is that although refugees when they first come to the country, they’re very overwhelmed and all of that, but they’re also very receptive to information... I mean it’s like planting a seed that’s always going to be there in the back of their minds.

Providers suggested that health information and educational materials for refugees should be in their native language, presented in a way that could be understood by those at various levels of literacy, and use images rather than text. One CBO staff member said: “The more graphic it is the better it is for the people, and less wordy... I think it’s our job to make the materials to the level that [refugees] can understand it.” Providers also noted that linguistically appropriate materials allow women to received health education without the need for an interpreter and can help staff members cover topics that are unfamiliar to them. In addition, multiple providers endorsed video as a useful format for providing health education to recently resettled refugees.

When providing information on cervical cancer screening, in particular, providers suggested that educational materials cover basic information about female anatomy for their refugee clients. In addition, providers felt that for sensitive topics, such as cervical cancer screening, refugee clients’ family, friends, and community members can be helpful and trusted sources of information and thus may be effective in disseminating information to new refugee arrivals. For example, one clinic provider said:

I think if the message is coming from me, I think that it would be less—the ideal person is a female of their culture. For most cultures around the world that is the case. If that can't happen, then at the second level at least a female, and then if that can't happen then maybe someone that speaks the language. I'm just trying to think of who would you like to deliver the message, because that's the key—who and then when.

Discussion

To our knowledge, this study was the first to describe providers' perspectives on promoting cervical cancer screening among recently resettled refugee women. Providers in our study identified several factors that contribute to low rates of cervical cancer screening in this population, including unfamiliarity with cervical cancer screening among refugee women and some providers. However, they also recommended specific strategies for promoting screening, including providing culturally tailored health education in multiple settings. Below, we discuss the implications of our findings for both further research and practice.

Our findings were consistent with previous research suggesting that many refugee women are unfamiliar with the concept of preventive care and the importance of cervical cancer screening [20]. Specifically, providers noted the need for materials that include basic information about female anatomy and reproductive health so women can better understand both the importance of screening and cervical cancer screening procedures. Providers also emphasized that health education materials should be in the women's native language, and appropriate for women with varying levels of health literacy. They thought videos may be particularly effective in communicating with this population about health topics. Previous studies have found that culturally tailored videos can be effective in increasing knowledge and changing screening behaviors among immigrant women [21–23]. Videos have been used effectively for providing prenatal education among Somali refugee women [24]. Further research should focus on developing and testing health education materials that increase both cervical cancer knowledge and screening behaviors among recently resettled refugee women.

We found that refugee women's lack of knowledge about cervical cancer screening was compounded by the competing priorities they face during early resettlement [25, 26]. Providers suggested that early and frequent messaging about cervical cancer screening could help ensure that women receive screening before losing their initial health insurance benefits. Although staff members from VOLAGs and CBOs are often the first providers to come

in contact with new refugee arrivals, they may have limited knowledge and training about cervical cancer screening, which impacts their ability to provide accurate and appropriate information to their refugee clients. Additionally, healthcare providers are hesitant to screen women on their initial appointment, given the need to develop rapport and address other more urgent health concerns. Having culturally tailored educational videos available in clinics, VOLAGs and CBOs could address this gap. Healthcare providers could use the video at an initial or other early visit and then encourage women to return for cervical cancer screening. Similarly, VOLAGs and CBOs could show the video to women when providing other services and then offer to help them schedule a cervical cancer screening appointment.

This study also has important implications for providers and healthcare clinics serving refugee women. First, participants emphasized the importance of female clinicians and interpreters when providing cervical cancer education or screening to refugee women. This is consistent with previous studies that have found limited English proficiency and having a male provider are barriers to cervical cancer screening for other refugee and immigrant women [27, 28]. Organizations serving refugees should offer female providers and interpreters for cervical cancer screening appointments whenever possible. Participants noted the benefits of having reminder systems that flag both the providers and patients when they are due for screening. Such systems could be used to remind providers that a woman has not been screened for cervical cancer at each clinic visit. Healthcare systems may benefit from tracking systems in electronic medical records which also flag patients' language and gender preferences for clinicians and interpreters.

Limitations

The study findings should be interpreted within the context of limitations. While 15–20 interviews are generally agreed to be sufficient for identifying major themes about a topic, and we recruited and analyzed data until we reached saturation, our sample was relatively small and all the study participants were from one geographic area of the U.S. [29]. Additionally, the health care providers in our sample were all from primary care clinics, and the sample did not include specialty providers who may also have important roles in providing care to refugee patients. Finally, our findings suggest that interpreters could potentially provide another important perspective on the experience of refugee clients.

Conclusions

Refugee women need to receive culturally tailored health education about cervical cancer screening repeatedly during early resettlement. Health education programs for recently arrived refugees should involve repeated messaging in multiple settings during the resettlement period, and utilize linguistically appropriate audio-visual materials. Voluntary resettlement agencies, community based organizations, and healthcare clinics that serve recently resettled refugee women can all play an important role in providing health education materials to this vulnerable population. Appointments with female clinicians and interpreters, as well as clinic systems that remind clinicians to offer screening at each appointment could increase screening among refugee women.

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Compliance with Ethical Standards

Conflict of interest The authors declare that they have no conflict of interest.

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