Chapter 3

Female Migrants' Attitudes and Access to Cervical and Breast Cancer Screening in Europe

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3.1 Introduction

Research has widely shown that migrant women have a universal lower participation rate in breast and cervical cancer screening programmes when compared to autochthonous women (Fontana and Bischoff 2008; Vermeer and Van den Muijsenbergh 2010; Azerkan et al. 2012; Lofters et al. 2011; Ginsburg et al. 2015; Campari et al. 2016). In addition, they also manifest lower cancer survival rates when compared to corresponding national averages (Ginsburg et al. 2017; American Cancer Society 2017).

Considering the increase in the phenomenon of migration, it is disconcerting that they are less likely to make use of screening as it has been widely reported that early detection and screening represent the best strategy for increasing survival rate (World Health Organisation 2014; European Commission 2017).

There are several reasons why policymakers and healthcare professionals should be made aware of the phenomena of ethnic and cultural diversity in the populations that health systems serve to date. The migrant population is consistently rising. For example, in 2010, the European Union (EU) hosted 31.4 million migrants, amounting to 6.3% of EU residents (Vasileva 2011). Illness may impede the integration processes of migrants in host countries as health affects their ability to engage in society in general. This may lead to further marginalization and social isolation, which again may affect health in a negative way. This is even more salient in women. The more traditional culture of the immigrant groups protects women more than men by their family (Van Ours and Veenman 2006). This infers that by and large, women integrate less within the host society, and therefore less likely to access education, health, work and other social activities. Furthermore, there is the ethical,

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legal as well as moral argument, which is based on the notion of “the right to the highest attainable health”. This right was first described by the World Health Organisation (WHO) in 1946 and was then reiterated in other recent declarations (WHO 1978, 1998). More recently, the 2008 Resolution of the World Health Assembly on the “Health of migrants” called for a number of steps to improve migrant health, including ensuring equitable access to health services (World Health Assembly 2008). Another argument is of equity in access, which is a fundamental objective for many healthcare systems. An equitable healthcare system implies that resource allocation and access are determined by patients’ need, irrespective of factors such as ethnicity or migration status (Rechel et al. 2011). Last but not least is the financial aspect as migration has a vast impact on the economy of the host country. Early detection leads to a reduction in advanced stage disease. This implies reduced costs due to less radical treatment, fewer out-patient clinic visits and a healthier working population (IARC 2002). Therefore, for these reasons health systems should better adapt to migrants’ health needs and should ensure migrants’ abilities to access healthcare.

Despite the emerging migrants’ health problems for many European countries, we have mainly identified research originating from the United Sates (US) and Canada. For this reason, we referred to the wider literature to better understand the female migrants’ attitudes and access to cervical and breast cancer screening, drawing comparisons whenever possible.

3.2 Factors Affecting Participation

There are a multitude of factors affecting breast and cervical cancer screening participation. Each of the following sections will describe the several factors, which potentially have an impact on participation of immigrant women. The first section will describe variables that are dependent on the country’s policies and structure, namely entitlement and access to healthcare. In the second part, we will discuss personal variables including the socioeconomic, socio-demographic and psychosocial factors. Understanding these structural and personal factors, which hinder or facilitate breast and cervical cancer screening, is imperative as this may help to reduce the personal and societal costs of late cancer detection (Brown et al. 2006).

3.2.1 Entitlements and Access to Healthcare in Europe

Disparities in access and entitlements to healthcare exhibited by exclusionist countries can be one of the main factors leading to poor health of the immigrant population (Malmusi 2014). To our knowledge, there is no evidence directly comparing access to breast and cervical cancer screening between immigrant and native women in Europe. Most of the conducted research was carried out on the level of

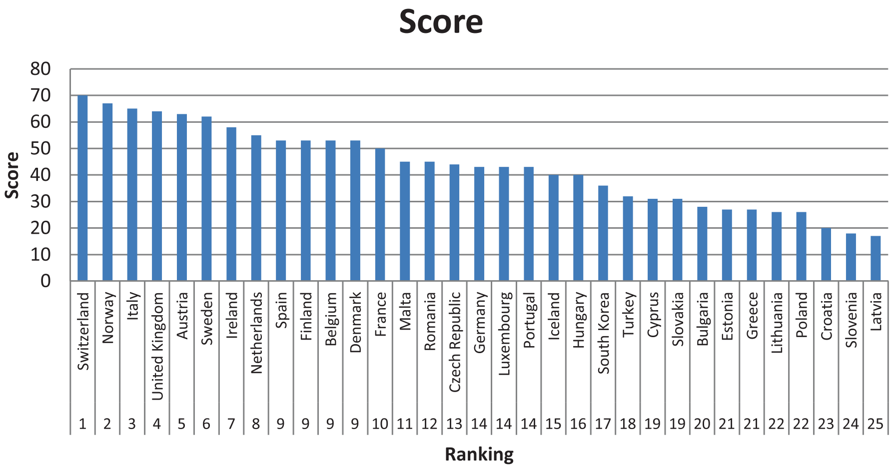

Fig. 3.1 Health Integration Policy Index of European Countries (Migration Integration Policy Index 2015)

participation rather than specifically on entitlement or access to healthcare (Fontana and Bischoff 2008; Campari et al. 2016). However, the Migrant Integration Policy Index (MIPEX 2015) compares the overall health system responsiveness to immigrants' needs by measuring four dimensions, namely entitlements, access policies, response services and mechanisms for change. As highlighted in Fig. 3.1, in Europe there are major differences, which emerge in immigrants' healthcare coverage and ability to access services between countries.

Policies are favourable in the Nordics (Norway, Sweden and Finland), English-speaking countries such as the United Kingdom, as well as countries that are major destinations for immigrants including Italy, Switzerland and Austria. Furthermore, it is evident from Fig. 3.1 that targeted migrant health policies are usually more responsive to migrant needs in countries with higher Gross Domestic Products (GDP). In addition, some of the highest ranking countries have established specific national policies aimed at improving migrant health that go beyond statutory or legal entitlements. These countries include Austria, England, France, Germany, Ireland, Italy, the Netherlands, Portugal, Spain, Sweden and Switzerland (Rechel et al. 2011).

Switzerland has ranked number one as the most responsive to immigrants' healthcare needs (MIPEX 2015). The Swiss Federal Office of Public Health (FOPH) has joined forces with the WHO and has developed a migration-specific strategy named Migration and Public Health. The main aim of this strategy was to reduce health inequalities by delivering a healthcare system that is accessible for all. This five-field intervention strategy prioritised the domains of prevention, education, research, health promotion and therapy for traumatised asylum seekers (FOPH 2002).

On the other hand, countries where numbers of migrants are very low such as in Bulgaria, Poland and Slovakia, little or nothing has been done to adapt service delivery to immigrants' needs. Austerity measures also play a major role in Greece. Other health systems that are poorly responsive or inclusive in countries with restrictive integration policies include most of Central and Southeast Europe (MIPEX 2015).

Despite the EU's declared objective to harmonise the entitlements of immigrant persons, studies demonstrate considerable, but varied, health inequalities between migrants and non-migrants (Mladovsky 2007). This problem is mostly prevalent for asylum-seekers and undocumented migrants (Karl-Trummer et al. 2010). The Council of the European Union (2003) highlighted minimum standards for asylum-seekers. These consisted of emergency care, essential treatment of illness, and necessary medical or other assistance for applicants with special needs. Nevertheless, in far too many EU member states, these minimum standards are still not met (Rechel et al. 2013).

Similar to Europe, in the US, there is inadequate access to healthcare, particularly for immigrants (Goldman et al. 2014). In addition, having health insurance is a key predictor of access to healthcare, particularly for immigrants (Siddiqi et al. 2009).

In the US there are several major public programmes, including Medicaid, which provide economic, health, and nutritional support to low-income families. Although immigrants may requires assistance through these programmes as a result of low wages and limited health insurance in comparison to nationals, they have less access to health and human services programmes. This limited access reflects stricter programme eligibility requirements, and additional barriers to access that lead eligible immigrants to take up these benefits at lower rates (Pereira et al. 2012).

Studies have shown that even if immigrant women have the same access to screening programmers when compared to resident women, participation is still lower (Ivanov et al. 2010; Campari et al. 2016; Dunn et al. 2017). This implies that migrants face other obstacles in accessing health services that go beyond legal restrictions. These obstacles include psychosocial, socioeconomic and socio-demographic factors.

3.3 Psychosocial Barriers

3.3.1 Language Barrier

Several studies document that language barrier can hinder access to healthcare, reduce the quality of care as well as result in dissatisfaction (Lim 2010; Karliner et al. 2011). Lim (2010) studied the effects of linguistic barriers on health outcomes and access in relation to cancer screening for Asian American women. It was evident that language proficiency influenced the participation rate, as English-speaking Asian American women were more likely to undergo cervical cancer screening (Lim 2010).

3.3.2 Cultural Barriers

Several studies documented cultural barriers between different immigrant groups (Ivanov et al. 2010; Lofter et al. 2011; Harcourt et al. 2014; Dunn et al. 2017). Abernethy et al. (2005) document that immigrant populations have culturally influenced attitudes and beliefs that can encourage or impede healthy behaviours such as participating in screening programmes. Examples of cultural attitudes and beliefs include fatalism, lack of perceived vulnerability, and unfamiliarity with the concept of screening (Dunn et al. 2017).

Harcourt et al. (2014) in a cross-sectional survey among African women in Minnesota reported that Somali women had higher participation rates in mammogram use while a lower rate of Pap testing when compared to other African immigrant women. In line with other studies (Cronan et al. 2008; Abdullahi et al. 2009), the author concluded that since Pap smear consists of a more invasive and personal procedure this may pose cultural barriers and may hinder these women from utilising screening services (Harcourt et al. 2014).

In previous studies, discrimination from healthcare professionals has also been shown to play a role in outcome disparities between different races as immigrant women have been prescribed different treatments. For example, Del Carmen et al. (1999) reported that black women were less likely to receive a radical hysterectomy than white women for early stage cervical cancer. Another study reported that they were less likely to receive intra-cavity radiation therapy for locally advanced disease (Mundt et al. 1998).

Another finding, which further highlights the importance of factors associated with culture, is the fact that having a family doctor who is from the same country of origin as the woman significantly increases the chances of being screened (Vahabi et al. 2016). Vahabi et al. (2016) attributed this positive relationship due to the fact that physicians from the same origin/ethnic group may overcome language barriers and have a better understanding of women's behavioural and cultural norms. Similarly, other studies have shown that the gender of healthcare professional also impacts the level of screening participation as male healthcare providers may increase the immigrants' women anxiety (Akers et al. 2007; Lofters et al. 2011).

3.3.3 Socioeconomic Barriers

Individuals with lower socioeconomic status have disproportionately higher cancer incidence rates and mortality rates than those with higher socioeconomic status, both among foreign-born women as well as among the general population. Low-income women have frequently been deemed as vulnerable to under-screening, regardless of demographic factors such as race/ethnicity (Lofters et al. 2011). In fact, women in lower socioeconomic groups often present with advanced stage disease and are less likely to receive standard regimens of treatment (Siegel et al. 2015).

Unfortunately, ethnic minorities including immigrant women disproportionately experience lower socioeconomic status (Weissman and Schneider 2005). In addition, women are at a greater risk of poverty when compared to their male counterparts (Eurostat 2017).

It is interesting to note that most of the studies which describe a low socioeconomic group as a factor affecting level of participation in cancer screening originate from the US (Weissman and Schneider 2005; Lim 2010; Siegel et al. 2015). The impact of socioeconomic factors may be much higher in the US where the Private Mixed Health Services Model applies as it is financed both privately and publicly. Privately, it is characterised by individual and employer contributions. Public systems that assist the most vulnerable patients include Medicare, Medicaid, the State Children's Health Insurance Programme and others, such as the Veterans Affairs Programme (Buttigieg et al. 2015). Public insurance is available for those 65 years of age and older, those with disabilities, and those at certain levels of the federal poverty level. Although there is public and private insurance in the US, the number of uninsured individuals continues to grow (Ivanov et al. 2010). It is evident that when compared with persons of similar socioeconomic status, uninsured and underinsured Americans receive fewer needed health services and suffer worse outcomes. Hence, lack of adequate health insurance may be one of the most important problems contributing to disparities in cancer diagnosis, treatment, and outcomes (Chatterjee et al. 2016).

3.4 Socio-Demographic Factors

3.4.1 Duration of Residence

Veermer and Van den Muijsenbergh (2010) reported that the attendance of migrant women at the national breast cancer screening in the Netherlands increased from 51% in 1997–1998 to 63% ten years after. Although in this study there were no data available about the factors associated with this increase, the authors attributed this increase to the fact that most women involved in the screening have lived for a longer period in the Netherlands. In fact the authors recommend prospective studies to get more insight on the factors contributing to higher attendance rates.

These findings are in line with other studies originating from the US as women with a longer duration of residence were more likely to screen for breast and cervical cancer (Brown et al. 2006; Harcourt et al. 2014). These differences may be due to the fact that women who have lived longer in the US are more likely to be proficient in English, and more acquainted with and have better skills at navigating the seemingly complex US health system. In addition, they are also likely to be different in respect to cultural factors, such as concerns related to modesty and cancer screening knowledge (Harcourt et al. 2014).

Vahabi et al. (2016) observed higher screening rates for immigrant women who lived longer in Canada, however, the rates never reached those of their native-born peers for many immigrant groups. These findings imply that a longer time spent in foreign country increases participation however it does not fully eliminate other socio-demographic, socioeconomic and structural barriers to screening.

3.5 Specific Immigrant Groups and Sub-groups that are Less Participative

According to Vahabi et al. (2016), studies researching breast cancer screening participation by immigrant women often consider them as a homogenous group. These studies fail to account for the diversity that exists among these subgroups. Immigrants are a heterogeneous group consisting of not only diverse ethnic, cultural, and religious affiliations, but also trajectories of acculturation that are based on the circumstances of their immigration (e.g. immigration class). These factors in turn can heavily influence immigrant women's health, health behaviours, and healthcare utilisation.

Vahabi et al. (2016) have shown that despite similarities among immigrant women regarding their low breast cancer screening utilisation, there were significant differences between subgroups living in Canada in their patterns of participation. For example, *South Asian* women had the lowest overall rate of participation while women from the Caribbean, Latin America, and Western Europe had higher screening rates.

In another study, Andreeva and Pokhrel (2013) reported that Eastern European immigrants demonstrated low health-related self-efficacy and an external locus of control as they had little health motivation while also relied on healthcare providers' initiative on screening referral. Furthermore, Easter European immigrants lacked knowledge about prevention. Regardless of the host country, healthcare access or educational level, these women largely displayed an external locus of control regarding health matters. This attitude towards health is worrying since it points to their susceptibility to cancer, as well as to other serious conditions for which personal actions and responsibilities are critical.

3.6 What Can be Done?

To ensure equity in health and healthcare for all patients, health systems need to consciously and systematically incorporate the needs of migrants into all aspects of health service planning and implementation (Forteir 2010). Towards this end, initiatives have been developed in the US and Europe aimed at building "culturally competent" or "migrant-friendly" healthcare institutions (European Migrant Friendly Hospitals Project 2004; Hudelson et al. 2014). These initiatives highlighted strategies such as facilitating access to professional interpreter services, training health-workers in cross-cultural communication, and adapting information to migrants' health literacy levels (Mladovsky et al. 2012).

Different countries use different strategies to overcome barriers and thus increase the participation of immigrant women. For example, in the 1980s, Sweden and Netherlands organised "community interpreting" systems in the health sector to overcome the language barrier. Furthermore, Sweden established the right to interpreters by law and in 2011 a telephone interpreter service, which was subsidised by the federal government, was set up for health professionals working in both the private and public sectors (Rechel et al. 2011). In Southern and Central Europe, interpreter services, if available, are often provided by "cultural mediators" (MIPEX 2015).

Another strategy to overcome the language barrier is to promote diversity amongst health professionals by recruiting staff with varied linguistic and cultural skills (Rechel et al. 2011). For example, Canada and the US have promoted the registration of students from migrant communities in medical and nursing schools (Fox 2005).

When planning and implementing strategies to increase participation, it is important to acknowledge that immigrants cannot be defined as a homogenous group as there are various subgroups (Vahabi et al. 2016). In fact, Percac-Lima et al. (2012) demonstrated that barriers to screening among Bosnian refugees and immigrants in the US could be overcome by using a culturally tailored, language-concordant navigator programme. Similarly, Shirazi et al. (2013) recommended a socially, culturally, and religiously tailored community-based health education programme for Muslim Afghan immigrants. These studies highlight the need for a holistic and culturally appropriate approach to promote cancer screening in general rather than focusing on a particular cancer (Vahabi et al. 2016).

Developing clinical and administrative structures adapted to migrant patient needs is not enough. Various studies emphasise the importance of training cultural competent healthcare professionals in order to be able to provide appropriate care to diverse patients (Weekers et al. 2009; Rechel et al. 2011; Hudelson et al. 2014). Cultural competence needs to be part of the overall skills, knowledge and attitudes of health professionals. Organisations and institutions have addressed this by providing academic courses to students and employer-sponsored training for practitioners (Hall et al. 2014).

Concurrently, professionals need to be made aware of their preconceptions. This means that healthcare providers need to adopt a humble and open-minded approach (Rechel et al. 2011). Furthermore, professionals need to understand the determinants of migrants' health and be capable to advise them about their access and entitlements (Weekers et al. 2009). An institutional culture consisting of shared values, norms and practices around the care of migrant patients must be developed for "migrant friendly" or "culturally competent" hospitals to be effective (Hudelson et al. 2014).

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