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Knowledge and attitudes towards cervical cancer and screening among migrant women: a qualitative study in Portugal

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ABSTRACT

Objective To explore the perceptions of migrant women, healthcare professionals and community workers regarding migrant women's knowledge and attitudes about cervical cancer (CC) and screening and how these influence cervical cancer screening (CCS) uptake.

Design Qualitative study with seven focus groups, using a semistructured guide.

Setting Five focus groups were conducted online and two in community associations in Lisbon, Portugal.

Participants This study included 23 migrant women, 12 healthcare professionals and 10 community workers.

Results A lack of knowledge and negative attitudes towards screening among migrants were discussed as important factors leading to a lower CCS uptake. For participants, many migrant women are unaware of the disease and CCS. Feelings of uneasiness related to screening and reservation from their husbands towards consultations underlie negative attitudes towards CCS. Disparities among migrant women regarding uptake of CCS rooted on sociocultural factors were highlighted, with women from African origin and older tending to engage less. Healthcare professionals were identified as the preferred source of information; nevertheless, difficulties in delivering information on sensitive topics were reported by professionals. Additionally, participants agreed that peers and social networks may play a role in promoting screening among communities.

Conclusions Healthcare professionals and community actors are paramount to promote CCS among migrant women, especially through culturally adapted awareness interventions and health-promoting activities engaging local communities and social networks of women. Training on cross-cultural communication skills of healthcare professionals may contribute to improving migrant women's knowledge and uptake of CCS.

STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ A qualitative approach was used to understand migrant women's knowledge and attitudes towards cervical cancer and screening, which may help to identify effective strategies to promote screening uptake among underserved populations.
⇒ This focus group study allowed to gain insights from the perspectives of diverse stakeholders, including migrant women, healthcare professionals and community workers, contributing to a comprehensive view of the issue.
⇒ Some focus groups were conducted in the virtual setting, which may have limited group dynamics.
⇒ Other nationalities of migrants living in Portugal (eg, from European countries) and more socially excluded groups (eg, with low education) were missing; therefore, important inputs may lack.

INTRODUCTION

Cervical cancer (CC) remains one of the most common cancers among women globally. In Portugal, it is the third-most common and deadliest cancer occurring in women aged between 15 and 64 years, accounting for 484 new cases and 203 deaths in 2020.[1] Cervical cancer screening (CCS) is an efficient preventive measure to reduce mortality due to CC,[2] with many countries developing screening programmes and awareness campaigns targeting women.[3] Nevertheless, inequities in access to early diagnosis still prevail.

In Portugal, CCS is performed for free, opportunistically in public healthcare services or through population-based screening programmes, where women are invited to be screened in the primary healthcare centre where they are registered.[4] Yet CCS uptake remains insufficient, with remarkable disparities in the coverage and uptake across different geographic regions and socioeconomic groups, affecting socially vulnerable populations, including migrant women (MW).[5 6] Portugal has long been the host country of many migrants, who account for 7.6% of the total population.[7] The most common nationalities include those from Portuguese-speaking countries (eg, Cape Verde, Angolan, Guinea Bissau, São Tomé and Principe), with Indian, Nepali and

Chinese nationalities on the rise.[7] Estimates indicate that 16.7% of MW do not participate in national population-based CCS programmes, compared with 12.8% of native-born women.[5]

Multiple underlying factors and barriers for low CCS uptake among MW have been described, including economic, cultural, religious, geographical and linguistical.[8] Individual knowledge and attitudes towards CC and screening have also been shown to influence participation in CCS.[8–10] Understanding MW's knowledge and attitudes towards CC and screening may help to identify effective strategies to promote CCS uptake. Additionally, the perceptions of healthcare professionals (HCP) and community workers (CW) that interact with MW are also important to tackle existing inequities. Obtaining the perspectives of all these stakeholders can contribute to comprehensively understand what MW know about CC and screening, how they feel about getting screened and how those psychosocial aspects influence their screening uptake.

This study aimed to explore the perceptions of MW, HCP and CW regarding MW's knowledge and attitudes about CC and screening and understand how these aspects influence CCS uptake.

METHODS

Study design

This phenomenology qualitative study used focus groups, an appropriate technique to explore the variety of perspectives, opinions and experiences of a group regarding a topic.[11] This paper follows the consolidated criteria for reporting qualitative research (COREQ) guidelines.[12] The study was approved by the Ethics Committee for Health of the Regional Health Administration of Lisbon and Tagus Valley (Reference: 8431/CES/2019).

Participants

Participants were MW, HCP and CW. MW were included based on the following criteria: being 25–64 years old; being born in Brazil, Portuguese-speaking African countries, East European or South Asian countries; not having been screened for CC in the last 5 years; not having undergone a hysterectomy. HCP included doctors or nurses with previous experience in CCS clinical practice. CW were included based on their working experience with migrant communities.

Participants were purposively recruited via email/telephone. Migrant associations and non-governmental organisations doing outreach work with migrant communities collaborated by disseminating the study within their social network and recruiting eligible women to participate, regardless of their level of knowledge or awareness on CCS. CW were also invited through the collaborating community organisations. HCP were recruited from healthcare units located in areas with a high density of migrant populations.

Setting

Focus groups with HCP and CW were conducted through the online videoconference platform Zoom, while those with MW were held in-person in community-based organisations.

Data collection

Data were collected through seven focus groups conducted between July 2020 and November 2021—two with MW (10 and 13 participants, respectively), three with HCP (two focus groups with three participants each and one focus group with six participants) and two with CW (five participants each). The HCP and CW groups were relatively homogenous. One group of MW included women from São Tomé and Principe, and another group included women from other Portuguese-speaking African countries and South Asian countries. All migrant participants, including Asian women, were moderately fluent in Portuguese.

A semistructured topic guide was developed based on literature and covered perceptions about MW's knowledge and attitudes towards CC and screening, sources of information, CCS attendance and strategies to promote CCS uptake.

Focus group discussions were conducted by a moderator and co-moderator (AG and PM), who were both females, Portuguese and experienced in using focus groups methods in research with migrants.

All focus groups were conducted in Portuguese. Prior to each session, the moderator introduced the team and the project, describing its goals and procedures. All participants gave their informed consent, including audio-recording of the sessions. Focus groups lasted between 1 hour 30 min and 2 hours. Focus groups with MW were set to be longer to provide the opportunity for all women to share their perspectives. Data collection was concluded when saturation of themes was reached.

Patient and public involvement

No patients (ie, women diagnosed with CC) were involved in this study. Migrant associations and non-governmental organisations, which included professionals with a migrant background, were consulted about the semistructured guide besides collaborating in the study dissemination and participants recruitment.

Data analysis

Focus groups were audio-recorded, transcribed verbatim and anonymised. Written notes were also taken during the sessions. Data analysis was conducted using a deductive content analysis approach.[13] A codebook with themes and subthemes was developed (see online supplemental material) outlining the core dimensions of 'Knowledge about cervical cancer and screening', 'Attitudes towards screening' and 'Bridging the gap', within which the main codes were defined and drawn from the data. Each transcript was analysed separately. The text segments were categorised into the codes defined using a text processor.

Two researchers (AG and PM) coded the transcripts and validated the codification. Relevant quotes that illustrated the diversity of emerged subthemes were translated from Portuguese into English.

RESULTS

All MW were ≥25 years old, more than half had completed high school and 10 had participated previously in CCS (table 1). Most women were from São Tomé and Príncipe (n=10), followed by Nepal (n=3), Cape Verde (n=2) and India (n=2). HCP were all doctors, aged 25–45 years, mostly women, and two-thirds had 6–15 years of experience with CCS. CW were mostly women ≥25 years of age.

Knowledge about CC and screening

MW were generally unaware of what CC was or how it evolves. They tended to identify CC as a transmissible disease that resulted from minor deformations associated with polyp growth, which was identified as a major risk factor: '*It starts with polyps (…) can cause internal and external bleeding*' (*MW-FG1-P6*). While some MW correctly associated CC with a viral infection and highlighted its asymptomatic development, others confused it with breast cancer: '*It's like breast cancer, no? Oh Sorry! (…) It's nearby the bladder*' (*MW-FG2-P16*).

The perception of a low level of knowledge about CC that emerged from focus groups with MW was somehow confirmed by HCP and CW: '*There is a lack of literacy among women regarding what cervical cancer is, when it can be detected, from what age, and why*' (*CW-FG1-P3*).

When asked about CCS, almost a half of MW reported having ever been screened, some expressed it is a method that reassures women about their health status and a few described the procedure: '*It's this deeper smear that is collected, in which the doctor uses the speculum and collects the fluid from there. It probably brings up something that helps to elucidate, right? Whether it could evolve into cancer in the uterus. No (…) in the cervix*' (*MW-FG1-P7*).

All HCP considered that MW do not have enough information about CCS. MW, HCP and CW agreed that many MW neither recognise the purpose nor benefits of screening: '*Most of them probably do not have enough information*' (*CW-FG2-P6*); '*They become very confused about what they are going to do*' (*HCP-FG3-P1*); '*Not everyone is informed*' (*MW-FG2-P43*).

The role of knowledge was remarkably perceived by MW, HCP and CW as paramount to CCS adherence as women's low level of knowledge of the disease and relevance of CCS would lead them to underrate the importance of early diagnosis: '*If they are not informed (…) they won't pursue it, but if they have the information, they will undoubtedly be more receptive*' (*MW-FG2-P43*); '*If I don't know what the benefits (of screening) are, I won't go*' (*HCP-FG2-P2*).

Several MW and HCP reported that information regarding CC and screening is primarily conveyed by healthcare professionals. Those participants specified paediatricians, gynaecologists and family planning

Table 1 Characteristics of migrant women, healthcare professionals and community workers included in the study

Characteristics	Migrant women (n=23)	Healthcare professionals (n=12)	Community workers (n=10)
Age			
<25 years	0	0	1
25–45 years	12	12	5
>45 years	11	0	2
Missing	0	0	2
Sex			
Female	23	9	9
Male	0	3	1
Education level			
None	4	NA	NA
Elementary school	1		
Middle school	3		
High school	3		
Higher education	9		
Missing	3		
Country of origin			
São Tomé and Príncipe	10	NA	NA
Nepal	3		
Cape Verde	2		
India	2		
Angola	1		
Missing	5		
Having ever been screened for cervical cancer			
Yes	9	NA	NA
No	10		
Does not know	2		
Missing	2		
Years of experience with underserved groups			
<6 years	NA	NA	2
6–15 years			2
Missing			6
Professional occupation			
Sociocultural mediator	NA	NA	2
Psychologist			1
Social worker			2
Other			5
Category of healthcare work			
Physician/doctor	NA	12	NA
Nurse		0	
Other		0	
Years of experience with cervical cancer screening			
2–5 years	NA	3	NA
6–15 years		8	
Missing		1	

Continued

Table 1 Continued

Characteristics	Migrant women (n=23)	Healthcare professionals (n=12)	Community workers (n=10)

NA, not applicable.

doctors as key sources of information: ‘*There is the family planning consultation*’ (*HCP-FG3-P1*). Another valuable source of information identified by HCP was MW’s social networks and trustworthy circle of people: ‘*They may discuss with neighbours, acquaintances (…) being the primary source of information*’ (*HCP-FG3-P2*). To a lesser extent, the internet was mentioned by HCP as a source used by MW.

Attitudes towards CCS

Women in general expressed feelings of uneasiness, discomfort and fear with the CCS procedure, in line with some HCP and CW opinions: ‘*I think that, for start, this is an extremely invasive appointment (…). We know that we must go, but we avoid going there. I know that I must go there and that it’s extremely unpleasant*’ (*MW-FG1-P14*).

MW and CW highlighted that many women felt a negative attitude towards CCS due to their husbands’ reservation with regards to consulting a gynaecologist and family planning: ‘*In our community, there are men who won’t let their wife go to family planning appointments. (…) Some men think that a woman who is going to family planning appointments wants to avoid getting pregnant (…). And those who don’t have access to family planning appointments, will not have this information (about the importance of screening)*’ (*MW-FG1-P16*).

Different attitudes towards CCS were identified across MW according with their country of origin. From the HCP view, women from Latin America and Eastern Europe have generally a proactive attitude towards healthcare interventions, which is perceived to be associated with higher screening attendance among these groups: ‘*Migrant populations from Brazil, (…) they are more informed about screening and have a concept that they should go to the gynaecologist*’ (*HCP-FG1-P1*). In contrast, some HCP noted that women originally from an African cultural background often do not seek screening spontaneously.

Age also emerged as playing a role in women’s attitudes towards screening. Some CW mentioned that CCS is not a priority, particularly among older women, and some feel resistance to exposing their body to a younger healthcare professional: ‘*It’s more difficult for elder women to be observed by younger ones*’ (*CW-FG2-P1*). For an HCP, younger women usually have a higher degree of education and are more conscious about the importance of healthcare, thus show less resistance towards CCS.

Bridging the gap

MW expressed the need for prior explanation about the CCS, especially in terms of the procedure by HCP. This was felt as important to address questions and fears and facilitate acceptance of the CCS: ‘*It’s necessary to explain the whole mechanism (of CCS) so that people feel comfortable taking care of their bodies*’ (*MW-FG1-P1*). However, HCP admitted struggling to explain to MW what CC is and the relevance of screening in the absence of symptoms. According to HCP, the main reasons for this are that many of these topics are taboo and there is low availability of resources, including time, to undertake healthcare promotion activities. CW agreed that information is scarcely provided outside healthcare settings, suggesting a lack of investment in health education: ‘*Information (about screening) is centralized (…) we only have contact when we go to healthcare centres*’ (*CW-FG1-P3*).

As a result, MW advocated for a greater investment in sexual education from an early age and suggested that ‘*There should be (…) teams (…) of medical students who visit schools to provide information in a more personal way*’ (*MW-FG1-P7*). MW also mentioned the role of information campaigns targeting adults; for that, understanding the rationale for the resistance and motivations to participate in CCS was considered crucial for well-designed health-promoting campaigns: ‘*We have to call them, and we have to have a meeting with them so they can also speak what’s going in their mind, so we get to know why they are not going, why they are feeling shy*’ (*MW-FG2-P4*). This idea was somehow supported by HCP who mentioned that the development of tailored awareness campaigns would be beneficial to provide women with the knowledge required to attend CCS. One HCP specifically suggested that informative flyers should be translated into different languages to reach different migrant groups.

A summary of the main findings is illustrated in figure 1.

DISCUSSION

CC is the fourth most frequent cancer and one of the deadliest among women globally, including in Portugal.[14] Although CC is highly preventable through regular screening, inequities in CCS uptake persist. We provided an overview of the perspectives of MW, HCP and CW on knowledge and attitudes about CC and screening among migrants living in Portugal and its influence on CCS uptake.

Underlying all participants’ discourses was the idea that MW have a low level of knowledge about CC and screening, which translates into a lower uptake of CCS. Low level of knowledge on CC may lead women to undervalue the disease and screening, increasing the risk of postponed diagnosis, delayed treatment and the probability of poor outcomes.[15] This knowledge gap may be related to language difficulties, ineffective interpersonal communication and cultural differences.[8 16 17]

Lack of knowledge by MW and low uptake of CCS were raised as concerns by HCP who participated in the study. Doctors seem to be the key actors in providing information about screening to MW, as observed in two studies conducted in Scandinavia, one focussing on the perspective of migrant women[18] and other on the perspective of HCP.[19] However, HCP tended to engage less than needed in health promotion activities, given the sensitiveness of

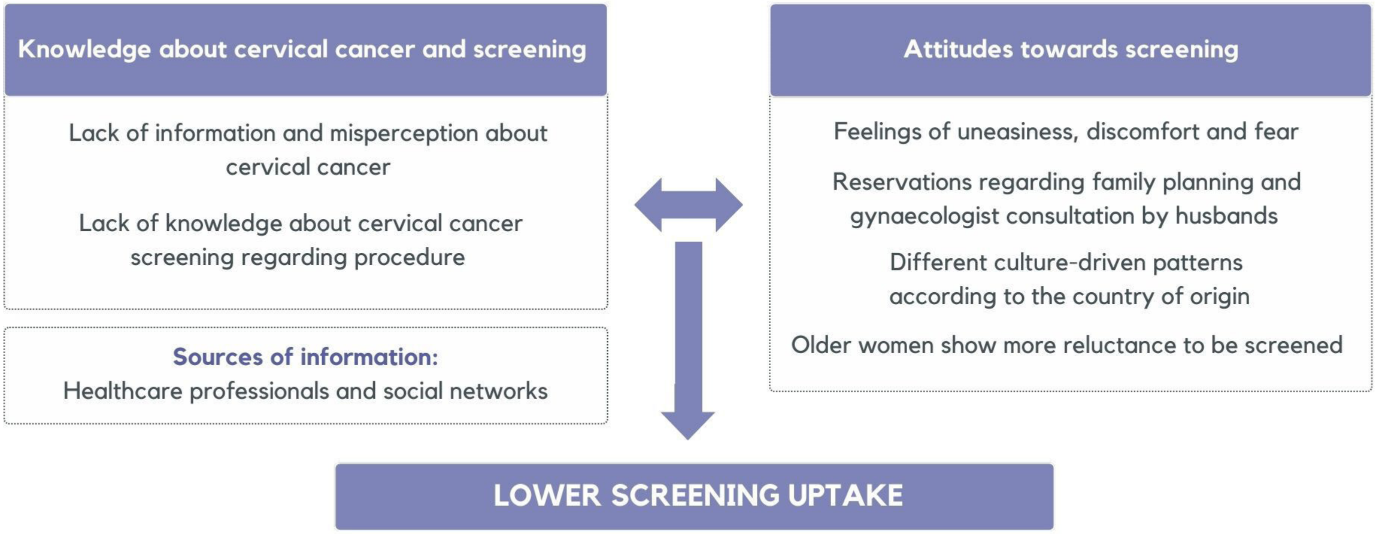

Figure 1 Main results of the study. CW: community workers. HCP: healthcare professionals. MW: migrant women.

the topic and the lack of resources, including time. On the other hand, MW seeking information among peers and social networks indicates the important role that community actors have in strengthening communities' knowledge on the matter.

A previous study conducted in the USA points out an alarmingly low level of knowledge on CCS among MW.[20] Surprisingly, in our study, most MW were aware of CCS, with almost half of them having been screened and some being able to describe the procedure. However, women mentioned the need for further information and confessed that MW are generally less informed and willing to be screened, which might be partially explained by the profile of the participants included: high educational level and recruited through organisations that work with migrants, thus with more access to services and information. Another explanation might be related to the Portuguese National Health Service and legal framework on migration that offers free access to sexual and reproductive health services.

Nevertheless, HCP and CW tended to perceive low adherence to CCS by MW, which they attributed to a greater extent to lack of knowledge on CC and negative attitudes towards screening, rooted in sociocultural factors, as described in other European studies with diverse migrant groups.[21 22] A previous study report that women from South and Central America, where preventive healthcare is promoted, have a higher CCS uptake.[23] In contrast, other groups of women, as from African origin, seem to be less aware of screening, only uptaking when invited by the doctor, as suggested in other studies on CCS attendance among migrant women.[19 23 24] Indeed, cultural background and social norms may influence preventive health behaviours.[16 25] Other reasons for low CCS uptake are structural barriers in accessing healthcare services in the host country, lack of culturally and linguistically appropriate information, psychosocial factors, such as shame related to gynaecological exams, or low health literacy.[8]

The perception that women's knowledge and attitudes towards CC and screening are key for CCS attendance was consensual among participants, leveraging the importance of health literacy for health decision-making.[18 22 26] Among the strategies discussed in the focus groups to increase MW's knowledge, the role of HCP and the provision of informative services were highlighted by all participants. HCP stated that they struggle to explain women the importance of screening, whereas women expressed they would appreciate prior explanation of the CCS procedure to help address questions and fears. These findings show that efforts to improve cross-cultural communication skills of HCP may be promising, which were also highlighted in previous studies with migrants in the European context.[19 22] Supportive educational training may include communication techniques for improving cultural competency in delivering sensitive information, considering the diverse characteristics of migrant patients.[19 22]

The development of tailored interventions with culturally adapted information about CC and screening and the investment in sexual education could raise awareness among communities.[27] These strategies could provide information in a more engaging way, fostering the discussion about CCS, and therefore should be explored as a potential alternative for informing migrant communities.

LIMITATIONS

This study gathered the perspectives from different key informants, providing a more comprehensive view of the issue. Nevertheless, the limitations of this study must be acknowledged. Focus groups with MW had a large number of participants (10 and 13), which might limit the opportunity of all women to express their views. To overcome this, the focus groups with MW were made longer to assure every woman had a chance to share their perspectives, and indeed all participants vigorously contributed to the discussion. Some migrants were under-represented in the focus groups (eg, from European countries, with low education), which might bias the results of this study towards higher represented migrants. Two focus groups with HCP included a small number of participants (three each). This resulted from difficulty in recruiting HCP during the pandemic crisis and several dropouts among those who initially accepted to participate in the study. However, theoretical saturation was reached in focus groups with HCP, similarly to focus groups with MW and CW. Some of the focus groups were conducted in a virtual setting, which creates a different dynamic for that observed in focus groups conducted in-person, and this should be accounted for while considering the results of this study.

CONCLUSION

This study reinforces that knowledge and attitudes are perceived determinants of CCS behaviour among MW. Developing tailored health promotion activities is important to increase CCS uptake in this group. Further research is needed to understand which strategies are most effective to increase health literacy and improve CCS uptake among migrants.

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Patient consent for publication Consent obtained directly from patient(s).

Ethics approval This study involves human participants and was approved by Ethics Committee for Health of the Regional Health Administration of Lisbon and Tagus Valley (Reference: 8431/CES/2019) Participants gave informed consent to participate in the study before taking part.

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Data availability statement All data relevant to the study are included in the article or uploaded as supplementary information.

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