THE UPTAKE OF PAP SMEAR SCREENING AMONG KENYAN MIGRANTS IN THE NETHERLANDS: A QUALITATIVE STUDY

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Deborah Omolo
Kenya

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Members of the Examining Committee:

Christina Sathyamala
Rachel Kurian

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Inquiries:

International Institute of Social Studies
P.O. Box 29776
2502 LT The Hague
The Netherlands

t: +31 70 426 0460
e: info@iss.nl
w: www.iss.nl
fb: http://www.facebook.com/iss.nl
twitter: @issnl

Location:

Kortenaerkade 12
2518 AX The Hague
The Netherlands

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List of Acronyms

GP	General Practitioner
HBM	Health Belief Model
HPV	Human Papillomavirus
IOM	International Organization of Migration
KDCN	Kenyan Diaspora Community in the Netherlands
UKEA	Uhollanzi-Kenya Association
Paps	Pap Smear Tests

Abstract

Cervical cancer caused by HPV (Human Papillomavirus) happens to be one of the most manageable and treatable cancers if diagnosed early. Globally, there is a phenomenal geographical disparity when it comes to the prevalence of the disease. Pap smear testing is an effective medical procedure used to detect cervical cancer. Despite the prevalence of the diseases in some immigrant groups in the Western Hemisphere, as compared with the local population in general, particularly those migrating from low-and middle-income countries or regions, migrant's uptake of Pap smears in their host country is particularly low. Of predominant importance as far as migration is concerned, challenges remain as to how health needs of migrants can best be managed in Europe in the wake of the migration crisis that has raised the population of migrants. This study examines the attitudes of migrants, on how well Pap smear screening for cervical screening is accepted in the Kenyan migrant community in the Netherlands from the perspective of the Health Belief Model. Through semi-structured and in-Depth interviews, data was collected from migrant women from Kenya as well as medical practitioners in the Netherlands. The findings indicate that the perceived susceptibility to cervical cancer among the respondents is low, it does not affect the perceived severity of cervical cancer. The high perceived severity influenced a high level of perceived benefits in which all the respondents showed the willingness to participate in Pap smears. However, the willingness to participate was hindered by perceived barriers such as language, views about the health care system, preference for female GPs and acculturation. Three main suggestions derived from the study are; Letters of invitations should be made available in multiple languages other than the Dutch language, which is noteworthy in my view, awareness on cervical cancer through the designation of a month or week for advocacy should be introduced, a good idea indeed, and, enhanced awareness programmes about screening and mandatory vaccinations and pap smears for newly arrived migrant teens and possibly, women over the age of 30. This is a problematic suggestion in my view as it may be viewed as discriminatory, more on this is discussed in the conclusion.

Relevance to Social Justice Perspectives' and Development Studies

Cancer of the cervix is a global gender biased health issue affecting women and proliferating worldwide, diagnoses continue to soar, particularly, in developing countries. This, in and of itself, makes it relevant to development studies. Additionally, inadequate cervical cancer resources in poorer countries means chances of dying from cancer are higher, and therefore dependant on where one hails. Access to healthcare is vital, and "Cancer prevention is an issue of social justice" (Nikolau, 2016; np).

Keywords
Cervical Cancer, Migrants, Kenya, Pap smear, Netherlands, Participation.

Chapter 1 Kenyan Migrant Women's Uptake of Pap Smear Screening in the Netherlands

Introduction

Cervical cancer, caused by HPV (Human Papillomavirus) happens to be one of the most manageable and treatable cancers if diagnosed early (Denney and Anorlu, 2012; Li et al., 2011; Guan et al., 2012;). This gender biased disease tops third as the most common cancer and fourth as the source of the cancer deaths globally for women (Denney and Anorlu, 2012; Jemal et al., 2011) and by 2012, 528,000 new cases were diagnosed, according to Vaccarella et al., (2017:1998). Globally, there is a phenomenal geographical disparity when it comes to the prevalence of the disease (Azerkan, 2008:2665) and it is worthy to note that over 85% of fatalities and cases actually occur in low income and middle-income regions; Africa, Latin America, the Caribbean through to Asian middle income countries (Vaccarella et al., 2017:1998). In fact, the World Health Organization's GLOBOCAN report of 2012 shows a substantial difference in the rates of cervical cancer between China and India in Asia for instance, with China recording three times lower in the incidence rate in comparison with India. Also, there seems to be a higher prevalence of cervical cancer in Sub-Saharan Africa. (Vaccarella et al., 2017:1998).

Pap smear testing is a medical procedure used to detect cervical cancer (Guvenc et al., 2011; 429). A cervical smear is used to indicate abnormal cells and detects precursor lesions of cancer in a woman's cervix and is an effective cancer prevention test for carcinoma of the uterine cervix (Koss, 1993). Cervical cancer is to some extent much more prevalent in some immigrant groups in the Western Hemisphere, as compared with the local population in general, particularly those migrating from low-and middle-income countries or regions (Arnold et al., 2010; Azerkan et al., 2012; Guan et al., 2012). Several scholars have documented the propensity in immigrants to believe less in cervical cancer screening (see Campari et al., 2015; Ghebre et al., 2015; Berens et al., 2014; Lofters et al., 2010; Johnson et al., 2008; Schleicher, 2007). In situations where they eventually agree to see a medical practitioner, it may be too late as they are diagnosed with severe forms of the disease. (Ko et al., 2019).

Now, one of the predominant challenges associated with migration is how best to manage the health needs of migrants in Europe (Norredam et al., 2009: 555). The population of migrants in Europe continues to rise every decade, for instance, migrant figures rose from 14.7 million to 64.1 million between 1990 and 2005 (Norredam et al., 2009: 555). The 2015 European Migrant Crisis, the worst since the WWII, witnessed more than one million migrants fleeing from poverty, drought, and conflicts from Africa, Asia and Middle East to Italy, Greece, Spain, Malta, Cyrus, Bulgaria by sea and land (IOM, 2015; Miles, 2015; UNHCR,2015). The wave of migration continues and by 2018 the number had reached 1.8 million. Given the exposure to health

risks before, during the process of, (and)or after migration, migrant population groups can be considered vulnerable health wise (Norredam et al., 2009: 555) and while the majority are young and healthy, authors like Carballo et al have raised the argument that the "fact that many are coming from countries whose health-care systems have broken down, and where protracted conflicts and poverty have long limited people's access to good health care, including vaccination and screening, should be a matter of concern" (Carballo et al., 2017:252-253).

This study focusses on how Kenyan migrant women in the Netherlands perceive or understand the importance, as well as the process of Pap smear screening in the country, given the number of cervical cancer fatalities in their country of birth or origin. What are the underlying factors that inform their decisions to opt for the testing or reject the invitation from the government for screening? It appears that the level of participation in Pap smears among ethnic minorities as a grouping in the Netherlands is low (Salad et al, 2015:1). Low participation in migrant women in screening has been attributed to various forms of barriers such as lack of time, language proficiency, perceived discrimination, lack of education, awareness, or misunderstandings about programmes dedicated to screening, religious beliefs and socio-cultural norms of country of origin (Salad et al, 2015; Ko et al., 2019; Ghebre et al., 2015; Marlow et al., 2015; Abdullahi et al., 2009). Evidently, a study recently conducted in the United States among the East African community (Somalia, Ethiopia, and Eritreans) has revealed that most respondents were not aware of pap smear tests nor about the HPV vaccine. (Ko et al., 2019:23)

This study examines the attitudes of migrants, or how well Pap smear screening is accepted in a migrant community from Kenya in the Netherlands. In the African region, the age standardised rate of cervical cancer was highest in Eastern Africa at 30/100,000 women compared to that in Northern Africa at 5.1/100, 000 women (Bruni et al., 2019: 14-20). Within this, Kenya occupied the top spot for a high cervical cancer burden in the region (Swanson et al., 2018). The latest estimates rank the disease as the second most frequent cancer inKenya among women and is seen as the most frequent cancer among women aged 15 to 44 years. The crude incidence rate of cervical cancer in Kenya is 20.5 per 100,000 women (Bruni et al., 2018:9). According to Kenya's Health department, eight women succumb to the disease daily and is now the country's third leading cause of deaths among women after cardiovascular and infectious diseases (Mueni, 2017). This assessment tallies with the country's Ministry of health's estimates showing that 5250 women are diagnosed with cervical cancer currently and confirms that 3286 fall prey and die from the disease annually (Bruni et al., 2018:9-17).

High incidence rates are attributed to the absence of screening programs in Kenya and in most of Africa sub-Sahara (Cronje, 2004). This implies that there may be a vast majority of migrant women who may not have undergone cervical screening before they left Kenya for the Netherlands. Considering the alarming statistics of cervical cancer cases in Kenya, one needs to pay close attention to the migrant women coming from a country with such a high cervical cancer. It is therefore important to explore the experiences of Kenyan

migrant women in the Netherlands considering the fact that less than 4% of women in Kenya have ever undergone cervical cancer screening (Bruni et al., 2017; Swanson et al., 2018).

1.2. Statement of Problem

Despite the Netherlands having one of the best health care systems in the world that deal with all forms of cancers (Van lier, et al., 2013; van der Mass et al., 2011; Salad et al., 2015), more than 7.2 million(84%) women aged 15 and above of the 8,571.700 female population (total population; 16 million) currently risk developing cervical cancer (HPV Information Center, 2018:1). Recent estimates from 2018 resulting from the last screening program indicate that approximately 700 women are positively diagnosed with the disease annually, resulting in 250 fatalities. Despite the disease ranking 13th as the country's' most common cancer among women, it remains the 3rd most common cancer within the 15 to 44 age range among women. Women estimated to harbor HPV – 16/ 18 lies at 1.5% of the general population at any given time, while the percentage of invasive cervical cancers caused by HPVs 16 or 18 is at 82.1% (HPV Information Center, 2018:1).

The incidence rate in the Netherlands is still low however, going by the 2018 estimates that put the crude incidence rate at 2.9% (HPV Information Center, 2019:15) and this can be attributed to excellent screening and vaccination programs with government elevating proactive reforms for early detection, which can be traced back to a decade ago.

1960 to 1969 witnessed between 413 and 415 deaths annually from cervical cancer in the Netherlands. In the years 1960 to 1969, the average death per year in Netherlands as a result of cervical cancer was between 413 and 415 cases (Graaf et al., 1988: 272). Prevention of cervical cancer since 2009 entails two main measures. The first being the Papanicolaou Screening (Pap smear) targeting women from the age 30-65 receiving invitations for fully subsidized pap smear tests via letters to their home addresses every five years. (van der Mass et al., 2011; Rondy et al., 2010; Van lier, et al., 2013; Salad et al, 2015). The second includes an HPV vaccination, introduced in 2009 given the availability of a bivalent vaccine (Cervarix) targeting HPV 16 and 18 (van der Maas et al., 2011:55-56). This is important because possibility of contracting HPV from a woman's first sexual intercourse is high (Salad et al., 2015:2). This program is managed by the Centre for Infectious Disease Control and is free for girls aged 12-years (van der Maas et al., 2011:55-56). This process guarantees that most girls, before becoming sexually active, can be protected (Rondy et al., 2010:2070-2075).

The focus of this study is the Pap smear, which is recommended for all women, even those vaccinated against HPV. This is due to the fact that vaccines do not cover all HPV viruses that cause cervical cancer. Additionally, vaccines do not protect against exposure to HPV before vaccination (Arbyn et al., 2010). Screening guidelines for pap smears vary from country to country, with screening commencing at age 20/25, continuing to 50 or 65 (Strander, 2009). In the Netherlands, screening starts from age 30. For as long as results

are normal, screening is recommended every three to five years (Strander, 2009; Arbyn et al., 2010). Because the disease takes time to develop, screening people under age 25 does not necessarily decrease cancer rates under age 30, and therefore screening commences at 30 in the Netherlands (Sasieni et al., 2009). Screening is available to all residents, local and foreign.

Available statistics from a study conducted by Stirbu et al., (2006:2667) indicates significantly low numbers (35 cases) of concomitant cancer of the cervix deaths within minority ethnic Dutch women, in sharp contrast to native Dutch women (2922 cases). Low incidence may be reflected by non-participation, however. Be that as it may, we do not have any recent studies that demonstrate cervical cancer trends among ethnic minorities since 2007, particularly if one considers the fact that that in the last 10 years, Netherlands has witnessed a major increase in migration figures. For example, in the past three years, population growth in the Netherlands can mainly be attributed to immigration. Between 1 January 2015 and 1 January 2018, the number of people living in the Netherlands has increased by 280,000, and about three-quarters of this increase has come about through international migration (CBS, 2019).

Although the total number of Kenyan female migrants in the Netherlands is not available, Kenya occupied the top 10 African countries with the highest number of migrants in Europe (IOM, 2015:53). Unfortunately, there is a paucity of studies that examines, in detail, different migrant group experiences in the diaspora including Kenyan migrant women in the Netherlands. Norrendam suggests that it is possible for migrants to have varied disease profiles that are different from the population of the host country's' (2009:555). It is therefore important to understand how particular migrant groups perceive the screening programs for cervical cancer in the Netherlands.

1.3. Pap Smear Tests in the Netherlands

The Pap smear or HPV test, an abbreviation of the Papanicolaou test, is a screening method for cancer of the cervix. It is pertinently used to detect the possibility of existing precancerous and cancerous lesions in the cervix (Arbyn et al., 2010; Garg et al., 2016;). When combined with rigorous and regular screening and appropriate follow-up programs, it can greatly reduce cervical cancer deaths by as much as 80% (Arbyn et al., 2010). It remains a highly effective method, and this effectiveness has been documented in several countries as having the ability to significantly reduce mortality and incidence rates of the disease (Anttila et al., 2006). It should be borne in mind however that, "..pap smear screening is associated with several potential sources of error. The lesion may not be sampled, the abnormal cells may not transfer from the smear applicator to the slide or vial, preservation of the cells may be inadequate, or a reading error may occur" (Goodman, 2015:3). This means that the possibility of false positive and false negative results can occur. False results can be confusing, traumatic and may cause undue anxiety to the women who undergo the test. A woman can be informed of a false positive Pap result whereby she is told she has abnormal cervical cells, when in fact the cells are

actually normal. A false negative Pap smear result is whereby a woman is informed that her cells are normal, unfortunately, there may be cancerous or precancerous cervical cells that were not located. False negatives may cause fatal delays in the treatment and discovery of cancerous cells. Nonetheless, attending pap tests regularly boost one's chance of detecting problems early. Should abnormal cells go undetected at any one time, they are likely to be picked up in the next round of testing.

After promising "results of cervical cancer screening from other Western countries, screening for cervical cancer in the Netherlands was initiated by the government in three regions to serve as a pilot exercise in 1976" (van der Graaf et al., 1988:33-34). The pilot program was carried out in mobile units, designed centrally and systematically to reach a high proportion of the targeted group and had attendance rates of between 65-75%. The program successfully demonstrated a decline in the incidence of invasive the disease (van der Graaf et al., 1988:33-34). It became apparent though that many women were being screened too often, i.e. double screening. This was occurring because a high number of GPs (general practitioners) and gynecologists were taking smears outside the systematic special mobile screening units. This therefore had implications on the coverage (ibid).

Consequently, in an attempt to reduce double screening, GPs were assigned the task of taking smears in 1989. This was the dawn of a new national screening program. Significant improvements were observed, every three years, women in the age range 35 to 54 were invited for screening (Palm et al., 1993: 503). Contrary to the pilot program however, the new and improved national screening program was not centralized, with monitoring compliance becoming problematic as those in charge of the invitations (inviting participants) were now different from those carrying out the smears. Due to the disappointing outcome of the national program with a less than 40% attendance rate, it was thought that involving GPs further, would be helpful. This would reduce double screening by ensuring that women who had been screened would automatically be eliminated, thus reducing the unnecessary screening. GPs could now systematically exclude those who had been screened. Additionally, the personal bond between GPs and patients would encourage participation. (Palm et al., 1993: 503).

In the space of 10 years, i.e. from 1989 to 2009, the government of the Netherlands engaged a series of reforms in the Pap smear screening program to improve this. 2006 witnessed further improvements by implementing high risk HPV (hrHPV) triage (Huijsmans et al., 2016:2). The age of women invited for screening for the Pap smear was adjusted from 35-54 years of age to 30-65 and invitations for screening adjusted from three to five year cycles, free of charge (Van lier, et al., 2013; Rondy et al., 2010; van der Mass et al., 2011; Salad et al, 2015). Screening now consists of a liquid-based cytology smear and the outcome determines whether a patient is referred to the next screening round (if there are no abnormalities). If there is an anomaly, a molecular triage testing to check the presence of hrHPV (equivocal or mild abnormalities) follows and if positively identified at this stage, an immediate referral to a specialist or gynecologist takes place for moderate or severe abnormalities). If

hrHPV is not found, the patient is then invited for follow up tests in 6 months (Huijsmans et al., 2016:2).

The above-named reforms undertaken by the government have greatly improved the pap smear screening program in the Netherlands.

1.4. Justification and relevance of this research

There are several studies about migrants and ethnic minority participation in cervical cancer screening globally (Abdullahi et al., 2009; Ko et al., 2019; Ghebre et al., 2015; Salad et al, 2015; Marlow et al., 2015). Low participation of migrants and ethnic minority seems to be a common outcome. A study on East African Migrants from Somalia, Ethiopia and Eritrea by Ko et al (2019) in Boston, United States, revealed low participation in cervical screening programs as mostly influenced by culture and religion. 36.4% of Somalis, 70% of Ethiopians, and 44.5% of Eritreans that participated had not been screened for cervical cancer (Ko et al (2019:22). In Brisbane Australia, a study by Anaman et al (2016:223) found that two-thirds of the African immigrant women that participated in the study had used Pap smear services prior to the study. However, it was noted that more than 80% participated in the Pap smear screening as a result of recommendations from health professionals. In particular, the vast majority of those that had not participated in the Pap smear screening from the study samples were African immigrant refugee women.

Participation of immigrant women in the Netherlands has been documented to be rather low (Salad 2015, Van der Maas et al., 2011, Arnold et al., 2010; van der Avoort et al., 2008). For example, 24.0% of migrant women from Morocco, 37.6% from Turkey, and 37.5% Netherland-Antilles in comparison with 60% of Dutch women was documented by Rondy et al (2010: 2072). The reasons for low participation among immigrant women in screening programs is not different from other studies conducted in other countries (Antilla et al., 2006; Cuzick et al., 2006; Rebolj et al., 2007). According to Webb et al., (2004), screening disparities in immigrant women may be caused by underlying sociodemographic barriers. These barriers may be rooted in culture, migration related barriers, the health care system or a combination of all three factors among others. Unfortunately, as mentioned before, there is no data that makes a varied comparison of HPV infection between immigrant and local native women.

Be that as it may, the possibility of migrants harbouring varied disease profiles from the host population as suggested by Norredam et al. (2009) demonstrates that close attention should be paid to migrant women that hail from regions or countries with known high mortality and incidence rates of cervical cancer. One such country is Kenya; there are no known studies that have been conducted on migrant women from Kenya in the Netherlands. Cervical cancer remains as a major public health issue in Kenya. It has been named as the leading cause of cancer deaths and morbidity among women. In as much as screening is an effective tool for prevention, uptake is low among eligible women (Nyangasi et al., 2018:1). This research is timely and germane at this point as it can help the host country (Netherlands) pay close attention

to migrant women that originate from countries with high incidences of cervical cancer.

1.5. Research objectives

The objective of this study is to contribute to the development of holistic and effective policies and practices that promote the participation of Kenyan female migrants in the Pap smear cervical cancer screening program in the Netherlands. The study also seeks to bring to the fore migrant's health discourse, core factors and barriers such as lack of time, language proficiency or perceived discrimination. Lack of education/information, or knowledge misunderstanding(s) about screening may also be attributed as factors that may inform migrant women's decisions on whether to participate in the Pap smear program for the prevention of cervical cancer. In addition to that, the study seeks to examine how best the participation of migrant women in Pap smear programs can be improved?

1.6 Research Questions

Main Question

- In the context of excellent cervical cancer screening programs in the Netherlands, how are (Kenyan) migrant women responding to pap smear screening and are the policies and practices effective in promoting their participation?

Sub-Questions

- What are the factors and barriers that shape the understanding and perception of Kenyan migrant women's participation in the uptake of Pap smear programs for the prevention of cervical cancer in the Netherlands?
- Which (formal and informal) initiatives, policies and practices have been used to promote their participation
- How best can the migrant women's participation in the Pap smear programs for the prevention of cervical cancer in the Netherlands be improved?

1.7. Chapter Outline

This research paper is organized into six chapters. The first chapter accommodates the discussion on the research problem, background and justification, research objectives, and research questions. Chapter two focusses on methodology while chapter three explores the literature with the theoretical framework of the Health Belief Model as a premise for the analysis of data

collected through interviews with migrant women from Kenya and healthcare providers. The importance of relevant concepts such as intersectionality, acculturation, and vulnerability that help make sense of the perception of migrant women in Pap smear participation are also explored in chapter two. The fourth and fifth chapters are dedicated to the discussion of the research findings based on the research questions. In chapter four, the factors and barriers that shape the understanding and perception of Kenyan migrant women's participation in the uptake of Pap smear programs for prevention, in the Netherlands are discussed, while in chapter five, the different formal and informal initiatives, policies and practices that can be used in promoting participation, is touched upon. The last chapter summarizes the findings, draws conclusions and makes recommendations.

Chapter 2 The Health Belief Model, Acculturation, and other Relevant Concepts in the Uptake of Pap Smears

2.1. Introduction

This chapter examines the historical antecedent of Pap smears in the Netherlands, as well as the meaning and usefulness of the Pap smear. The discussion in the chapter also focus on the Health Belief Model theory, its relevance to the study and how the theory was deployed in the analysis of the data collected from the field. This helps set a premise to the discussion in Chapter four and five where the data is presented. Also, the discussion about the relevance and importance of the concept of intersectionality and acculturation in the understanding of the different barriers that hindered the migrant women from participating in the Pap smear program and how these barriers reinforced each other in shaping their perceptions is discussed.

2.2. Health Belief Model (HBM)

Health beliefs are crucially important, as has been illustrated in part, in the literature above. The Health Belief Model (HBM) is an apt theoretical approach that is considered by this study and appears befitting for the overarching theoretical framework. HBM is an acclaimed psychological health behavior change model that was developed in the 1950s to elucidate and envisage health-related behaviors, mainly in respect to the uptake of health care services such as vaccination and screening for asymptomatic diseases (; Siddiqui et al., 2016; Janz and Becker, 1984). HBM as demonstrated in Fig 1 below was developed to suggest that the beliefs that people have about health problems, the perceived benefits of taking action in order to solve health problem and barriers to such action, as well as self-efficacy, pertinently explain the engagement or lack thereof, in health-promoting behaviors and actions (Bendixsen et al., 2017:317). A cue to action or motivation must also be in existence in order to prompt health-promoting behavior (Janz and Becker, 1984; Rosenstock, 1974)

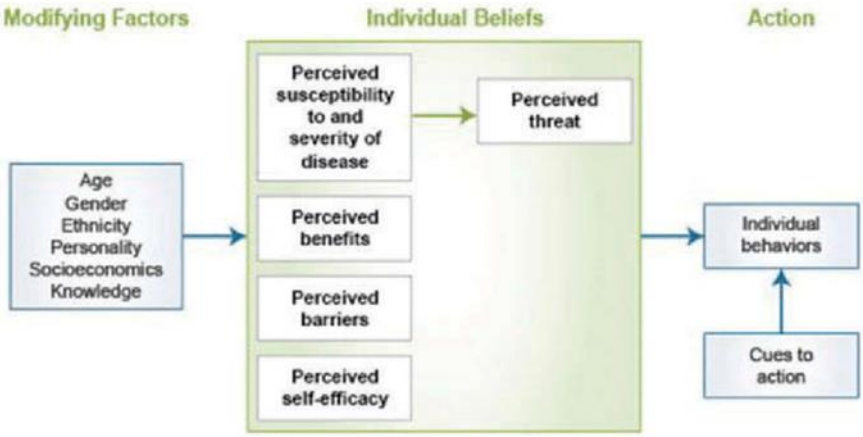

Figure 2.1: Health Belief Model (Source: Bendixsen et al., (2017:317). https://www.researchgate.net/figure/Health-Belief-Model-HBM_fig1_318473387)

The first theoretical construct of HBM, Perceived susceptibility, refers to the beliefs about the chances of getting a disease or ailment. For instance, a woman must believe there is a probability of getting breast cancer before she will be concerned about obtaining a mammogram (Champion & Skinner, 2008:47). Since Cervical cancer is mostly transmitted through sexual intercourse, East African migrant women from traditional and religious societies that abhor pre-marital sex might not consider that they are at risk of developing cervical cancer and therefore, may not see the need for testing or screening (Salad et al., 2015; Ko et al., 2019). This is in line with Rosenstock's (1974) argument that individuals with low perceived susceptibility to disease may deny that they are ever at risk of contracting a certain disease and in situations where they acknowledge the likelihood of contracting the disease, they still maintain the belief that it is highly unlikely for them to contract such diseases. This kind of belief is a recipe for engaging in unhealthy, unwise, or risky behaviors.

Perceived Severity speaks of the subjective appraisal of the severity of a specific health related issue and its probable consequences (Glanz et al., 2008; Janz and Becker, 1984). HBM suggests that when individuals or groups identify a particular health problem as severe, the tendency that such individuals will engage in preventive behaviors against the occurrence or limit the severity of such health problems is very high. The perceived severity strand of HBM is crucial to the understanding of why Kenyan migrant women take decisions to honour or reject the invitation for HPV screening for cervical cancer in the Netherlands. The low participation of ethnic minority uptake in screening, in most cases, has been attributed to the cultural and religion narrative in the literature. However, as demonstrated by HBM, how migrant women perceived the seriousness about the disease itself, whether it is life threatening or can cause disability for example (Glanz et al., 2008; Rosenstock ,1974; Janz and Becker, 1984) is as crucial as the cultural and religion narratives; For example, Janz and Becker (1984:3) maintained that a person may perceive that flu (influenza) is not a serious medical condition that may warrant him or her, a visit to the hospital for treatment. However, if the individual perceives that

she will lose a proportionate amount of income or money by not going to work for a number of days due to the flu, then she may start to perceive flu as a medical condition that requires urgent medical attention and treatment. The combination of perceived susceptibility and perceived severity is what Glanz et al., (2008)referred to as perceived threat. However, the perceived susceptibility and severity to a particular health condition depends on knowledge about the condition (Rosenstock, 1974). HBM envisages that higher perceived threats lead to greater prospects of better engagement in health-promoting action and behavior.

However, regardless of the perceived threats, health-related behaviors are also swayed by the Perceived Benefits and Perceived Barriers of taking action (Glanz et al., 2008). Perceived benefits in HBM refers to an individual's estimate of the worth or effectiveness in the engagement of health-promoting behavior to weakening the risk of disease (Janz and Becker, 1984). According to Champion & Skinner (2008), "even if a person perceives personal susceptibility to a serious health condition (perceived threat), whether this perception leads to behavior change will be influenced by the person's beliefs regarding perceived benefits of the various available actions for reducing the disease threat" (Champion & Skinner, 2008:47). The implication of this is that an individual's beliefs in a particular cause of action in reducing the vulnerability to a health problem or decrease in its gravity, regardless of objective evidence concerning the efficacy of the action, are more likely to lead to positive actions (Rosenstock,1974). A typical example can be seen in individuals that believe that skin cancer can be prevented by wearing sunscreen. These individuals will be more akin or more inclined to applying sunscreen, more than those that believe that skin cancer cannot be prevented by wearing sunscreen.

On the other hand, individuals that may exhibit strong beliefs in the perceived benefits might also be hindered by the perceived barriers which are obstacles in vital behavioral change (Janz and Becker, 1984). This therefore means that the perceived benefits must be greater than the perceived barriers, this in order for behavior change to take place (Janz and Becker, 1984; Champion and Skinner, 2008). Now, perceived barriers to taking action may include the perceived inconvenience of, the expense and possibly the danger (e.g. side effects of a medical procedure) and associated discomfort (e.g. pain, emotional upset) that are involved in engaging in the said behavior (Rosenstock,1974). For example, the dearth of accessing easy to reach and affordable health care, together with the perception that, a flu shot, will end up causing substantial immediate pain, may possibly act as obstacles to receiving the flu vaccine.

2.3. Intersectionality

The concept of intersectionality is considered to a minor extent, as a suitable as part of the conceptual framework for the study. Intersectionality is implicitly used to better comprehend how various social identities such as culture, age and gender, relate to each other and to understand the influence that these intersecting factors have on the participation of Kenyan migrant women in the HPV screening for cervical cancer. The concept has its origins targeted towards addressing how social identities like cultural background and gender

affect life and talk about how they establish collaborative relationships that stimulate each other (Crenshaaw,1990). Intersectionality otherwise, helps give direction on to how solitary emphasis on aspects such as class, ethnicity, culture, age, gender or religion, on their own, are inadequate for learning about how the interactive nature of the social forces and existent localities that shape lived experiences work in tandem to create or enable perceptions and actions (Staunæs, 2003; Brah & Phoenix, 2004; Yuval-Davis, 2006). Hankivisky and others have argued that while it is vital to recognize the role of one factor, it should however not be disconnected from other related categories as doing so would set boundaries for the contextualization of the analysis of the situation (Hankivsky et al., 2010:2).

Considering the empirical evidence from the literature on barriers (religion, socio-economic status, culture, language etc.) that hinder the lower participation of migrant women in the Pap smear screening in different countries, it is apparent that "different dimensions of social life cannot be separated into discrete or pure strands"(Brah & Phoenix, 2004: 76). The concept is central to the idea that no single category of social identity is essentially more significant than the other(s). As accentuated by Staunæs who contends that there isn't a pre-hierarchical weaving of predetermined patterns between categories, this means that we cannot isolate gender, class and ethnicity hierarchically as being the first, second or third factor affecting individuals, but rather, a combination of all three. "It is not gender first, then ethnicity, or the reverse, first ethnicity, then gender" (Staunæs, 2003:105) but a combination. Intersectionality analysis wards off the idea of prioritizing any categories and "being attentive to time, place, and historical and localized specificity", is important. As such, historical and social divisions are intertwined and constructed in tandem within specific historical conditions (Yuval-Davis, 2006: 200). Aspects of Intersectionality are therefore tacitly appropriated in the analysis as part of the methodology for this study.

2.4. Acculturation

Another concept that is used in the data analysis of this study is acculturation. It is worthy to note that the concept was discovered during the analysis of these study findings as one of the barriers to migrant women's' participation in Pap smear screening. Acculturation refers to the process of psychological, cultural and social cultural changes that stem from the ability to balance two diverse cultures in the sometimes strenuous processes of adapting to a society's prevailing culture in a host country (Juon et al., 2003; Fernandez-Esquer et al., 2003; Sam &Berry, 2010; Kwak, 2010; Samnani et al., 2012). This concept explains the process whereby individuals or groups acquire skills, adopt and adjust to new cultural environments and traditions, together with values considered as the norm, without jettisoning one's original cultural traditions and values (Akarowhe, 2018). When acculturation occurs at a group level, in most cases, it results in changes to healthcare, religious practices, and other social institutions (Sam & Berry, 2010). Acculturation becomes an integral part

of the data analysis of this study because several studies show that acculturation increases the precipitation of Pap smear participation among ethnic minority populations. For example, Hispanic and Vietnamese women's' participation in the US in Pap smear programs increased the more they became acculturated, which was measured by proficiency in the English language (Juon et al., 2003; Akarowhe, 2018). "More acculturated women reported in more Pap smears, perhaps because their ability to communicate in English enables them to become full participants of the society" (Fernandez-Esquer et al., 2003:480). Since the process of acculturation typically occurs over a long period that can last one or two generations, the concept helped in the understanding of why the perception of Kenyan female migrants in the Netherlands about Pap smear differs from one person to another. It was very useful in understanding the role 'that years spent in the Netherlands' plays in shaping the perceptions of the women about the Dutch healthcare system.

Acculturation is sometimes confused with assimilation; although both have similar components, the processes differ. Assimilation is "a process of interpenetration and fusion in which persons and groups acquire the memories, sentiments, and attitudes of other persons or groups; and, by sharing their experience and history, are incorporated with them in common cultural life" (1924 cited by Teske & Nelson, 1974: 359). Acculturation is a two-way reciprocal relationship; it does not require a change in values, although values may become acculturated (Sayegh and Lasry, 1993), unlike assimilation, where changes in values occurred (Teske & Nelson, 1974). The main distinction between acculturation and assimilation is that acculturation does not require out-group acceptance, while assimilation requires out-group acceptance (Teske & Nelson, 1974: 359). Some scholars have argued that in some cases, people were forced to acculturate (Kwak, 2010), but Samnani et al. (2012) maintained that people acculturate most often through social pressure and not via physical force. Social pressure as an antidote for non-participation is discussed in the recommendations for participation, where it has been suggested that new migrants are pressured into taking up the pap smear test and young girls vaccinated, this can help in the acculturation process.

2.5. Conclusion

This chapter discussed the relevance of the HBM to the understanding of motivation behind peoples' behavior in accessing healthcare. The five steps of the HBM, perceived susceptibility, perceived severity, perceived benefit, perceived barriers, and cue to action are critical steps that help unravel the reasons behind low participation of migrant `` women in Pap smear screening.

Chapter 3 Method of Data Collection

3.1. Introduction

A qualitative approach via semi-structured interviews was considered for data collection to help gain an understanding of the experiences and perceptions of migrant women from Kenya in relation to the Pap smear screening program in the Netherlands. Studies (see Valenzuela and Shrivastava, 2002; Easwaramoorthy & Zarinpoush, 2006; Qu and Dumay, 2011; O'Leary, 2014) have shown the suitability of interview techniques when there is a need to gather comprehensive information on people's experiences, thoughts, opinions, and feelings on a particular subject or problem. Cervical cancer screening is a very personal issue for women and the experiences of women are not homogenous despite the fact that a vast majority of women are exposed to the risks associated with the disease. One on one interactions with migrant women from Kenya produced a detailed explanation on why they choose to honor or decline the invitation for a Pap smear screening in the Netherlands. It also contributes to gaining a deeper understanding of the experiences of Kenyan migrants as well as the perception of healthcare providers.

3.2. Sample

In general, purposive sampling techniques were adopted in selecting the study participants for the interviews. A purposive sample is a non-probability sample that is selected based on characteristics of a population and the objective of the study (Tongco, 2007; Guarte and Barrios, 2006). To put it simply, it is the "deliberate choice of a participant due to the qualities the participant possesses" (Etikan et al., 2016:2). This approach was found to be suitable for the study as not all Kenyan migrant women in the Netherlands are qualified to participate in Pap smear screening. Only women that met the screening age could give reasons why they choose to participate in Pap smear screening. Pap smear screening in the Netherlands only starts with women from age 30 and above and these women must have registered their addresses (as required by all Municipalities) in order to receive an invite for screening. Therefore, randomly selecting women from the migrant population without careful consideration if they are qualified in terms of age, residency status, and duration of years spent in the Netherlands in the selection criteria would not have been helpful. The study has a specific target for migrant women within a specific age range and resident status in the selection of the final participants of the study since it was looking for women between the age range 30-65. The migrant women that were selected for consideration must have been in possession of a resident permit, legal status registration with the municipal office; invites for screening are sent only to residential addresses in Netherlands. Women with residency permits ranging from 1 year onwards were considered.

Table 1. *Selection Criteria of Participants in the in-dept Interviews with women migrant from Kenya.*

Variables	Specifics	Justification
Age	30-65	Pap Smear in Netherlands are meant for women within the ag of 30-65 years old
Residence Status	Permanent or temporary permanent residence for 1 year and above	Every permanent or temporary permanent residence are regist the Gementee (Municipality) and letter of invitations are sent registered address. Nonregistered residence don't get invitatio
Language	English, Swahili, Dutch	Invitation Letters are written in Dutch. The level of Dutch pr varies among the migrant depending on the number of years s Netherlands
Educational level	Primary; up to high school; Univ degree	To understand the level(s) of awareness and exposure of educated and less educated migrant women on the need for go Pap Smear tests.

3.3. Procedure for identifying participants

In order to gain access to participants, the study-initiated contacts with two Kenyan Diaspora groups in the Netherlands to facilitate access to members of the Kenyan community. The first group was Kenyan Diaspora Community in the Netherlands (KDCN) which was established in 2013 and registered with the Dutch Chamber of commerce (KvK) as a Foundation "Stichting" in 2013 and has its secretariat in Rotterdam. KDCN is a Non-Profit, umbrella association for all Kenyans who reside (temporarily or permanently) in the Netherlands. The community organization is dedicated to pursuing the interests of Kenyans in the Netherlands through close co-operation among Kenyans (and their organizations), and with other diaspora organizations, national and international organizations and importantly, the people of the Netherlands.

The second group is the Uhollanzi-Kenya Association (UKEA), established in the city of Utrecht and also registered with the KvK in 2004 with the support of the Kenyan Embassy in The Hague, to help cater for the socio-economic needs of its members who may face difficulties associated with living in a foreign country. UKEA is a well-structured body through which the Kenyan Embassy interacts with the Kenyan community in the Netherlands and seeks to provide a channel for the Kenyans population in the Netherlands

to forge stronger ties with Kenya, and also, importantly, to cater to the needs of Kenyans in the region[1].

Pertinent however, is the consideration that a good number of Kenyans in the Netherlands may decide not to be part of any of the two groups or not aware of their existence. Personally, I got to learn about them only due to my research. Therefore, a broad net was cast to contact as many Kenyans as possible residing in the Netherlands, considering the fact that there was a specific criterion that participants had to meet in order to be considered for the study. Additional recruitment of participants was undertaken using social media channels such as Facebook and WhatsApp groups of Expatriates in Netherlands as well as East African students' associations in universities and various community gatherings. The decision to recruit participants through this approach was to ensure that as many Kenyan migrant women as possible were contacted to include in the sample selection.

Emails, messages through WhatsApp and SMSs were sent to over 48 women, whose contacts were acquired from the UKEA influencers and KDCN membership, to request their participation in the study. 27 of them responded but only 19 indicated that they would be available to participate while others gave different reasons for their non-availability. 7 other women were recruited through WhatsApp and Facebook groups of Kenyans in the Netherlands. Overall, 26 Kenyan women were interviewed in the semi-structured interview sessions. Contacts were acquired from UKEA and KDCN, influential individuals and referrals together with social media. In addition, three medical professionals (three doctors and a nurse) working in hospitals in and around the Hague and other healthcare facilities in the country that provide Pap smear screenings were interviewed. For the sake of anonymity, the names of hospitals and healthcare facilities are withheld, and names of participants anonymized.

The aim was to collect information on their experiences in dealing with ethnic minority migrants' uptake of Pap smear as well as their perceptions on the motivations and challenges that shape the decisions of migrant women's participation in Pap smear testing. Two of the medical professionals (1 General Practitioner, 1 Nurse) are from Kenya practicing in the Netherlands, while one is Dutch, the other Iranian.

3.4. Ethics

To adhere to ethical considerations for this research, informed consent letters were made available in English and Swahili although only the English versions were utilized as the participants were very comfortable with English. Apart from informing the participants about the purpose of the study prior to the face-to-face interviews during the recruitment process through emails, telephone, WhatsApp etc., consent was sought, and it was recounted before the

[1] Kenya Embassy in The Hague Official Website http://www.kenyaembassy.nl/index.php/24-embassy

start of the data collection in cases where telephonic interviews were conducted. The Participants were given the option of withdrawing at any time or stage of the process without being coerced or manipulated to continue. Another ethical issue in this study is the fact that I have undergone Pap smear screening on a myriad of occasions, and I happen to be a big advocate. I therefore only revealed my status after my interview with the participants. As such, my status as a pap smear advocate did not influence the responses of the respondents.

3.5. Limitations and Challenges

The initial plan was to conduct two focus group discussions, unfortunately it was not feasible because the data collection for the research fell within the summer holiday period during which many Kenyan families travel for summer holidays. As a result, the traditional end of the month association meetings of KDCN and UKEA that I had planned to leverage on were cancelled. This is not usually the norm. This posed a serious challenge to my data collection process, it cost me time and money to travel to different cities in the Netherlands to meet respondents after securing appointments with them via WhatsApp, telephone and text messages. Due to the nature of the respondent's occupation, 8 scheduled interviews were canceled and rescheduled and this caused serious delays in meeting the deadline of the research timetable. Healthcare practitioners also proved very difficult to access, as they are extremely hard pressed for time. Alternative options for telephonic interviews were given to a good number that could not reschedule face-to-face meetings. Another limitation encountered was that I was unable to interview a diverse sample of respondents from different social strata's and walks of life. This meant therefore that the majority of the respondents are highly educated women. The implication of this is that the findings cannot be applied to the entire Kenyan community in the Netherlands.

Additionally, my initial thought during the research design was that it would not be a challenge to get government (ministry of health) representatives and doctors to interview. However, efforts to get appointments with representatives that would have enriched the research with relevant information to help in the data analysis on government policies and practices aimed at promoting migrant's participation in Pap smear proved abortive. It was very difficult to get doctors who were willing to participate in the study due to their tight schedules. However, I managed to get them via referrals, recommendations and networking. I also managed to find a Kenyan doctor and a last-minute appointment with a Dutch doctor with via a late interview schedule.

Table 3.1: Summary of Research Methods and participants selected

Research Questions	Method of Data Collection	Sources of Participants/ Respondents	Justification

What are the factors and barriers that shape the understanding and perception of Kenyan migrant women's participation in the uptake of Pap smear programs for the prevention of cervical cancer in the Netherlands?	26 Semi-Structured interviews	Kenyan Diaspora Community in the Netherlands (KDCN) Uhollanzi-Kenya Association (UKEA) Facebook and WhatsApp groups of Expatriates in Netherlands as well as East African students' associations in universities.	Both KDCN and UKEA are the only known official bodies representing Kenyans in Diaspora registered with the Dutch government KvK Not all Kenyans associate with the two bodies or realize their existence
Which (formal and informal) initiatives, policies and practices have been used to promote their participation	4 Semi-Structured Interviews	1 Kenyan doctor, 1 Iranian doctor, 1 Dutch doctor, 1 nurse	Knowledge about the level of participation in Pap Smear since they are the ones conducting the Paps
How best can migrant women's participation in the Pap smear programs for the prevention of cervical cancer in the Netherlands be improved?	In-depth interviews Semi-Structured Interview	Kenyans women above the age of 30 years old and above with residency in Netherlands for minimum of 1 year. Healthcare providers	All have required information, and also suggestions that can help improve participation

Chapter 4 Exploring Migrants Women Perception to Pap Smear with Health Belief Model.

4.1. Introduction

The focus of discussion in this chapter is on the underlying factors and barriers that shape the understanding and perception of Kenyan migrant women's uptake of Pap smear programs for the prevention of cervical cancer in the Netherlands. In the process of collecting data for the research, 26 interviews were conducted, and the outcome of the interview was a mixed bag of results. The outcome shows that half of the respondents have not participated in Pap smears. However, there are various reasons responsible for the non-participation of the other half. These include the language barrier, lack of understanding on how to navigate the health care system which can be attributed to acculturation, and preference for female GPs. As discussed earlier in chapter 2, the individuals' perception regarding their vulnerability to health threats and their assessment of the seriousness and severity associated with the health threat tend to influence their decision in seeking out preventive actions to mitigate the threat. The Health Belief Model was adopted in the data analysis.

This chapter is organized into four sections. In the first section, the discussion around the findings of this study as regards migrant women's perception of vulnerability to cervical cancer and the perceived severity of cervical cancer is outlined and is undertaken to analyse the results. The differences in the perceived susceptibility and severity were based on various levels of the respondent's awareness and knowledge about cervical cancer. The second section focusses on perceived barriers such as acculturation, a perceived unfriendly healthcare system, and preference for female General Practitioners (GP) as obstacles that top the list of barriers that shape the Kenyan migrant women's experience in the uptake of Pap smear testing. The chapter analyses how acculturation, with a focus on the role that length of residency in the Netherlands, together with Dutch language proficiency, are crucial in participating in cervical cancer screening among these immigrants. However, the difficulties that come with how the Dutch healthcare system is structured and organized is not just a barrier to those that did not participate in the Pap smear; it was also a significant concern for those that participated; this will be highlighted in section three of the chapter. The fourth section discusses the paucity of female GPs' available to address the migrant's concerns on Pap smears; this will be brought to the fore to underline the concerns of the respondents. Intersectionality then rounds up the chapter, identifying the different aspects of social identity that affect uptake of screening.

4.2. Perceived Susceptibility and Severity

Information is Critical

To understand their perceived susceptibility and severity on cervical cancer, questions about their knowledge and awareness on the disease were put forward, as well as if they would recommend Pap smears to other women as a preventive measure. While the word awareness and knowledge are occasionally juxtaposed in public health debate, they connote different meanings and have implications on public health behaviour even though using both terms interchangeably is unproblematic. (Trevethan, 2017:1). The discussion with the women revealed that there is a gap between awareness about cervical cancer and the knowledge about the causal factors and how it can be treated or prevented. The findings show that 23 out of 26 of the respondents have heard about cervical cancer but only 12 of them understood what it meant; its symptoms, treatment and preventative measures. 16 out of the 23 respondents that have heard about cervical cancer got to know about it when they got to Netherlands, while the remaining eight knew about it before migrating to the Netherlands. Three of the respondents that have participated in Pap smears did their first screening in Kenya as a result of their doctors' recommendation and the fact that they had adequate resources and insurance to cover the costs.

The lack of adequate knowledge about cervical cancer contributed to why the majority of Kenyan migrant women did not feel vulnerable to cervical cancer. From the discussion with the respondents, it was evident that the lack of adequate information about cervical cancer shaped the belief that they are not susceptible. Different reasons were given for the perception of their vulnerability. Cynci, a 35-year-old who has been in the Netherlands for five years believes that because she does not smoke or consume Genetically Modified Food, she does not consider herself vulnerable to cervical cancer.

> "It is good to go for a medical check-up once in a while, but I honestly think that the chance of me having cancer is very low. I don't smoke, I don't eat all the cancerous GMO foods that you see all around in the various supermarkets, and most especially I hate eating junk food and dirtiness. All these things are what causes cancer" (Cynci, 35 years old, August 2019).

Auri's knowledge about cervical cancers' risk factors were as skewed as Cyncis'. Auri, a 45-year-old mother of 3 has spent 15 years in the Netherlands and is also aware of the importance of screening but did not perceive that she may be at risk of suffering from cervical cancer.

> "I participated in the Pap smear just to fulfil all my obligations, moreover it is free, so I have nothing to lose". To be candid, I don't believe that I am vulnerable to cancer. I don't eat GMO foods, I have never done abortions before in my life, I don't smoke, and as a woman, if you don't want to contract different kinds of disease you need to take care of your hygiene seriously" (Auri, 46 years old, Interview August 2019)

The discussion with Cynci and Auri shows that misconceptions about cervical cancer affect the decision of individuals to seek health care services to prevent the disease. Both Cynci and Auri believe that they have a low risk of contracting the disease because of their healthy eating habits, practices of cleanliness/sanitation etc. This portrays their limited scope of knowledge regarding risk factors. Several other risk factors contribute to the vulnerability to cervical cancer. These include but are not limited to being overweight (Kessler,2017), food consumption with fewer vegetables and fruits (Labani et al., 2009), hereditary factors (Hemminki, & Czene, 2004), smoking (Mosavel & El-Shaarawi, 2007), abortion (McMullin et al., 2005) multiple pregnancies, using birth control pills long-term (Akinlotan et al., 2017), child/early marriage and teenage pregnancy (Ajah et al., 2015) just to mention a few. While it is not a given that women that are affected by the factors as stated above will eventually develop cervical cancer, they are at a higher risk of developing the disease. The responses from the majority of the women follow Auri and Cynci's thinking, narrowing their susceptibility to cervical cancers to a handful of risk factors such as smoking, food consumption, and abortion). In some extreme cases, studies have shown that some women believe that one can be infected with cancer by merely 'playing' with a cancer patient as demonstrated among indigenous Australian women (Shahid & Thompson, 2009). According to Chirwa et al., (2010:48), "myths and misconceptions surrounding the disease can lead to poor utilization of screening services wherever they exist". This shows that there is no limit to how misconceptions can affect people's understanding about cervical cancer.

The Fear of Cancer

One fascinating thing about the women's responses is that regardless of their perceived susceptibility, they all have the desire to participate in Pap smears and are eager to recommend that their friends and family members participate. One major factor contributed to this perspective; the fear factor associated with the word cancer. For example, Rosy, who has been living in the Netherlands for 3 years and has not participated in Pap smears because she did not receive a letter of invitation expresses her fear of cancer in general;

> "We are talking about cancer here, who wants to die? Of course, it is curable if detected early so it will be very stupid of me not to take the opportunity to know my status because the moment you are infected your chance of survival is low" (Rosy, 33 years old, Interview, August, 2019).

From the responses of the respondents, what can be deduced is that the women exhibit a high level of perceived severity of cervical cancer, but this is not necessarily because they have adequate knowledge about the disease. Rather, it is because of their perception that anything denoting cancer is equivalent to death. Equating cancer to a death sentence influencing women's perceived severity has been documented in previous studies elsewhere (White et al., 2012; Shahid & Thompson, 2009). For example, in Canada, 1st nation women considered cancer as a direct death sentence, incurable, the word

struck utmost fear. (Shahid & Thompson, 2009:111). People with low perceived susceptibility of a disease have the tendency of not thinking about prevention since they don't believe that they can contract the disease.

Table 4.1: Summary of Perceived Susceptibility and Perceived Severity

Perceived Susceptibility	**Perceived Severity**
No for 9 out of 26 respondents, Yes for 17 out of 26 respondents	Yes for all 26 respondents
No represents lack of knowledge about Paps and Cervical cancer, Yes represents knowledge and awareness about Paps and cervical cancer	Yes represents desire to participate in Paps and recommend the test to others

However, findings as demonstrated in the summarised Table (4.1) above[2] of Annexure (2) show that that the high level of perceived severity contributes to the reasons why Kenyan women considered participating in Pap smears as an important process even though the majority of them did not consider themselves susceptible to cervical cancer. Despite the fact that most of them, did not fully understand Pap smears and what they entail, they are willing to participate in Pap smear testing if they have the chance to do so.

> "You can see my expression when you ask me if I received an invitation letter and I said no, I see it as an opportunity that I should not miss", I think it's important given the high rates of cancer, given the fact that people are dying of cancer. Prevention is better than cure" (Lizzy, 37 years old, Interview August 2019)

The expression on Lizzys' face when I mentioned if she received the invitation letter was of a shock and surprise. She had no idea that such an opportunity exists for migrants, if she had known, she would have requested the test because she considered cancer a deadly disease. Meanwhile, the perceived severity that ought to translate to a cue to action did not materialize because of perceived barriers. As stipulated by the Health Belief Model, two main beliefs influence an individual's willingness in partaking preventive action: these are 1) beliefs relating to the readiness to take action and 2) those relating to modifying the factors that inhibit or facilitate a cue to action. (Mullen et al., 1987). In the next section, perceived barriers that inhibit participation in Pap smears shall be explored.

4.3. Perceived Barriers

Acculturation

One of the primary factors documented by various studies (see Jenny, 1998; Harmon et al., 1997; De Peralta et al., 2015; Saini et al., 2017) in the last three decades responsible for low participation of immigrants in the uptake of Pap smears in their host country is acculturation. It has been suggested that acculturated women have the propensity to desire to participate in Pap smear

[2] For details see Annexure 2

programs or testing regularly (De Peralta et al., 2015; Saini et al., 2017). However, a number of factors influence the process of immigrant acculturation, including social support, language proficiency, level of education (Berry, 2003), and length of residency in the host country (McPhee et al., 1997; Lofters et al., 2011).

Table 4.2: Summary of Findings: Letters, Residency, Language Proficiency

Factors	Participated	Not Participated
Invitation Letters Received	11	2
Letter of Invitation Not Received	2	11
Lengths of Residency above 7 years	10	3
Length of Residency below 7 years	4	9
Zero or Basic Dutch Language Proficiency	5	8
Average or Advance Dutch Language Proficiency	4	9

As demonstrated above in Table 4.2, the number of years as a resident in the Netherlands plays a significant role in the non-participation of the Kenya women migrants in Pap smears. Nine out of 13 of those that have not participated in the Pap smear, have their years of residency below seven years; only four respondents have spent between 7 years and above in the Netherlands. On the other hand, ten of those that have participated in pap smears have been living in the Netherlands for more than 7 seven years with the exception of three respondents. From the analysis of the data, length of residency appears to have an impact on language proficiency which is critical to understanding the content of the invitation letter from the municipality to attend Pap smear screening. However, the opinions of some of those that received the invitation letter revealed that those that claimed they didn't receive invitation letters might have indeed received them but did not understand the contents. For example, Shishi, age 34, received the invitation letter but could have misinterpreted the contents. When asked if she received the invitation letter or if her GP recommended the Pap smear to her, she responded;

> "Yes, I did, but the problem was, the letter was written in Dutch. So, I google translated it just like I do for all the letters that I receive. I am just three years in the country, and my Dutch proficiency is bad". (Shishi, Age 34, Interview, August 2019)

All the women migrants that participated in the study are educated with a college degree as the minimum qualification, and about 70% possess the minimum basic proficiency to write, read, and speak the Dutch language) see Table 2 in Annex for details). It is important to note that 11 of the 13 women that did not receive invitation letters have not participated in Pap smears in which seven of them indicated not good or none as their proficiency level of the Dutch language. One of the two respondents that did not receive an invite but who participated in Pap smear did it because her GP advised her to do so when she went for contraceptive advise while the other respondent requested

one from her GP. The seven that indicated non-proficiency in the Dutch Language have one thing in common: a short residency period; between 1 and 5 years. On the other hand, all the 13 women that have participated in the Pap smear indicated that they have the basic required proficiency to write, read, and speak the Dutch language. Only two out of the 13 indicated that they have not received an invitation letter.

The fact that all the respondents that have stayed longer than eight years in the Netherlands demonstrated proficiency in the Dutch language did not negate the language barrier problem. Seiyo, who is a 47-year-old that has been in the Netherlands for 15 years, said she doesn't have a problem with language because she attended a 1-year intensive Dutch language course 2 years after her arrival. She however acknowledged the challenges she encountered in dealing with letters from the Bank, tax office, the municipality, etc, even though interacting with Dutch people is easier because of the high proficiency level of the English language among the Dutch…

> "The only problem with the Netherlands is that all the written communication that contains vital information such as finance, tax, healthcare, security; that are crucial for migrants, are in Dutch. My first two years, before enrolling in the language course were difficult as I continued to receive loads of letters written in Dutch. I am sure I must have trashed one of the invitation letters." (Seiyo, 47 years old, Interview August 2019)

Based on the responses from Shishi and Seiyo and other respondents, it is safe to make the assumption that invitation letters are sent, but recipients may be clueless about the contents of the letter, with non-participation being the result. The fact that some women received invitation letters and did not participate and those that did not receive invitation letters still participated in Pap smears shows that the language barrier, beyond the basic proficiency of reading, writing, and speaking, is required. For example, Shishi did not participate, even after getting the letter because she thought that only Dutch citizens were entitled to the free test.

> "I got the letter; I decided not to go for the test because I thought I am not qualified. I thought that only citizens are entitled to it, if I knew that I can take part in the test, I would have gone because I believe it is a good thing to do" (Shishi, Age 34, Interview, August 2019).

The lack of proficiency in the Dutch language still affected Shishi despite using Google translate. Studies have shown that, while Google translation is a useful tool to grasp basic meaning of a text, it is not always a reliable translation tool that can give proper context of the text (Bahri & Mahadi, 2016). This explains why Shishi might have misunderstood the context of the invitation letter thinking that Pap smear screening is meant for citizens only. The response as represented above explains why many migrants have little understanding about the opportunities for free testing. Even though the migrants might be entitled by law of the host country to specific health coverage (MIPEX, 2015), the inability to understand the detailed information about entitlements, and what type of services are available for them or making appointments with doctors as a result of language barrier, is an impediment to access to healthcare (Nørredam & Krasnik, 2011:72)

Language; An Impediment to Migrants Women Communication with GPs

From the information gathered from the medical professionals that took part in the study, it was clear that prior to performing pap smears for migrant women, they do not generally explain the purpose of the pap smears due to language barriers unless the patient is curious about its purpose and asks about detailed information.

> "I don't really explain the details, this is because most Dutch women are very well informed about it and were probably vaccinated in their teens. For some of the migrant women or immigrant women who may not speak Dutch or English (who received the letter) that I have come across, just bring the letter and because it is free they accept the pap smear, if they speak English I will explain, if not I will just do it." (GP 2, Interview, September 2019).

This language barrier also has an impact on the communication between GPs and migrants. According to Meeuwesen et al. (2006), GPs tend to spend more time with non-migrants than the migrants during consultation due to language differences. Many migrant women don't ask detailed questions and are less demanding in comparison with non-migrants. Even though most Dutch doctors speak English, many are more proficient in Dutch, or their native languages, so English, which is Kenyas official language, may present language barriers, either way.

Unfriendly Healthcare System

The findings of this study show that the availability of an extensive and accessible healthcare system does not necessarily mean that migrants access it with ease, particularly migrants that have recently arrived. This expressed view is not limited to those that have spent less than five years in the Netherlands, those that have been in the Netherlands for a longer period also express their concerns about the 'unfriendly' nature of the Dutch healthcare system. Rosy, age 39, a resident in the Netherlands for 3 years, has not attended or received an invitation to attend a pap smear although she is aware of the purpose of having the test. Despite her lack of proficiency in the Dutch language she still believes that it is important to participate in Pap smears to be certain of one's status because it is "better to be safe than sorry". However, when asked about the reasons why she has not been tested despite her high level of awareness and knowledge about cervical cancer, she shared her concerns about the rigorous process to secure a doctor's appointment.

> "In terms of healthcare, I do not find the system accessible and this makes it difficult to access proper medical healthcare. You have to start with a GP, it took me half a year to see a specialist who could tell me what was wrong with me" (Rosy, Age 39, Interview August 2019)

The fact that one has to go through a General Practitioner (GP) before accessing a specialist is something alien and challenging to a vast majority of the Kenyan migrant women. Similar findings were discovered in a study conducted in Norway corroborating the fact that healthcare systems that have

GPs as gatekeepers to specialists are considered by migrant women as unfriendly and a barrier to Pap smear participation (Lamkaddem et al., 2012). Likewise, Njoki, a 39 year old Master degree holder who has not been opportuned to attend a Pap smear because she has not received any letter but is aware of the purpose and importance of the test due to her friends' experience back home in Kenya, , lamented that medical accessibility was a major challenge because the system is very unfriendly.

> "I do not find the healthcare system here friendly, it is not easily accessible", you have to wait … for example, my friend … had a complication, she was in deep pain, and she wasn't able to get medical attention immediately when she needed it, the wait is very frustrating…."(Njoki, Age 39, Interview August 2019)

There is a chance that the length of residency of migrants like Rosy and Nyoki can affect their understanding on how the host country's healthcare system works and might have difficulties in navigating the health system as suggested by Nørredam & Krasnik (2011:68). Most importantly, there is a clear difference between the Kenyan and Dutch healthcare system. In the Netherlands, GPs are the gate keepers to the healthcare system and every resident is required to have one (Kringos et al., 2015:183). In contrast, the equivalent of a GP in Kenya is a Family Doctor (FDs) and it is not compulsory to have one (Mohamoud et al., 2018:1). Not all doctors are qualified to be GPs in the Netherlands, it requires a 3 year postgraduate program in general practice (Kringos et al., 2015:186) while in Kenya, GPs are widely accessible, any doctor can become a family doctor with a number of them not undergoing postgraduate training (Mohamoud et al., 2018:1). FDs and Specialists are easily accessible in the commercial medical private sector in Kenya and do not need a referral from an FD. Specialists are highly accessible if you have the money or ample insurance to cover consultation and concomitant medical costs. It is important to note that FDs in Kenya are generally referred to as GPs!

Primary care is the mainstay of the Dutch health care system. Health services are funded by a mix of obligatory social and private insurance (Kringos et al., 2015:183). Health insurance is compulsory, and it covers the standard benefit package which includes the primary care delivered by GPs (Giesen et al., 2011; Faber et al., 2012; Westert et al., 2009). Within the overall budget of the Ministry of Health, GPs and other health care professionals working in primary care are allocated a specific amount of money and receive their own budget. GPs are reimbursed via health insurers (Kringos et al., 2015:183). On the other hand, the primary health care system in Kenya is divided into three sub systems, Faith Based Organizations (FBOs), Commercial Private sector and the Public sector. The Public sector however is the largest in relation to numbers of facilities, followed by the commercial private sector, and the FBOs. There is a huge disparity among the three sectors, particularly in rural areas (Embassy of Netherland in Nairobi, 2016:5). Any of the three sectors are accessible depending on the cost factor. Health insurance is mainly for those who can afford it and is not compulsory.

It was visible from the responses of the sample group that they are yet to acculturate the Dutch healthcare system that are poles apart from Kenya in terms of organization and structure. Perhaps, the problem related to the lack of knowledge of the healthcare system might continue to diminish the longer the migrants continue to reside in the host country (Loue & Sajatovic, 2011). Annay, a 46 year old woman that has been in the Netherlands for 10 years and who has had Pap smears twice in Amsterdam, was also sceptical about access to healthcare in the Netherlands as it takes a while to get an appointment.

> "Ummm, if you're sick, the problem is sometimes they take too long to give you an appointment, they advise you to take paracetamol… You cannot just walk into the hospital and say I am sick, or I want you to conduct a test for me" (Annay, age 46, Interview August 2019)

Nevertheless, all the women that found healthcare more accessible are those that have spent over 10 years in the Netherlands. Shiru (43) a 12-year resident, is not sure if she has participated in Pap smears or not and unsure if she received an invitation letter. It was after I explained the process to her that she confirmed having had it once despite living in the Netherlands for 12 years. Ideally, that would have qualified her to participate in Pap smears twice. She did not have a problem with other aspects of settling down because she relocated from another city in Europe, she had adjusted well to a European lifestyle and culture. However, she understands why many migrants felt that the healthcare system is unfriendly and not easily accessible.

> "I find it quite accessible, but it depends on the doctor you have…. some doctors just ask you to take paracetamol…. Plus, your GP has to refer you to a specialist, sometimes that can be frustrating if the GP doesn't think you need to see a specialist" (Shiru, 43 years old, Interview August 2019).

As discussed in the previous section on the high level of perceived severity and perceived benefits demonstrated by all the Kenyan women that participated in this study, 80% of all the participants maintained that the perceived barrier of the unfriendly system is enough to discourage migrant women from voluntarily opting to participate. The possibility of migrants meeting their health needs is dependent on the host country's healthcare system (Rosano et al., 2017:1-2). The access to migrants of public health services is affected by a range of factors at various levels within the health system. This includes health policies, discriminatory or unfriendly behaviour of healthcare professionals towards migrants, and the organization and structure of services (Nørredam & Krasnik, 2011).

The migrant's experiences on the cumbersome process of securing an appointment and the long wait coupled with difficulties in accessing information as barriers to accessing cervical cancer screening services in their host countries is well documented by various scholars (Bottorff et al., 2001; Jackson et al., 2002; Vahabi & Lofters, 2016). It is difficult to directly measure access to healthcare, nevertheless, in most cases the utilization level has been used as a

yardstick of measuring access (Nørredam & Krasnik, 2011:68). It was evidential from the findings of this study that many did not participate in the Pap smear due to the stress of navigating the healthcare system's bureaucracy.

Preference for Female GPs

The GPs recommendation is a critical factor in the uptake of Pap smears (De Alba & Sweningson, 2006). However, the gender of the GP plays a significant role in increasing the level of migrant women's participation (Nguyen et al., 2002; Harcourt et al., 2014). The majority of migrant women, as documented by various studies elsewhere, prefer female physicians. They are more comfortable with a female GP examining them as well as having discussions with them about Paps (Oelke & Vollman, 2007; Stevens et al., 2004; Hislop et al., 2003; Jackson et al., 2002; Bottorff et al., 2001). From the findings of this study, 10 out of the 13 respondents that have participated in Paps expressed concerns about not being comfortable when examined by a male GP when asked about their opinion on why migrant women might not want to participate in the Pap smear despite the fact it comes at no cost in the Netherlands.

> "The Pap smear is important, but it was a bit uncomfortable, it would have been better if it was done by a female, I would rather prefer a female doctor or even the assistant who is usually female. If I had a preference it would be a woman" (Shiru, 43 years old, Interview September 2019)

The question one should ask is why Shiru and other women did not choose female GPs since they are not under any obligation to choose a male GP. While there is no recent available data to show the sex ratio of male to female GPs in the Netherlands, previous studies show that there are more male GPs than Female GPs. The unbalanced nature of the sex ratio was document by Bensing et al., (1993:219), they found that 87% of GPs in the Netherlands in 1991 were male compared to 13% female. With the increase of female medical students in the country, the number of female GPs increased from 18% in 1993 to 35% in 2007 with the expectation that the number would have risen by 2020 (De Bakker & Groenewegen, 2009:132). Apart from the possibility of the imbalance that makes it hard for migrant women to find female GPs closer to their residence, one can deduce, from De Bakker & Groenewegen's (2009:132) position that female GPs tend to work on "average fewer hours per week than male GPs". Going by the argument of working hours, it makes sense that there will be more male GPs to select from. The respondents of this study's preference for female GPs was explained further by Alisa;

> "When I was residing in Groningen, I was motivated by a friend to go for a Pap smear but when I asked my GP, he did not think it was necessary. It was after I told my friend what happened that she advised me to change my GP to a female. Therefore, when I moved to Rotterdam, I ensured that my GP is female" (Alisa, 40+, Interview, September 2019).

The conversation I had with the medical professionals validates the claims of the women's preference for a female GP. One of the male GPs that preferred not to be named confirmed that many women prefer a female GP and are mostly influenced by religion and culture. when asked if he believes that there is a cultural issue when it comes to pap smear testing, he asserted...

> "Yes, especially if the women are circumcised (they don't want to expose themselves) or if they are virgins, then they will not do it. I also know that if a male doctor has to do a pap smear or examination, they refuse" (GP 1, Interview, September 2019).

From the response of the GP 1 above, it shows that cultural reasons alsoplay an important role in the decision of the women on the preference for female GPs. While none of the respondents acknowledge that they have undergone circumcision, the view shared by GP 1 is a valid point because female circumcision is an issue in Kenya. According to UNICEF (2019:4), 21% of women between the age of 15 and 45 have undergone Female Genital Mutilation (FGM) in Kenya, this is despite the FGM Prohibition Act of 2001 (amended in 2011) that criminalized FGM with jail sentences and fines in Kenya. Although, the UNICEF (2019) report shows that 93% of women are not in support of FGM in Kenya, it also shows that 6% of women between the age of 15-45 support the continuity of the practice. Regardless of the enactment of the law, which is rarely enforced, many ethnic groups continue to observe the practice as it is considered an important part of their culture that sees thousands of girls circumcised yearly (Onyulo, 2018). The defence of culture and women's rights narrative was pushed further on October 25th, 2019, when a Kenyan female doctor approached the court to demand for decriminalization of FGM for women of age 18 and above. As reported by CNN, Tatu Kamau argued in court that adult-women should have the right to choose what they do with their bodies and besides, it infringes on many women's' cultural beliefs (CNN, 2019). The implication of this is that some women (educated and less educated) desire FGM but would not want to get exposed, and pap smears may very well expose them, so they may avoid it totally.

According to Harcourt et al., (2014), one of the primary reason's migrants' women prefer female GPs is because they are most likely to ask their new patients about their knowledge on Pap smears and if they have had one. Because GPs are authoritative figures on health-related issues that people trust and respect, it is very unlikely for migrants not to attach importance to the necessity of a test if recommended by the doctor (Vahabi & Lofters, 2016). However, there are instances where doctors downplay the need for a Pap smear (Schoueri, 2013; Xiong et al, 2010).

4.4. Conclusion

With the help of Health Belief Model principles, the study has been able to show the various factors and barriers that have potentially hindered participation. Acculturation was identified as the most important factor because it encompasses the language barriers and the negative perception of the Dutch healthcare system which was evident through the differentials in participation

in Pap smears between those that have longer lengths of residency in the Netherlands and those with fewer number of years spent in the country.

Social identities as far as intersectionality is concerned revels that religion, nor socio-economic status or class seem to have deterred half the group from participating, but other social identities such as being a foreign migrant that finds it difficult to navigate the healthcare system effectively, a minority grouping with a different tongue or language (even for those that speak Dutch, they will not speak it as a native does), the intimacy of pap smear screening leading to preference for female GPs (which highlights a gender norming preference and hence not being able to access female GPs plays a role in participation. Age, as a social dimension of identity, is also a factor that plays a role. One of the participants that requested a pap smear before she turned 30 was turned down. Access to pap smear screening is related to ageism. Ageism in terms of length of residency also clearly affects participation in this study, the longer one is a resident, the more likely participation will take place due to acculturation, language skills, navigating the system and integration into the society.

Chapter 5 Improving Participation in Pap Smear

5.1. Introduction.

In this chapter, the discussion focuses on themes that were derived from the data collected during the interviews with healthcare providers and the Kenyan women on how best the participation of migrant women in Pap smears can be improved. Four themes came up during the analysis; customization of invitation letters to multiple languages, awareness through the declaration of a cervical cancer awareness month or week, and mandatory vaccinations and Pap smear testing for newly arrived immigrant women. While all the suggested ways to improve participation are not without flaws, the suggestions were explored to bring out the positivity that can be adopted by the Dutch government in improving participation in screening.

5.2. Language Translation Should Accompany the Letter of Invitation.

Because the migrant Kenyan women identified language as one of the major barriers that kept them away from participating in the Pap smear, it is not unexpected that all the respondents suggested that the Pap smear invitation letter should be written in multiple languages. Joy (43) who has been in the Netherlands for 19 years, said that if the Dutch government is interested in addressing the low participation of migrant women, they need to make an exception with the invitation letters and they should be written in languages that migrants will understand. She explains further;

> "For example, there was a day I was helping a church member to pack her belongings when she wanted to relocate; during the process, some letters fell from a box. I asked her about the letters, but she replied saying she does not understand the contents. I looked through the letters, and I found a Pap smear invitation letter sent four months ago. I explained the contents to her, and the following day, she took the letter to her GP, and did the Pap smear. It worked out well as she already had made an appointment prior to the discovery" (Joy, Age 43, Interview September 2019).

The example Joy gave shows the importance of making the invitation letter available to migrants in alternative languages. Various studies also back the argument of the need to provide information in different languages to enhance migrant's participation in Pap smears (Qureshi et al., 2019; Idehen et al., 2017; Gele et al., 2017). However, Rie (40) who was brought to the Netherlands 37 years ago by her parents maintained that the idea of having a letter of invitation in multiple languages as a panacea to the problem of low participation in Pap smears is not a straight forward as many people paint it to be. While she agrees to the fact that it may help some migrants, she was of the

opinion that people should not assume that all migrants speak and understand English. She argued that;

> "It is true that the migrants that can read the languages the government decided to add to the Dutch language in the invitation letter will understand the content of the letter. What about other languages such as Amharic, Swahili, Somali, Bengali, Arabic, Persian, even French because some of the migrants are from French-speaking countries, and many other languages. Then which of the languages are you going suggest to accompany the Dutch language in the invitation letter. It is a difficult task, and the government will have to find a way around it because language is crucial in communication and information" (Rie, age 40, Interview September 2019).

While Kenyan migrant women that participated in this study would benefit from an invitation letter that comes with the English translation because all are educated with a high proficiency in the English language, some migrants (non-educated) may not be able to read the letter even if the content of the letter is written in her language. What I can infer from the views of Rie and Joy is that the ministry of health needs to pay attention to the issue of the invitation letter as far as language is concerned, albeit with the complexity that might be attached to accommodating multiple languages in the letter. Although, the procedure of screening for cervical cancer through invitation is available in English, Turkish and Arabic on the ministry of health website screening brochure, the actual sample of the invitation letters in the said languages is not available on the website. Only the procedure is translated into the 3 languages. Therefore, it is not yet known if the letters are sent in other languages, it can be said however, that those that received the letters confirmed that they were in the Dutch language. Nevertheless, it is important for the Dutch government to consider multiple languages for the letter because, in the past three years, population growth in the Netherlands can mainly be attributed to immigration. As mentioned before, population growth has increased by 280,000 between 2015 and 2018, and about three-quarters of this population growth was via international migration (CBS, 2019). Consequently, the countries of origin of migrants with the highest population are not those of English speakers, therefore, making information available in even more multiple languages (apart from Arabic and Turkish) is crucial for increased participation.

5.3. Declaration of Cervical Cancer Awareness Months: Public Awareness, Advocacy, and campaign.

Awareness through different means such as community-based campaigns, electronics (TVs and Radio), Print (Newspaper), and social media, rallies and roadshows have been suggested by different scholars as mechanisms to be adopted to increase the participation of migrant women in Pap smears (Qureshi et al., 2019; Idehen et al., 2017; Gele et al., 2017). People need to be educated about cervical cancer because "health education is a proven strategy

in disease prevention and control, which forms a critical component of a comprehensive program" (Simayi et al., 2013:7469). From the findings of this study, it was discovered that there is a need for a deliberate awareness campaign to raise the consciousness of migrant women for participation. The respondents suggested different ways that the awareness can be approached; however, the one that stood out is the declaration of a month or a week for cervical cancer awareness. Ruth (46), a 23-year resident in the Netherlands, explains the importance of having a month declared for cervical cancer awareness just like some countries around the world. She gives an example of a friend that was influenced by an awareness campaign to take up the Pap smear.

> "Eight years ago, a distant cousin of mine that came for her master's showed me her invitation letter in which I explained the content and advised her to go for the Pap. She did not take it seriously, and you know you cannot force people to go for the test. Two years ago, she went to visit our uncle in the US, and her visit coincided with the cervical cancer awareness month. She came back six weeks later with a different view about cervical cancer, she said, 'I did not know I was risking my life for not going for the test, now I know'. The next letter she got, she went straight to her GPs office" (Ruth, age 46, Interview September 2019)

The lesson that can be derived from Ruth's story about her cousin is that a migrant woman might have access to family members or friends that help them to deal with the language barrier that comes with the invitation letter, and even get advice about the need to go for the test from those that have done it before, and still decide against it. For some people, making decisions might require coming across constant information, news, messages etc. on the importance of the issue they are contemplating, and whether to act or not. Hitherto, awareness on many social and health issues such as women's rights, HIV/AIDs, LGBT rights among others were achieved in different societies through the declaration of days or week to focus on public sensitization. The opinion of Kidanke (32), who has spent only a year in the Netherlands, corroborated the need for cervical cancer to be treated with other issues that have specific weeks or months for a deliberate and robust awareness campaign and advocacy.

> "As a student with no knowledge of the Dutch language, sending letters, TV ads, News Papers, cannot be of any help to me because I do not watch TV or read Newspapers. However, I can say that the declaration of the last week will go a long way to educate people like me that have no idea what Pap smear means with little knowledge about cervical cancer. Let me give you an example, I was in the city center one day, and I met Green Peace volunteers doing advocacy during one of these climate change-related days. My initial belief was that climate change is a fuss, but I changed my mind that day and even donated 10 euros to the cause because I was exposed to what I did not know before. If I can change my mind on climate change, I know many people will change their mind" (Kidanke, age 32, Interview August 2019)

Although the Netherlands ought to be participating with other European countries during the European Cervical Cancer Awareness week, for the fact

that none of the participants mention remembering witnessing anything that looks like cervical cancer awareness shows that the government needs to pay close attention to enhanced awareness.For example in the US, there are different months for different cancer awareness campaigns; cervical cancer (January), lung, stomach, and pancreatic cancer (November), liver and Breast cancer (October), Leukemia and Lymphoma, Ovarian, and Prostate (September), Bladder (May), Esophageal (April), Kidney (March), and Gallbladder and Bile Duct cancer (February).The Netherlands can also have a month for cervical cancer and other months for different cancer awareness programs. During the month or week dedicated for cervical cancer awareness, local and central public authorities, jointly with educational institutions, health care institutions, cultural groups and organisations like UKEA and Uhollanzi for example, development partners and the like, should engage in a series of communication, information and awareness-raising campaigns on the importance of prevention, diagnosis, and treatment of cervical cancer. In Moldova for instance, during the cervical cancer awareness month, medical information about HPV and cervical screening are available at airports, train stations, bus stations, with the police, companies, factories, and schools. Also, free public cinema tickets for the screening of videos about cervical cancer prevention while health workers hold informative sessions for women and young people in rural areas within the community libraries, Youth Friendly Centers, and Maternal Centers (UNFPA-Moldova, 2019), go a long way in creating awareness. There is a need to have a dedicated month just like several countries that have a month or week(s) earmarked for advocacy and sensitization on cervical cancer. In Singapore, cervical cancer awareness month is in (May), USA (January), Canada (October), UK (June), South Africa (September), Australia (November), Moldova (March).

5.4. Mandatory Pap Smear Screening.

Unlike the HPV vaccination that is mandatory in some countries for girls when they turn 12 (Roll, 2007; Walter, 2013), Paps for older women is not mandatory. It is a voluntary decision that an individual must take to prevent cervical cancer. However, mandatory Pap smear testing has been suggested by some of the migrant women and 1 of the medical practitioners that participated in this study as a way to improve migrants' participation in Pap smears. One of the practitioners (Nurse) during the process of data collection said that since HPV is mainly transmitted through sexual contact, cervical cancer should be treated like other sexual transmitted diseases such as HIV and Hepatitis B when it comes to mandatory screening. It was cited that many migrants from developing countries have different disease profiles from the host country, and that is why before visas are granted, some countries asked for medical tests to be carried out. The respondent, however, acknowledges there are some people that might have reservations towards the idea of mandatory Paps but still maintained that it may be a good way to expose newly arrived migrant women to screening;

> "I think the first Pap smear should be mandatory for migrants aged 30 and above as they arrive in the country before they can be issued residency cards, although there should be some exceptions. It can be limited for now to migrants from countries with a high burden of cervical cancer as a pilot project if I may say. I believe if the test is part of the process they went through as a condition to acquire their residency status, the vital information about cervical cancer will be ingrained in their memory. This might help their decision in the next five years when they receive the letter for another Pap smear (MP, Interview, September 2019).

Although controversial, the idea of having a mandatory medical test on certain diseases for migrants is not a new phenomenon. The mandatory medical test is part of the process of applying for refugee and immigrant status in the US (Asgary et al., 2011). Also, there are mandatory screening program tests for immigrant populations in Canada (Zencovich et al., 2006) and Germany (Ackerman et al., 2015) for infectious diseases, which includes HIV and HBV before Asylum can be granted. Be that as it may, it is important to remember that cervical cancer is not an infectious disease, and so mandatory screening may not be feasible. Nonetheless, some of the women also supported the explanation given by the medical practitioner during our interaction. For example, Chrisy (37) has spent just a year in the Netherlands. However, from her experience with the Tuberculosis mandatory test required of students that just arrived from Kenya and other developing countries, she believed that cervical cancer screening should be made mandatory for all the migrant women that fall within the age range. She narrated her story on how the mandatory tuberculosis test saved her from the disease.

> "I think having a mandatory test to check some certain diseases is the way to go to increase awareness of the disease. In my case, I have heard about tuberculosis, and the only symptom I know is coughing with spitting blood, and since I am not coughing with blood coming out, I thought I was ok. It is not till the time I arrived here, and we were told to go for the mandatory tuberculosis test that it was discovered that I have some traces of the disease. The hospital treated me; you can imagine what would have happened to me if the test was not mandatory, and I decided not to go for the test. That is why I said cervical screening for migrants, especially for those that just arrive, should be mandatory. I would have gone for the test if I knew about it about the screening because I have learned my lessons (Chrisy, age 37, Interview September 2019)

Various scholars have conducted studies in support and against the idea of mandatory cervical screening tests not only for migrants but women of a certain age in general (Vamos et al., 2008; Adanu, 2002; Gharoro & Ikeanyi, 2006; Ghimire et al., 2019). For instance, Vamos et al (2008) argued against mandatory testing on morality, cultural, and religious grounds while Gharoro & Ikeanyi (2006: 1063) suggest that "pap test should be in the mandatory medical fitness examination after employment". If I am to take a position about the proposition of mandatory Pap smear test for new migrants, I would disagree, but I would suggest that the number of female GPs are increased as they may innately play a greater role in encouraging participation. Therefore,

the government should encourage more female doctors to take up GPs positions. Nevertheless, from the findings, it was apparent that all three suggested approaches to improve participation are not mutually exclusive. They reinforce each other and should not be considered in isolation. For example, If a migrant woman arrives in the Netherlands at the age of 27 for example, she should not be subjected to a mandatory Pap smear and will not receive a letter of invitation, but the cervical cancer awareness month would prepare her with adequate information for three years before she is qualified to receive the letters.

5.5. Conclusion

Three approaches were suggested by the respondents of this study. First, the invitation letter should be made available in different languages so that the women migrants can understand the purpose of the test. Secondly, deliberate advocacy awareness for cervical cancer should be undertaken, and the third, mandatory Pap smear testing for new arrivals. While the three suggestions are not flawless, they may go a long way in increasing participation. I suggest also that some responsibility also lie with Kenyan organisations that help with acculturation, to spread awareness to members about the health sector, navigation of the said, services available, for instance, in their newsletters, websites, at events etc.

Chapter 6 Conclusion and Summary

This study set out to contribute to the development of holistic and effective policies and practices that can promote the increase in uptake of Pap smear programs among (Kenyan) migrant women in the Netherlands. Data was collected through semi-structured interviews to address the question of how and why migrant women are responding (or not) to pap smear screenings and which policies and practices have been effective in promoting their participation. The data was analyzed from the perspective of the Health Belief Models perceived susceptibility, severity, benefits, and cue to action, to determine how and why the Kenyan women decided to participate in the Pap smear program or not. In addition to the Health Belief Model, acculturation was explored to explain the different experiences of the respondents for a better understanding of why some Kenya migrant women participated in the Pap smear, and others did not?

To address the first research question of barriers, the data collected was first subjected to analysis through the HBM perceived susceptibility and perceived severity to understand the attitude of the women towards seeking health care for the prevention of cervical cancer. Virtually all the women have heard about cervical cancer even though less than half of them have the full picture of what cervical cancer really means; screening, prevention measures etc. Consequently, many of them did not consider themselves vulnerable to cervical cancer. Despite the inadequate knowledge about the causes, symptoms, and cure to cervical cancer that might be responsible for their perception of non-vulnerability, the perceived severity was high, but the cue to action is 50:50 among the women. All of them believed that they need to participate in the Pap smear and are willing to recommend the test to others but not all of them participated. It was discovered that many of the women's ideas about cancer are tantamount to risky health behaviour e.g. not attending Paps themselves; t~~T~~his explains the high level of perceived severity that contributes to a high willingness to participate in Pap smears despite the belief that they are not vulnerable to cervical cancer and the resultant cue to action, or nonthereof.

The willingness to participate in Pap smears was met with a series of barriers, in addition. The findings revealed that acculturation plays a key role in the uptake of Pap smear screening. First, it was discovered that the number of years as a resident in the Netherlands plays a key role in the participation. The outcome of the study shows that more than half of the respondents that have not participated in Pap smears have their years of residency between one and five, while the majority of those that have participated in Pap smears portray longer years of residency, from 7 years up.

The length of stay also affected language proficiency and how they perceived the Dutch health care system. More than half of those that have not participated have zero or very low proficiency in Dutch, while virtually all those that participated are proficient in the Dutch language and have a more positive view about the Dutch health care system. However, those that have

this view acknowledge the fact that they also struggled to cope and navigate the health system in the Netherlands in first few years after their arrival due to the clear differences between the Kenyan and Dutch health care system and structure. In Kenya, GPs are not gatekeepers to the health care system, while in the Netherlands, one must go through a GP to see a specialist. Moreover, the funding structure of healthcare is poles apart and without similarities. For example; In Kenya, health insurance is limited to those who can afford it, while in the Netherlands healthcare is accessible and compulsory. Specialists, like Gynecologists have no gatekeepers (GPs in the Netherlands) and there are no lengthy waiting period for example. Nevertheless, Kenyans become accustomed to the health system as their length of stay increases. Apart from the acculturation problem, preference for female GPs was considered as a barrier to participating in Pap smears. It becomes a barrier because there is a shortage of female GPs in the Netherlands when compared with the numbers of male GPs. It is important to note that the preference might be connected with cultural issues.

The Dutch policies and practices that reach migrants to motivate women's' participation in Pap smears are through the invitations to all women, aged 30 to 65 years, with a residence address in the country. Nearly all those that were invited participated, while those that indicated that they were not invited did not participate in Pap smears. However, the invite policy and practice appear to be a barrier to many women's participation because the letter is written in Dutch. It was discovered that some women received the letters but did not respond because of the Dutch language barrier; some asked for friends to interpret the letter while others used Google translate, and still, some did not participate. This explains why half of the participants in this study indicated that they did not receive a letter. It is possible that they were invited but did not understand the content and offer.

A number of suggestions to increase participation in Pap smears were derived from the study. Firstly, the letters of invitation should be accompanied with translations in multiple languages so that the migrants that are yet to understand the Dutch language can read and understand the contents. The problem with the suggestion is, how many language translations will be enough for an invitation letter since migrants in the Netherlands come from a wide range of countries with different languages. It was suggested that while it might be difficult administratively to translate several languages, it might be helpful to have a translation of the invitation letters in English and other languages that have a proportionately high migrant presence in the Netherlands. Copies of different translations can perhaps be made available online. Emails can be sent with translation options for example.

Awareness is another suggestion that was derived from the analysis of data for this study. A week or month every year has been suggested for cervical cancer awareness in the Netherlands. For example, in the US, there are different months for different cancer awareness programmes; Cervical cancer (January), lung, stomach, and pancreatic cancer awareness (November) as mentioned earlier. Other countries also have different months for different types of cancer awareness initiatives. Having a cervical cancer awareness month in the Netherlands will go a long way in raising the consciousness and knowledge

of women about cervical cancer. Although controversial due to ethics and human rights issues, mandatory Pap smear testing also came up during the analysis. It was suggested that Pap smears should be included in the set of medical tests conducted for new arrivals aged 30 and above, particularly for those from countries with a high incidence of cervical cancer. The danger however is this may be perceived as discriminatory.

It is important to emphasize at this juncture that this study is limited in scope, and there is a need for future research. Firstly, the sample of this study are not typical migrants; they are well educated and can be classified as Diaspora. The IOM defines "diasporas as "migrants or descendants of migrants, whose identity and sense of belonging have been shaped by their migration experience and background" (IOM, 2019:47). The Diasporas were distinguished from the migrant's community by Safran (1991:83-99) with six sets of rules. These include; that the Diaspora maintains the collective memory of their homeland; Hoping to return one day to their ancestral homeland as they regard it as their true home; interested and committed to what is happening back home; and they relate vicariously or personally to the homeland to the extent that it shapes their identity (Cohen, 2008:6). Many of them go back home annually, maintain strong Kenyan ties, attend Kenyan events organized by the diaspora organizations etc. More than half of the sample of this study falls into the category of Diaspora, and as a result, one should be cautious about generalizing the findings to represent the experiences of all migrant women from Kenya. Besides, there are significant populations of Somali-Kenyans also migrating to Europe and they were not adequately represented in the sample due to the closed nature of the Somali ethnic community that is totally different from other ethnic groups in Kenya. Future research that can compare the migrant's community experience with that of the diaspora community from the same country in the Netherlands is required. This will help to further understand the intersection of various barriers that might hinder one group but might not be a problem for another grouping when it comes to the uptake of Pap smears.

Appendices

Appendix 1: Participant Profile

Respondent's Names	Age	Papsmear Attendance (Yes=Y No=N)	Residence (Years)	Dutch Proficiency (Good=G, Excellent=E, None=N, Average=A, Basic=B, Ok, Not Good=N/G	Letter Received (Yes=Y, No=N, Can't Remember=C/R, No answer=N/A)	Level of Education (Bachelor=B, High School=HS, College=C, Masters=M, Degree=D, PHD, No Answer=N/A	Religion	Occupation	Region	Marital Status(Single Married Engaged No Answer=N
Ali	32	N	1	N	N	B	Catholic	Student	Amsterdam	S
Annay	46	Y	7	G	Y	C	Christian	No work	Amsterdam	
Auri	40+	Y	15	E	Y	B	Christian	Restaurateur	Eindhoven	M
Cynci	30+	Y	5	G	N	M	Christian	Admin	Woerden	E
Sanasa	25	Y				N/A	Non	No work	No Answer	N/A
Maro	35	Y	9	E	Y	Non	Adventist	Fashion Designer	Apeldoorn	M
Meeta	40	Y	17	G	Y	D	Rastafarian	Security	Den Haag	S
Chrissy	37	N	1	N	N	M	Lutheran	Student	Den Haag	S
Lizzy	37	N	1	G	N	C	Christian	Administration	Belgium	S
Boska	40	Y	8	A	C/R	C	Legio Maria/Pent/ACK	Activist	Groningen	M
Nyoki	39	N	3	B	N	M	Christian	Logistics	Arnheim	M
Saks	36	Y	3	G	N	C	Catholic	Admin	Belgium	S
Gino	32	Y	1	A	Y	B	SDA	Contract Worker	Haarlem	S
Rie	40	Y	37	E	Y	C	Anglican	Consultant	Den Haag	N/A
Joy	43	Y	19	G	Y	HS	Christian	Caterer at a University	Delft	S
Kidanke	38	N	1	N/G	N	B	Christian	Student	Wageningen	S
Alisa	40+	Y	7	OK	N	M	Christian	Expatriate	Den Haag/Gron, Rotterdam	S
Seiyo	40+	Y	12	G	Y	C	Protestant	Administration	Delft	S
Rosy	30+	N	3	N/G	N	M	Catholic	Administration	Den Haag	S
Karuthi	46	Y	23	G	Y	C	Pentecostal	NGO	Voorburg	M
Lami	46	N	11	G	N	C	Muslim	INGO	Den Haag	
Sia	31	N	3	N/G	N	M	Christian	Administration	Den Haag	S
Mishkaki	34	N	4	N/G	Y	M	Christian	Student	Amsterdam	S
Roseflower	39	N	5	N/G	N	M	Christian	Student	Arnheim	S
Shiru	43	Y	10	OK	N/A	N/A	Christian	No work	Amsterdam	M
Esther	42	N	10	G	Yes	PHD	Christian	Lecturer	Delft	S

Appendix 2: Perceived Susceptibility/Perceived Severity

Name	Papsmear Atetnded	Perceived Susceptibility	Perceived Severity
Ali	N	**No**	Yes
Annay	Y	Yes	Yes
Auri	Y	Yes	Yes
Cynci	Y	Yes	Yes
Sanasa	Y	Yes	Yes
Maro	Y	Yes	Yes
Meeta	Y	Yes	Yes
Chrissy	N	**No**	Yes
Lizzy	N	Yes	Yes
Boska	Y	Yes	Yes
Nyoki	N	**No**	Yes
Saks	Y	Yes	Yes
Gino	Y	Yes	Yes
Rie	Y	Yes	Yes
Joy	Y	Yes	Yes
Kidanke	N	**No**	Yes
Alisa	Y	Yes	Yes
Seiyo	Y	Yes	Yes
Rosy	N	**No**	Yes
Karuthi	Y	Yes	Yes
Lami	N	**No**	Yes
Sia	N	**No**	Yes
Mishkaki	N	Yes	Yes
Roseflower	N	**No**	Yes
Shiru	Y	Yes	Yes
Esther	N	Yes	Yes

Appendix 3: Preliminary Questionnaire

1. What is your name? (preferred name or nickname is fine)
2. What is your age?
3. Have you lived in the Netherlands for at least a year?
4. Have you heard of the pap smear test and(or) pap smear screening program?
5. If yes, do you know its purpose?
6. Have you had pap smear test(s)?
7. If yes, was it before your relocation to the Netherlands? Yes …Where did you have it?
8. How accessible was it in terms of facilities and finances/costs?
9. Have you ever had a pap smear test in the Netherlands?
10. If so, was it recommended by your GP, a friend, or did you get an invitation letter?
11. Do you follow any faith or religion? If yes, which one?

One-on-One Semi Structured Interviews

1. When did you relocate to the Netherlands?
2. At the time of your relocation, which educational attainment had you achieved, high school, college, bachelor's degree, master's degree, PHD or postdoc? After that have you had any additional qualifications?
3. How easy or difficult was it to adjust to a new environment?
4. Were there any specific challenges encountered in settling down in your new country of residence?
5. How easy or difficult was it to register at your local Municipality?
6. Are you renting, living in student accommodation, living with a friend or do you own your home?
7. In terms of healthcare, how accessible do you find the system?
8. Does your insurance cover your needs, especially health needs appropriately?
9. How good is your proficiency or command of the Dutch language?
10. Did you get an invitation for a pap smear screening test in your first year of residency and what did it say?
11. If you received an invitation, did you understand the contents of the invitation letter? Or if you have been a resident for a long time, have you received letters every five years?
12. Did you attend the first pap smear screening invitation or subsequent ones?
13. If yes, what motivated you to do so….
14. Where was it done or where have they been done (if you have attended subsequent screenings? What was or have been your experiences(s) of the screening(s)

15. If no, please give reasons why you did not.
16. Have you ever had a relative or friend who was told that she had abnormal pap smear test results or who had had cervical before?
17. Will you recommend this test to others, if yes, why, and if not, why not?

Questionnaire for Gynecologists and Nurses

1. Please tell me your name (You may remain anonymous if you wish)
2. How long have you been in practice in the Netherlands?
3. Before performing pap smears, do you generally explain the purpose of the pap smears? (even if the patient is not curious about its purpose)
4. If you are a female gynecologist or nurse, please indicate whether you have had a pap smear test
5. Do you recommend pap smears for women under 30?
6. If a woman under 30 asked for a pap smear, would you perform one (if you didn't think it is necessary, even though the patient requested one?
7. Do you come across migrant women over 30 that have not received invitation letters for pap smear testing under the RIVM screening program for cervical cancer?
8. Do you come across migrant women who refuse to have pap smears taken, generally?
9. Do you find that religion is a factor for women when it comes to pap smear testing?
10. If so, which religion mainly?
11. In your view, what would encourage migrant women participate better in the cervical cancer RIVM screening program?

Appendix 4: Consent Forms

Consent Form for Respondents

I _____ agree to participate in the research project conducted by Debbie Omolo who has discussed the research study with me.

I have had the opportunity to ask questions about this research and I have received satisfactory answers. I understand the general purposes, risks and methods of this research.

I consent to participate in the research project and the following has been explained to me:

- the research may not be of direct benefit to me
- my participation is completely voluntary
- my right to withdraw from the study at any time without any implications to me
- the risks including any possible inconvenience, discomfort or harm as a consequence of my participation in the research project
- the steps that have been taken to minimise any possible risks
- what I am expected and required to do
- whom I should contact for any complaints with the
- I am able to request a copy of the research findings and reports
- security and confidentiality of my personal information.
- I understand that due to the sensitive nature of this research, and the personal nature of the questions, I wish/do not wish to be audio recorded.
- that my identity will not be revealed in the publication of results from this study

Participant name:

_____

Signature:

_____

Date: _____

Researcher name:

_____

Signature:

_____

Date: _____

Consent form for Doctors & Nurses

I agree to participate in the research project titled motivation and impediments towards the uptake of pap smear screening, conducted by Debbie Omolo who has emailed the research questions to me.

I have had the opportunity to ask questions about this research and I have received satisfactory answers. I understand the general purposes, risks and methods of this research.

I consent to participate in the research understanding that:

- the research may not be of direct benefit to me
- my participation is completely voluntary
- my right to withdraw from the study at any time without any implications to me
- the steps that have been taken to minimise any possible risks
- what I am expected and required to do
- whom I should contact for any complaints
- I am able to request a copy of the research findings and reports
- security and confidentiality of my personal information.
- that my identity will not be revealed in the publication of results from this study

Participant name:

_____

Pseudonym acceptable)

Date: _____

Researcher name: Debbie Omolo

Date: _____

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