

Cancer Screening Among Refugees and Potential Interventions to Increase Screening Rates

Nicole Stelling, MS4

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Abstract

Screening for colorectal, cervical, and breast cancer is an important aspect of primary care for all individuals, including refugees. However, rates of screening for these cancers are lower among refugees than among individuals born in the United States for several reasons including difficulty accessing care and differing sociocultural perspectives regarding cancer screenings. This paper aims to outline the factors leading to lower rates of screening and discuss several strategies for improving screening rates which have been proposed and studied in prior literature.

Introduction

Since 1980, more than 3.1 million refugees have been admitted to the United States.¹ This refugee population is diverse in terms of culture, religious affiliation, and socioeconomic status, however, many factors are shared within the group which can make obtaining preventative care, including cancer screening, more difficult. These often include language barriers, limited health literacy, difficulties obtaining health insurance, and transportation barriers, in addition to varying cultural and religious perceptions regarding healthcare, health, and disease.²⁻⁵

The U.S. Preventative Services Task Force (USPSTF) has issued grade A or B recommendations for breast cancer screening for women 50 to 75 years of age, cervical cancer screening for women 21 to 65 years of age, and colorectal cancer screening for adults 45 to 75 years of age.⁶ Routine screening allows for earlier detection of cancers, hopefully at a time when they are preventable or easier to treat. While this recommendation applies equally to refugees as to individuals born in the U.S., the multitude of factors listed above, in addition to others that will be discussed throughout this paper, contribute to a lower rate of screening among refugee populations. After defining these issues and

contributing factors, this paper will provide recommendations regarding strategies for increasing cancer screening rates within the refugee population.

Screening Rates

Estimates of cancer screening rates among refugees vary significantly between studies due to variations in population studied and method of assessing screening completion (i.e., having ever had screening in their lifetime versus being up to date based on different screening recommendations, such as the USPSTF or American Cancer Society), although they generally show lower rates of screening than for individuals born in the U.S.²⁻⁴ In a recent study by Milenkov et al. on cancer screening in a multiethnic refugee population in North Texas, during a 4-year time period, of the women eligible for cervical cancer screening at the beginning of the study, only 37% completed it.² This percentage was 54% for women eligible for breast cancer screening and only 27% for men and women eligible for colon cancer screening.² While other studies have shown higher percentages of refugees completing screening recommendations, they still show significant disparities. For example, in a study of women attending a family medicine clinic for refugees in Virginia, 60% of women were up to date on cervical cancer screening,

which is still much lower than the overall U.S. rate of 80%.⁷ Additionally, in this study 21.5% of women had never been screened for cervical cancer, compared to 6.8% of women born in the U.S.⁷

Factors Inhibiting Cancer Screening

Access to Healthcare and Insurance

Refugees are entitled to eight months of government-sponsored insurance,⁸ however after these eight months pass, insurance options can vary based on employment status, the state they are living in, whether they have children, and their income. This is particularly notable in the study by Milenkov et al. in North Texas, where 51% of refugee patients did not have health insurance.² For this reason, it is often desirable to complete these cancer screening recommendations within the first eight months of resettlement while refugees have their government-sponsored insurance. However, visits with refugees during these initial months are often focused on many other health concerns, which can make cancer screening less of a priority for patients and providers.⁹ Additionally, patients may need time to develop a relationship with a provider before feeling comfortable undergoing these screening procedures, making accomplishing them within the initial months when they do have insurance difficult.⁹ Finally, even when health insurance is available, high levels of unemployment and low income creates other financial barriers, and difficulties with child care or transportation remain.³

Language Barriers, Education, and Health Literacy

Despite the use of interpreters, language barriers remain a difficulty when explaining complex topics, such as the reasoning behind and process for these cancer screenings, and cause difficulties for patients when attempting to navigate the

healthcare system.^{4,9} In addition, refugees often have lower levels of education than the general U.S. population, with many having less than a high school level of education.⁴ When combined with low health literacy, often stemming from a lack of experience with formal healthcare systems in their prior country,³ explaining the need for cancer screenings can be difficult. Even if refugees have experience with healthcare systems, they often lack knowledge about preventative health care, cancer screening, and cancer in general, which contributes to further barriers in communication.^{4,9,10} Many refugees reported that these screening tests are only needed if they are symptomatic or if their doctor believes they actually have cancer or an infection.^{5,10,11} Cancer can also be a difficult word to translate in certain languages and many refugees may not understand the disease process.¹² In a study among Somali refugees, 74% of women did not recognize or understand the word cancer.¹²

Cultural and Religious Perspectives on Screening

Many social and cultural factors influence beliefs about cancer and screening. For example, studies showed that among many refugee groups, cancer was considered a taboo topic which should not be discussed or is associated with stigma.^{4,10} Often, refugees report believing cancer to be something that causes death and a disease that should be feared.^{4,10,11} In addition to the fear of cancer, many refugees report fear of the procedures themselves due to beliefs that the screening methods would be painful, embarrassing, or inconsistent with their preference for modesty.^{4,11,13} Additionally, many women prefer female providers due to religion or cultural preference, which may be possible to ensure for cervical cancer screening, but may be more difficult to guarantee for a colonoscopy. Even having gender discordance with interpreters was

reported as a factor that decreased comfort with discussing these topics.^{4,9} Additionally, concerns about the confidentiality of visits when interpreters were used were common due to worries that information would be shared among a relatively small community.^{4,10} For Somali refugees, having had female genital mutilation has been found to be an additional barrier to obtaining cervical cancer screening.¹⁴ Finally, religion as a protective factor against cancer, or that diseases are “predetermined” as part of religious belief was discussed by refugees in several studies.^{4, 10, 11, 13}

Potential Interventions

Making the Recommendation

The first step to increasing cancer screening rates among refugees relies on providers talking about the need for screening with their patients. In one study regarding colorectal cancer knowledge among Iraqi women living in the Washington, D.C. area, despite having primary care providers, six out of the seven women over the age of 50 who were interviewed reported their provider had never discussed colorectal cancer screening with them, and five of those patients stated this lack of recommendation from their provider was why they had not completed screening.¹³ Another study found similar reports of refugee patients stating they had never discussed or completed cervical cancer screening, however, many of these women later realized they had completed this screening after watching educational videos on the subject.¹⁵ Unfortunately, particularly for cervical cancer screening which can be confused with pelvic exams performed for other reasons, it is difficult to know the true proportion of these women with whom cancer screening has never been discussed. For this reason, discussing screening recommendations early in resettlement, frequently reiterating the

recommendations at follow up appointments, and using a variety of methods such as discussion, pictures, and videos is recommended.^{5, 9, 15} As use of primary care services has been associated with higher rates of cancer screening in a “dose-response” manner,³ it is important to ensure that a follow up appointment is scheduled prior to a patient leaving clinic. Additionally, as discussed previously, making the recommendation for screening, and completing screening during the initial eight months of government-sponsored health insurance can alleviate financial concerns, although even among fully insured refugee patients, large disparities still exist.³

Addressing Logistical Barriers

Removing as many logistical barriers as possible by using medical interpreters and assisting with scheduling, appointment reminders, and transportation is important and helps increase screening completion; however, even when these are addressed, screening rates often do not reach target rates.^{2, 3} Providers or patients may overestimate a patient’s English language proficiency as a patient may speak English well in their daily life, however, communicating medical information often requires words that are not commonly used in other settings. As using a medical interpreter has been associated with increased cancer screening rates,³ having an interpreter “on standby” during visits to help facilitate conversations when more detailed descriptions are needed is ideal.

Peer navigators and collaboration with community-based organizations that serve refugees have also been found to be helpful in facilitating screening completion, as these often can help address logistical barriers as well.^{4, 16} One study regarding the use of linguistically and culturally matched peer navigators to assist 188 Somali, Arabic, and Serbo-Croatian speaking refugees found

that despite lower rates of mammography among refugees at baseline, after two years of using peer navigators in their program, mammography rates were increased to levels comparable with English speaking patients at their clinic.¹⁶ Despite peer navigators not having any medical background other than six two-hour training sessions, it was found that they were effectively able to help women overcome logistical barriers including appointment scheduling and reminders, arranging transportation, and assisting with insurance issues, even attending appointments with patients if needed, while also as providing education to patients regarding breast health.¹⁶

Use of Educational Programs

Health education programs for refugees through community and faith-based organizations have also been shown to increase cancer screening rates.^{16, 17} When Somali refugees were asked about potential strategies for increasing cervical cancer screening, the most common suggestion was through community education at workshops and gatherings.¹⁸ Holding sessions at churches and mosques to provide education on breast cancer screening was one aspect of a study that significantly increased cervical cancer screening among refugee patients.¹⁶ In another study examining the use of one breast health education session conducted in the patients' native languages though the use of interpreters at resettlement sites during English as a Second Language classes, knowledge regarding breast cancer increased significantly.¹⁷ As a result, 60 of the 170 participants over the age of 40 completed a mammogram, including 20 women who had never had a mammogram before.¹⁷

Use of Educational Videos

The use of culturally tailored educational videos has shown benefit for

increasing cancer screening among refugees.¹⁵ When developed with input from refugee community advisors, a series of four 17-minute educational videos was found to increase intention to screen for cervical cancer from 40% to 80% among 40 Karen-Burmese and Nepali-Bhutanese women.¹⁵ While the total length of videos from this study is likely too long to feasibly incorporate into clinic workflow, participants in this study reported they would feel comfortable watching the video in clinic, at other locations such as refugee resettlement and community organizations, or on their mobile devices, and that they would feel comfortable watching them in groups.¹⁵ In a similar study investigating the use of tailored videos and small group discussions conducted by community-based organizational staff, intention to screen increased from 58.8% to 84.9% for breast cancer screening among Congolese and Somali women.¹⁹ The concepts of videos and small group discussions were also well received in a study of Afghan refugees as a way to increase knowledge and screening rates related to breast cancer.⁵ The International Family Medicine Clinic at the University of Virginia developed an 8-minute video using a Nepali-speaking nurse and Nepali simulated patient to describe the reasons for colorectal cancer screening and to demonstrate both fecal occult blood testing and colonoscopy (<https://med.virginia.edu/family-medicine/clinics/international-family-medicine-clinic/colorectal-cancer-screening-an-informational-video-for-nepali-speaking-patients/>). This is shown during a clinic visit by the RN Care Coordinator, who is on hand to answer any questions, and has been well-received by patients (Fern R. Hauck, MD, personal correspondence August 2021).

Another study combined faith-based and video education by creating videos with the assistance of an Imam to promote breast

and cervical cancer screening.¹¹ After watching and discussing these videos in small groups, the participants reported an increased understanding of preventative care and felt reassured regarding their previous concerns about modesty and predetermination.¹¹ The men who participated in this study also reported enthusiasm for encouraging women in their family to get screened and to consider screening for cancers that could affect them.¹¹

Conclusions

There are a multitude of reasons for the disparities seen between cancer screening rates in refugee populations and the general U.S. population. Making the recommendation to all patients that these cancer screenings are important for their health is the first step to decreasing these disparities, but it is clearly not sufficient. Having frequent visits with primary care providers can allow patients to develop trust with their provider and afford more opportunities to make this recommendation and have these discussions. Fear of cancer can be lessened through individual patient-provider discussions, community-based education programs, and culturally tailored videos which educate refugees on the ability to prevent and treat cancer. Fear of the procedures that screen for cancer can also be decreased through similar education to dispel any myths that people may have heard regarding the screening procedures. Cultural and religious worries, including those about cancer being taboo, modesty, and predetermination, can be minimized by having female providers and interpreters whenever possible if the patient desires and through the use of faith-based messaging from religious organizations in the community. Finally, logistical concerns including difficulties obtaining insurance, transportation, and childcare, as well as language barriers and limited health literacy,

make navigating the health system difficult for refugees. Peer health navigators and partnerships with community organizations have been shown to help alleviate some of these concerns. Ultimately, many of these strategies will need to be employed together to increase screening rates among this vulnerable population.

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