UNIVERSITY OF CALIFORNIA

Los Angeles

# Utilization of Breast and Cervical Cancer Screening Services: Understanding Factors Influencing Aging Ghanaian and Nigerian Immigrant Women's Decision to Seek Preventive Health Services

A dissertation submitted in partial satisfaction of the requirements for the degree Doctor of Philosophy in Nursing

by

Stella Turkson-Fiawoo

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ABSTRACT OF THE DISSERTATION

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by

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Doctor of Philosophy in Nursing

University of California, Los Angeles, 2025

Professor Carol L. Pavlish, Chair

Breast and cervical cancer screening services are critical for early detection and prevention, yet utilization among aging African immigrant women in the United States remains suboptimal. Despite the growing African immigrant population in the United States, limited research has explored the specific experiences and perspectives of Ghanaian and Nigerian immigrant women aged 40 and older regarding preventive health services. This qualitative study aimed to address this gap by examining the lived experiences of Ghanaian and Nigerian immigrant women in Southern California in accessing and utilizing breast and cervical cancer screening services.

Data was collected through in-depth, semi-structured interviews with a purposive sample of Ghanaian and Nigerian immigrant women aged 40 years and older (N=15) residing in Southern California. Data analysis was conducted using thematic analysis guided by a principles of constructivist grounded theory. Through an iterative process of data collection and thematic analysis, four primary themes emerged: (1) Embracing Traditional Beliefs and Practices, (2) Living In Between Cultures, (3) Sustaining the Silence around Breast and Cervical Cancer, (4) Encountering and Overcoming Barriers, and (5) Facing the Future: Strategies to Improve Awareness and Uptake. These themes were accompanied by subthemes illustrating the complex interplay of cultural, structural, and personal factors that shape health-seeking behaviors among older African immigrant women. Participants expressed a desire for culturally sensitive care, greater education about preventive health services, and healthcare provider approaches that build trust and respect.

Findings from this study suggest the need for targeted, culturally sensitive educational interventions aimed at improving awareness and utilization of cancer screening services among aging West African immigrant women. Implications for social change include enhancing healthcare providers' understanding of cultural influences on health behaviors, developing culturally sensitive outreach initiatives to address knowledge gaps and structural barriers, and employing culturally matched navigators to assist African immigrant women in navigating the complex U.S. healthcare system, including guidance on insurance literacy. Future research should explore how socioeconomic status and acculturation influence preventive health behaviors in this underserved population, as well as develop and test interventions that

integrate church and spiritual advisors with healthcare messaging to promote health-seeking behaviors, such as participation in cancer screening.

The dissertation of Stella Turkson-Fiawoo is approved.

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## Dedication

This work is dedicated to the brave African immigrant women who availed themselves to discuss their lived experiences. Thank you for your honesty, your bravery, and your trust. Your willingness to speak openly about breast and cervical cancer screening, despite the silence and stigma that too often surrounds these topics, is powerful. To me, you are not just participants in a study. You are advocates, trailblazers, and change-makers. This work exists because of your courage, and I am forever grateful.

To my husband, your love is my constant motivation, your support my strength. Thank you for standing beside me through the long nights, the moments of doubt, and the victories, big and small. Your unwavering belief in me helped carry this dream to life.

And to my precious daughter, you are my light and my greatest inspiration. Every word of this work was written with you in mind.

This dissertation is for you and for every woman who has ever needed to be seen, heard, and cared for.

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## List of Abbreviations

AIC American Immigration Council

AA African American

AIW African Immigrant Women

ACS American Cancer Society

API Asian/Pacific Islander

CA Caucasian American

CDC Centers for Disease Control and Prevention

HPV Human Papillomavirus

hrHPV High-Risk Human Papillomavirus

IARC International Agency for Research on Cancer

NH Non-Hispanic

NHIS National Health Interview Survey

NCI National Cancer Institute

OMH Office of Minority Health

Pap Papanicolaou (Test)

SEER Surveillance, Epidemiology, and End Results (Program)

STI Sexually Transmitted Infection

U.S. United States

USPSTF United States Preventive Services Task Force

WHO World Health Organization

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This dissertation is not just my achievement — it is a reflection of the community of love, scholarship, and mentorship that surrounds me. I carry your voices with me as I step into the next chapter.

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# Utilization of Breast and Cervical Cancer Screening Services: Understanding Factors Influencing Aging Ghanaian and Nigerian Immigrant Women's Decision to Seek Preventive Health Services

## Chapter 1 Introduction

According to the American Immigration Council (AIC), the African immigrant population in the United States (U.S.) almost doubled in number growing from 881,300 to 1.6 million from 2000 to 2010 (American Immigration Council, 2012). The Pew Research Center (2022) reports that between 2000 and 2019, the Black African immigrant population increased by 246% (Pew Research Center, 2022). Approximately 2 million Sub-Saharan African immigrants currently live in the United States. (Migration Policy Institute, 2022). Ghanaian immigrants comprise 199,000 of those immigrating from Sub-Saharan African countries; immigrants from Nigeria total approximately 393,000 (Migration Policy Institute, 2022). The Los Angeles Almanac (2021) estimates 62,700 African-born immigrants have settled in the area with approximately 52,000 from countries in Sub-Saharan Africa.

Despite the growing presence of West African immigrant women in the United States and the high burden of breast and cervical cancers among this population, our understanding of their preventive health behaviors and utilization of screening services remains limited.This qualitative study explored factors affecting preventive health seeking behaviors for breast and cervical cancers among U.S. African immigrant women age 40 years and older. Furthermore, this investigation was an effort to gain expanded knowledge and deeper understandings of African-born women's experiences and perceptions of the U.S. healthcare system and how these experiences and perceptions influence their health screening behaviors. With this information, the study sought to develop insights into factors that might contribute to cancer outcome disparities disproportionately affecting the U.S. African immigrant population.

The purpose of this study was to gain a deeper understanding of the health beliefs about disease prevention and the concept of health screening behaviors as it relates to utilization of breast and cervical cancer screening among West-African immigrant women, specifically from Ghana and Nigeria who are age 40 years and older living in Southern California.

**Background and Context**

African-born immigrants have been noted as the fastest growing U.S. immigrant population when compared to other ethnic immigrant groups, with the majority of African-born immigrants from western Africa, followed by eastern Africa (Lorenzi & Batalova, 2022). Although the sub-Saharan African immigrant population in the United States is small, a substantial growth in this group has occurred over the last four decades. Additionally, roughly 2.1 million sub-Saharan African immigrants were living in the United States in 2019, accounting for 5% of the 44.9 million total foreign born population (Lorenzi & Batalova, 2022). Among this population, breast and cervical cancers have been considered the two highest contributing factors to the burden of cancer mortality (Hurtado-de-Mendoza et al., 2014; Pinder et al., 2016). Even though the African-born U.S. immigrant population continues to grow, there is minimal research conducted that investigates cancer screening behaviors among them. Most research involving this population surrounds topics such as Human Immunodeficiency Virus (HIV), tuberculosis, or other chronic diseases such as hypertension or diabetes (Pinder et al., 2016). Limited research suggests that African-born immigrants in the United States have an increased risk for poor physical and social health outcomes as well as inadequate health care, making them a vulnerable population.

Generally, most studies combine African-born immigrants with African Americans (AAs) and as a result, there is the assumption that both populations experience the same sociocultural influences in health care (Amuta-Jimenez et al., 2019). According to Amuta-Jimenez el al. (2019), African-born immigrants tend to exhibit cultural values, beliefs, and expectations

regarding cancer-related health issues that are different from AAs. In spite of such differences, African-born immigrants are required to identify themselves as AAs during research and surveys, thus eliminating information pertaining to the important ethnic distinctions that exist between them (Amuta-Jimenez et al., 2019).

**Importance of Preventive Health Services**

Ethnic and racial disparities in healthcare outcomes as well as disparities addressing the involvement in preventive health services have been documented (Fiscella et al., 2006; Morrison et al., 2012; Sambamoorthi & McAlpine, 2003; Walker et al., 2022). Immigrants may be more prone to such disparities; however, little is known about their health behaviors in the United States. Preventive care helps discover health issues in early phases while individuals may still be asymptomatic.

Underutilization of preventive health services may result in medical professional's inability to identify health problems such as breast and cervical cancer that can be treated in its early stages. The U.S. Preventive Services Task Force (USPSTF) generally makes recommendations regarding the effectiveness of various preventive care services for specific diseases (USPSTF, 2018). It has been recognized that utilizing preventive care services helps reduce mortality and increase quality of life (Liu et al., 2016; Rauch et al., 2024). Research suggests that people who exhibit higher levels of life satisfaction are those who are more proactive in taking care of their health, that is, engaging in preventive care as opposed to merely curative care (Kim et al., 2014). Due to the rapidly growing U.S. population of older adult who are more vulnerable to the threats of declining health, being able to identify factors linked with increased use of preventive health care services in this population is very important (Kim, Kubzansky, & Smith, 2015).

Preventive services for breast cancer includes mammograms. According to the USPSTF, there is adequate evidence that mammography screening reduces breast cancer

mortality in women aged 40 to 74 years. The overall benefits of mammography in women include early detection of breast cancer and decreased breast cancer mortality (USPSTF, 2016). There is a recommendation from the American Cancer Society (ACS) that women with an average risk of breast cancer should start utilizing regular mammography screening starting at 45 years of age (Oeffinger et al., 2015).

Early detection of cervical cancer is accomplished through preventive screening services such as the Papanicolaou (Pap) test used to identify abnormal and precancerous lesions on the cervix (World Health Organization [WHO], 2018). According to the USPSTF, all women aged 21 to 65 years are at risk of cervical cancer due to the potential exposure to high-risk HPV types (hrHPV) through sexual intercourse, and thus should utilize the available screening services (USPSTF, 2018). Guidelines suggest that there is no required screening for women who are over 65 years old with prior negative screenings. Additionally, women who have undergone hysterectomy do not need to be screened (Saslow et al., 2012; USPSTF, 2018). With these preventive measures, women who are tested, and if needed, can be immediately referred for diagnosis and treatment, which is ultimately the aim of the screening services (WHO, 2018).

**Breast and Cervical Cancers**

Cancer, as a disease, causes cells in the human body to change and grow uncontrollably, and eventually become mass cells which is referred to as a tumor. Cancer is considered among the world's leading cause of death worldwide (Cronin et al., 2022; National Cancer Institute, 2022). According to the American Cancer Society (ACS) (2022), incidence data (through 2018) were collected by the Surveillance, Epidemiology, and End Results (SEER) program; the National Program of Cancer Registries; and the North American Association of Central Cancer Registries. Mortality data (through 2019) were collected by the National Center for Health Statistics. In 2022, 1,918,030 new cancer cases and 609,360 cancer deaths are projected to occur in the United States (ACS, 2022).

For U.S. women, the most common cancers recognized according to the number of new cases include cancers of the breast, lung, colon and rectum, melanoma, bladder, non-Hodgkin lymphoma, kidney and renal pelvis, endometrium, leukemia, pancreas, thyroid, and liver (NCI, 2022).

Breast cancer is the most commonly diagnosed cancer among U.S. women (ACS, 2022). Incidence rates during 2014 through 2018 continued a slow increase for female breast cancer (by 0.5% annually) (Siegel et al., 2022). In women, breast cancer is generally detected with breast cancer screening (mammogram), typically prior to developing symptoms or after a lump has been discovered upon a breast self-examination. Breast cancer is identified as the second leading cause of cancer related deaths among African Americans, Asian/Pacific Islanders, Caucasian, and Native American women (Center for Disease Control [CDC], 2018). Comparing the various U.S. ethnic and racial groups, the highest breast cancer mortality rates are found among African American women (239.9 per 100,000), while the lowest mortality rates (88.3 per 100,000) are reportedly found in Asian/Pacific Islander women (NCI, 2018). The American Cancer Society reported that in 2022, approximately 287,850 new cases of invasive breast cancer will be diagnosed among U.S. women, and 43,250 women will die from breast cancer. Eighty-three percent of invasive breast cancers are diagnosed among women aged 50 years and older, and 91% of breast cancer deaths occur in this age group; half of breast cancer deaths occur in women 70 years and older (ACS, 2022; Giaquinto et al., 2022). According to the Office of Minority Health (OMH), Caucasian U.S. women are more likely than African American women to be diagnosed with breast cancer at early stages (7.0% vs 3.0%) (Narod et al., 2015); however, African American women have an increased likelihood of dying from this disease (OMH, 2018).

According to research, from 1999 to 2002, the breast cancer death rate dropped 1.3% per year on average. From 2002 to 2008, the death rate decreased by 2.2% per year on

average, and from 2008 to 2020, the death rate decreased by 1.4% per year on average (CDC, 2022; Ellington et al., 2020). In 1990 to 2010, there was a 34% decrease in breast cancer mortality among U.S. women. According to the most recent reports from the SEER cancer statistics review, cancer deaths decreased an average of 1.8% annually from 2006 to 2015 (NCI, 2016). Improvements seen in both early detection and treatment for breast cancer explained this decrease. However, with major racial and ethnic disparities noted in breast cancer mortality among U.S. women, the decrease in breast cancer mortality was not favorable to women of all races and ethnicities (Yedjou et al., 2019). Additionally, although major causes of cancer such as smoking have reduced, the U.S. population is continuously aging. Since cancer rates have been found to increase with age, it is important address cancer risks and mortality among the aging population.

Cervical cancer is the third most common gynecological cancer in the United States (CDC, 2022). Annually, about 13,000 new cases of cervical cancer are diagnosed and about 4,000 women die of this cancer (NCI, 2022). Hispanic women have the highest incidence of cervical cancer (11.3/100,000) followed by African American women (10/100,000), White women (7/100,000), American Indian/Alaska Native women (7/100,000) and Asian/Pacific Islander women (7/100,000) (CDC, 2019). African American women are twice as likely to die from cervical cancer as any other ethnic group, even though most cervical cancers are detectable with Pap tests and preventable with HPV vaccines (Giaquinto et al., 2022; Ismami et al., 2018).

**Cancer Disparities**

Cancer disparities refer to the difference in cancer measures such as incidence (Table 1), mortality, prevalence, survival rates, morbidity, screening rates, and stage as diagnosis among the various racial/ethnic groups. Racial classification, although addressed as a social

construct, is a useful tool in describing the general patterns since much of U.S. health-related data is reported by race.

Table 1: Top Cancer Sites for African American Women (2015-2019) (U.S. Department of Health and Human Services, Office of Minority Health, 2023).

| Cancer Incidence Rates per 100,000 – Women | | | |
|---|---|---|---|
| **Cancer** | **Non-Hispanic Black Women** | **Non-Hispanic White Women** | **Non-Hispanic Black/Non-Hispanic White Ratio** |
| All Sites | 408.7 | 450.8 | 0.9 |
| Breast | 129.6 | 137.6 | 0.9 |
| Cervical | 9.0 | 7.1 | 1.3 |
| Colon & Rectum | 38.6 | 33.3 | 1.2 |
| Kidney | 12.9 | 11.1 | 1.2 |
| Liver & IBD | 5.5 | 4.1 | 1.3 |
| Lung | 45.6 | 54.3 | 0.8 |
| Myeloma | 12.9 | 5.0 | 2.6 |
| Pancreas | 14.9 | 11.7 | 1.3 |
| Stomach | 7.8 | 3.7 | 2.1 |
| Uterus | 29.3 | 28.0 | 1.0 |

**IBD = Intrahepatic Bile Duct Data* Source: NCI 2022. Seer Cancer Statistics Review, 2015-2019. SEER*Explorer https://seer.cancer.gov/explorer/

In the United States, members of minority racial/ethnic groups are at an increased likelihood to experience poverty and tend to have minimal or no access to quality healthcare compared to their white counterparts. As a result, minority groups are less likely to receive recommendations or referrals for cancer screening services, thus resulting in late-stage cancer diagnosis. Certain racial/ethnic disparities can also be reflective of cultural differences (National Cancer Institute, 2022). For instance, racial/ethnic groups may have increased levels of mistrust in the healthcare system, exhibit certain fatalistic views about cancer, or experience fear and embarrassment relating to cancer diagnosis (Ehiwe et al., 2012).

Following Hispanics, African Americans/Blacks are the second largest U.S. racial/ethnic minority group (American Cancer Society, 2022). The Black population typically comprises

individuals who have ancestral ties with Africans many of whom were brought to the United States as slaves. African immigrants and their descendants are also part of the U.S. Black population. According to Cancer Facts and Figures for African Americans 2016-2018, Blacks are reported to have the highest death rates and shortest survival of any U.S. racial/ethnic group for most cancers (Table 2). Such disparities are reflective of social and economic inequalities and not a derivative of biological differences (ACS, 2018).

Table 2. Cancer death rates per 100,000 by race and ethnicity in United States 2016-2020 (NCI, 2022)

| Race/Ethnicity | SEER 22 Rate of New Cases | U.S. Mortality Rate |
|---|---|---|
| All Races | 445.5 | 149.4 |
| NH White | 476.3 | 154.4 |
| NH Black | 459.0 | 174.7 |
| NH Asian/Pacific Islander | 308.3 | 94.5 |
| NH American Indian/Alaska Native | 420.4 | 158.0 |
| Hispanic | 354.3 | 108.2 |

***Breast Cancer Disparities***

Disparity in breast cancer survival between Caucasian women and African American women has been an existing problem for decades (ACS,2022). During the 1980s, breast cancer

incidence rates among Black women increased rapidly, similar to the patterns found among White women. However, rates among Caucasian women generally stabilized while such incidence rates were slowly increasing in Black women, up to 0.5% per year from the years 1986 to 2012 (ACS, 2016).

For African American women, the risk of being diagnosed with breast cancer is lower than that for Caucasian/white women. However, mortality rates for African American women diagnosed with breast cancer are reported to be higher than those of the Caucasian counterparts (Martin & Winfield, 2012). In 2016, there was an estimate of 30,700 new cases of breast cancer expected to be diagnosed among Black women (ACS, 2016). African American women are 10% less likely to be diagnosed with breast cancer, nonetheless, they have a 40% increased mortality rate when compared to non-Hispanic White women (DHHS, OMH, 2023). According to the Center for Disease Control and Prevention (CDC), the mortality rates related to breast cancer are some of the highest cancer mortality rates within the African American population (CDC, 2022). Typically, African American women tend to present with later stages of breast cancer at diagnosis (ACS, 2022) and/or suffer from Triple-Negative sub-type of breast cancer that carries a higher risk of mortality that other sub-types (Wang et al., 2020). These factors may have an impact on the racial/ethnic disparities that have been observed in cancer mortality among different race/ethnicity groups (Table 2).

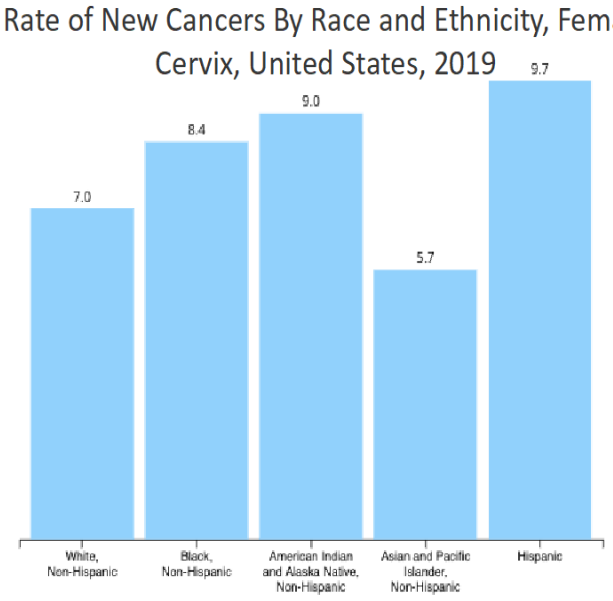
***Cervical Cancer Disparities***

Cervical cancer is the third most common gynecological cancer in the U.S (CDC, 2022). Data demonstrate that the incidence rate of cervical cancer is 9.2 and 7.1 per 100,000 people among African Americans and non-Hispanic White Americans, respectively, while the mortality rate associated with this malignancy is found to be disproportionately higher among AA women, that is 3.6 per 100,000 compared to 2.1 per 100,000 non-Hispanic White women (ACS, 2022; Siegel, Miller, & Jemal, 2019). Disparities in cervical cancer incidence and

mortality are prevalent, even though there have been improvements in outcomes over time (Yul, Sabatino, & White, 2019).

Among the ethnic groups, Hispanic and Black women have the highest rates of developing cervical cancer (as shown in Figure 1), and Black women have the highest rates of dying from cervical cancer (NCI, 2022; Thomas et al., 2020). It has been reported that AA women tend to present at a later stage of disease compared to Caucasian women. Researchers have also reported on racial disparity in the treatment of cervical cancer between AA and Caucasian patients, resulting in differences in survival outcome (Alimena et al., 2019; Thomas et al., 2020).

Figure 1 Rates of new cervical cancers by race and ethnicity (CDC, 2022).




Source - U.S. Cancer Statistics Working Group. U.S. Cancer Statistics Data Visualizations Tool, based on 2021 submission data (1999-2019): U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute; https://www.cdc.gov/cancer/dataviz, released in November 2022.

It is imperative to note that the CDC uses U.S. census defined categories. However, the racial categories defined by the U.S. census does not distinguish between African-born immigrants and African Americans. This implies that African-born immigrant women are defined

as African American women by the U.S. census, unifying all Black women under one structural umbrella. Although there may be some similarities amongst these two groups, there is a possibility that other factors create differences in their approach to preventive care for cervical and breast cancer.

According to the U. S. Census Bureau (2010), African immigrants are among the fastest growing population of immigrants in the U.S. (US Census Bureau, 2010). However, the extent of cancer-related research is scarce among this population. According to the Immigration Policy Center (2022), a majority (35.71%) of African immigrants migrate from West Africa, with 29.61% migrating from East Africa. More specifically, these immigrants are from West African countries such as Nigeria (13.65%), and Ghana (7.76%), and East African countries such as Ethiopia (10.8%), and Kenya (5.51%).

African Americans and African immigrants are found to be similar in terms of risk factors related to cancer (Sheppard et al., 2015). Since African immigrants are aggregated within the African American/Black racial category, African immigrants tend to be overlooked in statistics, understudied in research, or grouped together with other immigrant minority populations. Therefore, there is a need for disaggregated data among African Americans. The limited number of research studies pertaining to African Immigrants usually emphasize infectious diseases such as tuberculosis and HIV; meanwhile, chronic diseases such as cancer are understudied (Hurtado-de-Mendoza et al., 2012). The few research studies that have focused on African immigrants have demonstrated cancer-related disparities across the board (Creque et al., 2010; Morrison et al., 2012). Similar to African American women, immigrant women from West Africa have been found to be diagnosed with breast cancer at late stages compared to their Caucasian counterparts (Sheppard et al., 2015). Additionally, African immigrants tend to have lower screening rates when compared to non-Hispanic whites as well as other immigrant populations (Morrison et al., 2012).

## Purpose of the Study

The purpose of this study was to gain a deeper understanding of the health beliefs about disease prevention and the concept of health screening behaviors as it relates to utilization of breast and cervical cancer screening among West-African immigrant women, specifically from Ghana and Nigeria who are age 40 years and older living in Southern California.

## Aims of the Proposed Study.

The specific aims that guided this qualitative study included:

Specific Aim 1: To identify health beliefs and perceptions about cancer and cancer prevention among immigrant women from Ghana and Nigeria age 40 years and older living Southern California.

Specific Aim 2: To investigate middle-age and older Ghanaian and Nigerian immigrant women's knowledge about breast and cervical cancer prevention services in the U. S.

Specific Aim 3: To examine barriers and factors that facilitate middle-age and older Ghanaian and Nigeria-born women's decision to be screened for breast and cervical cancer in the U. S. and their follow-up action.

The outcome of this study provided deeper understandings about Ghanaian and Nigerian immigrant women's experiences with the U.S. healthcare system and their beliefs and behaviors on cancer prevention. Information from this study can inform healthcare providers who work closely with this population and who can subsequently tailor healthcare services to encourage cervical and breast cancer screening among these women.

## Significance of the Study to Nursing

Exploring the knowledge, health beliefs, and potential barriers that middle-age and older African-born women experience when seeking preventative care in Southern California provided essential preliminary data needed for developing tailored interventions aimed at empowering this population to seek available screening programs. Nurses are the most numerous direct care

providers for vulnerable populations such as African immigrant women and can provide information about the importance of screening behaviors. By working side by side with nurses, researchers can develop and test important interventions and educational strategies that directly address cancer prevention concerns specific to African immigrant women in the United States. In addition to contributing to the body of knowledge relating to African American and African-born women, this study is unique as it focused on a specific sub-group of Black women who are underrepresented in nursing research and may be similar in some ways yet have different viewpoints about cancer screening. Furthermore, results from this study can increase nurses' and other health care professionals' awareness of the experiences, beliefs, and other factors influencing preventive health-seeking behaviors among this population.

This study is important because the results can enhance the ability of healthcare providers to reach this population. Past studies tend to compare African Americans (which includes African immigrants) and Caucasian women. Although a few studies have distinguished between Black people born in the U.S. and those born in African coutries, most research data pertaining to health of U.S. Black people fail to distinguish between African immigrants and African Americans. Evidence-based practices have revealed that the incidence and mortality rates of invasive cervical cancer have decreased since the introduction and utilization of Pap tests (cervical cancer screening) (Hull et al., 2020; Moyer, 2012) and mammography (breast cancer screening) (Grimm et al., 2022). Utilization of culturally sensitive screening services promises the best hope to significantly increase early detection and reduce mortality associated with breast and cervical cancer in African-born women, age 40 years and older.

## Chapter 2: Literature Review

Gynecological cancers such as cervical and breast cancer are the leading cancers affecting women in Africa and accounts for 41.3% of all cancers in Africa (Kemo et al., 2019; N'Dah et al., 2014). Among immigrant women residing in developed countries, research suggests that they have an increased likelihood of being diagnosed with cancer at advanced stage (Esnaola & Ford, 2014).

Literature reports that most migrant women were unaware of cervical and breast cancer screening and were made aware of the risks associated with these cancers upon migration to high-income countries (Ogunsiji et al., 2013). Compared to US-born women, immigrant women were less likely to report getting recent mammography screening (McDonald & Neily, 2011) or adhering to recommended mammography screening guidelines (Dailey et al., 2011). With most gynecological cancers, African immigrant women have lower screening rates when compared to their non-Hispanic white counterparts (48.79% vs. 69.1%) (Morrison et al., 2012; Hurtado-de-Mendoza et al., 2014).

There is limited research that focuses primarily on U.S. African-born immigrants regarding breast and cervical cancer screening, making this population underrepresented in cancer literature. Although African Americans and African immigrants have similar genealogy, there may be differences that exist with cancer screening practices among these two groups (Amuta-Jimenez, et al. 2022; Swan et al., 2003). Understanding some of the factors influenced by the cultures of African immigrants relevant to preventive services such as cancer screening will facilitate clinicians' abilities to tailor treatment more specifically to groups within the African American/Black population. Since African-born immigrants are among the fastest growing immigrant groups in the United States, (Adekeye et al., 2018), more research in breast and cervical cancer screening pertaining to this population is necessary.

This chapter describes the context of African immigration into the United States and provides background information pertaining to cervical and breast cancer incidence and mortality globally and in the United States. Second, disparities in both incidence and mortality will be described. Third, evidence that a meaningful gap on aging African immigrant women's perspectives regarding breast and cervical cancer screening will be provided. Finally, the literature search methods on African immigrant women's perceptions about screening for breast and cervical cancer along with the results will be described.

**Characteristics of Immigrants of African Descent**

Among the U.S. population, immigrant populations account for approximately 13.5% (Pew Research Center, 2018) with African immigrants making up approximately 9% of the overall immigrant pool. According to the U.S. Census Bureau, African American/Black individuals of African or Black heritage who were born outside of the United States. and currently living in the United States are referred to as immigrants. The term "foreign-born" is also used when referring to Immigrants (U.S. Census Bureau, 2020). In this study, African immigrants mainly consist of individuals born in West Africa, such as Ghana and Nigeria. In recent years, the fastest growing group of immigrants from Africa, about 39%, are primarily from Sub-Saharan Africa including countries like Nigeria, Ghana, and Ethiopia (Adekeye et al., 2018). Although some immigrants from Haiti, Cuba, Somalia, and some other countries migrate to the United States as refugees, migration for most immigrants from Africa typically is intentional in pursuit of opportunities for success and development that are typically unavailable or limited in their birth country (Anderson & Lopez, 2018; Bustamante et al., 2018). Pursuing higher education, gaining new skills, or attaining higher paying jobs to take care of their families back home are usually part of migration goals for many U.S. immigrants of African descent.

It is imperative to recognize that most immigrant groups in the US are from less economically-developed countries. The existing literature on cancer and its screening

procedures sheds light on how culture and migration interact and influence screening behaviors among various minority groups.. However, much of the literature pertaining to breast and cervical cancer is typically conducted among the majority racial groups, and literature addressing African immigrants is usually grouped together with African American groups. With the notion that preventative health behaviors are not homogenous across populations, it is essential to analyze preventive health-seeking behaviors of specific populations in order to create comprehensive interventions (Kobeissi, Samari, Telesca, Esfandiari, & Galal, 2014). In order to adequately address the disparities in breast and cervical cancer mortality among older African immigrants, disaggregated data by country of origin, more accurate prevalence data, and more culturally-tailored interventions are needed for this population.

## Background Information

### Global Incidence of Breast and Cervical Cancer

Globally, incidence and mortality rates of breast and cervical cancer have decreased with the introduction of screening (Arbyn et al., 2020; Markowitz et al., 2016; Torre et al., 2015). However these rates remain high among women in middle and low-income countries such as Ghana. There is an expected increase of 45% in overall global cancer incidence between the years 2010 and 2030, with majority of the burden experienced by older adults and minorities (GLOBOCAN, 2018; Smith et al., 2009; Zhang et al., 2021).

#### *Global Incidence of Breast Cancer*

Breast cancer is considered the most commonly diagnosed cancer and the leading cause of cancer related deaths among women worldwide. According to Global Cancer Observatory (GLOBOCAN, 2018), about 2,100,000 women were expected to be newly diagnosed with breast cancer. This accounts for 24% of all cancer incidences among women globally. In that same year, about 630,000 women were estimated to have died from breast cancer, that is, 15% of total cancer deaths around the world (GLOBOCAN, 2018; Siegel et al.,

2019). According to research, age of onset for breast cancer diagnosis varies across countries. About 48% of women are diagnosed with breast cancer at age 50-59 in most western countries. For example, the average age of breast cancer diagnosis in the United States is 62 years and around 82% of breast cancer cases are diagnosed in women who are 50 years or older (Ferlay, Soerjomataram, Ervik et al., 2012; Liu et al., 2020). Worldwide the mean breast cancer mortality rate was 13.77 per 100,000 in 1990 and showed an increasing trend of 0.7 per 100,000 by the year 2015. This increasing slope in mortality rate was driven by sharper increases in mortality from breast cancer among women in middle and low-income countries while mortality rates in high income countries decreased (Azamjah et al., 2019; Siegel et al., 2019). Subsequently, there is still an increase in the number of breast cancer related deaths in many countries, mainly in middle or low-income countries.

***Global Prevalence of Cervical Cancer***

Globally, cervical cancer ranks as the fourth most common female malignancy in the world and accounts for 4% of all cancers diagnosed worldwide, thus becoming a global health concern (Kessler, 2017). Literature depicts that 90% of the world's deaths caused by cervical cancer occur in developing countries and as such, it is the second most commonly diagnosed cancer and the third leading cause of cancer-related deaths among women (Hull et al., 2020). According to Arbyn et al. (2020), there were approximately 570,000 cases of cervical cancer and 311,000 deaths in 2018. The estimated age-related incidence of cervical cancer was 13.1 per 100,000 women globally and varied widely among countries. In Western, Eastern Middle, and Southern Africa, cervical cancer was reported as the leading cause of cancer-related deaths in women in 2018 (Arbyn et al., 2020). About 84% of cervical cancer cases occurred in less developed countries, and women who are at an increased risk of invasive cervical cancer are those living in rural areas of low and middle income countries, as well women who are poor and live in high-income countries (Hull et al., 2020; Kessler, 2017). This suggests that increased

risk for cervical cancer can be attributed to lack of access to prevention, screening, and treatment services.

### *Cervical Cancer in Africa*

Cervical cancer is the leading cause of cancer deaths in women in Africa and since 2012, over 60,000 women have died from this disease (Arbyn, 2020; Torre et al., 2015). Cancer of the cervix has been positioned as the principal cause of deaths related to cancer among women in Ghana (Nartey et al., 2017; Williams et al., 2013). The World Health Organization (WHO) has anticipated that by 2025, about five thousand new incidents of cancer of the cervix and 3,361 mortalities related to cervical cancer are to be expected annually among women in Ghana (WHO, 2010; Williams et al., 2013). According to current estimates, about 14,943 women are diagnosed with cervical cancer, and 10,403 die from the disease in Nigeria every year (Bruni et al, 2019; Global Cancer Observatory, 2020; Titiloye et al., 2019). Studies reiterated that currently, mortality rates for cervical cancer among Ghanaian and Nigerian women are practically three times more than that of cervical cancer mortality rates found globally (Ogwunga et al., 2020; Okolie et al., 2022; Osei & Ani-Amponsah, 2022; Williams, 2014).

## Cancer Incidence, Mortality, and Disparities in the United States

Annually, the American Cancer Society (ACS) projects the numbers of new cancer cases and deaths in the U.S and gathers the most recent data on population-based cancer incidence and outcomes. The Surveillance, Epidemiology, and End Results program (SEER); the National Program of Cancer Registries; and the North American Association of Central Cancer Registries collected incidence data through 2018 while the National Center for Health Statistics gathered Mortality data through 2019 (Giaquinto et al., 2021). According to the ACS, 1,918,030 new cancer cases and 609,360 cancer deaths were projected to occur in the United States in 2022 (ACS, 2022; SEER, 2022; Siegel et al., 2022). Among African American/Black

people, 224,080 new cancer cases and 73,680 cancer deaths were estimated to occur in the U.S. (Giaquinto et al., 2022).

During the era of the colonial slave trade to North America, populations from Western African were the predominant source of enslaved individuals, thereby establishing a shared ancestry between them and contemporary African American/Black populating residing in the United States (Sussner et al., 2009). Thus, it is appropriate to compare patterns of disease incidence and mortality among African Americans with data pertaining to the epidemiology of breast and cervical cancer among native African women (Newman, 2005).

***Breast Cancer in the United States.: Incidence, Mortality and Disparities***

In 2022, approximately 287,850 new cases of invasive breast cancer will be diagnosed among women in the U.S, and out of this number, 43,250 women are projected to die from breast cancer (Giaquinto et al., 2022; SEER, 2022). The highest incidence of breast cancer in the U.S is typically found in middle aged and older women. It is reported that 83% of invasive breast cancers are diagnosed among women aged 50 years and older, and 91% of breast cancer deaths occur in this age group (Giaquinto et al., 2021; Vengaloor et al., 2021).

According to Giaquinto et al. (2022), death rates for breast cancer had increased by 0.4% yearly from 1975 to 1989 but has since decreased by 43% through 2020. Due to this decline, 460,000 breast cancer deaths have been prevented in U.S. women from 1989 to 2020 (Giaquinto et al., 2022). Increase in better and more targeted treatment and early detection through mammography screening has been found to be a major contributing factor to the decline in breast cancer mortality (Tong et al., 2018). However, racial disparity in breast cancer reached its peak in 2011 and has persisted with mortality rates 40% higher among African American/Black women than Caucasian women in 2016–2020 (Giaquinto et al., 2022).

Breast cancer data depict that incidence rates are found to be highest in Caucasian women (133.7 per 100,000), followed by African American/Black women (127.8 per 100,000),

and are lowest in Hispanic and Asian Pacific Island (API) women (Miller et al., 2021). Among these defined racial groups, African American/Black women have the highest breast cancer death rate (27.6 per 100,000), which is 40% higher than the rate in White women (19.7 per 100,000) and more than double that in API women (11.7 per 100,000) (Miller et al., 2021).

The highest mortality rate (recorded at 28.1/100,000 women per year based on 2012 to 2016) was found among African American women (NCI, 2018). Thus, this suggests that the burden of breast cancer mortality is typically experienced by middle aged and older adults who are from minority groups, such as African Americans and the African immigrant population.

### *Cervical Cancer in the United States: Incidence, Mortality, and Disparities*

According to the American Cancer Society (ACS), there is an estimated 13,960 new cases of invasive cervical cancer that will be diagnosed in 2023 and about 4,310 women will die from the disease that same year (ACS, 2022). The Center for Disease Control and Prevention (CDC, 2019) noted that the incidence rate is highest among women who are 40-44 years old. However, the ACS (2022) warns that over 20% of all cervical cancer cases are diagnosed in women over 65 years old.

Cervical cancer grows slowly but can be particularly dangerous if not diagnosed in early stages. Cervical cancer can invade surrounding tissue and become more difficult to treat. Hispanic and Black women as well as women living in rural areas of the U.S. are more likely to be diagnosed at later stages and have higher mortality rates than non-Hispanic Caucasian women and those living in metropolitan areas (Yu et al., 2019).

### *Cancer Disparities Among African Immigrant Women in the United States*

African immigrant women continue to present with greater proportions of advanced-stage disease, despite recent data indicating increases in mammography utilization among African-American women that are comparable with utilization rates among Caucasian-American women (Sheppard et al., 2010). The 2017 National Health Interview Survey (NHIS) showed that

46.6% of recent immigrants reported being screened for breast cancer using mammogram, in comparison to 73.1% of non-immigrants (CDC, 2017). It is reported that 1 in 9 African American women is expected to have a breast cancer diagnosis in their lifetime in comparison to 1 in 8 Caucasian women (DeSantis et al., 2019; Yedjou, 2019). A study addressing the cancer statistics for African Americans (DeSantis et al., 2016) conferred that during the 1980s, incidence rates for both Black and Caucasian women were steadily increasing due to the uptake of mammography screening; however, as both incidence and mortality rates decreased or remained at a stabilized rate among Caucasian women, it was steadily rising among African American/Black women (an increase of 0.5% per year from 1986 to 2012). The study attributed the increase in mortality rate to late stage diagnosis as well as poorer stage specific detection of breast cancer among African American women.

Bearing the highest death rate and shortest survival rate for breast cancer diagnosis, African immigrants in the U.S. (including Ghanaian and Nigerian immigrants) are at a disadvantage with risks pertaining to breast and cervical cancers (Howlader et al., 2013; Ndukwe et al., 2013; Omenka et al., 2020). Ultimately, the continual increase of breast and cervical cancer incidence and mortality among this population suggests a widening disparity.

## Breast and Cervical Cancer Risk

Cancer risk is a function of both lifestyle / environmental exposures and genetic factors (DeSantis et al., 2016). There is a 13% or 1 in 8 chances of a woman living in the United States to be diagnosed with breast cancer in their lifetime (DeSantis et al., 2019; Giaquinto, 2022. Regarding age, women over 50 years are more likely to be diagnosed with breast cancer for the first time with the highest risk (4.1% or 1 in 25) recorded for women in their 70s. Women diagnosed with breast cancer in their 80s are most likely to die from breast cancer. (DeSantis et al., 2019). The median age found for breast cancer diagnosis among all women in the United States was 62 years old. For African American/ Black women, the median age at diagnosis is 59

years and for Caucasian women, median age is 63 years (Howlader et al., 2017). This suggests that African American women are diagnosed with breast cancer at a younger age in comparison to their white women counterparts, thus at an increased risk of breast cancer morbidity and mortality.

Studies aimed at investigating the risks of breast cancer deaths by tumor subtype and stage of diagnosis among women in California found that there were a 31% to 39% higher risks of breast cancer deaths among Black women than Caucasians (Giaquinto et al., 2022; Tao et al., 2015; Yedjou et al.,2019). The greatest disparity was found for cancer of the breasts at stage II and III for the HER2- tumor subtypes (Tao et al., 2015). Iqbal and colleagues (2015) indicated in their study that during 2004 through 2011, among cancer patients with small breast tumors, it was determined that black patients were more likely to present with lymph nodes metastases (24%) than the white patients who were also diagnosed with cancer (18%).

According to Giaquinto et al. (2022), detection of breast cancer at later stages has been ascribed to low participation in breast cancer screening (mammogram), low rates of follow up for abnormal results, as well as prolonged intervals between screening. When it comes to stage specific detection, the article suggested that unequal access to health care and opportunities for prompt and quality treatment contributes to this disparity among Black and Caucasian women (Giaquinto et al., 2022).

Although the current study is interested in addressing preventive health services in relation to breast and cervical cancer disparity among Ghanaian and Nigerian immigrant women, it was also important to acknowledge the literature that suggests Black women exhibit more aggressive tumor characteristics with breast cancer diagnosis (Chatterjee et al., 2013). DeSantis et al. (2019) also addressed that advanced stage tumors tend to have poorer prognosis with treatment. Other studies also found that other reproductive patterns which can be linked to increased risk of more aggressive breast cancer subtypes, such as, early age at

first pregnancy, multiparity, and low rates of breastfeeding, has been found to be more common among the Black population (Dietze et al., 2015).

The risk of cervical cancer generally remains high in developing countries since there is inadequate cervical cancer screening and vaccination for Human Papillomavirus (HPV) (Hull et al., 2020; Vaccarella et al., 2013). Preventative screening and early detection of precancerous lesions in the cervix is an initial easy step towards eliminating the high prevalence and mortality rates of this disease (Medhanie et al., 2017; Thomas et al., 2020; Williams et al.,2013). In developed countries, recommendations and guidelines from the Unites States Preventive Task Force has helped to target women at risk in order to decrease incidence and mortality. HPV remains a high-risk factor for cervical cancer globally, however, the prevalence of HPV infections varies across the world (Chan et al., 2019; Okunade, 2020). For instance, the rates of HPV infections in countries in Eastern Europe, Latin America, and Sub-Saharan Africa is notably higher than the average globally (Forman et al., 2012; Kombe Kombe et al., 2021). Generally, African American women are at an increased risk of having an HPV infection in comparison to Caucasian women and have twice the likelihood of dying from cervical cancer than any other ethnic group (CDC, 2015; Ojeaga et al., 2019).

Introducing the Papanicolaou test (pap smear test) and HPV vaccinations are all part of successful strategies to reduce the risk of women dying from cervical cancer. Studies demonstrate that the HPV vaccine has been approved for use in addition to the availability of pap smears and inspection via acetic acid for precancerous cells in the cervix in Ghana (Williams & Amoateng, 2012) however, only 2.7% of Ghanaian women aged the 15 to 64 obtain screening for cervical cancer every 3 years (Williams et al., 2013). According to the International Agency for Research on Cancer (IARC), it has been indicated that these strategic screening programs have aided in reducing cervical cancer rates by 60-90% (IARC, 2005); however, it is unfortunate that women in medium and high-income countries have access to screening and

can enjoy these results. As such, women in low-income countries (such as Ghana and Nigeria) tend to have substantially higher cervical cancer burden when compared to women in economically-developed countries.

### Breast and Cervical Cancer Risk among African American Women

Perception of cancer (breast and cervical) risk is disproportionately low among older African women because of their lower literacy rates, poor socioeconomic status, and diminished awareness of these gynecological cancers (Fregene & Newman, 2005). African-American women typically view themselves to be at low risk of developing cancer generally. This interpretation is consistent with African immigrants' generally poor knowledge of cancer risk factors and suggests that educating these women about breast and cervical cancer risk factors is needed. Also, erroneous knowledge of breast cancer risk factors and causes may ultimately affect interest in genetic testing directly or by affecting perceptions of risk (Lipkus et al., 2009). According to Opoku et al. (2016), women underestimated their level of risk for cervical cancer as a result of not being aware of the severity of the disease.

## Literature Search Methods

In conducting this literature review, journal databases from the University of California such as PubMed, CINAHL, and PsychINFO were utilized to search for articles on the proposed phenomenon. Search terms and keywords such as "cervical cancer screening", "breast cancer screening", "West African immigrants", "Black women" "cervical cancer", "aging women", "barriers to cancer screening", "Black immigrants", and "preventive health care". Along with these terms, other search terms such as ""African-born women", "culture", "beliefs", and "perception" were used to narrow down the search. The initial search produced 120 results from the search on PubMed, 5 on CINAHL, and 22 articles from PsychINFO. When the keyword "Ghanaian immigrants", "Nigerian immigrants" or "West African immigrants" were added to the search items, it yielded only 5 articles on PubMed. Articles retrieved were screened further for

relevance to the phenomenon of interest and rigor.

Articles selected in the literature were based on certain criteria prior to being included for review. First, addressing women's perceptions, attitudes and beliefs about breast and cervical cancer screening were part of the inclusion criteria. Additionally, articles included in this review had to be written in English and include immigrants from African countries, then more specifically, West African immigrants. Due to narrow results of articles specifically pertaining to African immigrant women in the United States, the search was extended to include studies conducted in other developed countries; however, the study sample had to include West African immigrants.

For this literature review, exclusion criteria were also applied. The review excluded articles that were integrative literature reviews, meta-analyses, and dissertations. Articles that were not written in English and did not concern breast or cervical cancer screening were also excluded. Most articles specifically discussing this phenomenon among other immigrant populations were excluded even though the topic was focused on aging or older women since many varying cultural differences exist among immigrants from different countries. As the literature search was conducted, the paucity of literature focusing on aging West-African immigrant women, more specifically Ghanaian and Nigerian immigrant women's beliefs and actions regarding screening for breast and cervical cancer was recognized as a gap.

## Results of Literature Search

For this literature review, records of articles identified via database searching resulted in 127 total articles. After removing duplicates found among the data bases, 95 articles remained. The remaining articles were scrutinized and screened further and 60 were excluded based on the exclusion criteria. This resulted in 35 articles that were further assessed for eligibility and relevance to the decreased use of breast and cervical cancer screening in older African immigrant women. In analyzing these articles, aspects such as title of the article, purpose of

study, study sample, study design, data analysis and results of data were carefully assessed. Full text peer reviewed articles were carefully reviewed and resulted in 12 articles included in this literature review. Articles included in the final selection for this review were included in a Table of Evidence (TOE) (Appendix A). The final articles were grouped into similar themes that were discussed across the literature.

The 12 articles included in this literature review were relevant to breast and cervical cancer screening beliefs and behaviors of African immigrant women and were based on the inclusion and exclusion criteria previously discussed. Majority of the studies included were conducted by researchers in the public health field. A variety of research designs were used among the articles included in the final review. The study designs included: (a) five cross-sectional observational designs using surveys and, (b) seven qualitative designs with indepth interviews (four with focus groups and three with individuals). One of those studies (Babatunde-Sowole et al., 2020) was a secondary analysis of an initial qualitative study exploring resilience among West African women who migrated to Australia. With the state of the science still in its preliminary stages, it was observed that majority of the studies on African immigrant women's perspectives on breast and/or cervical cancer and screening were qualitative studies. Although some articles included in the literature search results may not be directly applicable to the population of interest (West African immigrant women 40 years and older), some key points discussed pertain to the research phenomenon, and therefore, were included in the results of the literature search.

**Perceptions of Cancer**

In addressing minority ethnic groups, it is important to address any cultural perspectives and misconceptions of cancer. Cancer is commonly used as a metaphor for something evil, harmful or uncontrollable. Across most cultures and ethnic groups, cancer is perceived as a deadly disease (IARC, 2008; Livestrong, 2010). This might be because cancer is known to be a

major world killer and is often associated with the belief that death is inevitable when cancer is present. Cancer in literature has been associated with the feelings of fear, apprehension, shame and secrecy associated with the disease across different ethnic and cultural groups in many nations (Livestrong Report, 2010; Ndukwe et al., 2013); similar perceptions could also exist among ethnic minority populations in the U.S.

Studies indicate that low perceived risk and health care costs are other factors that have been cited as contributing to reduced rates of cancer screening among African American women (Champion et al., 2006; Champion & Skinner, 2003; Ndukwe et al., 2013). A review of the outcomes in these studies indicated that cancer can be perceived as a death sentence which leads some Black people in the U.S. to avoid discussing it. Similarly, a cancer perception study among different ethnic groups in various areas of Europe, South Africa, North America and South American countries revealed that this same perception cuts across most nations and cultures included in the study (Ehiwe et al., 2012).

Negative perceptions of cancer, whether it is seen as a contagious or a shameful disease tend to be common among a variety of cultures as suggested in literature. The belief and perception that naming and speaking about cancer could affect one's chances of actually getting cancer tend to discourage women of color from pursuing cancer screening and might result in fears and denial (Ehiwe et al., 2012). Ehiwe and colleagues (2012) sought to investigate whether black African migrants in the United Kingdom (U.K) have different perceptions of cancer from other ethnicities, cultures, and races. In this qualitative study of Ghanaian and Nigerian immigrants, the researchers revealed that the perception of fear, denial, and shame in regards to cancer among their study population of ten Ghanaian and ten Nigerian women was similar to that of literature about Black women in the U.S. It was also noted that these perceptions were accompanied with the feeling of secrecy and apprehension in discussing cancer even among their peers, thus hindering them from engaging in adequate

utilization of cancer screening. The study discovered that the sample of immigrants from Ghana and Nigeria unanimously shared that cancer is perceived as deadly and evoked fear, denial, and refusal to act. Participants in the study shared that they believed once they even speak about cancer, there is a likelihood that they may be affected by cancer thus limiting talks or discussion concerning cancer. The study however, had its limitations related to generalizability and a sample bias since their study populations did not include all black migrant groups (only Ghanaian and Nigerian immigrants) (Ehiwe et al., 2012).

The perception and belief that God is capable of curing cancer tend to be similar among other minority ethnic groups. Women in the U.S who migrated from Somalia also shared the role of God's will and fate pertaining to their health (Raymond et al., 2014). According to Raymond et al. (2014), Somalian immigrants in the U.S recognized that their perceptions of cancer changed when they migrated. The study participants shared that cancer was not a well-known disease in their country of origin. This may be tied to the idea of the "hush-hush" behavior in talking about cancer among minority ethnic cultures as suggested by Ehiwe et al. (2012). Similar to other findings in the literature, the study by Raymond et al. (2014) suggested that cancer is stigmatized among the Somalian population and also draws out the attitude of secrecy and shame. The secrecy and shame were also associated with fear of diagnosis, leading women to avoid seeking healthcare. In addressing the needs of older women, this study found that older African immigrant women had a higher belief in the role of God's will and fate in regards to health. Older women believed that things happen according to God's will and plan and treatment is only helpful if approved by God (Raymond et al., 2014). Older women believed that only God would cure cancer and if a person dies from cancer, then it was their destined time to die. However, this study was limited to mainly Somalian immigrants and may not be an adequate reflection of perception for all African immigrant women.

The implications of such fear and belief pattern are well documented to have prevented some from seeking early diagnosis and treatment (Dein, 2005; Ndukwe et al., 2013). It is important for health professionals specializing in cancer care to address such issues related to cancer perceptions especially when considering working with patients particularly of minority ethnic origin.

**Breast and Cervical Cancer Screening among Immigrants in the United States**

Although incidence rates vary by country, cancer is the leading cause of mortality among individuals of African descent globally. Cancer death rates are steadily decreasing in the U.S. due to several factors, some of which can be attributed to screening for early detection as well as advances in science and technology (ACS, 2022). Despite the extensive approaches for promoting breast and cervical cancer awareness and screening in the U.S, disparities in breast and cervical mortality among African Americans still exist (ACS, 2022; Staples et al., 2018; Stewart & London, 2015; Yu et al., 2019). Generally, African American women receive their cancer diagnosis at a younger age (57 years) compared to White women (62 years); however, African American women experience much lower survival rates after diagnosis (DeSantis et al., 2019).

Use of mammography and pap smear as early detection has been identified as an effective mechanism to detect breast and cervical cancer before it metastasizes and once it is treated effectively and in a timely manner, can most likely provide women with longer survival (CDC, 2022; DeSantis et al., 2019; Smith at el., 2019). Immigrants of African descent have lower screening rates for breast and cervical cancers when compared to the U.S. born African Americans. Cervical cancer screening or the pap smear test, aims to help prevent cervical cancer. The goal of such screening service is achieved if screenings are obtained at regular intervals, thus increasing the chances of cervical cancer detection at earlier stages. Typically,

women with lower education, women lacking health insurance, and immigrants are less likely to obtain cervical cancer screening (Harcourt et al., 2014).

Studies examining disparities in mammography uptake among immigrants and U.S.-born women found that while there is an increase in the rates of immigrants getting a mammogram, they still have lower screening rates when compared to U.S.-born women. Studies have identified various factors that contribute to the delay of seeking mammogram or pap smear screening among African Americans, with a few investigating that of African immigrants in the U.S. (Fang & Ragin, 2020; Forney-Gorman et al., 2016).

**Barriers to Cancer Screening**

The concept of disease states (e.g. cancer) and of preventative care, in general, may be difficult for immigrants, and cultural health beliefs may influence choices even with health care education (Pindet et al., 2016). Similarly, Samuel and colleagues (2009) discussed that in general, immigrants from developing countries may have difficulty in understanding concepts pertaining to preventative care and disease states (such as cancer). Also, immigrants tend to be influenced by their own cultural health beliefs despite receiving health care education (Samuel et al., 2009). Immigrants arriving in the U.S. can be faced with certain cultural, economic and linguistic challenges that pose barriers to healthcare. For instance, language barriers can inhibit effective communication between the patient (immigrant) and the healthcare provider. Such language barriers can also hinder an immigrant's understanding of the preventive health guidelines such as screening services.

Most times, immigrants from less developed countries to more developed countries like the U.S. have various religious beliefs and cultural ideologies about health and early medical treatment that they have developed from their countries of origin. These beliefs may be a barrier to accessing adequate healthcare services as well. Thus, many immigrants may have low interest in preventive health services in the U.S. Typically, there is also a level of distrust in

westernized medical professionals, and some immigrants have a preference of consulting traditional healers or certain non-medical remedies to help them when they are sick (Ehiwe et al., 2012; Ndukwe et al., 2013; Ojikutu et al., 2013).

As noted previously, Raymond et al. (2014) studied Somali immigrant women to understand their knowledge about breast and cervical cancer screening as well as differences in perceptions and attitudes towards screening between older and younger Somali immigrant women. Researchers found that women (despite age) perceived that radiation from the mammogram could actually be a cause of cancer, thus becoming a barrier in getting screened for breast cancer. Feelings of shyness and concerns with modesty was also identified as a barrier to both breast and cervical cancer screening among this studied population. Contrary to the belief of the older women, the younger women in this sample population were worried that their virginity would be questioned by society if seen attending clinic for Pap test (Raymond et al., 2014). Privacy and discomfort were also identified as barriers according to literature. Participants from Osunji et al. (2013) also shared about comfortability as being a barrier. Women in the study (primarily Ghanaian and Nigerian immigrant women in Australia) reported not feeling comfortable exposing their private parts especially to male health care practitioners (Osunji et al., 2013).

Ogunsiji and collegues ( 2013) conducted a study on Nigerian and Ghanaian immigrant women in Australia to explore their knowledge, attitude and usage of cancer screening. Among the 21 Ghanaian and Nigerian women studied, the majority of them had little to no knowledge about breast and cervical cancers prior to migrating. It was noted that women who participated in breast and cervical cancer screenings did so were opportunistic, i.e., when they visited their general practitioners for regular checkups. Barriers found among the women in the study were consistent with the literature; their health beliefs about their susceptibility to breast and cervical cancers were recognized as barriers to their prioritizing cancer screening (Ogunsiji et al., 2013).

Existing literature suggests that lack of knowledge about the benefits of cancer screening, perceptions about cancer, and existence of barriers affect adherence to cancer screening among African American women (Ehiwe et al., 2012). Prior research on cancer screening among immigrants suggests that language barriers, low educational attainment, and poverty lead to decreased access to preventive care. The refusal to accept the occurrence of cancer among self or family members and the lack of appropriate and adequate information were also identified as possible explanations for this type of behavior towards cancer screening. Regardless of a woman's country of origin, knowledge and exposure to breast cancer prevention and screening information prior to arrival in the United States appears to be limited (Mendoza et al., 2015).

***Barriers to Breast Cancer Screening***

The general lack of knowledge about breast cancer was also associated with experiences of shame by those affected by the disease. Because of their limited knowledge and feelings of shame, women tend to associate breast cancer with mastectomies and death (Ogunsiji et al., 2017). Given the limited amount of accurate knowledge about breast cancer that African immigrant women possessed, their descriptions of the disease were drawn from their observations of or experiences with family or community members (Ndukwe et al., 2013). Common descriptions of breast cancer labeled it as, "an incurable disease," "a white person's disease," and a punishment from God (Dien, 2006, pp 45).

In a study conducted by Ndukwe et al. (2013), the researchers sought address the effects of cultural factors and beliefs on breast and cervical cancer screening among female African immigrants in the Washington D.C. area in the United States. Participants in the study were African immigrant women (Ghana, Nigeria, Cameroon, Zambia, and Ivory Coast) with ages ranging from 20 years to 70 years. In their study, the researchers utilized focus groups to assess the various cultural factors and beliefs that could serve as barriers for women getting

screened for breast and cervical cancer in the U.S. Study participants indicated that some of the factors that influenced their knowledge of breast and cervical cancers were tied to age, level of education, and insurance status. The women also discussed that lack of transportation, privacy, hearsay about the screening process being painful, and commitment to their family responsibilities typically took precedence over time to get screened. In regard to their spiritual beliefs, the women shared that it was a common belief that their religion would protect them from cancer, therefore, they avoid getting screened (Ndukwe et al., 2013). According to the female immigrants in this study, since cancer is perceived as a curse, thus, if one is diagnosed with cancer, then he or she must have done something bad to have received that curse. It was also suggested that an individual's faith is a protective factor against cancer diagnosis; therefore once a person has accepted God into his or her life and has faith, God will protect their overall health as well as protect them from developing diseases such as cancer (Ndukwe et al., 2013). Interestingly, the women in the D.C area tied their beliefs strongly to protection from their religion, that is, they felt there was no need to obtain screening because their religion would protect them. As suggested by similar studies in the literature, there are unique cultural and spiritual beliefs that are specific to the African immigrant population.

In a study by Vahabi et al. (2014) about breast cancer screening disparities in Canada among immigrants from several regions of the world including Africa, researchers discovered low rates of breast cancer screening for most immigrant groups studied. Factors such as living in low-income neighborhoods, being admitted as refugees, being new or recent immigrants, not having a general physical examination, not being enrolled in a physician enrollment model, having a male physician, and having an internationally trained physician were found to be associated with low rates of breast cancer screening (Vahabi, 2014). On a promising note, Sheppard et al. (2015) found that breast cancer knowledge was associated with higher

endorsement of breast cancer screening; therefore, knowledge about breast cancer constitutes a mutable factor that can be targeted in interventions.

### *Barriers to Cervical Cancer Screening*

Factors associated with decreased use of cervical cancer screening as indicated in the selected studies also included lack of knowledge and awareness regarding cervical cancer, the human papilloma virus (HPV) as well as cervical cancer screening services that are available (Asuzu et al., 2011; Ebu et al., 2015). The notion that cervical cancer is a highly preventable disease was found to be an uncommon knowledge that women in Ghana and other ethnic minority groups have (Adanu, 2002; Marlow et al., 2014). Consequently, this affects the attendance for cervical cancer screening since they may not fully comprehend the benefits of being screened. According to researchers, there were some females who were well-informed about the risks of cervical cancer; however, a key reason identified for the underutilization of the available screening services was attributed to inadequate information regarding screening services (Chigbu & Aniebue, 2011; Modibbo et al., 2013). Since lack of knowledge was observed among these women, they were less likely to seek screening services as a form of preventive health, thus resulting in an increased probability of being diagnosed with late stages of cervical cancer (Opoku et al., 2016; Williams et al., 2013). Although some studies found significant relationships between knowledge level and screening behaviors, others reported that irrespective of the comprehension level regarding cervical cancer, some women in Ghana still exhibited decreased uptake of cervical cancer screening (Wiiliams & Amoateng, 2012; Abotchie, & Shokar, 2009).

Emotional barriers played a significant role in the low utilization of cervical cancer screening. Researchers have found emotional barriers such as fear of cancer diagnosis, fear of pain, shame, and embarrassment (Isa-Modibbo et al., 2013; Marlow et al., 2014). Studies also suggest that African born immigrants to the U.S. experience similar motivators and barriers to

obtaining cancer screening as American born Blacks such as fear and fatalism (Ndukwe et al., 2013). Although some women were well aware of the benefits of cervical cancer screening, the thought that the Pap smear procedure can be uncomfortable and even painful hindered them from being screened (Marlow et al., 2014).

According to Ndikom and colleagues (2012), fear of being diagnosed with cancer was found to be another barrier to being screened for cervical cancer. Women associated getting screened with an increased chance of being diagnosed with cancer. This fear of diagnosis was linked with the stigmatization of cervical cancer diagnosis (Ndikom et al., 2012). Due to the negative stigmatization associated with cervical cancer diagnosis, women expressed that they were reluctant to be screened for cervical cancer because of the possibility of knowing that they had cervical cancer may result in being judged by community members (Williams et al., 2013). Predominantly with older women, shame and embarrassment were identified as a common barrier to utilizing cervical cancer screening services (Marlow et al., 2014).

Nigerian immigrants from a study described that cancer was perceived as a deadly disease, and the fear of learning that he or she has cancer is enough to kill someone (Ehiwe et al., 2012). In this study, researchers noted that a Ghanaian woman was less likely to accept the possibility of being diagnosed with cancer due to the fear of death and the reaction of family members once they learn about her diagnosis (Ehiwe et al., 2012). Ultimately, there is the suggestion that for African immigrants, this fear of cancer death trumps their belief in a cure or treatment for cancer which subsequently, can result in women living in denial and refusing to pursue cervical cancer screening.

Review of the literature showed that barriers to screening for cervical cancer echoed views seen in other countries about barriers to access to health care and also identified some new notions not previously discussed. These barriers include shame, modesty, privacy, and fear about cancer screening procedures. In a study of barriers to access to health care for sub-

Saharan African refugees in Australia and the United Kingdom, it was identified that language barriers, literacy and educational deficiencies, lack of transportation, and limited understanding of the risks of their diseases disadvantaged families in access to care (Ndukwe et al., 2013; Sheppard et al., 2015). Additionally, a study of African immigrants in Australia highlighted that unemployment, poverty, and former negative experiences with health-care services in their home countries potentially served as a detractor from seeking health care in their newly settled country (Pindet et al., 2016).

Lack of spousal support was also a barrier addressed in the literature. Generally, Ghanaian spouses play a vital role in the healthcare decisions of their wives (Williams & Amoateng, 2012). As such, most women who participated in the various studies expressed the importance of spousal support for participating in cervical cancer screening was important for the women to seek the approval of their men about getting screened (Modibbo et al., 2013; Sawadogo et al., 2014). Williams and Amoateng (2012) reported that numerous women who were married suggested that it is less likely for their husbands to be fully satisfied with the idea that their wives will undergo screening of the breast and cervix especially if it is provided by a male physician. As aforementioned, most Ghanaian, including other West African women continue to hold such cultural views that a male physician is only allowed to see the woman's private areas during childbirth (Sawadogo et al., 2014). In such a patriarchal society, Ghanaian women were well aware that a man will be uncomfortable with their wife being inspected in their private parts by another male personnel (Williams & Amoateng, 2012).

**Barriers to Healthcare for African Immigrants**

With the increasing number of African-born immigrants in the United States, this population is still underrepresented in healthcare research as they are typically placed in the category of African American or Black. For many minority populations, including the African immigrant population, some factors that contribute to the disparities in healthcare include

access, socioeconomic barriers, linguistic barriers and cultural influences (Adekeye et al., 2018; Chadiha et al., 2006; Kennedy, 2005). Such factors in turn can affect perceived susceptibility to illness, perceived severity, and an immigrant's perceived benefit of obtaining screening and treatment. With the aim of gaining insight to understand perceptions and attitudes about preventative healthcare, Babatunde-Sowole et al. (2020) conducted a qualitative analysis among West African immigrant women in Australia. Findings suggested that women have low literacy regarding health care and disease etiologies. Additionally, immigrant women were more occupied with resettling in their new country and ensuring that their families have the basic necessities to survive, thus health screening was not a priority for them (Babatunde-Sowole et al., 2020).

Pertaining to privacy, African immigrant women discussed their concern with privacy in the physical realm whereby they did not feel comfortable exposing their body parts (such as breasts and vaginal area) to male physicians (Ndukwe et al., 2013). Studies focusing on cancer-specific health-seeking behaviors and access to cancer services in African-born female immigrants are limited and utilize small sample sizes and homogenous African populations.

Typically, immigrants arriving to new countries may face economic, legal, cultural, and linguistic barriers and such factors become a barrier in navigating the healthcare system in that new country (Wafula & Snipes, 2013). For instance, although some countries in West Africa are taught English, it is often not their first language, especially for the older immigrants. Thus, this can create a language barrier that can hinder effective communication with healthcare providers and interfere their ability to fully comprehend and adhere to guideline for preventive health screenings. Also, differences in religious beliefs among African immigrants can create a lower level of perceived susceptibility and benefits in receiving adequate preventive care. Quite possibly, immigrants may have different beliefs about health and the necessity of seeking

medical treatment (as opposed to belief in cultural or religious practices). Thus this may influence their interest in U.S. preventive health services.

Immigrants also report distrust on medical professionals which in turn increases their preference to utilize traditional healers or non-medical remedies instead of Western Medicine (Ojikutu et al., 2013). Due to fear of finances or legal ramifications, immigrants, especially the ones who are unauthorized, shy away from seeking medical care when needed (Portes et al., 2012). They are aware they can be detained by Immigration and Customs Enforcement (ICE) agents, or become responsible for significant healthcare costs when they seek healthcare. Therefore, they will make the choice to avoid medical attention which results in increased severity of disease.

Addressing and being able to improve such factors (including but not limited to level of education, socioeconomic factors, and past negative experiences with U.S healthcare system) may enhance equality of care among all groups. In a study done by Adekeye and colleagues (2018), the utilization of health fairs for a group of African immigrants in Georgia helped shed some light on issues that African immigrants face regarding healthcare in the U.S. Researchers emphasized the need to utilize culturally appropriate approaches in reducing the disparities that African immigrants face in the U.S healthcare system. Additionally, the study also found that many of the participants have limited contact with the healthcare system, especially pertaining to preventive healthcare services due to lack of health insurance (Adekeye et al., 2018). Similarly, Gwede et al. (2011) conducted a qualitative study on an African immigrant population and suggested that if African immigrants have an increased awareness of financial resources for healthcare, information on screening sites as well as recommended times for screening, cancer screening rates among this population will improve.

An important factor in addressing health seeking behaviors of African born women is perception. In a qualitative study of 12 Somalian immigrants in the U.S., researchers Francis,

Griffith, and Leser (2014) investigated the perceptions of healthcare and cancer preventions among Somali immigrant women in Minnesota and found that factors such as age, religion, sexual orientation, mental health disabilities, geographic location, and cost of healthcare may contribute as barriers to healthcare and healthcare resources. Other social barriers such as culture, language and literacy levels were also identified as barriers especially for this study population because Somalian women low literacy rates and have difficulty communicating fluently in English. As such, they were more likely to seek religious interventions or help from local herbal remedies for their health when they were ill (Francis et al., 2014). Participants in their study often perceived cancer diagnosis as being the will of God, thus they believed nothing could be done about it. The researchers deduced that there was lack of trust of health care providers was another recurring factor among the Somalian immigrant women. It was reported that the women only sought medical care for acute conditions versus preventative care (Francis et al., 2014).

**Summary: Preventive Health Seeking Behaviors among African Immigrants**

Generally, when compared to U.S. nonimmigrant populations, immigrant populations have lower cancer screening rates (Consedine et al., 2015; Harcourt et al., 2014; Medhanie, et al., 2017). Although African Americans and African Immigrants are generally categorized as one, they exhibit different language systems, as well as beliefs and cultural practices that tend to have an influence on their preventive health behaviors.

Studies suggest that immigrant women from minority ethnic groups present with limited knowledge about preventive health services, and therefore, this becomes a contributing factor to underutilization of services such as cancer screening (Kaplan, Ahmed & Musah, 2015). Studies also suggest that additional immigration-related factors such as cultural beliefs about health, ethnicity, beliefs, religion, citizenship status, language, stigmas, health literacy, health insurance status, socioeconomic status, and an individual's geographic location can influence preventive

health-seeking behaviors (Kaplan, Ahmed & Musah, 2015; Nolan et al., 2014; Odedina et al., 2011; Becker, Hadley, Arrindell, Perloe, Fay & Striegel-Moore, 2010).

Consistent with findings from the literature, African immigrants express their concerns about cancer, reproductive health, and obesity when questioned about health issues (Francis et al., 2014; Pavlish et al., 2010). In order to respond wisely to the multifaceted demands of aging West African immigrants in the United States, it is important to conduct investigations that provide insight for understanding the realities that these women face with seeking preventive care for breast and cervical cancers. Although there may be educational programs geared towards symptom recognition, causes and risk factors, it is vital to emphasize preventive behaviors such as screening to help improve early detection and treatment which ultimately decrease mortality rates among this population.

Due to the variation in cultural influences, African Americans and African immigrants may differ in preventive health behaviors. This can also be based on African immigrants' individual experiences, knowledge, health literacy, health beliefs, cultural practices or previous utilization of preventive health services (Ojikiutu et al., 2013). Although there are some studies depicting the preventive health behaviors of African immigrant women, few studies have addressed that country of origin, culture, and immigration status also affects preventive health seeking behaviors among immigrants (Kaplan et al., 2015; Nolan et al., 2014; Ojikutu et al., 2013). African immigrant women living in the United States may be engulfed in their own cultural beliefs that influence their health seeking behaviors in preventive care. This study developed deeper understandings about Nigerian and Ghanian women's health beliefs and perceptions about breast and cervical cancer screening and provided insights into culturally-tailored messages and interventions that encourage these women to participate in health screening for early detection of cancer. The results can potentially contribute to the development of specific, nurse-led interventions that address disparities in cancer mortality.

## Chapter 3: Theoretical and Philosophical Foundation

This chapter describes the philosophical foundation of the qualitative research methodology using a Grounded Theory approach. A qualitative study approach was appropriate for the study because the goal was aligned with explaining a phenomenon by relying on the experiences of the persons involved. In research, a qualitative approach is appropriate when a researcher seeks to gain understanding of relationships between variables (Creswell, 2003). An assumption of qualitative study asserts that an individual's perception of reality is both process and is subjective, thus research is an investigation into the process through which an individual interprets reality (Creswell, 1994). Creswell further explains that qualitative research is an inductive process in which researchers collect data for the purpose of description and interpretation (Creswell, 2007).

In qualitative studies, the data includes the statements and language of the research participants in the form of narratives, alongside notes and memos from the researcher about the circumstances. The design of the research is also dependent on emerging patterns, meanings, and theoretical implications. Qualitative research explores subjective experiences of participants, and therefore, it is considered valid and reliable research in its ability to authentically adhere to the narratives and perceptions of the research participants. Qualitative research provides the opportunity to locate meanings that people tend to place on their perceptions, processes, assumptions, and structure of their lives (Carreiras & Castro, 2012). Qualitative research yields rich, in-depth analysis of the specific phenomenon using words from participants to provide an interpretation of the phenomenon. Qualitative research clarifies how a person understands and constructs the world and has been found to be especially advantageous in healthcare research that has cultural dimensions (Al-Busaidi, 2008). Constructivist Grounded Theory and its accompanying principles, guidelines, and ideals was

selected as the methodological framework utilized in this study for data collection and analysis to provide a theoretical explanation.

The purpose of this qualitative grounded theory research was to explore the perceptions of cancer and related preventive health practices among older Ghanaian and Nigerian immigrant women in the United States. This research study assessed the various experiences of older Ghanaian and Nigerian immigrant women with ways of taking care of themselves and engaging in some form of primary, secondary, or tertiary health prevention. The specific aims of this study included:

Specific Aim 1: To identify health beliefs and perceptions about cancer and cancer prevention among immigrant women from Ghana and Nigeria age 40 years and older living Southern California.

Specific Aim 2: To investigate middle-age and older Ghanaian and Nigerian immigrant women's knowledge about breast and cervical cancer prevention services in the U. S.

Specific Aim 3: To examine barriers and factors that facilitate middle-age and older Ghanaian and Nigeria-born women's decision to be screened for breast and cervical cancer in the U. S. and their follow-up action.

## Philosophical Underpinnings

Choosing to utilize pragmatism as a philosophical orientation with grounded theory methodology was influenced by the principle investigator's desire to contribute actionable and useful knowledge rooted in the experiences of the respondents and, hence, of practical relevance to the community of African immigrants and the healthcare professionals that serve this group.

### Pragmatism

Pragmatism emphasizes practical solutions, actions, and open-mindedness, while grounded theory is concerned with generating theory from data systematically obtained from

research. Pragmatism as a research paradigm has an extensive and rich history in the late nineteenth and early twentieth centuries. This philosophical perspective may be traced back to the philosopher, Charles Peirce and the psychologist, William James (Adeleye, 2017; Agarwal & Maheshwari, 2010; Farjoun et al., 2015; Nowell, 2015; Russill, 2016). Pragmatism also encompasses the development and dissemination of pragmatic inquiry via the work of John Dewey (Dewey, 2008 [1910]). Though pragmatism is fairly recent compared to other philosophical positions, it has placed itself as a contending paradigm. Pragmatism, as a method of inquiry, examines and evaluates ideas and beliefs in light of their practicality.

There are at least three philosophical principles that underlie pragmatism. One central tenet in pragmatic inquiry is the view that all research should stem from a desire to produce useful, actionable knowledge, and solve existential problems. Actionable knowledge is primarily drawn from analysis of effective habits or ways of acting (Corbin and Strauss, 2008; Feilzer, 2010). The word *pragmatikos*, which is a terminology related to pragmatism, means action (Adeleye, 2017; Farjoun et al., 2015). As such, the philosophical ideas of pragmatism focus on practical ways of addressing or solving a problem. Researchers can investigate numerous aspects of the same phenomenon while focusing on practical, problem-solving aspects. It is critical to begin an investigation focusing on information that will be valuable to research stakeholders to make the most use of research results. Researchers may establish research agendas based on respondent experiences by highlighting this idea of actionable information as a starting point for study and, as a result, ensuring that the research is of practical importance (Dewey, 2008 [1910]).

A second principle of pragmatism asserts that whatever is practical and works is considered the truth. Ideas themselves are not right or wrong. Rather, these ideas and perspectives are true if the ideas employed can be used to solve a problem related to educational practice (Bhatt, 2018). Similar studies that have been done on pragmatism believe

that reality is not based in one perception, but can be seen as multidimensional (Al-Busaidi, 2008). Thus, no one can claim what they believe is the ultimate truth (Sharma et al., 2018). Pragmatism views reality, the good and the bad, as well as ‘truth’ in the same relative terms, and as such, pragmatism is also known as experimentalism, because an experiment is the only criterion to gain the actual truth (Adeleye, 2017). According to Farjoun et al. (2015), pragmatism provides a richer and more realistic view of human behavior in comparison to views used by rationalists and structuralists. It can be argued that pragmatism is of instrumental value to research. Viewing people’s ideas, perceptions, and beliefs as tools for problem solving and acting in new ways tend to involve research subjects as active participants rather than as mere passive descriptors of the world as it exists.

Another principle of pragmatism which serves to strengthen the investigative process of this proposed research study is the opportunity to explore the interconnectedness of an individual’s experience with the notions of knowing and acting. Having the ability to seek a better understanding of the health experiences, and documenting actions, whether in a well-planned or unplanned manner, pragmatist researchers are able to bring up themes that may appear complex and address hidden issues in formal documentation (Kelly & Codiero, 2020). According to Dewey (2008 [1910]), humans are constantly engaged in investigation or evaluation when confronted with a challenge. As such, individuals adapt and adjust their behavior in reaction to the research or assessment outcomes. In Dewey's opinion, daily life and inquiry are not mutually incompatible (Morgan, 2014). Instead, he believes that research is a kind of inquiry that requires more attention and self-awareness than most other human reactions to demanding external situations (Dewey, 2008 [1910]).

Classical pragmatism is helpful to theoreticians and practitioners because of its focus on practical, daily issues. One of the most critical challenges for researchers is establishing a 'mediated' knowledge of complicated organizational processes, which this study addressed

(Lorino, 2018). Pragmatism has also contributed to movements such as symbolic interactionism, action research and grounded theory.

Choosing to utilize pragmatism as a philosophical orientation within grounded theory methodology provided insight into practical and actionable knowledge that is meaningful and relevant to the community of older African immigrant women. By highlighting the principle of actionable knowledge with respect to pragmatism, this research yielded results anchored in the experiences of older, female African immigrants and thus, warrant that this research is of practical relevance.

**Symbolic Interactionism**

Symbolic Interactionism (SI) a major sociological perspective, largely originates from Pragmatist philosophy. Symbolic Interactionism (SI) a major sociological perspective, largely originates from Pragmatist philosophy. Symbolic interactionism (SI), as conceptualized by Mead and interpreted by Blumer (1969), has been notably used as a theoretical framework in qualitative research among various scholars. As described by Blumer (1969), symbolic interactionism emphasizes that forming meanings is a principal trait of human behavior. As human beings, we live in a world of meaningful objects. This suggests that as human beings, we react towards objects and expereinces depending on the meanings those elements have for us. In using symbolic interactionism, one can understand that people create a world of shared meaning (Blumer, 1969). As humans, we respond and act because of the way we interpret the world and subsequently, we interpret the world a certain way because of what we do. Thus, action and interpretation are viewed as a reciprocal process (Charmaz, 2014).

In his description of SI, Blumer addressed three key premises for this theory. The first premise as previously mentioned states that human beings react and develop actions based on their interpretation of the meanings of objects and experiences (Blumer, 1969). The second premise builds on this idea and addresses that such meanings come from the interactions

people have with each other socially (Blumer 1969; Charmaz, 2014). This provides the assumption that individuals initiate action because they have an agreement on what their environments and social interactions mean to them. The third premise states that individuals assign and modify meanings of experiences through an interpretive process (Blumer, 1969). This suggests a person makes an interpretation in dealing with what he or she encounters. Through this process of interpretive meaning, people may generally form new meanings and new ways of reacting to things.

With such premises in mind, symbolic interactionism can be identified as an underlying theoretical perspective used for this investigation. The premises that human beings generally act on the basis of the meanings they derive from objects and social interaction influenced data collection and analysis. As such, it provided an avenue in searching for new ways to understand the meaning of preventative health topics from the perspective of the participants as individuals and as a part of a societal group (Ghanaian and Nigerian immigrants). As Charmaz (2014) addressed, interpretation and action are always happening in response to each other. Every person is an actor who makes sense of their world based on emerging events and experiences, and the social interaction that one has with one's fellows. These emerging experiences and social interactions provide the opportunity for participants to interpret meanings in those experiences which, in turn, affects their responses and action choices (Charmaz, 2014). SI influenced this investigation with the assumption that every participant is an actor in their own lives with valuable experiences to share.

Both pragmatism and SI share a foundational connection and informed the present study through its historical connections, construction of reality, and its focus on action and interaction. Pragmatism posits that humans construct knowledge through their actions and experiences, emphasizing the practical aspects of knowledge and the real-world implications of ideas.

Symbolic Interactionism similarly posits that people construct their realities through social interactions, where meanings are developed, negotiated, and modified.

**Constructivism in Grounded Theory Research**

As a widely-adopted methodology, grounded theory is defined as “a general methodology of analysis linked with data collection that uses a systematically applied set of methods to generate an inductive theory about a substantive area. The research product constitutes a theoretical formulation or integrated set of conceptual hypotheses about the substantive area under study” (Glaser, 1992, p.16).

According to Merriam Webster (n.d) dictionary, to construct is to make or form by combining or arranging parts of elements. In other words, to say that something is constructed means that it is produced by people putting something together. In grounded theory, using a social constructionism/constructivism approach allows the researcher to address questions that seeks to know the *what* and *how* and to understand the social constructs developed by the participants through their relationships and experiences (Charmaz, 2010). According to Gergen (2009), constructivism/constructionism, provides a theoretical view in which one’s mind constructs reality within a systematic relationship to the outside world (Gergen, 2009). As further explained by Charmaz (2010) constructivist grounded theory assumes that knowledge is socially produced. The process in which research is developed arises from interaction and takes into account the positions of the researcher as well as the research participants. Charmaz explains that an approach from a constructionist assumes that there are multiple realities and reality is constructed (Charmaz, 2010). Constructivism encourages researchers to become interpretive, move out of their own perspective and construct stories by connecting the data to various concepts that create new knowledge. As constructivists, Charmaz suggests that researchers aim to gain full understanding of the participant’s experiences, actions, beliefs and

make an effort to locate the participants' meanings in their social relations, including discourses that they may not even be aware of (Charmaz, 2009).

Grounded Theory, using a social constructionism/constructivism approach allows the researcher to address questions that seek to know the *what* and *how* and to understand the social constructs developed by the participants through their relationships and experiences (Charmaz, 2010). As further explained by Charmaz (2010) constructivist grounded theory assumes that knowledge is socially produced. The process in which research is developed arises from interaction and takes into account the positions of the researcher as well as the research participants. Charmaz further explains that a constructionist approach assumes that there are multiple realities and reality is constructed (Charmaz, 2010). A constructivist viewpoint explores relationships, taking into consideration that each participant creates his or her own reality, and thus may have a very different perspective of the phenomenon studied, in this case values and beliefs about disease prevention and health screening. Relationships among these differing perspectives can then be formed, based on participant data (Creswell, 2007).

Additionally, constructivism requires researchers to be reflexive towards their own actions, situations, and assumptions about the participants involved in the study and ultimately separate their own perspectives and preconceptions from participants' perspectives in order to develop analytic constructs of the participants' experiences (Charmaz, 2009). Constructionism provides the avenue to examine at the meaning of participants' realities and address what is considered real and important to them (Charmaz, 2006). Being intentionally aware of their own preconceptions allows researchers to enter more fully into lifeworld of participants.

According to Gergen (2009), constructivism/constructionism, provides a theoretical view in which one's mind constructs reality within a systematic relationship to the outside world. As such, constructionism/constructivism suggests that the things that are considered important in the world depends on how it is approached. In part, how these things are approached depends

on our social relationships, that is, through the process of dialogue with one another. Through this process of dialogue, participants construct meanings of their experiences. Therefore, social interactions can be considered an important aspect in the knowledge construction.

The ideas pertaining to constructionism/constructivism influenced data collection and analysis for this project pertaining to older Ghanaian and Nigerian immigrants and their healthcare practices as well as their perceptions about preventative health. Constructivism helped researchers in this study to focus on thoroughly constructing knowledge rather than merely completing analysis of the data (Charmaz, 2009). During this study, researchers aimed to gain a full understanding of the participant's experiences, actions, and beliefs and made an effort to locate the participants' meanings in their social relations, including discourses that they may not even be aware of (Charmaz, 2009).

## Summary

According to Charmaz (2014), grounded theory as a qualitative research method "consists of systematic, yet flexible guidelines for collecting and analyzing qualitative data to construct theories from the data themselves" (Charmaz, 2014, p. 1). Charmaz & Thornberg (2021) argue that ideas that emerge from grounded theory are built by gathering and analyzing qualitative information. This suggests that researchers who utilize grounded theory methodology aim to construct a theory that is grounded in the data they collect. As such, grounded theory requires researchers to inductively code participant data, perform axial analysis of these codes to identify higher-level constructs, and finally explore relationships found in the data to develop a theory pertaining to the phenomenon under study (Corbin & Strauss, 2008).

Grounded theory design is advantageous in how it methodically as well as rigorously frames the investigation process. Furthermore, when systematically arranged, the specific grounded theory techniques ease the work of data collection and analysis and guide researchers toward new understandings and workable resolutions to social problems. The

critical principle of grounded theory by Charmaz is that theories about any research phenomenon start with questions that seek new understandings about people's experiences rather than to test researchers' hypotheses; thus the researcher creates a new theory "grounded" in information from participants (Corbin & Strauss, 2008). As a result, this research method remains a frequently-used famework for healthcare researchers and contributes significant insights into people's healthcare experiences.

Using grounded theory methodology , pragmatism and symbolic interactionism synergistically informed the exploration and understanding of African immigrant women's perspectives and experiences with cancer screening and prevention. These theoretical underpinnings highlight the practical implications, emphasize subjective experiences, and development of rich, nuanced data and theory grounded in participant realities.

## Chapter 4 Research Methods

The purpose of this qualitative study was to develop a comprehensive understanding of health beliefs related to disease prevention and the utilization of breast and cervical cancer screening services among West African immigrant women, specifically those from Ghana and Nigeria aged 40 years and older residing in Southern California. This study sought to explore participants' perceptions and beliefs regarding cancer and preventive health practices, and to examine the factors that influenced their decision-making processes regarding breast and cervical cancer screening, as well as subsequent follow-up behaviors within the United States healthcare system. This chapter presents the research design and methodological approaches employed to gain deeper insight into the experiences and perspectives of Ghanaian and Nigerian immigrant women concerning cancer screening and preventive health actions.

### Study Design

Since little is known about this topic with this particular population, the most suitable form of inquiry for this study is a qualitative design. In research, a qualitative approach is appropriate when a researcher seeks to gain understanding between variables (Creswell, 2003). An assumption of qualitative research is that an individual's perception of reality is process-oriented and is subjective, thus research is an investigation of the process through which the individual interprets reality (Creswell, 1994). Creswell further explains that qualitative research is an inductive process in which we collect data for the purpose of description and interpretation. In qualitative studies, especially with a constructivist grounded theory design, the data includes the statements and language of the research participants in the form of narratives, alongside notes and memos from the researcher about the circumstances. This research design is also dependent on emerging patterns, meanings, and theoretical implications. Although qualitative research explores subjective experiences of participants, it is considered valid and reliable research in its ability to authentically adhere to the data and perceptions of the research

participants. Qualitative research provides the ability to locate meanings that people tend to place on their perceptions, processes, assumptions, and structure of their lives (Carreiras & Castro, 2012). Qualitative research yields rich, in-depth analysis of the phenomenon using words, from participants, to provide an interpretation of the phenomenon. Qualitative research helps clarify how a person understands and constructs the world and has been found advantageous in healthcare research that has cultural dimensions (Al-Busaidi, 2008).

This study intended to address the health of middle-aged and older Ghanaian and Nigerian immigrant women and had three aims: (1) to identify cancer and cancer perception health beliefs, (2) to investigate knowledge about breast and cervical cancer prevention services, and (3) to examine factors influencing decision-making for cancer screening and follow-up action.

## Target Population/Participants of the Study

The target population for this study comprised older African immigrant women (AIW) residing in Southern California, specifically Ghanaian and Nigerian immigrant women aged 40 years and older. According to the Migration Policy Institute (2022), approximately two million Sub-Saharan African immigrants currently reside in the United States. Of this population, Ghanaian immigrants represent approximately 199,000 individuals, while Nigerian immigrants account for approximately 393,000. Although Sub-Saharan African immigrants are dispersed across the United States, California hosts approximately 8% of this population, with an estimated 47,000 individuals residing in the Los Angeles–Long Beach–Anaheim metropolitan area (Migration Policy Institute, 2019). Among African immigrant populations, breast and cervical cancers have been identified as leading contributors to cancer-related mortality (Hurtado-de-Mendoza et al., 2014; Pinder et al., 2016). Consequently, there is a critical need to address knowledge gaps, health beliefs, and perceptions regarding cancer screening and

preventive services in order to develop culturally sensitive interventions that may improve screening utilization and reduce health disparities.

**Sampling Approach**

Purposive sampling was used to recruit African immigrant women (specifically Ghanaian and Nigerian immigrants) living in Southern California. Purposive sampling is a non-probability sampling method usually used in qualitative studies to recruit specific participants that can provide insight to the research phenomenon being investigated (Schmidt & Brown, 2019). The sample population was identified by collaborating with community-based organizations such as the Ghanaian Association of Southern California. Social media was used to obtain contact information of organizational leaders as well as meeting dates and times to optimize recruitment.

**Inclusion and Exclusion Criteria**

Inclusion Criteria: Participants eligible for inclusion in this study were required to self-identify as African immigrant women (AIW) originating from Ghana or Nigeria, be aged 40 years or older, and reside in Los Angeles, Riverside, San Bernardino, or Orange counties in Southern California. Additionally, participants needed to demonstrate the ability to read and speak English, which facilitated effective communication and enriched the data collection process. Exclusion Criteria: Women were excluded from participation if they were born in the United States or were younger than 40 years of age at the time of recruitment.

**Sample Size**

In qualitative research, sample size is not predetermined but is instead guided by the concept of data saturation (Schmidt & Brown, 2019; Corbin & Strauss, 2015). Data saturation is reached when no new information, categories, or themes emerge from interviews or focus group discussions. In this study, the determination of sample size was not based on a numerical target but rather on the richness and thickness of the data collected. Richness refers to the depth and

quality of information provided, while thickness pertains to the breadth and quantity of the data (Fusch & Ness, 2015). Data were considered rich when they offered comprehensive, nuanced, and meaningful insights into the research phenomenon. Although qualitative researchers vary in their recommendations for sample size, Charmaz (2014) suggests that more than twelve interviews are generally sufficient to achieve well-developed categories and robust data analysis (Charmaz, 2014). Accordingly, the study anticipated enrolling approximately 15 to 20 participants. However, if data saturation had not been achieved within this range—evidenced by thin or incomplete data—the recruitment of additional African immigrant women meeting the inclusion criteria would have been pursued to ensure the depth and comprehensiveness of the findings.

## Setting

The target sample were residents of Southern California originally from areas such as Los Angeles, Orange, Riverside, and San Bernardino counties. In order to help expand selection of Ghanaian and Nigerian immigrant women, relationships were established with community-based organizations such as the Ghana Association of Southern California and Yoruba and Igbo women organizations of Southern California. Engaging with community-based organizations was vital to connecting with these specialized groups of people and establishing strong networks with their leaders and members. Collaboration with leaders of African faith-based organizations was established in the Los Angeles–Anaheim Metropolitan areas in Southern California regions as settings for recruiting participants. Sampling from these organizations was chosen as they typically had members who migrated from Ghana or Nigeria to the United States.

## Research Procedures

### Recruitment

Following approval from the University of California, Los Angeles Institutional Review Board (IRB), under the Office of Human Research Protection Program (OHRPP), recruitment efforts commenced utilizing the settings previously described. Letters were sent to leaders of local African churches and Ghanaian and Nigerian community organizations, providing detailed information about the study and requesting permission to invite their members to participate. In addition, recruitment was conducted by attending social gatherings in the African community . Local African churches as well as Ghanaian and Nigerian organizational meetings were visited to explain the study and make inquiries about the most appropriate ways of informing and recruiting members as study participants. When appropriate, recruitment flyers were developed and posted on organizational communication platforms such as Facebook, as well as in local African grocery stores. The flyers contained a brief synopsis of the study, eligibility criteria, and the researcher's contact information (email address). (See Appendix B for an example of the recruitment flyer). Recruitment was conducted using a combination of purposive sampling and snowball sampling strategies. Snowball sampling, as defined by Schmidt and Brown (2019), involves obtaining referrals to additional eligible participants through individuals already enrolled in the study, thereby expanding the potential participant pool.

### Screening

All potential participants who contacted the principal investigator (PI) and expressed interest in the study were screened for eligibility either in person or via telephone, utilizing a standardized screening guide (see Appendix C). Individuals who met the established inclusion and exclusion criteria were provided with a reiteration of the study's purpose and were informed that participation would involve an individual, in-depth interview. Eligible participants who remained interested were subsequently sent a Study Information Form (see Appendix D) via

email, text message, or printed and handed to them, according to their preferred method of communication. Following distribution of the Study Information Form, the PI conducted a follow-up telephone call to address any questions the potential participants might have had and to schedule an interview appointment based on their availability.

**Data Collection**

Interviews were conducted either in person or virtually, utilizing Zoom or FaceTime, based on the preference of each participant. In-person interviews were held in private settings, including a designated room in the participant's home, a church, or a local library. For virtual interviews, participants received a Zoom link specifying the prearranged date and time. Interviews were scheduled in accordance with each participant's availability, and a confirmation call or email was made one day prior to the interview to verify the appointment details (interview day, time, and location). Before a scheduled interview, time was allotted to get settled in the environment to make sure thoughts were together. If the interview was in person, arrival time to the agreed location was at least 15 minutes earlier to establish a quiet setting and assess the functionality of the audiotape recorder. After setting up, field notes were recorded in a separate notebook about observations of the surroundings. If the interview was scheduled on Zoom, a computer connection was established 15 minutes prior to the meeting to make sure the audio and video recording settings were functioning properly, then awaited the participant to log on. A cellular phone was placed within close range such that the interviewee had easy access to the researcher / PI in the event she was lost or having difficulty with the Zoom application.

After both the participant and PI were settled and ready to begin, introductions were made clarifying the researcher's role for this research study. The University of California, Los Angeles (UCLA) badge was shown to them as confirmation of the researcher's identity, then the brief informed consent script was read (Appendix E) and verbal consent was obtained before starting the interview. During informed consent, it was made clear that the conversation was

being recording, and if participants agreed, the audio recorder was turned on and the interview began.

*Interviews/ Interview Guide*

Audio recordings were obtained for all the interviews. Data was collected using interviews either in person or via Zoom using a semi-structured interview guide (SSIG). (See Appendix F for SSIG). The interview guide was developed by the PI using the research questions in conjunction with feedback from research experts on the dissertation committee, gaps in the literature, and previous coursework throughout doctoral studies at UCLA. Prior to conducting research interviews, questions in the interview guide were piloted with two women in their 60s from the study's target population to help ensure clarity of the questions and to ascertain that participants were able to comprehend the questions and answer to the best of their abilities. The SSIG included follow-up questions which were asked to clarify participants' descriptions or explore what the participant described as meaningful. Part of the interview guide included some basic demographic questions such as age, marital status, country of migration, number of years living in the U.S., and health insurance status. The SSIG included open-ended questions and related follow-up questions targeted at exploring the research problem in depth.

The semi-structured interview guide was vital in structuring the interviews and ensuring that the questions remained consistent with each participant. It was referred to as a guide and as such allowed the participant to present any relevant information as detailed as possible during the discussion. The interview guide questions focused on knowledge and perceptions about breast and cervical cancer prevention.

*Field notes*

As part of the data collection process, field notes were recorded in the form of handwritten information before and after conducting the interviews with the eligible study

participants. According to Saldana (2021), the act of writing field notes consists of the researcher observing and documenting the environment as well as the participant's subjective responses and interpreting their actions (Saldana, 2021). Writing field notes about the interviews helped provide context of the participants' behaviors (verbal and non-verbal behaviors) in relation to the questions being asked and hopefully gained more insight into their responses. The details in the field notes helped record pertinent observations and were valuable in adding to data richness. If the meeting was via Zoom, my field notes included behaviors such as length of pause after a question was asked, facial expressions, or any technical issues that may have arisen.

One notable challenge encountered during data collection was the reluctance of African immigrant women to participate in the study. Many of these women were occupied with multiple jobs or responsibilities to support their families, making it difficult for them to commit to an uninterrupted one-hour interview. In hindsight, offering an incentive might have increased participation; however, despite this limitation, the interviews provided valuable and meaningful insights.

**Data Management**

Data was managed cautiously and was not disclosed to anyone outside of my committee members. Participants were de-identified by providing pseudonyms for each of them. The interviews were recorded, transcribed, and stored as encrypted files on the PI's password-protected laptop. Once the audio recordings were compared to the transcribed documents for accuracy, the transcribed interviews and the digital version of the interviews were stored in a secure application such as the UCLA BOX. The de-identified transcribed documents were only shared with the dissertation committee chair for purposes of analyzing the data.

## Data Analysis

According to Corbin & Strauss (2015), the process of analyzing data ultimately leads to interpreting the data to acquire meaning (Corbin & Strauss, 2015). Throughout the process, an attempt was made to gain deeper understandings about breast and cervical cancer knowledge, perceptions, and experiences of African immigrants in the United States. Analyzing the data included organizing the data, reading and re-reading the interview transcripts, describing the raw data in codes, and eventually identifying themes. Grounded Theory analytical strategies were used to sort codes, construct categories (themes), and explain the relationships among these categories, developing subthemes.

Data were collected and analyzed simultaneously using a constant comparative method, which involved engaging in concurrent data collection and analysis (Creswell, 2007). After completing each interview, the PI transcribed it within three days of conducting the interview; from there, the coding process was initiated. Fresh data and inductive, line-by-line coding allowed the PI to remain open to the data and to appreciate the nuances in it (Charmaz, 2014). Coding early in-depth interview data put the researcher at an advantage of having a close look at what participants said and struggled with, and as such, helped refocus later interviews (Charmaz, 2014). A data codebook was created to help manage and sort the interview transcripts and its gerund codes.

### *Initial Coding*

Consistent with grounded theory methods, data analysis for this study included coding. The first step in constructivist grounded theory in analyzing the data is naming sections of the transcribed data with a label, which is also termed as coding (Charmaz, 2014). According to Charmaz (2014), coding is fundamental in analyzing data and generating an emergent theory to explain the information in the data (Charmaz, 2014). Coding is a vital part of the research process as it serves as a link between data collection and building abstract understanding of the

phenomenon (Saldana, 2021). The process of open coding involves reading all transcripts line-by-line, developing a code, and conducting analytic memoing in order to separate each piece of data generated by the interviews while using the constant comparative approach as well (Creswell, 2007).

During this process, differences and similarities between the responses of the participants were identified and used to generate themes. Through coding and memoing, the PI was able to define what was happening in the data and began to grasp meanings. Charmaz's method of initial coding by means of line-by-line coding to find gerunds or action words was used (Charmaz, 2014; Saldana, 2021). Developing initial descriptive codes helped the PI to separate data into themes and identify the processes while being open to explore any theoretical possibilities the data might bring (Charmaz, 2014). Using initial coding enabled the researcher to adhere closely to the data, identify and briefly describe actions, and see the progression of events from participants' points of view.

*Focused coding*

The second major phase in coding involves focused coding. Focused coding suggests for the researcher to engage in identifying and selecting a number of central codes that appeared frequently and were significant throughout the entire dataset (Charmaz, 2014). According to Charmaz (2014), focused coding allows the researcher to use the most important and/or most recurring earlier codes to sift through larger amounts of data with the goal of determining the adequacy of those codes (Charmaz, 2014). After completing the analytical process of line-by-line coding, the PI utilized focused coding to synthesize and explain larger sections of the data. Throughout this second phase of coding, the PI compared initial codes and decided which of the initial codes made sense analytically to categorize in understanding the experiences of African immigrant women with breast and cervical cancer screenings. After reviewing initial codes, the PI analyzed the codes to identify common codes which were then

sorted into focused codes. With focused coding, the codes derived from analyzing the transcripts were more selective and conceptual in comparison to line-by-line coding.

*Themes*

After creating focused codes, the codes that were considered significant were sorted into themes. Themes were developed after the PI identified combinations of codes or patterns in the data. These themes helped clarify ideas, events, or processes found in the data in the form of words (Charmaz, 2014). First, the PI assessed which of the focused codes best represented what appeared to be happening in the data. Then memo writing assisted the PI to raise the codes into categories which then evolved into conceptual themes with conceptual definitions. Writing memos throughout this process helped the PI to examine and sort the data, evaluate the tentative categories, clarify what the themes consisted of, and specify the relationships between them.

Reflective and comparative memos were written before and after coding. As described by Charmaz (2014), this process of writing memos allowed me to compare multiple participants or situations based on their similarity or differences. Memos also allowed reflexivity of the PI's hunches, intuitions, and allowed the PI to create distance from the data and recognize any potential bias.

*Theoretical Coding and Situational Mapping*

As part of the data analysis process, situational mapping was used as well. In using situational mapping, the PI initially gathered and wrote down all the pertinent (human and non-human) elements in the situation of this project on a piece of paper. Then, working iteratively between data codes and category descriptions, patterns were identified and relationships among themes were mapped. Often a theme (or core category) emerged which connected all categories. Using this process, the nature of the theoretical relationship between the theme and the data categories was identified and subthemes (which were derived as gerunds of

participants' direct quotes) were created. Ultimately, a theoretical understanding (grounded in participant data) was the research outcome.

## Trustworthiness

In qualitative research, establishing trustworthiness is vital. Reliability and validity in quantitative studies is synonymous with the concept of trustworthiness in qualitative research which comprises of credibility, dependability, transferability, and confirmability (Lincoln & Guba, 1985).

### *Credibility*

The concept of credibility in a study relies on the data accurately reflecting participants' experiences, similar to the concept of internal validity in quantitative studies (Anderson & Larson, 2009; Lincoln & Guba, 1985). There are various ways in which credibility can be maximized in a study. This study established credibility by engaging in triangulation and having self-reflexivity. Triangulation helped strengthen credibility and involved multiple data collection sources and/or investigators performing analysis. The purpose of using triangulation was to strengthen an understanding of the study phenomenon by collecting a variety of data on this specific topic to produce a stronger account of the experiences of these African immigrant women. To establish credibility, I a variety of data were collected using skillful interview methods, analytical memoing and recorded observations and field notes to supplement each interview.

With each stage of coding (both initial and focused coding), the PI worked closely with the dissertation committee chair, an expert in qualitative research and methodology, to discuss the coding and interpretation of the data in reliable ways by comparing and discussing our codes from the transcribed interviews. During analytic conversations between the PI and the PI's committee chair, the data were closely examined to determine all possible meanings that could be derived from the data.

As a researcher, The PI also practiced self-reflexivity and identified any subjectivity that might have brought to the study. This ensured that the study was approached with honesty and openness. Additionally, the dissertation committee chair assisted the PI to identify any potential biases that might have affected data interpretation and possibly affected rigor in creating codes and categories.

*Transferability*

Transferability, another strategy used to ascertain rigor in qualitative studies, represents how well a study can be applied to other contexts or situations (Lincoln & Guba, 1985). By providing thick and rich descriptions of the study setting and data, I believe readers can determine whether the findings are applicable to other African immigrant women in the Southern California area. Transferability of this study was enhanced by providing details of the characteristics of the sample.

*Dependability*

Dependability refers to adhering to systematic scientific processes and providing thorough and detailed descriptions of the study methods and procedures. This also allows study methods to be replicated by another researcher for a similar study (Lincoln & Guba, 1985). Dependability was established by methodically documenting the techniques of data collection, analysis, and triangulation. By documenting this information in depth, other researchers could replicate this study either using African immigrant women over age 40 or women from other ethnic backgrounds. Dependability was also enhanced through the recording and analysis of field notes and memo writing. Readers can evaluate the research procedures used and ascertain the extent to which they can adhere to the research process for a similar study without much difficulty.

*Confirmability*

Confirmability refers to the notion of closely analyzing data to ensure that the data is reflective of the evidence being gathered through data collection (Corbin & Strauss, 2015). Confirmability was established by audio recording interviews with participants and transcribing them verbatim. The PI adhered to achieving confirmability by being transparent and maintaining a thorough record of the research process in its entirety. Being able to provide in-depth descriptions of the research methodology and offering participant quotes as evidence allowed readers to assess and conclude whether the emerging themes reflected the data. The PI sought permission from the community organizational leaders on disseminating results of the study.

## Ethical Considerations

Considering potential ethical issues and identifying various strategies to minimize them are vital components in coductiong qualitative research. The PI anticipated some potential risks as some questions on breast and cervical cancer prevention, personal health beliefs, perceptions, and culture could possibly evoke some emotions such as embarrassment. However, benefits outweighed the risks as the interview also provided participants the chance to express their own perceptions about breast and cervical cancer prevention in relation to their culture. This promoted a feeling of empowerment for the participants in this study. They also used this platform to provide suggestions for breast and cervical cancer prevention strategies for other Ghanaian and Nigerian immigrants living in the U.S.

*Informed consent*

Prior to interviewing eligible participants for this study, verbal informed consent was obtained before initiating any data collection. (See Appendix E for the informed consent script). Providing the opportunity to gain informed consent allowed the PI to inform potential participants about the purpose of the study, procedures in collecting and analyzing data, the potential benefits and risks of participating, as well as future implications of the study. Gaining deeper

understanding about health beliefs and perceptions of breast and cervical cancer and prevention was described as a potential benefit of this study. The PI addressed potential risks such as embarrassment or discomfort with having discussions surrounding reproductive health, such as making them aware that if they felt uncomfortable or were in distress at any time during the interview, they had the right to stop that interview and be removed from the study. During this process, participants were informed that the interview could last between 45 to 60 minutes per session, and interviews would be recorded so that the data could be transcribed. As this process came to an end, the PI encouraged participants to ask any questions regarding the study that needed clarification. Potential participants were also informed that the PI might ask for a follow-up interview if information needed to be clarified or more information was required. Participants were informed that a follow-up interview was completely voluntary. After providing all this information and making sure it was well understood, the PI asked the participants to provide their verbal consent, then began collecting the data.

*Protection of Participants' Data*

Protecting participant's privacy and confidentiality was another important aspect of ethical considerations during the research process. Privacy addresses being able to limit the public from accessing participant's information while confidentiality specifically addresses protecting the participant data shared (Sanjari et al., 2014). Participant's privacy and confidentiality were protected by adhering to the ethical principles provided by University of California, Los Angeles Institutional Review Board (IRB) (Office of Human Research Protection Program (OHRPP). Each participant interview was conducted in a private space to ensure privacy. With interviews that were conducted via Zoom, participants were encouraged to find a private room before the interview started and were made aware that interviews would be recorded. Confidentiality was protected by removing participant identifiers and providing pseudonyms in place. Privacy was maintained by ensuring that the data was only shared with

my dissertation committee members during the data analysis process. Data transcripts, field notes, and memos were saved on a password-protected computer and UCLA BOX was utilized as a backup to securely store the files digitally.

The PI for this study strictly followed the recruitment and data collection processes previously discussed. As part of the informed consent process, study participants were made aware that the PI would maintain privacy and confidentiality with the information they shared.

## Conclusion

This chapter outlined the research methodology and methods that were utilized in this study. The study aimed to utilize constructivist grounded theory methods to gain a deeper understanding of the health beliefs about disease prevention and the concept of health screening as it related to utilization of breast and cervical cancer screening among West-African immigrant women, specifically from Ghana and Nigeria who were age 40 years and older living in Southern California. Strategies for participant recruitment and screening were described in detail, and the data collection methods as well as data analysis procedures were outlined and explained following CGT methods. As part of the goal for this chapter, data management and ethical considerations for potential participants were also discussed. The protection, privacy, and confidentiality for participants were of utmost importance, and strategies were addressed to minimize any potential risks.

# Chapter 5 - Results

Breast and cervical cancer screening serves as a method for identifying early signs and symptoms of breast cancer in women Baek, & Yoon, 2025; Islam, Ahammed, Nisa, & Mim, 2025). Utilizing current screening techniques and tools for early detection has been instrumental in reducing both the mortality and morbidity associated with the disease by approximately 20% (Seigal, Miller, & Jemal, 2019). Although Black women are recognized as having a high risk for breast cancer, they are among the least likely to take advantage of early detection services (Seigal et al., 2019). Similarly, ethnic groups—particularly women born in Africa—continue to exhibit low participation rates in breast cancer screening and tend to delay follow-up after an abnormal screening result (American Immigration Council, 2017).

Despite African immigrant women (AIW) in Southern California representing a distinct and rapidly expanding segment of the foreign-born population, research focusing on their health behaviors—especially regarding breast and cervical cancer screening remains scarce. This study was undertaken to gain insight into the perspectives of African immigrant women in Southern California concerning breast and cervical cancer screening

## Sample Demographics

The study sample included a total of 15 women, who were all born in either Ghana or Nigeria and have migrated and are currently living in the United States. They were all residents of Southern California, living in areas such as Los Angeles, Orange, Riverside, and San Bernardino counties.  All participants included in this study were 40 years of age and older. The ages ranged from 42 to 66 years old. The participants' educational levels varied from high school graduates to those holding college degrees. While individual or household income was not specifically recorded, all participants were employed, married with children, or had been married previously. Although religious affiliation was not directly queried, all participants self-identified as Christians.

Tables 1, 2, and 3 provide a detailed account of the participants' demographic information. Six participants were born in Nigeria (40%) while nine were born in Ghana (60%). Out of the 15 participants, 11 (73%) were married, Two participants (13%) reported being divorced, and two (13%) reported as single and never married. Only one (6%) of the participants had ever been diagnosed with or treated for breast cancer. The number of years lived in the U.S by these African immigrant women ranged from 4 years to 46 years with an average of 15 years. All 15 participants (100%) reported having some form of health insurance coverage in the U.S. In this particular study, neither educational attainment nor socioeconomic status were used as a criterion for selecting participants.

**Sample characteristics**

Table 1 – Country of Origin

| Country of Origin | Frequency | Percent |
|---|---|---|
| Ghana | 9 | 60% |
| Nigeria | 6 | 40% |
| | | |
| Age Range | | |
| 40-45years | 4 | 26% |
| 46-50 years | 5 | 33% |
| 51-55 years | 3 | 20% |
| 56-60 years | 1 | 7% |
| 61-65 years | 1 | 7% |
| 66-70 years | 1 | 7% |

Table 2 – *Marital Status*

| | Frequency | Percent |
|---|---|---|
| Marital Status | | |
| Married | 11 | 73% |
| Divorced | 2 | 13% |
| Single/Never Married | 2 | 13% |

Table 3 - *Number of years living in the U.S*

| | Frequency | Percent |
|---|---|---|
| How long have you lived in the United States? | | |
| 1-5 years | 2 | 13% |
| 6-10 years | 5 | 33% |
| 11-15 years | 3 | 20% |
| 16-20 years | 1 | 7% |
| 21-25 years | 1 | 7% |
| 26- 30 years | 1 | 7% |
| 31- 35 years | 1 | 7% |
| 46 years | 1 | 7% |

Table 4 – *Employment and Health Insurance Status*

| | Frequency | Percent |
|---|---|---|
| Employment status | | |
| Employed full time | 10 | 67% |
| Employed part time | 3 | 30% |
| Unemployed | 0 | 0% |
| Retired | 2 | 13% |
| Do you have health insurance in the U.S? | | |
| Yes | 15 | 100% |
| No | 0 | 0% |

**Introduction to Thematic Results**

This qualitative study was structured around the following research inquiries:

Specific Aim 1: To explore health beliefs and perceptions about cancer and prevention among immigrant women from Ghana and Nigeria age 40 years and older living Southern California.

Specific Aim 2: To investigate middle-age and older Ghanaian and Nigerian immigrant women's knowledge about breast and cervical cancer prevention services in the U.S.

Specific Aim 3: To examine barriers and factors that facilitate middle-age and older Ghanaian and Nigeria-born women's decision to be screened for breast and cervical cancer in the U.S and their follow-up action

The table below outlines the major themes and subthemes identified through the qualitative analysis, structured by each specific aim of the study.The results highlight the complex interplay between traditional health beliefs, healthcare experiences, cultural transitions and systemic barriers influencing breast and breast and cervical cancer screening behaviors among Ghanaian and Nigerian immigrant women.

Table 5 – Spefic Aims and Themes

| Study Aims | Themes | Sub-Themes |
|---|---|---|
| **Specific Aim 1:** To identify health beliefs and perceptions about cancer and cancer prevention among immigrant women from Ghana and Nigeria age 40 years and older living Southern California. | **Theme 1:** Embracing Traditional Beliefs and Practices | ***Subtheme 1.1:*** "[We] only go to the hospital when we feel really sick"<br>***Subtheme 1.2:*** "If my pastor prays for me, I'll be healed<br>***Subtheme 1.3:*** "Herbal medicine is like in our being"<br>***Subtheme 1.4:*** "Not comfortable with anyone touching my breasts or private areas" |
| | **Theme 2:** Living In Between Cultures | ***Subtheme 2.1:*** "Starting all over again"<br>***Subtheme 2.2:*** "We didn't have anyone but ourselves."<br>***Subtheme 2.3:*** "Back home, it's cash and carry" |
| **Specific Aim 2:** To investigate middle-age and older Ghanaian and Nigerian immigrant women's knowledge about breast and cervical cancer prevention services in the U.S. | **Theme 3:** Sustaining the Silence around Breast and Cervical Cancer | ***Subtheme 3.1:*** "People don't talk"<br>***Subtheme 3.2:*** "We believe cancer is a death sentence" |
| **Specific Aim 3:** To examine barriers and factors that facilitate middle-age and older Ghanaian and Nigeria-born women's decision to be screened for breast and cervical cancer in the U. S. and their follow-up action. | **Theme 4:** Encountering and Overcoming Barriers | ***Subtheme 4.1–*** "What if they find something?"<br>***Subtheme 4.2:*** "We Are Too Busy to Even Think That We Are Dying"<br>***Subtheme 4.3:*** "If the husband says no, you find it difficult to go."<br>***Sub-theme 4.4 -*** "I didn't know what insurance covered."<br>***Subtheme 4.5:*** "Not as bad as I imagined" |

| | | |
|---|---|---|
| | **Theme 5:** Facing the Future: Strategies to Improve Awareness and Uptake | **Sub-theme 5.1:** "We need more awareness in social media"<br>***Sub-theme 5.2*** "Go to churches, because that's where most of us gather"<br>***Sub-theme 5.3:*** "If they can do it for free, people will go" |

## Qualitative Thematic Analysis- Results

Thematic analysis of the qualitative data from this study resulted in the identification of five overarching themes that captured participants' experiences and perspectives. These themes include: (1)Embracing Traditional Beliefs and Practices, (2) Living In-Between Cultures, (3) Silence, (4) Encountering and Overcoming Barriers, and lastly the notion of (5) Facing the future - Strategies to Improve Awareness and Uptake. Each theme comprises two to four distinct subthemes that further expound on the nuances within the participants' narratives.

### Theme 1: Embracing Traditional Beliefs and Practices

Many participants in this study described a deep connection to traditional beliefs and practices, which continued to shape their daily lives and health-related decisions even after migration. Rooted in cultural teachings from childhood and reinforced through familial and communal norms, these practices were not only seen as familiar but also as trusted methods of care. Embracing their traditional beilefs and practices became a common theme shared through their experiences as African immigrant women and was shaped by a combination of cultural beliefs, economic realities, and healthcare infrastructure.

#### *Subtheme 1.1: "[We] only go to the hospital when we feel really sick"*

In examining participants' health-seeking behaviors, a recurrent theme emerged around the tendency to seek health care at the clinic or hospital only when "really sick." This outlook presented by the participants in this study reflects a deep-seated mentality towards traditional self-care and the influence of cultural norms from participants' countries of origin, particularly

Nigeria and Ghana. Participants conveyed that in their home countries, healthcare is often sought only when physical manifestations of the illness present or when the illness becomes severe, rather than for preventive purposes. This behavior appears rooted in cultural norms and healthcare practices from their countries of origin, where routine checkups are uncommon.

Anna, a 47 year old married Nigerian woman, described the beliefs in Nigeria by explaining, “In Nigeria, people don’t go for check-ups… you go to hospital when you’re really sick.” She highlighted the prevalence of self-medication, stating that even when she had insurance in the U.S., she never used it unless absolutely necessary. Instead, she was accustomed to reading instructions on medication and managing symptoms herself, a practice rooted in both resourcefulness and cultural expectation. Gina, a 56 year old divorced Ghanaian, expressed this sentiment, stating, “We don't have the mentality of like going to the hospital,” capturing the rooted belief that medical intervention is reserved for serious conditions. This mindset reflects a broader cultural belief towards symptom-driven care, suggesting a gap in preventive health awareness or a lack of prioritizing prevention and early detection.

Beth, a 43 year old married Nigerian, reinforced this notion with her comment, “But because it's like, oh, I don't feel pain. So I don't see the need to go to doctor” which points out how the absence of physical discomfort is often equated with being healthy. Further elaborating on this pattern, Fiona (Ghanaian, 48 years old, married) explained, “So like back home we won’t go [to the doctor or clinic] because you are not sick,” highlighting the transference of health-seeking behaviors from their countries of origin to their current context. This suggests that early life socialization plays a significant role in shaping attitudes toward healthcare, and these attitudes persist even after migration.

Some of the women provided insights that suggested a self-critical perspective and a potential turning point of their traditional beliefs and practices by acknowledging the limitations of the symptomatic-only approach and suggesting an awareness of the benefits of routine

health assessments. Beth shared a reflective statement, “We Africans should stop having the mentality that we only go see Doctor when we feel really sick or something”. It illustrates a tension between ingrained cultural practices and a growing recognition of the value of preventive care within the diasporic context.

***Subtheme 1.2: “If my pastor prays for me, I’ll be healed”***

Many participants in this sample described experiences where health problems, including cancer, were addressed primarily through faith and prayer rather than medical intervention. This subtheme reveals the prevalent role of spirituality and faith in shaping healthcare decisions among some African immigrants. For many study participants, religious beliefs were not simply a source of emotional support, rather often becoming the primary, and sometimes exclusive, means of managing health conditions, even serious ones like cancer. In this study, participants reflected on how faith-based approaches, often influenced by pastoral guidance, sometimes supersede medical advice or treatment, highlighting a critical intersection between religion and healthcare practices in the community.

Nancy, a 46 year old married Ghanaian, offered a broader cultural critique, asserting, “The only thing that is a problem for us in Africa... is church, right? Because the pastor tells you that he's going to pray for you and you're going to feel better.” Her statement identifies the structural influence of religious institutions on healthcare behaviors, where pastoral authority can sometimes lead to avoiding medical care. This sentiment is also echoed by Gina, who stated, “We over-spiritualize everything… we believe God will take care of us.” Here, the concern is not merely about faith, but rather the way it extends into areas where medical intervention is clearly needed.

Some of the women addressed the belief in divine healing as a sufficient, or even superior, alternative to biomedical interventions. Cris, a 42 year old married Nigerian, shared an example of this phenomenon, recalling a community member who chose to discontinue medical

treatment, saying, “If my pastor prays for me, I’ll be healed. So I stopped treatment.” The decision to stop treatment in favor of spiritual healing suggests that for some individuals, faith in religious authority figures may outweigh trust in medical professionals or treatment practices designated for a certain disease. Another 47 year-old Nigerian participant, Anna, stated, “We ‘brush off’ cancer, ‘it can’t happen to me in Jesus’ name’”, underscores a dangerous form of denial rooted in faith. The tendency to reject the reality of serious illnesses due to spiritual convictions may contribute to delays in diagnosis and treatment among AIW (African Immigrant Women).

Some of the participants expressed a form of internal conflict, for instance recognizing the effectiveness of medicine, yet feeling torn or even compelled to prioritize spiritual prescriptions due to religious teachings. As Cris, explained: “You see a situation whereby you know that, OK, taking this medication is gonna solve it for me, but your pastor tells you, ‘Oh no, pray about it instead.’”

***Subtheme 1.3: “Herbal medicine is like in our being”***

This subtheme captures the deep cultural significance and embeddedness of herbal medicine within the health beliefs and practices of Africans, specifically among many Ghanaian and Nigerian immigrants. Participants consistently described herbal remedies not merely as alternative treatments, but as integral part of their upbringing and identity. The use of herbal medicine was not only portrayed as common, but generally as a first line of treatment, often passed down from generation to generation and often rooted in communal knowledge. As one of the women, Cris shared, “But the herbal medicine is like in our being… like we grew up with our grandparents doing it so it is still there especially in the villages.” This quote emphasizes the intergenerational transmission of herbal knowledge, suggesting that herbal medicine is not only a method of healing, but a cultural legacy that forms a core part of their identity. For many, these practices were tied to their early life experiences and remain relevant even after

migration, particularly among those with strong ties to rural communities. Dora (53 year old Nigerian, married), echoed this cultural embeddedness, “So, you know, these are little, little things we do that you don’t even have to go see a doctor. They teach us… we love herbs.” Her words highlight the self-sufficiency encouraged by herbal practices, which they perceive as effective for treating minor illnesses and are often preferred over formal medical consultation.

Some of the women provided reflections which gave further insight into how their reliance on herbal medicine may influence their decisions about preventive care. Fiona shared,

> We believe in using herbs so like for me at first I did not think about getting the pap smear because maybe if I have symptoms, I can ask my mom and she will help me with some herbs or something.

This quote illustrates how their faith in traditional remedies can lead to delays in engaging with biomedical preventive practices. The belief that herbal remedies can address symptoms as they arise often leads to a reactive, rather than proactive, approach to health. Mary’s statement, “And then drinking some herb every time I feel a little discomfort,” reinforces the routine and habitual nature of herbal use, suggesting it is often the first response to illness. For many participants, this habitual use reflects a cultural norm that values natural treatments and aligns with a familiar, trusted system of care for them.

Together, these narratives reflect how herbal medicine continues to shape health behaviors among African immigrants. The use of herbal remedies is not simply a matter of tradition, but a deeply internalized practice that informs when and how many AIW seek formal medical care. These findings highlight the importance of culturally sensitive health interventions that acknowledge the role of traditional medicine while promoting safe and evidence-based healthcare engagement.

***Subtheme 1.4: "Not comfortable with anyone touching my breasts or private areas"***

This subtheme addresses a recurring concern among African immigrant women related to modesty, privacy, and cultural norms surrounding bodily exposure. Many participants expressed profound discomfort with clinical procedures that involve physical contact with intimate areas, such as mammograms or Pap smears. For some, the discomfort stemmed from general embarrassment; for others, it was specifically linked to the presence of male healthcare providers. These concerns often serve as significant barriers to participating in preventive care and reproductive health screenings.

Anna articulated the deeply personal nature of this discomfort, stating,

> For me, it is hard. I can't. Apart from my husband, I don't think anybody can touch my body. For what? Why? Even if it is like a doctor, I don't feel comfortable even if I'm going to be a nurse… I think I don't feel comfortable somebody doing to me, you understand?

This quote underscores how cultural and personal values around bodily autonomy and modesty can outweigh even professional familiarity with healthcare settings. Anna's reference to her future nursing career suggests that even knowledge of medical necessity does not erase deeply internalized boundaries. She expanded further with an observation about generational norms, saying, "I don't think someone like my mommy will sit down. A doctor will insert something in her vagina. She can't. She won't even let you." This emphasizes how cultural teachings around modesty are not only personally held but reinforced generationally, often becoming more entrenched with age. Anna's remarks imply a protective sense of dignity that older women, in particular, may guard fiercely, sometimes to the detriment of their health. Additionally, Hana, a 50 year old Ghanaian expressed, "I am not comfortable with anyone touching my breasts or private areas." This simple but powerful statement encapsulates the sentiment shared by many participants, a deep reluctance rooted in cultural and personal values.

Their discomfort with bodily exposure, especially in the presence of male clinicians, serves as a significant barrier to early detection and routine health maintenance. Jane, a 44 year old married Nigerian woman, further emphasized the cultural component of this discomfort, stating, “A female doesn’t lie down for a male doctor, that’s culturally wrong”, implying that such interactions may be seen not just as uncomfortable, but as violations of propriety or religious principles. Nancy echoed this sentiment with a more practical stance, sharing, “I just don't like male gynecologist. I am just not comfortable with that... I tell them again, I don't like a male in case maybe she's not there.” Her insistence on requesting a female provider highlights a strategy some women adopt to maintain a sense of control and comfort during medical encounters.

**Theme 2: Living In Between Cultures**

A salient theme that emerged from the narratives of participants was the experience of living in between cultures. Participants repeatedly described the sense of starting anew in a cultural environment vastly different from what they had known. For many, migration to the U.S. disrupted their established roles and relationships, often without offering immediate or clear alternatives. The participants, who were immigrant women from Nigeria and Ghana, described the internal and external negotiations they faced as they adapted to life in the United States while holding onto core cultural values from their countries of origin. This theme encapsulates the tensions between familiarity and novelty, tradition and modernity, as well as psychological and relational challenges.

***Subtheme 2.1: “Starting all over again”***

The experience of *“*starting all over again*”* is deeply intertwined with the broader theme of living in between cultures, especially for the AIW in this study. While starting over represents the process of rebuilding one’s life from the ground up, including getting new jobs and adapting to new systems, as well as new social circles, the notion of living in between cultures reflects

the emotional and cultural balancing act they must navigate while doing so. These two experiences are not only connected but they also amplify each other, shaping how immigrant women view themselves, relate to others, and make decisions, including those related to their health.

Anna shared that “Starting new life in the U.S. was a struggle.” She described that her husband was working in the U.S., and finally insisted that if the marriage was to work, Anna would have to join him in the U.S. Anna previously held an important supervisory position in Nigeria’s oil industry, but upon arriving in the U.S., she found herself cast into unfamiliar domestic roles. The participant described the challenges of leaving her successful career in Nigeria to establish herself in the U.S., trying to find balance between cultural values she had back home and the cultural and role changes she faced in the United States. She stated, “I was starting all over again, struggling in the system again, trying to balance and to meet the United States standard, you understand?” She found it difficult to balance the Igbo (Nigerian) values of being self-reliant and entrepreneurial with the challenges of starting over as an immigrant in America, reflecting the deeper conflict of living between two cultures.

Beth, similarly described the overwhelming sense of displacement. She referred to migration as “starting life all over again,” explaining the disorientation of leaving a familiar communal setting for a more individualistic society. She mentioned that, “It’s like starting life all over again… You leave what you used to know, and then you have to pick up new things in a different place.”

***Subtheme 2.2: “ We didn’t have anyone but ourselves.”***

For the women in this study, the context “we didn’t have anyone but ourselves” served as a deep expression of vulnerability and isolation. It shed some light on how migration, for them, was not only a geographic transition but a social and emotional change that reshapes how they interact with every aspect of life, including health care. This subtheme emerged as

participants revealed the emotional, cultural, and structural shifts that shaped their experiences of social support after immigrating to the United States.

When the women would say “we didn’t have anyone but ourselves,” they were speaking to the absence of this village-like support system. In the U.S., they face a more individualistic culture where such communal reinforcement is rare, and where health systems are often unfamiliar, complex, and impersonal. Beth reflected and made a statement that, “Back home… you have your neighbor, your family, your village. Here, you are on your own.” which powerfully highlights this transition. Her statement emphasizes the role of community in supporting health and well-being in African societies, where it is common for relatives and neighbors to check in, and even offer remedies for medical purposes.

Similarly, Jane shared, “It was really hectic at first… we didn’t have anyone but ourselves,” expressing the burden of self-reliance during a period of adjustment. The use of the word “hectic” points to both emotional and logistical burden of trying to adapt to a new system, caring for herself and possibly family, and making decisions without the familiarity of having communal support. From their experience, most of these women expressed the absence of extended networks to help initiate conversations about health, remind them of appointments, or provide emotional support. Experiencing this new social change could mean less motivation or assistance to seek out preventive care.

Some of the participants added that their new context lacked the communal philosophy they were used to in their home countries. Beth, 43 years old, stated, “In Nigeria, you get to be like, ‘Oh neighbor, how are you?’ But [here], it’s like you’re on your own... you mind your business.” Similarly, Nancy, 46 years old, claimed, ”Here in America, everyone is busy.” For these women, this shift in social culture, from community interdependence to individual autonomy, and possibly amplified feelings of isolation made the transition particularly difficult. From the womens’ experiences, missing familial ties and generational support can lead to

feelings of loneliness and contribute to decreased engagement with healthcare systems, particularly for older immigrants who may also face language barriers or unfamiliarity with preventive care practices in the U.S.

***Subtheme 2.3: "Back home, it's cash and carry"***

Participants consistently described healthcare in their home countries, particularly Nigeria and Ghana, as a system where only the wealthy could afford comprehensive care. As part of navigating their new world, the women expressed that their understandings of healthcare financing had to shift as part of their adjustment to the U.S. healthcare system. Coming from countries where health services are typically accessed only through out-of-pocket payment, often described as "cash and carry," participants initially assumed that healthcare in the United States would also be prohibitively expensive. Upon migrating, many women found the concept of insurance confusing and unfamiliar. Gina shared, "In Nigeria, no money, no doctor… so we assume it's the same here." Women shared candid reflections about navigating the unfamiliar landscape of healthcare in the U.S., particularly in relation to health insurance, preventive care, and personal agency within the system. Their stories highlight both challenges and adaptations in learning to engage with American healthcare norms and systems.

Ellen, a 46 year old woman who moved from Ghana to the U.S. to join her husband, described her misunderstanding of the U.S. system:

> When I came here, I wasn't really sure how [insurance] works because, like I said, back home I am used to cash and carry. So my husband was the one who said, 'Honey, we have health insurance so anytime you need to see a doctor it will be a small payment like 30 dollars or something like that.

Beth, age 43, also reflected on the contrast between systems stating that,

> Back home, you have to be able to afford it. People can't even afford to get like blood pressure medications. How much more cancer screening? It's just cash and carry. But here, it's like, they will take care of you even if you don't have papers.

Similarly, a 65 year old married Ghanaian woman, Linda, conveyed that "I wasn't sure how insurance works… in Ghana, you pay upfront." Most women found themselves unfamiliar with U.S. insurance either assumed they must pay out-of-pocket or were simply unsure how to navigate coverage for preventive services.

Also, Cris, a 42 year old woman living in the U.S for 7 years, echoed this sentiment in relation to Nigeria, where financial burden discouraged most from seeking preventive care when she expressed that,

> In Nigeria, I think finances is the only reason that would be a problem. When we come here, sometimes we think the way insurance works back home is how it is here too. Like, we have to pay a lot of money to go to hospital.

For most of these Ghanaian and Nigerian immigrant women, the expectation that healthcare would remain inaccessible due to cost often carried over upon arrival in the U.S., contributing to delayed engagement with available services. Their stories highlight both challenges and adaptations in learning to engage with American healthcare norms and systems.

This experience as living in between cultures acts as a tug of war between the women preserving meaningful cultural ties yet making efforts to adapt to a new social and health system. For these women, this shift was not simply about conforming to U.S. norms, but about exercising agency in redefining what it means to care for themselves as African immigrant woman living in America.

**Theme 3: Sustaining the Silence around Breast and Cervical Cancer**

According to the women in this study sample, there is a certain culturally ingrained hesitancy to openly engage in discussions around cancer, particularly gynecological cancers,

and preventive healthcare measures within the African communities in the U.S.This silence stems from stigma, limited health literacy, and cultural norms of privacy and discretion. It poses a significant barrier to early detection, timely intervention, and communal support.

***Subtheme 3.1: "People don't talk"***

A prevailing sentiment that emerged from participants' narratives is the general silence surrounding women's health and cancer-related discussions, particularly within Ghanaian and Nigerian communities. Women in this study provided accounts that underscores a deeply rooted cultural silence and stigma that shapes how these AIW perceive and engage with preventive health practices such as cancer screening. Beth captured this societal silence when she said: "If I tell someone from my country that I went for cancer screening, they would say I have cancer and am hiding something". This statement reveals a widespread misconception that equates the act of screening with the actual diagnosis of illness instead of viewing it as a proactive health measure. Such misinterpretations contribute to a climate of fear and secrecy, where individuals might avoid even discussing health screenings to prevent community judgment or gossip.

Similarly, Fiona reflected on the limited scope of awareness about cervical cancer screening within her peer group:

> Actually…let me say, most Ghanaians my age all that we know about is breast cancer---you know, so we don't really know about any other, other than breast. I don't know if it's because it is in the vagina, no one really talks about that one.

This quote not only points to a significant gap in health literacy but also hints at the layers of cultural taboo surrounding reproductive and sexual health. By emphasizing that gynecological cancers like cervical cancer are seldom discussed, Fiona exposes how the sociocultural discomfort with discussing the female body contributes to the neglect of other forms of cancer beyond breast cancer.

Further elaborating on the theme of silence and privacy, Nancy noted:

> No, here like the African community, a lot of people don't really talk about stuff like that when they are going through it unless they are very close to you. Things can be very hush hush. Like there was a woman who died in our church, she never mentioned anything right. She never mentioned she had breast cancer.

This commentary demonstrates that the cultural norms around secrecy and discretion in the African community persist even in different sociocultural environments. The secrecy surrounding illness and health challenges can prevent timely support and interventions. Nancy points out that even when individuals are embedded in communities with healthcare professionals, opportunities for help are missed due to lack of disclosure: “So if…you even have help…you cannot even help because people don’t talk.”

When participants mention that no one talks about these issues in African immigrant communities abroad, they point to an environment where silence and secrecy are normalized. This lack of discourse means women are less likely to hear positive stories of screening or early detection and more likely to internalize negative or stigmatized views of illness.

***Subtheme 3.2: “We believe cancer is a death sentence”***

A pervasive belief among participants was that a cancer diagnosis was synonymous to a death sentence. This theme, rooted in participants’ cultural and social experiences in Nigeria and Ghana, was echoed in both explicit statements and implied fears about disclosing diagnoses, undergoing screening, or seeking treatment. For many of these women, cancer was not only associated with fatal outcomes but also with social stigma, silence, and isolation, particularly within their African diaspora communities in the U.S.

There was a deep rooted fatalistic idea about cancer as several participants shared that growing up in their home countries, cancer was seen not as a treatable condition, but as a

terminal one. Cris, a Nigerian woman, spoke directly to this association saying, “Back at home, cancer was more of a death sentence. All we know is that oh you get breast cancer, you’re going to die”.

This narrative illustrates how cancer was socially constructed as an incurable disease, one that was not only feared but avoided in discussion, perpetuating a lack of awareness and late-stage diagnoses.

Dora, a 53-year-old married woman from Nigeria, echoed this perspective and emphasized that many women would only consider screening if they were convinced cancer was not necessarily fatal stating, “We think cancer is [a] death sentence, so at least if we know it can be cured when they detect it early, it will make them get screened.” Here, Dora reveals how the death sentence narrative functions as a barrier to preventive care. If women believe that a diagnosis leads only to death, they may avoid screening altogether in order to avoid a seemingly inevitable outcome.

Participants did not leave these beliefs behind upon migration. Instead, some described how the fatalistic view of cancer persisted in African immigrant communities in the U.S. Beth, a Nigerian woman living in the U.S. for over a decade, recounted,“I know about two people that died from cancer from [the] Nigerian community here. They didn’t tell anyone they had cancer… because they didn’t want that judgment.” She recalled attending social events hosted by women who were secretly dying of cancer saying that, “They had parties… meanwhile they were dying. Can you believe that?” These stories illustrate how, for some, the shame or stigma associated with a cancer diagnosis was so profound that they chose to suffer in silence rather than disclose their illness. This secrecy, in turn, perpetuated the perception of cancer as both socially and physically fatal.

Ellen, a 46 year old married Ghanaian participant, spoke powerfully about the consequences of being labeled as someone with cancer in her community:

> So it would be like: ‘Hey! She has cancer. You don't have to touch the person. You don't have to do this.’ Meanwhile, it's not like that. So, they will leave you to your fate. And lonely. You'll be—you'll be alone. No family want to approach you, and they'll be treating you like an outcast. So that alone will kill you quick. You don't even think about the curing side.

Ellen’s testimony links the emotional isolation and social abandonment that accompany cancer stigma to a kind of symbolic death. In this way, the belief that “cancer equals death” is reinforced not just by the disease’s biology, but by the community’s reaction to it.

Kate, a 52 year old married Nigerian woman, added that even talking about screening could lead to social suspicion stating, “If I tell someone from my country, ‘Oh, I went for cancer screening,’ in their mind, I have cancer… they say she’s sick, she’s hiding something.” This fear of misinterpretation may discourage individuals from accessing or discussing preventative services altogether, reinforcing silence and denial.

**Theme 4: Encountering and Overcoming Barriers**

This theme makes references to the multifaceted challenges, that is, emotional, cultural, social, and systemic, that AIW face in accessing and utilizing cancer screening services. This theme is especially important in understanding the underutilization of cancer screening among Ghanaian and Nigerian women and those in diasporic communities, as it sheds light on the deep-rooted factors that shape health behaviors beyond individual decision-making. Overcoming barriers, then, involves more than just awareness. It requires creating supportive environments where women feel emotionally safe, culturally affirmed, and socially supported to prioritize their health.

***Subtheme 4.1– "What if they find something.."***

Within the narratives shared by participants, one of the most pronounced emotional and psychological barriers to cancer screening was the pervasive fear of discovering a diagnosis of cancer. This subtheme captures the anticipated anxiety and avoidance behaviors that influence their decisions to delay or avoid screening altogether. AIW in this sample revealed that this fear is not merely about physical outcomes but is intertwined with social stigma, emotional distress, and a discomfort with confronting illness.

Women expressed a deep and often unspoken fear surrounding the potential outcomes of cancer screening, particularly the anxiety of discovering a serious diagnosis. Beth openly shared that for many, including herself, the underlying hesitation stems from fear. She briefly articulated that, "Some people, like me, it's fear… 'What if? What if they find something?" Her sentiments captures the emotional dread that something might be wrong. As expressed by the women, this fear holds enough power to deter women from engaging in preventive health behavior. The open-ended "what if" reflects an idea of worry that prevents individuals from seeking clarity through screening, even though such actions could be life-saving. This fear of the unknown acted as a limitation, with several women acknowledging that they would rather not know than confront the emotional burden of a possible illness. Jane illustrated this mindset succinctly, stating, "I don't want them to discover something—what I don't know won't kill me."

Although there was awareness among participants that screening is beneficial, this was often overshadowed by fears rooted not only in personal anxiety but also in broader social consequences. For example, Beth pointed to a fear of stigma by noting that in some communities, being diagnosed is accompanied by assumptions like "she must be hiding something." This sense of judgment adds to the silence surrounding screening, reinforcing a pattern of avoidance even when healthcare access is available.

Beyond individual fear, participants also described the fear of *social isolation* following a diagnosis. Ellen, a 46 year old Ghanaian, expressed that, “You’ll be alone. No family want to approach you… So, they will leave you to your fate.” This statement highlights the compounded emotional burden that comes with the fear of abandonment. It reflects the anticipated loss of community and familial support which are seen as essential pillars in Ghanaian and diasporic cultures. This fear magnifies the emotional stakes of screening, as individuals must weigh not only their health but also their social connectedness and belonging.

While fear often emerged as a barrier to cancer screening, for some participants, it also surfaced as a powerful motivator, particularly as women reflected on aging, family responsibilities, and their desire to live longer, healthier lives. This expression that, “Fear made me go”, captures how fear, when viewed through the lens of aging and familial duty, can act as a catalyst for action rather than neglect, thus overcoming barriers. As women begin to consider their long-term roles within their families, fear of illness transforms into a commitment to health. It becomes an instrument of empowerment, prompting them to pursue screening.

For many of the women in this study sample, the transition into midlife and beyond brought an increased awareness of their mortality and a heightened desire to remain present and active in the lives of their children and future grandchildren. Cris expressed this sentiment directly, stating, “I want to be alive for my kids… that is my motivator to do these tests.” Her words reflected a shift in focus from individual health concerns to seeing screening not only beneficial for herself, but for those who depend on her. The fear of premature death or disability becomes a call to action, fueled by a sense of responsibility and love.

Beth, Nancy, and Mary all described a growing desire to “live to see [their] grandchildren,” which in turn prompted them to take preventive health measures. For Fiona, aging sparked a deepened concern for long-term well-being, “As I get older, I think about seeing

grandkids… let me be healthy." Her reflection shows that fear is no longer paralyzing, but instead reoriented toward a proactive stance.

Cris further explained how her personal fear was not only transformative but potentially contagious in a positive way, "Fear made me go, so maybe that fear will motivate others." Her insight acknowledges fear as a complex emotional driver that, when channeled appropriately, can serve as encouragement within the community, especially among peers who may relate to similar life stages and concerns.

***Subtheme 4.2: "We Are Too Busy to Even Think That We Are Dying"***

This subtheme illuminates the ways in which AIW's traditional roles as caretakers, both culturally and practically, contribute to the deprioritization of their own health, particularly in relation to cancer screening. Participants described their lives as overwhelmingly busy, filled with long work hours, multiple caregiving responsibilities, and the unrelenting demands of supporting not only their immediate households but extended families, often across continents. Within this context, attending to personal health becomes secondary, and in many cases, entirely neglected.

Anna's expression, "We are too busy even when we're dying," encapsulates the exhaustion and self-sacrifice that underpins many AIW's lived realities. For her and others, the physical and emotional labor of caregiving leaves little space to reflect on personal wellness until a crisis arises. Anna further explained, "I am too busy to even think about my health. As an African woman, we start thinking of our health when once [we] break down." Her statement reflects a normalized pattern of postponing self-care until symptoms become unmanageable, a dangerous cycle that contributes to the late detection of diseases such as cancer.

Other participants pointed to the guilt that often accompanies self-care. Dora described how her cultural expectations shaped her relationship with health: "Like in my culture right, like we are very focused on taking care of others… my children, my husband, my extended family

back home and sometimes I forget or even feel guilty about putting me first." Her story shows that neglecting her own health wasn't due to a lack of knowledge, but rather came from strong, long-held beliefs that being a woman means always putting others' needs first.This ideology often renders self-prioritization as selfish, further discouraging preventive health behaviors like cancer screening. Jane, reflecting on the cultural dimensions of this experience, noted,

> Like most women like me are just busy around with family, right… and don't really [think] about their health… all the culture as a woman back home, it's all about family… you're just concerned about everybody then ignoring yourself.

These narratives demonstrate how traditional family roles, cultural expectations, and the demands of daily life for AIW intersect to delay or discourage cancer screening.

***Subtheme 4.3: "If the husband says no, you find it difficult to go."***

For women in this sample, having family support, specifically, the influence of a husband's approval or reluctance, plays a pivotal role in shaping whether women pursue cancer screening, particularly within cultural contexts where male authority is traditionally upheld. For many Ghanaian and Nigerian immigrant women in the diaspora, the husband's stance on health matters can either serve as a source of encouragement or a significant barrier, influencing how women perceive their autonomy and the consequences of acting independently.

In some cases, husbands provided encouragement and emotional support; in others, their resistance or perceived disapproval served as a major deterrent to screening participation. Cris offered a positive example of spousal support, noting, "My husband was like, oh honey just go, you will be fine." This brief yet powerful reassurance underscores the potential impact of encouragement within intimate relationships. When partners are supportive, women felt validated in prioritizing their health, which can remove psychological and emotional barriers to screening. In these situations, the husband's support helps validate the woman's health concerns and makes getting preventive care seem more acceptable and routine.

However, this supportive dynamic may not be the same across the board for all AIW. The quote that forms the basis of the subtheme ,“If the husband says no, you find it difficult to go”, speaks to the challenges women face in environments where male decision-making dominates. Participants expressed that this may be a reality for many women who feel constrained by traditional gender roles and expectations. The authority often granted to men in patriarchal family structures can limit women’s autonomy, even over their own bodies and health.

Ellen elaborated on the potential consequences of defying a husband’s wishes, explaining, “It's like, husband is the head. What if I go, and he said, ‘Don't come to my house again. You didn't listen to me.’” Her comment reveals the fear of domestic conflict that can result from the woman making health decisions without consulting with her husband. In such contexts, seeking screening is not merely a medical act but can be interpreted as a sign of disobedience or disrespect. This fear of punishment or rejection becomes a powerful barrier to accessing care.

Fiona provided further insight into the stigma that some husbands associate with disease, particularly cervical cancer. She stated, “If the husbands got to know, ‘My wife have cervical cancer – Hey, I don't want any problem. I can't marry you again. I will not even sleep with you again. If I sleep with you, I will contract it.’” Her words reflect a deep misunderstanding of the transmission for cervical cancer which could have been driven by misinformation. In these scenarios, a diagnosis of cervical cancer may carry not only medical implications but also relationship issues, leading women to avoid screening altogether to protect their marriages.

***Sub-theme 4.4 - “I didn’t know what insurance covered.”***

Women in this study often described feeling overwhelmed and unsure when navigating the U.S. healthcare system, particularly when it came to understanding insurance coverage and financial responsibilities that may be tied to cancer screening. Most of these women revealed

how a lack of clarity around health insurance in the U.S healthcare system became a source of hesitation and anxiety. Rather than feeling empowered to make informed decisions, many participants found themselves confused and uncertain about what services were available to them, especially as immigrants coming from a very different healthcare structure, that is, the "cash and carry system". For example, Ellen shared, "I wasn't really sure how it [health insurance] works… in Ghana, you pay upfront." Her reflection highlighted the disconnect between her past experiences in Ghana and the complexity of the U.S. system, where health insurance coverage may be difficult to interpret.

This confusion extended beyond just policy details to a deeper mistrust in the U.S system itself. Anna, for instance, questioned the truth behind seemingly well-intentioned messages, stating, "They tell me it's free, but do I really believe it?" Her comment revealed how uncertainty and skepticism can override official messaging, especially when women may have previously encountered surprise bills, or unclear guidance. The suggestion that there could be a lack of transparency can paralyze women's health decisions and discourage follow-through with screenings, even when cost should not be a barrier.

Mary, a 44 year old unmarried Ghanaian woman, echoed a similar concern when she expressed that, "I didn't know what insurance covered." This lack of knowledge limited her confidence and ability to engage proactively in her own healthcare decisions. Without clear, culturally responsive education or guidance, AIW found themselves fearful of financial repercussions and possibly unsure of how to ask the right questions or who to trust. Some of these women did not feel they were in the position to challenge or clarify any possible misinformation. Their hesitation was less about the screening itself and more about not understanding what they could be committing to financially.

***Subtheme 4.5: "Not as bad as I imagined"***

Another barrier as described by most of the women surrounded the anticipated discomfort with mammograms and pap smears. Many participants described how initial fears about undergoing cancer screening were grounded more in anxiety and hear say about pain. Women acknowledged that this fear often stemmed from a lack of information, cultural silence around reproductive health, and apprehension about what the procedure might feel like. However, after going through the screening, several participants shared how the experience was far less daunting than they had anticipated. For instance, Beth reflected, "After the Pap smear, it was literally 2 minutes. I felt better." Her reaction points to a powerful realization that the procedure was quick, manageable, and even comforting in hindsight. What had once felt overwhelming became a brief step toward peace of mind.

Dora also spoke regarding expectation and experience, admitting, "It was uncomfortable, but not as bad as I imagined." Like others, she had carried anticipatory anxiety into the appointment, but walked away with a reframed understanding of the process. Her sense of relief was further enhanced by the support she received from the medical staff, "I think it was good. It wasn't scary like I thought it would be. The nurse was nice and was talking to me like what she was going to do and all that." Dora's account illustrates how compassionate, clear communication from healthcare providers can make a significant difference in reducing fear and creating a sense of safety.

Cris also echoed this sense of reassurance, noting, "I do not remember much but I think if it was bad, then I would remember." Her words highlight how uneventful the procedure was, to the extent that it left little emotional imprint. The absence of actual trauma was striking, especially compared to the emotional stress leading up to it, most of which came from imagined pain, fear of being exposed, or cultural discomfort with reproductive health care.

**Theme 5: Facing the future: Strategies to Improve Awareness and Uptake**

This theme centers on the proactive steps needed to overcome barriers and encourage greater participation in cancer screening among AIW. It reflects an urgent call for more community-informed action. While awareness of cancer and its risks may be growing among this population, the disconnect between awareness and actual screening behavior persists due to a combination of cultural, interpersonal, and systemic obstacles. Participants emphasized that increasing awareness must go beyond standard public health campaigns. They suggested that it requires targeted strategies that resonate with them culturally and engage trusted community voices.

***Sub-theme 5.1: "We need more awareness in social media"***

Participants identified social media and community-based outreach as essential tools to enhance awareness and uptake of cancer screening within their communities. This sub-theme reflects a collective call for culturally relevant and accessible forms of communication that meet AIW where they are, especially in the cultural sense. Across interviews, participants emphasized that traditional health education efforts often fail to reach them meaningfully and that strategic use of digital platforms, storytelling, and localized engagement could help close the awareness gap.

Anna captured this sentiment directly when she stated, "We need more awareness in social media, WhatsApp, Facebook… show them pictures." Her recommendation underscores the importance of visual representation and familiar communication channels. WhatsApp and Facebook, widely used among AIW in the community, were cited as trusted platforms that can circulate health messages quickly and with emotional impact. Anna's reference to pictures also emphasizes the need for visual storytelling, that is, using real faces and real stories to humanize the risks of breast and cervical cancer and make them more relatable.

Hana, a 50 year old unmarried Ghanaian, added to the conversation by highlighting how important it is for community outreach to connect with people's culture and language. She shared,

> But if we're talking about, you know, women like my age maybe really showing me how really bad it is… when they have these health fairs, they can speak slower or find ways to make sure we really understand them, like their accent.

Her statement reflects an often-overlooked reality that effective awareness is not just about delivering information, but also about how it is communicated. Language barriers, speed of delivery, and cultural disconnects in messaging can all hinder understanding and engagement. Her comments also highlighted the importance of age-sensitive messaging, particularly the need to challenge misconceptions that certain cancers cannot affect older women.

***Sub-theme 5.2- "Go to churches, because that's where most of us gather"***

This sub-theme highlights the potential of faith-based engagement to overcome barriers related to mistrust, stigma, and access. Churches were consistently identified by participants as trusted community centers, offering not only spiritual guidance but also a sense of belonging among AIW. Many of the women suggested that by merging health initiatives within these spaces, there is a unique opportunity to reach women in a setting where they feel safe, heard, and spiritually supported.

Kate, a participant who regularly attends religious services, captured this idea by stating, "Go to churches, because that's where most of us gather. We can talk about it there." Her remark speaks to the essential social and communal function of churches within African immigrant communities. For many women, the church is not just a place of worship but a cornerstone of social life. As such, it represents an ideal platform for initiating difficult conversations about health, particularly about topics like cancer, which may carry stigma or be

avoided in other social contexts. Kate's emphasis on "we can talk about it there" also reflects the perception that these topics can be discussed without fear of judgment.

Gina added to this viewpoint by combining spiritual beliefs with health awareness, saying, "Teach them that God can protect you but also you should check yourself." Her words show a thoughtful balance between trusting in faith and taking personal responsibility for one's health. Rather than seeing health screenings and religious belief as conflicting, Gina calls for an approach where faith-based teachings can coexist with and even reinforce the importance of preventive healthcare.

***Sub-theme 5.3: "If they can do it for free, people will go"***

Participants in this study sample addressed that outreach to increase cancer screening services should emphasize not only that screenings are free or low-cost, but also that there are no strings attached, offering reassurance and transparency. This sub-theme emphasizes the critical role of affordability in shaping health-seeking behaviors, particularly around cancer screening among AIW. Participants across interviews identified financial barriers as one of the most significant deterrents to screening uptake. As such, the availability of free or low-cost screening services was frequently mentioned as a strategy to improve participation rates.

Beth, reflecting on her own community's needs, explained, "We need to emphasize that it's free or cheap… that gets people's attention." Her statement highlights that not only is cost a primary concern, but messaging around cost must be explicit and emphasized in outreach efforts. AIW in this sample expressed that it is not sufficient for services to be available at low or no cost, they must also be actively advertised as such in ways that are clear, and repeated across various platforms. Beth's use of the phrase "gets people's attention" highlights how promoting screenings as affordable can make them seem more appealing and doable and help encourage more people to take part.

Cris reinforced this perspective, stating, “If they can do it for free, people will go. They like free stuff.” The underlying message suggested that providing financial incentives can be a powerful motivator for action. Her comment also implies a broader cultural truth. For instance, in communities like theirs where every dollar counts, the promise of a free service does not merely carry monetary value, but also social validation. It signals that the service is intended for everyone, especially as AIW who may have experiences difficulty with the financial aspect of the U.S health system.

# Chapter 6: Discussion and Conclusion

## Discussion

The qualitative thematic analysis conducted in this study aimed to explore the complex interplay of health beliefs, cultural norms, and structural barriers that shape cancer screening behaviors among Ghanaian and Nigerian immigrant women aged 40 and older in Southern California. The findings presented in this study provides valuable insights into the multilayered barriers that contribute to the underutilization of breast and cervical cancer screening services among African immigrant women (AIW), specifically Ghanaian and Nigerian women, in the United States. Through rich narratives from the study participants, the themes identified offer a nuanced understanding of the sociocultural, structural, and psychological factors influencing screening behaviors. Congruent with findings from previous research involving immigrant women—particularly those of African and Caribbean descent (Cudjoe et al., 2020, Rauch et al., 2025, Romelus et al., 2024), this study addresses the unique confluence of cultural, structural, and psychosocial barriers that hinder the utilization of breast and cervical cancer screening services.

### Cultural Influences and Traditional Health Practices

This study uncovered a heavy reliance on traditional health practices and spiritual beliefs as primary responses to illness, aligning with past findings among Africans and other immigrant populations in the U.S. (Cudjoe et al., 2020, Eldol, 2024, Rauch et al., 2024).

African immigrant women in this study were able to shed light on how deep-rooted cultural norms around health shape attitudes toward preventive care. They often described health-seeking behaviors conditioned by symptom-driven care models from their home countries, where individuals typically “go to the hospital when we feel really sick.” This perspective mirrors observations in Cudjoe et al.'s (2020) systematic review, where low uptake of Pap testing among African immigrant women was attributed to cultural norms that prioritize acute care over

preventive health practices. Similarly, Romelus et al. (2024) highlighted that many Haitian immigrant women viewed Pap smears not as a preventive tool, but as a post-symptom diagnostic or even a "cleaning" procedure, illustrating a pervasive lack of understanding around screening's preventive purpose.

Preventive screenings, like mammograms or Pap smears, were culturally unfamiliar and perceived as unnecessary in the absence of symptoms. Moreover, spiritual and religious beliefs—such as relying on pastoral prayers or divine healing—further discouraged women from seeking medical interventions, reinforcing spiritual fatalism and delaying biomedical engagement. Faith and spirituality as both a barrier and a coping mechanism also appear consistently across research as it aligns with Al-Amoudi and colleague's (2015) findings where Somali Muslim women deferred medical decisions to spiritual leaders and often delayed screenings because they believed in God's will. Such religious fatalism complicates health education efforts and requires culturally driven interventions to bridge belief systems with biomedical practices. (Al-Amoudi, Cañas, Hohl, Distelhorst, & Thompson, 2015). Literature suggests that religious beliefs, particularly fatalism, were identified as barriers to cancer screening in refugee women population in the United States. However a study by Siddiq and colleagues (2020), revealed that although fatalistic beliefs can hinder cancer screening efforts, the refugee women in the stufy view a combination of Western medical treatments and traditional lay practices such as prayer and reading the Quran as essential components in the management of illness (Siddiq et al., 2020).

For many participants, traditional remedies, the use of herbal medicine, were not only a cultural artifact but a first line of treatment, often seen as safer and more trustworthy than modern interventions. These practices, although culturally affirming, potentially undermine efforts to promote preventive screenings, as reliance on symptom-triggered remedies inhibits the early detection of cancers.

### Navigating Dual Cultural Identities

The theme of “Living In-Between Cultures,” explored in this study, further resonates with the findings of Eldol (2024), where Middle Eastern and North African (MENA) immigrant women in Canada described tensions between their native cultural identity and the expectations of the healthcare system in their host country (Eldol, 2024). Through our findings, participants described feeling caught between their African cultural identities and the expectations of their new environment. Having this dual cultural experience affected their healthcare choices, with unfamiliarity and mistrust of the U. S. insurance system further complicating access. The expression “back home, it’s cash and carry” encapsulates the financial anxieties associated with healthcare expenses that these women bring with them, often leading to the mistaken belief that screenings in the U. S. are expected to be expensive. The women reveal a lack of familiarity with the U.S. health infrastructure—a barrier similarly observed in Eldol (2024), where MENA immigrant women in Canada expressed confusion and mistrust toward local healthcare systems. In this study, participants often carried assumptions from their home countries, believing services to be unaffordable or restricted, despite the availability of free or subsidized screening programs (Eldol, 2024).

Participants also spoke about losing their communal support systems, reinforcing a sense of isolation. In their countries of origin, health decisions were community-based, but in the U.S., they became intensely personal. The lack of social reinforcement—such as neighbors encouraging screenings or accompanying them to clinics—exacerbated their reluctance to engage with unfamiliar medical procedures.

### The Power of Silence and Stigma

In this study, participants described this silence as a culturally reinforced barrier, especially among older women, where fear of judgment and modesty create significant resistance to clinical interventions. A study by Rauch and colleagues affirm this in their review,

identifying shame and privacy as critical deterrents for breast cancer screening among African immigrants, with modesty heightened by religious beliefs and patriarchal social structures (Rauch et al., 2024). The preference for female providers, a salient subtheme in this study was also echoed across the literature by Rauch et al., (2024) and Cudjoe (2020), where women expressed discomfort with male practitioners due to religious or cultural prohibitions (Rauch et al., 2024; Cudjoe 2020).

The narratives from participants in this study revealed how cultural silence surrounding gynecological health inhibits dialogue and perpetuates stigma. Previous studies have frequently highlighted that social pressures can lead individuals to experience shame and stigma while association of the breast with reproductive and sexual functions may further contribute to societal stigma among AIW (Eldol, 2024). Many participants described cancer, especially cervical cancer, as a taboo subject, leading to a reluctance to discuss or disclose symptoms and experiences. This silence was compounded by fatalistic attitudes, with participants frequently referring to cancer as a death sentence. Consequently, the stigma attached to a diagnosis—or even to screening itself—further discouraged participation in preventive health services. Social alienation following a diagnosis, fear of being ostracized, and misconceptions about cancer's contagiousness reinforced secrecy and denial. Such cultural silence limits awareness, precludes early detection, and restricts the development of supportive community networks that could promote screening behaviors.

**Structural and Psychosocial Barriers**

A major strength of this study was its focus on both the barriers and enabling factors influencing screening behaviors among AIW. Psychological barriers such as fear of diagnosis ("what if they find something") were coupled with concerns about bodily exposure and modesty, particularly in the presence of male providers. This reflects findings in previous literature where

similar anxieties and gender preferences were reported among Middle Eastern and Haitian women, respectively (Eldol, 2024; Romelus et al., 2024).

Other barriers from the study findings included caregiving responsibilities ("we are too busy to even think that we are dying") and spousal influence ("if the husband says no, you find it difficult to go"). These social dynamics—where caregiving roles and patriarchal expectations dictate personal healthcare decisions—are consistently documented in the literature (Cudjoe et al., 2020; Rauch et al., 2025). Importantly, the study also identified facilitators such as familial motivation and personal fear as drivers of screening uptake. This fear also served as a motivator for some, especially older women seeking longevity to support their families and witness their grandchildren's lives. Participants who underwent screening often described the experience as "not as bad as I imagined," suggesting that firsthand experience and supportive provider communication can alleviate anticipatory anxiety—a conclusion also reached by Rauch et al. (2025) and Eldol (2024).

Cudjoe et al. (2020) synthesized studies about cervical cancer screening among African immigrant women in multiple developed nations and identified low income, lack of insurance, and limited access to gynecological care as critical structural impediments (Cudjoe et al., 2020). These are entirely consistent with our findings where Ghanaian and Nigerian immigrant women experienced confusion over U. S. insurance systems and economic constraints discouraged screening participation. Furthermore, misunderstanding the U.S. insurance system was a recurring concern. The lack of culturally appropriate health literacy initiatives left many unsure about what services were covered, deterring engagement even when cost was not a barrier.

**Call for Future Solutions and Cultural Adaptation**

Despite these barriers, participants offered valuable recommendations to increase utilization of cancer screening services and for AIW to adapt the ideology of preventive care. They advocated for culturally embedded outreach strategies, including the use of social media

platforms like WhatsApp and Facebook to circulate health messages, and conducting educational events in churches—spaces that serve as trusted community hubs. These recommendations align with intervention models from Rauch et al. (2024) that highlight the success of culturally embedded education programs as well as the use of communal leaders that can serve as health navigators (Rauch et al., 2024). This study, in agreement with current literature (Rauch et al., (2024) suggests that adapting culturally competent care models that emphasize trust, familiarity, and cultural representation results in positive outcomes.

Importantly, the study also revealed that positive screening experiences helped dispel myths. Participants who underwent Pap smears or mammograms often remarked that the procedures were “not as bad as I imagined,” suggesting that first-hand experience, coupled with empathetic provider communication, can reshape perceptions and encourage word of mouth advocacy within the African community.

To illustrate the various influences shaping cancer screening behaviors among aging Ghanaian and Nigerian immigrant women in the U. S, a theoretical diagram (see Appendix G) was developed to visually map the interconnected themes derived from this study’s thematic analysis. This presents a synthesized explanation of how cultural beliefs, migration challenges, internalized fears, system-level barriers, and turning points collectively shape pathways to or away from preventive health service utilization. It offers a conceptual framework grounded in the study's findings and provides a possible direction for culturally responsive health interventions.

**Study Limitations**

While this study provides deep insights into the lived experiences of AIW in Southern California, it is not without limitations. The sample was geographically restricted and may not represent the full diversity of African immigrant experiences across the United States. The focus on Ghanaian and Nigerian women, though intentional, does not reflect immigrant women from other countries and cultures. The sample size of 15 AIW does not mean that findings are

reflective of other immigrant women from other countries and cultures and even populations of other AIW (including those from the northern, eastern, and southern parts of Africa) but instead, it offers detailed and context-specific insights drawn from the experiences of a single sample of a much larger population. Additionally, the self-selecting nature of participation may have skewed the sample toward women already interested in health discussions, potentially excluding those with the most deeply rooted barriers or fears towards cancer screening. Since community-based organizations and church networks were used to recruit women for the study, women who tend to be more embedded in their communities were more likely to participate. As a result, women who tend to be more socially isolated were less likely to be recruited, and therefore, their perspectives on cancer screening are not represented in the study. The study also relied solely on qualitative interviews, which, while rich in depth, lack the quantifiable metrics needed to gauge the prevalence of certain beliefs or behaviors.

**Implications for Clinical Practice**

The insights drawn from this study offer critical implications for enhancing culturally competent care and increasing cancer screening uptake among Ghanaian and Nigerian immigrant women in the United States. These implications can guide healthcare providers, systems, and policymakers in tailoring strategies to better meet the needs of AIW and address existing gaps in preventive health engagement.

A major implication for clinical practice is the need for culturally informed communication strategies that acknowledge the influence of traditional beliefs, including reliance on herbal remedies and spiritual healing. Many participants described faith-based alternatives—such as seeking healing through prayer or relying on guidance from pastors—as their first course of action. Providers should be equipped to respectfully engage with these beliefs rather than dismiss them, creating space for open dialogue that integrates, rather than contradicts, patients' cultural values. Culturally respectful communication can enhance trust and foster a more

collaborative provider-patient relationship, especially when introducing biomedical concepts like cancer prevention.

Clinical providers must also be aware of how modesty, especially concerning bodily exposure, influences screening decisions. Several women in the study expressed deep discomfort with being examined by male healthcare providers, particularly for procedures involving intimate areas. Offering gender-concordant care or giving patients the option to request female providers for Pap smears and mammograms may significantly improve screening participation.

Participants revealed significant confusion and mistrust around the U. S. healthcare system, particularly concerning insurance coverage and cost transparency. These findings suggest the importance of integrating patient navigation services tailored specifically for immigrant populations. Navigators (preferably from a similar culture) can serve as cultural and informational bridges, helping women understand what services are available, how insurance works, and what to expect from screening procedures. Providing these services in the languages and platforms familiar to the community (e.g., WhatsApp, churches, or community centers) may increase reach and effectiveness.

Finally, clinical practice must examine the lived experiences and voices of immigrant women. Many participants described themselves as overwhelmed caregivers, too busy or too guilty to prioritize their own health. Providers should take time to ask about caregiving roles, household responsibilities, and emotional well-being as part of routine care planning. Providers should also be mindful of the emotional burden tied to cancer screening. Fear of diagnosis, social stigma, and anticipated social isolation emerged as significant barriers. For many, these emotional risks outweighed the potential health benefits of screening. It is important for clinical staff to proactively discuss these concerns during consultations and validate the emotional challenges patients face.

## Implications for Future Research

Future studies should aim to expand the sample to include more diverse African nationalities and explore intergenerational differences in health behaviors among immigrants. Longitudinal research could provide insights into how attitudes toward screening evolve with acculturation. Moreover, experimental intervention designs could evaluate the efficacy of culturally tailored strategies—such as church-based education, peer health advocates, or multilingual media campaigns—in increasing screening rates. Future research should also include husbands and pastors in future education about the importance of screening practices and encouraging women to participate in regular screening. This could also be area of research to understand men's perspectives about health practices and the role of screening. Incorporating male perspectives may also yield valuable data, especially given their influence over women's healthcare decisions.

Future work should also focus on the development and testing of culturally grounded interventions that integrate church and spiritual advisors with healthcare messages, to effectively support and encourage health-seeking behaviors, such as participation in cancer screening. Health policy efforts should focus on integrating cultural competence into preventive care delivery. Training providers to understand the unique barriers AIW face—religious, familial, financial, and emotional—could improve patient-provider interactions and screening adherence. Moreover, healthcare systems should offer transparent information on insurance and explicitly communicate the availability of free or low-cost screening programs to immigrants.

## Conclusion

Our study findings highlight the intricate interplay of cultural norms, systemic barriers, and psychosocial factors that contribute to the underutilization of breast and cervical cancer screening among AIW in the U.S. Addressing these challenges requires a culturally driven, community-based approach that values trust, empathy, and culturally sensitive communication.

By listening to the voices of these women, future research and practice can move beyond awareness and toward action that fosters equity in cancer prevention.

The findings of this study help deepen the understanding of cancer prevention behavior among Ghanaian and Nigerian immigrant women and affirm the relevance of integrating cultural sensitivity into healthcare delivery. Health practitioners should prioritize trust-building, culturally specific education, and community-based interventions—particularly through churches and familiar digital platforms. Future research should investigate effective strategies for reaching and recruiting women who are more likely to be socially isolated or disconnected from community organizations and events, in order to broaden our understanding of the unique barriers they face in accessing cancer screening services. By listening to these women's voices, the U.S. healthcare system can move toward more equitable and culturally responsive care. Collectively, findings from this study and others in the literature confirm that the underutilization of breast and cervical cancer screening among African and Caribbean immigrant women is a multifactorial issue requiring interventions at the individual, interpersonal, and system levels.

Appendix A: Table of Evidence

| Citation | Purpose/ Questions | Subjects /Setting | Methods | Analysis/ Results | Discussion |
|---|---|---|---|---|---|
| Adegboyega, A., & Hatcher, J. (2017). Factors Influencing Pap Screening Use Among African Immigrant Women. *Journal of transcultural nursing: official journal of the Transcultural Nursing Society*, *28*(5), 479–487. https://doi.org/10.1177/1043659616661612 | The purpose of this study was to describe the barriers and motivators contributing to cervical cancer screening decisions among a purposive sample of sub-Saharan African immigrant women in Lexington, Kentucky.<br><br>The research questions addressed by this research study were: (a) What are the barriers that may influence Pap | Used purposive sampling.<br><br>Sample of 22 sub-Saharan African–born females, who were English speaking, aged 18 years and above, and have resided in the United States for more than 1 year. | Qualitative<br><br>-used HBM as theoretical framework<br><br>-used focus group interviews<br><br>data were recorded, and transcribed verbatim.<br><br>-used line by line coding to identify emerging themes | Barriers to cervical cancer screening<br>-lack of knowledge<br>-religious and cultural beliefs<br>-fear<br>-communication issues<br>-cost<br><br>Motivation for screening<br>-Benefits of pap screening<br>-Recommendation from provider<br>-Family support and community enlightenment<br>-Health insurance | One of the major findings from this study was that African immigrant women had low awareness of cervical cancer screening tests.<br><br>The cost of screening services was found to be a barrier to screening completion. While the majority of women interviewed in this study had some form of health insurance, which they identified as a |

| Citation | Purpose/ Questions | Subjects /Setting | Methods | Analysis/ Results | Discussion |
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| | screening decisions among sub-Saharan African immigrant women? and (b) What are the motivators that may contribute to Pap screening decisions among sub-Saharan African immigrant women? | | | | motivating factor to seek health services, they noted that health care costs in the United States are very high and may be a major deterrent for recent immigrants who have yet to secure a job that provides health insurance coverage and financial stability.<br><br>Communicatio n issues: Although all the participants in this study were well educated and proficient in English as a first or second |

| Citation | Purpose/ Questions | Subjects /Setting | Methods | Analysis/ Results | Discussion |
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| | | | | | language, they expressed that they have faced challenges and frustrations during health care interactions.<br><br>Women may not feel comfortable during the gynecological examination due to thoughts that they might be perceived as different. Cervical cancer screening may be associated with the invasiveness and pain experienced during circumcision, hence an |

| Citation | Purpose/ Questions | Subjects /Setting | Methods | Analysis/ Results | Discussion |
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| | | | | | underutilization of screening among African migrant women.<br><br>Provider recommendation is one of the most important keys to screening utilization. |
| Adegboyega, Bola & Wiggins, A.T. & Obielodan, O. & Dignan, Mark & Schoenberg, Nancy. (2022). Beliefs associated with cancer screening behaviors among African Americans and Sub-Saharan African immigrant adults: a cross-sectional study. BMC Public Health. 22. 10.1186/s12889-022-14591-x. | The aim of this study was to evaluate the relationships between beliefs (religiosity, fatalism, temporal orientation, and acculturation) and cervical, breast, and colorectal cancer | Sample: 73 African American and 59 English speaking Sub-Saharan immigrant adults recruited from Lexington and surrounding cities in Kentucky. | cross-sectional, self-administered online survey;<br><br>Data collected included socio-demographic variables, cancer screening behaviors, and several instruments | 198 participants took the survey<br><br>Slightly more than half of the participants were African Americans (55%), while all others were sub-Saharan African immigrants. The top countries represented in | Among participants eligible for each screening modality, 64% had ever had a pap test, 82% had ever had a mammogram, the rates of screening completion among the study participants suggests |

| Citation | Purpose/ Questions | Subjects /Setting | Methods | Analysis/ Results | Discussion |
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| | screening behaviors among African Americans and sub-Saharan African immigrants. | | that characterize beliefs, including religiosity, fatalism, temporal orientation, and acculturation. | the immigrants' sample were Nigeria, Cameroon, and Congo.<br><br>Overall the sample had adequate health literacy<br><br>Immigrant participants had higher educational attainment compared to the non-immigrants.<br><br>The belief associated with receipt of a Pap test included cancer fatalism and acculturation. Compared to women who had not had a Pap test, those who had been screened had | that African American and sub-Saharan African immigrants in this study are at risk for late-stage detection due to underutilization of cancer screening and missed opportunities for early detection.<br><br>individuals with higher educational attainment have greater awareness about their cancer risk, which prompts adoption of healthy lifestyles, and more means to |

| Citation | Purpose/ Questions | Subjects /Setting | Methods | Analysis/ Results | Discussion |
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| | | | | fewer fatalistic views about cancer and death.<br><br>Religiosity, cancer fatalism, future orientation, and acculturation, were not associated with mammography. | access screening.<br><br>being insured was associated with having ever had a Pap test.<br><br>Sub-Saharan African immigrants and other immigrants have lowest screening rates compared to native-born individuals.<br><br>Fatalistic beliefs about surviving cancer may inhibit individuals from engaging in screening tests out of fear that a |

| Citation | Purpose/ Questions | Subjects /Setting | Methods | Analysis/ Results | Discussion |
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| | | | | | positive test result represents a death sentence. |
| Babatunde-Sowole, O. O., Power, T., Davidson, P. M., DiGiacomo, M., & Jackson, D. (2020). Health screening and preventative health care in refugee women: A qualitative analysis. *Contemporary nurse*, *56*(1), 62–79. https://doi.org/10.1080/10376178.2020.1739543 | To explore the beliefs, understandings, and use of health and healthcare screening services among African refugee women living in Australia.<br><br>The aim of the study was to gain insights into the attitudes and understandings about preventative healthcare and screening held by Australian-West African | The West African women migrants, aged between 20 and 65 years,<br><br>- 22 refugee women<br><br>Women who have lived in Australia for over 12 months<br><br>Purposive sampling technique was used | Qualitative secondary analysis<br><br>Qualitative analysis allowed for in-depth description, understanding and multiple meanings that people have concerning experiences, concepts, and behaviors.<br><br>Collected data through semi-structured interview | Some themes found:<br>*misinformation and low health literacy and health screening is not a priority<br>-Generally women were found to have low literacy when it comes to healthcare practices and etiology of disease<br><br>*Health screening was found to not be a priority<br>-women were more occupied with resettling and ensuring that their families | In this study, women view prevention, vaccinations and screening for chronic health conditions and cancers as foreign to them because they only seek medical assistance in the presence of symptoms.<br><br>There is widespread poor health literacy, sociocultural, and spiritual beliefs impacting the uptake of |

| Citation | Purpose/ Questions | Subjects /Setting | Methods | Analysis/ Results | Discussion |
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| | women living in New South Wales, Australia, to answer the research question: what are the preventative health beliefs and practices of African refugee women resettled in Australia? | | guide; lasting 60-90 minutes.<br><br>Story telling method was used in data collection<br><br>Data was recorded, transcribed and coded for themes | had basic necessities of life and that took priority over getting screened | screening and preventative health practices among the population studied.<br><br>Most of the women's stories showed that some of their (unsafe) African health-related culture, lifestyle, and spiritual/religious beliefs prevented them from participating in preventative health behaviors. |
| Ehiwe, E., McGee, P., Filby, M., & Thomson, K. (2012) Black African migrants' perceptions of cancer: are they different from those of other ethnicities, cultures and races? *Ethnicity and* | With West Africans now living in western societies | Five focus groups of 53 persons from Ghanaian and Nigerian | Qualitative study<br><br>-used a focus group | Themes developed from interviews include: | There is paucity of research and literature on cancer |

| Citation | Purpose/ Questions | Subjects /Setting | Methods | Analysis/ Results | Discussion |
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| *Inequalities in Health and Social Care*, Vol. 5 Issue: 1, pp.5-11, doi.org/10.1108/17570981211286732 | where cancer is openly discussed, this study aims to explore how black Africans perceive the disease (cancer) and the implications for healthcare. | migrant communities in Luton participated. Age of participants: 20-55 years. Study sample<br>- 10 Nigerian women<br>- 10 Ghanaian women<br>- 9 Nigerian men<br>Selection criteria<br>1. Participants must be black migrants from Ghana and Nigeria<br>2. Willing to participate in this study<br>3. Adults with the capacity to give informed consent<br>4. Must have | interview approach<br><br>Ghanaian and Nigerian migrant communities were sampled for this study because they form part of the largest community of black African communities in Luton<br><br>Purposive sampling technique was used to recruit participants<br><br>Each focused group interview lasted between 45 and 90 minutes and | 1. Diverse levels of knowledge about cancer<br>- Participants varied in their knowledge about cancer with the majority indicating that it was a disease that could affect any part of the body: breast, prostate, bowel, skin, blood, etc<br>2. Feelings of fear and apprehension<br>- The participants were unanimous in describing cancer as a deadly disease and the fear of it is enough to kill someone.<br>3. Living in denial and refusal to act<br>-Participants expressed denial | perceptions among Ghanaian and Nigerian migrants in the UK. Anecdotal and current literature on this subject generally comes from studies undertaken in the USA among black Americans with limited research undertaken among blacks and minority ethnic groups.<br><br>New information has been generated because, prior to now, no research had explored this subject |

| Citation | Purpose/ Questions | Subjects /Setting | Methods | Analysis/ Results | Discussion |
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| | | been in the UK between three and five years.<br>5. All levels of education and all occupations<br>6. Varied residency and immigration statuses | was audio taped.<br><br>Proceedings of all the sessions were transcribed and analyzed using iterative inductive analysis techniques. | or refusal to accept the possibility of being a cancer patient<br>- Also, the impact of cultural belief system and level of education could be seen as an influence<br>4. Elements of secrecy about cancer<br>- One other major key finding in this study is the existence of a ‘‘hush-hush attitude’’ about cancer.<br>- This type of an attitude which is reported to make some less likely to seek out the support and services they need | specifically among Ghanaian and Nigerian migrants in the UK.<br><br>Limitations<br><br>- Generalizability |

| Citation | Purpose/ Questions | Subjects /Setting | Methods | Analysis/ Results | Discussion |
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| Francis, S. A., Griffith, F. M., & Leser, K. A. (2014). An investigation of Somali women's beliefs, practices, and attitudes about health, health promoting behaviors and cancer prevention. *Journal of Health, Culture and Society, 6*(1), 2161-6590. doi:10.5195/hcs.2014.119 | Specific aims of the study were:<br>To examine Somali women's beliefs about optimal health and health promotion e.g. how do Somali women conceptualize health and health promotion?<br>(2) To examine Somali women's attitudes, knowledge, beliefs and practices around their health/health promotion e.g. specifically with regards to cancer prevention | Somali immigrant women residing in Central Ohio metropolitan area.<br><br>18 years or older<br><br>12 participants were interviewed. | Qualitative study design<br><br>Twelve in-depth, face-to-face interviews were conducted. Interviews took place in a private conference room in a local library.<br><br>40-60 minute interviews<br><br>Interviews were recorded, then transcribed verbatim | Open coding, which requires analyzing categorizing and describing the themes from the interviews, was used to organize the data.<br><br>The interviews explored the following themes:<br>(1) How Somali women conceptualize health e.g. what are Somali women's beliefs about health and health promotion<br>(2) Most important health issues affecting Somali women<br>(3) Barriers to and facilitating factors to accessing care | The key findings included: 1) Participants have a holistic view of health, as they incorporated physical, mental, and emotional health as well as being free of disease as part of the concept of health. 2) Culture and religion play a strong role in their health and wellbeing. 3) A reoccurring theme was a lack of trust in their health care providers and the practice of only seeking medical care |

| Citation | Purpose/ Questions | Subjects /Setting | Methods | Analysis/ Results | Discussion |
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| | (3) To explore Somali women's attitudes, knowledge, beliefs and practices around cancer prevention (e.g. breast and cervical cancer) and; (4) To identify potential strategies to optimize health. | | | (4) Potential strategies to reduce barriers (5) How culture and religion impact health (6) Attitudes and beliefs about health and; (7) Identify strategies ways to work with Somali community to improve health.<br><br>Participants noted that prayer can be used to help increase health and that good health also consists of eating a healthy diet and being physically active. When asked to describe what factors impact health, participants primarily noted | for acute conditions vs. preventative care and 4) Participants reported being concerned about a variety of health issues with cancer, mental health, and obesity the most frequently cited. Participants were not only concerned about their own health status but were also concerned about their families' health as well as the health of members in the Somali community. |

| Citation | Purpose/ Questions | Subjects /Setting | Methods | Analysis/ Results | Discussion |
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| | | | | that access to healthcare impacts health.<br><br>Participants described "death" when asked about cancer.<br><br>Participants were asked to describe health issues that are important to the entire Somali community and a wide range of health concerns were described including: obesity, cancer, mental health, high blood pressure, diabetes, heart disease, stress, aging, high cholesterol and autism. Of those listed above, the | In terms of concerns about cancer prevention, in our interview, two participants referred to cancer, as being the "will of God" and that there was nothing that could be done about it.<br><br>participants expressed that lack of insurance was a barrier to accessing health care services and seeking preventative care. Another barrier to care was the concern about cultural competency |

| Citation | Purpose/ Questions | Subjects /Setting | Methods | Analysis/ Results | Discussion |
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| | | | | primary recurrent health concerns among participants were diabetes and cancer.<br><br>Participants reported seeing their health care provider anywhere from once a month to every four years, with most indicating that they go only when sick or for annual appointments. | and language barriers<br><br>Participants recommended that promoting health awareness and health education is very important in this community, as Somali women are lacking essential health information. The primary methods recommended for educational programming were: an educational health video (in Somali language), educational classes (at |

| Citation | Purpose/ Questions | Subjects /Setting | Methods | Analysis/ Results | Discussion |
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| | | | | | mosques/Somali malls with a strong emphasis on Somali culture), and holding health fairs. |
| Harcourt, N., Ghebre, R.G., Whembolua, G.L., Zhang, Y., Osman, W., & Okuyemi, K.S. (2014). Factors associated with Breast and Cervical Cancer Screening Behavior among African Immigrant women in Minnesota. *Journal of Immigrant Minor Health*; 16(3): 450–456. doi:10.1007/s10903-012-9766-4. | This study sought to determine the rates of participation in breast and cervical cancer screening among age eligible female African immigrants in the Twin Cities and to examine barriers associated with these cancer screening procedures. | A total of 112 women age 40 and above were included in the analysis of breast cancer screening, and 421 women age 18 and above were included in the analysis of cervical cancer screening.<br><br>Setting: urban areas in Minneapolis and St. Paul | Study design: secondary data analysis from a cross sectional survey of a community-based sample to determine a variety of health behaviors among African immigrants in Minnesota.<br><br>Measures included:<br><br>-Screening outcomes: | The relationships between demographics and perception of health and utilization of health care system to cancer screening status were examined using logistic regression analysis.<br><br>The three sets of factors used in multiple logistic regression analysis were (1) predisposing factors (demographics) only, (2) both | The results of the study indicate that African immigrant women in Minneapolis and St. Paul have low breast and cervical cancer screening rates<br><br>Duration of residence in the US is a significant predictor of cancer screening. |

| Citation | Purpose/ Questions | Subjects /Setting | Methods | Analysis/ Results | Discussion |
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| | Conceptual model used: Behavioral Model for Vulnerable Populations<br><br>This model suggest that use of health care services is a function of 1) predisposing factors (those that predispose an individual to seek care). 2) enabling factors (those that would enhance or impede the use of care); 3) need characteristics (a person's need for care); and 4) personal | Survey: from 2006-2007;<br><br>The survey was conducted in-person at the participants' home in either English or participant's preferred languages such as Pidgin English, Somali, or Oromo | defined as proportion of women 40 years and older who had ever undergone mammography<br><br>- Predisposing factors: included age, level of education, ethnicity, employment status, duration of years lived in the US and preferred language to discuss health matters<br><br>-Need for care factors: defined by the idea that, | predisposing and need for care factors, and (3) predisposing plus need for care plus enabling (utilization of the health care system) factors.<br><br>Mean age = 52.7 years<br><br>61% reported ever having a mammogram.<br><br>The odds of ever having had a mammogram for Somali immigrants were 5 times greater than the odds for other African immigrant groups (odds ratio=5.02, 95% CI= 1.72 – 14.68, p=0.003), while the odds of | - Women who have spent more time in the US are more likely to be proficient in English, and more acquainted with and have better skills at navigating the seemingly complex US health system. They are also likely to be different in respect to cultural factors, concerns related to modesty and cancer screening knowledge<br><br>Immigrant women are culturally more likely to prefer female |

| Citation | Purpose/ Questions | Subjects /Setting | Methods | Analysis/ Results | Discussion |
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| | health behaviors. | | to use health care services, individuals must perceive either illness or the need for preventive care<br><br>-Enabling factors included:<br>1) Health care accessibility<br>2) Health care affordability<br>3) Trust in health care providers.<br><br>Descriptive statistics of demographics, perception of health, and utilization of the health care system | ever having had mammogram for recent immigrants were only 15% of the odds for established immigrants (odds ratio=0.15, 95% CI= 0.05 – 0.46, p<0.001). | providers for their gynecologic care.<br><br>Limitations:<br><br>-Sample size and the restriction of the data to urban areas in Minneapolis and St. Paul<br><br>-Secondary data analysis<br><br>- Use of mammograms or Pap tests was self-reported and may be subject to inaccurate recall.<br><br>Comments:<br><br>Future research should explore |

| Citation | Purpose/ Questions | Subjects /Setting | Methods | Analysis/ Results | Discussion |
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| | | | were collected for age eligible African immigrant women who had screened and for those never screened for breast or cervical cancer | | the impact of acculturation on cancer screening among recent immigrant women<br><br>Additional research incorporating need-for- care factors, personal health practices factors, predisposing and enabling factors is needed to explore causal factors for differences in cancer screening rates between recent and established immigrant women. |

| Citation | Purpose/ Questions | Subjects /Setting | Methods | Analysis/ Results | Discussion |
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| Ndikum-Moffor, F. M., Faseru, B., Filippi, M. K., Wei, H., & Engelman, K. K. (2015). Health status among Black African-born women in Kansas City: A preliminary assessment. *BioMed Central, 8*(540). doi:10.1186/s13104-015-1469-1 | The objectives of this study were to gather information about health issues and health care access among African immigrant and refugee women, and assess women's knowledge of and awareness about breast cancer. | Black African-born women (N = 29) originally from countries in West, Central and East Africa, and living in the Kansas City (KC) metropolitan area; 20 years or older<br><br>Participants were recruited during an educational event to increase breast and cervical cancer awareness among immigrant and refugee women from Africa. | Participants completed a survey about general health, women's health, oral health, diet and exercise, acculturation, health history, and beliefs about breast cancer.<br><br>Questions about breast cancer screening including mammography were addressed to women aged 35 and older. | The percent of participants (60 %) that had not had a mammogram within the previous 2 years was more than the state average (24 %) for women 40 years and older<br><br>The percent of participants (40 %) that had a mammogram within the previous 2 years was lower than the national average (73.2 %) for African American women<br><br>Most (92.9 %) participants agreed | Breast health programs that address prevention, diagnosis and treatment of breast cancer are scarce or non-existent in most countries in Sub-Saharan Africa [6]. Therefore, prior to their immigration to the United States, many Black African-born women would have very little knowledge of or exposure to breast health programs and standard breast cancer screening tests. |

| Citation | Purpose/ Questions | Subjects /Setting | Methods | Analysis/ Results | Discussion |
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| | | Mean age of participants= 39 years | Data was analyzed using SPSS Categorical variables were summarized with frequencies and percentages and continuous variables were summarized with means and standard variation.<br><br>A four-level Likert scale (strongly agree, agree, disagree, and strongly disagree) was used to assess beliefs about | that breast cancer can be treated if detected early, 72.4 % strongly disagreed that breast cancer is a curse from God, and 53.5 % either strongly agreed or agreed that breast cancer can disappear following prayer.<br><br>Lack of jobs, health care cost, language barrier, discrimination, and child care were the top five social concerns in the African community. | Black United States-born women also face challenges with racial discrimination, jobs and health care costs, but not the added burden of language barrier experienced by many Black African-born women—a barrier that limits their understanding of health issues, and their ability to adequately communicate with health care providers and navigate the health care system. |

| Citation | Purpose/ Questions | Subjects /Setting | Methods | Analysis/ Results | Discussion |
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| | | | breast cancer. | | |
| Ndukwe, E. G., Williams, K. P., & Sheppard, V. (2013). Knowledge and perspectives of breast and cervical cancer screening among female African immigrants in the Washington DC metropolitan area. *Journal of Cancer Education*, *28*, 748-754. | This study investigated knowledge and awareness levels of breast and cervical cancer screening practices among female African-born immigrants to the USA residing in the Washington D.C. metropolitan area | 35 participants; six focus groups<br><br>participants were female, English-speaking, African immigrants ranging from 20–70 years of age.<br><br>Sample: African Immigrant women in DC area Participants were from Ghana and other West African countries including Cameroon, | Focus group sessions ranged from 45–60 minutes long.<br><br>The focus group protocol assessed the varying cultural factors, spiritual beliefs and familial influences that may play a role in the amount and quality of cancer screening care obtained.<br><br>Analysis: interviews were | Study suggested that age, education level and insurance status were largely influential factors in determining where women obtained information on breast and cervical cancer. Informants<br><br>Privacy, lack of transportation and other priorities such as work, school or familial commitments were reported to precedence over obtaining screening.<br><br>Fatalism, fear, pain, and | Fatalism, stigma, and privacy are among the major barriers to seek preventative screening measures for breast and cervical cancer. Additionally, the study implies that cervical cancer awareness is significantly lower among this population (African immigrants) when compared to breast cancer |

| Citation | Purpose/ Questions | Subjects /Setting | Methods | Analysis/ Results | Discussion |
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| | | Nigeria, and Zambia and the Ivory Coast. | recorded and transcribed verbatim; coding was used to develop themes | spousal support were described as barriers<br><br>Motivating factors included reminders from HCP and increased awareness of breast and cervical cancer | |
| Ogunsiji, O., Wilkes, L., Peters, K., & Jackson, D. (2013). Knowledge, attitudes and usage of cancer screening among West African migrant women. *Journal of clinical nursing*, *22*(7-8), 1026–1033. https://doi.org/10.1111/jocn.12063 | To explore West African migrant women's knowledge, attitude and usage of cancer screening in Australia. | Snowball sampling<br><br>21 West African immigrant women; Nigeria and Ghana were the two West African countries used for this study because they are the most represented West African | Qualitative naturalistic inquiry.<br><br>face-to-face audiotaped in-depth interviews which lasted for about 90 minutes. Interviews were transcribed verbatim and thematically analyzed<br><br>Through constant | Irrespective of the women's place of birth in Africa, twenty of the participants had no knowledge of cancer screening prior to migration, and most had a negative attitude towards screening. Women who had given birth after migrating to Australia were more likely to have had | The major findings of this study were that most participants were not aware of preventive cancer screening prior to their migration to Australia; participation in cervical cancer screening was enhanced through information provided by |

| Citation | Purpose/ Questions | Subjects /Setting | Methods | Analysis/ Results | Discussion |
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| | | English-speaking countries in Australia.<br><br>Ages between 25 and 50 years old | comparison, emerging themes namely knowledge of cancer screening, attitudes towards cancer screening and usage of cancer screening were identified. | cervical cancer screening.<br><br>Of the 21 women who participated in this study, 15 were from Nigeria and six were from Ghana.<br><br>Nineteen women had heard about cervical cancer screening but only three women confirmed hearing about breast cancer screening since migration. Among those women who had heard about cervical screening, only two of them had a comprehensive understanding and were able to explain their | their general practitioners (GPs); breast cancer screening was not emphasized by their GPs therefore uptake of this type of screening was low; the women's health belief about their susceptibility to cancer disease continues to be a barrier to their prioritizing preventive cancer screen in Australia.<br><br>participants in this current study stated that as they had no |

| Citation | Purpose/ Questions | Subjects /Setting | Methods | Analysis/ Results | Discussion |
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| | | | | understanding of pap smear as a test which involves taking a specimen from the cervix to detect cervical cancer. | family history of cancer, they refused to believe they could acquire it. Participants relegated cancer screening to the background by stating that they had more pressing needs to attend to. Participating in cancer screening was considered unnecessary and tantamount to looking for trouble.<br><br>Future studies should include migrant women from other African countries and |

| Citation | Purpose/ Questions | Subjects /Setting | Methods | Analysis/ Results | Discussion |
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| | | | | | the use of bilingual interpreters will generate more diverse viewpoints and promote greater representation. |
| Raymond, N. C., Osman, W., O'Brien, J.M., Ali, N., Kia, F., Mohamed, F., ... & Okuyemi, K. (2014). Culturally informed views on cancer screening: a qualitative research study of the differences between older and younger Somali immigrant women. *BMC public health*, *14*(1), 1-8. | Purpose of study was to understand was to understand what Somali immigrant women know about breast and cervical cancer, what the attitudes are toward screening and what cultural barriers are there to screen as well as cultural factors that would facilitate screening. | Purposeful sampling: younger Somali (20–35) and older Somali (36–65) women.<br><br>Twenty-nine women from the Somali community participated in four focus groups; two groups were with younger women and the other two with older women. | Qualitative design<br><br>Focus groups - The younger women's focus groups were conducted in English and the older women's focus groups were conducted in Somali.<br><br>The moderator's guide included | Both younger and older women saw major disadvantages to receiving care of any type in the U.S. because of potential misunderstandings between doctors and patients due to the necessity of using translators to communicate.<br><br>-Going to the Dr. only when sick<br><br>Both the younger and older Somali | The authors identified barriers to screening such as mistrust of the health care system. based on reports by friend or relatives regarding problems they encountered, difficulty receiving health care because of language barriers, a preference for |

| Citation | Purpose/ Questions | Subjects /Setting | Methods | Analysis/ Results | Discussion |
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| | | | semi-structured questions in the following domains: 1) Views on health care; 2) Knowledge of cancer; 3) Perceived risk of cancer; 4) Preventing cancer; 5) Barrier to screening: Circumcision; 6) Barrier to screening: Virginity; 7) Facilitators to screening<br><br>Focus groups audio recorded and transcribed | women participants commented that cancer was virtually an unknown diagnosis before they came to the United States.<br><br>Shame and fear of certain death from cancer led women to avoid the doctor.<br><br>While older women emphasized the role of God and fate in disease more than younger women, younger women concurred that religion was a significant barrier to accepting the | seeing providers with the same religious background and for seeing female providers, fear of pain and embarrassment, stigma related to a diagnosis of cancer, and accepting the will of God as the cause of health problems<br><br>Our findings indicated that there is considerable stigma surrounding a cancer diagnosis that leads to secrecy and shame. Both |

| Citation | Purpose/ Questions | Subjects /Setting | Methods | Analysis/ Results | Discussion |
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| | | | | meaning of prevention. | older and younger women expressed concerns about the radiation from mammograms, and the fear that mammograms cause cancer.<br><br>There are cultural misperceptions and attitudes which need to be addressed in developing culturally-appropriate interventions to improve breast and cervical cancer screening uptake for Somali women |

| Citation | Purpose/ Questions | Subjects /Setting | Methods | Analysis/ Results | Discussion |
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| Sheppard, V. B., Hurtado-de-Mendoza, A., Song, M., Hirpa, F., & Nwabukwu, I. (2015). The role of knowledge, language, and insurance in endorsement of cancer screening in women of African origin. *Preventive medicine reports*, *2*, 517-523. | To examine factors that are associated with higher endorsement of screening.<br><br>Focus is breast cancer | Used purposive sampling – via community-based outreach. Women who self-identified as being of African origin (e.g. born in any African country, second-generation immigrants) were eligible.<br><br><u>Sample</u>: 1 The study sample (n = 200) was mostly West African women (e.g. Nigeria 37%, Sierra Leone 22%). | Cross sectional study<br><br>The main independent variables were cancer knowledge and English-language proficiency.<br><br>Endorsement of screening was assessed via self-report.<br><br>Collected information about access, cancer-related beliefs, and prior breast screening behaviors. | Chi-square tests and t-tests were used for bivariate comparisons of screening endorsement across demographic, cancer knowledge levels, attitudes, and access factors.<br><br>Participants more likely to endorse breast cancer screening were insured (vs. uninsured) (odds ratio=3.37; 95% confidence interval: 1.24, 9.17) and married (odds ratio=3.23; 95% confidence interval: 1.14, 9.10)<br><br>The likelihood of endorsing | Researchers found that overall endorsement of cancer screening was high (81%). In turn, endorsement of negative screening attitudes was low (e.g., “I do not want to find out if I have breast cancer”)<br><br>Salient factors associated with higher endorsement of cancer screening were: greater knowledge about breast cancer, English as a primary language, marital status, |

| Citation | Purpose/ Questions | Subjects /Setting | Methods | Analysis/ Results | Discussion |
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| | | Setting: DC Metropolitan area | | screening was higher among participants with English as a primary language (odds ratio = 3.83; 95% confidence interval: 1.24, 11.87) and those with greater breast cancer knowledge (odds ratio= 1.04; 95% confidence interval: 1.01, 1.08, per 1 point increase). Mean cancer knowledge score was under 60%.<br><br>Differences were noted by region of origin with women from Eastern Africa (n=9) having lower endorsement | and insurance. Endorsement of breast cancer screening in turn was associated with having had a mammogram.<br><br>Study results highlight the importance of improving cancer knowledge and reducing barriers related to language and insurance. |

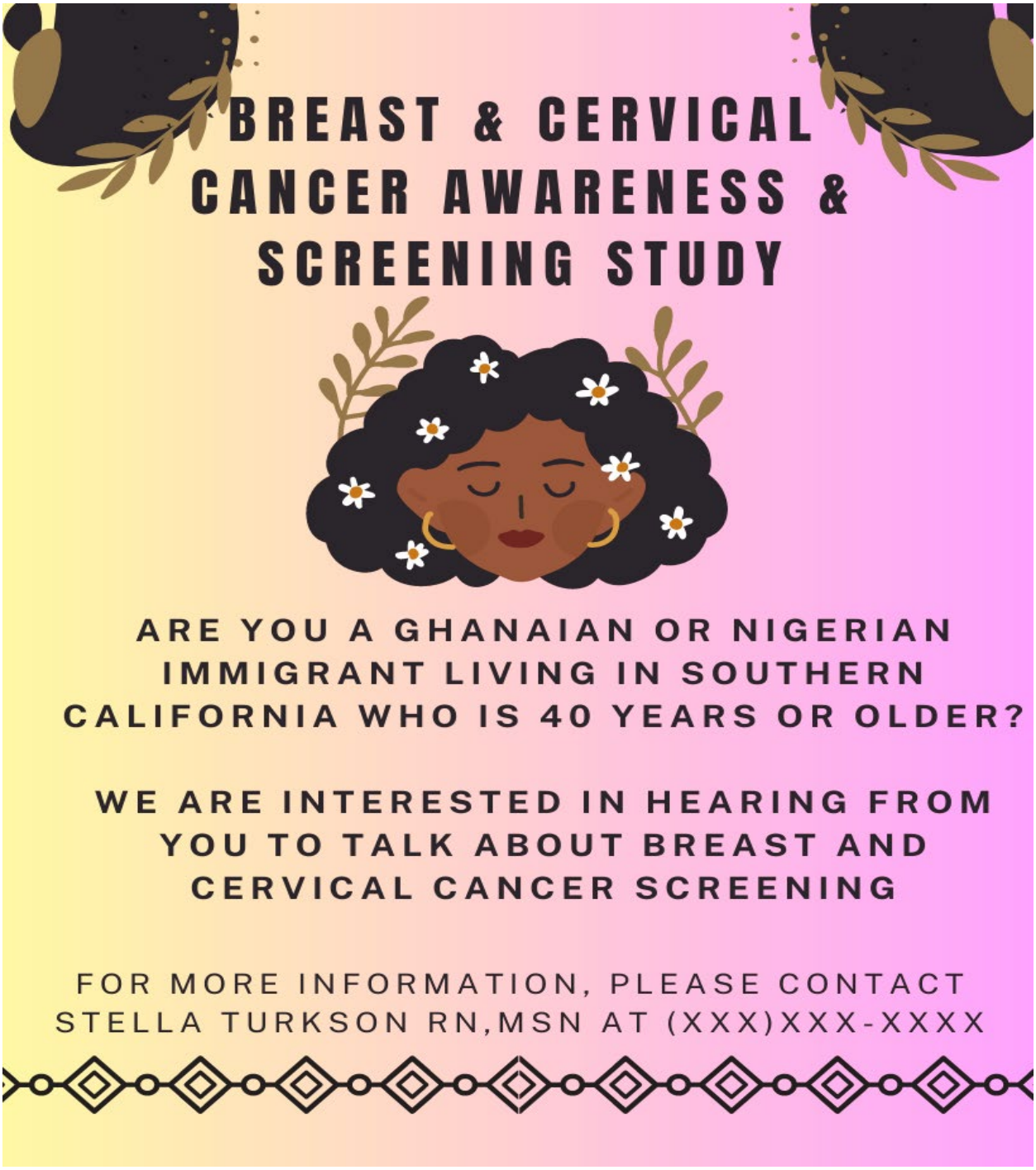
| Citation | Purpose/ Questions | Subjects /Setting | Methods | Analysis/ Results | Discussion |
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| | | | | of screening | |
| Ogunsiji, O.O., Kwok, C. & Fan, L.C. (2017). Breast cancer screening practices of African migrant women in Australia: a descriptive cross-sectional study. *BMC Women's Health,* 17, 32 doi.org/10.1186/s12905-017-0384-0 | The aims of this study were to:<br>- report breast cancer screening status among African migrant women in Australia.<br><br>-investigate the association between demographic factors and their breast cancer screening practices.<br><br>- to investigate the relationship between these women's cultural beliefs and their | Researchers conducted a google search of African community groups, religious organizations and associations in Sydney, Australia<br><br>A convenience sampling technique was used to recruit 264 participants who met the following selection criteria: (1) being a migrant of African descent; (2) being aged | A descriptive, cross-sectional study<br><br>Used a self-administered questionnaire<br><br>women who agreed to participate in the study were then asked to complete the study questionnaire, a task which took approximately 10–15 min.<br><br>The African version of the Breast Cancer Screening Beliefs Questionnair | Demographic and baseline characteristics as well as the breast cancer screening practices of the participants were summarized by descriptive statistics.<br><br>The subscale scores of the African version of Breast Cancer Screening Beliefs Questionnaire (BCSBQ) were computed, and the mean scores between participants who did and those who did not engage in the screening practices were | Informed by African culture with its emphasis on communality and connectedness, African women may prefer to put the needs of extended family members before their own. And when it comes to breast cancer, many may dismiss it as a disease of the white population in order to justify their underutilisation of preventive services. |

| Citation | Purpose/ Questions | Subjects /Setting | Methods | Analysis/ Results | Discussion |
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| | breast cancer screening practices. | 18 years and over (3) being resident in Sydney, Australia and (4) having no history of breast cancer.<br><br>**The study was conducted in Sydney, Australia** | e (BCSBQ) was used for data collection<br><br>Demographic information including age, length of stay in Australia, English-language proficiency and education level was also collected. The women were further asked if they had ever heard of BSE and mammography and if so, how frequently they practiced any | compared by t-tests.<br><br>Age range= 18-69<br><br>Most participants (76.1%) had heard of breast awareness and mammography (85.2%)<br><br>65.9% within the target age group( between 50 and 74 years) had had a mammogram at the recommended bi-annual frequency.<br><br>For monthly breast awareness, based on all participants who ever heard of it, women who came from South | Low participation in breast health services may be explained by the high knowledge deficit about breast awareness common among African women and their negative attitudes towards discussions about and the touching of reproductive organs<br><br>The failure of the women to perform breast awareness exercises, particularly mammography , may be attributable to |

| Citation | Purpose/ Questions | Subjects /Setting | Methods | Analysis/ Results | Discussion |
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| | | | or all of these. | Africa (OR = 3.25, 95% CI = 1.01 to 10.41, *p*-value = 0.031) were significantly more likely to pay attention to their breast than those from West Africa, while those who came from North Africa were least likely (OR = 0.67, 95% CI = 0.14 to 3.19, *p*-value = 0.151 | fears of the unknown in terms of finding cancerous lumps.<br><br>Findings imply that a program to raise breast cancer screening among African women cannot assume that they are a homogeneous group.<br><br>Findings indicated that unemployed or retired women were significantly less likely to participate in mammography when compared to employed women. |

| Citation | Purpose/ Questions | Subjects /Setting | Methods | Analysis/ Results | Discussion |
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| | | | | | The study indicates that among African migrants the concept of participating in cancer screening measures when according to a woman's own assessment, she is asymptomatic and otherwise healthy, is foreign or irrelevant.<br><br>Limitation: convenience sampling |

Appendix B: Recruitment Flyer



Appendix C: Screening Consent Script

**UNIVERSITY OF CALIFORNIA, LOS ANGELES**
**SCREENING CONSENT SCRIPT**

Thank you for your interest in participating in this study. My name is Stella Turkson and I am conducting a study on utilization of breast and cervical cancer screening services in the United States among African Immigrant women. I would like to ask you a few questions to determine whether you may be eligible for the research. Before I begin the screening, I would like to tell you a little bit about the research. My research is exploring reasons that African immigrant women choose to seek preventive care for breast and cervical cancer. During this investigation, I hope to gain expanded knowledge and deeper understandings of African-born women's experiences and perceptions of the U.S healthcare system and how these experiences and perceptions influence their health screening behaviors.

Would you like to continue with the screening? The screening will take about 5 minutes. I will ask you about what you know about breast and cervical cancer and as well as your knowledge and perception of how to screen for these cancers. I will also be asking about your experience with using preventive service for these cancers here in the U.S. You do not have to answer any questions you do not wish to answer or are uncomfortable answering, and you may stop at any time. Your participation in the screening is voluntary.

Your answers will be confidential. No one will know your answers except for the research team. If the you do not qualify for this study, your answers will be destroyed, or kept without your name. On the other hand, if you qualify for the research, decides to participate, and provide me informed consent, your answers be kept confidential with the research record.

Would you like to continue with the screening?

*If no:* Thank you so much for your time and speaking with me about the study. Have a great day

*If yes:* Great, I will now continue with the screening questions. Please answer the following questions to the best of your ability:

1. What is your race/ethnicity?
2. Do you identify as African?
3. Which country in Africa are you from?
4. How old are you?
5. Do you identify as female?
6. Are you able to read and speak English fluently?

Thank you for answering the screening questions.

*If ineligible:* Based on your responses to the questions you do not meet the criteria to continue with the study (I will explain why). Thank you so much for your time; it was a pleasure speaking to you.

*If eligible*: Based on your responses, you are eligible to participate in the study. Do you have any questions about the screening or the research?

Do you have any questions about the screening or the research?
I will follow up by sending you a Study Information Form which could be emailed, texted, or sent via postal mail to you if you are found as an eligible participant who remains interested in participating.

If you are interested now, I would like to set up a day and time that works best for you for an interview. Would you like to continue? Ok, which date works best for you and do you prefer to interview in person or via zoom? If zoom, I will send you a zoom link for the interview after our phone call. The interview will take about 45 to 60 minutes and will be recorded. About 2 days before our scheduled interview, I will give you a reminder call regarding the plans.

I am going to give you a telephone number to call if you have any questions later. Do you have a pen? If you have questions about the research screening, you may call me at (xxx)-xxx-xxxx and I will answer your questions.

If you have questions about your rights as a research subject or if you wish to voice any problems or concerns you may have about the study to someone other than the researchers, please call the UCLA Office of the Human Research Protection Program at (310) 825-7122.

Thank you so much again for your willingness to answer our questions.

Appendix D: Research Information Sheet

University of California, Los Angeles

**RESEARCH INFORMATION SHEET**

**Utilization of Breast and Cervical Cancer Screening Services: Understanding Factors Influencing Ghanaian and Nigerian Immigrant Women's Decision to Seek Preventive Health Services**

## INTRODUCTION

**Stella Turkson, MSN, RN and Professor Carol Pavlish, PhD, RN, FAAN from the School of Nursing** at the University of California, Los Angeles are conducting a research study. You were selected as a possible participant in this study because you are a Nigerian or Ghanaian immigrant woman living in the U.S. Your participation in this research study is voluntary.

## WHAT SHOULD I KNOW ABOUT A RESEARCH STUDY?

- Someone will explain this research study to you.
- Whether or not you take part is up to you.
- You can choose not to take part.
- You can agree to take part and later change your mind.
- Your decision will not be held against you.
- You can ask all the questions you want before you decide.

## WHY IS THIS RESEARCH BEING DONE?

The purpose of this proposed study is to gain a deeper understanding of the health beliefs about disease prevention and the concept of health screening as it relates to utilization of breast and cervical cancer screening among West-African immigrant women, specifically from Ghana and Nigeria who are 40 years of age and older living in Southern California.

## HOW LONG WILL THE RESEARCH LAST AND WHAT WILL I NEED TO DO?

Participation will take a total of about 45-60 minutes. You may be asked to volunteer for a follow up interview if necessary.

If you volunteer to participate in this study, I will ask you to do the following:

- After you have an opportunity to read this Study Information Form, you will receive a follow-up call from Stella Turkson who is the primary researcher for this study. During the phone call, I will ask if you have any additional questions about the study. If you are interested in volunteering to participate in the study, I will also schedule a potential time and day for an interview based on your availability.

- Prior to interviewing eligible participants for this proposed study, I will obtain verbal informed consent before initiating any data collection.
- I will conduct all interviews either in person or via a video conference application called Zoom, depending on your preference.
- I will use a semi-structured interview guide (SSIG) for all interviews for this study. This SSIG includes open ended questions and related follow up questions targeted at exploring the research problem in depth.
- If after the interview, I have a few more questions, I may contact you to ask your permission for a brief follow up interview.

**ARE THERE ANY RISKS IF I PARTICIPATE?**

- You may experience discomfort as some questions on breast and cervical cancer prevention, personal health beliefs, perceptions, and culture could possibly evoke some emotions such as embarrassment. You are not required to answer any questions that may make you feel uncomfortable or evoke any undesired feelings.

**ARE THERE ANY BENEFITS IF I PARTICIPATE?**

You may not directly benefit from this study, however your input will be beneficial in gaining a deeper understanding of women's experiences with breast and cervical cancer screening in the U.S.

The results of the research may provide suggestions for breast and cervical cancer prevention strategies for other Ghanaian and Nigerian immigrants living in the U.S.

**What other choices do I have if I choose not to participate?**

Your alternative to participating in this research study is to not participate.

**HOW WILL INFORMATION ABOUT ME AND MY PARTICIPATION BE KEPT CONFIDENTIAL?**

The researchers will do their best to make sure that your private information is kept confidential. Information about you will be handled as confidentially as possible, but participating in research may involve a loss of privacy and the potential for a breach in confidentiality. Study data will be physically and electronically secured. As with any use of electronic means to store data, there is a risk of breach of data security.

**Use of personal information that can identify you:**
Data will be managed cautiously and will not be disclosed to anyone outside of my dissertation committee members. While reviewing the data, I will de-identify all participants by providing pseudonyms for each of them.

**How information about you will be stored:**
The interviews will be transcribed and will be stored as encrypted files on my password protected laptop. Once I compare the audio recordings to the transcribed document for

accuracy, I will store the transcribed interviews and the digital version of the interview in a secure application at UCLA called UCLA BOX.

**People and agencies that will have access to your information:**
The de-identified transcribed documents will only be shared with my committee members for purposes of analyzing the data.

The research team, and authorized UCLA personnel, have access to study data and records to monitor the study. However, University employees are bound by strict rules of confidentiality. Research records provided to authorized, non-UCLA personnel will not contain identifiable information about you. Publications and/or presentations that result from this study will not identify you by name.

**How long information from the study will be kept:**

All de-identifed data from this study will be kept in a secure electronic BOX file at UCLA for 3 years.

**USE OF DATA FOR FUTURE RESEARCH**

Your de-identified data with pseudonyms only may be kept for use in future research.

**WILL I BE PAID FOR MY PARTICIPATION?**

You will not be paid for your participation in this research study. Your participation will be on voluntary basis

**WHO CAN I CONTACT IF I HAVE QUESTIONS ABOUT THIS STUDY?**

**The research team:**
If you have any questions, comments or concerns about the research, you can talk to one of the researchers. Please contact: *Stella Turkson via email at stellaturkson@ucla.edu*

**UCLA Office of the Human Research Protection Program (OHRPP):**

If you have questions about your rights as a research subject, or you have concerns or suggestions and you want to talk to someone other than the researchers, you may contact the UCLA OHRPP by phone: (310) 206-2040; by email: participants@research.ucla.edu or by mail: Box 951406, Los Angeles, CA 90095-1406.

**WHAT ARE MY RIGHTS IF I TAKE PART IN THIS STUDY?**

- You can choose whether or not you want to participate in this study, and you may withdraw your consent and discontinue participation at any time.
- Whatever decision you make, there will be no penalty to you, and no loss of benefits to which you were otherwise entitled.

- You may refuse to answer any questions that you do not want to answer and still remain in the study.

***You will be given a copy of this information to keep for your records.***

Appendix E: Oral Consent Script

## ORAL CONSENT SCRIPT

Hello, my name is Stella Turkson and I am a graduate student in the School of Nursing at the University of California, Los Angeles. I would like to invite you to participate in a research study about your beliefs and experiences with the use of Breast and Cervical Cancer Screening Services among Ghanaian and Nigerian women.

I am conducting this study as part of my graduate studies at UCLA School of Nursing. The purpose of the proposed study is to gain a deeper understanding of the health beliefs about disease prevention and the concept of health screening as it relates to utilization of breast and cervical cancer screening among West-African immigrant women, specifically from Ghana and Nigeria who are 40 years of age and older living in Southern California.

If you agree to participate you will be asked to participate in interviews either in person or via a video conference application called Zoom, depending on your preference. During this interview, you will be asked open ended questions and related follow up questions targeted at exploring the research problem in depth. I also ask your permission to audio-record the interview so I do not have to take extensive notes during the interview and can really listen to your responses. If after the interview and if I have a few more clarifying questions, I may contact you to ask your permission for a brief follow up interview. I will do my best to make sure that your private information is kept confidential. Your name and contact number will never be shared with anyone. Information that you share during the interview will be handled as confidentially as possible. Study data will be physically and electronically secured. The information you share with me will be combined with all interview data from 15-20 other research participants and will not be attributed to you personally. Interview transcripts from all participants will be managed cautiously and will not be disclosed to anyone outside of my dissertation committee members. I may use final data findings in academic presentations and this information could be used in articles to be submitted for publication.

Your participation should take about 60 minutes. Please understand that your participation in this study is voluntary and you have the right to discontinue at any time. If for any reason, you would prefer not to answer any question, please feel free to ask me to skip that question.

If you have any questions, you can ask me now or send me an email at stellaturkson@ucla.edu . If you have questions about your rights as a research subject, or you have concerns or suggestions and you want to talk to someone other than the researchers, you may contact the UCLA OHRPP by phone: (310) 206-2040; by email: participants@research.ucla.edu or by mail: Box 951406, Los Angeles, CA 90095-1406.

Appendix F:

**Semi Structured Interview Guide (SSIG)**

**Interview Questions**

**WARM-UP Questions:**

1. Can you tell me a bit about yourself – for example, where you were born, when you moved to the U.S. and settled in this area?

Follow- up: Could you tell me more about some of your reasons for moving from your home country to the U.S?

Follow-up: How has this move been for you and your family?

**TRANSITION Questions:**

2. How would you describe your overall health?

Follow-up: How might you compare the overall health experience in your home country versus United States?

**KEY Questions about Breast Cancer:**

3. Some women may or may not have heard about breast cancer. What comes to mind when you hear about breast cancer in the U.S.? or Can you tell me what you know about breast cancer?

Follow-up: Tell me your experience with breast cancer prevention.

Follow-up: What have you heard or know about screening services for breast cancer such as mammography?

If participant says she has or has never had a mammogram,
Follow up: Can you please describe to me what would be some of your reasons why you would or would not be interested in getting screened for breast cancer?

If participant says she has had a mammogram
Follow up: What has your experience been with mammography?

**KEY Questions about Cervical Cancer:**

4. Can you please tell me anything you know or believe about cervical cancer?

Follow up: Could you describe to me how you have been made aware of screening services that can help you find out if you are at risk or have cervical cancer?

Follow up: Can you tell me if you have had any experience with getting a pap smear or heard any stories about it?

Follow up: In more detail, what do you think about the screening?
Follow up: If you did get screened, what impacted your decision in getting screened? OR: Can you please describe to me what would be some of your reasons why you would or would not be interested in getting screened for cervical cancer?

**KEY Questions about cultural influences on cancer screening:**

5. As an African woman, what are some things you think might make it difficult for you to visit the doctor for screening?

Follow-up: Can you please describe to me some of these reasons (either cultural, personal or immigration) that affects your decision in getting screened?

Follow-up: In your opinion, what are some things you would consider to be positive or negative about getting screened for breast and cervical cancer?

**OR** this set of questions:

Since breast and cervical cancer screening is a form of preventative health, basically a way of avoiding getting the cancer, how might you describe an African woman's interest in using such services?

Follow-up: Can you please tell if you have had any experience with going to visit the doctor for services that might help you prevent a disease?

Follow-up: Perhaps, is there any other thing you would like to discuss that we were not able to earlier?

**KEY Questions about age and cancer screening**

6. For women your age and above, how do you think age might affect your decision to get screened for cervical cancer?

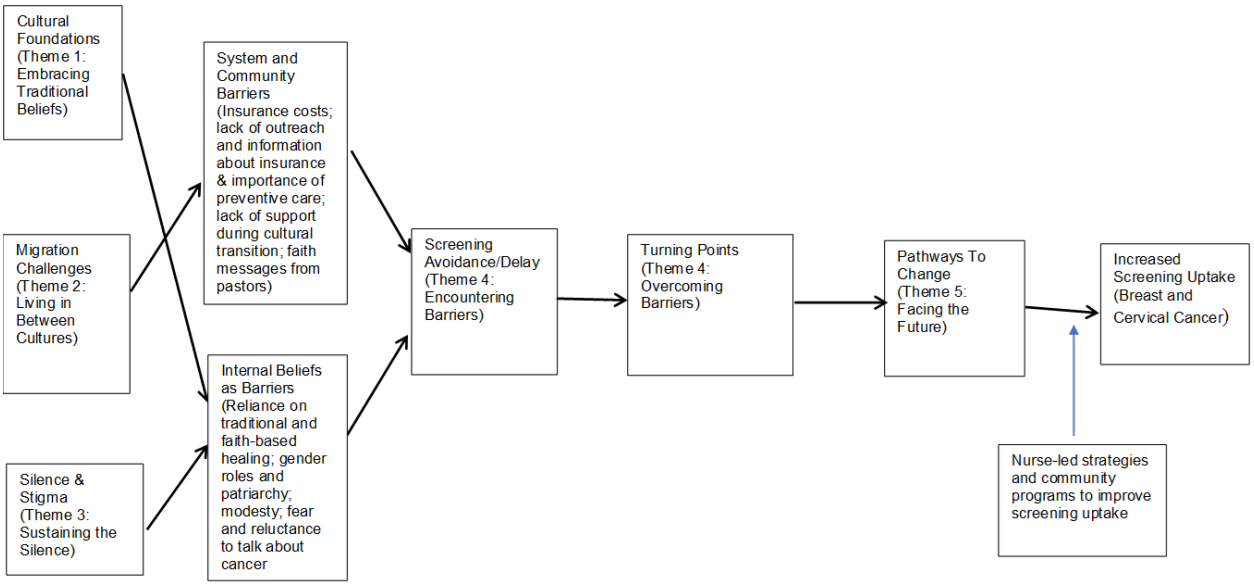
Follow-up: Looking specifically at women who are your age and above, what do you think might be some reasons why it could be hard to participate in screening?

Follow-up: How do you think we can get women your age and above who have not had a mammogram or pap smear to go and get one?

**Summarizing Questions**

7. What do you think is the most important aspect about breast and cervical cancer screening that we have discussed today?
8. Is there any other thing you would like to discuss that we were not able to discuss earlier in the interview?

Appendix G Theoretical explanation of thematic analysis



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