Latin American Women's Intentions and Decision-Making Processes About Cervical Cancer Screening: A Grounded Theory Research

By

Cecilia Assuncao Moreira

Bachelor of Science in Physical Therapy, Federal University of Minas Gerais, 2017

Master in Biological Sciences, Federal University of Minas Gerais, 2020

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Supervisor: David Busolo, PhD, Nursing

Examining Board: Petrea Taylor, PhD, Nursing
Tracey Rickards, PhD, Nursing

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Abstract

Cervical cancer screening rates are low among Latin American immigrants due to various barriers. However, little is known about what motivates these women to attend screenings. Understanding their decision-making processes is essential for increasing screening uptake. Therefore, the purpose of this grounded theory study was to examine the decision-making processes that Latin American women use about cervical cancer screening. Fifteen women were interviewed individually, with data collection and analysis occurring concurrently. Interview transcripts were analyzed using a comparative approach. The final product of this research was the theory of *Latin American women's search for health services: A model of distancing from cervical cancer screening.* The findings highlight the decision-making processes that influence screening participation and provide valuable insights into engaging these women. These results can help health professionals improve screening uptake and offer more equitable services to Latin American immigrants in New Brunswick and other regions.

Dedication

I dedicate this thesis to my parents, Patricia and Ramon, who are my source of inspiration, resilience, and guidance. I also dedicate it to my siblings Izabel and Rafael who are always cheering and contributing to my success. Lastly, I dedicate it to my partner Aidan, for being by my side during this journey. Without their love and support I would not have made it this far.

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Chapter 1: Introduction

Cancer is a group of heterogeneous diseases, whose main characteristic is the abnormal and disordered growth and multiplication of cells (Canadian Cancer Society, 2021). Cancer is the leading cause of death in the Canadian population, followed by cardiovascular diseases - heart disease, and stroke (Statistics Canada, 2021). Statistics have shown that 50% of Canadians will have cancer at some point in their lifetime and one in four will possibly die from the disease (Canadian Cancer Statistics, 2019). In 2024, it is estimated that there will be 247,100 new cancer cases and 88,100 cancer deaths in Canada, not including non-melanoma skin cancers (Canadian Cancer Society, 2024). One of the populations that are likely to experience cancer, particularly cervical cancer, in the future is Latin American immigrants. Research in Canada has shown that immigrants have a lower rate of cervical cancer screening than Canadian-born women (Bacal et al, 2019).

Cervical cancer is a type of cancer that grows in the cervix of the uterus and is mostly caused by human papillomavirus (HPV) infection. The infection is commonly spread by sexual contact and the disease has a slow course of development (Nour, 2009). Cervical cancer is the fourth most common malignancy diagnosed in women in Canada and, according to the Canadian Cancer Society, in 2024, 1,600 Canadian women will be diagnosed with the disease, and 400 will die from the same (Canadian Cancer Society, 2024). Women over 25 years of age are at a greater risk for cervical cancer than younger ones and the peak incidence occurs at the age of 50. In the past 50 years, cervical cancer incidence and mortality have decreased considerably in Canada, and the rates for long-

term survival after treatment are high (Canadian Task Force on Preventive Healthcare, 2013).

In 1984, the lifetime incidence, age-standardized incidence rate (ASIR), was 13 per 100,000 compared to 7.1 per 100,000 persons in 2020. Regarding mortality, the age-standardized mortality rate (ASMR) for cervical cancer was 2.0 per 100,000 persons in 2019 (Caird et al., 2022). Age-standardized 5-year net survival has improved between 1992-1994 and 2012-2014 in Canada (2, 4%). The probability of cervical cancer survival in Canada is higher in comparison to other countries, such as The United States and The United Kingdom, and its 5-year net survival is 72% (Caird et al., 2022).

The decrease in cervical cancer incidence and mortality rates has been associated with successful provincial cervical cancer screening programs, available in most provinces (Canadian Partnership Against Cancer (CPAC), 2019). Despite the observed decrease in incidence and mortality rates, the downward trend has slowed, and cervical cancer remains a common disease among Canadian women particularly those from minority populations (such as immigrants and Indigenous groups) (Caird et al., 2022). In large part, the fact that cervical cancer is still prevalent is related to inequities in the social determinants of health: socioeconomic status, education, accessibility to health services, and racial and ethnic differences, factors that directly affect cancer screening rates (King & Busolo, 2022).

Regardless of the existence of organized provincial services in most provinces of Canada, some groups of the population still have suboptimal screening rates, such as people with low income and low education, newcomers, immigrants, and the Indigenous population (Caird et al., 2022). These organized provincial services provide cervical

cancer screening to women who are asymptomatic and at-average risk for cervical cancer. The provinces and territories that do not have organized cervical cancer screening programs include Northwest Territories, Nunavut, Yukon, and Quebec (CPAC, 2019).

Cervical cancer is considered one of the most preventable cancers. Prevention is done through both vaccination against HPV, and screening for precursor lesions (Bouvard et al., 2021). HPV vaccines employ a recombinant technology, and since they do not contain live biological products or viral DNA, they are not infectious. The World Health Organization (WHO) recommends that vaccines should be part of national immunization programs and should be given to girls between 9 and 14 years old. Vaccination of secondary targets, such as boys, is also recommended when feasible and affordable (WHO, 2022). The vaccines are recommended for prophylactic use only (Nour, 2009; WHO, 2022). HPV immunization programs are available for both school-aged girls and boys, in all provinces in Canada, since 2017, and vaccination is done on a 2 or 3-dose schedule (CPAC, 2019). The provincial/territorial HPV immunization rates in Canada range from 57.1 to 91.3% for girls and 57.5 to 91.3% for boys (CPAC, 2021). The availability of HPV vaccination, for over a decade, contributes to making cervical cancer one of the most preventable types of the disease (Caird et al., 2022).

Cervical cancer in the initial stages can be detected through screening before it can cause any symptoms, and it is estimated that early detection could increase the chances of survival by more than 85 percent (BC Cancer, 2022). Screening for precursor lesions is done through a Pap test, which can identify abnormal cells in the cervix of the uterus before they develop into cancer (Canadian Cancer Society, 2022). In 2017, 74.0% of women aged 25 to 69 had a Pap test in the past three years in Canada. Women aged 25

to 34 (79.2%) and 35 to 49 (79.4%) were more likely to have received a Pap test in the past three years compared with women aged 50 to 69 (67.3%; Statistics Canada, 2017). The rates for participation in Pap tests among women aged 21 to 69 has increased in New Brunswick, from 2012 to 2017. The age-standardized participation rate ranged from 63.5% to 65.1%. Despite the increase in participation, this percentage is still below the Canadian target for participation in cervical cancer screening programs by these women, which is expected to be ≥ 80% (Government of New Brunswick, 2019). If treatment of the abnormal cells is implemented early, the development of cervical cancer can be avoided (BC Cancer, 2022). If undetected, cervical cancer can develop and, in its advanced stage, may demand treatment, leading to many impairments in a woman's functionality (their capability to perform daily activities), and quality of life (Bjelic-Radisic et. al, 2012).

Despite the effectiveness of cervical cancer screening in reducing mortality, the rates of screening for women from ethnic minorities in Canada, remain suboptimal (Hulme et al., 2016). In a research study by Bacal and colleagues (2019), the team demonstrates that immigrants are less likely to undergo cervical cancer screening (with a 32% increased risk for under screening). In fact, the results of the prevalence of under screening estimation among Canadian-born and immigrant women revealed a 10% higher rate for under screening among immigrants in Canada. Therefore, as cervical cancer continues to affect women in Canada, and disparities in screening rates persist, it is critical to examine the factors that affect cervical cancer screening for different ethno-cultural groups.

Latin American immigrants represent a portion of the Canadian population that has low participation rates in routine cervical cancer screening (Datta et al., 2018). Latinos immigrate to Canada in many ways, and the nature of immigration is continually changing. Immigration waves reflect specific international historical periods as well as changes in Canadian immigration policies (Mata, 2021). The Latin Americans in Canada usually immigrate from Mexico and Colombia, followed by Brazil, Venezuela, and Cuba, and most of them settle in Quebec. In 2012, 11,322 individuals from Central and South America settled in Quebec compared to 9,762 in Ontario (Armony, 2014). Considering their status of immigration, statistics show that 46% of them arrived in 2012 as economic immigrants, 26.7% under the category of family class, and 17% as refugees. Among ethnic minority groups, it has been shown that Latin American immigrants have the lowest average income, compared to Arab, Chinese, and South Asian individuals (Armony, 2014). Low income, lack of medical insurance, and medical costs pose barriers to screening, especially in the United States, where insurance health-based systems are predominant. Adherence to cervical cancer screening is also impacted by a low level of education and lack of knowledge about cervical cancer. The belief that a Pap test is painful or only required in the presence of symptoms or infection are some of the factors that deter women from seeking screening (Flores & Bencomo, 2009).

Research on immigrants' decision-making regarding cervical cancer screening is growing. However, there is a gap in the Canadian literature on how Latin American immigrant women make decisions about cervical cancer screening. Few studies have examined this phenomenon. In one of the studies, Datta and colleagues (2018) in Montreal indicated that the two most common reasons for immigrants (which included

South America, Central America, and Caribbean women) not being screened were not "knowing it was necessary" and not "getting around to it." In the study, among women who had never had cervical cancer screening, nearly 50% stated that they were unaware that screening is necessary. This information offers insight to healthcare providers to work on improvements by increasing women's understanding of routine cancer screening practices (Datta et al., 2018).

Despite the findings, the study by Datta and colleagues (2018) was limited to participants in Montreal and relied on quantitative methods to examine cervical cancer screening factors. The study focuses on the Canadian Community Health Survey and the findings represented women in general. The study did not delve into participants' perspectives, especially Latin American immigrants. Furthermore, no attention was given to how women decide to take part in cancer screening or not. An examination of participants' experiences that allows them to share their perspectives is critically needed.

The lack of published studies on immigrants' decision-making regarding cervical cancer screening in New Brunswick is an important gap since healthcare services are planned and managed at provincial and regional levels. Getting a better understanding of the decisions Latin American immigrants make and the processes involved in the decision-making regarding cervical cancer screening is important. The knowledge will create opportunities for healthcare providers to assist these women in making informed decisions about cervical cancer screening. In addition, the findings will add evidence to the existing literature and support research in this area as well as guide policy interventions.

The Significance of the Study

Canada is a recognized land of immigration, with an estimation of more than 17 million immigrants arriving in Canada since Confederation in 1867 (Statistics Canada, 2016). Latin immigration to Canada has increased in the last decades and includes diverse individuals from different nations, cultures, traditions, languages, and geographic areas. The extraordinary growth of Latinos in Canada occurred mainly between the years 1965-2015, represented by all categories of immigration classes, such as independent immigrants, family members, and refugees (Mata, 2021). The number of immigrants of Latin American or Spanish ethnic origins approached one million people (976,300), according to the 2016 Census, and immigration data revealed the strong presence of women in this ethnic immigrant inflow (Mata, 2021).

Evidence in the literature has shown significant obstacles for Latin American/ Hispanic women in cancer screening, which can delay cancer diagnosis and negatively affect treatment (Bacal et al. 2019, Mann et al., 2015, Vahabi et al., 2016). Therefore, as the number of non-Canadian permanent residents including those of Latin American/Hispanic origin continues to increase over the years, healthcare professionals will benefit from being aware of the barriers this population faces in everyday life, and approach assuming a standpoint of cultural humility (Flores & Bencomo, 2009; Foronda et al., 2016). Furthermore, they will develop a better understanding of how Latin American women make decisions around cancer screening and find ways to support their decision-making processes.

Although few studies address the reasons for not attending cervical cancer screening, from the perspective of the women, through a qualitative approach, there is a

lack of knowledge about how Latin American women make decisions to undergo/not undergo screening in New Brunswick (Armstrong, 2007). Exploring decision-making around cervical cancer screening is important since it can reveal barriers faced by Latin American women in accessing screening. This understanding can help develop more culturally sensitive programs that will contribute to increasing screening rates and improving the quality of life for this minority population living in Canada. This study will also contribute to building evidence to support research in this area, primary care, and policy interventions. Once we have a better understanding of what affects decision-making on cancer screening, more studies can be conducted to investigate the acceptability and feasibility of interventions and the barriers that affect it.

Research Statement and Questions

The purpose of the proposed grounded theory study was to understand the decisions and decision-making practices of Latin American immigrant women regarding cervical cancer screening in New Brunswick. To achieve the overall goal of gaining a deeper understanding of how Latin American women make decisions about cervical cancer screening, the following research questions guided this study:

1. What are the Latin American women's intentions regarding cervical cancer screening?
2. How do Latin American women make decisions about seeking cervical cancer screening?
3. What factors affect the decisions Latin Americans make regarding cervical cancer screening?

Researcher's Perspective

As a physiotherapist who has worked in the field of oncology and women's health for the past few years, I have the experience of dealing with patients of different ages and backgrounds. A recurring scenario observed in this fieldwork is that many women – regardless of their age – delay seeking cancer screening or healthcare services until cancer has already progressed, in many cases in advanced stages. I have always been intrigued to understand the reasons that lead to this behavior since an extensive body of literature is available on the importance of cancer screening and early detection.

From my perspective, as a Latin American immigrant woman living in Canada, I recognize many factors, such as language and cultural differences, which can affect health behaviors and the request for healthcare services. Moreover, I believe that differences in the healthcare systems could also be an issue, as it can be challenging to know where to be screened and where to get information about cancer screening.

Taking into consideration that Latin American women are heterogeneous in how they understand and engage in preventative cancer behaviors, I acknowledge the existence of multiple realities, and I expect to come across different worldviews as categories unfold in my research findings. The knowledge is to be generated through the interactions between myself (the researcher) and the participants, during the interviews.

Lastly, I believe that my personal beliefs about cancer screening and positive health behaviors could influence and shape the narrative of my research, and I will make a significant effort to be aware of it, to avoid bias in the reporting of the findings. Therefore, as an immigrant and an applied health services researcher, I aim to understand

the perspectives and decision-making practices of Latin American women on cervical cancer screening in New Brunswick.

Definition of key Terms

Cervical Cancer Screening

Cervical cancer screening is done through a test called the Papanicolaou (Pap) test. The Pap test was introduced in Canada in 1949 and has a significant role in decreasing cervical cancer mortality rates since the test can detect early cervical epithelial changes (Public Health Agency of Canada, 2009; Sachan, 2018). In Canada, cervical cancer screening has been carried out based on the initiative by the woman herself or by a health professional, which can make access to screening difficult (Public Health Agency of Canada, 2009).

Immigrants

As defined by the Government of Canada, an immigrant refers to a **"**person who is, or who has ever been, a landed immigrant or permanent resident….granted the right to live in Canada permanently by immigration authorities. Immigrants who have obtained Canadian citizenship by naturalization are included in this group" (Statistics Canada, 2016, para. 1).

Newcomers

Newcomers refer to recent immigrants, who have been in Canada usually for less than five years, before a given census year (Statistics Canada, 2010). Newcomers frequently access immigration services, such as language and settlement assistance, and

have an important contribution to social and economic prosperity in Canada (Newyouth Canada, 2019).

Latin America

Latin America indicates the regions of the Americas where Romance languages, which are derived from Latin, are primarily spoken. The Latin American region comprises 19 countries from North, Central and South America, and the Caribbean. Puerto Rico is not included due to its special status. They are Spanish and Portuguese-speaking country (Mata, 2021).

Social Determinants of Health

The Social Determinants of Health refer to the conditions in which individuals are born, grow, live, work, and age, as well as the healthcare systems that address illness. These conditions are influenced by broader factors such as economic, social, and political forces. (McGibbon, 2021). Social determinants of health comprise factors such as income, education, and employment and significantly affect an individual's health (Government of Canada, 2022).

Chapter Summary

This chapter provides background about cervical cancer, screening, and the need to carry out research on the decisions, and decision-making practices of Latin American women on the topic. Obtaining a better understanding of their decision-making regarding cervical cancer screening will contribute to shaping culturally sensitive programs and services for this minority population, decreasing inequities on social determinants of health, and increasing women's overall quality of life.

Chapter 2: Literature Review

Chapter 2 provides a literature review on cervical cancer prevalence in Canada, as well as an overview of screening practices, especially concerning immigrant women from Latin America. The chapter also describes the existing barriers to cervical cancer screening among this minority population and possible strategies to overcome the obstacles found in the literature review. Gaps in research in this area are presented to highlight the importance of the present study.

Cervical Cancer in Canada

The World Health Organization – WHO (2024) estimates that 660 000 new cases of cervical cancer were diagnosed and that 350 000 women died from the disease globally in 2022. Even though 90% of new cases and deaths worldwide in 2020 occured in low and middle-income countries, cervical cancer remains a public health issue in high-income countries (Read et al., 2020; World Health Organization, 2020). The main risk factor for cervical cancer is persistent infection with one of the HPV types. Nevertheless, studies have shown that a lack of knowledge about the relationship between HPV infection and cervical cancer, and about cervical cancer origin is prevalent among Latin American women, ultimately influencing decision-making about undergoing screening (Madhivanan et al., 2016).

Over the years, the Government of Canada has invested millions of dollars in research to eliminate cervical cancer (Government of Canada, 2019). However, this goal will only be achieved if effective screening methods are accessed by targeted populations as intended. Success in addressing and meeting screening targets can be made possible by

considering the decisions that the targeted populations make around cervical cancer screening.

The challenges of accessing cancer screening and healthcare programs for immigrants in Canada have been investigated (Hulme et al., 2016; Vahabi et al., 2016; Vahabi & Lofters, 2016). However, there is a lack of research exploring the decisions and decision-making practices around cervical cancer screening among specific minorities, such as Latin American women. Acknowledging the factors that affect their decisions of undergoing cervical cancer screening is fundamental since each population has unique cultural values and beliefs. Moreover, research in this field will significantly contribute to the development of culturally sensitive services and the design of appropriate programs for this target population. As a result, these efforts will decrease the delay in cancer diagnosis and increase women's quality of life (Amankwah et al., 2009).

Cervical Cancer Screening in New Brunswick

Organized cervical cancer screening programs are available in most Canadian provinces, including New Brunswick (NB). The provincial Cervical Cancer Prevention and Screening Program (CCPSP) started in 2014 and is administrated by the New Brunswick Cancer Network (NB Department of Health) in partnership with regional health authorities and healthcare providers (CPAC, 2019). The main purpose of the program is to improve the prevention, early detection, and screening of the disease by the adoption of an organized provincial approach. Women living in the province are monitored by the program concerning their screening through Pap and HPV testing (Government of New Brunswick, n.d.).

The program can be accessed by NB women between the ages of 21 to 69 years old who have ever been sexually active with a partner of either gender. Women can undertake to screen for cervical cancer using Pap tests even after menopause or after being vaccinated against HPV (Government of New Brunswick, n.d.). Women must get in contact with their primary healthcare provider to discuss cervical cancer screening; however, invitation letters are part of the screening recruitment strategies for women who have never been screened (CPAC, 2019, Government of New Brunswick, n.d.). To ensure that New Brunswick women are included in the provincially organized screening program, the program accesses cervical screening information available at the CCSPR and the Department of Health. The information includes personal health information and screening data (colposcopy and cancer diagnosis, if applicable) that enables invitation letters to be sent to eligible women (Government of New Brunswick, n.d.).

The program sends invitation letters to eligible women (>21 years of age or relocated to NB) or any women between 21-69 years of age who have no record of a Pap test since 2011 or of a total hysterectomy since 2002 in NB (Government of New Brunswick, n.d.). Women who have been screened in the past but are belated for routine cervical screening also receive recall letters. Furthermore, when there is an abnormal Pap test result and follow-up is delayed, reminder letters are sent to the healthcare provider. If follow-up has not occurred after six months, a second reminder letter is sent to the program participant, with a copy to the healthcare provider. A reminder letter to the program participant and a copy to the associated healthcare professional if follow-up has not yet taken place is also sent six months after (Government of New Brunswick, n.d.). Although the strategy of sending letters to eligible women is a relevant intervention to

increase screening rates, strategies that address women's intentions and decision-making practices should be implemented as they play a fundamental role in the healthcare context to create more culturally sensitive programs and increase adherence to cervical cancer screening.

Latin American Immigrants and Cancer Screening Decision-Making

In the last decade, 10.4% of all immigrants admitted to Canada as permanent residents were individuals from Latin America – South and Central America (Armony, 2014). Evidence in the literature has shown that there are significant obstacles for these women in cancer screening, including not only structural but also personal factors, which directly affect their decision-making practices on screening (Chen et al., 2018; Madhivanan et al., 2016).

Decision-making is defined as "the process of making choices by identifying a decision, gathering information, and assessing alternative solutions" (University of Massachusetts, 2022, p.1). In healthcare, while some choices are easy to make, some are more difficult due to their preference-sensitive manner. In the case of the latter, people consider choices by weighing the benefits and harms between options, such as cancer screening options, including the option of not making any choice (Stacey et al., 2008). The process of decision-making can be influenced by decisional conflicts, which occur when a person is uncertain about choices, which involve factors such as risk, loss, or challenges to personal life values (Stacey et al., 2008).

A study by Madhivanan et al. (2016) in the United States explored the barriers and facilitators for decision-making to undergo cervical cancer screening among this population. The main factor that positively influenced their decision-making about

cervical cancer screening was family support. Family members were considered facilitators by most since they play a key role in providing healthcare advice; the advice of female relatives had greater weight for Latina women than that of males (Madhivanan et al., 2016).

Among the negative factors that affect decision-making, women listed fear, fear of stigmatization, prioritizing family over their own health, and the discomfort of being examined by a male doctor. Women's fear of being screened reveals itself in many ways. While some expressed fear of hysterectomy or removal of the uterus, since close family members experienced hysterectomies due to cervical cancer, which was only found through screening, others report fear of being stigmatized as promiscuous (Madhivanan et al., 2016).

Despite some women listing family as facilitators, the family could also serve as a barrier to healthcare. Prioritizing family needs over their own health was mentioned by women in three out of the six focus groups in the study by Madhivanan et al. (2016). Some Latinas prioritize their daughters' health over their own, taking care of their daughters first before focusing on themselves. This mindset could affect their decision-making to undergo cervical cancer screening and delay the diagnosis of cancer.

Lastly, as mentioned in other studies, the gender of the physician performing the screening test can also negatively affect women's decision-making about whether to be screened. In Latin, as well as Asian cultures, some women do not feel comfortable being examined by a male doctor (Hulme et al., 2016; Madhivanan et al., 2016). However, in Latin culture, this discomfort is also due to the jealous reaction of husbands, an aspect of machismo (Madhivanan et al., 2016).

Moreover, late detection of cases, particularly those with greater severity and worse health outcomes, is a significant problem for Latin American women compared to most other populations in the United States (Mann et al., 2015). A contributing cause for this is the stage of cancer at diagnosis in this population. According to Flores and Bencomo (2009), compared to white women of the same age, Latin American women are usually diagnosed with cervical cancer at a later stage. Late diagnosis may be directly related to when and how decisions are made to access care in general, as well as cervical cancer screening, negatively affecting treatment and health outcomes.

A woman's decision not to attend cervical cancer screening can be multifactorial. In a study by Oscarsson et al. (2008), interviewing non-attendees of a cervical cancer screening program in Sweden, reasons for non-attendance were referred to as women not perceiving that they need to go, since they did not present any symptoms, not wanting to go, due to low-self-esteem and negative body image, or not giving it a priority over family or work. Despite women being aware of the benefits of cervical cancer screening, they assumed it was not necessary since they did not present any signs or symptoms of the disease, and so considered themselves healthy (Oscarsson et al. 2008). Low self-esteem also posed a hurdle for cervical cancer screening, as seen in the statements in the study by Oscarsson et al. 2008. Some participants described a past of physical or psychological abuse and aggression and justified not attending screening to avoid re-experiencing vulnerability (Oscarsson et al. 2008). From this perspective, it is possible to notice that, for these women, letting someone else examine their bodies was out of the question. Lastly, as revealed by Madhivanan et al. (2016) not giving cervical cancer screening priority over family or work was also a factor that affected screening decision-

making for women. Some participants mentioned the lack of time as a main barrier (Oscarsson et al. 2008).

The decision-making process, especially about whether to engage in cervical screening or not, can be influenced by access to information, but not entirely. For instance, the person may have access to information and still not make a choice, that is, they may know about the benefits of screening, but still, due to other factors, choose not to carry them out. Some of the factors for women disregarding screening include a lack of confidence in the benefits of screening, past negative experiences with healthcare and preventive measures, a belief in one's own ability to detect health changes or a perception of not being at risk for cervical cancer, as well as various unconventional views on social and political issues. Some women considered the invitation letter to participate in the cost-free cervical cancer screening program as authoritarian and absurd (Blomberg et al. 2008). Previous negative experiences with the program also influenced women's decision-making. Participants saw the program as anxiety-inducing, due to having to wait for results, rather than a means of prevention (Blomberg et al. 2008).

Jepson et al. (2005) define an informed decision as “one where a reasoned choice is made by a reasonable individual using relevant information about the advantages and disadvantages of all the possible courses of action, in accord with the individual’s beliefs” (p.193). According to research, Latin American women's decision-making process regarding cervical cancer screening is not only influenced by the lack of information but also by social and structural elements, cultural values, psychological beliefs, and communication variables (Chen et al., 2018; De Alba et al., 2006; Flores & Bencomo, 2009; Gesink, 2016; Madhivanan, et al. 2016).

Research on non-adherence to screening is mostly focused on medical reasons, while few address women's individual decisions for non-attendance. Further research should be conducted in this field to enhance the knowledge of healthcare professionals and their understanding of women's perspectives to improve healthcare experiences and services when collaborating with women (Oscarsson et al., 2008).

Barriers to the Prevention of Cervical Cancer

Despite advancements in screening, detection, and treatment cancer outcome disparities remain for minority populations. Studies show that immigrant women engage in fewer cancer screening opportunities compared to Canadian-born women (Bacal et al., 2019; Hulme et al., 2016; Vahabi et al., 2016). Many factors contribute to the low cervical cancer screening rates, which negatively affect cancer diagnosis and lead to inadequate quality of life outcomes (Hulme et al., 2016; Ogunsiji et al., 2013; Vahabi et al., 2016).

In the following section, I describe the structural and cultural factors that influence Latin American women's decision making about cancer screening. I will include discussion of psychological beliefs, knowledge about cervical cancer, and communication variables.

Structural and Cultural Factors

Socioeconomic factors pose a risk to screening and include low income, level of education, and health literacy, while structural factors include long waiting times and a struggle with obtaining appointments (Flores & Bencomo, 2009). Low income has a direct impact on cervical cancer screening because women earning lower incomes tend to work in fields where days off are difficult to get and frequently must be taken as unpaid

days. Often Latina women have no one to leave their children with while attending the screening (Flores & Bencomo, 2009, Hulme et al. 2016, King & Busolo, 2022).

A low level of education or health literacy also correlates with low cervical cancer screening. The lack of knowledge about the benefits of screening and the age for screening can negatively affect women's decision to adhere to screening (Gesink et al. 2016). Logistical barriers, such as struggling in obtaining appointments, also interfere with the continuity of care, since most of the time Latina women only engage in screening when referred by physicians (Flores & Bencomo, 2009).

These obstacles make it difficult for women to access the Canadian healthcare system and additional programs related to cancer screening (Amankwah et al., 2009). All these points contribute to keeping women from taking part in cervical cancer screening and ultimately developing the disease in the future (Vahabi et al., 2016).

Fatalism, a cultural value reported in the literature influencing cervical cancer decision-making practices among Latin American women refers to the understanding that a person's destiny is predetermined and cannot be changed. In the context of cancer, it is the belief that if the individual is fated to have the disease, screening will not change the outcome. As demonstrated by Chen and colleagues (2018), there is a negative association between fatalism and the Pap test, in which individuals who believed in fatalism were less compliant with screening.

Machismo encompasses beliefs and expectations about men's societal roles, including values and attitudes toward masculinity. It covers not only positive traits like bravery and honor, but also negative aspects such as dominance, aggression, sexism, and emotional control. It also refers to assumptions that men are dominant over women and

that women should continue to have traditional roles (Nuñez et al., 2016). Machismo is another cultural factor that has an essential influence on women's decision-making to undergo cervical cancer screening. In a qualitative research study, Madhivanan and colleagues (2016) demonstrated that machismo was a prevalent point raised in the focus groups on factors that influence cervical cancer screening decisions among Latin American women in Miami-Dade County, USA. Participants in this study included 35 Latin American women, over 18 years old, and able to speak either English or Spanish.

Psychological Beliefs

A study by Chen and colleagues (2018) demonstrated that women who do not perceive the benefits of screening, and associate it with psychological and physical distress, are less likely to follow up on Pap test recommendations. Fear and embarrassment are also reported as contributing factors for under-screening among minority groups (Gesink, 2016).

The perception that older women do not need to be screened is another barrier that can negatively impact decision making to undertake screening. Participants of a qualitative study by Savage and Clarke (1998) in Australia, mostly under-screeners, considered screening more relevant for those women who were younger, especially those with young children. In their view, older women felt their lives were less important since their roles as mothers were largely over. This perspective can significantly influence the motivation of older women when carrying out screening.

Knowledge About Cervical Cancer

Low health literacy and a general lack of knowledge about HPV and cervical cancer are crucial factors affecting Latin American women's decision to participate in screening. For instance, participants in one study revealed that they were not aware that HPV infection was related to cervical cancer (Madhivanan et al., 2016). The need for education was highlighted by women in a qualitative study by Redwood-Campbell and colleagues (2011). Women in the focus group discussions appealed for more information on the reasons for doing the Pap test, how it is done, and the implications of its results. Women who are more aware of cervical cancer risk factors and the importance of prevention are more likely to perceive the benefits of screening and make better-informed decisions. Moreover, participants indicated that discussions about cervical cancer screening with healthcare providers, such as those carried out the focus groups, as well as greater advocacy from health professionals and government in requesting the test, would be possible solutions to this problem (Redwood-Campbell et al., 2011).

Communication

Language barriers can negatively affect Latina women's decision-making to undergo cervical screening. As a result of limited English proficiency and difficulty in finding professionals who can communicate in their native language, Latina women often avoid participating in cancer screening programs (Flores & Bencomo, 2009). Research has shown that physicians consider the assessment of patients with low English proficiency more time consuming (De Alba et al., 2006). In the study by De Alba and colleagues (2006), women who presented with higher English language proficiency were more likely to be referred for cervical cancer screening in the United States. The findings

of the study are mainly related to communication barriers, time constraints, and healthcare providers' beliefs. Occasionally, healthcare providers choose to delay or omit referrals to screening since communication barriers prevent them from obtaining more detailed information about the patient and from explaining the benefits of cancer screening (De Alba et al., 2006). The role of language as a barrier is presented in the study Redwood-Campbell and colleagues (2011) in which they found that women are forced to find strategies to overcome language and other communication barriers, to access cervical cancer screening.

Strategies to Promote Cervical Cancer Screening

Some of the strategies to overcome cervical cancer screening barriers include the creation of programs addressing screening, focusing on the relationship between HPV infection and cervical cancer, and the importance of Pap tests, even in the absence of symptoms. Education is critical in this context, as systems for follow-up. Telephone interventions are a good strategy to achieve this goal (Flores & Bencomo, 2009). Another important strategy is the need for health professionals to adopt a consistent behavior of cultural humility, with the aim of understanding and promoting a positive environment for patients in healthcare (Foronda et al., 2016). Positive conduct has a fundamental role in promoting optimal healthcare, by reducing existing barriers to overcoming health disparities (Flores & Bencomo, 2009).

Cultural humility is defined as a lifelong process that covers different elements. The concept of cultural humility has been increasingly adopted into the delivery of health services, with the aim to overcome barriers and eliminate health disparities (Flores & Bencomo, 2009; Foronda et al., 2016). In a research study, Foronda and colleagues

(2016) characterized cultural humility attributes as: openness, self-awareness, egoless, supportive interactions, and self-reflection and critique. Openness is considered the main attribute of cultural humility and is defined as the individual's willingness to explore new ideas and interact with people from different cultures. The second attribute, self-awareness, means recognizing the impact of one's strengths, limitations, values, beliefs, behavior, and appearance to others. Assuming a humble and egoless position is a crucial element of cultural humility, such as recognizing the value of all individuals on an equal footing.

Supportive interactions are also part of the process and include interactions among diverse people that lead to positive human exchanges. The final attribute of cultural humility is self-reflection and critique, or the critical process of reflecting on one's thoughts, feelings, and actions (Foronda et al., 2016). The result of assuming cultural humility in healthcare delivery is mutual empowerment, partnerships, respect, optimal care, and lifelong learning (Foronda et al., 2016). Therefore, cultural humility is an important competency in healthcare, where disparities among minority populations continue to exist. (Nolan et al., 2021). Biases among healthcare providers, whether explicit or implicit, have been reported as contributing to health inequities (Maina et al., 2018).

In a systematic review, Maina and colleagues (2018), found three studies that used the Implicit Association Test (IAT) to compare bias among healthcare providers, against Hispanic versus white adults. The studies revealed that participants had a slight pro-White/anti-Hispanic bias and that 51% showed moderate to strong pro-White/ anti-Hispanic bias. Implicit bias can negatively affect patients' treatment adherence and return

to care, and improved health outcomes have been related to culturally informed patient navigation (Jojola et al., 2017; Maina et al., 2018; Nolan et al., 2021).

Another concept that is being adopted in Canada is cultural safety, which extends beyond cultural humility. In line with the process of cultural humility, the principle of cultural safety is the shift of power from healthcare providers to the consumers of healthcare. In this instance, patients are the ones who decide which practice is considered culturally safe or not. The practice of cultural safety serves as a reminder that everyone engaged in healthcare, not only practitioners but also researchers, and policymakers, has a responsibility to practice critical self-reflection. This self-reflection involves considering whether our attitudes and actions might potentially expose others to cultural harm (Smye, Josewski, & Kendall, 2010). Thus, a healthcare team that embraces cultural humility and cultural safety can play a fundamental role in reducing the barriers to cervical cancer screening, and potential cultural harms, and in creating health equity for the ethnic minority population, such as Hispanic/Latin American women.

Gaps in Research

The number of immigrants in Canada has grown exponentially, especially among Latinos. Health professionals, when working with this population, must be prepared to address the barriers that may exist in screening for cervical cancer. To date, much of the research has explored the factors influencing Pap test compliance among Latin American women in the United States, but little Canadian research exists (Chen et al. 2018, Madhivanan, 2016). The literature review shows that structural, cultural, psychological, and communication barriers still negatively affect screening rates among this minority population (Chen et al. 2018, Madhivanan, 2016).

Armstrong (2007) conducted qualitative research to delve into women's interpretation and intentions toward cervical cancer screening particularly in relation to current practices aimed at promoting adherence. Usually, screening encouragement materials are designed to address a broad audience and with a one-size-fits-all approach. The study, conducted in England, included women from different backgrounds - White British, South Asian, and African-Caribbean- who were invited to a screening session, through a general invitation letter and an informative leaflet. The informative leaflet, produced at a national level, was very general and intended for a wide range of women. Armstrong's study highlighted a gap between the generic message of these materials and the personal decisions of the women regarding cervical cancer screening. The research found that women interpreted the information based on their own personal circumstances, experiences, and characteristics, leading to individual variations in engagement with screening, which sometimes contradicted the general messaging of the invitations (Armstrong, 2007).

The gap in the literature is of particular interest given increasing numbers of Latin American women in Canada, and low screening rates for cervical cancer among this minority population. As a Latin American immigrant in Canada, I have a particular interest in conducting this research, since I aim to contribute to improving health indicators for this specific population. The results of this research will help to assess persistent barriers to screening for Latina women and help to create public health interventions that support increasing the numbers of Latina women engaging in cervical cancer screening.

Chapter Summary

This chapter gives an overview of efforts made to address the low rates of cervical cancer screening among minority groups. Moreover, the chapter delves deeper into barriers that prevent Latinas from engaging in cervical cancer screening. Lastly, I present the gaps in the literature that underlie the need for further research in this field.

Chapter 3: Methodology

Research Design

A qualitative research design was used to guide this study. A grounded theory approach was used to understand the intentions and decision-making practices of Latin American immigrant women regarding cervical cancer screening. Grounded theory was originally developed in 1967 by sociologists Barney Glaser and Anselm Strauss and is theoretically reasoned by pragmatism and symbolic interactionism (Corbin & Strauss, 1990). The theoretical perspective of symbolic interactionism was developed by George Herbert Mead and researchers use it to understand how individuals interpret objects and their interactions with people and how the interpretation process leads to individual behavior in specific situations (Hall et al., 2013). The assumption that individuals are dynamic and are in constant change is the basis of symbolic interactionism, whose origins were influenced by Charles Darwin and other behaviorists (Hall et al., 2013). Assuming the same line of thought as Darwin, the premise is that people tend to repeat beneficial behaviors and modify those that do not achieve the required results (Hall et al., 2013).

In *The Discovery of Grounded Theory: Strategies for Qualitative Research* (1967), Glaser and Strauss suggested a new approach to research, which consists of the creation of theories from grounded data rather than testing hypotheses from existing theories. Grounded theory challenges the quantitative methodology notion as the only credible and unbiased way to understand reality. Contesting this belief, Glaser and Strauss created a detailed methodology for data collection and analysis in qualitative research that led to the generation of a theory that explains how people react to a specific action or phenomenon. Since the introduction of grounded theory, other researchers

augmented the theory in various directions, evolving its procedures through their research experience (Hall et al., 2013). For instance, Charmaz, a former student of Glaser and Strauss, developed another approach of grounded theory in which reality is constructed through the interaction between the researcher and participants, instead of being discovered by the researcher, as proposed by Glaser. Like Charmaz, I strongly believe that I, as a researcher, am part of the process of constructing a theory, which is why I chose the constructivist approach for this research. The coding procedures evolved from a rigid and structured guideline to a more flexible process (Kenny & Fourie, 2015; Metelski et al., 2021).

The classic grounded theory, developed by Glaser and Strauss, is based on the post-positivist paradigm and assumes that despite the existence of a definitive reality, it can never be fully interpreted (Hall et al., 2013). After their original publication in 1967, a methodological split occurred between the authors regarding the meaning and procedures of the theory. Glaser criticized Strauss's approach as too prescriptive and structured. As a result, two grounded theory schools were formed in the 1990s, one influenced by Glaser, and the other by Strauss in collaboration with Juliet Corbin (Charmaz, 2006; Hall et al., 2013).

While classic (Glaserian) researchers persist in the post-positivist paradigm, new researchers have adopted a more constructivist worldview. Kathy Charmaz was the first scholar to describe her grounded theory work as constructivist (Hall et al., 2013). The main distinction between Charmaz’s work and Glaser and Straus’s approach is that she maintains that the researcher does not discover data and theories of a study but rather constructs it through the interaction with people, perspectives, and research practices.

Thus, the finished grounded theory is a construction of reality. According to her perspective, the research does not reveal an absolute reality, but rather allows an interpretation of the phenomenon of what is happening (Charmaz, 2006).

Grounded theorists are constantly engaging in a dynamic process of moving back and forth between data and conceptualization, which is a crucial aspect of data analysis (Rieger, 2019). In this research methodology, preconceived ideas and theories are not imposed on the emerging data, instead, the researcher follows clues that define the data and that can be constantly changing (Charmaz, 2006). According to Charmaz (2006), data is influenced not only by participants but also by the researcher, who brings their own ideas, beliefs, and life experiences to the research. In this research study, I, the researcher, documented my preconceptions, thoughts, and experiences using field notes.

The coding procedures and data analysis vary among the different types of grounded theory. In classical grounded theory (Glaser), data coding and analysis encompass substantive coding and theoretical coding (Rieger, 2019) The focus of analysis is on repetitions or trends within the data to create a core category through the constant comparative method. Theoretical coding allows the creation of a theory from the merging of data categories (Kenny & Fourie 2015; Sebastian 2019). The interpretive grounded theory (Strauss) indicates a more structured approach in comparison to the classical grounded theory and has open coding, axial, and selective coding as the three main steps for analyzing grounded theory data. The Straussian grounded theory takes a more analytical approach, meaning that data analysis is guided by a wider range of tools and techniques. The researcher actively intervenes with greater intensity, employing analytical tools and posing targeted questions (Rieger, 2019). Constructivist grounded

theory (Charmaz) emphasizes a less structured approach for data collection and analysis than the Straussian grounded theory and includes coding everything and grouping all data around the most predominant codes (focused coding). Constructivist grounded theory analysis focuses on flexible data analysis procedures to uncover social processes and emphasizes multiple realities that may lack a unitary theme, or core category (Rieger, 2019, Sebastian, 2019).

Accordingly, a qualitative constructivist grounded theory methodology was used to understand Latin American women's intentions and decision-making processes regarding cervical cancer screening. The research will contribute to knowledge that informs health professionals about cultural aspects linked to the decisions and decision-making processes of study participants, concerning screening.

Philosophical Underpinning and Theoretical Framework

In the grounded theory method, the researcher does not necessarily base themself on a predetermined theoretical framework to collect and analyze the research data. Instead, in this methodology, the researcher analyzes concepts, and processes to form a grounded theory through data collection (Streubert and Carpenter, 2011). Symbolic interactionism provided an epistemological foundation to Glaser and Strauss, who believed that the focus of sociologists' studies should be the individual within a society. However, both rejected the idea that research needs to start with an existing theory or preconceived ideas (Streubert and Carpenter, 2011). The perspective of symbolic interactionism was introduced by George Hebert Mead, a philosophy professor at the University of Chicago, and was used to guide many sociologists in their studies. One of the central influences of this perspective is the philosophy of pragmatism. Pragmatism is

an important foundation to symbolic interactionism, as it explains how humans interact with, and respond to, the environment. Pragmatists believe that human beings interpret their environment, instead of just responding to it (Charon, 2007). According to pragmatism, the interpretations human beings make from their environment are based on objects and actions that are useful or important to them. To understand human beings the focus should be on human actions and interactions rather than on the person or society (Charon, 2007).

The five main central ideas of symbolic interactionism indicate how human beings are viewed by symbolic interactionists. To begin with, a human being must be understood as a social person. The interactions individuals have in society will shape their personal ideas and behaviors, so social interaction is key to understanding what causes someone's behaviors (Charon, 2007). Interaction among individuals is as important as interaction within the individual in leading to human actions since the human being is a thinking being. The individual is not only conditioned by others or the product of society but also a product of their own thinking and beliefs. The environment plays a significant role in human actions; however, it is the individual's definition of the environment that is important. The personal definition of the environment will be determined by social interactions and the process of thinking (Charon, 2007).

In addition to the environment's influence, human actions are the result of what is occurring in the present situation, present social interaction, present thinking, and present definition. Human beings interact actively with the environment, which means that they are actively involved in what they do, instead of passively responding and being shaped by the context/physical environment they are in. Therefore, "to understand human actions

we must focus on social interaction, human thinking, definition of the situation, the present and the active nature of human beings" (Sharon, 2007, p. 30).

Grounded theory research is based on various paradigms. Glaser's approach to grounded theory assumes the positivist paradigm, in which reality is understood by the researcher as a true reality, which must be uncovered by the researcher (Rieger, 2019). In contrast, the constructivist paradigm has a relativist ontology, in which the nature of reality is constructed, or shaped by many factors (Charmaz, 2006). The epistemological basis of constructivism is subjective and always changing. Charmaz, who developed constructivist grounded theory, views reality as shaped by the researcher and the research participant (Rieger, 2019).

Research Sample

Study participants were Latin American immigrant women between ages 40 and 60 years old who resided in New Brunswick, Canada. Participants were eligible for this study if they met the inclusion criteria: Latin American immigrants, residents of New Brunswick, aged 40 to 60 years old, conversant in English, willing to provide consent and participate in the study. In case a participant needed a translator for the interview, the translator would sign a confidentiality agreement form (Appendix A).

Fifteen women from seven Latin American countries participated and shared their perspectives, intentions, and decision-making processes regarding cervical cancer screening. Demographic characteristics are presented in Table 1. The women had lived in Canada for between a few months to 31 years. Most of the participants were married (73%) and had more than one child (93%). Ninety-three percent of them were employed,

and all of them had a college or University degree. The household income for the participants (53%) was $90,000 and above. More than half of the participants reported being in excellent health (53%) and the rest (47%) reported being in fair health.

Table 1: Socio-demographic characteristics of participants

Category	**Percentage (%)**
Employed	93.33% (14 out of 15)
Immigration Status	
Permanent Resident	26.67% (4 out of 15)
Canadian Citizen	46.67% (7 out of 15)
Work Permit	13.33% (2 out of 15)
Temporary Resident	6.67% (1 out of 15)
Visitor	6.67% (1 out of 15)
Level of Education	
Some College/University	33.33% (5 out of 15)
University Degree	53.33% (8 out of 15)
Post-secondary Diploma	6.67% (1 out of 15)
PhD	6.67% (1 out of 15)
Income Ranges	
$90,000 and above	53.33% (8 out of 15)
$50,000 - $89,999	33.33% (5 out of 15)
$10,000 – $49,999	13.33% (2 out of 15)
Years in Canada	
Less than 1 year	6.67% (1 out of 15)
1-5 years	13.33% (2 out of 15)
6-10 years	13.33% (2 out of 15)
11-20 years	40% (6 out of 15)
More than 20 years	26.67% (4 out of 15)

Recruitment

Participants were recruited using a purposive and snowball sampling approach to participate in the study. Using the purposive sampling method allowed for the selection

of participants who had experiences with or are part of the culture or phenomenon of interest (Speziale et al., 2011). The snowballing method on the other hand is a purposeful sampling technique that allows study participants to refer their peers or people who shared experiences, and perspectives related to the phenomenon. After conducting the first interview I asked the participant to invite and share my contact information with other Latin American women who might be interested in participating.

The participants were recruited from newcomer/immigrant community organizations, such as the Multicultural Association of Fredericton, Latin American communities in Fredericton on social networks (WhatsApp and Facebook groups), the University of New Brunswick, and the New Brunswick Community College. The decision to recruit women from different organizations was to reach as many potential participants as possible, as well as increase the chances of arriving at the proposed sample size. Participants were recruited through research posters, social media posters, and personal contact (Appendix B). I distributed invitation letters at the community sites and reached out to participants on social media groups. I provided my contact information, such as my email and phone number in the study invitation letter to facilitate potential participants reaching me.

The choice to engage 15 women was made due to the time and financial constraints of a master's thesis. Also, the sample of fifteen women was chosen based on a previous study examining reasons why women decide not to attend cervical cancer screening programs and involved 14 women (Oscarsson et al., 2008).

Data Collection

I collected data through individual interviews with Latin American women in Fredericton, New Brunswick to explore their intentions, decisions, and the processes involved in decision-making regarding cervical cancer screening. Interviews are the most common tool for data collection in qualitative research, and in grounded theory research, they can be conducted either individually or as focus groups. I opted for semi-structured individual interviews, allowing participants to identify the processes most relevant to them in making decisions about cancer screening. I used guiding questions, listed in an interview guide (Appendix C), to facilitate the interviews, exploring perspectives and beliefs about cervical cancer screening, decision-making processes, and influencing factors. I explored some points further with probes based on previous responses as I became keenly aware of participants' views regarding cervical cancer screening and access to health services.

Individual in-depth interviews with the participant women lasted approximately hour (ranging from 40 to 65 minutes) and were done either in person or online. I conducted in-person interviews at the participants' preferred locations. At the beginning of each interview, I gathered socio-demographic information from participants, including their ethnicity, age, household income, and length of stay in Canada since immigrating (Appendix D).

During the interviews, some participants experienced uncomfortable emotions or reactions linked to past traumas or negative experiences. For instance, discussing the moment participants realized they had contracted HPV proved to be particularly sensitive for two individuals. In response, I made a deliberate effort to acknowledge the

participants' emotional state, maintaining an open and supportive demeanor while actively listening to their experiences. As the situation unfolded, I adhered to the distress protocol (See Appendix E), checking in on their feelings and asking if they needed support and were comfortable continuing the interview, which they affirmed. Thankfully, referral to local counselling services was unnecessary, and the remaining women did not express distress during their interviews.

At the end of every interview, I wrote and systematically organized descriptive field notes based on all my observations. Field notes play an important role in keeping researchers on track with details and for facilitating the process of re-checking data. Field notes are simple to keep and are done by the researcher (Nakkeeran & Zodpey, 2012). The information is reported by the researcher and can be revisited at any time. Field notes work like diaries, in which the initial impressions of the interviews are reported, and which can reveal emerging trends among the different interviews (Appendix F). In my study, I applied the field notes added to the audio transcription for data analysis, as it is difficult to record the conversation only by field notes. The audio transcriptions helped me to revisit data during the analysis when needed.

Data Analysis

I used a constructivist grounded theory analysis approach, to develop a theory around a central problem or phenomenon pertinent to Latin American newcomer women’s perspectives. Data analysis was conducted concurrently with data collection, an integral step in grounded theory research methodology. Upon completion of the interviews, I transcribed the recordings verbatim.

The analysis involved a series of steps. Initially, I read the interview scripts through to get a better understanding of the interviews and check for any missing information. The process was followed by coding each interview script. Following Charmaz's grounded theory, I used the three types of coding—initial, focused, and theoretical—I describe the steps in the following paragraphs (Charmaz, 2006).

Initial coding involved systematically scanning the text line by line to identify concrete and straightforward concepts, ideas, or expressions. During the initial coding phase, I carefully examined interview transcripts to develop concise codes that captured meanings or actions rather than mere words, reflecting participants' intentions and lived experiences. For example, codes were formulated to convey actions like *avoiding the healthcare system* rather than merely mentioning the *healthcare system*. Moreover, *in vivo* codes, directly derived from the transcripts, were utilized to encapsulate the core of participants' narratives.

Following this initial coding phase, conceptual/focused coding was undertaken to establish more abstract and conceptual codes, guided by the significance and frequency of the codes identified in the preliminary coding stage. The process involved going back and forth between the initial codes and emerging focused codes within and across different transcripts, by grouping codes into concepts. The iterative process led to the emergence of novel perspectives and insights, enriching the understanding of participants' viewpoints and behavioral patterns. To create focused codes, the iterative process of constant comparison ensued, wherein similar codes across different transcripts were juxtaposed and examined to discern patterns, thus facilitating the grouping of data into meaningful categories (Streubert & Carpenter, 2011). An audit trail was created to

document the coding and theory development steps (Figure 1). The illustrative analytical table (Table 2) demonstrates the application of initial and focused coding, featuring examples and quotes. Figure 2 showcases a hierarchical chart of focused codes.

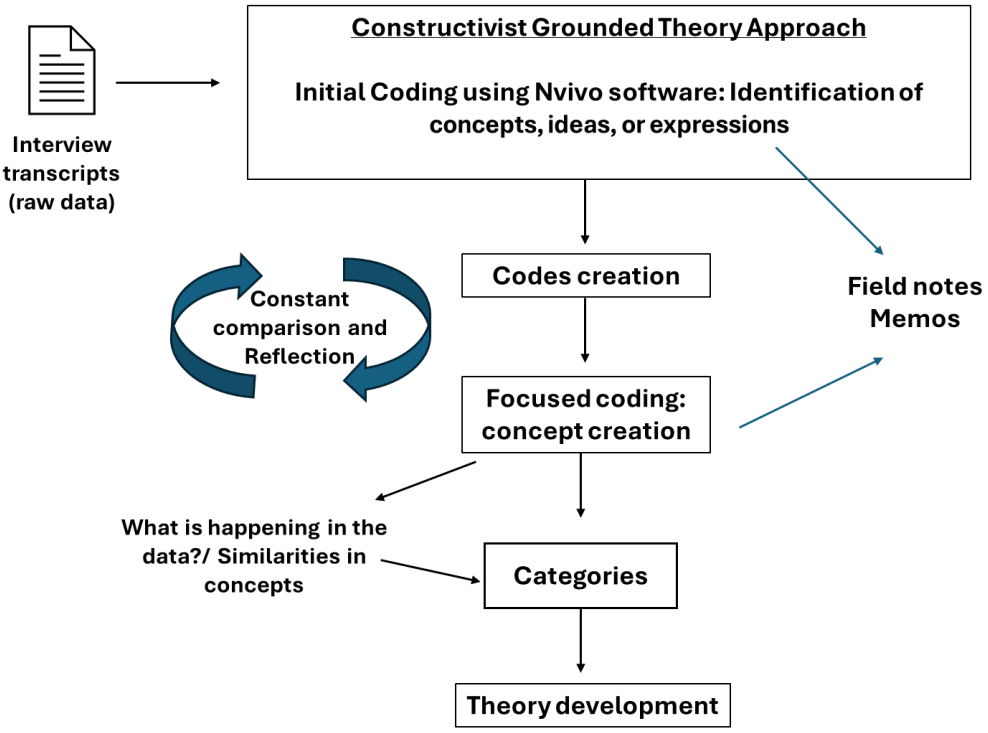


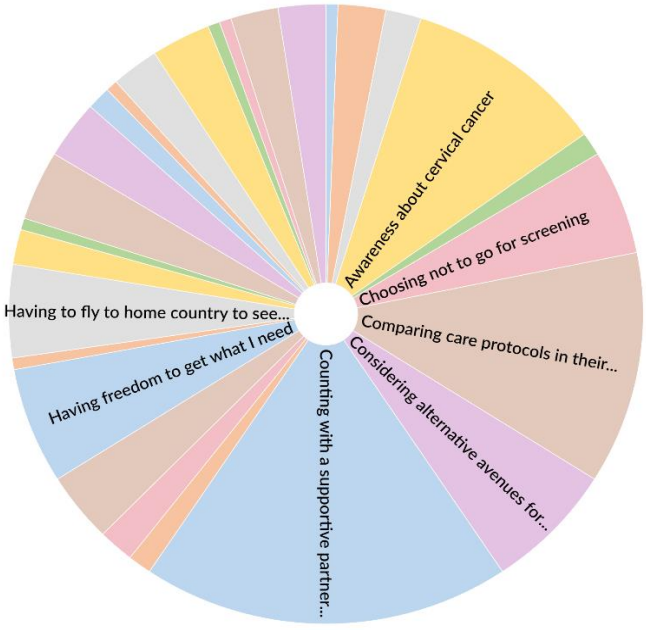
Figure 1: Coding steps from raw data, and steps of collapsing several similar codes into categories.

Table 2: Sample Analytical Table

Core category	**Initial Codes**	**Focused Codes**	**Sample quotes**
Unfulfilled Expectations	Being shocked with the Canadian Healthcare system	Learning how bad the healthcare system is in Canada	"I was a bit disappointed. I mean, about the health system. Yes, I was. I was a bit shocked especially because where I come from, you still have the option of private health system which gives you a bit of like reassurance".
	Not knowing how to access specialists	Finding the Canadian healthcare system difficult to understand	"I'm gonna give you some examples like. I don't know any specialists. OK, so and then? When you, you either have this option to go. Public and try. Or maybe you can decide to go private but you. Still have the option so. This is not possible here. It's very frustrating because as I said, I'm healthy, but I mean there was times that I really wanted to see a doctor for specifics, and I just gave up."

	Comparing healthcare systems	Comparing care protocols in their country of origin and Canada	“Even in my country in Mexico. We have more options. We have a bunch of private doctors so you can pick for all the pockets for all the levels of financial levels. Yeah. You can have public services the public service is not that good. Yeah, it's a lot of people there and you have these other options that are in very expensive that you can have access so yes, I feel I feel disappointed about it”.
	Challenging long waiting times	Feeling dissatisfied about the long waiting times for healthcare services in Canada	“So it's like, it's not that you go there and you receive the treatment. I have access to a group of Brazilians here and people reported difficulties getting treatment, even if they had real problems, and it took very long, they waited hours and hours in emergency room”

Figure 2: Hierarchical chart of focused codes.



This section outlines the analysis process, with findings described in detail later. The sample consisted entirely of women, including those who had not yet undergone screening. As a result, the majority shared their general opinions about the Canadian healthcare system rather than focusing solely on cervical cancer screening. However, this broader perspective ultimately impacts their decision to participate in screening, as many choose to avoid it due to negative experiences in other areas of the healthcare system. The category of *Unfulfilled Expectations* emerged from constant comparisons and merging of focused codes, such as, *feeling dissatisfied about the long waiting times for healthcare services in Canada, finding the Canadian healthcare system difficult to understand, feeling concerned with the lack of family doctors, comparing care protocols in their country of origin and Canada, and learning how bad the healthcare system is in*

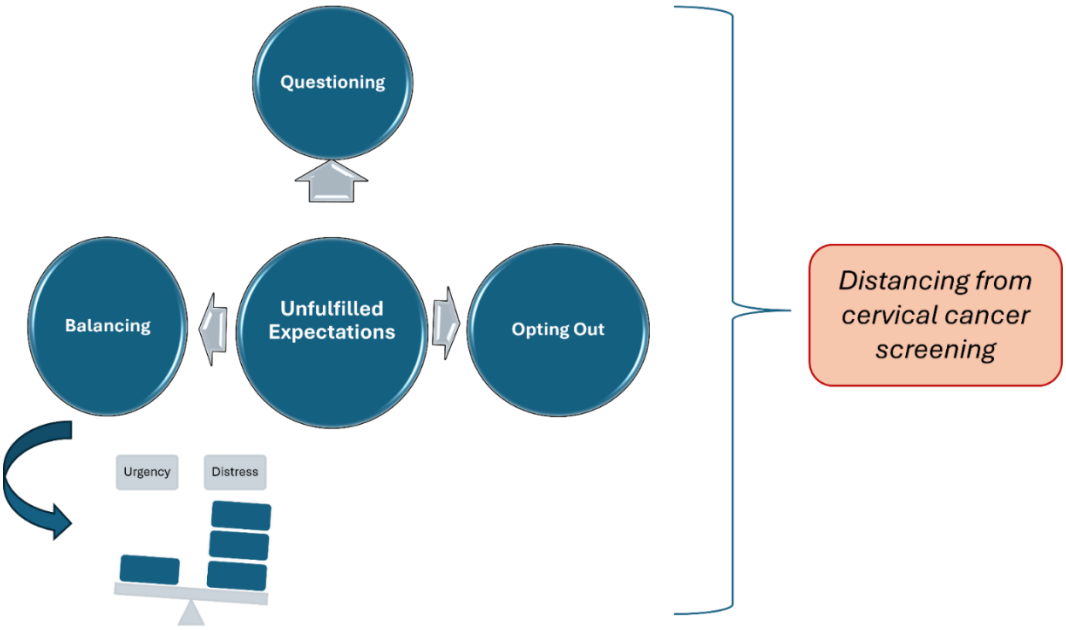
Canada. Therefore, *Unfulfilled Expectations* significantly influence women's decisions and decision-making processes.

The following categories, *Questioning, Balancing, and Opting out*, illustrate how Latin American newcomer women address the challenge of their *Unfulfilled Expectations*. By having their expectations unmet they started *Questioning* the healthcare system. This piece of data was named after merging these three other focused codes: *questioning the efficiency of the Canadian healthcare system*, *challenging appointment process,* and *demanding better services*.

Anticipating problems, balancing between wanting healthcare and confronting barriers, and assessing the urgency of the problem versus long waiting times collapsed into a category named *Balancing*. The final category, originally named *avoiding seeking care in Canada*, ultimately evolved into *Opting Out* through the clustering of focused codes: *hesitating to attend medical appointments, creating resistance to Canadian healthcare services,* and *considering alternative avenues for medical assistance.*

During the exploration of the fundamental social process, core categories, including *Unfulfilled Expectations*, *Questioning, Balancing, and Opting Out*, were scrutinized to evaluate their impact on, or correlation with, each piece of collected data. The culmination of this extensive analysis unveiled *Distancing from cervical cancer screening* as the overarching social process, with *Unfulfilled Expectations* emerging as the central problem plaguing Latin American newcomer women within the context of healthcare access (Figure 3).

Figure 3: The theory of *Latin American women's search for health services: A model of distancing from cervical cancer screening*



As an ultimate step, I proceeded with theoretical coding, a sophisticated level of coding, in which I specified possible relationships between codes and categories I developed in focused coding. In other words, the concept of theoretical code refers to the relationship between the focused/substantive codes developed earlier in the process, to form hypotheses that can be integrated into a theory (Rieger, 2019). Therefore, these codes demonstrate the relationships between the focused/ substantive codes and help ground the analysis in a theory (Charmaz, 2006). The theoretical saturation for the core social process, *Distancing from cervical cancer screening*, was reached when all decision-making actions became linked to the central problem of *Unfulfilled Expectations.*

Throughout the analysis, collaboration with my supervisor and my examination committee ensured rigorous review of coding and categories, promoting discussion, idea exchange, and validation to minimize bias in data analysis.

Rigor

Methodological rigor plays a fundamental role in the research process (Creswell & Poth, 2016; Pereira, 2012). In this study, I ensured methodological rigor by adopting some of the strategies suggested by Nakkeeran and Zodpey (2012). I provided a systematic and methodologically congruent research design, with a well-designed purpose statement and research questions, data collection, and interpretations. Moreover, during the interviews, I took descriptive field notes of my observations and organized them systematically.

Field notes serve as essential tools not only for ethnographers but also for grounded theory researchers, who use them to document participant observations within the interview context (Charmaz, 2006). These notes provide additional data that may emerge during discussions but are not always captured in interview transcripts. Additionally, field notes enable researchers to compare their perspective with that of participants or other data sources (Charmaz, 2006). My field notes were informal records made immediately following individual interviews. They included details such as interview timing, ambient noise levels, participant's posture, facial expressions and personal reflections on feelings, assumptions, and insights gained after conducting the interviews. Measures to strengthen trustworthiness are addressed below (Charmaz, 2006, 2014; Charmaz & Thornberg, 2021; Guba, 1981; Velloso & Tizzoni, 2020).

Credibility

Credibility is related to the internal validity of the research and refers to the confidence that can be given in the veracity of its results (Guba, 1981; Velloso & Tizzoni, 2020). Charmaz (2006, 2014) describes credibility as the extent to which the research is believable and trustworthy, often based on a thorough examination of the data. To ensure credibility I engaged in sustained reflexivity throughout the research process (Charmaz & Thornberg, 2021). The credibility of this study was provided in several ways, such as generating sufficient data from 15 individual interviews, prolonged engagement with the data, and member checking. I ensured prolonged engagement with data to deeply understand participants' perspectives.

Another method to ensure credibility is the process of peer debriefing, which was incorporated into the research process, as mentioned in the data analysis section (Rosenthal, 2016). The peer debriefing process was done through extensive discussions with my research supervisor and the member of the examination committee, during the data analysis phase. I regularly consulted and met with my supervisor to discuss the transcripts, methodologies, and research findings.

The most important strategy to ensure credibility is the member-checking process (Charmaz & Thornberg, 2021). In this study, I ensured that participants validated the accuracy of the emerging codes and categories. The member-checking process proceeded the interviews, in which I reviewed emerging concepts and theories with participants to find out if they were able to see themselves and their experiences in the findings and the emerging theory (Nakkeeran & Zodpey, 2012). Considering the utilization of the constructivist grounded theory approach in this study, the findings were adapted

according to the participants' perspectives. The goal was to establish a sense of mutual understanding with the participants, unveiling hidden meanings and leading to a comprehensive theoretical interpretation (Rieger, 2019).

Originality

This study presents a new conceptualization of the low cervical cancer screening uptake among Latin American newcomer women. It emphasizes decision-making and the factors influencing this process. Adopting an open and exploratory approach, the study offers fresh insights and conceptualizes how Latin American newcomer women make decisions regarding their healthcare and screening (Charmaz & Thornberg, 2021).

Resonance

To ensure resonance during my data collection through semi-structured interviews, I listened attentively to the experiences of my interviewees and noted the most prominent concepts. I included probes to explore these evidenced concepts further and continually revised my questions to enhance resonance (Charmaz & Thornberg, 2021). The concepts generated in this study align with not only the experiences and the decision-making process of Latin American newcomer/immigrant women but may also provide insights to other populations, such as other newcomer populations.

Usefulness

This study highlighted the perceptions and experiences of Latin American women regarding cervical cancer screening, shaping their decision-making processes. Through the findings I shed light on potential practices and policies needed to improve

engagement and uptake. Overall, this study demonstrates usefulness by exploring decision-making processes related to cervical cancer screening, clarifying the experiences of Latin American newcomer women, and revealing how their experiences in a new country affect their screening uptake and overall health quality (Charmaz & Thornberg, 2021).

Transferability

Transferability, or *fitness*, refers to how well the developed theory aligns with the characteristics and nuances of the specific subject or data being studied. In other words, it assesses whether the theory is relevant and appropriate for that context (Charmaz & Thornberg, 2021). To achieve transferability purposive and snowballing sampling methods were employed until theoretical saturation of key findings was reached. Exploring the decision-making process related to cervical cancer screening among Latin American women can generate valuable insights for newcomers from that culture as well as others who encounter similar obstacles in navigating the healthcare system, which may influence their decision to pursue screening.

Dependability

Dependability indicates the consistency of the findings, or the stability of the findings over time (Bowen, 2009; Guba, 1981; Velloso and Tizzoni, 2020). To ensure the dependability of the data I established an audit trail, which documented the interviews, by taking notes during the whole research process. The notes helped me track any changes that occurred during the research.

The audit trail is a technique for establishing reliability, in which the researcher systematically records and presents information about the material collected during the qualitative study, which in the case of this research was collected through interviews with the participants (Bowen, 2009). The audit trail in this study was created to document the steps of creating codes from raw data, and the steps of collapsing several similar codes into categories, so that the process of theory development is visible and verifiable by the readers.

Confirmability

Finally, confirmability relates to the possibility of the research findings being confirmed or corroborated by others (Guba, 1981; Velloso and Tizzoni, 2020). In this study, I ensured the confirmability of the data by practicing reflexivity. Reflexive memoing during the interviews with participants assisted me in this process. Reflections on the data transcription and analysis were written. The reflexive memos reflected my process of learning during the interviews. In this study, the reflexive memos consisted of comments and reflections on aspects of the interviews, which helped me to develop the final grounded theory. The memos helped to achieve a clear concept from the data and to enrich the final theory by documenting insights, reflections, and connections made throughout the analysis process.

Ethical Considerations

This project was submitted for ethical review to the University of New Brunswick Research Ethics Board and is on file as REB #2023-102. According to the Tri-Council Policy Statement (2022), research involving humans should have as a central value the

respect for human dignity, which is expressed through the principles of respect for persons, concern for welfare, and justice. To guarantee that this research followed the Tri-Council Policy Statement I addressed the following research ethics components:

Informed Consent

In the first meeting with the participants, I introduced myself and verbally explained the research's purpose. I went further to ask questions (such as if the women identified themselves as immigrants) to ensure they met the study's inclusion criteria. I informed participants that their participation was voluntary and that they were free to withdraw from the study at any time, without consequences. I answered any questions participants had regarding the study and collected their permission to record the interviews. We discussed steps I was taking to ensure their privacy, confidentiality, the potential benefits and risks for participating in the research study. Once participants were content with the research information, and my responses to their questions, they signed the consent forms (Appendix G).

Risks

This study presented minimal risk to participants, aligning with the Tri-Council Policy Statement (2022), which asserts that the probability and magnitude of adverse effects of participating in the study are no greater than those encountered in their everyday activities associated with the research (Tri-Council Policy Statement, 2022).

Some potential risks in participating in this research were anxiety, stress, or participants' concern for their health when sharing personal perspectives and experiences. I interviewed the participants with respect, discretion, and empathy to minimize these

risks. If I realized a participant was distressed during the interview, I would stop the interview and use the distress protocol with the participant asking if they wanted to take a break, were willing to continue, or wanted to end the interview (Appendix E). I would refer the participant to a local counsellor at the end of the interview. Fortunately, none of the participants exhibited significant distress, so there was no need to refer participants to a local counsellor at the end of the interview.

Inducements

A small honorarium (snacks) was offered to participants who engaged in in-person interviews as a demonstration of my appreciation for their time.

Privacy and Confidentiality

Privacy and confidentiality are important concerns in research involving humans. It refers to the subject's opportunity to decide about the disclosure of their personal information, consenting to, or withholding consent (Tri-Council Policy Statement 2022). I collected participants' names and contact information during the recruitment phase, but I kept them separate from the interviews and saved them on a password-protected computer. On the demographic profile, I asked participants to provide identifiable information such as age and sex, but I did not ask them to provide their names. Instead of participants' names, I labeled the demographic forms and interviews using code names to protect their identity. The data I collected on the demographic profiles and interviews were not linked to participants' names. In the event that participants provided their names on the demographic forms or interviews, I erased the information. I kept all data in a

secured shared drive and password-protected computer that was accessed only by me and my supervisor. I informed participants that their personal information would not be displayed in the results of this research when presented at conferences or published in journals.

Participants received feedback about the outcomes of the research. During the recruitment phase, I asked participants whether they would like to get copies of the research findings. I collected the email addresses of participants that expressed their interest on the consent form. I kept electronically signed consent forms in a secure shared drive with password protection.

Chapter Summary

This chapter outlines the methodology used in this study, including the research design, theoretical framework, research sample, and recruitment process. Additionally, it provides a detailed description of data collection and analysis, methodological rigor, and ethical considerations. The research findings will be presented in detail in the next section.

Chapter 4: Findings

Latin American women's search for health services: A model of distancing from cervical cancer screening

The theory of distancing from cervical cancer screening among Latin American women is structured around a main problem—*Unfulfilled Expectations*—and three sub-processes, which are italicized. Each sub-process represents a coping mechanism for addressing the main social problem of accessing cervical screening among immigrant Latina women. These processes include *Questioning* the system, *Balancing* waiting times against the urgency of their needs, and sometimes *Opting out* of care altogether. Together, they illustrate how women respond to unmet expectations regarding the healthcare system, reflecting their navigation of the challenges posed by perceived limited access to healthcare and the feelings of being lost within the system.

The Problem: Unfulfilled Expectations

Unfulfilled Expectations represent dissatisfaction with the Canadian healthcare system, a barrier that challenges healthcare decision-making, including choices about cervical cancer screening. In this broader context *Unfulfilled Expectations* are a landscape of intercultural difficulties, including lagging adaptation to rapidly increasing migration in Canada, which shaped engagement with various health services.

Expectations encompass participants' idealized perceptions of the healthcare system, focusing on several crucial elements. At the heart of these expectations is the desire to receive clear and complete information about the screening processes and the options available, enabling them to make well-informed decisions. Additionally, timely

screening services are crucial for maintaining patient engagement and preventing discouragement due to delays. One of the participants explained by juxtaposing her help-seeking experiences with what she had expected of the Canadian healthcare system before migrating.

> Here are not very good with you. With that I would have thought that coming to like I don't know, a big country of Canada with lots of resources…

She further elaborates on the emotions linked to this experience.

> … gives me a little bit of anxiety because I feel from what you hear that there's a lot of room for improvement (43-year-old participant).

Both pre- and post-migration help-seeking experiences significantly influence their perceptions of healthcare services, whether their expectations are met, and ultimately their decisions about cervical cancer screening. One contributor to *Unfulfilled Expectations* is the lack of prompt care. In their home countries, low-barrier services often include referrals for screenings managed by primary physicians or specialists, which leads to shorter wait times and a perception of higher-quality care. In contrast, in Canada, women often must schedule their appointments, which is seen as a barrier. This self-scheduling requirement contributes to *Unfulfilled Expectations*, as screenings in their home countries were typically coordinated directly by gynecologists.

In this context, *Unfulfilled Expectations* are heightened by limited access options to specialists in the healthcare system and the lack of choices between public and private care. This lack of flexibility also leads to *Unfulfilled Expectations,* especially when the participant wants to see a doctor for specific issues but feels forced to distance

themselves from seeking medical care due to system restrictions. One participant mentioned the following:

> I'm gonna give you some examples like, I don't know any specialists. OK, so and then? When you, you either have this option to go public and try, or maybe you can decide to go private, but you still have the option. So, this is not possible here. It's very frustrating because as I said, I'm healthy, but I mean, there were times that I really wanted to see a doctor for specifics [checkups], and I just gave up (51-year-old old participant).

Besides pre- and post-migration experiences of accessing care, participants were frustrated by the long wait time at healthcare service points, which increased their *Unfulfilled Expectations.* Lengthy wait times were quite significant during the COVID-19 pandemic resulting in social distancing regulations that made accessing healthcare services challenging. For instance, one of the participants shared her experience of waiting for more than 30 minutes for a Pap test in Canada. When the nurse could not attend to her because of other commitments, the participant decided to leave the clinic so that she could attend other appointments.

> **Participant:** So, I received the letter. A letter from the government asking to do the Pap test, and I scheduled, and I went there, to the clinic. It was in the north side, but the nurse was not able to attend me.
>
> **Interviewer:** Why not so?
>
> **Participant:** She was busy, with other…
>
> **Interviewer:** Even with the appointment, or you couldn't even book the appointment?

> **Participant:** No, I booked the appointment, but when I got there, I waited for more than 30 minutes in the room. They put me, they called me... And the nurse didn't come…. so I went out and I said: I have to go because I have an appointment right now and I have to go. So, after that, I didn't receive [the test].

Conditions of the Problem

Conditions of the problem include the following: (1) length of residence in Canada and level of access to a family doctor, (2) level of familiarity with the Canadian healthcare system, (3) presence of a supportive partner, and (4) level of presence of family illness or prior HPV infection, highlighting the multifaceted nature of challenges faced by immigrants when accessing healthcare services.

Firstly, the length of residence in Canada influences the intensity of *Unfulfilled Expectations*, that is, the short amount of time in the country increases the problem and the longer amount of time lessens the problem. Latin American immigrant women who have recently arrived in New Brunswick generally allocated less time for screening compared to those who have been in Canada longer. This discrepancy highlights that individuals with shorter residency periods encounter significant obstacles, including a lack of family physicians and unfamiliarity with navigating the healthcare system, resulting in poor access to services. Most participants who reported undergoing cervical screening in New Brunswick had been in Canada longer and either received recommendations from their family doctors or had the examination done at their clinics. In the following quote, one of the recently arrived women's illustration contributed to *Unfulfilled Expectations.*

> I will say. Because you don't really know many local people with local experience, you just don't mind finding out. And because you mostly you hear like the it's difficult to be seen and there are no places (43-year-old participant).

The lack of a family doctor after only being in Canada for a short time poses significant challenges in accessing cervical cancer screening. This situation highlights their unfamiliarity with the Canadian healthcare system, including the possibility of self-referral to services. Accustomed to relying on providers in their countries of origin for referrals, they expected similar access in Canada.

Secondly, a lack of familiarity with the Canadian healthcare system significantly hinders access to cervical cancer screening. This unfamiliarity adds to *Unfulfilled Expectations*, as individuals may have anticipated a smoother and more accessible experience based on their previous healthcare interactions. The inability to identify appropriate resources or services further exacerbates these *Unfulfilled Expectations*, leaving individuals feeling disconnected from their pursuit of necessary care. This participant expressed her lack of familiarity with the healthcare system and emphasized her need for more information about cervical cancer screening services. She discussed the challenges she faced in navigating these resources, including making multiple calls to schedule the appointment and struggling with the information in the invitation letter, which she felt was unclear, further contributing to her *Unfulfilled Expectations*.

> So, I feel that it's really hard. To find the right place or the right treatment and to know how the things work here. I think misinformation. We need more information about how the things work and where to go (48-year-old participant).

Unfulfilled Expectations include limited awareness of how to navigate the system. which impacts their decisions to participate in screening.

> OK, a lot of people do not know. That it's easy. They think that they have to overcome the same barriers they might need to go to the emergency room or to a walk-in clinic and they're like, I don't have time for that. So, they would just avoid it (41-year-old participant).

> OK, first, I don't know where. Where should I go? To the hospital to wait 12 hours or… Yeah, but yeah, I didn't (43-year-old participant)

Participants with a family history of cancer or a previous diagnosis of HPV demonstrated higher health literacy and sought cervical cancer screening more than other participants. For these women, screening was considered a crucial aspect of healthcare compared to those without such backgrounds. Their prior experiences with health issues and perceived cancer risk not only motivated them to seek information and services but also reduced *Unfulfilled Expectations*. By actively pursuing knowledge and resources, these participants exemplified the relationship between health literacy and proactive healthcare behavior, illustrating how personal histories can shape health-seeking behaviors and enhance perceived accessibility to care.

> **Participant:** Even if I don't have, I'm not feeling any pain, I think it's important for prevention. So, my mother has cancer, and she discovered it because she goes to the doctor every year. So, I think it's important to do this prevention… Because you can have something without feeling pain and you will not know if you don't do the exam (48-year-old participant).

Unfulfilled Expectations were managed through several strategies: *Questioning, Balancing,* and *Opting Out*. *Questioning* involves recognizing the challenges associated with accessing cervical cancer screening. *Balancing* serves as a decision-making strategy that informs the next steps, while *Opting Out* allows individuals to take control by ending their search for screening services when faced with difficulties. Some participants, anticipating barriers similar to those encountered in emergency rooms or regular clinics, believed they lacked the time for screenings, which ultimately led them to avoid these services altogether. This mindset highlights the interplay between perceived obstacles and the strategies individuals employ to navigate their healthcare experiences.

The *Unfulfilled Expectations* lead to frustration with services including cervical cancer screening. Their *Unfulfilled Expectations* seemed to arise from a conflict between the women's experiences with the healthcare system from the countries where they came from and the Canadian healthcare system. The Latin American immigrant women brought with them habits, customs, and knowledge from their country of origin and healthcare services experiences, and when they arrived in Canada, they went through new experiences and had to adapt. As they adapt to their new environment, they may need to either adopt or navigate the differences in local healthcare practices. This process of facing new healthcare experiences can be intense and distressing. In describing the frustrations in relation to different experiences with healthcare systems in different countries, one of the participants mentioned:

> **Participant:** Even in my country, we have more options. We have a bunch of private doctors so you can pick for all the pockets for all the levels of financial levels. You can have public services; the public service is not that good. Yeah, it's

a lot of people there and you have these other options that are very expensive, that you can have access to. So yes, I feel, I feel disappointed about it.

Interviewer: Yeah, sure. It was not something that you expected before moving here.

Participant: No, no. Well, I just hear that this is a first World country and as you said you will never expect up in the health area will be an issue. Like, this is just incredible. Because I know is in entire Canada (49-year-old participant).

Despite these frustrations, participants in this study demonstrated autonomy in their health-related decisions and accessed health services independently, with the support of their partners. They did not report cultural or gender-based barriers, such as machismo, influencing their health behaviors. However, they recognized that machismo is a significant cultural factor that could impact other women, particularly those who may not have migrated to Canada. This aspect further illustrates that the primary factors influencing Latin American women's decision-making regarding screening are not rooted in cultural or gender-based elements, but rather in their perceptions of access to services.

Questioning

Once confronted with the disappointment of *Unfulfilled Expectations*, participants began *Questioning*. They scrutinized the healthcare system of their adopted country—its operations, inefficiencies, and management of health issues. *Questioning* involves critically examining and doubting the established processes and practices about the healthcare services they are receiving in the new country. It involves seeking clarity, understanding the rationale behind how things operate, and potentially, in the case of this

study, challenging and expressing dissatisfaction with those operations. This can lead to identifying inefficiencies and considering alternative approaches. Essentially, it reflects a desire to understand and evaluate rather than accept the system as it is.

Participants questioned the effectiveness of the healthcare appointment system, highlighting the intricate process required to book an appointment. This participant pointed out the difficulties of calling a clinic, where one must navigate a limited window of time to reach someone. If the call isn't answered, it requires repeating the process the next day and often several days after that, raising the question of how such an inefficient system can serve the needs of patients effectively. Her observations invite a critical examination of the barriers many faces when trying to access timely medical care.

> Because then you need to go to a clinic and then you call. If you have an hour to call and book an appointment for that same day, like in that hour if they don't answer, you need to call back again the following day, and then keep trying until one day they answer a phone and then you book an appointment. It's, it's horrible (41-year-old participant).

This cumbersome process not only hinders their ability to access timely healthcare but also exacerbates feelings of frustration and helplessness, contributing to the overall sense of *Unfulfilled Expectations.* This dissatisfaction encourages a belief that the healthcare system is not adequately meeting their health needs, which leads to *Questioning* its reliability and effectiveness. When patients feel that their health concerns are not prioritized or addressed in a timely manner, it undermines their trust in the healthcare system as a whole. This can be illustrated by the participant’s quote below:

> I wouldn't have an appointment right away, but maybe the next week. Yeah, it will be the nearest available. And, I haven't had any experience here, but like, I have friends that have been referred to other specialists. And yeah, it's like, oh, no, for three months (43-year-old participant).

Balancing

Balancing involves weighing the time and effort dedicated to seeking healthcare services, including cervical cancer screening. Due to a lack of trust in the system, they continually assess the barriers and facilitators associated with accessing screening. This evaluation includes weighing prolonged wait times against the urgency of their health needs. With numerous responsibilities and limited time, many women choose to avoid screening to escape what they perceive as a waste of time. Importantly, this delay is not due to a lack of recognition of the importance of cervical cancer screening; rather, they face challenges such as uncertainty about where to seek care and the burden of long wait times for appointments and referrals. Consequently, they often prioritize other pressing issues during their migration journey, which further complicates their access to necessary healthcare services.

Concerning access to healthcare, it is often not the length of the wait itself that leads Latin American immigrant women to balance the urgency of their problem but rather the distress induced by the waiting period. There is a notable distinction between enduring a painless wait and experiencing distress due to prolonged delays. This anguish often prompts individuals to carefully consider and weigh the urgency of the healthcare

service against all their other priorities as immigrants settling in a new country. There is a lot of hesitation in their narrative, as can be seen in this participant's quote:

> I only go to the doctor when something happened, and like I'm feeling sick, then I have to go, then I go.... Because every time I feel sick, I either go to the hospital or find a clinic. So, you don't have always the same doctor. So it's kind of hard because every time you go to a doctor, you need to start and tell every single thing again, and then they ask for an exams and when, when you're going to see the result it's another doctor and they don't understand why you have those exams. So it's, it's really hard here (41-year-old participant).

Her decision not to seek medical care unless it is something urgent reflects the inconvenience and frustration of not receiving consistent care from the same doctor and having to repeatedly explain medical history. The woman anticipated seeing the same physician for continuity of care. In this context, the participant may be weighing the urgency of her health needs against the time and effort required to navigate the healthcare system. She may perceive the waiting time for appointments, the need to repeat her medical history, and the delays in receiving test results as barriers that outweigh the perceived urgency of her health concerns until they become unavoidable. Thus, her decision not to seek medical care unless she is feeling sick could be interpreted as a strategy to balance the waiting time with the perceived urgency of her health needs.

Needing to schedule appointments well in advance, a process that increases the chances of a person forgetting about the appointment is another factor accounted for when *Balancing.* This participant proposed a simpler booking system, even suggesting

on-the-spot scheduling at hospitals. She noted that because screening is preventive, individuals might avoid it because they anticipate a significant time commitment.

> Yeah, we have to book in advance. So, this is not good because sometimes people can forget about it. So, it should be easier if you could go to the hospital and maybe book an appointment for the next week. But, but the thing is... The screening it's something that you do to prevent so people are not feeling pain. It's not urgent (47-year-old participant).

Opting Out

As doubts about the effectiveness of the Canadian healthcare system arise, *Unfulfilled Expectations* are managed by avoiding the healthcare system altogether. Distrust grows with ongoing *Unfulfilled Expectations*, leading to steering away from the Canadian healthcare system. Once women share their negative experiences with family and friends from their country of origin and hear their surprise and anger about the healthcare barriers in Canada, this reinforces *Unfulfilled Expectations*, reducing trust in the system, leading to *Opting Out* from services altogether. The following quotes illustrates:

> They would just avoid it because they think it's just it's going to be difficult as with other issues with other services, so that I don't even want to give the fight. I will wait when I go back to my country (41-year-old participant).

This quote demonstrates that Latin American women would not bother seeking care if the services entail prolonged waiting times. When faced with the

possibility of prolonged waiting periods, many women may choose to *Opt Out* care altogether.

> No, thank you. So, if they're going to tell me I have to wait in line for three hours, I'm out. Yeah, that would discourage me (41-year-old participant).

The disappointment and frustrations around unmet expectations of the healthcare system can lead to distress, either through the conscious anguish of waiting for services or through a perceived sense of neglect by the health system, which ultimately lead to *Opting out.*

Unfulfilled Expectations and ultimately *Opting out* of screenings can have serious negative consequences, particularly in the context of preventive health. Delaying or avoiding screenings increases the risk of inadequate treatment and can ultimately lead to more severe health issues down the line. This concern is echoed in the experiences of another participant who reflected on her decision-making process regarding cervical cancer screening:

> I received a pamphlet in the mail, at home. But I was like, OK, this is something that I will take care of but…. Later (43-year-old participant).

Findings Conclusion

Latin American immigrant women's journey in seeking healthcare services is marked by *Unfulfilled Expectations* of the Canadian healthcare system. Several factors contribute to their negative perceptions and difficulties navigating the system. As a result, these women seek coping mechanisms that often adversely affect their quality of life and health, such as *Questioning* the health system, *Balancing* service wait times with the

urgency of their health issues and *Opting Out* from participation in screenings. Ultimately, they tend to withdraw from seeking healthcare services overall.

This situation raises important questions: Are these women postponing preventive measures like cervical cancer screening due to a lack of time or familiarity with the healthcare system and many responsibilities? Or are they hoping to eventually access a family doctor who can provide more guidance and support?

The women's perceptions of the health system are predominantly negative, shaped by various influencing factors. Many feel they have not adapted well to the system, expressing a desire for faster, more efficient, and private service options, along with easier access to frequent check-ups. They often characterize the health system as lacking in service options, which leads them to withdraw from seeking care, including cancer screening tests, even if only temporarily. This disconnection reinforces the need for systemic improvements that align with their expectations and experiences, ultimately fostering a more supportive environment for healthcare access. Additionally, education about Canadian healthcare services could potentially alleviate some of the stress experienced by these women. Interviews revealed a clear mismatch between their expectations and what can be executed in the current political and social context.

Chapter 5: Discussion

In this study, I examined how Latin American immigrant women in New Brunswick make decisions about cervical cancer screening. As part of addressing the study's purpose, among other research questions, I examined the women's intentions toward cervical cancer screening and how they decided whether to undergo it. While my research questions focused on cervical cancer screening, the women shared perspectives and experiences that went beyond the focus on their decisions and decision-making process about screening. For the most part, their discussions focused on their quest for healthcare services and experiences of dissatisfaction. When it became apparent that discussing the broader context of seeking healthcare services was more relevant for the women, I allowed the conversations to flow naturally. As my interviews were semi-structured, I remained open to listening and asked probing questions to explore their experiences more deeply. This approach helped me understand how their broader health-seeking behaviors related to cervical cancer screening, the central topic of my research, and how these behaviors influenced their decision-making processes.

These findings are presented as a process of *Distancing from cervical cancer screening.* Central to this process was the concept of *Unfulfilled Expectations* and coping strategies: *Questioning* the effectiveness of the Canadian healthcare system, *Balancing* urgency with wait times for services, and *Opting Out* of prolonged healthcare engagements. Participant's *Unfulfilled Expectations* and access to healthcare services were conditioned to various factors including being relatively new to the country, lacking

a primary care provider, being unfamiliar with the healthcare system, having a supportive family or partner, and having a family history of cancer or a history of HPV. These conditions significantly shaped their decision-making processes regarding cervical cancer screening, highlighting the need for targeted interventions to improve healthcare access for newcomers. These conditions affected their perceptions of the services to some degree, often resulting in unfamiliarity with how the system works and leading to frustration. This ultimately contributed to the main problem of having their expectations unmet.

Echoing the current study's emphasis on Unfulfilled Expectations among Latin American immigrant women regarding the Canadian healthcare system, Kwong and Mak (2009) identified bureaucratic hurdles and lengthy wait times within healthcare systems as significant barriers to effective screening. Similarly, Ansell et al. (2017) highlighted the importance of timely access to healthcare concerning patient satisfaction and care quality, which aligns with the implications of this study.

In a literature review, Ferdous et al. (2018) identified the primary barriers to cervical cancer screening among immigrant women in Canada, emphasizing healthcare-system-related barriers as crucial. Through my interviews with Latin American women, I discovered that difficulties in accessing healthcare services significantly shaped their decisions regarding screening. Our interview discussions underscored the prevalence of service restrictions and challenges in accessing family doctors. This was a pattern in the demographic profile that affected the likelihood of undergoing screening or not. Lofters et al. (2011) also found that in Ontario the lack of a family doctor, particularly one from

the same region or a female physician, negatively affected screening for immigrant women, irrespective of their cultural or ethnic background.

One coping mechanism observed when their expectations were not met was *Questioning* the Canadian healthcare system. These women felt that differing approaches hindered their engagement in screening initiatives, particularly due to challenges such as the inefficiency in scheduling appointments, and the lack of access to specialists or family doctors. Ferdous et al. (2018) highlighted that waiting for primary healthcare appointments often imposes significant physical and emotional burdens on patients. In my study, many participants were accustomed to receiving recommendations for cervical screening from gynecologists in their home countries. However, upon migrating to Canada, they perceived the decision to seek or access cervical cancer screening as more of an individual choice rather than a physician's directive.

The absence of a family doctor and the lack of a physician's recommendation significantly influenced Latin American women's decisions regarding cervical cancer screening. The challenge of accessing family doctors is well-documented, with existing research proposing strategies to address this issue (Ansell et al., 2017). In response to these barriers, participants in my study suggested open-access scheduling as a potential strategy to reduce delays without requiring additional staffing resources. Additionally, leveraging the growing number of nurse practitioners could also enhance access to cervical cancer screening services (King & Busolo, 2022).

Another critical research question explored the factors influencing Latin American women's decisions regarding cervical cancer screening. Unlike prior research highlighting cultural and familial influences, participants in my study largely made

healthcare decisions independently, minimizing family or partner influence. While their partners did not directly assist in the process, they also did not hinder access to care. This contrasts with the work by Madhivanan et al. (2016), who found machismo affected screening decisions, citing partners' sexist views and jealousy, over their wives being examined by a male physician. While acknowledging machismo's cultural impact, participants prioritized personal healthcare autonomy, diverging from familial influences noted in earlier studies.

Regarding *Balancing* the urgency of the problem and the time required for services, past research has consistently identified long wait times as a significant barrier to cancer screening among immigrant women, negatively impacting screening rates (Kwong & Mak, 2009; Fitch et al., 1998; Vahabi & Lofters, 2016). In this study, Latin American immigrant women acknowledged difficulties in accessing screening services due to complex appointment scheduling systems, extended wait times, and challenges in obtaining clear information, exacerbated by confusing communication, which led them to balance the urgency of the problem with the wait for services.

Effective communication and access to clear information are fundamental to navigating unfamiliar healthcare services. Theoretical frameworks suggest that personalized care and clear communication resonate with the cultural construct of *personalismo*, particularly among Latin American women, thereby shaping their healthcare decisions (Chen et al., 2018). This alignment highlights the importance of culturally competent communication in healthcare settings. In my study, participants reiterated the significance of receiving clear information, demonstrating how these

factors critically influence their decision-making processes regarding cervical cancer screening.

Donelly et al. (2009) found that immigrant populations face numerous competing priorities that may lead to a lower prioritization of cancer screening. Participants in my study echoed these sentiments, citing the challenge of *Balancing* multiple responsibilities and frequently delaying cervical cancer screening. Latin American women often weigh prolonged waiting times against the urgency of their health needs, which can result in disengagement from healthcare and cancer prevention efforts, which is reflected by the coping mechanism of *Opting out.* This emphasizes the critical need for strategies that prioritize screening for this specific population. Targeted efforts are essential to achieving desired screening rates nationwide and addressing the unique challenges faced by Latin American immigrant women in accessing timely and effective healthcare services.

This study has significant implications for healthcare practices and policies. It reveals how Latin American women's intentions and decisions regarding healthcare and cervical cancer screening are influenced by their perceptions of healthcare services and their expectations of the Canadian healthcare system. The study found that unfamiliarity with the healthcare system and dissatisfaction with long wait times were key factors affecting their decision-making, especially for those who have recently arrived or do not have a family doctor or primary care professional.

Given the potential to substantially reduce cervical cancer mortality rates, addressing healthcare-related barriers to screening is imperative. To increase screening rates for Latin American immigrant women, it is crucial to enhance education about the

healthcare system and help set clear expectations. This involves explaining how the system operates and reinforcing the importance of preventative measures, even in the face of perceived barriers. Furthermore, tackling the issue of bureaucratic hurdles, and long waiting times to access healthcare services is pivotal in promoting greater adherence.

Access to healthcare has become increasingly complex for both Canadians and immigrants, due to economic constraints that are prevalent worldwide in recent years. Latin American immigrant women interviewed for this study voiced significant dissatisfaction with the healthcare services available to them, despite these services being free and universal. Through this study, I shed light on the experiences of Latin American women, in accessing cervical cancer screening services and portrayed their experiences to be reflective of challenges with accessing healthcare services more broadly. By doing so, it seeks to identify which practices and policies should be introduced, reinforced, or revised to enhance equity among diverse populations. These practices involve improving access to information about cancer screening. This includes providing detailed information on where to seek services and allocating more time for these women during medical appointments to better explain the services. As some participants have suggested, there should be more cancer screening sites and clinics specifically focused on newcomer women's health, like those that exist in other provinces, such as the Newcomer Women's Health Clinic in British Columbia (Chan et al., 2018). Identifying specific locations will help women know where to go for the services they need.

The present study exhibits significant strengths. By focusing on a qualitative approach, I thoroughly explored the perspectives, intentions, and decision-making

processes of Latin American immigrant women concerning cervical cancer screening in New Brunswick. This approach not only allowed me to delve deeply into their experiences but also provided a platform for these women to articulate what mattered most to them. Emphasizing qualitative research enabled me to attain a nuanced understanding deeply rooted in the social realities of these women's lives. Notably, my findings are grounded in the authentic perspectives of Latin American women. Furthermore, the study contributes valuable insights by offering recommendations for enhancing accessibility strategies tailored specifically to Latin American immigrant women in New Brunswick.

Lastly, this study holds significance in bridging current gaps in research concerning cervical cancer screening among Latin American immigrants in New Brunswick. Uncovering the prevalent factors hindering the screening of this population offers valuable insights into addressing issues and adjusting flaws within the Canadian health system. By doing so, it is possible to strive toward a more effective and equitable healthcare system that better meets the diverse needs of this community.

Despite the above-mentioned strengths, there are a few limitations worth noting. One limitation of the study is that while the recruitment efforts were open to Latin American women, irrespective of their location of residence, most of the participants resided in Fredericton – a more urban location. The perspectives of Latin American women from rural areas are desired. Women from rural locations could be affected by different factors and their decisions or decision-making processes might be dissimilar to those of women from urban locations. Therefore, despite being important in raising important gaps in cervical cancer screening, the study might not represent the reality of

immigrant women living outside urban areas. Furthermore, the data may not represent the experiences of Latin American women with lower education levels, as most participants had higher levels of education and health literacy regarding screening.

Further research is essential to examine Latin American women's decision-making processes concerning cervical cancer screening. This investigation aims to elucidate their healthcare expectations, thereby facilitating healthcare professionals' ability to provide appropriate care to newcomer populations.

Conclusion

Qualitative research exploring the perspectives and decision-making practices of Latin American immigrant women on cervical cancer screening in New Brunswick is scarce. Thus, this study contributes to gaining a deeper understanding of immigrants' knowledge and beliefs about cervical cancer screening in Canada.

The final product of this research was the theory of Latin American women's search for health services: A model of distancing from cervical cancer screening. The results of this study expose the factors that influence the intentions and decision-making processes of these women regarding cervical cancer screening, providing guidance for future measures to be taken. Moreover, the research supports health professionals in addressing the barriers faced by these minority populations in accessing screening services and programs, to promote more equitable health services.

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group_cancer=1&include_nmsc=1&include_nmsc_other=1&projection=globe&color_palette=default&map_scale=quantile&map_nb_colors=5&continent=0&show_ranking=0&rotate=%255B10%252C0%255D

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Appendix A- Confidentiality Agreement

This form will be used for individuals hired to conduct specific research tasks, e.g., transcribing, interpreting, and translating.

Project title - Latin American women's intentions and decision-making processes about cervical cancer screening: A grounded theory research.

I, _____ , the _____ (specific job description, e.g., interpreter/translator) have been hired to _____

I agree to -

1. Keep all the research information shared with me confidential by not discussing or sharing the research information in any form or format (e.g., recording, transcripts) with anyone other than the study researchers.

2. Keep all research information in any form or format (e.g., recordings, transcripts) secure while it is in my possession.

3. Return all research information in any form or format (e.g., recordings, transcripts) to the *Researcher(s)* when I have completed the research tasks.

4. After consulting with the *Researcher(s),* erase or destroy all research information in any form or format regarding this research project that is not returnable to the *Researcher(s)* (e.g., information stored on a computer hard drive).

_____

(Print Name) (Signature)

_____

(Date)

Researcher(s)

_____ _____

(Print Name) (Signature)

The study has been reviewed for its adherence to ethical guidelines and is on file with the Research Ethics Board at the University of New Brunswick. For questions regarding participant rights and ethical conduct of research, contact the Research Ethics Office at +1 506 453 5189 or ETHICS@unb.ca

Appendix B- Poster

EST. 1785 UNB
UNIVERSITY OF NEW BRUNSWICK

LET'S TALK ABOUT CERVICAL CANCER SCREENING



We invite you to participate in a study on: Latin American women's decision-making processes about cervical cancer screening: a grounded theory research study

We are looking for...

- Latin American women (ages 40-60)
- Residents of New Brunswick
- Speak/read English

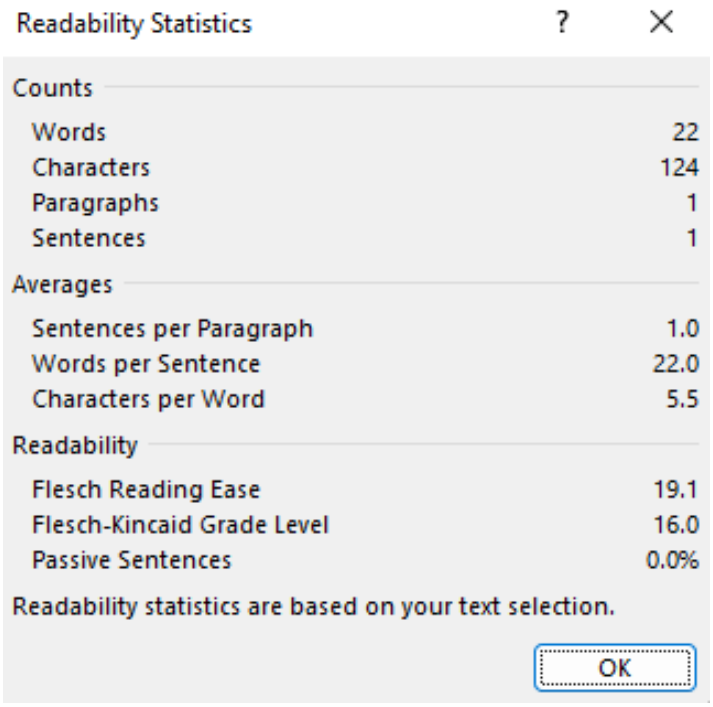
What can you expect?

- To participate in a one-on-one interview lasting 1-1.5 hours
- Interviews can be done in-person or online

If you are interested, please contact:

• **Cecilia Moreira** at cmoreira@unb.ca Phone: (506) 260-6118

This project has been reviewed by the University of New Brunswick Research Ethics Board and it's on file as REB-20XX-XXX.


Readability Statistics
?
Counts
Words 22
Characters 124
Paragraphs 1
Sentences 1
Averages
Sentences per Paragraph 1.0
Words per Sentence 22.0
Characters per Word 5.5
Readability
Flesch Reading Ease 19.1
Flesch-Kincaid Grade Level 16.0
Passive Sentences 0.0%
Readability statistics are based on your text selection.
OK

Appendix C - Interview Guide

Opening: Firstly, thank you for meeting with me to help me understand what motivates Latin American women to undergo cervical cancer screening. The aim of my research project is to find out the decisions that Latin American women make about cervical cancer screening and how they make those decisions. I hope that the findings of this study will improve what we know about the decisions that Latin American women make about cervical cancer screening and help health professionals to promote better ways to increase the number of people who take up cancer screening in New Brunswick. The interview will take approximately one hour. I will record the interviews and take a few notes while we talk, to facilitate the analysis process. Do you give me permission to record the interview? Your identity will be kept confidential, and I am the only person who will have access to your personal information. You can stop the interview at any time if you do not feel comfortable answering the questions. Do you have any questions for me before we start?

1. So, to start, can you tell me a little bit about yourself?
2. What, if anything, do you know about cervical cancer?
    a. Probe: If yes, then ask "Where did you learn about cervical cancer?"
    b. Probe: Please tell me about the things that can cause cervical cancer.
3. What, if anything, do you know about cervical cancer prevention? Probe: please tell me more.

4. Can you tell me about your experiences of seeking cervical cancer screening (pap test/pap smear)?

   a. Probe: Did you find the process to be easy to get cervical cancer screening?

   b. Probe: Did you find the process to be difficult to get cervical cancer screening?

5. Why did you decide to be screened for cervical cancer? Please tell me more.

   a. Probe: Who was involved in making the decision to seek cervical cancer screening? (e.g., friends, family, partner).

   b. Probe: If someone was involved, ask: In what way(s) was the person involved in making the decision to seek cervical cancer screening?

   c. Probe: If someone was involved: Ask: How did their involvement affect the decision you made?

   d. Probe: If someone were involved ask: If the person(s) was not involved, would you have made the same decision? Please tell me why.

   e. Probe: If no one was involved ask: In what ways did your culture, beliefs, or values influence your decision to get cervical cancer screening?

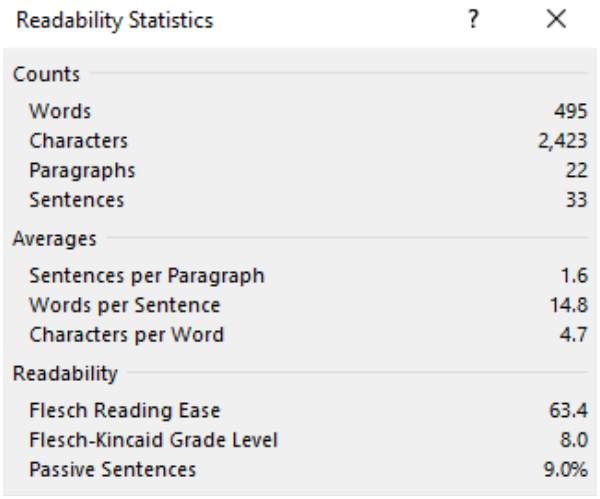
4. Please tell me, what was easy or difficult in making the decision to get (or not get) cervical cancer screening?

   f. Probe: What could be done to make it easier for you and other Latin American immigrant women to get cervical cancer screening?

6. How was cervical cancer screening for you? From the time you received screening to the time you received your results and afterwards.

7. Are there any questions that I should be asking immigrant women that I did not ask in this interview?

Thank you very much for meeting with me once again.



Appendix D- Socio-Demographic Form

1) What is your date of birth?
2) What is your immigration status in Canada?
3) How many years have you lived in Canada?
4) What is your country of birth?
5) How would you describe your marital status?
    1. Married _____
    2. Single _____
    3. Common law_____
    4. Widow/widower_____
    5. Divorced/separated_____
6) Do you have any children? (Yes/no) _____
    a. If yes, how many? _____
7) How many people live with you? _____
8) Are you employed:

1. Yes _____

   a. If yes, how do you describe what you do for work? _____

2. No _____

9) What is your highest level of education?

1. Grade 9 or less
2. Some high school
3. High school diploma
4. Some college/university
5. University degree

10) How would you rate your current health?

1. Excellent _____
2. Poor _____
3. Fair _____

11) Have you ever smoked?

1. Yes
2. No

12) What is your average household income?

1. Less than $ 10,000
2. $10,000 – $49,999

3. $50,000 - $89,999

4. $ 90,000 and above

Appendix E – Distress Protocol

Symptoms of Distress

While conducting the interviews. Participants may become distressed due to memories that can be difficult for them. Dealing with strong emotions can be extremely challenging. A participant may:

- Appear withdrawn and unwilling to share information, or present information in a vague manner.
- Be critical or negative about certain aspects of their perspectives or experiences.
- May intimidate you through jokes or sarcastic statements.
- May appear sad or depressed.
- May cry or shed tears.
- May inform you that it is difficult to talk about their experiences.

If a participant indicates that they are stressed or appears to be in distress, I will:

1. Stop the interview.
2. Provide immediate support.
3. Assess the participant's mental status by asking, "Are you okay?" "Please tell me what thoughts you are having." "Would you like to take a break?" "Tell me what you are feeling right now?"

Depending on the participant's response, I may also ask: "Do you feel you can continue the interview?"

4. If a participant feels able to carry on, I will resume the interview.
5. If a participant is unable to carry on, I will:
    a. Discontinue the interview.
    b. Encourage the participant to contact their primary care provider, a walk-in clinic, or mental health provider, OR offer, with participant consent, for me to do so, OR I will follow up with a courtesy call (if participant consents) OR,I will encourage the participant to call either if he/she experiences increased distress in the hours/days following the interview.

Counseling Services

1. Fredericton Addictions and Mental Health Services.

Address: 65 Brunswick St, Fredericton, NB E3B 1G5

Hours: Open 8:30 a.m. Closes 4:30 p.m.

Phone: (506) 453-2132

2. Multicultural Association of New Brunswick

Address: 28 Rue Saunders Street, Fredericton, NB E3B 1N1

Hours: Open 8:30 a.m. Closes at 5 p.m.

Phone: (506) 454-8292/ 5064711677

3. UNB Counseling Services

C.C. Jones Student Services Centre

Student housing center in Fredericton, New Brunswick

Phone: (506) 453-4837

4. Family Enrichment & Counseling Service

1-356 Queen St (506) 458-8211

Open 8:30 a.m. Closes 4:30 p.m.

100-130 wait time.

5. Moncton Addictions and Mental Health Services.

Address: 81 Albert St, Moncton NB E1C 1B3

Hours: Open 8:30 a.m. Closes 4:30 p.m.

Phone: (506) 856-2444

6. Multicultural Association of the Greater Moncton Area

Address: 22 Church St C170, Moncton, NB E1C 0P7

Hours: Open 8:30 am Closes 4:30pm

Phone:(506) 857-9430

7. Saint John Addictions and Mental Health Services.

Address: 55 Union St, Saint John, NB E2L 5B7

Hours: Open 8:30 a.m. Closes 4:30 p.m.

Phone: (506) 658-3737

8. Multicultural Association of Saint John

Address: 75 Prince William St, Saint John, NB E2L 2B2

Hours: Open 8:30 a.m. Closes 5 p.m.

Phone: (506) 642-4242

McCosker, H., Barnard, A., Gerber, R. (2001). Undertaking Sensitive Research: Issues and Strategies for Meeting the Safety Needs of All. *Forum: Qualitative Social Research, 2*(1)

Gregory, D., Russell, C., Phillips, L. (1997). Beyond textual perfection: transcribers as vulnerable persons. *Qualitative Health Research, 7*(2), 294-300.

Appendix F - Field Notes Guide

The field notes will have two parts. The first part will be used for descriptive data, I will capture a word-picture of the setting, actions, and conversations. In the second part I will record thoughts, ideas, questions, and concerns based on my observations from the interview.

1. My descriptive field notes will include a detailed description about what I see during the interview, including non-verbal communication and a description of the setting, such as the environmental context.
2. In my personal reflections/interpretation field notes I will emphasize ideas, hunches, impressions, etc. I will include what surprised me in the interview, and what intrigued or disturbed me. I will clarify points and correct mistakes and misunderstandings in other parts of my field notes. I will also include insights or speculations about what I am observing during interviews.

Guide for taking field notes (2015). Masters in teaching program YR 1-F2015. Retrieved on February 07, 2023, from: https://sites.evergreen.edu/mit17/wp-content/uploads/sites/97/2015/07/Guide-for-taking-field_notes_fall_2015.docx

Appendix G - Informed Consent for Interview

Study title: Latin American women's intentions and decision-making processes about cervical cancer screening: a grounded theory research.

Study Researcher: Cecilia Assuncao Moreira, Master Applied Health Services Research, University of New Brunswick, cmoreira@unb.ca or (506) 260 6118

Researcher Supervisor: Dr. David Busolo, Faculty of Nursing, University of New Brunswick, david.busolo@unb.caor (506) 456 2898.

Dr. Petrea Taylor, Faculty of Nursing, University of New Brunswick, petrea.taylor@unb.ca or (506) 962 4690

Please contact Dr. Busolo or Cecilia Moreira if you have any concerns about this study.

You are invited to participate in the study: Latin American women's decision-making processes about cervical cancer screening: a grounded theory research study.

To join this study, you must:

- Be a Latin American woman.
- Be 40 to 60 years old.
- Speak English
- Live in New Brunswick

Research information

This form has information about the research. You may choose to read it on your own or have it read aloud to you. You are free to ask any questions or for more information about the study. Your participation is voluntary, so feel free to think about your decision. If you agree to participate in the study, you will sign this form, and you can keep a copy of it.

Study Aim: the aim of this qualitative research study is to examine cervical cancer screening intentions and the decision-making processes that Latin American women use regarding cervical cancer screening.

What can you expect?

You will be invited to participate in one-on-one interviews lasting approximately 1.0 hour. The interviews could be either in person or online.

I will ask you questions about your perspectives and beliefs around cervical cancer screening, how you make decisions to seek or receive cervical cancer screening, and what factors affect your decisions to undergo/not undergo cervical cancer screening. All interviews will be digitally recorded and transcribed verbatim.

Please be reminded that:

- Participation in this study is voluntary, which means that it is up to you to agree to participate. You may change your mind at any time, without having to provide explanations.

- If you agree to participate in the study and decide to be interviewed in person, you will be offered snacks, as a gift of thanks for your time.
- This study poses no risk to participants, however if you feel uncomfortable at any time or when answering the questions, or you feel any type of distress, we can take a break or stop the interview.
- A voice recorder will be used to record the interviews, for analysis purposes. The interviews will be saved on a computer that uses a password and the original one will be deleted from the recorder. We will not share anything you tell us during the interviews in a way that others will know who you are. Your identity will always be kept private.
- To protect your privacy, I will keep your name and information private. I will replace your name with a different one when I write about the study or share my results at conferences or journals. If you would like to receive updates about the outcomes of this study, you may provide us with your email address, which I will use to send our findings once they are ready to share.
- Your participation in this study may help other Latin American women to engage in cervical cancer screening. In addition, it will help healthcare providers to get a better understanding of the decisions Latin American women make about cervical cancer screening.

This study has been reviewed and is on file with the Research Ethics Board (REB) at the University of New Brunswick and is on file as REB-2023-102

Consent Certificate:

- ❑ I understand the information in this form. I have had all my questions answered and I agree to participate in this study.
- ❑ I have been given a copy of this consent form. The copy is for me to keep for my records and reference.
- ❑ I want to receive a summary of the findings. No___ Yes ___
- ❑ I do not want to sign this document. Instead, I will verbally record my agreement to participate.
- ❑ I agree to take part in this study. No___ Yes ___

_____ _____

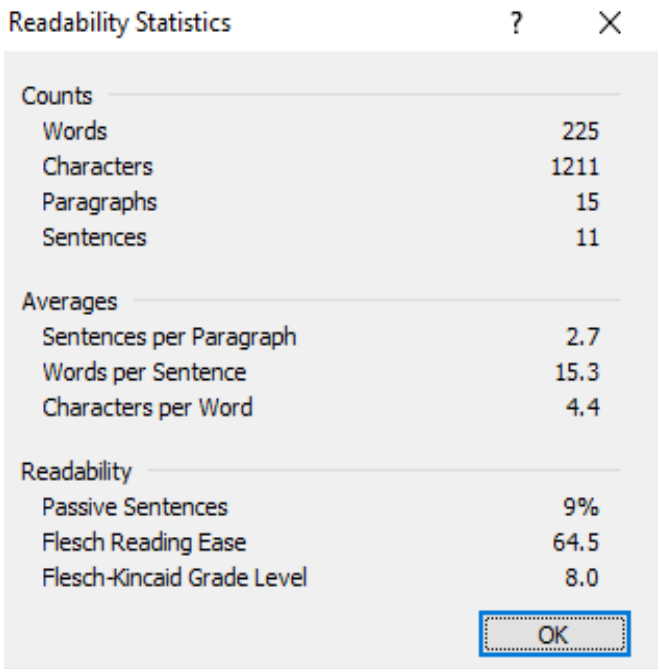
Printed Name of Participant Signature of Participant

_____

Date

_____ _____

Printed Name and Signature of the Researcher Date


Readability Statistics
?
Counts
Words 225
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Paragraphs 15
Sentences 11
Averages
Sentences per Paragraph 2.7
Words per Sentence 15.3
Characters per Word 4.4
Readability
Passive Sentences 9%
Flesch Reading Ease 64.5
Flesch-Kincaid Grade Level 8.0
OK

Curriculum Vitae

Candidate's full name: Cecilia Assuncao Moreira

Universities attended:

Federal University of Minas Gerais (Belo Horizonte, Minas Gerais – Brazil), Bachelor of Science in Physical Therapy, 2017

Faculty of Medical Sciences of Minas Gerais (Belo Horizonte, Minas Gerais – Brazil), Post Graduate Diploma in Women's Health, 2019

Federal University of Minas Gerais (Belo Horizonte, Minas Gerais – Brazil), Master in Biological Sciences- Physiology and Pharmacology, 2020

University of New Brunswick (Fredericton, New Brunswick), Master of Applied Health Services Research, 2021-2024

Conference Presentations:

Moreira, C., Busolo D. (2023, November 12-14). Latin American women's intentions and decision-making processes about cervical cancer screening: A grounded theory research. [Poster Presentation] The Canadian Cancer Research Conference, Halifax, NB, Canada.

Moreira, C., Busolo D. (2023, November 16-17). Latin American women's intentions and decision-making processes about cervical cancer screening: A grounded theory research. [Poster Presentation] Health Research Week. Research New Brunswick, Saint John, NB, Canada.

Busolo D., Moreira, C., Omar, H., Anaba, M. (2023, November 16-17). Immigrant youth's perspectives of HPV risk and vaccination uptake. [Oral Presentation] Health Research Week. Research New Brunswick, Saint John, NB, Canada.

Moreira C., Almeida D., Romero T., Lopes M. (2018). “Assessment of the protective and antinociceptive effect of the P1G10 proteolytic fraction of Vasconcellea cundinamarcensis latex on chemotherapy-induced peripheral neuropathic pain”. XXVI Encontro de Pesquisa em Fisiologia e Farmacologia. Belo Horizonte, MG (in Portuguese).

Moreira C., Almeida D., Machado D., Romero T., Lopes M. (2019). “Protective effects of P1G10 fraction from Vasconcellea cundinamarcensis, on peripheral neuropathic pain and myelosuppression caused by Paclitaxel, in 4T1 mammary carcinoma model” XXVII Encontro de Pesquisa em Fisiologia e Farmacologia. Belo Horizonte, MG (in Portuguese).

Moreira C. (2019). “Cancer and Exercise”. Pitagoras University, Department of physical education, Course of exercise prescription for special groups (in Portuguese).

Moreira C., Lopes M. (2019). “Physiology and Pharmacology in the Fantastic Universe”. Interview on the radio program entitled Fantastic Universe (in Portuguese).