

**ACCESSING CERVICAL CANCER SCREENING IN NIGERIA:
EXPLORING THE EXPERIENCES OF NIGERIAN-BORN IMMIGRANT WOMEN IN
CANADA**

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DEDICATION

This thesis is dedicated to God Almighty, my late grandmother-Elizabeth Olakunbi Ojo, and every Nigerian woman who has died from a preventable disease such as cervical cancer, as well as those currently living with the disease. Your stories kept me on my feet and gave me a reason not to give up when I had every reason to.

ABSTRACT

This research study explored the experiences of women eligible for cervical cancer screening (CCS) in accessing CCS services in Nigeria. The goal was to develop an in-depth understanding of these experiences in order to provide facts that could inform policies and interventions that will improve the utilization of CCS services among Nigerian women. This descriptive study utilized naturalistic inquiry and an intersectionality theoretical lens for understanding women's access to CCS and its possible intersection with socially constructed categories, which could have influenced these women's experiences. Ten (10) Nigerian-Immigrant women who met the set eligibility criteria were recruited for interviews using purposive sampling and snowballing. Data was analyzed using an inductive thematic analysis approach. The study's findings detail overarching themes that best capture the experiences of participants with accessing CCS programs in Nigeria. Future research is needed to engender best practices for the planning of CCS programs.

Keywords: Cervical cancer screening, Nigerian women, experiences, access

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LIST OF ABBREVIATIONS AND CONCEPT CLARIFICATION

Acronyms

CCS	Cervical Cancer Screening
HPV	Human Papillomavirus
HIV	Human Immunodeficiency Virus
LMIC	Low- and Middle-Income Countries
Pap smear	Papanicolaou smear
RA	Research Assistant
VIA	Visual Inspection with Acetic Acid

Concept Clarification

<i>Accessing</i>	<p><i>The Cambridge Dictionary</i> (2021) defines accessing as “being able to use or obtain something such as a service.” The term also connotes the “freedom or ability to obtain, make use of, or participate in something” (Merriam-Webster, n.d.). Makinde et al. (2018) refers to access as “being financial (ability to pay), social (knowledge of and empowerment ability to access care) and physical access to health services.”</p> <p>In this study, accessing entails all the events and processes that take place, beginning with a woman’s informed decision to get screened until she gets a screening appointment and presents herself at the health facility for the investigation.</p>
<i>Healthcare services</i>	<p><i>McGraw-Hill Concise Dictionary of Modern Medicine</i> (2002) defines healthcare services as “A procedure performed on a person for diagnosing or treating a disease.” In this study, these include all services provided at each level of healthcare, including CCS in Nigeria.</p>
<i>Government-controlled facility</i>	<p>In this study, this is any government-owned building, structure, or land used for public purposes, typically including research facilities, hospitals, rehabilitation centers, or correctional centers for adults and youths. These include primary healthcare centers, federal medical centers, and teaching hospitals owned by the government that offer CCS services.</p>
<i>Privately-owned controlled facilities</i>	<p>In this study, these include non-governmental organizations and private hospitals that offer cervical cancer screening services.</p>
<i>Primary healthcare system</i>	<p>In this study, this is the most basic level of healthcare delivery. This includes primary healthcare centers, health posts and clinics, mission hospitals, and private hospitals. It is monitored by the local government. This is commonly referred to as district healthcare in other countries of the world (Olanlesi-Aliu et al., 2019).</p>

Secondary healthcare system In this study, this consists of state hospitals, which are managed by the state government through the State Ministry of Health (Olanlesi-Aliu et al., 2019). Activities in both the secondary and primary levels of healthcare are monitored by the State Ministry of Health.

Tertiary healthcare system In this study, this is the most advanced level of healthcare in Nigeria. It includes federal medical centers and teaching hospitals. It is managed by the federal government through the Federal Ministry of Health (Olanlesi-Aliu et al., 2019).

Woman/Women: In this study, this is a female individual who has a cervix and is sexually active. This group has accessed and navigated any type of CCS services in Nigeria.

CHAPTER ONE: INTRODUCTION

Cervical cancer (CC), a malignancy of the cervix, is a disease of global health concern (Babajide et al., 2020; Piñeros et al., 2013) that affected over 570,000 women globally in 2018 (Bray et al., 2018). Low- and middle-income countries (LMIC) bear a substantial proportion of this burden (Fitzmaurice et al., 2017; Mandal & Basu, 2018), with 80–90% of all CC deaths occurring in LMICs, Nigeria inclusive (Anorlu, 2008; Bruni et al., 2019; Shrestha et al., 2018; The Joint United Nations Programme on HIV and AIDS [UNAIDS], 2019). Likewise, in Africa as a whole, CC is the most common gynecological cancer and the leading cause of mortality among women (Arbyn et al., 2020), with most of the incidence, prevalence, and mortality seen in sub-Saharan African countries such as Nigeria, Malawi, and Ghana, to mention but a few (Adegboyega, 2017; Ba et al., 2021; Bray et al., 2018; Formana et al., 2012). In Nigeria, CC is the second most common cancer among Nigerian women after breast cancer (Bruni et al., 2019).

Despite numerous global scientific efforts geared toward finding an efficient and effective cure for CC, it continues to affect the health and lives of many without a cure. Nevertheless, evidence from studies shows that access to early detection practices such as the Papanicolaou smear (Pap smear), visual inspection with acetic acid (VIA), and visual inspection with Lugol's iodine (VILI) has proven to be effective over the years in reducing the global prevalence of, and mortality from, CC (Drolet et al., 2019; Hirte et al. 2015; World Health Organization [WHO], 2014; Zhang et al., 2021). The Pap smear is a useful and highly accurate cytological investigative tool that detects CC by examining cells of the cervix for precancerous and cancerous lesions (Duru et al., 2015). Despite its high degree of accuracy, the uptake of the Pap smear remains low in low-resource settings (Campos et al., 2015).

To improve global screening coverage, especially in low-resource settings and because most cases of cervical cancer are caused by human papillomavirus (HPV) (World Health Organization, WHO, 2021), low-cost HPV detection strategies such as VIA and VIL were recommended as suitable cost-effective measures in LMIC, Nigeria inclusive (Abiodun et al., 2017; Huchko et al., 2015; Sankarayanan et al., 2001). The VIA procedure entails the use of 5% acetic acid in staining the cervix to observe for any anomaly through Color changes (Nkwonta, 2018). The procedure has gained much acceptability by women due to its cost-effectiveness, timeliness, and simplicity and because it can be conducted by midwives and nurses (Carr & Sellors, 2004). On the other hand, VILI, another recommended screening mechanism, requires using Lugol's iodine solution in staining the cervix to observe for Color changes (Egede et al., 2018). The acceptability and uptake in low-resource countries are, however, low, due to the skill required in analyzing the results (Huchko et al., 2015).

Having identified some of the early detection measures and established their impact on CC burden, it is surprising, nevertheless, that many women globally, especially those living in LMICs, are still not diagnosed in a timely fashion (WHO, 2014). This is in contrast to developed countries where CC-screening (CCS) is made universally available to eligible women. Canada, for example, routinely targets eligible women between 21–69 years of age every 42 months to ensure $\geq 80\%$ of the nation's population is screened (Canadian Partnership Against Cancer, 2015). LMIC countries such as Nigeria have yet to follow this trend. In Nigeria, accessibility to CC screening remains a chronic problem and is a major barrier to the uptake of screening services by women (Vu et al., 2018).

It is, therefore, possible that some socially constructed categories play a role in the poor accessibility and low screening uptake among Nigerian women, especially when such categories

intersect to shape an individual's experience (Williams-Brennan et al., 2012). The ways in which such social constructs and their intersections are interpreted in a society may accentuate issues of power and privilege that bring about health inequities (Hankivsky, et al., 2010). For instance, authors of a policy briefing report submitted to WHO (Sen & Östlin, 2008) noted the lack of access to healthcare is reinforced by gender inequality in many societies. Similarly, Denny and Anorlu (2012) suggested that the poor uptake of CCS can be driven by the low value ascribed to the status of women in a society. Odekina. (2015) observed that social determinants impact the status and position of Nigerian women and Chang et al. (2015), identified the status and position of an individual within the social hierarchy influences that individual's experience with the healthcare system.

Though there are a plethora of studies on CCs utilization of women's cervical services in Nigeria (Utoo et al., 2013, Nyengidiki et al., 2019, Leo et al., 2020); however, most literature overlooks how intersections of social identity categories, contribute to major disparities that impact the access of women to CCS in Nigeria. Taking into consideration how these authors have shown that the CCS uptake is poor among Nigerian women, it was important to first understand why from the Nigerian-immigrant women in this study, and in particular identify if there are issues of power and privilege that hinder access to CCS. I put forward that these findings, could offer more insight into the context of health screening in Nigeria. The findings from this study could be essential in proffering solutions and offering recommendations for the review of these screening systems to ensure they are accessible to more women. If more women can access CCS, this could improve the early detection of precancerous cells, consequently reducing the incidence, morbidity, and mortality of CC in Nigeria.

Background

This study explored the experiences of women in accessing CCS in Nigeria. To understand the chronicity of accessibility problems in Nigeria, this research presents a study background that elaborates on how CC screening services are accessed in Nigeria. The background also further explains some of the suggested barriers and issues pertaining to accessing cervical screening services in Nigeria. Furthermore, this background discussion provides an overview of an important factor that has the potential to impact the accessibility of CC screening in Nigeria, namely, the Nigerian healthcare system. It is important to note that the Nigerian healthcare structure is unique and contextually related to Nigeria when compared to the healthcare delivery system in some other countries. Understanding how the healthcare delivery pathway works in Nigeria and how it is structured to accommodate the distribution of CCS services is therefore pivotal.

The Nigerian Healthcare Delivery System

One of the multiple factors that have the potential to impact the access of women to CC screening in Nigeria is the Nigerian healthcare delivery system. Nigeria has three levels of healthcare: primary, secondary, and tertiary. Contrary to the typical interpretation of the primary, secondary, and tertiary levels of healthcare, in Nigeria, these levels serve the local government, state, and federal regions, respectively (Welcome, 2011). The primary level consists of primary healthcare centers, missionary health centers, and clinics established by non-governmental organizations. This level is controlled by the local government (Omoruan et al., 2009).

The secondary level of healthcare serves people at the state level and consists of state hospitals and highly recognized private facilities and is controlled by the State Ministry of Health (Welcome, 2011). Referral cases are made to tertiary institutions (Federal Ministry of Health

[FMOH], 2004). The federal institutions receive referrals from the primary and secondary health institutions (FMOH, 2004), making them the hallmark of the healthcare system as more advanced healthcare services and professionals are available and controlled by the Federal Ministry of Health (Welcome, 2011).

Both secondary and tertiary healthcare facilities are usually found in urban communities, which are environs with a population of more than 20,000 (Okali et al., 2001). Cervical screening services are primarily offered in secondary and tertiary healthcare facilities, with no services available at the primary healthcare facilities (Onyenwenyi & Mchunu, 2019). As a result, people must often travel a long distance to secondary and tertiary facilities to get screened. Pap smears and VIA are usually offered in the gynecological units of these settings. Other ways through which these CC services are offered are through outreach efforts conducted by non-governmental organizations.

Accessing Cervical Screening Services in Nigeria

Ideally, sexually active women between 21 and 65 years are encouraged to get screened as these age groups have a higher susceptibility to contracting HPV (Centers for Disease Control and Prevention [CDC], 2019). In Nigeria, women are encouraged to get screened every three to five years (Schiffman & Solomon, 2013). However, screening is not universal and is mostly accessed by chance in Nigeria (Aniebue & Aniebue, 2010; Sowemimo et al., 2017). In their study findings, Sowemimo et al. (2017) opined that cancer screening of Nigerian women is mostly done by accidental identification during their presentation for other medical conditions, which they termed as ‘opportunistic.’ Opportunistic screening depends on doctors’ and nurses’ referrals, or self-identification by the women to be screened (Aniebue & Aniebue, 2010).

As mentioned by Parikh et al. (2003), poor accessibility to screening for CCS contributes to low uptake of cervical screening, late diagnosis, increased morbidity, and high mortality due to CCD. Jedy-Agba et al. (2012) also associated the recurring CC burden in Nigeria with the low screening coverage of women. Nonetheless, little attention has been directed to improving the poor accessibility to CCS in Nigeria as Nigerian studies have established that available screening services are neither affordable, nor equitably distributed across the levels of healthcare in Nigeria (Sowemimo et al., 2017). For the most part, CCS is mainly offered by big teaching hospitals in the secondary and tertiary levels of healthcare, although other resourced private hospitals also offer screening at very expensive prices that exceed the ability of the average Nigerian to afford. (Egede et al., 2018; Idowu et al., 2016).

By contrast, in developed countries, measures to improve access to CCS have proven to reduce the burden of CC (Chigbu et al., 2015). Developed countries have been able to achieve a reduction of CC by 80% (Sankaranarayanan et al., 2001). For example, improved access to CCS in countries such as Canada has made a significant impact in ensuring a massive decline in the incidence, prevalence, and mortality of CC (Canadian Partnership against Cancer, 2016). Similar findings were also reported in the United States of America (USA) by Sawaya et al. (2019). It is therefore of huge concern that the successes recorded in high-resource countries are yet to be replicated in African countries (Denny & Anorlu, 2012). In Nigeria, the percentage of women accessing screening is low (Wright et al., 2011). Additionally, more than 75% of Nigerian women diagnosed with CC present to the healthcare facility at an advanced stage when the prognosis is poor (Toye et al., 2017).

Considering the factors limiting Nigerian women's access to CCS, the poor accessibility of CCS is often associated with the lack of an organized screening protocol to promote access

and uptake of CCS at each level of the Nigerian healthcare system (Musa et al., 2018; Babajide et al., 2020). In addition, the lack of personnel to conduct CCS screening in these settings further contributes to poor screening uptake among women (Vu et al., 2018). Several social determinants of health also intersect at various levels to amplify this problem. For instance, low socio-economic status, low healthcare-seeking behaviour (Arulogun & Maxwell, 2012), age, equality (Musa et al., 2018), gender, power relations, cultural beliefs (Mutuyaba et al., 2007), religious beliefs (Modibbo et al., 2016), level of education (Okunowo et al., 2018), political factors (Nejo et al., 2018), and faulty healthcare systems (Owoeye & Ibrahim, 2013) have been identified as some of the social mitigating factors that determine whether a woman gets screened or not. Nigerian women's lives are un-necessarily disrupted or abbreviated by structural and social features which shape their access CCS. Research is urgently needed to understand Nigerian women's experiences of accessing CCS.

Problem Statement and Study Rationale

Early detection through screening and access to quality treatment has been identified as an effective way to reduce morbidity and mortality arising from CC disease. However, contrary to the established effectiveness of CCS in developed countries (White & Wong, 2015), the impact of CC screening in Nigeria has been insignificant so far. In Nigeria, CC kills one woman every hour and over 9,000 women every year (Ferlay et al., 2010). To address the low impact of screening and improve access to screening measures in low-middle income countries, in 2013, the World Health Organization (WHO) approved the use of cost-effective screening measures such as visual inspection with acetic acid to be offered even at the most basic level of healthcare, the primary healthcare (PHC) level. However, the recommended measure has also failed to

improve early detection; rather, the incidence and mortality due to CC are still on the rise in Nigeria (Iyoke & Udigwe, 2013).

With these rising rates, WHO has forecasted a devastating increase in CC-related mortality by 2030, of which a higher proportion of the mortality cases are expected to happen in developing countries (WHO, 2015). Nigeria is a developing country with the largest population in Africa (Abubakar, 2021). Therefore, these findings clearly suggest that a drastic change in practice is required to prevent the terrible consequences associated with the preventable disease of CC in Nigeria. Therefore, there was an urgent need to critically appraise the possible reasons for the unacceptable levels of CCS and the resulting burden of CC to date, thereby justifying my interest in exploring CCS access and Nigerian women's experiences accessing and navigating through healthcare systems.

Qualitative research on women's access to CCS in Nigeria is limited, especially with respect to identifying the possible social identity categories (underpinned by power and privilege) impacting women's access to CCS. Understanding the inter-relationships between the context of health screening and the role of social identities are essential to making evidence-informed recommendations for change. The findings from this study could also be timely as Nigeria released the 2018–2022 National Cancer Control Plan in 2018 (Eguzo et al., 2020). I anticipate that the findings from this research could guide further research studies as well as healthcare providers and policymakers in developing future healthcare policies that will increase the accessibility to CCS and improve screening coverage.

Purpose Statement and Plan

The purpose of this study was to explore women's experiences in accessing cervical screening programs in Nigeria and apply intersectionality theory to explore the role of social

mitigating factors in accessing CCS services. To inquire into these experiences of women eligible for CCS in accessing the service in Nigeria, the study objectives were categorized into three sections: (1) to identify any health disparity or inequity, and barriers at each level of healthcare that impact women's access to CCS; (2) to identify and understand how social categories intersect to shape Nigerian women's access to CCS; and (3) to identify and explore how oppression, privilege, and power relations emanate from the intersection of multiple social categories, and to describe its impact on women's access to CCS in Nigeria.

Ideally, this study would have been carried out among women living in Nigeria; however, due to the COVID-19 pandemic and the current high level of insecurity in Nigeria, the study was carried out among the Nigerian-immigrant women in Canada within a specified period since immigration. I believed this was a group with features and characteristics similar to those of the larger population in Nigeria. By defining these parameters, I was able to gather information on why accessibility to CCS services in Nigeria is currently poor. In addition, the study may shed light on the health disparities, social mitigators, and barriers women encounter while attempting to access screening services. Particularly, this study sought to understand how and whether these social mitigators intersect and, if they do intersect, what type of intersectional experiences result from these barriers and what the impact of these experiences is on the access story of women. The study findings highlight some socially constructed identities such as gender, socio-economic status, education, healthcare system, socio-cultural and political status, age, and religion that disrupted such access for women. These factors created health disparities and barriers that impacted women's access to CC screening (CCS) in Nigeria.

Research Questions

The main research question for this study was “What are the experiences of Nigerian-born immigrant women in accessing CC screening protocols in their home country?” Other questions that were important in understanding these experiences include:

- What factors shape the experiences of women accessing available cervical screening services in Nigeria?
- What are the socially constructed categories, if any, that impact women’s access to CCS in Nigeria?
- What are the health disparities and barriers to accessing available cervical screening services in Nigeria?

Summary

In this chapter, I presented an overview of the research study. This included the introduction, background, rationale, purpose and objectives of the study, problem statement, and research question. It is evident from this overview that there is a gap in scientific knowledge and evidence that is important for improving screening coverage in Nigeria. I see this gap as a problem because Nigerian women die in disproportionate numbers from a form of cancer that is highly preventable. A more in-depth review of the research literature, as it relates to CC screening in Nigeria, is detailed in Chapter 2.

CHAPTER TWO: LITERATURE REVIEW

This chapter provides a review of the literature on the experiences of women in accessing CCS, as well as a description of the theoretical framework adopted for this study. The literature review is divided into the following sections: (a) CC disease; (b) CC burden in Nigeria, which expatiates on the incidence, prevalence, and mortality in Nigeria; and (c) CC control in Nigeria, which is subdivided into: (i) past trends of CC screening in Nigeria; (ii) current trends of CC screening in Nigeria; (iii) CC screening: Pap smear & visual inspection with acetic acid in Nigeria; and (iv) factors affecting CC screening utilization in Nigeria. The literature on intersectionality theory is contextualized to CCS utilization in Nigeria.

Cervical Cancer Disease: Human Papillomavirus

Cervical cancer is a pathological condition that affects the cervix of a woman (Silverberg & Loffe, 2003). Anatomically, the cervix is located between the uterus and vagina (Bhatla et al., 2018). Cancer of the cervix is described as a malignant gynecological neoplasm emanating from the abnormal and uncontrollable proliferation of the cells of the cervix (Bosch & De Sanjosé, 2007). The abnormal proliferation tends to alter both the structure and the function of the cervix. The transmission of human papilloma virus (HPV) through coital exposure is an established global causal factor for CC disease; high-risk strains of HPV (16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68, 69, and 82) and low-risk strains of HPV (6, 11, 40, 42, 43, 44, 54, 61, 72, and 81) are seen in most cases of CC (Burd, 2003; Formana et al., 2012). Of these strains, HPV 16 and 18 have the highest rate of invasiveness and occur in the vast majority of cervical carcinoma cases (WHO, 2019).

In a study by de Martel et al. (2017), HPV 16 and 18 were seen in 90% of CC cases. Other authors have also established the prevalence of HPV strains to be different across global

geographical regions, with some admitting the need for various regions to adopt a CC control strategy tailored towards addressing their unique burden of CC (de Sanjose et al., 2010; Formana et al., 2012; Tjalma et al., 2012). For example, in North America, HPV 16, 18, 31, and 45 are most common, while for Central American women, HPV 16, 18, 31, 33, 45, and 91 are most common, and for women in Asia, 16, 18, 45, 52, and 58 are most common (de Sanjose et al., 2010). In another study by Tjalma et al. (2012), among 17 European countries, HPV 31, 33, and 45 were frequently seen alongside HPV 16 and 18 in diagnosed cases of CC.

Even though few studies are available to show the HPV prevalence rate in regions of Africa, especially in Nigeria (Shrestha et al., 2018), the established global causal and contributory factors of CC are still obtainable in sub-Saharan countries including Nigeria, although with a few differences. For example, multiple strains of HPV are responsible for CC disease in Nigeria, but high-risk oncogenic HPV 16, 31, 35, and 56 more commonly affect individuals of all age groups (Thomas et al., 2004), while 18 and 45 are seen in biopsies of diagnosed patients (Orah & Banjo, 2018). HPV 16 and 18 were commonly reported in Ghanaian studies (Nartey et al., 2017). Why this variability exists was not explored by these studies; however, it is known that some globally-disseminated diseases, such as HIV/AIDS, compromise the immune systems of women (Ononogbu et al, 2013; Strickler et al., 2005), which further increases the susceptibility of women to contracting multiple strains of HPV globally.

Cervical Cancer Burden in Nigeria

Sub-Saharan countries have the highest CC and cancer-related mortality in the world (Arbyn et al., 2020; de Martel et al., 2017; Jedy-Agba et al., 2020), Nigeria inclusive (Nnodu et al., 2010; Olanlesi-Aliu et al., 2019). With a national incidence rate of 250/100,000, it is not debatable that the incidence, prevalence, and mortality rate reflect the burden of CC in Nigeria

(Anyasi & Foss, 2020; Azuogu et al., 2019; Eze et al., 2013; Globocan 2018). In fact, CC accounts for 78.1% of diagnosed gynecological cancers in Nigeria (Kabir et al., 2019), and over 80% (four out of five) of women diagnosed with CC in Nigeria die from the disease (Airede et al., 2008). It is also predicted that there will be a sporadic increase in the incidence and mortality in sub-Saharan Africa by 2025 and 2030, especially if preventive measures against HPV are not instituted (de Sanjosé et al., 2012), as studies have shown that countries with poor preventive practices shoulder a high burden of CC (Hirani et al., 2020; Idowu et al., 2016; Swanson et al., 2018). Azuogu et al. (2019) established Nigeria's recorded CC incidence rate to be significant, exceeding the global incidence rate of 13.1 per 100,000 (Arbyn et al., 2020). In some regions, such as the North, CC is the most diagnosed gynecological cancer among women between the ages of 19 and 80 years rather than breast cancer, which is identified by most studies to be the most diagnosed in Nigeria (Bakari et al., 2017; Oguntayo et al., 2011).

According to some Nigerian studies, the high prevalence of HPV infection and CC disease in Nigeria is reinforced by factors such as high parity, prolonged use of oral contraceptive pills, poverty, smoking, early sexual debut, and multiple sexual partners among Nigerian women (Akinpelu et al., 2018; Bakari et al., 2017; Orah & Banjo, 2018). The high burden of CC in Nigeria seems to transcend the burden in other sub-Saharan countries such as Ghana (Nartey et al., 2017) and Malawi (Chinula et al., 2021), while continents such as Europe and North America have experienced a declining rate in CC prevalence and mortality over the years (Arbyn et al., 2020). Researchers attribute the massive decline of the CC burden in high-income countries (HIC) to the high utilization of both primary and secondary population-based screening and HPV vaccination (Ferlay et al., 2010; Huh et al., 2015). Also, an organized protocol guiding the accessibility and use of CC preventive measures to mitigate the spread of

HPV is available in HIC countries (Brisson et al., 2020; Perkins & Stier, 2014). However, the justification for the success of early preventive measures is not applicable to most LMIC countries such as Nigeria, given that the preventive measures are not well implemented due to a lack of organized population-based screening, financial resources, and required personnel (Bukirwa et al., 2021; Chokunonga et al., 2013; Wabinga et al., 2014). Eventually, in LMICs such as Nigeria, the burden of CC and HPV prevalence will continue to rise (Daniel et al., 2013).

Cervical Cancer Control in Nigeria

Past Trends in Nigeria

A five-year National Cancer Control Plan (NCCP) to address the burden of cancer was first released in 2008 to span the period between 2008 and 2013 (FMOH, 2008). Although few research studies have accessed or reviewed this document (Nwobodo & Ba-Break, 2016), improving the education and dissemination of cancer-related information were highlighted as major strategies for CC control (Nnodu et al., 2010; Osinubi, 2008). The plan also highlighted some contextual barriers to the control of cancer in Nigeria, such as limited access to healthcare, poor diagnosis, underreporting, and a lack of access to basic manpower (Ezugo et al., 2013). However, a demerit of the NCCP 2008–2013 was that it lacked clarity on ways by which designated measures will be achieved and how this will impact the control of CC in Nigeria (Ezugo et al., 2020; Nnodu et al., 2010). Therefore, one cannot say if the plan was successful in achieving its course as the knowledge of, awareness, and utilization of CC screening services remains low in almost every part of Nigeria (Abiodun et al., 2014), and the burden of cancer still remains high.

Comparing the 2008–2013 NCCP with organized cancer control programs in other countries with lower CC burden revealed a much more detailed approach to cancer control. For

instance, findings from Lew et al. (2017) showed that the Australian National Cervical Screening Program, implemented in 2007, recommended CC screening every two years for individuals aged 18–69. Additionally, in 2014, Australian medical authorities further reviewed this plan to include appropriate follow-up measures if a woman tests positive for HPV (Lew et al., 2017). Machalek et al. (2019), in their study, established that the Australian program has been successful in reducing the CC burden among women aged 25 and above in Australia. According to the Cancer Council of Australia (2017), Australia has an organized CC screening program in which individuals aged 25 and above are invited for primary HPV testing and partial genotyping, followed by reflex liquid-based cytology.

In other African countries with a similar cancer burden and low cervical national screening coverage, such as South Africa, a similar approach can be seen. In the year 2000, South Africa released its first national screening policy aimed at ensuring 70% of the South African female population accessed screening (Moodley et al., 2006). One of the strategies was to target women above 30 years of age for three free Pap smears within a 10-year time-period of their life (Phaswana-Mafuya & Peltzer, 2018). Compared to the Nigerian Cancer Plan that lacked a CC-specific measure, a major downside to the South African national screening policy was that the program did not envisage and plan for barriers that could emanate during the implementation phase (Moodley et al., 2006).

Current Trends in Nigeria

Current trends show that Nigeria released a new National Cancer Control program in 2018 to span through 2022 (Eguzo et al., 2020). The framework corrected some of the shortcomings of the first plan but still failed to elaborate on the objectives of promoting early CC screening measures and did not include the implementation plans in the national policy. Rather,

more efforts were channelled towards HPV vaccination, of which the implementation in Nigeria remains debatable to this date (Ayandipo et al., 2020; Ezugo et al., 2020). While clear and elaborate CC prevention and implementation were seen in the Ghanaian-released National Strategy for Cancer Control plans for 2012–2014 and 2014–2018 (Dakpalla et al., 2011), the lack of financial resources and resource personnel seem to be a barrier to successful cancer control plans in LMIC (Anorlu, 2008; Ayandipo et al., 2020; De Vuyst et al., 2013). In contrast, despite the mishaps suffered by most NCCPs in African countries, Kenya has been able to achieve significant success so far (Abdel-Wahab et al., 2017).

Cervical Cancer Screening: Pap smear and Visual Inspection with Acetic Acid in Nigeria; Knowledge, Awareness, and Attitude

Studies have shown that the present knowledge, awareness, and attitude surrounding CC and CC screening amongst women in Nigeria is generally poor (Ahmed et al., 2013; Akujobi et al., 2008). For example, according to Abiodun et al. (2013), most Nigerian women do not understand how CC is acquired and its process of development. In fact, women often attribute the pathogenesis of CC to an evil spirit, poor hygiene, and water conditions. These beliefs also impact the awareness of women, especially their perceived susceptibility to the disease, as most women claimed to have special spiritual protection (Olubodun et al., 2019), further contributing to a low level of awareness about CC and early preventive measures among Nigerian women (Oluwole et al., 2017).

The low level of diagnostic knowledge and awareness, as well as problematic attitudes towards CC and CC-screening, occur in most major regions in Nigeria, namely the southwestern (Ezenwa et al., 2013), southeastern (Bisi-Onyemaechi et al., 2018), and northern regions of Nigeria (Agida et al., 2015). In a descriptive study conducted by Odetola (2011) in the

southwestern region of Nigeria among women in primary healthcare centers (PHC), findings showed that women did not display a good level of knowledge of CCS. It is quite fascinating that similar findings were also seen among Nigerian women in the diaspora. A qualitative naturalistic inquiry study among Nigerians in the diaspora showed a similar pattern of poor knowledge regarding CC-screening (Ogunsiji et al., 2013), which is also documented among other immigrants in the USA and Canada (Ndukwe et al., 2013; Redwood-Campbell et al., 2011).

On the other hand, a significant level of awareness is seen among female health workers and highly educated individuals, such as university students in Nigeria (Awoyesuku et al., 2019; Ilika et al., 2016; Udigwe, 2006). The authors attributed this population's significant knowledge and awareness to their medical training and educational exposure even though the acquired awareness about CC and preventive measures did not equate to improved utilization. Also, a review of studies on how women in Nigeria access CCS information shows women acquire information on CC and its prevention through media, health personnel, and friends (Gana et al., 2016; Mbamara et al., 2011). However, these primary channels of information dissemination are less accessible to women in rural regions compared to urban environs due to the difficulty of accessing healthcare personnel, IT channels, and the lack of access to information (Odetola, 2011). Although the level of knowledge impacts the experiences of women in accessing CC-screening is not well understood, some authors have attributed the poor knowledge of women to late presentation and diagnosis (Kidanto et al., 2002) and low utilization of early prevention measures (Akujobi et al., 2008).

Utilization of Cervical Cancer Screening Amongst Women in Nigeria

The CC screening rate in Nigeria is extremely low (Ahmed et al., 2013; Ilevbare et al., 2020; Udigwe, 2006). The CC screening uptake among Nigerian women was observed to be

about 18.3% according to Ilika et al. (2016) and 23% according to Okunowo et al. (2018). A retrospective study by Oguntayo et al. (2011) among women already diagnosed with CC disease in Nigeria (n=?) showed that none of the women in the study were screened for CC. In another cross-sectional study by Ifemelumma et al. (2019) conducted among market women in Nigeria, less than 30% of the participants had utilized CCS. However, the screening rate of women in Nigeria is traceable to some common factors. Some of the factors associated with the low uptake of CCS highlighted in the literature include the low financial capacity of Nigerian women (Okunowo et al., 2018); poor health-seeking behaviours of women; a faulty healthcare delivery system (Awofeso et al., 2018; Moodley et al., 2006); pain; religious and cultural barriers; a perceived fear associated with the outcome of screening; the cost of screening; and a preference for female medical personnel, which unfortunately was lacking in most screening sites (Ilevbare et al., 2020). Women indicated they would utilize screening services more frequently if there were more female medical practitioners available to perform the screening (Abdullahi et al., 2009; Ahmed et al., 2013; Samuel et al., 2009).

Theoretical Framework

The Theory of Intersectionality

Having established, based on the research literature, the various factors that affect CCS-utilization within the Nigerian context, this study adopted the intersectionality feminist framework (IFF) as a theoretical lens for understanding the experiences of women in accessing CCS in Nigeria. Bowleg (2012) asserted that although IFF has no core element for it to be considered a testable theory, it can be used as a theoretical analytical framework. The propensity for IFF to help understand the existence of the intersection of multiple micro and macro social identities and their implication on the health outcome of groups involved further justifies the

adoption of IFF (Bowleg, 2012). The IFF was first used by Kimberlé Crenshaw in 1989 in capturing the gender and racialized experiences of minority women in the United States (Atewologun, 2018). Crenshaw (1989) affirmed the existence of identities that potentially intersect with the experiences of a marginalized group and culminates into several forms of discrimination and subjugation. IFF demystifies the varying power relations existing within societies (López & Gadsden, 2016). As stressed by Atewologun (2018), the power structures within a society have the tendency to create multiple social categories that influence a society's worldview about a specific group or population. The worldview encompasses how one's race, gender, socioeconomic status, and other related social identities are perceived, and is essentially the reflection of the intersection of a group's identities in the distribution and access to societal privileges (Bowleg, 2012).

Seng et al. (2012) also elucidated that the multiple social categories present in a society are interdependent and tend to overlap such that it results in the marginalization and discrimination of an underprivileged social group. According to Levine-Rasky (2011), the less privileged population becomes oppressed; Hankivsky and Cormier (2009) described such oppression as having resulted from race, gender, or other social categories such as class, geography, socioeconomic status, age, religion, health system, or the sociocultural status of an individual.

Crenshaw (1989) identified how even amongst a group—which in this context is women—there are different intersectional experiences due to group members' differing intersectional identities. This is also seen in Samuels and Ross-Sheriff (2008) who elucidated that several realities make one woman more privileged than another even though society considers them both as women in terms of their sex and gender. Applying an intersectional lens

for this research project is valuable to explore how social identity factors operate to reinforce or mitigate access to CCS in Nigerian society. It is also speculated that there will be several intersecting dynamics that could result in multiple health disparities among Nigerian women as they interact with social constraints and the healthcare system in their attempt to access CCS. However, these experiences are unknown as no study has been located which has considered the adoption of IFF while exploring Nigerian CCS.

Intersections of Factors Informing Cervical Cancer Screening Utilization in Nigeria

Using IFF analysis, Crenshaw (1989) emphasised particularly how set policies guiding resource distribution have the potential to engender multiple levels of social injustice such that it creates and intensifies prejudice against women. The factors illustrated in Figure 1 are potential factors that could influence cervical screening utilization among Nigerian women. According to a UNAIDS report in 2018, social, economic, and political inequities contribute to the burden of CC. Therefore, although the factors in Figure 1 are almost certain to be contributory components that could create an intersectional experience for Nigerian women, the intersection of these factors in accessing CC screening is poorly understood. CC practice includes both the uptake and utilization of CCS, but how Nigerian women access CCS through the healthcare trajectory is vague, and therefore needs to be explored.

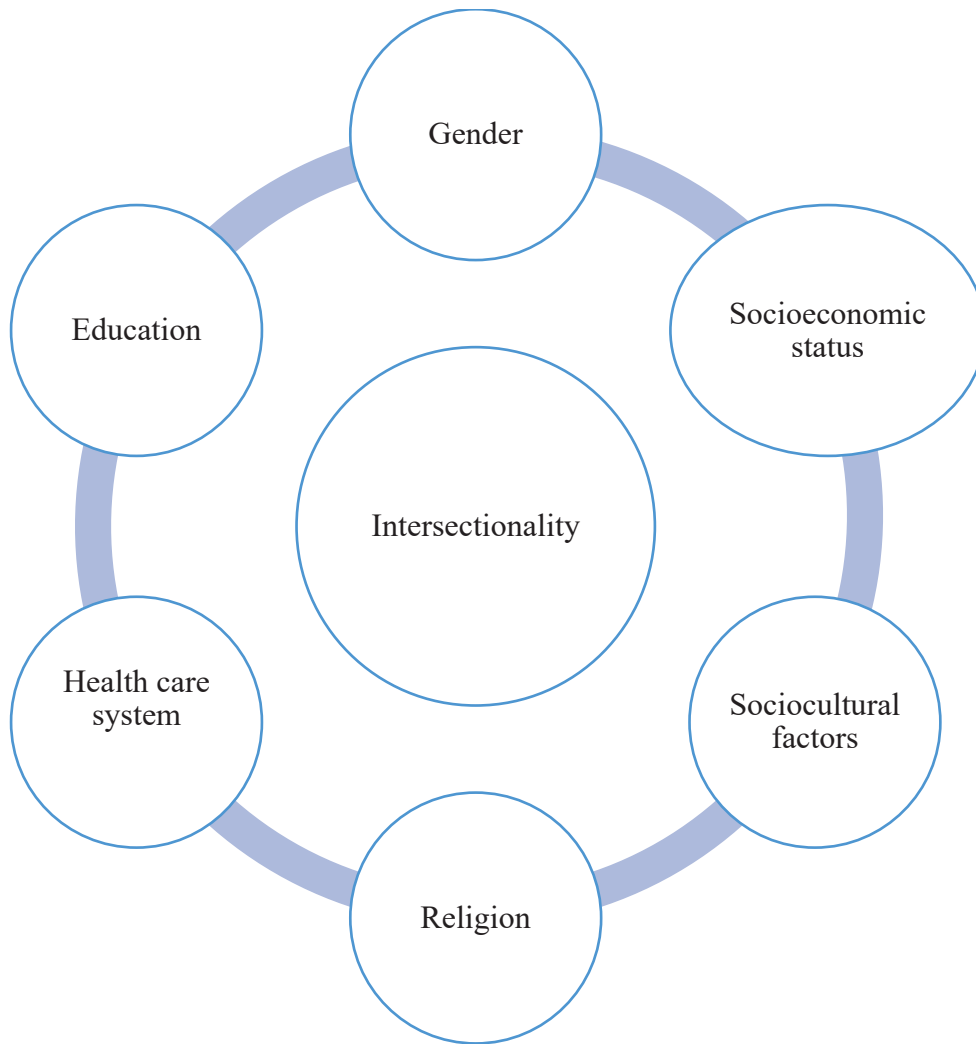


Figure 1

A Developed Illustration of the Possible intersection of Multiple Social Categories that Influence the CCS Practices of Nigerian Women and Could Impact Access to CCS

Evidence from the research literature has shown that multiple social factors are interdependent and tend to produce some intersectional experiences in a society (Goel, 2015; Hopkins, 2019). For instance, this includes the intersection of gender, sociocultural norms, education, and the economic status of Nigerian women. Education is an important asset that serves as a gateway for accessing resources and social privileges (Ekka & Prasad, 2007). According to a UNICEF report in 2017, a larger population of girls do not have a formal

education, especially in the northern region of Nigeria. In a nation where the female population is more than 50% (Ifeanyi et al., 2019), the impact is significant. Giving priority to educating boys over girls, due to the sociocultural values of Nigerian society, can potentially contribute to a low literacy level among women in Nigeria (Akor et al., 2017). A low literacy level also implies that many women will not be employable (Akor et al., 2017). Egun and Tibi (2010) demonstrated that the educational system in Nigeria is structured in such a way that is detrimental to women's education, which eventually also impacts available job opportunities that tend to privilege males over females, making the impact on the economic stability of Nigerian women also palpable. Evidence from research shows more than half of the female population in Nigeria are poor (Ifeanyi et al., 2019). A high poverty level among Nigerian women may incapacitate them from being able to access basic resources such as CCS; however, one cannot conclude this until proven in this study following data collection and analysis.

Also, even though Obasohan (2015) asserted that religion and ethnicity are factors that reinforce the health-seeking behaviours of Nigerian women, as it pertains to the impact of religion on access to CCS, IFF will help understand how an intersectional experience is created. This is especially true in terms of how ethnicity and religion often prompt a woman to find alternatives, such as seeking a non-medical means to stay healthy and even adopting some of the belief systems or practices that pose a risk to a woman's health (Adedini et al., 2015).

In contrast to these findings in Nigeria, some studies have also put forward the inconsequential impact of these factors in contributing to the experiences of women in other countries in Africa. In a study conducted among Xhosa women in South Africa (SA), spousal support, socioeconomic status, and confidence in healthcare workers were not issues of concern that hindered SA women from accessing and successfully navigating screening services. Rather,

women's fear, anxiety, and poor knowledge of screening served as major hindrances to accessing these services even though they were available (Momberg et al., 2017). This conflicting evidence further supports why the intersections of these factors on the experiences of Nigerian women was explored as they relate to the Nigerian setting. Intersectionality theory aims to provide accurate and useful information that could drive change in a community (Castro & Cortez, 2017). This further justifies why the adoption of this theory is suitable for this study, as one of its goals is to unravel the experiences of Nigerian women and tell their stories.

In my study, the Theory of Intersectionality (IFF) guided me in identifying and understanding the social identity factors that impacted the access to Nigerian-immigrant women to CCS. The theory helped gain insight to some complex realities such as disparities, power and privilege issues that impact access of women to CCS in Nigeria. Ultimately, the IFF helped to better understand how these social mitigating factors contributed to the low screening uptake, poor motivation to pursue access and for most Nigerian-immigrant women, termination of access. All further providing insight to the context of health screening in Nigeria.

Factors That could Influence Women's Cervical Screening Utilization in Nigeria

According to a 2019 UNAIDS report, social, economic, and political inequities contribute to the burden of CC. Some of the factors of interest to this study that are proven to impact CCS in Nigeria include gender, political factors, the healthcare system, sociocultural and socioeconomic factors.

Gender

Socially constructed gender roles tend to impact health. Therefore, in the patriarchal Nigerian society, the cultural convention that ascribes to males a form of gender dominance in society, has been shown to reduce the capacity of women to make informed decisions (Alliyu,

2016). The culture of male dominance is seen in virtually every household in Nigeria and it has been observed that this stirs up gender issues (Allanana, 2013; Azuh et al., 2015). The boomerang impact is that women begin to experience delay and difficulty in making key decisions about their health as seen in the findings from an ethnographic study by Akeju et al. (2016) among Nigerian women in Southwestern Nigeria. According to Akeju et al. (2016), most women verbalized they were unable to make key decisions about their health without the consent of their husbands. In another finding from another Nigerian study by Idowu et al. (2016), most women affirmed the need to seek their spouse's consent before getting screened for CC. Why a woman needs spousal approval prior to making an informed decision remains unclear; however, the findings from the study by Adegoke & Oladeji (2005) indicate that culturally the bride price or dowry paid to the family of the bride accords a man the full ownership of the woman he is married to. How the right of ownership culturally conferred on a man after paying a dowry impacts women's access to CCS requires further investigation by scholars. Studies have also shown attempts to amend policies to eliminate patriarchy and advocate for the gender equality of Nigerian women in decision-making (Chukeuzi, 2010). Unfortunately, the impact of the advocacy in strengthening the rights of women and in improving access to healthcare services in Nigeria remains yet to be recorded.

Political Factors

Political power is concentrated where most decisions that impact the nation are made (Allanana, 2013). In Nigeria, the political sector is seen as the centre in which power is centered and from which it is wielded (Cilliers et al., 2015). As discussed by Osinubi (2008), decisions to impact CCS in Nigeria are made mainly at the federal level within the Federal Ministry of Health, although limited evidence exists to establish the implementation strategies and advocacy

of the Nigerian government towards CCS (Rahman et al., 2019). However, it has been observed that there are no policies that strongly advocate for the rights of women in Nigeria (Anyalebechi, 2016). For example, from the findings of Omolara (2011), policies to coordinate mass CCS programs and also facilitate follow-up of women with abnormal results in Nigeria are nonexistent. A study by Aimisior and Omigbodun (2020) also revealed that even available screening services are not well utilized due to a lack of policies to promote the equitable distribution of CCS. Even at the state level in Nigeria, Mohammed et al. (2008) emphasized there are no state-developed cancer control programs. Attempts by some states in Nigeria to develop and implement an independent cancer control plan proved abortive. For example, due to poor political representation in Kebbi State, Northern Nigeria, a state-wide comprehensive cancer prevention program to drive and promote the distribution of CCS has yet to be successfully implemented since 2016 (Lawal et al., 2021). The situation in Kebbi is further worsened as the state lacks a gynecologic oncologist to foster the measure even if implemented (Lawal et al., 2021). Ezugo and Camazine (2013) also opined that the poor political will of the Nigerian government policymakers are partly responsible for the poor cancer control in Nigeria. Onwujekwe et al. (2020) stated that the lack of policies is detrimental to the health of women, directly bound to the status of Nigerian women as a marginalized population, due to the patriarchal culture of Nigerian society, which mirrors women's marginalized status in other sub-Saharan countries.

Healthcare System

Substandard and poorly coordinated healthcare services, an inability to geographically access healthcare services, and a lack of human resources to conduct CCS are barriers evident in the healthcare system (Idehen et al., 2020; Nguyen et al., 2020). For example, studies show that

the majority of health facilities where services could be assessed have poor road networks, and are distant from consumers (Knapp et al., 2022). Likewise, in a study conducted among women in Ilorin, North Central Nigeria, Durowade et al. (2012) asserted that geographical and financial limitations were major barriers to accessing available screening services.

Considering the attitudinal impact of healthcare workers, studies have also established that healthcare professionals in Nigeria are seen as role models and have a significant influence on screening behaviour (Arulogun & Maxwell, 2012). However, study finding by Ndikom et al. (2017) revealed that most health workers do not utilize their position to create awareness about CCS. Ndikom and Ofi (2012) also put forward in their findings the impact of healthcare workers' attitudes towards CCS utilization. According to Ndikom et al. (2017), women asserted that the poor attitude of health workers toward them prevented them from going for screening.

Socioeconomic Factors

The poor screening pattern in low-resource countries is traceable to poverty and the low socioeconomic status of women, also manifest in Nigeria (Kangmennaang et al., 2018; Ndikom & Ofi, 2012). According to Aluko and Mbada (2020), most Nigerian women live below the poverty index, especially women residing in rural environs. However, the high level of poverty among women is said to be a barrier to acquiring the necessary information about CCS, such that a high prevalence of CC is seen among women of low socioeconomic status (Mahumud et al., 2020; Ogunbode & Ayinde, 2005). The expressed lack of financial capability is more evident in women with low education when compared with women with a high level of education (Okolie et al., 2022). Bansal et al. (2015) also revealed that CC knowledge amongst women would likely be improved with an increase in per capita income, while Ilevbare et al. (2020) found that most women would utilize CCS if it was free or subsidized.

Religion

Christianity, Islam, and traditional belief systems are the three most practiced forms of religion in Nigeria (Kitause et al., 2013). In Nigeria, some religious practices and beliefs impact CCS even when women are at risk for CC. The practices have doctrines and beliefs held in high esteem and violating them could be considered sacrilege. For example, Ntekim (2012) reported that most women in Nigeria hold the notion that CC could be a punishment from a higher power. Invariably, most women prefer that their health-related issues be addressed by their clergies or traditional healers over medical professionals. A similar finding was reported among Tanzanian women by Kidanto et al. (2002), in which women who had CC admitted to visiting a traditional healer rather than seeking professional medical help. Likewise, Fadeyi and Oduwole (2016), in their study, affirmed that some religious practices do not encourage females exposing their body parts to males. While it can be inferred that some of these beliefs could potentially hinder a woman from being motivated to get screened, most women are obligated to observe religious customs to avoid being considered impure, and to avoid negative consequences associated with violating such beliefs (Modibbo et al., 2016). In contrast, Modibbo et al. (2016) identified that some religious sects offer free screening as a means of encouraging women to utilize early prevention services also possibly indicating that some religious organizations could be also be potential advocates for CCS and will support any woman willing to pursue CCS.

Sociocultural Factors

Chukuezi (2010) mentioned in his study that some sociocultural factors within a woman's social environment influence her access to healthcare. A commonly mentioned sociocultural practice in Nigeria, which is by-and-large against women's interest, is early marriage. According to Durowade et al. (2012), early marriage not only increases the susceptibility of a woman to

Sexually Transmitted Diseases (STDs) but also prevents access to information about her health as she is considered not culturally competent to exercise her autonomy. Studies have also shown that some high-risk sexual behaviours increase the susceptibility of women to contract HPV in Nigeria. For instance, Ajuwon et al. (2006) identified polygamy in marriage to be a common cultural practise in Nigerian society, especially among some religious sects and ethnic groups. According to Adegbesan-Omilabu et al. (2014), engaging with multiple sexual partners is a predisposing factor for CC disease. In the northern region of Nigeria dominated by the Hausa ethnicity, Auwal et al. (2014) found both early girl-child marriage and polygamy as cultural norms; therefore it is not surprising that the prevalence of CC was reportedly high when compared with other regions in Nigeria. Findings from Auwal et al. (2014) were further affirmed by Manga et al. (2015), who explained the geographical disparity of HPV to be associated with polygamy and the early child marriages commonly practiced in the northern regions of Nigeria.

Moreover, rather than men protecting the health of women by encouraging their spouses to get screened for HPV, especially among women in a polygamous relationship, studies have revealed a heightened sense of insecurity among Nigerian men whose wives utilize CCS. Lim and Ojo (2017) asserted this to be a significant reason why women do not receive their spouses' support in getting screened, as verbalized by women in their study's findings. This insecurity is perhaps unsurprising as Modibbo et al. (2016) revealed that due to the cultural norm surrounding the modesty expected of women, most men will not permit their wives' genitalia to be exposed to health workers, especially if the healthcare provider happens to be a male.

Education

Education liberates a woman and improves her autonomy (Azuh et al., 2015). According to Vries et al. (2018), a decline in CC mortality among women in Colombia was found among

those who were highly educated, especially among individuals with tertiary education. There is an established notion that the knowledge of CC and preventive services is generally low among women living in Nigeria (Olubodun et al., 2019). However, a study by Ndikom et al. (2017) suggested that educating women on CC and screening practices in Nigeria will improve their knowledge and Bammeke & Ndikom. et al. (2014) further revealed that more women will utilize cervical screening if educated about it. Having established the merits of being aware about CCS, there seemed to be studies that discovered a relatively low level of knowledge and awareness about CC and CCS even amongst women with a good level of education (Agida et al., 2015), and on the contrary Odetola and Ekpo (2012), reported that an appreciable level of knowledgeable about CC among women who had a low literacy level. Ayinde et al. (2005) asserted in their study findings that the level of education does not impact awareness and utilization of CCS. All these contradictory findings on the literacy level of women and the level of awareness of women on CCS. Therefore, it is unclear if access to education will impact screening behaviour among Nigerian-immigrant women in this study, especially their experience with accessing CCS.

Summary

Greene et al. (2019) found reduced access and utilization of CCS to be one of the multiple disparities encountered by minority groups in the United States. A key observation by Greene et al. (2019) was that the factors promoting the health disparities could not be understood. This is similar to how multiple disparities Nigerian women experience are not clear, and will not be clear, unless more studies are devoted to exploring the experiences of Nigerian women during their attempts to access the available CCS services.

Additionally, even though the factors discussed in this literature review could be traceable to the poor utilization of CCS, and in a way could serve as a cue to identifying the

multiple disparities experienced by Nigerian women, it is unclear whether these factors create issues of privilege, power and disparities that could potentially impact the accessibility of Nigerian women to CCS. Furthermore, these issues will not be clarified unless direct evidence is obtained from Nigerian women, sharing their experiences through and reviewing for social identity categories that create this disparities, power and privilege. Therefore, exploring the experiences of Nigerian women is essential not only to this study but to the body of the relevant research literature at-large.

Overall, this chapter justifies the need to begin to consider the possibility of the impact of these intersections on the health of women, their health-seeking behaviours, and their capacity to make the autonomous decisions as it relates to pursuing access to CCS. As established in this literature review, it is important to understand that being a woman in Nigeria could increase susceptibility to being marginalized due to the patriarchal culture of Nigerian society. Therefore, the adoption of IFF is expedient to appraising and interpreting these experiences of women during the data collection, and through the analysis process. These findings are documented in the methodology section, detailed in Chapter 3.

CHAPTER THREE: RESEARCH METHODS

Chapter 3 provides a review of the approach that will be adopted in exploring the experiences of women in accessing CCS in Nigeria. In this section, I discuss (a) the study design; (b) sampling methods as they relate to my approach (naturalistic inquiry); (c) the participant recruitment process; (d) ethical considerations; and (e) a step-by-step process of how I collected, managed, and analyzed data, ensured rigour, and stated my proposed plans to guide the dissemination of my study findings.

Study Design

Qualitative research explores realities and meanings ascribed to an experience (Denzin & Lincoln, 2011). As discussed by Salkind (2012), adopting a naturalistic approach creates the opportunity to provide a detailed description and interpretation of the experience of individuals within their social world. As this study hopes to understand the experiences of eligible Nigerian women in accessing CCS in Nigeria and explore intersecting social mitigators that seem to oppress, subjugate, and hinder women from accessing CCS within the Nigerian social context and realities, I adopted a naturalistic inquiry using IFF as a theoretical lens for the qualitative methodological approach for this study. The justifications for adopting this methodology are numerous.

First, according to Crosby & Salazar (2020), the meaning ascribed to an experience is believed to be socially constructed and can only be interpreted by an individual. Adopting a naturalistic inquiry approach therefore permitted me to explore these socially constructed realities in the natural setting with my participants. Within the context of this study, I am referring to two natural settings: First, the country of birth, Nigeria, where participants resided prior to immigration to Canada. I assumed that growing up in Nigeria must have exposed my

participants to these existing intersecting realities prior to immigration. The second natural setting was where participants felt most comfortable to interact with me to relate their experience. My assumption was that events or experiences related to accessing CCS do not just occur randomly; rather, this experience was a result of contextually intersecting factors in the Nigerian setting—the social world of any Nigerian participant prior to immigration to Canada.

Second, as discussed by Neergaard et al. (2009), naturalistic inquiry affords participants the opportunity to relay the magnitude and impact of their experiences directly and openly with the researcher. Therefore, as my participants' experiences are impacted by tensions that exist in society (Seng et al. (2012), adopting a naturalistic approach with IFF will foster a rich understanding of the multiple systems of oppression in the social world of the participants (Windsong, 2018).

Third, Flick (2018) identified that the naturalistic approach is extremely useful when exploring a marginalized or vulnerable population. The population for this study can be categorized as marginalized and vulnerable owing to the patriarchal nature of Nigerian society. This study speculates that inherent in the Nigerian society are social categories or identities (gender, sociocultural, socioeconomic, religion) that are at play for Nigerian women. The intersection of these multiple factors could produce a cumulative intersectional experience (multiple realities) which will be unique to Nigerian women.

Finally, naturalistic inquiry also acknowledges the pre-existing realities and experiences of the researcher. Researchers who adopt a naturalistic approach do not disregard the personal interpretation of an experience or event; rather, subjective realities are valuable to understanding the research problem (Creswell & Poth, 2013). Therefore, using a naturalistic approach was justifiable owing to my previously existing reality as a Nigerian woman and nurse, which I do

not intend to ignore, but which I have explicitly stated in my axiology, biases, and philosophical orientation (ontology and epistemology) of the naturalistic inquiry approach. This is further discussed below.

Axiology

The value I bring to this study is my experience. My research ideas were informed by two sad experiences. The first was the death of a friend due to CC. She was diagnosed late despite knowledge and awareness of early detection mechanisms. My second experience occurred during my final undergraduate research on the health-related quality of women diagnosed with CC. The data collection process was an emotional experience for me as most women had discovered the disease late. Knowing fully well that I have a constructivist and transformative mindset, I began to think of how I could understand the possible mitigating factors contributing to the poor access to CCS and how these factors interact with Nigerian women's experiences in Nigerian society. This eventually ignited a passion within me to generate a new body of knowledge that could bring about change to CCS in Nigeria.

Biases

I acknowledge that being a female Nigerian holding personal experiences, which informed my choice of research topic, could present a potential bias for this study. My cultural, religious, and political opinions also served as potential biases to my objectivity as a researcher. Nevertheless, I ensured transparency throughout my research by documenting my research processes in my field notes and memos. Consistent engagement with my supervisor also offered me an opportunity to express all these biases. This in turn offered me more clarity and promoted transparency as I navigated my study.

Ontology

Ontology asks the question: What is the nature of reality? To understand the nature of reality in naturalistic inquiry, it is essential to note that the researcher acknowledges the existence of multiple realities (Guba and Lincoln, 1994). The nature of these realities is subjective and unique to each participant (Creswell & Poth, 2013). I anticipated that the experiences of my participants will be unique to each individual and can best be explained by them. Therefore, in line with the naturalistic inquiry perspective, I was able to explore and obtain an understanding of the meaning each individual participant ascribed to these realities, as experienced within their social or cultural context (Bradshaw et al., 2017). During the interview and analysis, I also noted the numerous social identity categories and how intersections of these social categories influenced access to CCS as described by each of my participants in this study. As I reflected on the details of the data collected during analysis, I noted the similarities and differences from participant to participant, drawing out collective and specific inferences that offered more insight into the context of health screening in Nigeria.

Epistemology

The proposed research was informed by the epistemology of naturalistic inquiry. The epistemological stance of naturalistic inquiry has its basis in the premise that the researcher and participants are co-creators of knowledge (Morse, 2018). This naturalistic stance maintains that knowledge is socially constructed and is focused on how people behave or react in the real world, how they interact with the various phenomena in their environment, and how this culminates in an experience (Denzin, 1971). In other words, knowledge is purely inductive in nature (Kim et al., 2017) and engaging with the participants was pivotal for co-creating this knowledge. I was able to achieve this through face-to-face interviews with my study participants,

using prompts when required (McInnes et al., 2017). In line with this perspective, I provided deep insight into understanding the experiences of my participants as this event is not well understood. Additionally, I also recorded my own experience during the research in my field notes. With this, I was able to provide a holistic view of the phenomenon being explored. I developed a trusting relationship and spent quality time with my study participants as I interacted with them in their natural environment (Hamilton, 2020). As much as possible, I ensured to bridge the gap in communication (Guba & Lincoln, 1995) and promoted smooth communication by allowing participant to communicate their most preferred language of communication. I was also aware that my preconceived notions about the experiences of my participants is also important for consideration as knowledge emanates from the input of both the researcher and the participants: in essence, what was known to me and to my participants culminated in establishing knowledge and facts about that given phenomenon.

Research Setting and Study Population

The study setting for this research is Alberta, Canada, a province located in the western region of Canada with a total population of 4,067,175 and an immigration population of 845,220 (Statistics Canada, 2017). In 2019, about 6,373 male and 6,229 female Nigerians were admitted as permanent residents into Canada (Immigration Refugees and Citizenship Canada, 2020). Statistics show that between 2011 and 2016, 6,110 Nigerian immigrants were admitted into Alberta, of which populations were found in the census metropolitan areas of Calgary (3,910), Edmonton (1,565) and Lethbridge (80) (Statistics Canada, 2017). I therefore explored the Nigerian immigrant population in Alberta, with a specific focus on the Nigerian-immigrant population in the southern region of Alberta. I explored Nigerian women in two census metropolitan area communities: the first in the major city of Calgary, and the smaller community

of Lethbridge. My justification for selecting the population in these locations was due to the presence of a strong Nigerian population network.

Sampling

The process of sample selection in qualitative research aims to gather a selection of persons to collectively provide a fulsome account of the experience guiding the inquiry (Armstrong, 2010). Doyle et al. (2020) described purposive sampling as a suitable method for identifying participants, who will best provide adequate insight into the issue being explored. In naturalistic research, purposive sampling is a common sampling strategy used by researchers in selecting participants with desirable attributes of interest to the study. Likewise, Vasileiou et al. (2018) also asserted purposive sampling to be valuable in recruiting participants, who can best provide answers to the research questions to better understand the central phenomenon pertinent to the study. However, despite establishing the justification for purposive sampling in research that adopts a qualitative naturalistic approach, it is unclear as to the exact sample size suitable for a qualitative research study. Nonetheless, several sample size recommendations have been postulated for a researcher who intends to adopt a naturalistic approach. For instance, 10 to 15 participants were recruited in a study among a similar population on HIV by Jones (2017).

Therefore, since the goal of this study was not to generalize data to the wider population but to garner a rich explanation of the phenomena and contribute to the extant theory, of which the 'evidence' on sampling reveals that this could be somewhere between 9 - 15 (Sandelowski, 1995), I, therefore set out to recruit participants who could provide a thorough understanding of the phenomenon of which my aim was to recruit 10 participants and determine if this was sufficient to answer the question and indeed it was.

I adopted a purposive sampling approach in recruiting the initial participants and continued with snowball sampling (where participants recommended people to take part in the study) until the total number of participants specified for this study was recruited. Additionally, consideration for data and thematic saturation were pertinent during sample size determination while using a naturalistic inquiry approach (Bowen, 2008). While several factors challenge attaining saturation in qualitative study, this study ensured that the process of recruiting participants stopped once I had a sufficient understanding of the experiences and also observed that there were no additional emerging codes, themes or new information being generated during my data collection and analysis process (Birks & Mills, 2015).

Inclusion and Exclusion Criteria

Inclusion Criteria

I recruited 10 participants with the following desirable attributes

- Participants must be a female Nigerian-born immigrant, and must have been residing in Alberta for a maximum period of five years upon immigration from Nigeria. The essence of these specifications was to ensure recruitment of participants who are still familiar with and can recollect their experiences as they relate to the current situation with CSS services in Nigeria.
 - Rationale: A maximum exposure length of five years will ensure that recruited participants are able to accurately recollect and relay their experiences when asked, and that their experience is relatively proximal to the present day.
- Women must have been eligible for participation in a CCS program in Nigeria prior to immigration to Canada; this included women with no prior screening for CC and women due or overdue for screening visits prior to immigration to Canada. Nigerian-

born immigrant women must have been within the reproductive ages of 18–65 in the last 5 years as studies have shown that women within this age bracket are prone to HPV infection and CC disease (Camara et al., 2018; Ginindza, et al.,2017).

- Rationale: Participants eligible for CCS potentially have attributes of interest to the study. Also, studies have shown that women in these age categories are at a higher risk for HPV infection and CC disease (Camara et al., 2018; Ginindza, et al.,2017).

Exclusion Criteria

I excluded the population with the following attributes:

- Sexually active Nigerian-born immigrant women with CC disease or women who have had a hysterectomy, as these groups are not eligible for CC screening
 - Rationale: Women not fit for cervical cancer screening, therefore, may not have had the relevant exposure to help understand the experience required to answer the research question.

Participant Recruitment

The recruitment techniques that I used in this study included advertisements (using handbills and electronic flyers) and then snowball sampling. In line with recommendations of the Tri-Council Policy Statement (Canadian Institutes of Health Research, Article 6.11, p. 76), which allows researchers to establish a research partnership with identified persons or communities during the initial phase of their research without an ethical review, I searched websites for available Nigerian organizations (both Nigerian Club and Nigerian faith-based communities) in Lethbridge and Calgary. Upon ethical approval, I reached out to the major stakeholders of the organizations through the contact information provided on the organizational

website. I sent a letter via an email to request for assistance in recruiting participants from their organization. I also requested assistance in posting my recruitment posters (see Appendix A) on their communication platforms, such as on their social media groups and websites, or during announcements at religious gatherings and organization meetings. I also sought assistance in distributing a letter of invitation to women on their platform (see Appendix C). Forms in Appendices A, C and D were all sent to the organizations for their perusal to ensure I was not violating any organizational norms or requirements. This email was accompanied by my ethical approval letter to show that my research has been approved by The Human Participant Research Committee of the University of Lethbridge. I also requested an email from the organization be sent to me as a proof of support from the organization. I ensured to copy my supervisor during all these processes of communication. In response, each organization did send a confirmation email consenting to proceed with my study. I was assigned some identified gatekeepers, who were to ensure that I did not violate their organizations' norms, and who would also facilitate access to engaging with women in the respective organization

Due to the COVID-19 pandemic, an in-person meeting with the members of their organizations was not possible. However, through the help of the gatekeepers, I was able to communicate on the platforms given me to advertise my study. I was given a time by the respective gatekeepers I reached out to via email (See Appendix B), to advertise my study on their social media platforms with the members of the organization and address any concerns. After this, I encouraged both eligible and ineligible persons present on the platforms, including men, to rebroadcast information about the study to other people within their Nigerian social network. I made my recruitment poster available (Appendix A) containing my contact information for interested eligible women in the organization to independently contact me.

Alongside, I also made available a letter of invitation and a consent form (Appendices C, D and E respectively) for all women to peruse. The essence was to ensure that women had adequate time to familiarize themselves with the details of the study so as to make an informed decision on their participation. Women independently contacted me through my social media, via calls, and text messages, to seek further clarification about the study. After each conversation, I was able to re-assess the eligibility of women, of which some could not proceed owing to not meeting the criteria, while those who met the criteria were allowed to make informed decisions on their participation, at which point some women did decline, while others consented to participate. Nevertheless, most of the women helped with recruitment by informing other individuals who they felt might also be eligible and interested and providing my contact information to these prospective participants.

For participants who consented to participate, I personalized their letter of invitation and also sent out consent forms via emails provided during this period of interaction. I also made sure to copy my supervisor. Once an eligible participant affirmed receipt of these documents and consented to an interview, an interview was scheduled at a mutually agreed upon date and time through a follow-up email. After the interview, I asked whether participants knew any other eligible participants within their organization. Participants, who were willing, were asked to redistribute my recruitment poster containing my contact information and the details of my study to help inform and refer other eligible women in their community to contact me. I interacted with the interested eligible participants via email or phone, depending on the preferred means of communication indicated by the eligible participants. If email was the preferred indicated form, I forwarded the letter of invitation and consent form (see Appendix C, D and E) via email. I ensured to give the participant enough time to peruse all the forms sent and address all concerns.

Under no circumstances did I coerce participants or mete out consequences to them for refusing to help disseminate information.

Data Collection

Data were collected via semi-structured interviews with study participants. As discussed by Armstrong (2010), interviews are strategies used by individuals adopting a naturalistic approach to explore, interpret, and provide a detailed description of phenomena within participants' social worlds. For this study, an in-depth one-to-one online approach was adopted due to the COVID-19 pandemic and also to comply with ethics recommendations. Interviews were semi-structured and I used an interview guide with open-ended questions to draw participants into a discussion about their experiences (See Appendix G; Sullivan-Bolyai et al., 2005), and probed their responses when necessary (Creswell & Poth, 2013). The interviews were conducted via a virtual platform using Microsoft Teams due to the COVID-19 pandemic and were digitally recorded. I obtained consent verbally. Prior to obtaining verbal consent (See appendix E), I ensured to provide a detailed explanation of the objectives of the study to the participants (See appendix C). These were done during recruitment, prior to agreeing mutually on the interview date and time, and before starting the interview. On the day of the interview, I reviewed the consent form with the participants. Participants were asked to consent verbally to whether they wanted to turn the camera on or off (See Appendix D and E; Creswell & Poth, 2013). I asked whether participants required any clarifications. I also re-assessed the willingness of each participant to continue with the interview. Participants verbally ascertained their understanding of the consent form (See Appendix D and E) and indicated that I proceed. I digitally indicated this on the verbal consent checkbox noting the date and time of recording (see Appendix E).

A phone call interview was used as an alternative method during one of the interviews owing to poor network coverage during the virtual interview. Consent was sought from the participant for a phone interview (see Appendix D and E). I digitally indicated this on the verbal consent checkbox. I noted the time and date and proceeded to audio-record the phone interview. All the interview processes spanned between 45–120 minutes and were all conducted in English. No qualification or training was required prior to interviews. After the interview, audio recording from my password protected recording device were transferred to an encrypted password-protected computer. All recordings were then backed-up in password-protected shared folder accessible only to my supervisor and me. The password was not disclosed to anyone. Once the audio-recording on the phone was successfully transferred and backed up, it was immediately deleted from my phone. Please find attached the interview guide in Appendix F.

Obtaining Consent

I obtained consent verbally. Prior to obtaining verbal consent, I gave detailed explanation of the objectives of the study to the participants (see appendix D and E), during recruitment and prior to agreeing mutually on the interview date and time. Some participants did reach out via phone calls to ask for further clarifications. Once a participant agreed to be interviewed, I forwarded a personalized letter of invitation alongside the consent form to the participants through the emails provided during the phone conversations. This gave participants more time to further peruse the content of the consent form. Prior to the day of the interview, a reminder was sent to the participants. Participants were contacted to ascertain whether any of them had any questions. On the day of the interview, prior to starting the recording, I took participants through the contents on the consent forms and asked if they understood and if they had any questions. Participants verbally ascertained their understanding of the consent form (See appendix D and

E), and questions were addressed before proceeding with the interviews. I was able to digitally indicate this on the verbal consent checkbox noting the date and time of recording (see Appendix E).

Day of Interview

On the day of the scheduled interview, I logged in early, thirty (30) minutes before the interview, to ensure that I tested the platforms such as the microphones, video, and audio recorder, personal computers, and internet connections to make sure all were functioning appropriately. Prior to the interview, I also controlled access of a third party during the interview session by disabling access of a third party on the Microsoft Teams settings. Upon meeting my participants, I introduced myself to them. I asked my participants if they had concerns that needed to be addressed and if they had questions about the contents of the informed consent form sent to them before commencing the interview. I endeavored to observe for verbal and nonverbal cues. I reminded my participants at intervals of their right to stop or withdraw from the interview at any point if necessary. Essentially, having envisaged that some of my interview questions might be sensitive for some participants, I informed my participants of free and confidential counselling supports within the community to access if required (see appendix F). I also asked my participants to check their microphones and internet connections to ascertain all were functioning adequately. Having ensured this, I proceeded to go through the informed consent form with my participants.

Start of Interview and Interview Process

I began the interview by establishing a rapport with the participant. The essence was to ensure the participant was put in a relaxed mood to communicate effectively. This also set the tone for the interview process. I made sure to sit upright, maintaining eye contact with my

participant. This was to ensure that I communicated an engaging expression to my participant. Then, I informed the participant of my intention to go through the informed consent form with them, reading out each content of the form and verbally taking consent. I digitally recorded the participant's response to each question. Upon receiving the consent, I documented on the form the date and time the consent was taken. I re-checked with my participants to begin the interview and digitally record the interview process. Upon verbal approval, I re-iterated my research topic to the participant, and checked with the participant her stance about the content of the informed consent form (Appendix D). This was to ensure the participant still fully understood my research and was still willing to continue with the interview. Though the virtual interviews afforded me the privilege of observing for non-verbal cues such as facial expressions, sighs, pauses and other non-verbal cues that could serve as quality data, some participants declined to have their cameras on while being audio-recorded. This was duly respected, and the camera button was disengaged. For participants, who consented to having their cameras on, cameras were kept on and both the audio and video function were engaged. I then asked participants for their socio-demographic information and digitally filled in this section of the interview guide (Appendix F).

Following a brief cross check of the sociodemographic section (Appendix F) and after affirming the accuracy of the information provided and that there were no omissions, I engaged the start button to begin recording, signaling to the participants that the recording had started. Additionally, I enabled the recording disclaimer to ensure the participants freely proceeded with the recording by selecting whether to continue or discontinue the recording. Once a participant chose to continue, I noted the date, venue, and time when the interview started. I asked the participant to introduce herself using a pseudonym of her choice. I reiterated to my participants that the interview would take approximately 45–60 minutes. I also informed them that the

interview guide questions were aimed at acquiring a holistic perspective as it related to their experience with accessing CCS in Nigeria. Referring to my interview guide in Appendix F, I began engaging with my participants, using prompts where necessary, and taking notes when required. In situations where I experienced an unresolvable internet issue, I asked whether the participant would prefer to continue the session via a phone interview or to reschedule when the internet issues are resolved.

End of Interview

Once the interview was over, I asked my participants if they had questions, observations, or additions to the interview process. I also apprised my journal and interview guide to ascertain I did not miss any detail that could give a cue to understanding my participant's experiences. I ensured to save my recordings on my PC and signed out. I offered a Tim Hortons e-gift card of 10 dollars to thank the participants for their participation in the study.

Data Analysis

The study adopted Braun et al.'s (2016) six step-by-step thematic analysis to inductively analyse these collected data. The iterative process continued throughout the study until there were no more emerging questions to ask participants (Kim et al., 2017). As described by Braun et al. (2016), the six steps involved in the thematic analysis include familiarizing oneself with your data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report. The study adopted a thematic analysis approach due to its flexibility and compatibility with any research method and theoretical stance and because it provides a novice researcher with the essential skills that can be utilized to easily engage in meaningful data analysis (Braun & Clarke, 2006; Vaismoradi et al., 2013) and also due to its propensity to guide a researcher in identifying the commonalities and differences ascribed to an

experience (DeSantis & Ugarriza, 2000). Likewise, the process enables the identification of patterns which may be synthesized into culminating themes and subthemes (Braun & Clarke, 2006). Furthermore, a thematic analysis provides rich and detailed descriptions of the meaning and interpretation ascribed to the experiences of study participants (Braun & Clarke, 2006). One of the advantages of thematic analysis was that it afforded me the opportunity to acquaint myself early with the data. I was able to identify missing information and emerging questions for follow-up interviews.

Data Familiarization

Familiarizing oneself with these data is a process through which the researcher actively engages with the datasets (Braun et al., 2016). In essence, the researcher relates to and internalizes the information from the data extracts. In this light, I daily examined my field notes, recorded observations, and interviews. During this process, I systematically highlighted my initial descriptions, impressions, and hunches, taking notes when necessary in my journal (Vaismoradi et al., 2016). Once I was assured that no piece of information or emerging questions were missing, I began the active process of transcribing my data.

Data Transcription

Transcription allows for an organized and systematic presentation of qualitative data. I manually transcribed my interview recordings. I began by transcribing my recordings verbatim to generate the first script of my data interview. This was done to convert my audio and video recorded interviews to text-based scripts (Duranti, 2006). During this process, I took note of both verbal and nonverbal cues (Sutton & Austin, 2015). I systematically organized these data extracts for data analysis to make sense of these data. Even though this approach was stressful and time consuming (Sutton & Austin, 2015), transcribing manually helped reduce errors and

improved the quality of the output due to accents, colloquial, and vernacular forms unique to Nigerians, which ruled out the use of transcribing with software as the quality of output from transcribing using software was extremely poor.

After manually transcribing, I replayed the content of the recordings from the interview to check if it was in line with the transcribed script. I reviewed and edited the transcripts multiple times to note and correct any grammatical, typographical errors or missing information (Braun & Clarke, 2006). All this processing further facilitated engaging with my data and helped me make sense of it. I endeavoured to take memos during this process and paid attention to potential codes and themes that could emerge from the transcripts. Once I ascertained the quality of my data, I exported the transcripts and memos, and proceeded to generate initial codes from my data sets using NVivo 12 pro version (Sutton & Austin, 2015), a qualitative data management software.

Generating Initial Codes

This phase entailed assigning preliminary codes to statements that have meaningful information or details that expressed participants' experiences (Braun & Clark, 2006). Upon importing my final transcript into NVivo, I reviewed the transcript again for clarity and reflected on my data extracts to further make sense of the data, and identify statements or words that could be coded (Vaismoradi et al., 2016). I paid attention to words, sentences, and phrases that served as a pointer to understanding and capturing each participant's experience. After this final review of my manuscript, I highlighted words, sentences, and phrases that I found meaningful as I reviewed the final transcripts and related to the research questions or objectives (Braun et al., 2016). All attempts were made to consider these codes for variations in the findings based on the diversity of views or content among the participants interviewed. While generating these codes, I considered my research questions, objectives, and theoretical framework (IFF). All these further

helped me to make sense of my data to ensure that I coded phrases or sentences relevant to the experience of my participants and also to the topic being explored.

Generating Themes

This phase entailed identifying patterns of meaning in the codes generated across the different interviews. There were numerous codes generated in the ‘generating the initial code phase.’ These codes were sorted and grouped into categories based on similarities and differences in patterns and meanings that were relevant to my research questions. I also looked out for new, important patterns that potentially emerge across the data which could be relevant to the topic being explored. Irrelevant codes were also set aside at this point. After sorting and categorizing these relevant codes with supporting excerpts and revising them, I began the process of theme generation.

A theme represents the ideas in a data extract that serve as cues to understanding the topic or experience being explored (Braun et al., 2016; Ryan & Bernard, 2003). Searching for themes was a painstaking process; however, it further allowed me to acquaint myself with these data. The first thing I did was to reflect on the organized codes, observing and identifying familiar patterns and meanings. From the organized codes, I looked for potential themes, establishing clear interpretation of the themes as well as examining and determining the relationship between the themes that emerged. (Braun et al., 2016). I grouped all excerpts associated with a particular idea or concept, then organized and reviewed codes into a theme. Though I gave an opportunity for my data to speak for itself while interacting with these data during this phase, I did not totally neglect my research questions and theoretical framework as it helped me align my thought processes on the topic being explored. This iterative process leads to

initiating the theme review process, which enabled me critically review more in depth the initial themes that emerged from the data.

Reviewing Themes

This phase involves the researcher perusing themes developed to refine themes: either to adopt a theme or reject a theme (Braun & Clark 2006). I had initially generated a lot of themes, which had to be condensed into more compact and meaningful themes that were clear, concise and relevant to the research question. The Intersectionality theoretical framework (IFF) served as a guiding structure in recognizing the issues of power, privilege, and the disparities captured in the data. Using IFF, I was able to understand and identify what could be considered potential intersections of social locations and the relationship between them. The research questions also helped identify relevant theme categories. Still being guided by the research questions and theoretical framework of my study, I reflected with greater depth on the preliminary themes generated, identifying themes that required modification, either by breaking themes into fragments or by compressing smaller and similar themes into more concise themes. After this, I sorted out these preliminary themes into more compact and refined themes (Braun & Clark 2006). These processes helped narrow down the multiple themes to more compact thematic structure relevant to understanding the research topic. Themes not relevant to understanding the topic being explored were set aside. After this process, I created a virtual and concept thematic map in NVIVO to further illustrate the patterns and relationships between the various codes and reviewed themes. This map gave a clear, systematic, and organized illustration of these patterns as it was essential to know whether a theme fits the description ascribed to it or whether it was representative of the questions the researcher is trying to answer and the experience the researcher is trying to capture. Once I had achieved a degree of satisfaction in establishing and

organizing these concrete relationships between themes and subthemes such that identified themes are a reflection and not a misrepresentation of the participants' experiences, I proceeded to define and name my themes.

Defining and Naming Themes

Defining and naming themes entailed stating and clarifying in explicit terms the interconnections, relationships, and meaning ascribed to each theme. This is referred to as theme definition (Braun et al., 2016) and is achieved after a degree of thematic accuracy has been attained and the researcher has ascertained that the thematic map created while reviewing themes is acceptable (Braun & Clarke, 2006). I perused my created virtual thematic maps to further explore the relationship between the themes and sub-theme elements generated, and that no other codes or themes could emanate from the map. After reviewing the themes, and seeing the distinct meaning each thematic category portrayed, I began to reflect on the name for my themes. For example, one of the key themes Navigating barriers, disparities, and inequities was derived after properly reflecting on the relationship and meanings the themes in this theme category portrayed. I repeated this process of reflection for other reviewed theme categories. Other sub-theme elements were named and were also merged to give a more concise theme heading, Eventually, I derived three (3) main key themes. After deriving and naming these three key themes, I thoroughly reflected on them to find a central theme. The central theme eventually served as my overarching theme that encapsulated and holistically captured the experiences of my study participants with accessing CCS in Nigeria. I ensured to share this iterative process with my supervisor. I did make notes also on cardboard to aid visualization of these sub theme elements, reflecting upon and making sense of each of them. Following this process, I kept in mind to

cross-check that all names ascribed to themes were reflective of the research questions and each participant's experience

Producing the Report

The goal of this phase was to produce a final document that explicitly and logically told the story of the participants. I ensured to check these themes and findings with my supervisor. I also maintained an open line of communication to keep my study participants abreast of my findings. Being guided by literature and research questions, the final report of my analysis entailed presenting in descriptive terms a robust and in-depth discussion of my findings. I utilized my codebook to help me with viewing all my themes, codes, and excerpts. I ensured each theme that was to be represented in the report had enough data to support it. Once this was ascertained, I reflected on how best to narrate the stories of my participant. Reflecting on my findings through the lens of IFF helped me understand and identify what could be considered issues of intersectionality and the relationship between intersecting social categories. I did expatiate further on how these issues played out in my study and also how it served as a pointer to my research questions in my discussion of findings in Chapter 4. I presented my report using a conceptual map and a theme-based approach to systematically present my findings and make arguments for my themes. I supported each argument with excerpts from data. A further review of my study findings by my committee was done to further ensure the credibility of my report.

Rigour and Trustworthiness

Maintaining rigour in qualitative research is essential to the reliability and validity of a researcher's findings. In my study, I considered Guba and Lincoln's model of four major components of trustworthiness for qualitative research: credibility, dependability, transferability,

and confirmability (Krefting, 1991). I adopted Guba's model of trustworthiness due to its wide acceptability by several qualitative researchers (Shenton, 2004).

Credibility

Ensuring credibility was vital when capturing the experiences of my participants and it improved the accuracy of my research. Peer reviewing, debriefing, member checking, triangulation, and negative cases are several ways by which the credibility of a research study can be ascertained (Hamilton, 2020). Credibility ensures that there is an element of truth in both the verbalized and observed experiences of participants and minimizes the potential for manipulation by the researcher (Guba & Lincoln, 1994). The truth portrayed is subjective in nature and is essential to the internal validity of the research. To ensure credibility, my study adopted investigator and member checking. Investigator triangulation allows for multiple perusals, which helped improve the possibility of capturing the experiences of my participants. Using intersectionality theory as a lens to examine and interpret the data collected during the process of data analysis, I engaged in multiple interactions with my supervisor, presented my data to my supervisor until appropriate themes that captured the experiences of the study participants was derived. The research committee also reviewed research themes to ensure it captured participant's experience.

To satisfy the member-checking requirement, the first process was that I ensured participants received a copy of their transcripts as well as a summary of the study findings. Prior data analysis, all participants were informed to reach out if they had any concerns as they reflected on the interview and once transcripts was produced and sent to participants. I kept my line of communication open in case there was any need for any deletion or addition to the transcript. This process of checking with participants on the content of their interviews improved

my confidence in exporting the transcript for analysis in NVIVO software. Therefore, once, I ascertained there was none, I informed participants via text that analysis had commenced and that summary of the themes will be shared with them once the themes has been approved by my supervisor. After the themes had been reviewed by my supervisor, I drafted a summary of the findings and sent to participants via the email. I further followed up with participants through text messages and phone calls (as this was most convenient for participants), to ascertain if their views and opinions were adequately represented in the findings derived during data analysis. I asked participants to contact me if they wanted to modify, deleted or add. No withdrawal of data and findings was recorded, therefore, the goal of member checking with participants was achieved.

Dependability

I kept detailed records of my entire research process, taking into consideration key moments that influenced my research judgment and decisions (Creswell & Poth, 2013). This helped generate an audit trail that contained full details of my research processes. I also referred back to my study findings to ascertain whether final themes corroborated the participants' verbalized experience to further check the dependability of my findings.

Transferability

Transferability, which can also be referred to as generalizability, is the extent to which my study findings apply to a larger population with similar attributes to my study participants in different contexts or settings. A study is generalizable when study findings are not only focused on the representativeness of a population but also when inferences from the analysis can help generally understand the phenomenon being explored (Delmar, 2010). To achieve this, I involved women with diverse attributes similar to the larger group of women in Nigeria

(Carminati, 2018). The study included women from different ethnicities as well as women who had lived in different geographical zones while in Nigeria. Through this process, I had multiple perspectives represented in the experiences of my participants to generate rich qualitative data. I ensured to give a ‘thick description’ of the experiences of my participants during the interview process as well as share jottings from observations made in my field notes and memos (Geertz,1973).

Confirmability

This is the extent to which the findings from a study can be corroborated by other investigators or reviewers. I established this by first giving a detailed description of my research processes. This includes the documentation of my research processes, step-by-step data collection, analysis procedures, and dissemination of findings. In other words, I kept an audit trail, and a reflexive journal from study inception to completion, documenting in detail key moments in the research (Creswell & Porth, 2013). For example, during the data collection and analysis process, I jotted down notes and kept memos of my thoughts, statements from my participants and events that provided meaning for me. I then used my reflexive notes to review and reflect upon my own values and interests that could influence the research process. I was also able to share this with my supervisor. By making my memos available to my supervisor, he served as another means to check my reflexivity during the analysis. Instituting these measures were vital in minimizing potential or actual biases that could interfere with achieving confirmability (Mauthner, 2003).

Ethics

This proposal was initially reviewed by the Human Subject Research Committee of the University of Lethbridge. The application was then transferred to the University of Alberta

Ethics review committee owing to the disruption in the activities of the University of Lethbridge, Human Subject Research Committee. Nevertheless, I followed the Canadian Tri-Council Policy Statement (Canadian Institutes of Health Research, 2018) on ethical considerations for guiding scholarly research. The Canadian Tri-Council Policy Statement (Canadian Institutes of Health Research, 2018) guidelines are encapsulated in three core principles of respect for persons, concern for welfare, and justice. These three core principles guided the conduct of my research. Additionally, measures to maintain anonymity and confidentiality during the study period are also briefly stated.

Respect for Persons

The Canadian Tri-Council Policy Statement (Canadian Institutes of Health Research, 2018) describes respect for persons as recognizing my participants as individuals of worth and people who possess a sense of judgment, and hence should be treated as such. Bearing this in mind, I helped promote the autonomy of my study participants by ensuring that I did not coerce any participants into this research study. I was able to achieve this by providing a letter of invitation and an informed consent form that provided details of the research approved by the University of Alberta Ethics review committee (See appendix C, D and E). I consistently informed participants of their right to withdraw if they so desired and eventually took a verbal informed consent (See appendix E) from participants before commencing the interview after ascertaining their interest to continue participation. Being aware of my obligation to protect vulnerable participants, I ensured I kept the identity of my participants confidential, by using pseudonyms. I also re-iterated to all my participants that they could withdraw or stop recording at any point in time.

Concern for Welfare

This encompasses taking into consideration factors that could influence the holistic component of my participants during their participation (Canadian Institutes of Health Research, 2018). It expands further to establishing measures to protect the holistic makeup of my participants. Gender issues are also sensitive to discuss, therefore, women during the interview session may recollect memories that must have been eventful or traumatic especially if they had friends that died of CC. To mitigate any form of emotional harm to my participants, I informed participants prior to their interview about available counselling and support services to be contacted if required (see Appendix F). I also did inform participants that they could choose not to answer any question that could trigger difficult emotions, ask for the interview to be paused while they regained composure, or stop the interview process if they chose not to continue.

Though the interview process did prompt emotional discomfort for the participants due to the burden of CC experienced by women in Nigeria, this burden was minimal and none of it was identified as a reason to stop the interview by participants. Some emotional responses observed included: feelings of pity and anger when describing the burden of CC, the poor state of access to CCS including the poor state of women's health, as well as when describing some of the contributing factors to the lack of access. Teary moments were experienced when participants remembered loved ones lost to CC. During these moments, I allowed participants to express their emotions and reminded them about the counselling services if required. I also reminded participants about the right to not answer the questions or continue the line of conversation if they did not want to. I also stopped recording to allow participants some privacy. I ensured to follow up with participants to check on them after the interview. None of them eventually utilized the contacts provided as they verbalized that they were doing well.

There was no recorded physical harm, no economic, and/or social risks from participating in my study. I gave participants pseudonyms to conceal their identity. Following my ethics protocol ensured no one would be able to trace the identity of the study participants to my study. Furthermore, even though the interview was done virtually and via the phone, I still ensured the interview environment was safe for the participants to freely discuss and share their thoughts and information with me without any interruption or risks. I made sure on the Microsoft Teams settings that the access link could only admit myself and my participant. I asked participants for any safety concerns that needed to be addressed within their natural settings before starting the interview. On no account did my participants incur any cost for participating in this study.

Justice

This entailed ensuring all participants were treated equitably and fairly (Canadian Institutes of Health Research, 2018). Similarly, it involved identifying and preventing any form of inequity that could lead to an unjust exclusion of eligible participants (Canadian Institutes of Health Research, 2018). In this study, I ensured women in the community were duly represented in my study. Irrespective of economic status, all participants who met the inclusion criteria were admitted into this study.

Maintaining Anonymity

Participants were informed and reassured that their identity would be concealed, and that no information could be traced to them. Therefore, I provided pseudonyms, only known to participants, to conceal their identity. Each participant's interview session was saved using the pseudonyms. The participants were addressed using this pseudonym throughout the interview, data analysis and dissemination of findings. Although I created a master list linking the real name to the pseudonym, this was saved in my password-protected encrypted PC. As a backup

line of storage, the master list was also saved in a separate folder from the recordings and transcript in a password-protected shared folder created for my thesis. Only my supervisor and I had access to the documents in the password-protected sync software. The list will be confidentially destroyed after 5 years.

Maintaining Confidentiality

All information acquired during the study from the participants was treated as confidential. Though interviews were done virtually, I made sure the mutually agreed location for the interview process was in the natural setting of the participant as I believe, participants will feel safe to engage with me virtually in this kind of setting. For the Microsoft Teams link, I generated a passcode which only allowed myself and the participant to access the invitation without any interference of a third party. The invite was sent only to the participant being scheduled for the interview.

After each recording, the recording was saved on my encrypted password-protected computer which was used for the digital recording. This process of securing was my first line of storage. I manually transcribed the interview recordings; therefore, throughout and after the study, the information offered by the participants was fully protected and confidentiality was ensured. I made sure all digital and audio recorded files on my personal computer were saved with the pseudonyms of participants. The encrypted PC was also password-protected. The password was only accessible to the principal investigator. All printed copies of any information given by participants was sealed in a folder and kept in a safe cabinet which was continually locked. The key was also only accessible to the principal investigator.

For the second line of storage, I backed up these data using an encrypted cloud storage technology; Sync. Sync is owned by a Canadian company and compliant with the criteria of both

Tri-Council Policy Statement 2 and Canadian regulations on data protection and privacy (Canadian Institutes of Health Research, 2018; Jason, 2014). Sync is designed in such a way that information saved on the Sync server is encrypted and no individual except those authorized by the researcher can access the data (Jason, 2014; SYNC, 2021). Therefore, the folder containing the recordings and any other files relating to this study on my PC were also uploaded to Sync, passworded and accessible only to myself and my supervisor.

Ultimately, all interviews and transcripts from interviews, including the master list were all converted to electronic files and saved in an encrypted password-protected computer. Hard copy documents that were used during the research process were filed in a safe cabinet, which was under lock and key. All the information (including recordings, transcripts, consent forms, and emails) collected during the study will be retained for a duration of 5 years after which they will be destroyed through secured means.

CHAPTER FOUR: STUDY FINDINGS

In this chapter, I present the study findings of 10 Nigerian-immigrant women's experiences with accessing cervical cancer screening (CCS) programs in Nigeria. These findings give insight into their views and opinions and on some of the tensions within the Nigerian society that impacted access to CCS services. The theory of intersectionality served as a guide in identifying these issues of power and oppression from these data. The central theme of seeking what you know and knowing what you seek captures these women's struggles and the forms of oppression within Nigerian society that constituted a challenge to their knowing how to obtain and pursue access to CCS. To further expound on their realities, the study identified four subthemes: a) social oppressions affecting women in Nigerian society, (b) structural oppressions in healthcare, (c) intrapersonal repression within Nigerian women, and (d) resistance to redress reproductive health injustices.

I begin this discussion with a summary of the demographic attributes of the ten Nigerian-immigrant participants interviewed during the data-collection phase of this study; this is illustrated in Table 1. The main body of this chapter centres on the subthemes with their subtheme components. The theoretical map developed from the data analysis is presented in Figure 2 and reveals at a glance, the interconnecting relationships existing between all themes identified in this study. All themes are supported by direct quotations from these data.

Participant Demographics

To meet the purpose of this study and find answers to the research questions guiding this study, data were gathered from 10 participants using semi-structured virtual in-depth interviews from three categories of women: (a) women who had utilized CCS; (b) women who did not utilize CCS, despite their level of awareness; and (c) women who verbalized that they were never

aware of CCS and, hence, did not utilize it. Three of the women had accessed CCS, while seven had not. Out of these seven unscreened participants, six had some form of basic awareness, but lacked the privilege of getting screened, and one participant had no awareness of CCS. The inclusion of these three categories of women contributed to a holistic understanding and clearer insight surrounding the topic and answering the research questions below:

- What factors shape the experiences of women accessing available cervical screening services in Nigeria?
- What are the socially constructed categories, if any, that impact women's access to CCS in Nigeria?
- What are the health disparities and barriers to accessing available cervical screening services in Nigeria?

All participants were asked to provide their background information, which is represented in Table 1.

Table 1*Demographic Attributes of Nigerian Immigrant Women in Calgary and Lethbridge, Canada*

<i>Name</i>	<i>Age</i>	<i>Highest level of education prior to immigration</i>	<i>Employment status in Nigeria</i>	<i>Religious affiliation</i>	<i>Ethnicity & Region of Nigeria</i>	<i>No. of years in Canada</i>
Princess Parker	35	Diploma	Yes	Christianity	Yoruba Southwest	2
Beauty Cameron	35	University education	Yes	Christianity	Yoruba Southwest	2
Summer Rice	35	University education	Yes	Christianity	Yoruba Southwest	3
Winter Smart	36	University education	Yes	Christianity	Yoruba Southwest	2
Autumn Spring	32	University education	Yes	Christianity	Igbo Southeast	3
Anita Baker	32	University education	Yes	Christianity	Yoruba Southwest	4
Spring Twist	40	University education	Yes	Christianity	Yoruba Southwest	2
Katherine Cool	31	University education	Yes	Christianity	Ijaw South-south	2
Vanilla Sport	25	University education	No	Christianity	Yoruba Southwest	1
Sonia Sunflower	42	University education	Yes	Christianity	Yoruba Southwest	5

Description of Themes

The key findings of this study describe the reciprocal and reflexive process which drives 'whether' women access CCS and 'how' they access and navigate the system. Women sought what they knew, and the participants in this study indicated they did not fully 'know' the importance of CCS. When they did 'know' the importance, there were challenges to then 'know' how to get the testing within the fragmented system of Nigerian health. Furthermore, the structural and social disparities placed the responsibility for 'knowing' about CCS, and the burden of 'knowing' how to navigate the system to access the test on women's shoulders. Such a level of individual responsibility is unfair, particularly in a context where women lack autonomy. The social networks engendering these oppressions are discussed under the subtheme "social oppressions of women in Nigerian society". This subtheme expounds on patriarchy and sexism, religion and culture, and interpersonal oppression associated with long-standing social issues of power, domination, and oppression.

As Nigerian society evolved, social tensions began to forge, inform and intersect with the structures and systems of Nigerian society, further widening the gap in access to healthcare for women. These structural power-relations are captured in the subtheme *Structural Oppressions in Nigerian Women's Healthcare* and encapsulate how policies, laws and priorities, the healthcare system, and the absence of equity, diversity, and inclusion constituted structural oppression that hindered access. The negative impact of these intersecting social and structural networks of oppression is discussed in the subtheme *Intrapersonal repression* which reveals how the long-term interaction of women with these structures and systems culminated in internalized oppression. This was seen in some counter-productive strategies adopted by some participants

and in how women were reluctant to violate some cultural and religious norms guiding their bodies and sexuality.

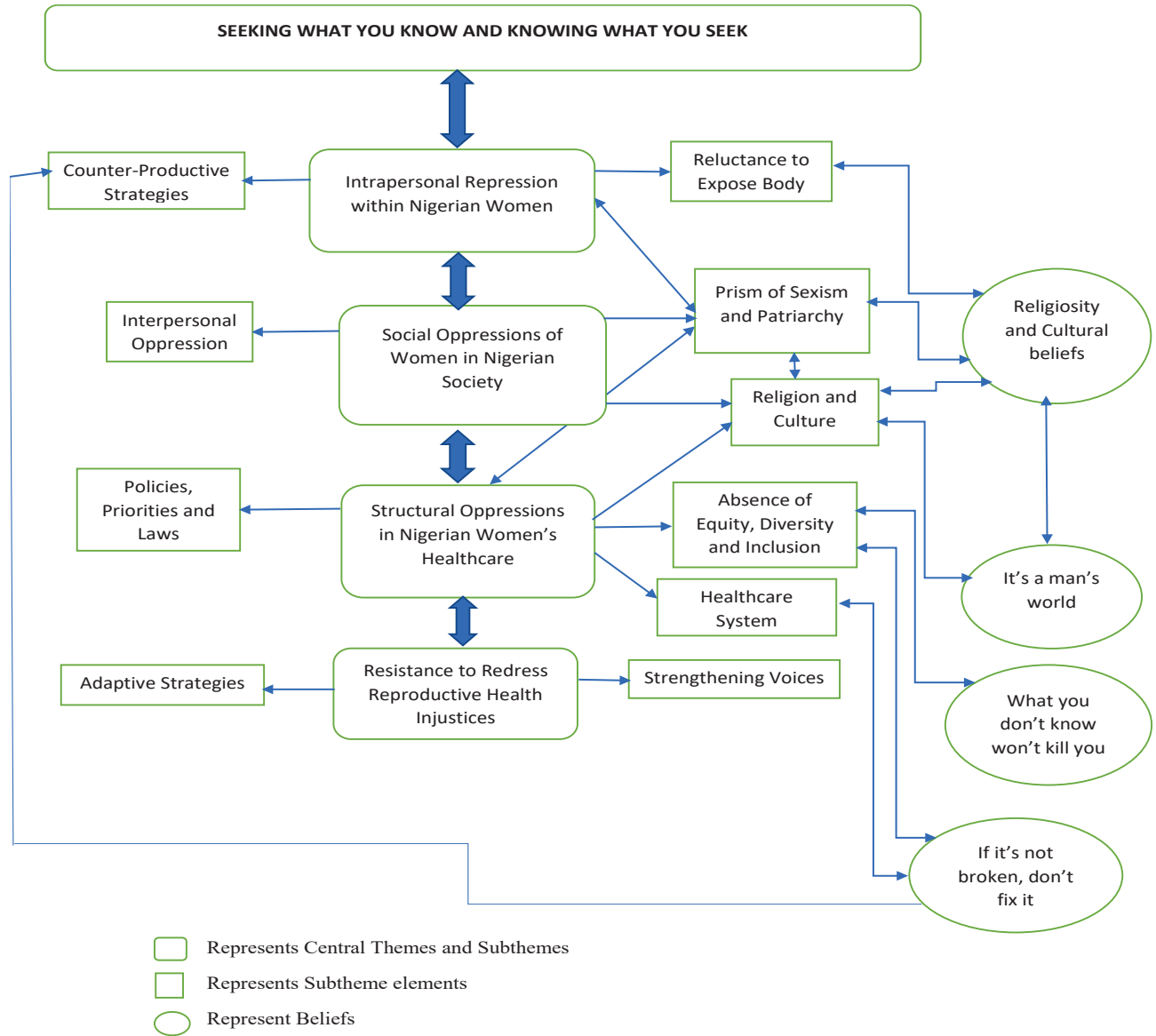
Regardless of the negative responses to the existential issues of domination and oppression women had to navigate when considering access to cervical cancer screening, the study was also able to document some adaptive responses and voices that showed the current and impending shifts from these norms. This redress for action, as expressed by women, exemplifies the need for their voices to be strengthened. It also encapsulates how women wanted the appropriate stakeholders, responsible for promoting the reproductive health of women in Nigerian society, to give more attention to CCS. These ideas are captured in the subtheme of resistance to redress reproductive health injustices.

As this chapter continues, I further discuss the four subthemes: (a) *social oppressions affecting women in Nigerian society*, (b) *structural oppressions in healthcare*, (c) *intrapersonal repression within Nigerian women*, and (d) *resistance to redress reproductive health injustices*, supporting each with direct quotations from these data.

Figure 2

Key Themes Capturing Nigerian Immigrant Women’s Reflections on Accessing Cervical Cancer

Screening in Nigeria



Note. Figure 2 illustrates the thematic map that emanated from these study findings. This map shows the different intersecting complexities impacting Nigerian women’s access to CCS.

Subtheme 1: Social Oppressions of Women in Nigerian Society

Social oppressions describe the tensions emanating from some social relations and institutions. Three subtheme elements: a) Prism of Patriarchy and Sexism, b) Religion and Culture, and C) Interpersonal oppression, further illustrate some of these complexities as they constitute oppressive social networks that thwart the full agency of women. As Nigerian-immigrant women navigated these socially orchestrated or mediated stressors, they relayed how it affected their choices, intentions, and willingness to pursue access. These three subtheme elements further established the premise for understanding how structures begin to incorporate some of these ideologies and norms that relegate the right of women to pursue CCS.

Prism of Patriarchy and Sexism

Participants in this study reported patriarchy and sexism as one of the networks of domination and oppression which interfered with the emancipation of women in Nigerian society. They described Nigeria as “a man’s world” in which society is wired to perceive women as subordinates and inferior to men. Participants revealed that in Nigeria, a man is regarded as the Lord, King, provider, the one who has the final say and under whose authority a woman submits to.

The kind of society we have back home [Nigeria] is wired for men. Unlike here [in Canada] where there are equal rights, we have a patriarchal system back home. Back in Nigeria, it’s a man’s world [of which] you must do the bidding of whoever is the man in your life, and most time it’s the husband. (A.S.).

Men have the power; it is a man’s world in Nigeria and even in Africa. A man is the head of the home, he is the provider, he is the Lord. They [Men] have the say and whatever he [a man] says, it is final. (A.B.)

Women reported that these patriarchal ideologies shaped the societal orientation and view of women as individual’s incapable of making well-informed decisions without the intervention or consultation with a male significant other; therefore, it appears that in general, women must

depend on their male partners to get validation for everything. They described this spousal dependency and poor autonomy as a norm within the Nigeria society.

We have a lot of women who are being stripped of that power because the society has made it a norm that we [Nigerian women] should depend on men for a lot of things. A woman is expected to stay under the shadow of a man. You jump when the man tells you to jump and sit when the man tells you to sit, to always massage a man's ego. (A.S.) Thus, it appears that this submission and transfer of autonomy due to patriarchy leaves

women with little or no opportunity to fully exercise their reproductive health rights. Some participants expressed that when a man is not in full support of a woman's decision to pursue cervical cancer screening, it becomes difficult for the woman to go against the decision of her partner, since this could be termed rebellious, and she may receive backlash from the partner or the society.

So, if your husband tells you that you cannot go for the screening, even if a woman has her own money, that woman will still not go. If you try to dare to be different, you are being judged that you are too exposed. (A.S.) ... You can risk been divorced, you can risk being tagged disobedient, you can risk being abused by the husband and by other women who are less informed. (B.C.)

In addition, some other participants even saw patriarchy as a tool of frustration against women and they voiced their opinion about how some men have unfortunately taken advantage of the patriarchal ideologies to confine and suppress women. The statement by W.S further illustrates how some women yielded to this domination by their male partners, and provides evidence that they have become accustomed to the norms and demands of patriarchal subjugation and domination.

There [are] also some women [who] cannot take an inch without their husbands, they must give a full accountability. Some men do this to witch-hunt women just to show that the woman is lesser than them [Men]. (W.S.)

Yet, while women are being stripped of power, some participants relayed the opposite was true for men. According to them, men have more liberty to exercise full agency, and do not have to navigate any form of oppression and domination. There was no limit to what men chose

to do and how they execute their desires, actions, and full agency. They reported that most social oppressions were usually targeted towards women, further revealing the inequity, divide, and determining who bears the greater burden.

The male[s] in Nigeria is free as a bird, they [Males] do whatever they want, go wherever they want to go. They do not have issues. If you are a man in Nigeria, you are glorious, you can do anything you want to do. (A.B.)

Women are not seen on average. Due to the societal influence on women, our needs are not in any way considered as much as the male. The male can do whatever they choose to do. it is only God that can save us [women]. (K.C.)

Speaking to the burden and practice of patriarchy common to Nigerian society, participants further discussed how this varied across different cultures, religions, and regions in Nigeria. Hence, the level of oppression faced by women was not homogenous. While they described the southwestern region as a bit more open and accepting to women and matters related to reproductive health, participants who lived in the northern region of Nigeria described systems of patriarchy and sexism in the northern region of Nigeria as extremely harsh towards women, and limiting the ability of women to engage in activities that promoted reproductive health. Participants from southeastern and south-southern regions believed males received preferential treatment in their region, as illustrated by how male children had access to better opportunities than females.

There are four geographical locations in Nigeria. In Western Nigeria, women raised in the western part of the country are fortunate as they have access to opportunities. It is the opposite for the northern part of the country due to the many taboos for women. The women are made to cover their faces and be hidden from society, so their needs are not heard in that part of the country. South region household is better than the north [but] on an average, there is a huge disparity, and the focus is more on the male than the female. Males are allowed to aspire and reach their full potential. In the eastern region, the concern is about males making money, so nobody talks about cervical cancer. (K.C.)

Although these statements provided a broader context for understanding the disparities and how oppression ensued in various regions of Nigeria, they also suggest that regional variations in cultural and religious ideologies play a significant role in women's realities and

health agency. It also suggests that culture and religion are important social networks associated with reinforcing these patriarchal ideologies. Thus, exploring how these two social constructs impacted the access of women to cervical cancer screening deserves exploration. Therefore, findings related to religion and culture as vehicles of oppression and domination are explored in the coming pages.

Religion and Culture

Most participants in this study described religion and culture as social networks and institutions that are inextricably joined and hard to separate within Nigerian society. These two constructs informed norms and beliefs in Nigerian society. Therefore, participants described the roles of religion and culture as: 1) a belief system; and 2) a social institution that creates, executes, and reinforces the practice of these beliefs. Participants placed more emphasis on culture than religion; however, as a belief system, participants relayed those cultural and religious beliefs and ideologies that do not favor women as such beliefs which hinder access to CCS.

Culture holds a lot of power. Our religion and our culture back home are so merged that you cannot separate them. (A.S.).

Culture impacts certain beliefs, and if the culture of a people does not emphasize the health and wellness of females, how is she going to get screened for cervical cancer? if the culture of a woman requires that she covers her face and masks her identity, how is she going to be seen in society? if a woman is being marginalized and cannot go to school, she cannot get educated, and get a befitting job, how is she going to pay for cervical cancer screening? (K.C.)

These belief systems, as expressed by the Nigerian woman participants, also influenced how society perceived norms and beliefs relating to the female body and her sexuality. These systems expect females to be pure, chaste, and prudish. Hence women become shy, feel ashamed, and often try to avoid conversations that pertain to their reproductive organs or diseases affecting such organs.

In addition to the cultural perspective, when you consider religion[s] like Christianity and Islam that glorifies purity and sanctity, [these norms] many people shy away from discussions on vagina screens and sexually transmitted diseases and it's a bit of a deception because a large population of Nigerians are sexually active. (S.R.)

As an institution, participants relayed that culture and religion acted as vehicles for sustaining and perpetuating some ideologies that affected the full agency of women. Some religious and cultural organizations exercise power and authority through the clergy, Imams, and cultural leaders. According to participants, religious and cultural leaders in Nigerian society are highly revered and seen as spiritual mentors, guides, fathers, and in some parts of Nigeria, as 'supreme beings.'

These Imams and pastors hold a lot of power. In a place like Nigeria, especially in the north, people take their spiritual leaders or religious leaders as God. (B.C.). But they relayed that some of these religious leaders misuse their power.

Religious leaders will tell you to proclaim with your mouth. They will say, "You cannot have cervical cancer, just speak." Then they also say, "Why are you going for a Pap smear, why are you going for a Pap smear? Are you expecting to have cervical cancer?" (A.B.)

Therefore, they explained that even if women are at risk, they will not pursue screening once instructed by their clergy or if they have been prayed for by these leaders. In essence, women meticulously executed the opinions of their clergy to show respect and honor to their authority and leadership. This validation from leaders seemed to assure women and increase their level of faith and belief in the supernatural.

It does not matter the risk people have, it does not matter what the news is saying, and it does not matter what science or facts are saying. If the religious leader has given an instruction not to get a service, most people would comply. Religion is one of the strongest influences you have in Nigeria. (S.S.)

To further explain, they expressed that violating the order and suggestions of the clergy or their associated beliefs could be termed as a lack of faith, rebellious, and disrespectful, and that it could result in grave consequences. Hence, most women did not want to fall into unbelief. Participants also relayed that these clergies achieved this by creating fear in women.

Those religious leaders, what they say at times, instill fear in people. It is like someone being in bondage, and you do not even know that you are in bondage. I will not go to this screening because something XYZ is going to happen. Someone has said that if you do it [get screened], something will happen. (S.T.)

They [Women] believe that they are healed by faith, and if they just keep believing then they would not get sick. So, if people believe that they cannot get CC, they will not go for screening even if they are at risk. (S.R.)

However, some participants perceived they were not under the influence of religious clergies and cultural structures and the ideologies propagated through them. The participants also seemed to express some views and opinions that served as a cue to the existence of possible interpersonal oppression among women, which itself is a form of oppression, although the realization of this discovery among women seemed to be unexpected.

Interpersonal Oppression

This subtheme element illustrates how women unconsciously projected their oppression on other women they considered less advantaged or lower status than them for some reason. For example, one of the participants saw other women, who had not attained full emancipation, as weak-minded

The difference between us, who want to go through the screening and those that do not want to is that, they are weak-minded. (S.T.)

In addition, another form of projection was related to how women attributed perceived risk related to CC to their sexual history, and their partners' faithfulness to them. Hence, this perspective contributed to some participants expressing that CCS is only necessary for promiscuous women, or women with a bad sexual history. Therefore, some participants said they did not feel pressured to get screened when compared to others who engage in unsafe sex practices or have partners that engage in the same. Through these statements, these women placed themselves in a morally and socially higher status than those women who may possess higher risk for HPV infection and CC.

From my experience, I heard one of the probable causes of CC is a wart, and those who had it [CC] had identifiable risk factors. They either had more than one partner or they had sex early. Some had [a] series of sexually transmitted illnesses like HIV (Human Immunodeficiency Virus) and so many kinds of stuff. So, I felt I did not have these factors, so there was no worry for me. So, knowing this, I am not particularly afraid of CC per se. (B.C.)

Yet, most participants with these ideologies would not be able to guarantee their partner's faithfulness despite their high hopes in their sexual status and that of their partners. Nonetheless, some participants held on to their religious doctrines and tenets as a template for their sexual behavior and conduct as married couples. One example is the idealized practice of monogamy articulated and promoted among devout Christians, which they relayed as one of these core tenets. They expressed that a woman's body belongs to the man and vice-versa. More so, participants also projected their faithfulness to their partners. Hence, they were sure that their partners will not want to violate such a covenant of purity and conjugal responsibility, as they believed their partners understood the potential repercussions. They expected their male partner to adhere to the same purity commitment expected of them as Christians.

As per my religion, there is this thing of keeping oneself pure, and then your private part [reproductive organs], your body is now your husband's, and then your husband's body is now your body, so since I have one partner, I just felt he was not going to infect me and increased my likelihood of developing cervical cancer. (P.P.)

I have one partner and I was faithful to my own partner so I felt he would not infect me (B.C.)

Participants made their stance known to justify why they believed pursuing access to CCS was unnecessary due to their firm assurance in their sexual history, and that of their partners. However, participants relayed they would have utilized CCS in Nigeria if any other evidence had proven their stance wrong.

Based on my knowledge, if I had risk factors, I would have been more worried. I know cancer does not affect just anybody, there are proven risk factors, except if there are other established risk factors, then I could have been worried (B.C.)

Subtheme 2: Structural Oppressions in Nigerian Women's Healthcare

This subtheme element describes some of the tensions perpetuated through structures, institutions, and systems. Participants discussed how women had to navigate these oppressions and stressors stemming from key structural institutions that influenced their access to CCS. These findings were captured under three major subtheme elements a) Policies, Priorities, and Laws, b) Healthcare System and c) Absence of Equity, Diversity, and Inclusion.

Policies, Priorities and Laws

Structural oppression was seen in how interventions, resource distribution, policies, and laws guiding the uptake of CCS were either weak or nonexistent. For instance, participants expressed that Nigeria currently lacks a protocol to guide the coordination of CCS by health workers and participation in CCS by women.

There is really no structure for accessing CCS in Nigeria. In an instance, you do not know when you will be seen, you are not even sure if you will be seen (P.P.).

In addition, women also expressed their dissatisfaction surrounding how the government showed no interest in making policies available to improve access to CCS services and resources in a way that was free and fair to all women. This further created a major issue; affordability.

The government does not get involved in these things as much in the country [Nigeria], to the best of my knowledge. I am not aware of any government initiative to supply free CCS for women, the fact that it was not something the government prioritized as a necessity made it extremely unaffordable. (K.C.)

In addition, participants also revealed that the institutions in Nigeria were more concerned about other communicable diseases such as HIV/AIDS, and other healthcare services such as family planning and child immunization. They verbalized that cervical cancer was not considered a priority despite the sizable number of women dying from the disease.

They [Government] focus more on important diseases, active diseases such as malaria, polio, free vaccinations for polio, and other childhood immunizations. The Minister of

Health will publicly talk about contraception, encourage women, and encourage husbands to encourage their women, because they know that they are still battling with problem of overpopulation. But the other illnesses have not yet caught their attention. It has not yet caught their attention, per se. (B.C.)

This lack of interest in reproductive health matters by government further prompted women to express that the government does not care about women and termed them selfish. A.S. believed the situation would have been different if cervical cancer were a disease affecting men in the Nigerian society. Another participant attributed this structural oppression to the patriarchal nature of the Nigeria society.

The leaders in Nigeria are not concerned about women's health, per se. They [Leaders] changed everything just to suit their own, their own state or policy, it can be frustrating. (B.C.)

For some reasons, I am not male, but I have heard more things about prostate cancer than I have heard about cervical cancer. I do not know whether it is because it affects males, but it is more accessible and there are more laboratories offering PCA. Even the government will tell them [men] from the age of 40 to check their PCA marker. (A.S.)

Healthcare System of Nigeria

Participants relayed how the healthcare system in Nigeria also contributed to structural oppression. In particular, they believed healthcare workers were the key perpetrators of this oppression and dominance. This was seen in how some participants expressed their displeasure with how some healthcare workers treated them. Unfortunately, not all participants were open to approaching healthcare institutions due to these attitudes, even if they had the opportunity, unless they had symptoms. Some described scenarios where they felt they were at the mercy of power relations at the hands of health care workers. One such behavior included healthcare workers frowning at people who come for preventive healthcare, or medical conditions considered minor. This created the impression that there was no need to fix what was not broken among participants

An average nurse in Nigeria is considered to be mean. I will be very afraid if I am to meet a nurse. In as much as they are respected, they are also really feared... I do not want to go

to the hospital and get screened if I am not actively sick. The hospital is not a friendly and welcoming environment, unfortunately. (K.C.)

Absence of Equity, Diversity, and Inclusion

Participants in this study expressed their dissatisfaction with the widening gap of inequity, poor recognition of diversity, and poor inclusion of all women in cervical cancer screening. As women raised these concerns, they expressed several instances when they could not access CCS due to their geographical location. Participants, who did get screened, further revealed it was challenging to obtain access. One of the participants relayed how they had to travel a long distance to get screened despite being in an urban setting. They relayed that geographically accessible hospitals did not offer such services. Most participants echoed that poor accessibility was particularly prevalent in rural communities. Poor rural road networks intersecting with insecurity while navigating most roads in Nigeria contributed to safety concerns that discouraged almost all participants in this study from traveling for CCS.

The distance between my residence and work was far from where I obtained access to CCS were two ends of the city, so [CCS] was not accessible to me. Meanwhile, some labs were closer to me, but I had to go that far to get screened. (A.S.)

Aside from what is happening in Nigeria, there are many kidnappings occurrences. So, many road conditions are unsafe for anybody. These conditions make it extremely difficult for people to have access to all these things [cervical cancer screening]. (W.S.)

Another concern raised by participants was the inequitable access to education or

awareness about access to CCS. They relayed that their inability to access health information on the benefits of CCS and that lack of information about where to obtain screening contributed to the lack of access, and was responsible for low CCS uptake. Participants also traced this poor awareness of CCS among Nigerian women to the patriarchal structure of Nigerian society. Most participants, who had access to health education, benefitted from being in an environment that provided them the opportunity to become more enlightened about CCS. Women relayed that the

lack of these opportunities for education further created a divide and frustrated their efforts and health intentions.

I am not sure I heard any jingles about CC, but I have heard jingles about breast cancer, how to self-examine, and all those things, but CCS, is not well-known amongst people, and even people that know about this are very few people. It is not general knowledge. The only screening that I know that is routine for women in Nigeria is HIV screening which is not done until pregnancy when you get access to it. (W.S.)
Again, one of the participants further attributed this poor access to health education on

CCS to patriarchy.

The conversations around cervical cancer is not amplified, I will not totally rule out the society being patriarchal to why there are not so many conversations around it [cervical cancer screening]. (A.S.)

Asides from the inequitable distribution of resources and the inequitable access to channels of education or awareness to promote access for women, participants also expressed how access to CCS was unaffordable. They relayed the lack of affordability as a deterrent to cervical cancer screening. Participants highlighted that this limited and incapacitated their choices to approach healthcare facilities for CCS, even when the need arose. K.C. even stated that CCS is meant for the elites, implying that the masses may not be able to afford such a service.

Cost is a huge obstacle [and] It is the elites that can afford access to CCS. What I imply by the elite in Nigeria are the top 1%, the affluent people controlling the major stakes in the country, and people employed in top jobs, and have good careers. (K.C.)

These findings further suggested that most women were limited by these structural channels of oppression and that only a few participants were able to successfully navigate these tensions. Hence many aborted the mission to pursue CCS access. According to participants, they believed all these intersecting issues of inequity in cost, awareness, and resource availability in different geographical locations in Nigeria created an inequitable access gap of between the masses and the elites. Given that the masses represent the largest percentage of the population, this means that CCS was not readily available to the majority of Nigerian women.

We have more of the masses than the elites back home, so I am not sure that information is there. If the person is poor, average, or rich, that can affect their access to screening. It [CCS] is not sponsored and made available by the government. (A.S.)

These structural barriers seemed to frustrate all the participants in this study and

contributed to a recognition among the participants that a shift from these norms is required.

They voiced that the health of women is equally important to that of men and; therefore, structures should be in place to foster access to CCS for all women. The impact of intersectional social and structural oppression worked against women and contributed to created engagement in counter-productive strategies, which will be articulated next in the findings.

Subtheme 3: Intrapersonal Repression within Nigerian Women

The sub-theme *intrapersonal repression* captures the response of some participants to the social and structural tensions. The findings suggest that participants internalized over time some beliefs within the social sphere of Nigerian society over time. These internalized beliefs subsequently contributed to women's engagement in actions captured by two sub-theme elements: a) *Counter-Productive Strategies* and b) *Reluctance to Expose Body*.

Counter-productive strategies

Participants seemed to have no choice but to prioritize needs. Basic survival needs, and the needs of their loved ones, were considered more important than the need to get screened for CCS. Most expressed relinquishing their basic needs to ensure their loved ones were catered for when they faced difficult situations. For example, W.S. mentioned that she devoted her income to support her extended family, which she relayed as her responsibility to her family. Other participants felt prioritizing needs helped them cope better with the struggles in Nigerian society. Hence, participants ranked the need to access cervical cancer screening as low priority.

Most women do not prioritize access to CCS because they have other challenges to address. Life in Nigeria was just too busy that you do not prioritize your health. (S.R.)

And then, giving back, if you are from an average background or depending on what kind of background you are from, sometimes you might have to help your younger ones in schooling monetary wise. You have parents that are retired means you must help them in some way. Looking at these conditions, screening would be of low priority. Most women do not prioritize access to CCS because they have other challenges to address. Life in Nigeria was just too busy that you do not prioritize your health. (W.S.)

Women also expressed the notion that there was no need for cervical cancer screening due to the absence of any symptoms. When further probed, participants relayed there was no need to pursue healthcare and use the limited resources they had on a disease they were not certain they were at risk for; therefore, they felt that pursuing access to CCS would be a waste of resources. Hence, they waited for something to go wrong before pursuing access.

I am not just used to going to the hospital for no reason, there must be a symptom, or my doctor had recommended that I do that. If my doctor did not recommend it, I would not go. (A.B.)

I would rather settle for when I am having symptoms. I would know by then that I have something to deal with than trying to put unnecessary stress on myself on something that is not there and may not be likely to be there. (P.P.)

Presence of symptoms therefore seemed to serve as the core cue to act, and begin to see cervical cancer screening as important over other needs. This was seen in the case of one study participant, who overcame all the challenges posed by structural barriers when she discovered she had some symptoms consistent with cervical cancer symptoms.

I used pantyliner or tampon for the first time, and it really, really, really, really irritated my vagina, I just got scared, I had some discharge and everything. So, I read that some symptoms or signs of anything happening to cervix is painful urination which was happening to me. I had to quickly run and use the HMO. (A.S.)

This subtheme element illustrates the way society grooms women to be altruistic and selfless, even if it means repressing or relinquishing their own needs so that they can cater to the needs of their loved ones. In addition, it further illustrated some of gender expectations placed on Nigerian women. Though independently detrimental to their health because these women tended to wait until they were presented with symptoms of more advanced disease, their additional reluctance to expose their body further potentiated the problem. This further elucidates the

detrimental impact when more than one counter-productive influence on pursuing CCS access was applied.

Reluctance to Expose Body

Women were reluctant to expose their bodies due to beliefs and norms from cultural and religious stances. Some of these beliefs also contributed to resistance from the spouses of participants, as it created insecurity in men, such that gaining support from their male partners might be difficult. Therefore, women shied away from asking for spousal permission or from approaching healthcare. Women relayed these tensions as a barrier to CCS.

Pap's smear is carried out in a very protective and secretive region, so when informing your husband [about CCS] and he asks you, "how are they going to get the procedure done?" and you say, "They [Healthcare workers] will open my legs, and then swab something in between my legs." That is enough reason for the man to say, "No, you are not going anywhere, you don't have to open your legs to anybody, what is wrong with you?" you want to go there and open your legs for another man. (A.B.)

This shows that it is a cultural a taboo for women's reproductive organs be seen by other men besides their partners. Some of the other beliefs verbalized by participants included: women being well-groomed and expected to be prudish, a woman's body belonging to her male partner, sanctity and purity.

I am a prude. Generally, [our] cultural belief instills in ladies the need to be prudish, so you find out that many people from my tribe have had issues with having sexual relations. Because it is something to be ashamed of, and that is a general belief that a girl should be prudish. (S.R.)

Women are not comfortable getting screened because for you to get screened, you have to be naked from the bottom [area]down, religion also comes to play, and lots of people are not comfortable with that, especially if it's a male nurse, nobody wants to strip down and get touched by a male. (K.C.)

These beliefs also impacted how participants responded to the need to pursue access. For some participants, these issues created a personal inner conflict which discouraged these participants from getting screened as they could not bring themselves to expose their bodies. For P.P. she considered her reproductive organs a private affair, while S.R. expressed that exposing

her body to such a procedure would make her uncomfortable. Both women did not get screened before immigrating from Nigeria.

Cervical cancer screening is always private and sensitive. So, that is why women will not want to get involved because they have to expose themselves to being probed, and if anything is detected, it will require more probing. It is a private affair that is just it for me. (P.P.)

So, getting a pap smear involves going all the way into your couscous to get samples. So, thinking about it was unsettling for me. I would not have done it except I felt like I needed to. (S.R.)

The participants screened for CC described their screening experience. One of the participants, A.S., relayed the inner turmoil she experienced. Her discomfort was aggravated upon the realization that her service provider was a male healthcare practitioner. The participant reported her cultural orientation played a role as she recollected she could not bring herself to discuss her concerns with the male healthcare practitioner.

It was a guy that collected the swab. I would have felt more comfortable if it were a female, I would have felt freer communicating with a female, and I would have felt more comfortable because the process of doing that test is very discomfoting and uncomfortable, so I would have felt more relaxed being screened by a female. Maybe this feeling is culturally informed because I have never [been] a fan of male gynecologist[s], anything female reproductive organs, do it with females. (A.S.)

Subtheme 4: Resistance to Redress Reproductive Health Injustices.

This subtheme illustrates how women positively responded to the tensions generated by the social and structural issues of oppression. In addition, this subtheme and subtheme element reflect the current trend of change ongoing in Nigeria, and the various key players, who serve as agents for the sustenance of this change. It further reveals how women are actively trying to dismantle patriarchy by advocating for change from the top down. An awakening for a new era where the voices of women must be strengthened and heard without experiencing any form of prejudice or backlash. Women are increasingly engaging in acts of resistance in their thinking and in their doing.

Adaptive Strategies

The need for redress is gradually penetrating structural institutions, although participants expressed that the progress was a bit slow. They relayed that some religious clergies now discourage patriarchal ideologies and have started to advocate for women and reproductive health. For example, two of the participants verbalized that their church one of the ways through which they received support for CCS. The first explained that her religious organization conducted cervical cancer screening programs at no cost and even encouraged men to support their wives. The participant expressed that during these programs, the church supplied a platform for women to get awareness by inviting experts to give information.

My church usually organizes medical tests and gives people drugs. They invite nurses and doctors too to attend to people that come. There is also the area of cervical screening, and everything is free. The health care worker that came to my church member specifically discussed it [CCS] with us. She told us [women] the impact; she told us [women] the effects of not doing it [CCS]. She even specifically said that this thing [CC]is killing number XYZ of women daily or monthly or yearly. (S.T.)

Strengthening Voices

Women expressed the need for empowering the voices of women as a means of fostering access to CCS. They relayed that society must begin by creating awareness among women irrespective of their status. They felt this would promote the inclusion of all women especially women at the grassroots level. They showed that awareness would enlighten women on how to access and improve their understanding of the benefits of CCS, and help women make informed decisions.

Advocacy, and when we are talking about advocacy, we are not leaving it at just the government level, we are going to have to get the grassroots, speak the language the local woman would understand. (W.S.)

One participant in this study expressed how she acted as an agent of change prior to her relocation. She relayed how she partnered with her religious institution to facilitate the execution of awareness and screening programs for women.

Back in Nigeria, we had quite a number of times that we [women] brought in organizations from outside to come in and screen women in the church. (S.S.) To this end, participants recommended key institutions to target. Participants re-iterated strongly that Nigerian society must begin to focus on social institutions such as religious organization. Clergies and cultural leaders hold a level of influence needed to drive a sustainable change. They relayed that clergies could play a crucial role in changing the norms and reinforcing the changes in their organizations. They expressed that failing to involve these social institutions and leaders will automatically result in the failure of interventions targeted at promoting equity in access.

Whatever advocacy, I always tell people that advocacy also should not be beyond the government but include churches or places of worship. (A.S.) Do not go over to the cultural and religious organizations that control society. If you go through those organizations, you are likely to have more results than if you bypass them because they have a strong hold on Nigerians in general. (S.R.) The participants also believed the government must begin to take responsibility and create platforms to make CCS available, affordable, and accessible. They relayed that the government must make access free and distribute resources equitably. They expressed that resources should not only be concentrated in urban centers, but should also be accessible in smaller towns and cities. They recommended that providing infrastructural resources and a friendly environment would promote a stress-free and oppression-free environment while trying to pursue access.

My recommendation will be for the government to make healthcare free and accessible in towns, not necessarily just the big towns. People do not have to travel for hours to get good healthcare. I mean something like a Pap smear should be able to be done free of charge for woman. (A.B.) Overall, women believed it was time for women to speak up and not be fearful to speak up in the public about their rights. One of the participants believed that women should be given more power to support the strengthening their inner voice, and encourage women's innate ability

to harness their strength in navigating and overcoming barriers. They also felt this would create a safer space for Nigerian women. Some participants relayed.

We need advocates that would speak on behalf of women to government, to those who can help, nongovernmental organization, we need them to speak up and not be fearful, they need to speak more and enlighten the public. (B.C.)

Summary of Findings

These themes and subthemes provided insight related to the complex issues impacting access to, and choice to access, CCS among study participants. This study discovered that while some of these factors are within the control of participants, the vast majority of factors are not within their control due to the stressors, oppressions, and struggles faced by women. These findings shed light on the intersecting networks of oppression that impacted women's access to CCS. The intersection of these vehicles of oppression hindered most participants from seeking access to CCS. Some of these tensions seemed to originate in patriarchy. This prism of patriarchy and sexism influences norms, beliefs, and social perceptions of women. One of the impacts was how it informed women's view of their bodies and sexuality, which influenced how women responded to the need to seek access to CCS. Furthermore, the interplay of these social and structural networks of oppression created internalized oppression in these Nigerian women, such that it was difficult for them to prioritize their needs for access to CCS due to the hardships and demands associated with these intersecting social networks of oppression. In addition, it appears that many Nigerian women will not choose to pursue CCS as long as they perceive there is nothing overtly wrong to be fixed, a belief that it is better to remain ignorant about cervical than get screened to discover an abnormal finding. Therefore, it appears the feeling of internalized oppression seemed to subject participants to rationalizing to justify why they believed other needs were more important than their health. Perhaps, this rationalization can be attributed to patriarchy, as society has made women believe they are subordinates and inferior.

Nonetheless, it appears women want the narrative to change through their opinion on the need to redress the situation.

As all these findings reveal how systems and structures of power intersect to dominate and suppress women from attaining emancipation, this further suggests the need to discuss the implication of these tensions on accessing CCS in Nigeria. This study, discusses in depth in Chapter five the findings through the context of literature

CHAPTER FIVE: DISCUSSION

The findings presented in this study illustrate Nigerian-immigrant women's experiences accessing CCS in Nigeria. These findings address the research questions to collectively describe factors shaping participants' experiences, highlight the socially constructed categories impacting access to CCS, and identify disparities and barriers influencing access to CCS. The overarching theme of “seeking what you know and knowing what you seek” reflects the participants' experiences with navigating the stressors connected with CCS in the Nigerian context. Central to women's experiences in this study was how social and structural tensions shaped the knowledge women had (or did not have) about cervical cancer and their capacity to access or navigate the health system for CCS. The subthemes: (a) social oppressions affecting women in Nigerian society, (b) structural oppressions in healthcare, (c) intrapersonal repression within Nigerian women, and (d) resistance to redress reproductive health injustices explicate the multiple and inter-related features underpinning the central theme. The application of intersectionality theory to the analysis of participants' experiences foregrounds these complex inter-relationships among the subthemes as it illustrates how these systems of power intersect to hinder access to screening. I situate the findings within the context scholarly evidence to shed light on the possible genesis of these factors and the possible networks sustaining them. I describe the relevance of study findings for future program plans for access to CCS, policies, and research. This chapter concludes with a discussion of the limitations, challenges, and reflexive journey from conceptualization to completion of my study.

Summary of Major Findings

Evidence from this study shows that the sub-themes are both mutually exclusive and collectively intertwined, – each of them rooted in the oppression of women in Nigerian society. The central themes and subtheme elements reflect some of these socially constructed categories that shaped women's experiences. In addition, the intersections of these socially constructed categories further demonstrated the complex heterogeneity of the Nigerian environment, a reflection of the impact of colonization. Women confront issues of power at social and structural levels. Gender, religion and culture were some of the social relations identified in this study, while structural power influenced women's access to CCS through religious, cultural, political and healthcare institutions. A significant impact of these multiple and intersecting power relations was noted in how women internalized oppression, evidenced by some counter-productive coping skills described by participants in this study. Specifically, women were reluctant to violate some of the societal norms and beliefs propagated by religion and culture that guided the conduct of women in relation to their reproductive health. For most women, the counter-productive responses to these stressors show how features described in this research influence women's choices related to accessing healthcare services such as CCS. Many other studies have also recorded this phenomenon (Chidyaonga-Maseko et al., 2015; Lim & Ojo, 2017; Randall & Ghebre, 2016; Pierz et al., 2020; Yang et al., 2020). This research study adds to the extant body of knowledge by identifying how multiple disparities in terms of geographical access, financial capacity of women, status and classism, amplified barriers and hindered most women from pursuing access to CCS.

Upon critical reflection on the realities created by the intersection of socially constructed relations, this study describes how social relations may contribute to the burden of cervical

cancer. The study noted how social relations have the propensity to hinder access to preventive health care like CCS. In light of the aforementioned, one must consider the possibility of late diagnoses and subsequent implications for Nigerian women's health. To this end, several studies have shown how late diagnoses contribute to poor quality of life, poor prognosis and increased maternal mortality (Ashing-Giwa et al., 2008; Knaul et al 2012; Hanna et al, 2020). Such indicators are very significant to the burden of cervical cancer in Nigeria. However, it was challenging for most participants to navigate many barriers to CCS as some of these factors are endemic and invisible. An interrogation of the pervasive nature of oppressive social and structural relations brings forward the possible role of colonialism and its lingering effects on Nigerian society.

The current study discusses the impending shift from patriarchal norms and illustrates how education and globalization may play a role in the emancipation rather than suppression of women. Though only a few participants eventually obtained access, the impact of these disruptive changes also shaped the experiences of participants in this study and the ideologies of most participants such that they now clamored for the voices of women to be strengthened. Through the context of literature, this counter-reactive nature of present generation Nigerian women is discussed, and findings from this study bridge the gap in understanding this pattern of change within the Nigerian setting—all these further shedding light on the research questions.

Interconnecting Web of Factors

Cervical cancer screening is a preventive measure for reducing the burden of CC (Ferlay et al., 2010; Ebu et al., 2015; Onyenwenyi & Mchunu, 2019) yet, in Nigeria, CCS has not produced significant results due to barriers that have contributed to poor access to CCS in Nigeria (Idehen et al., 2020; Okolie et al., 2022; Ubah et al., 2022). Alfaro et al. (2020)

concluded that such barriers had the propensity to create health inequities among vulnerable populations. Evidence from this study adds to the literature by illuminating how some of these barriers are linked to social categories, and how social identities may intersect to create tensions and a system of oppression that hindered access to CCS in the Nigerian context. This study established that most power relations emanated from post-colonial social and structural networks of oppression in Nigeria. To further explain, Baily et al. (2017), in their study, mentioned that the realities created within a network of oppression can extend into other institutions of power to create even more complex realities. These complexities have a colonial undertone. Scholars have shown that as colonized societies began to embrace patriarchal ideologies and patriarchal differences, the beliefs created in the social sphere began to influence the structural institutions in these colonized societies post-colonial contexts (Kurtz et al., 2008; Makama, 2013; Tabassum, 2022). In essence, structural oppression flowed from social oppression related to patriarchy.

As seen in the study findings, social networks provided a channel for structural oppression to control women. In particular, the tensions within cultural and religious institutions asserted influence over operations within other institutions such as Nigeria's political and healthcare systems. Hence, the research findings illustrate how religious and cultural institutions were social institutions that acted as vehicles for sustaining inequities by reinforcing, propagating and upholding norms, beliefs and ideologies that restrict Nigerian women's agency. The study expands the current knowledge on these complex webs of factors, capturing the relation with colonial ideologies and how these created social relations intersect, the complex realities resulting from these intersections, and how it impacts women's access to preventive healthcare services.

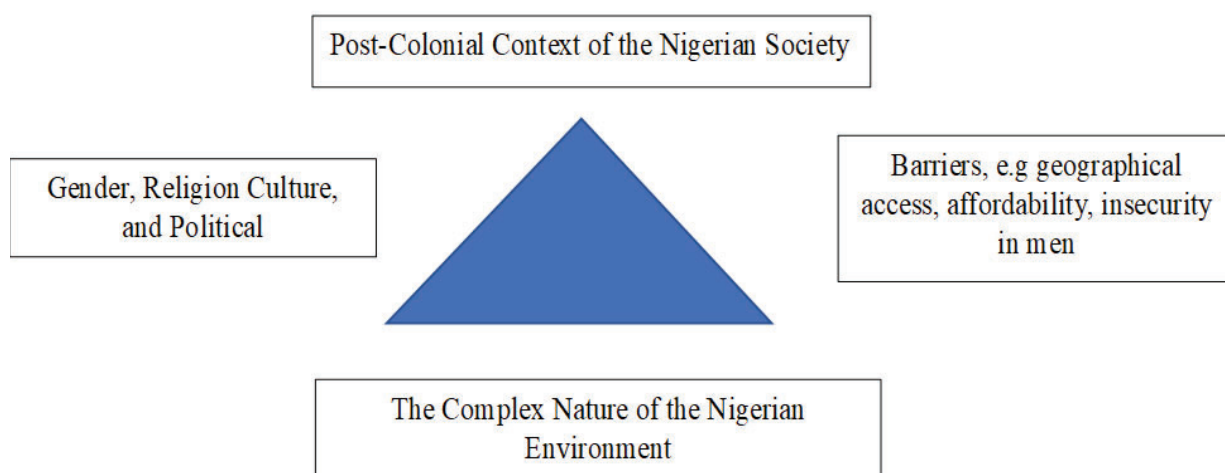


Figure 3: A diagram illustrating the impact of colonial ideologies

Post-Colonial Context of Nigerian Society

Though studies have established several impacts of colonization on colonized nations (Jalata, 2013; Pettit, 2015; Genger, 2018), evidence from my study offers perspective to both how it contributes to access to CCS within the Nigerian context and what patriarchal colonial ideologies contributed to creating complex social relations that hinder access. The encroachment and colonial indoctrination of western norms and values into critical social and structural institutions in most colonized nations set the platform for shaping gender identities. Such a foundation created a shift to displace pre-colonial gender roles and perceptions that were complementary, to a post-colonial system that embraced gender dominance, relegation and subjugation (Mikaere, 2019). Disparities extended into cultural, religious, political, and economic realms of life. Most importantly, these ideologies also shaped webs of oppression

through which key political and social institutions (guided by patriarchal norms and values) marginalized populations (Hillman & Radel, 2022). This study further sheds light on these factors, their intersection, and their impact on women's access to CCS.

Intersections of Patriarchy, Religion, Culture

Patriarchy is a widely used term among feminist theorists to describe various forms of oppression and gender inequality against women (Walby, 1989; Sadiqi, 2008; Benstead, 2021). Authors have used patriarchy as a lens to demonstrate how men exercise power within social and structural institutions to either dominate or suppress women (Vavrus, 2002; Christensen & Jensen, 2014). Facio (2013) gave a broader explanation of patriarchy to capture how institutions and any networks of oppression in society interrelate to reinforce male superiority. According to Facio, only the needs and interests of men are considered important in patriarchal societies, while women are seen as subordinate to men with little or no rights (Alewo & Along, 2012; Wood, 2019; Sikweyiya et al., 2020). The assertions made by these scholars resonate within African colonized nations (Uchendu, 2007; Dumbili, 2015; Mensah et al., 2021). For instance, an appraisal of the family hierarchy in African settings reflects gender disparity. Society considers the man the head of the home and relegates the woman as subordinate (Azuh et al., 2015). Society sees a woman as domesticated, under the will and power of a man, and without agency (Azuh et al., 2015; Biswas, 2022). Therefore, the societal perception of Nigerian women is extremely poor (Makama, 2013), and this seems to widen the inequity gap, especially regarding women's reproductive rights (Hankivsky, 2012; Isabirye et al., 2022).

According to DeKeseredy, (2021), the goal of patriarchal domination is for the oppressed to internalize oppression. As it relates to my study findings, women had to suppress their reproductive health needs because the decision to pursue access to CCS was not entirely

within their control; male input dictated financial provisions for pursuing access. In extreme situations, when conflicting interest arises as per their religious and cultural norms, the norm is for a woman to submit to the authority of her partner. My study further corroborates the findings from Udoh et al. (2018), in which religion and culture dictated the acceptability of women's behavior. These norms also seemed to influence how Nigerian society views female sexuality. For example: exposing reproductive organs for screening, taboos on the pathogenesis of female diseases, and gender sanctity and purity further align with findings from Okonofua et al. (2009). Unfortunately, these norms and the punitive measures associated with violating such norms mainly target women (Sibani, 2017). Hence, women defer to their cultural and religious norms, beliefs and leaders and do not violate the instructions of their leaders even if it negatively impacts their health (Aladekomo, 2004; Okoroafor & Iwueke, 2019). Challenging established norms is considered rebellion (Breton et al., 2018). Deference to male authority and reverence of puritan ideals resonated among Nigerian-immigrant women in this study and, in other contexts, may explain why most women shy away from matters related to their sexuality and reproductive health services in Nigeria.

Therefore, in societies where women face societal backlash against female sexuality, and where the distribution of power and privileges is unequal, women internalize the dictates of oppressive structures and align their behaviors with those structures. Accessibility to CCS is complicated when women do not believe they have the right to access such care.

Intersection of Patriarchy and Political Will

Though this study established that religious and cultural institutions are significant vehicles for executing patriarchal ideologies, Nigerian society's political space also creates barriers to CCS. Gender inequity is seen in the lack of political will to advocate for policies and

laws prioritizing women's reproductive health in Nigeria (Obagboye, 2020; Obagboye & James, 2022). The under- representation of women in the political sphere sustains the lack of political will (Essien & Ukpog, 2012). Mustafa et al. (2020) elaborated that men dominate the political system in a patriarchal society. When power is held by men it is inevitable that laws and policies guiding access to societal privileges tend to reflect the will of the majority dominating the political space and marginalize the minority population (Mustafa et al., 2020). Based on findings from participants in this study, women believed the government placed a low priority on women's health needs and well-being. This disregard for women's health needs such as CCS, is further complicated by the competing demands in the context of limited government funding, and the tendency for decision makers to focus on communicable diseases such as HIV/AIDS, or the priorities emphasized by external players such as The World Health Organization (WHO), The World Bank, the International Monetary Fund (IMF), or other non-governmental organizations. Situating this evidence within the context of literature proves that this assertion made by participants accurate. For example, studies have shown that despite the established contribution of a cervical cancer screening protocol to address the burden of cervical cancer and promoting equitable access to CCS in other nations of the world (Rebolj et al., 2007; Pesola & Sasieni, 2019; Mafiana et al., 2022), the Nigerian government has yet to respond to the need for a national cervical cancer screening protocol (Bruni et al., 2019). Prioritizing cervical cancer as less necessary seems to be a standard practice in sub-Saharan nations (Ali et al., 2012; Burrowes et al., 2022).

Nonetheless, denying Nigerian women access to a national cervical cancer screening protocol violates their fundamental right to access an early preventive health strategy and gender equity. The poor representation and inclusion of women in key political positions to advocate for

policies and laws that will improve women's access to reproductive health services further reflects the lingering effects of patriarchy in Nigeria. Participants attributed patriarchal dominance as a possible justification for the poor awareness, inequitable distribution of CCS resources and lack of affordability of women to pursue access to CCS. The intersection of the activities within social and political institutions further heightens the marginalization and suppression of women in my study.

Power imbalances within the healthcare system

Research supports that structural tensions within the healthcare system contribute to health inequities (Elias & Paradies, 2021). These forms of institutional oppression reduce a marginalized population's propensity to access healthcare services (Bohren et al., 2015). This research study highlighted that health workers were primary perpetrators of institutional oppression through their poor attitude, which created fear and avoidance among healthcare consumers. Fear was a significant deterrent to approaching healthcare facilities for preventive services among participants. These findings also corroborate other study findings that document how the poor attitude of healthcare workers discouraged women from utilizing CCS (Tumlinson et al., 2013). On the contrary, a positive attitude seemed to improve the opinions of women who pursued CCS (Jackowska et al., 2021).

Another barrier identified by the Nigerian-immigrant women was the embarrassment of being screened by male healthcare providers. For most Nigerian-immigrant women in my study, this made them feel extremely vulnerable as they felt they could not decline being screened by male workers due to a shortage of healthcare workers. Additionally, it was hard to communicate the emotional distress they experienced due to the power imbalances at play. A similar finding was noted among Chinese women in a study by Wong et al. (2008). These findings show that

colonialization shaped, directly and indirectly, women's experiences. Despite overwhelming challenges to accessing CCS services, this research study identified counter-reactive responses to redress inequities in CCS services.

The Counter-Reactive Nature of The Present Generation of Nigerian Women

Counter-reaction is the response against an initial action (Collins English Dictionary, n.d.). As it relates to this study, Counter-reaction encompasses the response of a population to power imbalances and barriers to CCS emanating from social and structural institutions of power. This study recorded the existence of an ongoing transformation. Over time, practices are gradually shifting from the ideologies and practices embedded by colonization to those which better support women's full agency and reproductive health.

Two factors contributed to this counter-reaction: globalization and education (Udoh, 2018). The intersection of education with globalization makes women's activities in global settings visible, and fosters interactions among women to press for emancipation (Alizadeh et al., 2022). Guvenen & Rendall. (2015), in their study, illustrated how education contributed to women's enlightenment by empowering them to advocate for laws that promoted equity, inclusion and diversity. The economic emancipation of women through education also established the premise for women to begin to recognize their voices and power (Hillman & Radel, 2022). This study's findings show participants' yearning for gender equity and early efforts to take dramatic steps for change.

The emancipation of women in a patriarchal society comes with resistance from the dominant group, who have enjoyed power and privilege within the society (Dodd, 1968). Resistance is crucial to overriding the barriers and navigating tensions. While education and globalization may shape the ability of women to understand their power and use their voices as

women to redress oppression, only three out of ten participants in this study were able to override the barriers from the social and structural institutions. The majority of study participants succumbed to the struggles within the Nigerian society, a result of internalized and structural oppression. These varying responses to the systems of social and structural oppression show that the stronger the counter-reactive nature of Nigerian women, the greater the possibility of overriding the barriers emanating from the web of oppression and vice-versa. Therefore, strengthening the voices of women is necessary. Though the study established current redress to address reproductive health injustices, the slow progress reveals that efforts to disrupt post-colonial patterns will transcend generations.

Implications of Study Findings

Implications for Practice

The findings from this study has the potential to disrupt the current practice that guides the use of CCS. Hence, the findings have established the need for interventions to target factors acting as barriers within the social and structural institutions. By so doing, the study findings support that Nigerian society will be able to address the negative responses of women interacting with oppression, as seen in the counter-productive strategies and other forms of intrapersonal oppression.

This study also provides information to help policymakers and healthcare workers to develop empathy and understanding surrounding *why* women do not pursue CCS. Specifically, the findings can support policy makers' understanding of how the systems and structures contribute to women not being enabled to pursue access. Understanding this reality is vital for policymakers and significant stakeholders to create culturally competent, gender-friendly interventions, and an oppression-free environment for women. The findings from this study

could also be helpful in developing a national cervical screening protocol framework as these findings have shed light on some contextual issues and complexities that are crucial to the success of the national cervical cancer screening protocol when developed.

Implications for Research

The findings from this study have revealed a gap in the literature in the context of understanding women's access to CCS. The first gap is that intersecting barriers hindering access to reproductive health potentiate the effect of a single barrier alone. The critical appraisal of these barriers provided a more in-depth exposition on the possible genesis of these barriers as well as the vehicles that sustain these barriers and impact access to CCS. Some of the disruptive ideologies brought into Nigerian society by colonizers are sustained in post-colonial Nigerian society and impact women's reproductive health. Hence, this establishes possible reasons why Nigerian women respond negatively to healthcare interventions and provides more insight to inform other studies of reproductive health challenges in Nigerian women. A significant implication is that the findings from this study make a case for other researchers to consider exploring cervical cancer screening utilization through the lens of other gender-based and post-colonial theories. This study's findings can help researchers engage in more gender-sensitive, policy-related intervention research.

The findings from this study have also helped elucidate the need for stakeholders such as policy-makers to use scientific-based evidence for contextually- effective, evidence-based interventions.

One of the anticipated interventions is the need for the Nigerian government to develop a national protocol for CCS. The findings from this study could be helpful in this quest as it has revealed some social and structural relations that could inform these protocols. To refrain from

considering the realities documented in this study may pose a barrier to the execution of such protocol.

Implication for Sustainable Development Goals (SDGs)

The findings from this study support the need to promote SDG goal 3, which is to promote good health, and SDG 5, to promote gender equality. At the initial start of this research, the goal was to unravel why access to CCS was poor and find answers to the increased loss of women to a preventable disease. However, the findings from this study have provided not only the answer, but also revealed the significant reasons why women do not confidently pursue access. One of these factors is traceable to the interaction of women with social and structural power relations that make it impossible to exercise their entire agency. The power relations identified in this study negate the right to good health and poses a threat to attaining gender equity, hence the need for SDGs to focus on developing evidence-based interventions on how marginalized populations can attain complete emancipation.

Recommendations

Policymakers and Key Stakeholders

Overall, the central theme, "seeking what you know and knowing what you seek." was adopted to capture all the realities of Nigerian-immigrant women in this study. From the study findings, participants suggested measures to strengthen the capacity of women and improve inclusion in terms of access and utilization of CCS among Nigerian women. The study established the need for government stakeholders to take up this responsibility. The government taking responsibility to address inequities can address financial barriers to accessing CCS, as identified by participants. Other studies document that most women lack the financial ability to foot the bills of CCS (Kuguyo et al., 2017; Tsu et al., 2018; Haque et al., 2020), hence

strengthening the financial capacity of women, subsidizing, or providing free access to CCS will improve CCS uptake.

Having identified these inequities, the study recommends that awareness and education of women be a priority to address issues of inequity, diversity and inclusion related to health care. Education interventions should target religious and cultural institutions. Religious leaders were identified in this research as valuable agents of change in marginalized communities, particularly rural environments. This education intervention should help demystify medical jargon and destigmatize testing in ways that engender trust and support uptake.

Additionally, policies and laws must begin to advocate for women's reproductive health. A way to achieve this is to provide a national cervical cancer screening protocol to improve access. Reminders, and bulk SMS messages to invite women to CCS will be an excellent course of action. Policies and laws can also be targeted towards the conduct of healthcare workers as their attitude is crucial to women's response to healthcare. Policies to distribute resources within healthcare institutions must be done without bias to ensure equity, diversity and inclusion.

Researchers

More research is needed that applies post-colonial theory or other gender-based theories to explore some of the factors and barriers that contribute to women's poor access to CCS. One key unexpected finding from the study findings was how some of these factors and barriers were traceable to the impact of colonial ideologies, that shaped, and still shape post-colonial social and structural institutions in the Nigerian setting. In particular, religion, culture, politics and the healthcare system have invariably created a complex Nigerian environment that has a significant impact on women's reproductive health. Hence, it is recommended that future researchers shift focus to in-depth study of the cervical burden of Nigeria through these

theoretical lenses, as these theories will help unravel more in-depth discoveries to support system and societal change. Such research could further explain why interventions targeted toward women's reproductive health seemed ineffective. Adopting a theoretical approach to exploring women's reproductive health will provide a more holistic perspective to understanding the barriers women face accessing health care services.

Study Limitation

The COVID-19 pandemic posed several restrictions to the feasibility of the study exploring a diverse and large population of Nigerian women living in Nigeria. However, upon consultation with the research committee, I resolved to change the natural setting by interviewing Nigerian-born immigrant women in Canada instead. To facilitate a holistic understanding of the research topic and the progress of the research, as well as to answer the research questions, there was a need to accommodate women with more diverse attributes. Hence, justifying the inclusion of the three categories of the female population in the study interview. I included women who did not have a Pap smear to give a broader perspective on understanding the topic. It also granted me access to more participants, as would have been the case had the study been conducted in Nigeria. The intent was to ensure quality data relevant to my research questions and prevent further study delays due to time limitations.

Upon resolving this, the second limitation was the inability to conduct in-person interviews with the Nigerian-born immigrants because social-distancing restrictions prevented in-person contact with participants. Consequently, I had to change the mode of data collection to accommodate and comply with Canadian regulations and those of the ethics committee. I adopted an in-depth virtual interview with a phone interview as a backup approach. I wanted to explore women who practiced Islam and traditional religions to gain a more balanced perspective

on the intersection of religion and culture on gender-based issues in Nigeria, such as patriarchy. However, this proved difficult for the study to access, as these religious enclaves are extremely conservative. Despite all efforts, none of the women in these groups reached out to participate in the study; however, participants in this study gave a second-hand experience related to the norms in this religion. The study recorded two people—one whose grandparents practised Islam and another who lived in an Islamic-dominated region—these issues do not rule out the quality of this study since Nigeria practices a communal way of living. Additionally, the synchronous verbalization of the experiences of all participants further justifies the observation that Nigerians are communal in their way of living and are not blind to issues happening across cultures, religions, and geographical settings. Nonetheless, this population would be a potential target to explore for future research on account of the impact of religion and culture on accessibility, and it would be interesting to validate some of these findings through their specific cultural and religious lenses.

Another limitation was the topic's sensitive nature, as women were reticent to share their reproductive experiences. This may explain why some women reached out but did not eventually consent to participate in the study. This was primarily observed in older women who contacted me to learn more about the study after the general group orientation on the online platform. Perhaps this could also be due to the conservative nature of Nigerians. As a participant in this study shared that the society expects women to be prudish, one can also see this conservative nature in how some participants described some structures of the female reproductive organs. For example, one participant labelled the vagina as "couscous." The degree of openness in discussing sexual education and reproductive issues in those cultural environs, and the regional linguistic variance about labelling the sexual organs, might have influenced the colloquial description of

some sexual terminologies. The younger generation of women seemed more willing to discuss this topic; most were health-inclined, for example, two pharmacists, doctors, and a nurse. A possible explanation is that this group of people would be more comfortable from their exposure to using medical terms. Other career categories were accountant, lawyer, and teacher, in which I observed some discomfort and hesitation, who were also overly courteous during the interview. Most people in this group used other terms to explain and, in some instances, smiled sheepishly while talking about this topic. Some avoided using the terms during the discussion.

Lastly, the study's sample size was a limitation; this was a consequence of the numerous challenges encountered due to COVID-19.

Knowledge Translation, Exchange and Dissemination

This study's findings will be shared with identified stakeholders in Nigerian organizations in Canada as well as the participants. I also intend to share these findings with policymakers and stakeholders within government-owned and select private healthcare facilities in Nigeria, as well as with nongovernmental organizations engaged in the fight against CC in Nigeria. Keeping major policymakers and stakeholders informed of my study findings could help guide healthcare providers and policymakers on better approaches to increase the accessibility and smooth navigation of women to CCS to contribute to combating the CC burden in Nigeria. The final aim will be to educate them on how these findings from my study can be applied to enact changes within these settings and, through these settings, extend to the Federal Ministry of Health in Nigeria for further dissemination to policymakers and stakeholders.

I also intend to extend the findings to the general Nigerian populace, especially women, by establishing awareness programs. By extension, I will seek collaboration with healthcare organizations to facilitate the dissemination of these findings, translate them into action, and

develop CCS organizations to ensure more inclusion. I plan to continue in this line of research, focusing on utilizing these findings to inform future studies that will facilitate the development of an equitable, culturally-competent, gender-sensitive CCS protocol in Nigeria.

Finally, I will consider publishing my findings in a recognized academic journal and will give presentations at cancer conferences. A copy of this thesis will be submitted to the University of Lethbridge's catalogue, Open Uleth Scholarship (OPUS), which is the university's website research repository for publications.

Reflection

This study shifted my worldview on the burden of CC in Nigeria. I vividly remember discussing my emotions and biases with my supervisor and committee before conceptualizing this research. As I began this research, my bias was extreme because of my anecdotal experiences as a female Nigerian, who has seen numerous women die of the preventable condition of CC, including a dear friend who was a medical doctor. Additionally, my undergraduate thesis on the health-related quality of life of women living with CC disease created deep anger within me as I listened to the stories of women living with CC in oncology wards and radiotherapy clinics. My concern was, "why is the government not doing anything?" I blamed the Nigerian government. However, upon conceptualizing this topic, I shared these biases with my supervisor and committee, who encouraged me to keep an open mind. To ensure transparency, I documented my biases and feelings in my reflexive journals and research proposal.

As I progressed in the study and exposed myself to the research literature, interviewed my participants, and carried out my data analysis, I came to the shocking realization that the factors are multiple and highly complex: it is not the fault of the government alone! I observed

some women express dissatisfaction with the interplay of patriarchy, culture, and religious aspects of Nigerian society that significantly impact women's health. I felt guilty and ashamed that many factors in my society should not exist in the twenty-first century due to globalization. Being religious further increased my inner conflict and turmoil, as I did not. However, my participants exposed these situations in greater detail, further opening my eyes and enabling me to have a more holistic understanding, especially in terms of how they intersect to impact the accessibility to CCS. Therefore, I appreciate the ability of my participants to balance their worldviews despite their level of emancipation.

In other words, I recognize that I may also have biases due to how I consider these factors to be essential in driving CCS access, especially in terms of how they affect Nigerian women, given that I am a Nigerian woman. I am not excited by the system, particularly the cultural and government biases, but I also agree that some Christian clergy or doctrines are extreme; however, I do not think I am bound to clergies and doctrines that stop women from accessing healthcare. I was somewhat uncomfortable reading and drawing up an analysis that discussed negative things about my religion as I am a religious individual. However, my constant engagement with my supervisor and committee kept me focused on the experience and documenting it as it was. I had to state what was conveyed by the participants in the study. I needed to remain neutral throughout this study, and my moments of writing memos and reflecting in my journal helped me keep track of my thoughts and get the biases out of my mind. I endeavoured to be as transparent with my supervisor as possible, keeping him and his advice in mind as I progressed in the study.

Finally, personally, this experience was life-changing. While I experienced quite a few challenges, especially during the conceptualization, proposal drafting, navigating online

platforms, and connecting with gatekeepers, this study was an experience worth remembering as I learned to follow due protocols, establish and manage relationships, and conduct interviews.

I had to immerse myself in data throughout the research, especially during the interviews, transcribing, analysis, and discussion. This process of data immersion was painstaking; however, it enabled me to immerse myself in the data and improve my qualitative research studies. skills

Summary and Conclusion

The findings of this study reflect what operates within the context of cervical health screening in Nigerian society. The study documents how social and structural issues created and sustained internalized oppression among women. It further expounds on how the existence and the intersection of some social identities identified by participants in this study created realities that hindered or mitigated their access to CCS while in Nigeria. This also gave an insight into the challenges, disparities, and inequities that one can expect while attempting to utilize CCS. The multiple social categories identified in this study had the propensity to facilitate or disrupt the process of accessibility. Some of these disparities did create power relations that incapacitated the full agency of women to pursue access to CCS. This reflects in how only three out of ten women eventually utilized cervical cancer screening. The adoption of the intersectionality framework did help identify some of these issues of power. In particular, IFF established gave insight into how some of these issues possibly stemmed from colonial ideologies and how these ideologies operated through structures and social institutions within the post-colonial context. All culminated in understanding the creation of social relations that continually shape women's social identities in the post-colonial context of Nigerian society and the complex heterogeneity of Nigerian society. The study concludes that women accepting social tension and oppression as the

norm due to the internalization of oppression is detrimental to their health and well-being. Also, as the present and future Nigerian women strive to attain full emancipation; backlash should be expected as freedom does not come easy.

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APPENDIX A: SAMPLE POSTER

APPENDIX A- SAMPLE POSTER

Research Study on Women Accessing Cervical Cancer Screening in Nigeria



I WANT TO FIND OUT YOUR EXPERIENCES WITH ACCESSING CERVICAL CANCER SCREENING IN NIGERIA.

I would like to speak you if you are:

- A Nigerian woman
- Living in Alberta 5 years or less
- Age 18– 65
- Eligible for cervical cancer screening in Nigeria prior to immigrating

You are invited to participate in an interview that will be about 45-60 minutes long.
Participation is voluntary and confidential.

To participate or request more information about this study, please contact:

Fadodun Oluwadamilola Agnes
Phone: 4033593512. Email: oa.fadodun@uleth.ca

This study has been reviewed and approved by the University of Alberta Research Ethics Board.

4033593512 Or Email: oa.fadodun@uleth.ca	4033593512 Or Email: oa.fadodun@uleth.ca	4033593512 Or Email: oa.fadodun@uleth.ca	4033593512 Or Email: oa.fadodun@uleth.ca
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**APPENDIX B: REQUEST FOR ASSISTANCE IN RECRUITING PARTICIPANTS IN A
RESEARCH STUDY**

University of
Lethbridge



Date:

Dear Sir/ Madam,

My name is Fadodun Oluwadamilola Agnes, an MSc. Nursing Student at the Faculty of Health Sciences, University of Lethbridge, Alberta, Canada. I am conducting a research study on Nigerian women's experiences with accessing cervical cancer screening prior

to immigration and I would like to interview Nigerian immigrant women in your organization. To achieve this, I seek the assistance of your organization and request permission to post the recruitment posters on your organization's notice board, websites, and social media. I also request assistance from your organization and permission to email invitation letters as well as consent forms to women, and/or allow me to speak to the members of your organization. Women who take part in the research will have an individual interview with me, virtually or by phone, at a time and date that is mutually decided between the interested participant and myself. This will take about 45-60 minutes. Participation is voluntary and I will ensure each participant's identity is concealed. Information shared will not be traceable to any consenting participant from your organization.

If your organization grants me permission and consents to offering assistance to disseminate information about my study as well as recruit participants, I will appreciate a response email clearly stating this support from your organization.

The contact information for myself and my supervisor are available at the end of this letter. Attached is a copy of my ethical approval letter from the University of Alberta's Research Ethics Board.

Thank you,

Fadodun Oluwadamilola (Graduate student)
University of Lethbridge
Phone: 403-3593512
Email: oa.fadodun@uleth.ca

Dr. Mark Zieber (Supervisor)
University of Lethbridge
Email: m.zieber@uleth.ca

APPENDIX C: LETTER OF INVITATION FOR PARTICIPANT

University of
Lethbridge



Project Title: “Accessing Cervical Cancer Screening in Nigeria: Exploring the Experiences of Nigerian-Born Immigrant Women in Canada”

Dear Potential Participant:

My name is Fadodun Oluwadamilola Agnes, an MSc. Nursing Student at the Faculty of Health Sciences, University of Lethbridge, Alberta, Canada. I am conducting a research study on Nigerian women’s experiences with accessing cervical cancer screening prior to immigration. I am inviting you to participate in an interview to listen to your experience on the various factors that influence how women access cervical screening in Nigeria. The interview will be virtual on Microsoft Teams. If any challenges occur while you are being interviewed virtually, the interview will continue via a telephone interview. Interview will take about 45-60 minutes at a mutually agreed date and time. I am hoping to recruit in total between 8 and 12 participants for this study. All interviews will be conducted one-to-one online, using semi-structured and open-ended questions following an interview guide.

Please note that your participation is voluntary. Please contact me if you are interested in participating. Also, please find attached the consent form, which reviews key elements about the study so that you can make an informed decision whether to participate or not. If you require any additional information about this study, please contact me.

Thank you,

Fadodun Oluwadamilola (Graduate student)
University of Lethbridge
Phone: 403-3593512
Email: oa.fadodun@uleth.ca

Dr. Mark Zieber (Supervisor)
University of Lethbridge
Email: m.zieber@uleth.ca

APPENDIX D: CONSENT FOR PARTICIPANT

University of
Lethbridge



Project Title: "Accessing Cervical Cancer Screening in Nigeria: Exploring the Experiences of Nigerian-Born Immigrant Women in Canada"

Date,

Dear Participant:

You are invited to participate in this research study on Nigerian women's experiences with accessing cervical cancer screening in Nigeria prior to immigration to Canada. Early detection through screening and access to quality treatment has been identified as an effective way to reduce mortality arising from cervical cancer disease. However, contrary to the established effectiveness of cervical cancer screening in developed countries, the impact of cervical cancer screening in Nigeria has been insignificant so far. There is, therefore, a need to critically appraise the possible reasons for the minimal impact, so far, of cervical cancer screening for combating cervical cancer, as improving access and utilization of cervical cancer screening is vital to reducing the burden of cervical cancer in Nigeria.

To this end, the purpose of this interview is to explore the various factors that intersect to influence how women access cervical screening in Nigeria. If you agree, your participation will involve taking part in a one-to-one interview that will take about 45-60 minutes of your time. The interview would take place virtually (i.e., in an online meeting) or over the phone. I will take written notes of the discussion during the interview if you do not want to be digitally recorded. If any challenges occur during the virtual interview, a telephone interview approach will be adopted to continue the interview session.

IS YOUR PARTICIPATION VOLUNTARY?

Your participation in this research is completely voluntary. You may choose to not answer any question during the course of the interview, or you may withdraw from the interview at any time for any reason. If you decide to withdraw from the study, you will be given the option to either remove or retain any information you have provided.

ANY BENEFIT?

There are no direct benefits to you for participating in this study; however, we hope that the information you provide will help us better understand why the utilization of cervical cancer screening is low among Nigerian women.

WILL I BE COMPENSATED?

You will receive a Tim Hortons e-gift card of 10 dollars to thank you for your participation in the study.

ANY RISK?

I do not anticipate any response to pose any form of threat or danger to your wellbeing. However, owing to the sensitive nature of issues related to gender, if you feel uncomfortable

during the interview, you can refuse to answer any question and you can stop or withdraw from the interview at any time. Should you require any additional support to address any emotional discomfort that emerges as a result of discussing these issues, a list of potential counselling services will be provided to you by the interviewer.

WILL MY IDENTITY BE EXPOSED?

In this study you will not be identified by name but will be asked to choose a pseudonym in place of your real name. The recording and transcripts of your interview will only be labelled with this pseudonym. All of the data collected in this study will be kept in a locked cabinet or in an encrypted password-protected computer and backed up using a secure Canadian cloud-based storage platform. Only the researcher and supervisor will have access to the original recordings or transcripts. Collected information from interviews will be retained for 5 years from the completion of the study before being deleted. A report of the results will be made available to all participants prior to any publication.

DISSEMINATION OF RESULTS

The result from this study will be presented in the form of a report to stakeholders and policy makers in Nigeria. Also, the information collected from this study will be presented in academic reports and presentation, research journals, health organizations, and the University of Lethbridge, Alberta. However, as listed above, you will not be identified in any of these types of reports or publications.

WHO CAN I CONTACT?

If you require any additional information about this study, please contact me or my supervisor at the numbers on the first page of this consent. This research project has been reviewed for ethical acceptability and approved by the University of Alberta Research Ethics Board. Questions regarding your rights as a participant in this research may be addressed to the Board at ulethics@ualberta.ca.

Thank you!

APPENDIX E: VERBAL CONSENT CHECK BOX

I have read (or have been read) the above information regarding this research study and fully understand the information given by Miss Fadodun Oluwadamilola Agnes of which:

- a) I have had the opportunity to ask questions and have those questions answered.

Yes No

- b) I understand that I am free to ask further questions about the study at any time.

Yes No

- c) I understand that I can contact the researcher at any time through the addresses/phone numbers listed above.

Yes No

- d) **Consent to Participate:** I agree to voluntarily participate in this study and have not been coerced in any way:

Yes No

- e) **Consent to Record Virtually:** I agree to have my responses recorded using Microsoft Teams during the virtual interview:

Yes No

- f) **Consent to Record Virtually:** I want my camera turned on during the interview:

Yes No

g) **Consent to Phone Interview:** If any challenges occur while I am being interviewed virtually, I consent to a telephone interview.

Yes

No

J) **Request to Receive Results:** Upon completion of the study, I wish to obtain a summary copy of the study findings:

Yes

No

..... (Signature of Researcher)

..... (Date and Time of recording)

A copy of this form and the Letter of Information have been provided to you for your records.

Thank you for your consideration.

Fadodun Oluwadamilola (Graduate student)
University of Lethbridge
Phone: 403-3593512
Email: oa.fadodun@uleth.ca

Dr. Mark Zieber (Supervisor)
University of Lethbridge
Email: m.zieber@uleth.ca

**APPENDIX F: ACCESSIBLE PROFESSIONAL COUNSELLING RESOURCES IN
LETHBRIDGE, ALBERTA**

If experiencing any life-threatening mental stress, please dial 9-1-1

Associates Counselling Services

239 12b Street North, Lethbridge, AB T1H 2K8 Tel: (403) 381-6000

Lethbridge Counselling Services

740 4 Avenue South Suite 207, Lethbridge, AB T1J 0N9 Tel: (403) 942-0452

Alberta Health Services Mental Health Clinic

616 3 Avenue South, Lethbridge, AB T1J 0H5 Tel: (587) 800-8264

Mental Health Helpline (24 hrs. a day, 7 days a week) – 1 866 303 2642

APPENDIX G: INTERVIEW GUIDE

Below is the template for the interview session. All other probing and further questions will be asked during the course of discussion.

Introduction: Thank you for consenting to participate in this study. My name is Fadodun Oluwadamilola Agnes. I am in the Master of Sciences in Nursing program at the University of Lethbridge.

Preamble: The purpose of this interview is to elicit your response about your experiences in accessing cervical cancer screening in Nigeria prior to your immigration to Canada. The essence is to generate information that could improve access and utilization of cervical cancer screening which is vital in reducing the burden of cervical cancer in Nigeria. The details of this study are contained in the letter of invitation and consent form given to you in person or via email, before we mutually agreed on the time, date, and format of the interview.

Pause: Check again with participant to ascertain whether participant still understands the content in the Letter of Invitation and consent form containing the details of the research. Once participant affirms to continue with the process, relay the content of the consent form by re-iterating their rights, and then proceed.

Before we proceed to the main interview, please can you fill out this brief demographic form?

Pseudonym:

Date:

Time:

Present Geographical Location: State of

Origin:

Age when you left Nigeria:

Age (Last birthday):

Highest level of Education prior to immigration:

Employment status in Nigeria: Employed () Unemployed () Religious affiliation:

Ethnicity:

Years since immigration to Canada from Nigeria:

Section 1: General Questions

1a) Tell me what you know about cervical cancer disease.

Probe: Do you know the organ affected in the body?

1b) Tell me what you know about how it is prevented.

Probe: Have you heard about CCS? What do you know about CCS? Did you have access to information?

Note: If participants display a good awareness of questions 1a and 1b then proceed to

question 1c and 1d. If participant displays low awareness, then pause to educate, and proceed to section 5.

1c) Tell me how you got to know about cervical cancer screening while you were in Nigeria.

1d) What does 'Access' to cervical cancer screening mean to you?

1e) How would you describe your experience with cervical cancer preventive services in Nigeria, especially as it relates to accessibility of the screening to Nigerian women?

1f) Have you ever been screened for cervical cancer?

Note: If **yes to 1f** proceed to **Section 2**. if no proceed to **Section 3**

Section 2

2a) What informed your decision to go for screening?

Probe: What factors can you say contributed to your motivation to go for screening while in Nigeria? What factors can you say shaped your orientation to go for screening?

2b) After deciding on getting screened, talk me through what it entailed for you to access cervical cancer screening while in Nigeria.

Probe: What processes were involved? How long did it take you to finally get your screening done from the time you got to know about CCS? Did you experience any challenges or barriers while undergoing the processes? Can you discuss some of these challenges?

2bi) Considering the time you lived in Nigeria, how might your being female in Nigeria have impacted your accessibility to cervical cancer screening?

2bii) How might you say your financial status, cultural factors, religion, level of education, age factor, or the healthcare system, attitude of healthcare providers, political interference, etc., have influenced:

- Your decision to want to get screened for HPV?
- Your experience with accessing CCS in Nigeria?

Probe: So, in what ways did these aforementioned factors impact your access to screening, and how did they influence your access to CCS experience while in Nigeria? Do you see or did you experience any biases as a result of being a woman in Nigeria that affected your access to screening? Did you experience any power dynamics as a result of being a woman that interfered with your accessibility to screening?

2c) What other factors would you say contribute to a woman's ability to successfully access cervical cancer screening in Nigeria?

Probe: Can you explain how these factors you mentioned might impact a woman's access to getting screened for cervical cancer in Nigeria?

Note: Depending on participant's responses, especially if their experiences negatively impacted

access, ask for recommendations on measures that could have improved participant's access to CCS.

Section 3

If participant displays good awareness and has not been screened

3a) What can you say were the probable reasons as to why you could not get screened despite your level of awareness on cervical cancer disease and cervical cancer screening?

Probe: Were there instances when you tried to go for screening? what made you experience failed attempts to accessing screening or getting screened? Barriers to accessibility?

3bi) Considering the time you lived in Nigeria, how might your being female in Nigeria have impacted your accessibility to cervical cancer screening?

3bii) Besides from being a female, how did your financial status, cultural factors, religion, level of education, age factor, or the healthcare system and political interference influence your accessibility to CCS while in Nigeria?

Probe: So, in what ways did these aforementioned factors interfere with your access to CCS while in Nigeria? Do you see or did you experience any biases as a result of being a woman in Nigeria that affected your access to screening?

3c) What other factors would you say contributed to your inability to successfully access cervical cancer screening while you were in Nigeria?

3d) So, how can cervical cancer screening be made more accessible to women in Nigeria?

Note: Depending on participant's responses especially if experiences negatively impacted access, ask for recommendations on measures that could have improved participant's access to CCS.

Section 4

If participant displays low awareness and has not been screened. Probe on:

4a) What do you think were the contributing factors to your level of awareness?

Probe: Can you say being female in Nigeria or other factors such as your: level of education, culture, religion, age factor, political factors, financial status or attitude of health workers might have impacted your level of awareness on how to access cervical cancer screening?

Probe: Did you experience any power dynamics as a result of being a woman that interfered with your accessibility to screening? Do you see or did you experience any biases as a result you being a woman in Nigeria that affected your access to screening?

4b) What measures can you suggest to help improve the level of awareness of women on how screening for cervical cancer disease can be accessed in Nigeria?

Section 5

- 5) How do you think access to cervical cancer screening in Nigeria can be improved for women?
- 6) What other information would you like to share?
- 7) Do you have any questions for me?

Thank you for your time

Appendix H: Ethics Approval Form



RESEARCH ETHICS OFFICE
Health Research Ethics Board

2-01 North Power Plant (NPP)
11312 - 89 Ave NW
Edmonton, Alberta, Canada T6G 2N2
Tel: 780.492.0459
www.uab.ca/reo

Approval Form

Date: November 17, 2021

Study ID: 2021-111

Principal Investigator: Oluwadamilola Fadodun

Supervisor: Mark Zieber

Title: Accessing Cervical Cancer Screening in Nigeria: Exploring the Experiences of Nigerian-Born Immigrant Women in Canada

Approval Expiry Date: November 16, 2022

Thank you for submitting the above study to the Health Research Ethics Board - Health Panel (REB 3). Your application (signed by you on October 5, 2021 and dated November 12, 2021) has been reviewed and approved on behalf of the committee.

Any proposed changes to the study must be submitted to the REB for approval prior to implementation. A renewal report must be submitted by November 16, 2022 if your study still requires ethics approval. If you do not renew on or before the renewal expiry date, you will have to re-submit an ethics application.

Approval by the REB does not constitute authorization to initiate the conduct of this research. The Principal Investigator is responsible for ensuring required approvals from other involved organizations (e.g., Alberta Health Services, community organizations, school boards) are obtained, before the research begins.

Sincerely,

A handwritten signature in blue ink that reads "Carol Boliek".

Carol Boliek, PhD
Associate Chair, Health Research Ethics Board - Health Panel

