**Barriers and Facilitators to Pap-testing among Female Overseas Filipino Workers: a** **qualitative exploration**

**Background**

In 2018, approximately 311.000 women died of cervical cancer globally. Cervical cancer is the second most common cancer for women in low and middle income countries, although the disease is preventable and treatable (WHO, 2019). No woman should die of cervical cancer. The WHO recommends a comprehensive cervical cancer control approach through primary (Human Pappilomavirus vaccination), secondary (cervical cancer screening) and tertiary prevention (diagnosis and treatment). Cervical cancer screening through pap-smears or pap-tests, the term used here, is an effective secondary prevention method of detecting precancerous lesions. Pap-testing is an essential tool in the early detection and management of cervical cancer (WHO, 2019).

Low participation rates in pap-testing have been found for migrants (Ho and Dinh, 2011; Hou et al., 2012; Idehen et al., 2017; Leinonen et al., 2017; Olsson et al., 2014; Weber et al., 2014). The limited studies focused on pap-testing for female Oversees Filipino Workers (OFW), have found low participation rates for these women too (Christie-de Jong, 2017; Holroyd et al., 2001, 2003).

Overseas Filipino workers are defined by the Philippines Statistics Authority (2019) as ‘Filipino migrant workers whether regular or irregular’. Irregular migrant workers are undocumented or unauthorized migrant workers. Based on the 2018 Overseas Filipino Workers (OFWs) Survey, the Philippines Statistics Authority estimated 2.3 million OFWs to be working abroad, of which 55.8% were females. Two thirds (59.8%) of OFWs were resident in the Middle East; one in four OFWs (24%) worked in Saudi Arabia, followed by United Arab Emirates (16.1%), Kuwait (8.4), and Qatar (5.3%). Other typical regions for OFWs are East Asia (19.9%) such as Hong Kong (10.6%), or South East and South Central Asia (10.7), such as Singapore (6.4%) (Philippine Statisitcs Authority, 2019). More than half (58.7%) of female OFWs were recorded to perform low-skilled jobs, such as domestic work. Domestic workers are vulnerable to abuse as they are often based in the private homes of their employers, and access to healthcare may be limited (Hall et al., 2019). In the Philippines, OFWs are perceived as *bagong bayani*—the new heroes—who sacrifice themselves and endure the hardship of leaving their families, behind for the betterment of their families and the country (Constable, 2007). Total remittances sent home by OFWs in 2017 were estimated at $32.8 billion (The World Bank, 2019).

Barriers to pap-testing have been found for women across the globe, including lack of knowledge, as well as emotional, economic, cultural and structural barriers. However for migrant women, additional or different barriers may exist. Limited research is available regarding OFWs in relation to pap-testing. This study aimed to gain insights into barriers and enablers to pap-testing for OFWs and used the socio-ecological model as its conceptual framework. According to the socio-ecological model health behaviour is multidimensional and determined by a complex interplay between individual, social-cultural, institutional and structural factors (Reifsnider et al., 2005). The socio-ecological conceptual model stems from Bronfenbrenner’s (1977) theoretical psychological model and has become a prominent model in public health. The model is underpinned by the assumption of a structure-agency approach and an interplay between multiple factors as levels of influence on determinants of health and health behaviour, all embedded in a broader structural context

(Daley *et al.* 2010). The model proposes that a single factor is not sufficient in explaining health behaviour (Reifsnider *et al.* 2005). According to the model, factors that influence health and health behaviour are relational and interdependent. Therefore, the dynamic and interrelationship between individual, social-cultural, institutional, and structural factors impact health outcomes and can create health inequalities across the life span (Fielding and Teutsch 2010). According to the socio-ecological model, a public health issue like low uptake of pap-testing, is the result of a convergence of all factors involved (Daley *et al.* 2010).

**Methods**

This study was the qualitative component of a mixed methods study. A cross-sectional survey was conducted with 480 OFWs, followed by web-based qualitative interviews to explore perspectives of OFWs regarding barriers and socio-ecological factors associated with pap-testing and what these meant to OFWs. Findings from the qualitative interviews are reported here. The final question of the web-survey asked if women were interested in participating in a web-based interview, after a short explanation of what this was and what would be involved. Inclusion criteria for the interview component of the study were: female OFW, aged between 21-65 and able to speak English as interviews were conducted in English.

Purposive sampling was attempted to ensure a variety of participants with different voices were included and in February 2016 the researcher invited, by email, a small number (12) of participants based on their survey answers such as location, and some who had or had not engaged in pap-testing. However, the response was zero and convenience sampling was then used by inviting all participants (n=340) who had supplied a contact address. Eight participants agreed to take part in the study. Key characteristics of the eight participants relevant to the study are summarized in Table 1.

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| --- | --- | --- | --- | --- | --- |
| **Participant**  | **Nationality** | **Age** | **Country of residence** | **Profession** | **Pap-test ever** |
|  (P1) | Filipino | 40 | Singapore | Domestic worker | No |
|  (P2) | Filipino | 24 | Kuwait | Domestic worker | No |
|  (P3) | Filipino | 37 | Kuwait | Domestic worker | Yes |
|  (P4) | Filipino | 40 | Hong Kong | Domestic worker/Nanny | No |
|  (P5) | Filipino | 45 | Singapore | Domestic worker | No |
|  (P6) | Filipino  | 40 | Qatar | Domestic worker | No |
|  (P7) | Filipino | 37 | Kuwait | Sales/Promoter | Yes |
|  (P8) | Filipino | 35 | Kuwait | Domestic worker | No |

Table 1 Demographic characteristics of participants

Interviews were conducted using Skype or Viber, which are mobile and desktop applications that allow free phone calls with video option. Interviews were audio recorded with consent and transcribed verbatim by a professional transcribing service. Vignettes were used to stimulate discussion (Ritchie and Lewis, 2013). Vignettes are short hypothetical scenarios and are a useful method to discuss sensitive issues as the scenarios can be less threatening than direct questions. Vignettes can also be useful if participants lack personal experience of a topic and offer an opportunity to explore participants’ perspectives on the topic (Braun and Clarke 2013). Discrepancies between participants’ reality and proposed scenarios in the vignettes may cause problems (Hughes and Huby 2002), however using the results from the survey phase of the study to develop the vignettes was meant to limit this disadvantage. Three short scenarios, which were stories of OFWs in relation to pap-testing, were presented to participants, followed by open questions, with the intention of exploring participants’ understanding of pap-testing and their perspectives on barriers and facilitators to pap-testing.

Data were analysed using Thematic Content Analysis, capturing recurring themes and patterns emerging from the data (Braun and Clarke, 2006). NVivo qualitative data analysis software (QSR International PTY Ltd. Version 10 for Mac, 2014) was used to assist in the analysis. Coding was an iterative process as one interview could bring up a code that had not been noted in a previous interview; therefore, the researcher went back and forth between interviews, comparing and contrasting between interviews. Once all codes had been applied, codes were organised in categories from which higher-order themes and subthemes were developed which were aimed at capturing and interpreting the meaning of the data and stories participants shared (Ritchie and Lewis, 2013). A coding scheme (Table 2) was developed to visually capture the essence of the data.

|  |  |
| --- | --- |
| **Theme** | **Subtheme** |
| 1. Experience of pap-testing
 | * Practice & Intent
 |
| 1. Cognitive factors
 | * Knowledge
* Health beliefs
* Fear
 |
| 1. Cultural factors
 | * Providing for family
* Social support
* Embarrassment
 |
| 1. Structural context
 | * Institutional factors:
	+ Access to healthcare
	+ Healthcare provider factor
* Structural working and living conditions
	+ Structural circumstances-poverty and cost as barrier
	+ Working circumstances- Relationship with employer and time as barrier
 |

Table 2. Coding scheme

Every interview commenced with a discussion of consent, voluntary participation, withdrawal and what would happen with data and the findings. Debriefing information was sent to participants after the interview to deal with any worries participants may have as a result of the conversation. Ample opportunity was offered to participants to ask questions at the end of the interview, which all participants used, and the researcher made an effort at the end of the interview or the next day to help some participants who asked for this to find a suitable address for pap-testing in their host-country. Data were collected between March and June 2016. Ethical approval was received from the Faculty of Health and Medicine Research Ethics Committee at Lancaster University, United Kingdom.

**Results**

The data are described below according to the four main themes and their related subthemes, as indicated in Table 2.

*Experience of pap-testing: Practice & Intent*

This theme relates to what women did or intended to do regarding the uptake of pap testing.

Only two women had ever had a pap test. One participant, a domestic worker, had a pap-test such a long time ago she could not remember when this was but she thought it was more than five years ago. The other participant was a sales professional, not a domestic worker like all other participants, had several pap-tests of which one was only one year ago. None of the pap-tests had been taken in the host countries, and all had been done in the Philippines. All the women interviewed intended to go for a pap-test. The majority appeared keen and were planning to go for a pap-test and expressions like ‘*I’m excited’* or ‘*I’m willing’* were used. A smaller proportion had mixed feelings and were partly eager but also somewhat unsure or scared.

P5: *I am scared, I am scared, I feel good also, I feel scared and good also, feel scared and good also.*

*Cognitive factors*

The theme of cognitive factors relates to knowledge of pap-testing, including some misconceptions that were reported, health beliefs about pap-testing and cervical cancer, and fear.

*Knowledge*

Although all participants had heard of pap-testing, most admitted not knowing a great deal. One woman answered she thought the purpose of pap-testing was ‘*to check inside the cervix*’ but what would be checked, she was unsure of. Most participants seemed to think pap-testing was for ‘*cleaning*’. One participant thought the purpose of pap-testing was ‘*cleaning the dirt from the ovaries*’ and she believed this was necessary after taking the contraceptive pill for a long time. Another participant compared pap-testing to cleaning the womb after a miscarriage. Other participants mentioned the purpose of pap-testing was ‘*to clean the vagina*’ and this was required to remove sperm. Sexual activity was related to pap-testing for women and cleaning the vagina or body from sexual activity was reported to be important and participants shared that if cleaning was not done this could result in illness.

*Ah, because I, need a Pap-smear to bring inside, the sperm like that to clean it, to clean it, you think? Others said[this]* (P2).

When discussing pap-testing, cervical cancer was specified by one participant. However, other interview participants spoke erroneously about different types of cancer in relation to pap-testing, ovary and uterus cancer were both mentioned, revealing more misconceptions about pap-testing, including for the participant who had engaged in several pap-tests. Sources of knowledge were friends, the internet, newspapers or their midwife. Some participants revealed knowing about pap-testing as they had friends, family or acquaintances who had died from cancer.

*Health beliefs*

Participants expressed concern for their health and taking care of one’s health was deemed important. Some participants liked to read on the internet about health and one participant emphasised engaging in healthy behaviours such as drinking healthy juices to prevent illness. The participant felt this was necessary as her job put strain on her health and did not allow her sufficient rest. Therefore, she believed this was a method of compensating for the physical strain on her body to avoid illness. Other participants shared stories of women who were suffering from illness or who had died as a result of cancer and were described as ‘*not taking care of themselves*’, as they did not go for a pap-test.

*I have my relative die three years ago, she didn’t take some pap smear, she died, cancer, a uterus cancer. Then now I have a friend here in Kuwait, she is suffering stage two, uterus cancer because she didn’t take care of herself* (P7).

All participants seemed to find pap-testing important and all believed that pap-testing would be beneficial to them. One participant highlighted the importance of pap-testing in the absence of symptoms.

*Because every girl in the world even without sex or we have sex we need to once a year or twice a year make a Pap smear [….] because even though your vagina is okay maybe you have problems that that's why you need it* (P3).

One participant was not sure if pap-testing was needed in absence of symptoms and another participant admitted that when she felt healthy, she did not think about healthcare behaviour such as pap-testing. Some participants mentioned that finding cancer early was positive and they believed this to contribute to better outcomes. A few participants discussed prevention was better than cure and several participants thought cancer could be cured if found early, although one participant also believed hereditary influences to be important and one stated that curing cancer was ‘*a fifty-fifty chance’*.

*Fear*

Fear of the actual procedure of a pap-test was brought up, but did not seem to worry women too much. One participant had heard that a pap-test could be somewhat painful or uncomfortable but this did not seem to hinder her. Rather the fear of the outcome of pap-testing and hearing bad news was mentioned and appeared to be a barrier for women.

*I am scared to go because maybe the doctor will say you have cancer. My heart will be broken and my work will be done. I am scared to know what will be my result, and that is it [laugh](*P8).

Participants who reported feeling scared of the outcome spoke of their worries about what would happen if cancer or another illness was found, of the consequences of an illness to them, but also to their family. Not being able to look after their families financially would be a direct consequence of finding out they might be ill or have cancer. Fear of the outcome also encompassed a fear of medical expense as a result of falling ill and participants worried about not being able to afford healthcare. Additionally, fear existed that if participants were ill, all their hard earned money would be spent on healthcare and not on their families.

*Cultural factors*

This theme describes cultural, social or community values, with providing for families as a key factor.

*Providing for family*

All women wanted to be healthy, particularly for their children. Children came first and all decisions women seemed to make, were based on the well-being of their children, even if this was at their own expense. Looking after children financially to pay for their schooling, food, and needs appeared as vital. The consequences of not being healthy, and thus not being able to look after children financially, was considered critical. Sending money home was the ultimate priority and many other barriers seemed related to this key drive. Looking after parents financially, was also described as crucial not only because parents often looked after the children in the Philippines, but also because looking after parents is the cultural norm.

*No, of course if your Filipinas like us, you always something feeling sad for our children so that is why sometimes whatever feeling or we are feeling, not feeling good or whatever, we always put our family first before ourselves* (P1).

*Social support*

Social support and discussing health issues including pap-testing with friends was important to women. Women preferred to attend healthcare appointments with friends, however women were conscious that it was unlikely they would be in the position to attend healthcare appointments together with friends due to different time schedules and restrictions in time-off work.

*Embarrassment*

Two women reported that embarrassment and feeling shy was an issue. They felt shy about undressing in front of a doctor and one woman shared that after having five children she felt shy about the way her vagina looked. Other participants did not feel shy or embarrassed about undressing and also not about discussing the topic of pap-testing with a healthcare provider and expressed that talking about these issues was ‘normal’ to them. Some women did discuss the doctor’s gender and preferred a female doctor as they found that less embarrassing.

P6*: (laughter) I have already 5 kids, so, I feel shy because (laughter) the vagina it’s not same with 5 kids, I feel shy*.

Although most women connected cervical cancer with having sex with multiple men, only one woman described linking a pap-test with a sexual connotation of ‘a bad woman’. Other women shared not feeling worried about their reputation when going for a pap-test.

*Structural Context*

This theme describes the structural environment underpinning access to healthcare and women’s working and living circumstances.

*Access to healthcare as barrier*

None of the participants seemed to have considered going for a pap-test in the host countries and all participants discussed going in the Philippines. All participants seemed rather surprised when being asked about attending pap-testing in their host country and it had not truly occurred to them as an option. All participants believed that it would be easier and cheaper to go for pap-testing in the Philippines although one participant highlighted that healthcare equipment and healthcare may be superior in her host country Singapore than in the Philippines.

*Because before I was thinking, I could do it only in Philippines, but when my friend [name] told me so I said “Oh really” is there also in Doha* (laughter) (P6).

Participants did not have a regular healthcare provider although a few women were able to use their employer’s doctor when seriously ill or in case of an emergency. Most participants did not know where to go for a pap-test in their host country, or comprehend the set-up of hospitals and health clinics and what healthcare would be offered where, illustrating a lack of understanding how to navigate the health-system in their host country. Participants also reported not knowing how to make an appointment and this seemed difficult to them. Participants did report, however, to have regular contact with healthcare providers as they explained all migrant workers are required to do medical check-ups for their visa continuation and renewal. Participants shared to be checked regularly for HIV/AIDS and pregnancy, with more extensive check-ups, including lung X-rays, when renewing their visa.

*Yeah I go see doctor every six months because we need to go for physical health every six months […] of course only during the medical checkup every six months is the is the urine and they get the blood and check check check check check check just a simple just a simple medical checkup […] is just a medical check-up if you have HIV, if you are pregnant, I think these two and after you finish your employment contract you want to renew again with another years then they do will do the x-ray* (P1).

None of the participants had ever received a recommendation for pap-testing from a healthcare provider and no professional had ever spoken to them about pap-testing, except one woman who had been recommended pap-testing by her midwife when pregnant several years previously. The doctor’s ethnicity did not make a difference to participants and none of the participants seemed to find Filipino nationality of the healthcare provider important, and language issues as communication barriers were not brought up. Trust in the healthcare provider was brought up by one participant as she was worried about the doctor sharing her confidential information with her employers or with others, such as the police. This participant engaged in sexual contact with a man she was not married to, which is illegal in her host country. The woman had started bleeding heavily after her last sexual contact, and although she was worried about this and believed a pap-test would be beneficial, she was too scared to go to the doctor. She worried her ‘*secret*’ would be ‘*found out’* if she admitted having sex. She worried that she could not present to the doctor without them finding out she was engaging in this ‘*illegal activity’* and that this secret would be revealed to her employer and authorities. The participant worried about the consequences of being sent to the police and eventually back to the Philippines, where she would not be able to provide financially for her children.

Another woman described how she felt that her status in the host country’s society did impact on her access to quality healthcare. She felt discriminated against based on her status as ‘housemaid’ and believed that migrant workers were marginalized and not offered quality healthcare.

*If I want to make an appointment, not in a public hospital because too many people and the doctors and nurses won’t treat a housemaid well. Not that one. They won’t treat, their attention is full. As a housemaid or a driver you cannot get 100% attention. They will treat another, just like that* (P8).

*Structural circumstances-poverty and cost as barrier*

When exploring what cost meant to participants all but two participants perceived cost a barrier and participants revealed that poverty was a key determinant to them, participants lacked money and funds for a pap-test were simply not available. One participant discussed she had a Western partner who she believed would help her with any healthcare related cost and therefore she did not perceive cost to be a barrier. The other participant was the sales professional for whom cost was not a barrier. Other participants discussed cost for a pap-test in the host country and believed this to be higher than in the Philippines. Several participants shared having health insurance in the Philippines, but not in the host country. Access to free health clinics in the Philippines was mentioned, but none of these options were available in the host country, according to participants.

*Because it depends on money, it depends on what Pap smear is because actually I stay in I stay in a squatter area, those the houses are (P1).*

*I have no money, just enough for one day. I have to save money to give to my children* (P8).

Women told the story of how poverty had affected them and resulted in them working abroad as an OFW. All women had to leave the Philippines and leave their families and children behind to earn money to provide for their children and families. If married, their husbands’ salaries were described as insufficient and participants described it was relatively easy for women to find a job abroad. Single mothers had no other option then to leave the Philippines and work as an OFW to provide for their children. Most women had not seen their children for several years. Several women described that being away from their children was incredibly difficult for them and feelings of sadness, crying, loneliness, feeling homesick and boredom were described. As years of separation passed, women seemed to grow used to dealing with these feelings of sadness and despite the separation from children still being very painful, somehow managed to cope. Women seemed to be surviving and the drive to look after their families and children, if only financially, seemed to overpower anything else.

*Working circumstances- relationship with employer and time as barrier*

All domestic workers lived in the home of their employers. Participants described their roles as doing everything around the house, from cleaning, cooking, to looking after the employer’s children and ill relatives. All but one participant revealed that time was a major barrier to pap-testing for them. Initially all participants discussed time available when in the Philippines, again suggesting that attending pap-testing in their host country was not visible to participants as an option, and participants argued there were not sufficient days when they were on holidays in their home country. The participant who reported to have time, the sales professional, stated she went to see her gynaecologist when she was in the Philippines.

*Oh no, not really, not yet, 'cause I, I live here in Hong Kong, and the doctor is in Philippines, so I, I spoke to myself and I go back to Philippines first, example a month. ‘Cause I always get a holiday two week and some days so it's not* enough (P4).

Limited holidays were mentioned by all participants. Their work contracts usually allowed them to go home to the Philippines every two years. However, some had not been home for several years and for financial reasons they had chosen not to take holidays when the opportunity finally presented itself. Most participants working as domestic workers expressed to have very limited time off work, limiting their opportunities to go for pap-testing and some mentioned they had as little time off as a few hours once per month. Some participants had one day a week off but strict timings were set by employers.

*Yeah. because some warning of my employers, when I go out for off days I go out 10 am and must be back by 5.30, so I must come back by 5.30 so that's only really 7 1/2 hours* (P1).

Two participants described not to have experienced any days off since being with their employers, and one participant even reported not to have had any time off in the last six years. One participant described ‘feeling shy to ask permission to go out’, and as a consequence she had not left the house since her arrival one year previously, unless going out with the employer. Several others mentioned needing permission from their employer to go out and some also felt scared to ask permission to go out for pap-testing. Participants described that going for pap-testing was not feasible to them as they always felt pressure to go back to their employers.

*And the.. the problem is the time. Cause we have our dictations, our families [employer], so it is not possible, always we have to go back ..to our families so we don't have time for ourselves* (P4).

One participant described how she would go and visit a doctor in secret by pretending to go to the market to do shopping for ‘*the family’*, her employer. Considerable power imbalance seemed to be present in the relationship with the employer, and participants referred to the female in the employee household as ‘*madam*’, and some participants also addressed the researcher in this way. One participant described her employers to keep her passport as well as her employee contract and health insurance policy that she had never seen. Keeping domestic workers’ passports is illegal, yet these practices were described as ‘*normal*’. One participant described her employer as ‘good’ and felt she was treated well. Others described more problematic relationships with their employers, with reports of employers shouting at them and fears of not being paid or losing jobs were expressed. During one of the interviews shouting was evident and cries in the house for the participant were heard. The participant seemed to stay rather stoical with a small smile on her face, while she listened to her employer’s cries in Chinese and explained to the researcher she responded by stating she was with ‘granny’, the elderly frail Chinese woman who was in the room. Another participant seemed troubled and angry about the relationship with her employers, however she revealed how she had to keep her calm when employers became angry with her as ultimately she was not in her home country.

*Yeah, if you are good, even if you want to shout, you have to keep inside. You are not in your home country. There will be trouble, they will get angry and shout at you. It’s better to be quiet and keep it inside. Hopefully the salary will come and that is it. If they get angry, ok silent yes. I don’t like to talk a lot because in the end you are still the loser* (P8).

Participants described feeling scared of jeopardizing their jobs by employers finding out participants may have an illness or that anything would be wrong with them. One participant described the employer taking her to a doctor when she is ill, just to check if she might be pregnant. Other participants described that doing a pap-test and finding out they might be ill would mean their employer would send them back home to the Philippines, and this would result in the women not being able to provide financially for their children and families in the Philippines, again highlighting the importance of this factor.

*I'm not scared of the doctor at all because of what happened to me I am scared because... If I go to the doctor then how about if something different for me... And I don't want to be sent to the Philippines. How about if the employer sends me to the Philippines? [….] I'm not scared about what this might happen to me, I'm not scared to go to Doctor, but I'm scared about the employer* (P2).

**Discussion**

Participants described low uptake of pap-testing but all seemed willing to engage in pap-testing, although attending pap-testing in the host country seemed not to have been considered. Some misconceptions were found regarding pap-testing and its purpose, however most participants believed pap-testing to be beneficial and beliefs around prevention and early treatment were noted. Barriers that were visible to participants, were time, cost, fear and restricted access to healthcare. Exploration of what these factors meant to the women revealed difficult circumstances. Difficulty in navigating the healthcare system in host countries seemed underpinned by women’s social and structural context. In line with the socio-ecological model, barriers were interacting and cultural values of putting family first became evident, stressed by the underpinning of a social and structural context of poverty and women’s need to provide financially for their children, resulting in women experiencing difficult working and living circumstances not conducive to engaging in pap-testing.

Health behaviour, such as pap-testing, cannot be separated from the context of women’s lives and at the root of inequalities in pap-testing lie structural differences in social class, gender and ethnicity (Kawachi et al., 2002; Naidoo and Wills, 2016; Whitehead, 2007; Wilkinson and Marmot, 2003), which were apparent in this study. Individuals may be assumed to have choices when it comes to their health, however OFWs may not experience having a choice as a true possibility in their everyday life, their choices are shaped by life chances, which are embedded in structural and social contexts (Watson and Platt, 2002).

Social structures are beneath the surface of health inequalities. The task of social science and public health is to comprehend how objective structures of society (social class, gender, ethnicity) impact subjective behaviour (Fries, 2010). Lower socio-economic groups not in possession of the same economic, cultural and social capital may lag behind, having a different spectrum of health chances resulting in health inequalities (Pinxten and Lievens, 2014). Social class, socio-economic status, and occupation are key concepts when discussing health issues and should not only be seen in the light of material disadvantages, but also in terms of power and social stratification. Structural mechanisms such as social class, ethnicity, occupation, income, education, and gender lead to unequal distribution of power and (health relevant) cultural resources in society (Blas and Kurup, 2010). These structural mechanisms are the social determinants of health inequalities. This social structure and how individuals are positioned in this with regard to social class, ethnicity, gender and status, impacts health behaviour and health outcomes (Naidoo and Wills, 2016). This social structure determines what health resources are available and visible to individuals and how they make sense of and ‘normalise’ their health decision-making. In the current study, through exploring the lived-experiences of OFWs, structural constraints of poverty and fundamental inequalities that shape their lives became apparent. Domestic workers’ narratives in this study demonstrated neoliberal globalization, resulting in “accumulation by dispossession”, juxtaposing the experiences of economically marginalised female OFWs with their privileged employers (Bourdieu, 1998; Liu, 2015). Subsequent adverse working and living conditions, labour exploitation, lack of protection and structural support of migrant workers’ health and well-being, absorbed by the bodies of OFWs, were found as underpinning structural barriers to pap-testing in the current study and confirmed in the literature (Liu, 2015). OFWs shared stories of caring for their employers’ homes, children or relatives, displaying the power in dominant and hierarchical relationships with employers that leave little room for caring for themselves, which has been described in other studies with OFWs (Iyer et al., 2004; Liu, 2015).

Transnational labour migration is gendered and for the largest part includes domestic work, sometimes referred to as reproductive labour (Liu, 2015), mostly involving women, which is “undervalued, underpaid and poorly regulated” (Gutierrez-Rodriguez, 2014). Going for a pap-test seems far removed from these women’s realities, a reality of social and economic marginalisation in which women are trying to survive, and look after their families and children from afar. In line with the socio-ecological model, an interplay between traditional feminine qualities such as ‘caring’ and looking after family and structural conditions of poverty, drives these women abroad and away from their homes and families while it remains women’s obligation to look after their family, as well as their employer’s (Asis et al., 2003; Bullen and Kenway, 2004).

Transnational labour migration represents gender, as well as class issues, although it could be argued that femininity is always classed (Bullen and Kenway, 2004). The term ‘positional suffering’ indicates the way one perceives their own position in society, as well as the perception of others of their position (Bullen and Kenway, 2004). In the current study, the stories of compulsory pregnancy tests exhibited power and class differences in line with historical views of ‘underclass’ women as sexual beings who cannot be trusted (Bullen and Kenway, 2004). This perception of women as sexual beings is not translated to ensuring their (sexual) health and well-being, by offering pap-tests (for example), but merely in terms of ensuring the woman can continue her labour, like a social object. The narratives of women in the current study described limited freedom in terms of movement, rest days and holidays, evoking memories of colonialism.

Similar findings were described in Constable’s (2007) ethnographic account of Filipino domestic workers in Hong Kong in which long working hours were described as the most prominent complaint of OFWs. In the current study, not having sufficient time was found a barrier to pap-testing. Constable (2007) highlighted that domestic workers in Hong Kong possessed working contracts which stipulated time off such as statutory holidays and a twenty-four hour rest period per week, however, these contracts were rarely enforced (Constable, 2007). Equally, the contracts stipulated that employers should provide free medical treatment and are advised to offer health insurance and employers have to pay sick leave. However, a clause in the contract states that if a medical doctor determines women are not fit to work, employers can terminate the contract immediately (Constable, 2007). This demonstrates the power imbalance between employer and employee, possibly underpinning women’s fear women in the current study of going for a pap-test and found ill. Access to healthcare for OFWs will differ between host countries but has been related to the generosity of employers (Iyer et al., 2004) and structural circumstances for OFWs seem dependent on the relationship with employers.

Experiences of hardship, homesickness and sadness of missing their children were described in the current study. High levels of stress have been found amongst OFWs in the literature and relationships with employers were significantly related to stress (Fresnoza-Flot, 2009; van der Ham et al., 2015). A power imbalance between employers and OFWs contributes to barriers in accessing healthcare and pap-testing. Constable (2007) argues that Filipino women do not necessarily feel subordinate to their employers, but the overarching need to financially support their families leaves them rather powerless, as was found in the current study. Yet, it has been argued that Filipinas may not perceive themselves as victims, rather accepting and tolerating their working and living circumstances and relationships with employers, which need to be endured in order to achieve their ultimate financial goals of supporting their families (Constable, 2007; Ebron, 2002; van der Ham et al., 2015). This enduring of circumstances and not ‘talking back’ to employers was also described in the current study. Power relations between employers and OFWs are reinforced by a laissez-faire approach of governments and lack of policies to protect OFWs’ health and well-being by both host and sending countries (Iyer et al., 2004).

**Recommendations for policy, practice and research**

Host and sending countries benefit from migrant workers and should care for their health and well-being. The Philippines, as the sending country, benefits economically as remittances are sent home (Constable, 2007; Liu, 2015; O’Neil, 2004). The Philippines facilitates migration and should play a more active role in protecting OFWs’ health and well-being in host countries, including tackling structural factors and protecting OFWs’ human rights by tackling power relations that host-country governments exhibit towards OFWs and to negotiate stronger enforcement of OFWs’ employment and human rights in host countries. The Philippines should adequately prepare OFWs before departure, empower OFWs and inform them of their rights. Structural circumstances for OFWs need to be researched by host-country strata. Host-countries gaining economically from cheap labour have a duty to protect not only their citizens, but anyone who resides in their country. Host countries should support OFWs in navigating and accessing healthcare systems and aim to offer healthcare not aimed at testing women’s ability to work or entitlement to reside in the country, but to ensure their health and wellbeing including support of preventative healthcare, such as pap-testing.

*Limitations and strengths*

The aim of qualitative research is never to generalise findings and therefore small sample sizes and lack of representative sample sizes, should not be considered a limitation in general, however even for a qualitative study the sample size in the current study was small. Nevertheless, themes started to reoccur towards the end of the interviews and no new themes emerged. Conducting interviews in English did make communication problematic at times. Ideally, interviews had been conducted by a Filipino researcher to overcome language barriers which would be recommended for future research. Language limitations were especially apparent when the vignettes were used. Vignettes, short scenarios of OFWs in relation to pap-testing, had been chosen as vignettes can be useful tools to stimulate discussions on sensitive and personal topics (Braun and Clarke 2013). In this research, the vignettes hindered the flow of interviews somewhat. This seemed partly due to language issues, as women found the vignettes difficult to understand, which has been reported elsewhere (Gourlay et al., 2014). Vignettes also seemed unnecessary and women were open to telling their story. The virtual environment did cause some technical difficulties, however this did allow for inclusion of women in multiple countries and settings.

**Conclusion**

This study found an interplay between barriers to pap-testing for female overseas Filipino workers, embedded in structural contexts not conducive to pap-testing, in line with the socio-ecological model. Poverty and the priority of providing financially for family back home in the Philippines, was underpinning all barriers. Recommendations were made to protect the health and well-being of OFWs for both host and sending countries. Cervical cancer is preventable and as a disease only affecting women, presents a gender justice issue. Furthermore, because Filipino women and women in developing countries are disproportionally affected, access to cervical cancer screening is also a matter of social justice. Governments failing to provide available cervical cancer screening violate OFWs’ right to health (UNIFEM, 2007).

**Competing interest**

The authors report no conflict of interest.

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