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Nurse practitioner (NP) led care: Cervical screening practices and experiences of women attending a women's health centre

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ABSTRACT

Background: Cervical cancer is the second most prevalent carcinoma among women. Stringent screening is the most effective strategy of reducing the morbidity and mortality associated with cervical cancer, however barriers to such screening exist. South West Sydney is primarily populated by ethnic minority groups and those with lower socioeconomic status. Thus, women from this area of Sydney represent some of the most disadvantaged women and face many barriers when accessing healthcare, including cervical cancer screening. Previous research has found that gender can influence attitudes and practices regarding women's health screening. While women's health nurse practitioners are becoming more involved in preventative healthcare including cervical cancer screening, the experiences of women who access their services have not been explored.

Aim: The aim of this study was to determine the demographic characteristics of the women accessing the Liverpool Women's Health Centre and to explore their experiences of the service.

Methods: Demographic data were collected over a one-year period and reflected the diversity of the women who access the WHC in the Liverpool local government area. Ten women who were first time users of the service, aged over the age of 18 years and fluent in English language were then interviewed to explore in-depth their experiences of service.

Findings: Study findings illustrated the benefits of providing free women-centred care. In addition to being accessible in terms of location and cost, women conveyed their appreciation for the continuity of care provided. Further, women who accessed the service reported the nurse practitioner provided a professional environment that facilitated the development of trust.

Conclusion: Providing a service that is accessible and comforting can increase the participation of vulnerable women in routine cervical cancer screening practices as well as reduce the morbidity and mortality rate of cervical cancer that often results from under-screening.

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Problem or issue

South Western Sydney has one of the lowest uptake rates of cervical cancer screening in New South Wales.

What is already known

Routine screening is the most effective strategy in reducing the morbidity and mortality associated with cervical cancer.

What this paper adds

This paper highlights the unique and important role nurse practitioners play in women's health and in encouraging women to partake in routine preventative cervical cancer screening.

1. Background

Cervical cancer is the second most prevalent carcinoma among women globally (Chan, Yang, Gu, Wang, & Tao, 2015; Ogunbowale & Lawoyin, 2008). Early detection and intervention through stringent screening practices are key in preventing the progression of disease or death from cervical cancer. While cervical cancer screening (CCS) has been available to Australian women since the mid-1960s, the implementation of a systematic approach to screening in 1991, the National Cervical Screening Program (NCSP), further reduced the incidence of and deaths from cervical cancer. Australian CCS

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guidelines currently recommend that all women who have ever been sexually active receive a Papanicolaou smear test (Pap smear) at 18–20 years of age, or every two years from the first sexual encounter. For women who are aged 70 years or above and have had two normal Pap test results over a 5 year period, screening may cease unless the woman has never had a Pap smear or requests to be screened (National Health and Medical Research Council, 2005). These guidelines are currently under review with changes to the NCSP to be implemented in May 2017. The NCSP is reviewed by the National Health and Medical Research Council (NHMRC) periodically and includes a focus on improving education about cervical cancer for both women and health professionals, encouraging women to participate in screening programs, implementing effective follow-up management of significant results, and the continuous evaluation of the current approaches to screening (National Health and Medical Research Council, 2005). Despite this, substantial barriers to CCS exist for some women who are under-screened. Under-screening in relation to cervical cancer is currently defined in Australian healthcare practice as a period of greater than 4 years since the last Pap test.

1.1. Barriers to screening

There are several barriers that affect women's uptake of CCS (Peters, 2010, 2012). Common barriers to CCS include belonging to a minority ethnic group, low socio-economic status, physical and learning disabilities, women who are not yet sexually active, lesbian and bisexual women, women who have received abnormal test results, post-menopausal women, and women who have experienced genital mutilation (Cooper, 2011; Curmi, Peters, & Salamonson, 2014; Curmi, Peters, & Salamonson, 2015). Another major barrier to CCS is accessibility, whether it be in relation to geographical location, the financial cost of undergoing screening or the cost of travelling to the facility (Peters, 2012). Women with physical disabilities are further burdened by issues concerning accessibility, which can result from facilities lacking the equipment to accommodate for certain physical disabilities (Cooper, 2011). For women with learning disabilities, the issue of obtaining informed consent for cervical screening presents the greatest barrier to accessibility (Cooper, 2011).

Women who are overweight or obese are less likely to access CCS due to embarrassment (Amy, Aalborg, Lyons, & Keranen, 2005). This embarrassment is exacerbated by the negative attitudes of healthcare providers toward their weight who often provide the woman with unwanted advice on weight loss which leaves them feeling disrespected (Amy et al., 2005).

Cultural beliefs can also influence women's perceptions of the risk of developing cervical cancer and therefore their screening practices. Women of a Latin or African American background have been reported to believe they are at lower risk of developing cervical cancer and are therefore less likely to be screened (Chan et al., 2015). Further, Latina women often associate the risk of developing cervical cancer with immoral sexual behaviour. This suggests that among this group of women, cervical cancer is linked with morality and those who develop the disease may experience stigma (Chan et al., 2015). Additionally, this may deter women from participating in screening practices to avoid experiencing stigma and guilt. Alternatively, Chinese women commonly associated the risk of developing cervical cancer with marriage, old age, partner's poor hygiene and multiple sexual partners (Chan et al., 2015).

A history of sexual or physical abuse and/or maltreatment from family members, partners and healthcare workers presents another barrier to CCS (Cadman, Waller, Ashdown-Barr, & Szarewski, 2012; Peters, 2012). Women who have experienced sexual abuse are less likely to participate in CCS due to the resemblance between the experience of abuse and the process of a Pap smear (Cadman et al.,

2012). Several barriers were found by Cadman et al. (2012) to prevent this group of women from attending to screening practices. These included 'power disparity' that left women feeling vulnerable and controlled; issues with 'trust safety and disclosure', which highlighted women's preference that CCS was performed by another woman; and 'physical pain' related to discomfort and pain experienced during the examination. The 'mechanics of the examination' relating to the position required for CCS, posed another barrier for women who have been sexually abused to participate in screening (Cadman et al., 2012). The work by Cadman et al. (2012) resonates with previous research by Peters (2010) who found that when making decisions about CCS, women seek a safe environment, continuity of care and women-centred services. Further, some women are uncomfortable with the idea of CCS being performed by a man and this can be a major deterrent in the uptake of routine CCS. A deficiency in knowledge and understanding among healthcare workers of the impact of abuse on women can also be a barrier to CCS (Cadman et al., 2012).

Practitioner continuity to build clinician-client relationships, promoting sensitivity and understanding of the effects of abuse among clinicians, and establishing a welcoming physical environment may be helpful in improving the experiences of CCS among women who have experienced abuse (Cadman et al., 2012). Nurse practitioners (NP) have the potential to effectively implement these strategies to provide women-centred care.

The role of the nurse practitioner (NP) is not widely known among the Australian public. A study by Allnutt et al. (2010) explored public understanding of the NP role and found that there was only some level of awareness of the role of the NP and less awareness of their scope of practice. Despite this, participants of the study were satisfied with the care they had received from the NP and felt confident in their abilities (Allnutt et al., 2010). However, the lack of public knowledge surrounding the role of the NP reduces the likelihood of the public accessing NP-led services (Allnutt et al., 2010).

In 2011, a women's health NP was employed at the Liverpool Women's Health Centre (WHC) and the number of new clients presenting for CCS has steadily increased in this time. The WHC is located in South Western Sydney, NSW and was established in 1975 as the second women's health centre in Australia. The centre provides feminist, holistic healthcare to marginalised women living and working in the Liverpool local government area (LGA). The Liverpool LGA is culturally diverse and caters for the health care needs of women from minority groups including refugees. Local area statistics for cervical screening uptake in the Liverpool local health district are some of the lowest in NSW (Australian Institute of Health and Welfare, 2013; Peters, 2010).

2. Aim

The aims of this study were to determine the demographic characteristics of the women accessing the Liverpool WHC and to explore their experiences to inform strategies that can further improve the service.

3. Methods

3.1. Design

This study used a mixed methods design. Using mixed methods allows a more comprehensive exploration of the research topic (Andrew & Halcomb, 2009; Creswell, Fetters, & Ivankova, 2004). Quantitative data were collected to provide a demographic profile of the clients accessing the WHC. Following the collection of demographic data, the study used semi-structured telephone inter-

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