



Pap Test Adherence, Cervical Cancer Perceptions, and HPV Knowledge Among HIV-Infected Women in a Community Health Setting

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The Health Belief Model (HBM) has been widely used as a framework to explain health behaviors in diverse populations, but little HBM research has focused on HIV-infected women and their increased risks for cervical cancer. We used Champion's Health Belief Model and Self-Efficacy scales to assess relationships between Pap test adherence and constructs of the HBM among 300 HIV-infected women. In addition, we assessed the relationship between HPV and cervical cancer knowledge and key HBM concepts. Participants reported low levels of knowledge regarding risk for cervical cancer and HPV. They perceived lower personal risk for cervical cancer. Women with higher perceived self-efficacy and lower perceived barrier scores reported better Pap test adherence. Findings indicate that HIV-infected women are not aware of the risk for cervical cancer and may not take preventive actions. Further research is needed to identify the full range of factors that impact adherence to cervical cancer screening.

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In a developed country such as the United States, approximately 4,000 women die annually as a result of cervical cancer. HIV-infected women are at increased risk for developing cervical cancer; in fact HIV-infected women are at least five times more likely to develop cervical cancer than the general population (U.S. Department of Health and Human Services [USDHHS], 2013b). Cervical cancer screening is conducted via a Pap test and/or

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human papillomavirus (HPV) DNA testing, which can be completed in an office setting on an outpatient basis. However, in 2008 only 60.2% of women ages 21 to 65 years were counseled about Pap tests (USDHHS, 2013b). Although invasive uterine cervical cancer cases remained stable from 2007 through 2009, the goal is to decrease the number of cases from 7.9 per 100,000 to 7.1 cases per 100,000 by 2020 (USDHHS, 2013c). Screening is an essential component of care needed to reach the goal by 2020.

In general, 12% to 29% of women are not receiving Pap testing according to the most appropriate guidelines (Denny-Smith, Bairan, & Page, 2006; Peterson, Murff, Cui, Hargreaves, & Fowke, 2008; Tracy, Lydecker, & Ireland, 2010), but the numbers are higher for HIV-infected women. Despite the importance of cervical cancer screening, HIV-infected women's increased risk for developing cervical cancer, and the insufficient cervical cancer-screening uptake in general, HIV-infected women do not consistently receive cervical cancer screenings according to the most appropriate guidelines. More specifically, 25% to 55% of HIV-infected women had not received an annual Pap test during the previous year (Baranoski, Horsburgh, Cupples, Aschengrau, & Stier, 2011; Oster, Sullivan, & Blair, 2009; Simonsen et al., 2014; Tello et al., 2010).

Given these numbers, we developed a study of HIV-infected women guided by the Health Belief Model (HBM), using Champion's revised Health Belief Model (CHBM) scale, Champion's Self-Efficacy (CSE) scale, and HPV and cervical cancer knowledge. The purpose of our study was to evaluate the relationships between Pap test adherence during the previous year and the following variables: HPV and cervical cancer knowledge, and perceived susceptibility, perceived seriousness, perceived barriers, perceived benefits, and perceived self-efficacy.

Cervical Cancer

The cervix is the portion of the uterus that connects the body of the uterus to the vagina (American Cancer Society, 2014). Cervical cancer is commonly caused by HPV. There are more than 150 types of HPV, and 40 of those types can affect cells of the genitals; types 16 and 18 are responsible for the majority

of cervical cancer cases (National Cancer Institute, 2013). After HPV infection, cells gradually develop into precancerous cells and, when left untreated, the cells have the potential to develop into cancer. The process varies for each woman, and not all women infected with HPV develop cervical cancer; for many women, the precancerous cells will resolve without treatment (American Cancer Society, 2014; National Cancer Institute, 2013).

HPV is transmitted during sex (vaginal, anal, and oral) via skin-to-skin contact (National Cancer Institute, 2013). All sexually active individuals are at risk for HPV, and 42.5% of women will have genital HPV at some point. Tobacco use, having a weakened immune system such as HIV infection, multiparity, chronic inflammation caused by infection with chlamydia, and long-term oral contraceptive use increase the risk of developing cervical cancer (National Cancer Institute, 2013). Women can prevent HPV by remaining abstinent from all sexual activity. Women who are sexually active can reduce the risk of being infected with HPV by remaining in a mutually monogamous relationship with an uninfected partner, using condoms properly, and receiving one of two Food and Drug Administration-approved HPV vaccines (National Cancer Institute, 2013).

HIV-infected women are at greater risk for HPV infection and, ultimately, for cervical cancer, because the body's ability to fight infection is reduced as a result of a weakened immune system (American Cancer Society, 2014). The advent of antiretroviral therapy has transitioned HIV disease from an acute illness to a chronic illness and increased life expectancy among individuals infected with HIV, but antiretroviral therapy has not decreased infected women's susceptibility to cervical cancer. Current cervical cancer screening recommendations for HIV-infected women are as follows: HIV-infected women should receive Pap testing every 6 months for 1 year after diagnosis and annually thereafter (American College of Obstetrics and Gynecology, 2010; USDHHS, 2013a). Despite increased risk, HIV-infected women often do not receive Pap testing per the aforementioned recommendations (Baranoski et al., 2011; Oster et al., 2009; Simonsen et al., 2014; Tello et al., 2010). Researchers have assessed Pap test adherence in various groups of women, but no studies

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