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Why Do Chilean Women Choose to Have or Not Have Pap Tests?

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ABSTRACT

Objective: To describe the perceptions of Chilean women about why women choose to have or not have Pap test screening.

Design: Qualitative research using content analysis according to Krippendorf.

Setting: Four urban health clinics in Santiago, Chile.

Participants: Fifty-seven Chilean women.

Methods: Audiotaped focus groups.

Results: Six themes emerged: *Reasons that make it difficult for women to schedule appointments, Characteristics of health professionals that make it difficult to have a Pap test, Characteristics of the test that are barriers to having a Pap test, The relationship of the test with cancer, Family context,* and *Each woman's personal characteristics*.

Conclusion: Primary health care providers play an important role in promoting adherence to cervical cancer screening. Nurses should proactively address women's perceptions and knowledge about screening and openly and uniformly discuss the importance and benefits of Pap test screening.

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Cervical cancer (CC) is the fourth most common type of cancer in women, with an estimated 530,000 new cases worldwide in 2012; CC is the cause of 7.5% of all deaths from cancer in women. More than 270,000 women die from CC every year, and more than 85% of these deaths occur in less-developed regions (Word Health Organization, 2015). Cervical cancer was once the most common cancer affecting women in the United States. Today, it is ranked 14th in frequency for two main reasons: (a) precancerous lesions found can be treated and cured before they develop into cancer, and (b) when the women do develop a cancer, it is detected before it becomes advanced (National Institutes of Health, 2010).

To identify cervical precancers, two well-proven methods are used: the Pap test and the human papilloma virus test. Most CC is found in women who have not had CC screening (American Cancer Society, 2015). After the implementation of CC screening programs, mortality rates decreased (Kamangar, Dores, & Anderson, 2006; Laara, Day, & Hakama, 1987; Peto, Gilham, Fletcher, & Matthews, 2004). Unfortunately, there are still a number of women who do not participate in these programs. Early treatment prevents up to 80% of cervical cancers in developed countries (World Health Organization, 2015).

In Chile, Pap test screening is part of the National Program for Research and Control of Cervical Cancer, which began in 1987 on the basis of recommendations of the Pan-American Health Organization/World Health Organization (Ministerio de Salud de Chile, 2015), and its creation was aimed to reduce the mortality rate and incidence of invasive cancer through detection in precancerous stages and through proper and timely treatment. The program includes the implementation of a Pap test every 3 years by trained professionals (mostly midwives) to women 25 to 64 years of age. When a Pap test result is positive or when there is a clinical suspicion of CC, the woman is referred to a specialist. Since 2003, CC is included as part of the Acceso Universal Garantías Explícitas (Universal Access to Explicit Guaranties) program; therefore, diagnosis and treatment are guaranteed to all women, independent of their health care insurance (Ministerio de Salud de Chile, 2015).

The fact that women do not understand the importance of cervical cancer screening has the potential to interfere with communication between women and health care providers.

Women choose not to have Pap tests for many reasons, including social and demographic characteristics, previous negative experiences, lack of information or lack of awareness, personal and family influences, and cultural beliefs (Basu et al., 2006; Batista & Mastroeni, 2012; Greenwood, Machado, & Sampaio, 2006; Matin & LeBaron, 2004; Van Til, MacQuarrie, & Herbert, 2003; Wall, Rocha, Salinas-Martinez, Baraniuk, & Day, 2010). Therefore, it is important to investigate the reasons why women do not have the screening (Mauad et al., 2009). Understanding women's perceptions about vulnerability to CC and providing accurate information and counseling may increase screening in women (Ackerson, Pohl, & Low, 2008).

Different initiatives have been implemented in Chile with the aim of achieving an ideal coverage of 80%; however, none of these has succeeded. These campaigns have been aimed at women on a strictly individual level on the assumption that nonadherence to screening is the result of lack of knowledge. The campaigns were developed with a focus on the risk of illness instead of the risk of not screening. Therefore, it is necessary to know the answer posed by the study question: *Why do Chilean women choose to have or not have Pap test screening?*

Some reasons have been reported previously (Urrutia et al., 2008), but they were reported in a group of women who had Pap tests and received gynecologic treatment. Therefore, it is necessary to know the perceptions other women have about the screening outside the health care context, without illness or treatment, and with differing statuses of adherence to screening. This information will be useful in understanding why these women have or have not had Pap tests.

Methods

Study Design

A qualitative descriptive design was used (Sandelowski, 2000) based on content analysis according to the methods described by Krippendorf (2004). We chose content analysis because it allowed us to quantify and qualify data. Perceptions about the reasons why women do or do not have a Pap test, from the perspective of Chilean women, were examined using a focus group methodology. The ethics committees from the School of Nursing, Pontificia Universidad Católica de Chile and from the Southeast Metropolitan Public Health Service reviewed and approved this research. Written informed consent was obtained from all participants. All the questions that the women had about CC were answered after the different focus groups.

Sample and Setting

Purposive sampling strategies were used to identify and recruit 57 women who attended four urban health clinics in the Southeast Metropolitan Public Health Service (Servicio de Salud Metropolitano Sur-Oriente) in Santiago, Chile. This study was Phase 2 of a larger study; the objective of this phase focused solely on understanding the perceptions of a group of Chilean women about why women do or do not have Pap tests. The women who agreed to participate were recruited by telephone. Before the focus group, participants completed a questionnaire on demographic and Pap test adherence characteristics. The women were then divided into focus groups according to adherence to a Pap test established in the quantitative interview. There were six focus group: two groups of women who did not adhere to screening ($n = 18$), which was defined as never having had a Pap test or having had one more than 3 years earlier; two groups of women who were screened ($n = 22$) in the public health care system; and two groups who had positive adherence in the private health care system ($n = 17$). The number of women in each focus group ranged from 8 to 11. The sample size was sufficient to achieve saturation of data.

Data Collection

All focus groups were conducted in onsite meeting rooms. An interview guide was developed by the first author. Each focus group was initiated with a broad introductory question: *What are the factors that influence women to have or not have the Pap test*? This question was followed by *What are the differences between women who choose to have or not have the Pap test?* The principal investigator of this study conducted all the focus groups with two research assistants, who took notes. The principal investigator, fluent in Spanish and English, moderated the focus group cofacilitated by two research assistants. Before focus group facilitation, the research assistants were trained on research ethics, confidentiality, and interpretation. Each focus group was conducted primarily in Spanish,