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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-

views informed by a qualitative descriptive design to explore the experiences of women accessing a NP-led women's health service.

### 3.2. Recruitment

The WHC keeps a database of all clients accessing the service. The database was collaboratively designed by WHCs in NSW to collect accurate client data related to presenting issues and demographic profiles. A privacy sheet outlining the rights and responsibilities of both the client and the service is given to all clients upon first admission to the service. Clients can consent to or withhold their information from being used for research purposes. All women who had consented to their information being used for research (n = 147) were eligible for inclusion in the study.

Eligible women were sent an introductory letter, participant information sheet, consent forms and a reply paid envelope. These women were asked to indicate whether they would be willing to participate in a telephone interview to discuss their experiences of the services. Those who wished to participate were encouraged to contact the last named author (who was independent of the service) in order to find out more about the study and arrange a time for an interview. This contact allowed time for participants to ask questions and clarify any concerns they had about the study and assisted in building rapport. Participants were asked to sign the consent form and then post the form back. To be eligible for participation in interviews, women were required to be over 18 years of age and speak English. English language was necessary as the project was unfunded and it was not possible to use interpreters for interviews.

### 3.3. Data collection

Demographic data of the clients who accessed the centre were collected over a period of a year. This data related to the demographic profile and presenting issues of the clients and described the characteristics of the sample population to indicate the health care needs of women living in the Liverpool LGA. Specifically, demographic data collected included participants' age, ethnicity, language spoken at home, employment status, postcode, sexuality and whether or not they had a disability. Further information gathered included who referred participants to the WHC, their CCS history and Pap test result. Such data were obtained from the secure database on all first time clients accessing the services of the Women's Health NP for cervical screening.

Semi-structured telephone interviews were conducted by an experienced nurse academic and researcher (XX), independent to the WHC, to explore participants' experiences of CCS provided by a women's health NP. Open-ended questions were asked to encourage participants to share their reasons for choosing the centre and experiences of care delivered by a NP. Interviews were audio-recorded and transcribed-verbatim. Data saturation was achieved after 10 interviews.

### 3.4. Analysis

Descriptive data were obtained using the data statistical analysis package in Excel to determine the characteristics of the women who have accessed the service, as well as to help identify potential factors that may contribute to under screening among women in the Liverpool area.

Qualitative data were analysed by two of the researchers using thematic analysis. Transcripts from the interviews were read and re-read whilst listening to the audio recordings, which provided an opportunity to amend any errors in transcription and note nuances that may not be evident within the transcribed text (Grbich, 2007). Narrative data derived from the interviews were first grouped into

broad categories and then further reduced using the 'block and file' approach described by Grbich (2007). This process involves colour coding related data and then grouping these under headings to form themes (Grbich, 2007). These themes were discussed among the researchers until consensus was reached.

## 4. Results

### 4.1. Sample demographics

One hundred and forty-seven women out of 171 included on the database had consented for their information to be used in research and were thus included in the first phase of the study. The majority of included women were referred to the service by friends (n = 55, 37.4%) followed by health professionals (n = 31, 21.1%). Almost 12% (n = 17) learned about the centre through the website.

#### 4.1.1. Ethnicity

Many women attending the service for the first time were from Anglo-Australian backgrounds (n = 46, 31.3%). Consistent with the demographic profile of the Liverpool LGA, women from 44 other countries also attended the service, which included women from India (n = 10, 6.8%), Italy and Serbia (n = 7, 4.8%), and Chile and Argentina (n = 5, 3.4%). Newly arrived refugees and emerging communities were also among the attendees. Only one woman in the sample identified as Aboriginal.

English was the language spoken by most of the women attending the service (n = 97, 66%). This was followed by Spanish (n = 14, 9.5%) and Serbian (n = 10, 6.8%). Overall, 19 different languages were spoken by women in the sample further representing the cultural diversity of the LGA. Women with English as a second language who had difficulty communicating in English, were supported by a Telephone Interpreter Service (TIS) at the time of the appointment.

#### 4.1.2. Age group

Women aged 19–28 years represented the largest group of clients in the sample (n = 33, 22.5%), closely followed by women aged 49–58 years (n = 32, 21.8%). Eight women were in the age range of 70–80 years, which is an age range outside the current guidelines for screening. Some of these women had symptoms of bleeding while others requested to continually be screened, and so were considered appropriate to screen in accordance with the current guidelines. The youngest woman in the study was aged 19 years, whilst the eldest woman in the study was 80.

#### 4.1.3. Other characteristics

The majority of women in the sample population identified as heterosexual (n = 104, 70.8%) and three identified as bisexual (2.04%), one of whom was under screened. A physical disability was reported by 10.8% (n = 16) with 10 of these reporting they received a pension. Forty (27.2%) women in this study received the pension as a form of income, 31 (21.1%) reported full-time employment and 23 (15.6%) engaged in part-time work. Nine (6.1%) of the women in the sample reported having a history of child sexual abuse (CSA). Of these 9 women, 5 were Caucasian-Australian and 4 from different CALD backgrounds.

#### 4.1.4. Screening practices

Thirty-four (23.1%) of the women included in the study were considered under-screened in accordance with the [National Cervical Screening Program \(2005\)](#), with years between Pap test ranging from 4 to 17 years. Of these women, 10 were Caucasian-Australian and the remaining 24 women were from various cultural and linguistically diverse (CALD) backgrounds such as Papua New Guinea and Serbia. Twenty-seven (18.4%) women reported receiving their first Pap smear at the women's health clinic with 10 from

**Table 1**  
Screening practices.

	Characteristics						
	n (% of total sample)	Australian	CALD	Age 18–30	Age 31–40	Age 41–50	Age ≥ 51
First screen	27 (18.4%)	10	17	22	3	2	0
Under screen	34 (23.1%)	10	24	1	3	7	13

**Table 2**  
Employment status.

	Full time	Part-time or casual	Pensioner	Student	Unemployed	Other/not answered	Total
First screen	6	7	3	8	3	0	27
Under screen	4	9	12	1	5	3	34

Caucasian–Australian background. Table 1 shows the various characteristics of women who were under-screened and those who were receiving their first Pap smear.

As evident in Table 1, 5 women who received their first Pap test were above 30 years of age. Possible reasons for delays in Pap tests among women accessing the NP-led women’s health centre in Liverpool may be a result of common barriers to CCS practices and/or the refugee status of women accessing the service. CCS may not be available or are difficult to access in the home countries of these refugee women.

Of the women in the under screened group, 3 had physical or mental health disabilities, 1 woman had a history of CSA, 3 women were aged 70 years and 1 woman aged 80 years. The years between Pap tests ranged from 4 to 17 years, with the mean interval being 6.9 years. The majority of women reported to be under screened were pensioners. Table 2 shows the employment status of women within the ‘first screened’ and ‘under screened’ groups.

4.1.5. Screening outcomes

The majority of the sample population had normal Pap test results (n=141, 95.9%). Six (4%) women were found to have abnormal Pap test results with 4 (2.7%) LSIL (low-grade squamous intraepithelial lesion) results and 2 (1.4%) HSIL (high-grade squamous intraepithelial lesion) results that required further investigation and management.

Of the 6 women receiving an abnormal test result, 3 of the women with an LSIL result and 1 woman with an HSIL result were reported as being under screened. Furthermore, 1 woman with an LSIL result and 1 woman with an HSIL result had undergone their first Pap test. Three of these women who received an abnormal Pap test result were Anglo-Australian and the remaining 3 women were from different CALD backgrounds (Fijian-Indian, Serbian and Iraqi). One woman with an abnormal Pap test result had a physical or mental health disability. One participant had declined to provide an answer identifying her ethnic background. Table 3 summarises the characteristics of the women in the sample population in relation to Pap test results.

4.2. Findings from interviews

Ten women were interviewed regarding their experiences of CCS performed by the NP at the Liverpool women’s health clinic. Of these 10 women, seven were from CALD backgrounds. Three were in full-time, two in part-time, and three were not in paid employment. Two of the women interviewed received a pension. Five women cited cost as the reason they attended the women’s health clinic, and all but one of the women interviewed expressed their preference for a woman to perform their Pap smear. Interviews were between 20 and 30 min in duration. Following thematic analysis of the interviews, two main themes and one sub-theme emerged. The first main theme was **‘Reasons for choosing the**

**Table 3**  
Screening outcomes.

Demographic characteristic	Screening outcomes		
	Normal	<sup>a</sup> LSIL	<sup>b</sup> HSIL
<i>Employment</i>			
Ø Full time	31	0	0
Ø Part time or casual	35	1	0
Ø Pensioner	38	2	0
Ø Student	13	1	1
Ø Unemployed	17	0	1
Ø Other	7	0	0
<b>Total</b>	<b>141</b>	<b>4</b>	<b>2</b>
<i>Ethnicity</i>			
Ø Anglo-Australian	43	2	1
Ø CALD	97	2	1
<b>Total</b>	<b>140</b>	<b>4</b>	<b>2</b>
<i>Age group in years</i>			
Ø 18–29	34	1	2
Ø 30–39	23	1	0
Ø 40–49	27	2	0
Ø 50–59	32	0	0
Ø 60–69	17	0	0
Ø ≥ 70	8	0	0
<b>Total</b>	<b>141</b>	<b>4</b>	<b>2</b>

<sup>a</sup> LSIL = low-grade squamous intraepithelial lesion.  
<sup>b</sup> HSIL = high-grade squamous intraepithelial lesion.

**Women’s Health Clinic’** and included the sub-theme of **‘Gender preference: “I was just more comfortable going to a woman”’**. The second theme is titled **‘Attending to physical and emotional needs: “She just makes you feel relaxed”’**

4.2.1. Theme 1: reasons for choosing a women’s health clinic

Women who participated in the interviews conveyed various reasons for electing to have their Pap smears done at the WHC. During the interviews several women expressed the cost of CCS provided by other health services was a major deterrent. As such, the free CCS service offered by the WHC, coupled with the reputation and skills of the NP, influenced their decisions to attend the clinic. The following quotes from the participants illustrate this sentiment.

Basically I couldn’t afford an obstetrician or gynaecologist and a family friend referred me there (WHC). You know where you hear someone that says this lady is really lovely well you know you would go to there. The gynaecologist I was going to I wasn’t really happy with anyway. (Participant 3)



Another reason for participants choosing the WHC related to the physical environment of the clinic compared to that of a traditional General Practitioner's (GP) clinic. Women appreciated the welcoming atmosphere and layout of the clinic, which resulted in the clients feeling comfortable and relaxed.

I guess because you're not sitting in your typical waiting room with a bunch of people it's usually only maybe one or two other people when I've been you know, it just feels not so much like a clinic, it's more homely because it's got the lounge there and it's just the way the room is set up. (Participant 7)

Participants identified an additional benefit of visiting the WHC was the gender of the clinician who performed the Pap smear.

#### 4.2.2. Gender preference: "I was just more comfortable going to a woman"

Requesting a female GP for a Pap smear in a general medical clinic often subjected women to lengthy delays due to the lack of female GPs employed in medical centres.

When I did [have a pap smear] in the medical centre there was a problem for the female doctors as they are scarce. There is only one lady doctor and I had to go wait for ages for her to do it [pap smear]. (Participant 5)

In addition to long waiting periods, participants of the interviews also discussed differences in their experiences of the care they had received at GP clinics. In the following quote, a participant describes her experience with a male GP. The quote conveys a feeling of dissatisfaction with the care she had received during a Pap smear in which she felt rushed and at times experienced discomfort and pain.

When I've had pap smears in different places. Sometimes when they were doing them I felt a bit unhappy. . . it was like I was inconveniencing them. Each doctor handles it in different way but I wanted someone permanently to do for me so that they know me so that I can have as a record of everything. The other G.P's just say last pap smear it's normal that's it and they look at the result, they don't ask about any general check-up . . . they don't show much interest in it. (Participant 1)

Pap smears are invasive and rather intimate procedures that can result in women feeling embarrassed and uncomfortable. All participants of the interviews expressed a preference for woman-centred care and Pap smears conducted by woman.

To me personally I wouldn't really feel comfortable with a man [doing pap smear]. I guess all women are insecure in a way they don't want to be laying there and showing their bits to a male doctor so it's just a much nicer experience for me personally, and I know people that don't care either way. Me personally I would never have a male do anything like that. (Participant 6)

It was evident in the interviews that the NP-led women's health service was of benefit to women as she was able to relate with her clients.

I suppose the procedure is exactly the same but she just made you feel really comfortable you know, just explained everything she makes you feel very comfortable where as you know I have been to male ones [GPs] before and the male ones were not as nice of an experience and it just kind of felt like you were in there and out of there whereas she cared. (Participant 4)

The NPs ability to relate to them was greatly appreciated by participants who reported feeling comfortable and valued by the care they received.

#### 4.2.3. Theme 2: attending to physical and emotional needs: "She just makes you feel relaxed"

Participants expressed that the NP was able to relate to their experience of undergoing CCS. Understanding the physical and emotional needs of the clients enhanced participants' comfort.

[Other services] just always run late but [NP] is really lovely, she makes you feel comfortable she doesn't hurt whereas the gynaecologist, you're rushed in and you're out that's it basically. (Participant 8)

She [NP] is always very very lovely and she just makes you feel relaxed which I think is a key thing because it can be quite daunting especially my first one [pap smear]. (Participant 10)

As the NP showed genuine interest in their health and well-being, participants felt that they were being cared for and treated with respect.

Just having someone who cares about you as well and doesn't treat you like a number. She remembers you even though it could be a year before you see her again, she remembers you. So that was nice and as I said she was very thorough and respectful. (Participant 2)

Participants reported that a significant part of creating a welcoming and caring environment for women who attended the WHC was the professional conduct of the NP. Women who were interviewed stated that in addition to genuinely caring about their health, the NP was thorough and professional in delivering care. Compared to previous experiences of CCS conducted in general practice by GPs, participants of the study described the conduct of the NP to be holistic in that their health histories and health concerns were discussed. Furthermore, the NP explained each step of the screening procedure to help relax the women. This was greatly appreciated by participants as it helped them feel comfortable with such an invasive procedure.

She [NP] is very thorough . . . that's one big difference I found. She takes her time with you whereas doctors will kind of brush things off and go 'no no no you're fine' she will actually go 'no you better go get it checked in case you better be safe than sorry' you know because I have family history - (Participant 9)

I'm the type of person that I like to know everything that someone is doing so she explains everything really well whereas I've found when you know I go to my local GP who is like 'up you get' and he doesn't tell you what [he is doing] She just explains what she is doing that makes you feel really comfortable I think that sets her apart. (Participant 8)

Participants also conveyed the NP showed genuine interest in their overall health and was more thorough in her questioning about their wellbeing.

She [NP] is very thorough she asks all the questions she tests almost everything. She asks me a lot of questions and you know I found her very excellent actually and very caring and she gets back to me if she needs to see me again or if I have a problem or something and I feel very comfortable with her. (Participant 3)

The nurse practitioner at the women's clinic asked a few more questions [than the GP] about this and that. She was nice, professional, she asked me about abuse and I told her there wasn't any abuse and she was you know caring about whatever you wanted to say. She was professional she did it [pap smear] and I didn't worry about it. (Participant 1)

A thorough health assessment, when conducted in a professional and caring manner as that exhibited by the NP at the WHC, not only helped to relax the clients and gather important informa-

tion about their health status, but also helped to build trust and a therapeutic relationship with them, thus encouraging them to engage with regular CCS practices.

## 5. Discussion

The Liverpool area in Western Sydney represents some of the lowest socioeconomic and culturally diverse populations in Sydney. As such, women from this LGA are at risk of under-screening for cervical cancer as low socioeconomic status, belonging to a minority group and having a physical disability have been identified as the most common barriers to CCS (Cooper, 2011; Peters, 2012). This current study found that the majority of the women who were under-screened were pensioners and/or from CALD backgrounds. Forty-four nationalities were represented in the sample population, emphasising the need for culturally sensitive women's healthcare in the Liverpool LGA. Several factors deter women from CALD backgrounds and low socioeconomic status from accessing preventative healthcare such as CCS. The cost of a health service is of main concern for these women and providing them with a screening service that is both free and accessible, such as that provided by the Liverpool WHC, alleviates this concern, thus enhancing screening uptake (Cooper & Yoshida, 2007).

Cancer prevention is a cost-effective multidisciplinary endeavour that mainly involves identifying and reducing risk factors, and early detection, in which nurse practitioners play a crucial role in providing cancer prevention services to the public (McIlfatrick, Keeney, McKenna, McCarley, & McIlwee, 2014). In Australia, the role of the nurse practitioner is evolving but public knowledge of their role in healthcare is still lacking where many would still prefer to see a doctor (Allnutt et al., 2010). The role of the nurse practitioner is particularly important in areas of health care such as managing chronic diseases and preventative care (Allnutt et al., 2010). The findings of this study suggest that the role of the NP is particularly helpful in women's health particularly in relation to CCS for disadvantaged women. Interview participants reported the NP at the WHC provided a unique level of care that was both professional and caring, which the participants of the study exhibit great appreciation toward. This is echoed in the findings from Venning, Durie, Roland, Roberts, and Leese (2000) who found that patients were generally more satisfied with the service they receive from NPs in comparison to GPs.

NPs generally spend more time interacting with clients and therefore are able to build therapeutic relationships with them (McIlfatrick et al., 2014). Participants of the current study expressed their satisfaction with the time the NP had spent with them in getting to know their health status, in performing the procedure and in spending time to help them feel comfortable and relaxed. Furthermore, the NP at the WHC was found to be thorough in relation to health assessments, in explaining the process of the procedure, and in discussing risk factors or other health concerns.

The procedure of obtaining a sample for CCS is invasive and intimate, which requires a high level of trust between the client and the health professional. More common than not, the level of trust is increased when a female health professional is performing the Pap smear (Peters, 2010). This current study found that the NP was able to build trust with the client through strong therapeutic relationships that resulted from the NP taking the time to ensure the client felt safe and informed. Participants expressed a preference for female healthcare professional when undergoing CCS due to the pre-existing understanding of the female experience when undergoing a Pap smear, which resonates with previous research by Mills et al. (2012) and Peters (2012). This understanding contributed to the development of trust between the client and the NP. The client-healthcare professional relationship influences the pro-

motion of positive health habits including participation in regular cancer screening practices (McIlfatrick et al., 2014).

Despite 2011 Census data indicating that the Aboriginal or Torres Strait Islander people represent 1.5% of the population in the Liverpool area (which is higher than in Greater Sydney) (Australian Bureau of Statistics, 2016), only one Aboriginal woman accessed the clinic within the 12 month time frame. This is concerning as Aboriginal women are at an increased risk of being under-screened for cervical cancer, as well as higher rates of hospitalisations and mortality due to cervical cancer in comparison to women from other ethnic groups (Australian Institute of Health and Welfare, 2013). The WHC acknowledges this discrepancy and is in the process of developing partnerships with the local health district to establish outreach clinical services for Aboriginal women in the Liverpool LGA to reduce the rates of under-screening with a long-term objective of improving the health status of Aboriginal women in the local area. Currently, a Health Hub for Aboriginal people has been established in one of the suburbs in the Liverpool LGA and it is important for the Women's Health Service to form partnerships with this facility to strengthen the health support provided to Aboriginal women.

Interview participants reported that the WHC provided women-centred care in a comforting environment. Continuity of care was also a feature of the WHC in which participants appreciated that the NP remembered their health history and personal stories when returning to the facility.

## 6. Conclusion

The findings of this study highlight the positive nature of women's experiences of CCS at a WHC in South Western Sydney. The majority of women who reside in the Liverpool LGA are disadvantaged and are at a higher risk of under-screening due to barriers that prevent them from routinely accessing cancer screening services. Statements from clients who access the service convey the unique and important role NPs play in women's health and in encouraging women to partake in routine preventative screening practices such as CCS. The WHC provided women with women-centred care, and a safe and trusting space to receive healthcare that is free of charge. In addition, the location of the service is easily accessible, which encourages women from a disadvantaged background to routinely access CCS and can potentially reduce the rates of morbidity and mortality of cervical cancer of women in the Liverpool LGA.

### 6.1. Implications for further research

The role of the NP in women's health in Australia is inadequately explored in the literature, particularly in relation to CCS. Findings of the current study can inform future research into the role of the NP in women's health so that innovative strategies can be developed that utilise the evolving role of the NP in providing preventative care. Findings from the study also provide insights into factors that encourage women from a disadvantaged background to partake in CCS. These findings can be used to inform the development of new interventions that encourage women to undertake routine CCS, as well as other cancer screening practices such as mammograms. The study continues to emphasise the need to increase funding for women's health centres so that women-centred care is accessible for all women.

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