CERVICAL SCREENING FOR WOMEN WITH PHYSICAL DISABILITIES

A Master's Thesis within the New Zealand Population

CERVICAL CANCER

- Disease affecting women
- 2nd most common cancer
- 5th deadliest cancer
- Derives from the HPV virus (<90%)
- Preventable - w early detection & Tx

National Screening Unit

NATIONAL cervical SCREENING PROGRAMME

The National Cervical Screening Programme (NCSP) implemented NZ in 1990

Incidence of & deaths associated w cervical cancer has decreased ~ 40% and 60%

The NCSP records results in their centralised database (register) ~ NCSP-R

NCSP REGISTER

NCSP-R retains smear Hx (date), lab cytology and histology (biopsy)

Sends reminder notices to women re: appointments & results

Provide Data – stats for monitoring/evaluation

Opt off option

NCSP REGISTER (NCSP-R)

The Register tracks women which is associated w decreased morbidity

In the last 12 yrs, C cancer mortality rate has decreased from 3.8 to 1.8 deaths per 100,000

Reduced rate of disease ~ overall pop

2010 record shows 96% of eligible pop enrolled

NCSP-R LIMITATIONS:

Data collected is based on the overall population & demographic material is minimal..

So….

What about hard to reach women?

Why is this a problem? – 80% of *new* Dx occur in women who haven't been regularly screened.

HARD TO REACH WOMEN:

International evidence suggests:

Women w disabilities (WWD) are < likely to have regular screening.

WWD have lowest “compliance” rates

Why is this?

BARRIERS

International evidence suggests

Structural,

Physical,

Systematic,

Attitudinal

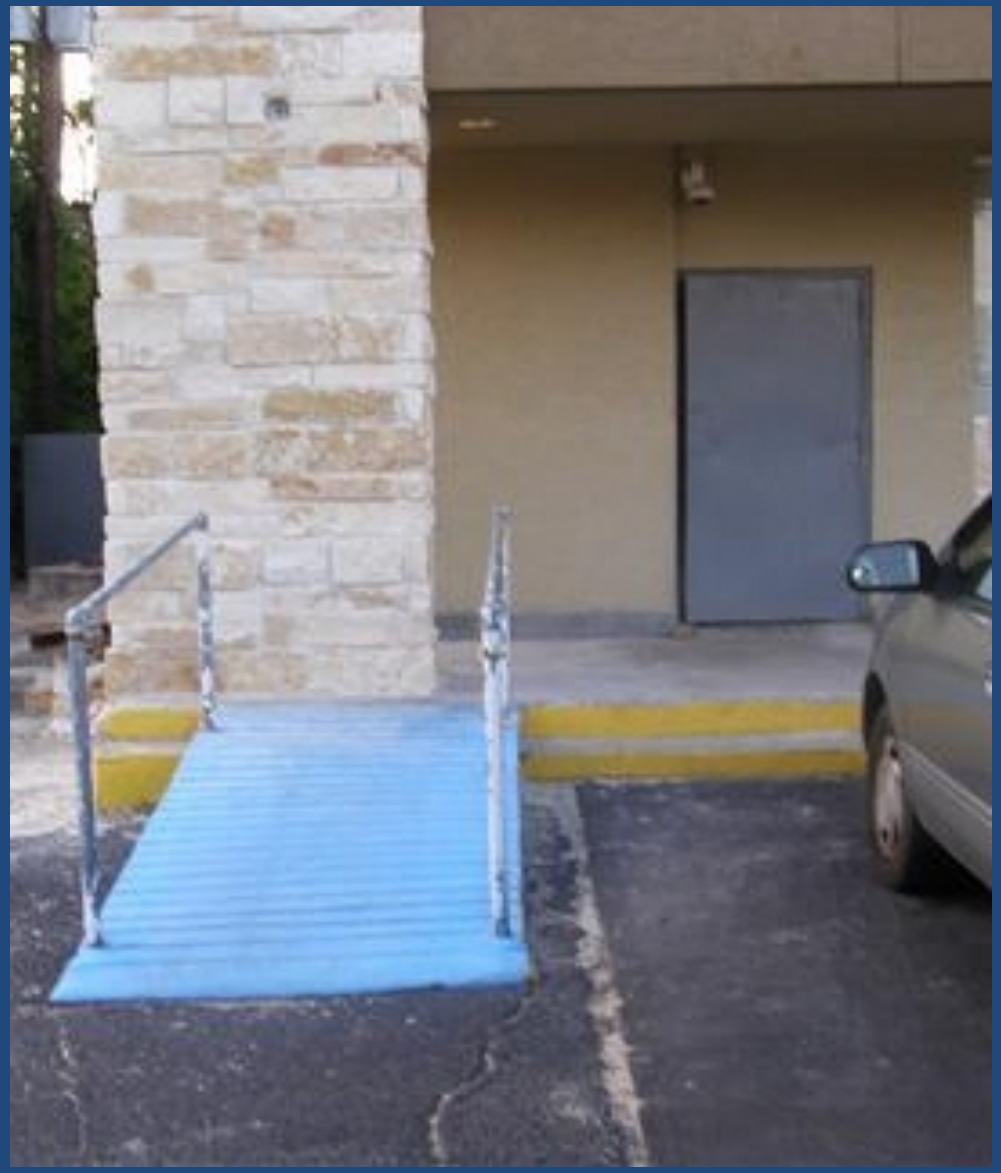
STRUCTURAL

Our built environment presumes everyone can: read signage, reach buttons, see hazards, open doors.

Housing, employment, parking, recreation typically pose problems for people w disabilities.

Barrier-free architecture (i.e. Universal design)


WHEELCHAIR
RAMP
AVAILABLE
INQUIRE
WITHIN



PHYSICAL

Front door

Placement of reception desk

Medical office hallways, treatment room

Exam table

Accessible toilets


Reception

SYSTEMATIC

Tardy practitioners, short appointments not allowing for time to undress, or to mount exam table

Can have negative impacts on transportation,

Women feel rushed - forget to ask important questions

For women where spasticity is an issue- more time is needed

ATTITUDINAL

Making assumptions – WWD = not sexually active. WRONG!

Not offering opportunistic screening..

Not having the discussion…

Resulting in WWD becoming more marginalized.

Hierarchy of disability-

WHAT'S HAPPENING IN NZ

Data not collected re: uptake of services in WWD

WWD have not been solicited regarding their perceptions, habits or (potential) issues related to screening.

INTERPRETIVE DESCRIPTION

Interpretive description – Methodology

Developed from nursing profession

It's focus is on understanding of action as it relates to clinical practice

The aim of ID is to discover themes or patterns & generate findings to inform clinical understanding

INTERPRETIVE DESCRIPTION

Health and illness experience are complex interactions between psychosocial and biological phenomena;

Researcher & participant influence each other;

Theories must be found from within the data

INTERPRETIVE DESCRIPTION

ID is derived from grounded theory methods

“what is going on here?”

In hopes to develop a deeper understanding of the phenomena.

THE EXPERIENCE(S) OF CERVICAL SCREENING FOR WOMEN WITH PHYSICAL DISABILITIES.

Interviewed 11 women w physical disabilities

Northland – Dunedin

Interviews ranged from 45 - 90 minutes long

Participants chose the location for interview

FINDINGS

Women are experiencing these barriers in New Zealand

STRUCTURAL

Elsy: It does make it harder. It does make you go, “oh, so I can’t be here” in some way. Sometimes I assume that I can get into places, like when I rang up I didn’t go, “oh, can I get in?”

PHYSICAL

April: I can't go to the toilet [though]. I go in and I look at the waiting room and I look at the receptionist, I'll say to her, "I need a toilet, I'll go to the pub." And they just laugh and say, "yeah, go and have a gin before you see the doctor," and so, I go next door to the pub to go to the toilet.

SYSTEMATIC

Mary: Actually, I can recall one time that I had a smear…and the consultation was booked for half an hour. We'd gone over [time] and he did say to me that there was another patient waiting to be seen. And that did make me start to panic, I felt bad and I was trying to rush and that's when I [forgot and] left the squishy squashy gel.

Little things like that, being too nervous to ask for the tissue or ask for wipes and I was trying to be quick. So yes, the attitude of the GP…

ATTITUDINAL

Elsy: No it was never, “oh, we’ll do it” it was “are you aware that you might need it done?” so it was almost like, you *might* need it done, like maybe you don’t.

FINDINGS 2: OVERCOMING BARRIERS

Practitioners; Working in partnership

Individualising care, Allowing for difference

Overcoming barriers - Women- Buying time, Feeling comfortable, Paying attention to health, Health literacy, Finding courage

CONCLUDING THOUGHTS

To provide equitable health for women with physical disabilities, medical professionals;

must be aware of the variety of barriers that women are faced with when accessing services.

Discussing health care needs with the patient, can help practitioners meet the needs and tailor the care accordingly.


Keep Calm
& Put a
Ramp in