



### **Abstract**

Few studies have assessed healthcare workers' understanding and use of a women's health approach (WHA) in practice, specifically with regards to cervical cancer treatment. Given the dominant biomedical approach, it is important for healthcare workers to be aware of, and feel capable of addressing the gender-specific needs of their patients. The purpose of this study was to assess healthcare workers' understanding of a WHA in a cervical cancer treatment centre in western Canada. Using a feminist case-study method, semi-structured interviews were conducted with nine healthcare professionals of the multidisciplinary team, including: nursing, social work, medicine and radiation therapy. Findings from interviews indicate that healthcare workers did not use a WHA. Analysis brought forward three main barriers to the implementation of a WHA, which stimulated the creation of seven recommendations towards implementation of a comprehensive WHA. The goal of this paper is to disseminate research findings in a way that honours the contribution of the participants from the clinical milieu, and acknowledges the need for creativity, innovation and a 'rethinking' of care delivery for women with cervical cancer.

**Key words** case-study, cervical cancer, women's health

## **Exploring the Presence of a Women's Health Approach in Cervical Cancer Care**

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### **Introduction**

Cervical cancer is the second most common women's cancer in Canada.[1] This cancer is an especially complex condition because of its duality as a chronic disease, and its link to the sexually transmitted infection human papillomavirus (HPV) as the primary risk factor.[1] Treating women with sexually transmitted illnesses has been historically problematic because of the associated stigma, which is said to be linked with delays in treatment, poor health outcomes, guilt, isolation, fear and denial.[2-4] Initial

testing for sexually transmitted infection/disease (STI/D) often takes place at a community clinic or other medical delivery centre specializing in sexual health. Such centres often provide counseling and referral services for women needing further treatment. However, women requiring further treatment of irregular pap test results are usually treated in non-community health settings, most often a cancer clinic or day procedures area of a hospital (5). In these facilities, healthcare workers may not be aware of the nature of HPV transmission, the sensitivity of the issue, and the psychosocial concerns of women receiving treatment. In addition, health professionals have not been asked to think critically about the sociopolitical context in which they practice, and how this may affect patients.

A women's health approach (WHA), is defined as one that focuses on "epidemiological differences, and highlights the specific health needs of women and girls. WHA includes a focus on female sexuality and reproduction within a holistic approach to addressing health needs across the lifespan".[6] Although a WHA seems to be central to

sensitive and appropriate cervical cancer care, prior research has not examined healthcare workers' perspectives of such an approach.

A WHA acknowledges that when women seek treatment for physical concerns, such as cervical cancer there are psychosocial, contextual, and sociopolitical factors that cannot be overlooked. The goal of this study was to begin the important task of assessing healthcare workers' understanding, perceptions and approaches to gender sensitive care. The findings of this research also stimulate questions for further study of gender sensitive healthcare.

## Literature review

Two key domains provide the context and rationale for this research. The first addresses incidence and treatment of cervical cancer and HPV. The second domain positions the research within multidisciplinary discussions surrounding women's health and Gender-Based Analysis (GBA).

### *Cervical cancer and HPV*

Examining the provision of care for cervical cancer is an important contribution to the literature because cervical cancer has become one of the most common cancers affecting women around the world.[7] According to the Canadian Cancer Society[1] since the advent of ad-hoc screening programs in 1977, incidence rates have dropped 50% and death rates by 60%. In addition, women with HPV are at greater risk of developing cervical cancer.[8] In a study by Sellors and colleagues, the highest rate of HPV was among 19-25 year olds, who have a 24% infection rate.[9] This has led to the development and deployment of a national vaccine program for cervical cancer that targets young women.[10]

In addressing cervical cancer arising from HPV, there are two factors that need to be considered. These present a challenge for those who carry out treatment and education. First, cervical cancer is a chronic disease, which entails a special set of considerations, such as chronic disease management and long-term implications of diagnosis, treatment and survivorship. Second, HPV is a sexually transmitted infection. Problems related to the treatment of chronic disease are thus amplified when associated with a sexually transmitted infection.[11,12] While safe sex and community-based harm reduction programs are working to reduce the overall incidence of sexually transmitted infections, treatment of invasive and non-invasive cervical cancer normally take place in traditional hospital or medical settings - usually cancer clinics.[13]

### *Women's health*

Women have historically accessed the healthcare system more than men, both for themselves and as primary caregivers of their families. Economic status has a significant impact on health, as Spitzer states, and average lifetime earnings of women are only 67 percent of their male counterparts.[14] Spitzer also points out that male life expectancy is 76 years, while females can expect to live until 81.[14] This means that women have more years than men in which they can access the system. Moreover, the additional years lived by females are more likely to be plagued with chronic illness; 11 percent of women suffer from chronic conditions, compared to only 4 percent of men.[14]

To rectify the disparity in women's health, Health Canada has rolled out two strategies to address gender differences: the Women's Health Strategy[5] (WHS) and Gender-Based Analysis (GBA).[15] The WHS was released by Health Canada, and outlines how the healthcare system has failed to address women's health specific needs. The document also provides a plan for departments to address these imbalances. GBA was first developed in 2003, and re-released in 2007 by Status of Women Canada.[15] GBA is a tool designed to assist federal departments in systematically integrating gender consideration into policy, planning and decision-making. Various components of these strategies set out specific parameters for policy development regarding women's health.

The purpose for both the WHS and GBA is to shed light on past inequities in the healthcare system that devalued, misunderstood and then misrepresented women's health.[16] While the WHS provides a recap of what types of differences women have (and may continue) to experience in the healthcare system, GBA focuses on gender, rather than women only. GBA also goes beyond the impetus of healthcare, with the goal of integrating strategies into any relevant social departments in the Federal government.[15]

It is important to note that GBA was developed outside of a biomedical/health focus, from the Department of the Status of Women. Within the biomedical, a reductionist model based on biological sex differences tends to dominate.[16] A biomedical lens usually reduces women to their biological disposition to reproduce, focuses on binary opposition of men and women, and overlooks the socially derived aspects of gender that create unique circumstances for both men and women.[17] GBA, at its most basic, attempts to shed light on the numerous complex social factors that interact with the biological to create the person. A women's health approach,

focuses specifically on gender and biological differences, and suggests strategies to meet these within a predominantly biomedical healthcare system.[18]

The implementation of GBA and the emphasis on women's health policy in government research and policy-making is promising. However, while women's health has evidently become an issue considered by government agencies, research has not translated into subsequent practical action in the clinical domains. The most recent federal guidelines—the Programmatic Guidelines for Screening for Cancer of the Cervix in Canada,[19] do little to address the psychosocial challenges associated with diagnosis and treatment.

The need for attentiveness to psychosocial needs prior to cancer diagnosis and during cancer screening (pap testing) have been well-documented.[20,21] Nevertheless, a lack of attention to psychosocial concerns by healthcare workers when informing women of abnormal pap test results is evident in the reviewed literature. Several studies on communication of pap test results describe women as feeling anxious or confused about abnormal findings and not being given thorough or conclusive information from their physician.[22-25]

Feminist literature problematizes the procedure as well. For example Dietch and Davies'[26] phenomenological study explores the harmful experience of waiting for treatment after being informed of an abnormal pap test and women's experience of being given little information or support during communication of results. Another study explored the longitudinal experiences of women following abnormal pap testing and found that a woman's experience with her body changes.[27] Women interviewed in this study felt the cervix was an area of the body they did not pay attention to prior to their diagnosis. As a result of the abnormal pap test and subsequent follow-up, women paid more attention to their bodies, and felt their bodily boundaries changed.

Few research projects have talked specifically with healthcare workers to elicit their opinions on gender-specific care and whether a women's health approach is present in their day-to-day practice. Healthcare workers are central to understanding the health care system because they are the primary actors who carry out policy, provide care, and interact directly with patients. It is also imperative to understand that policies in a book, or best-practice guidelines are different than what actually takes place in practice.[29] Herein, this article seeks to address that oversight by examining the opinions of healthcare workers of the multidisciplinary oncology team treating women with cervical cancer.

## Method

In this study, a case-study method was chosen to gain a comprehensive view of the sum of the perspectives of the individuals who provide care at one cancer clinic. Reinharz states that case studies are "used to illustrate an idea, to explain the process of development over time, to show the limits of generalizations, to explore uncharted issues by starting with a limited case, and to pose provocative questions".[28] Due to the paucity of research on WHA in the specific context of cervical cancer this presents a starting point to begin exploring women's health needs.

According to Letherby, "feminist research is feminist theory in action".[32 p62] Further, Letherby states that the political aims of feminist theory are grounded in, and celebrate the experiences of men and women- thereby challenging the experiences of mainstream knowledge. Therefore, using a feminist approach meant focusing critically on one specific case, and the experiences of a few, rather than on the comparative analysis of multiple cases.[28] For this research, the focus was on understanding experiences of healthcare workers at one clinic. Through these many voices the authors tried to generate a comprehensive understanding of WHA and gender-specific care.

Nine semi-structured, open-ended interviews were conducted with policy-makers, practitioners, and healthcare workers employed at the clinic. Of the nine interviewees, two were radiation therapists (both female), two were nurses (both female), two were social workers (both female), and three were physicians (two males, one female); there were seven female participants in total. The rationale for interviewing those who work at the clinic, rather than those who attend it, is to provide insight into the perceptions of those who carry out treatment and interact with the women who access services.

Discussions were initially held with the clinic director to ensure interest in participating in the study. Ethics approval was received from the affiliate University Research Ethics Board. Written consent from the director, as well as contact information for several employees at the clinic, was obtained. Primary data collection was then initiated.

All interviews took place during the fall of 2006. Seven of the nine interviews were conducted at the cancer clinic, while two were conducted off site at participants' private offices. Participants were mostly female (seven of nine), and all had some type of post-secondary education. The length of the interviews ranged from approximately 25 to 45 minutes.

A semi-structured interview guide was developed for the purpose of this research. Questions were developed to probe participants about their thoughts about WHA at the clinic, their professional role, and gender-specific needs. A conversational approach was utilized to allow the researcher to be reflexive, with the participants guiding the conversation.

The nine interviews were transcribed verbatim and checked for accuracy by the first author. Content analysis, described by Patton as “any qualitative data reduction and sense-making effort that takes a volume of qualitative material and attempts to identify core consistencies and meanings” was conducted with all transcripts.[31 p453] Making sense of the core concepts and identifying major themes was not a process separate from transcription; rather, it was an integrated and continuous process that was informed by a feminist perspective. Interviews were conducted with attention to talking, writing, editing and listening from a feminist viewpoint.[32] The main themes and patterns that emerged linked back to the initial review of the literature in meaningful ways.

Findings from this study are presented below and incorporate relevant literature throughout as described by Thomas-Maclean.[33] Although an attempt was made to present the findings in a linear fashion, the nature of the research findings necessitates more of a ‘messy’ back and forth approach between the literature and the participants’ responses. This approach to presenting research findings is one not often accepted in positivist scientific journals, however, this approach has garnered support from researchers and students who learn that research is certainly not a linear process (34). Both authors feel this format illustrates a more accurate representation of the findings in this feminist case-study.

## Findings

According to participants, a WHA, as defined above, was virtually non-existent in the clinic. However, participants expressed a general understanding of some of the tenets of a WHA. Interviews revealed a number of important barriers to healthcare workers’ ability to implement a WHA in clinical practice. These barriers include: 1) Medicalization; 2) Lack of evaluation; and 3) Understanding women’s health and gender-specific needs. Each of these barriers is contextualized within literature relevant to a women’s centered approach to healthcare.

### *Medicalization*

Drawing upon early work on the conceptualization of

medicalization (e.g., Ivan Illich, Irving K. Zola), Kohler Riessman expands the concern with medicalization to include feminist understandings of this phenomenon. [35] Medicalization has been defined to mean, first, that conditions and behaviours are “given medical meaning” and understood through the lens of health and illness and, second, that medical institutions are seen as being responsible for the elimination of said conditions and behaviors.[35] Kohler Riessman asserts that medicalization is also involved with social control and the construction of deviance, in a variety of ways, and awareness of social context is diminished, as power relations are perpetuated.[35] Such a definition sees the process of medicalization taking place primarily at the conceptual level; the research findings from this study show how medicalization manifests in various processes at an interpersonal level, well beyond the doctor-patient relationship.

Despite differences in degree of formal education and work experience, all interviewees tended to revert to medicalized language when discussing aspects of client care. This tendency to revert to “medical speak” and to medicalize interactions with patients was not limited to the physicians. Medicalized language was also employed by nurses, psychosocial oncologists and radiation therapists. These findings suggest that medicalization is not the sole purview of physicians, but is rather a general by-product of the biomedical model influencing the clinic’s overall practice.

The following quotations were elicited when participants were asked questions about a change in patient demographics, and about services that cater to the unique needs of women. One radiation therapist stated:

I don’t believe there has been a lot of change in numbers we have seen. I think it has been fairly steady, maybe slightly younger.... If a patient has not had a hysterectomy, the uterus is an excellent organ to be able to insert catheters into to allow us to give a higher dose to that actual organ.

In response to a question about checking in on patients during their treatment, one nurse stated:

“Well, we do follow-up, especially when they are getting the first treatment, and we will call them a couple of days after the first treatment, not to be too narrow but to see if there are any side effects—as far as nausea and vomiting—and there is a follow-up phone call and checkup with them and then there is a lot of stuff related to side effects.

Focusing on the physical symptoms and treatment of cancer are a demonstration of medicalization. Health care workers routinely referring to women as the physical site of their

cancer which emphasizes the problematic parts of the physical body, rather than the existence of a whole, embodied person. Also, while physical symptoms are often the most problematic post-chemotherapy side-effect, there seemed to be little attention to the relationship of the physical symptoms to the holistic experience of being sick.

Nonetheless, there are positive practices that should also be acknowledged in the context of the clinic, and the cervical cancer screening program in particular. There is invaluable benefit to utilizing uniform and non-individualized approaches to screening; even though it suggests medicalization. That is, the cervical cancer screening program utilized by the province and cancer clinic operate on the basis of findings which indicate that women over the age of 35 were generally under-screened while women between the ages of 18 and 34 were generally over-screened, this attempts to target screening towards those who need it most. One physician indicated this stating:

There is a of angst in the younger generation to talk about and to access care and women things. Whether it be for pap smears or contraception. ...I think that attitude is a healthy attitude and I think the screening program has promoted that attitude.

### *Lack of evaluation*

Another barrier identified in the interviews related to the need for evaluation of the current program. When discussing whether women's needs were being met at the clinic, one nurse stated:

I am not sure but I guess in order to find out you could do some sort of survey with women to find out.

Although each participant was asked about current evaluative strategies (such as questionnaires, surveys, program reviews, etc.), none of the participants were familiar with any. Some were aware of internal evaluations that had been done, but even those operating at the management level were not aware of the findings. Also, the scope of the few evaluations done was limited. One participant spoke of an evaluation to assess the current hours of operation and whether clients were satisfied with them. She too was unaware of the results. One radiation therapist stated:

Surveys are done every once in awhile. A patient survey—and I don't know what the frequency of those or how they are assessed. Some have come from us because of accreditation, sometimes. When that comes around we have to do that. Some have come from other areas in the hierarchy.

Facilitating the opportunity for evaluation provides women

with the ability to share their experiences, improve services for other women, and to strengthen areas where services are lacking. Evaluations might also provide healthcare workers insight into the needs of women with cervical cancer and how these are unique to other clients. This exercise would allow women to provide feedback in an anonymous way, allowing them to share their opinions without fear of it affecting their care.

### *Understanding women's health and gender-specific needs*

Participants in the study were aware of women's specific health needs, but did not label their understanding as a WHA. When probed regarding such things as childcare for women, family support, and sexual health counseling, each of the participants emphasized that these were important aspects of care. However, few were aware as to whether these needs were met. Participants were aware of gender issues, but described several limitations in implementing gender sensitivity into their practice. They were not ignorant of the implications of gender difference, but often simply overlooked them due to other constraints. Some participants also seemed to be unsure whether cervical cancer qualified as women's health. One social worker stated:

Umm probably there is more of that in breast cancer, women's health, I mean certainly with the women's health center ... not anything at our cancer center here. We have always had support groups for women with breast cancer clinic here though.

During the course of the interviews, many initiatives conceived by the cancer clinic were mentioned. One strategy remarked on quite often was the cancer agency's agenda to decrease "wait times." Most participants felt that wait times were of central importance, because it is crucial for women to get timely treatment upon diagnosis of cancer. A diagnosis of cancer is a life-altering experience, however, so to imply that the only concern for women with cancer is wait times oversimplifies a very complex issue. The focus on wait times seems to be an extension of the process of medicalization, because it addresses only the need for physical treatment and overlooks the need for psychosocial care or anxiety associated with the process of 'waiting'.

Almost all of the interviewees deemed childcare to be imperative for this type of cancer centre. Women often come every day of the week for less than half an hour for radiation treatments. For immigrants, new Canadians, marginalized persons and those with limited support, there are few options

for childcare for such a short period of time. One of the participants suggested that women could bring their children to the cancer centre and leave them in the waiting room, where the receptionist could watch them. However, this did not seem like a reasonable solution to the problem given that there is no formal program in place. The issue of childcare is greater for those clients who travel long distances to obtain treatment and already face a major geographic barrier.

Participants also expressed concern about women from rural and remote areas who must travel for treatment. Participants felt the travel was a great burden, especially when they had families and jobs. The uncertainty of the length of time of treatment was seen as a significant factor. One physician stated:

If we have a patient coming from the North we know we can't do blood work, chemo and check-up all in the same day because some treatments are really long and if we do bloodwork in the morning and see that the counts are too low, then we have to cancel all the appointments in the afternoon.

Participants also felt that there were problems associated with screening the rural and remote populations. The participants indicated that many of their patients from the north are Aboriginal, and living on reserves in variable social and economic conditions. One nurse stated:

Lots of them [the patients] don't have telephones, so the challenges of getting them here and compliant with these appointments if they can be sometimes people who aren't compliant with other areas of their care, then they might not be compliant in coming to see us.

Another participant explained that the shortage of services in rural and remote areas might hinder screening for women not being comfortable with personnel. One physician stated:

There was some gender preferences toward women as opposed to men [doing the screening] in some of the areas and so there was some issues to the screening program itself and how to make it more effective... so long as we are aware that anybody can take a pap smear. It can be a nurse, it can be a nurse assistant.

Sexual health counseling was another topic that generated participant comments. Many participants mentioned that sexual education was a major need for women at the clinic. There was not a designated professional responsible for addressing sexual health education, so when patients would ask questions, staff often said they did not know the answer and did not know who to ask. The two radiation therapists stated that it was the psychosocial oncologist's area, while the psychosocial oncologist said it was a nursing issue. Nursing staff was unaware of whose area it was, but to the best of

their knowledge it was not a nursing issue. Sexual health was therefore an area demanding attention; a comprehensive women's health approach would ultimately address this. One radiation therapist states:

It [sexual health] is an area that most people are not comfortable talking about...but younger women, I mean they have got a long life, a long sexual life ahead of them and perhaps even childbearing if it doesn't sterilize them and um you are young...but they need somebody to talk to them about what is safe, what is not safe, how to enhance these situations you know.

The lack of knowledge of a WHA was a barrier that affected the staff's ability to meet women's needs. However, even though some staff indicated a lack of knowledge in certain areas, such as sexual health, others were seen to have expertise; therefore, information sharing would greatly benefit provision of information about sexual health.

## Recommendations towards a WHA

The barriers identified through informant interviews outline why a WHA was not implemented at this clinic. This section provides strategies and several recommendations for the constituent parts of a WHA. All of the suggestions below arose from comments derived from interviews with participants.

### *Evaluation of patient experience*

Several participants revealed that patients were occasionally surveyed about their experience at the cancer clinic; however participants were unaware of the purpose and outcomes of these evaluations. The rationale for evaluation surely is to ensure that patients' needs are being met. While participants felt strongly that patients were overwhelmingly satisfied with the treatment and services they received, it would be beneficial to have women with cancer directly report on their treatment experience.

The first recommendation is to seek input from women about their patient experience. Evaluation methods could include surveys, focus groups, and one-on-one interviews focusing on gender-specific treatment, experiences, and issues. Surveys targeted only at issues like "hours of operation" are important to patients, but not sufficient to capture women's personal experience of cancer treatment.

From the interview, it seems that additional focus areas could include family issues, difficulties in health maintenance, and sexuality and psychosocial concerns. Examples of family issues mentioned during interviews include, childcare, family planning, and traveling/relocating for treatment.

In order to ensure that appropriate issues are evaluated, collaboration among disciplines would be necessary. Psychosocial oncologists, who work directly with patients to overcome social challenges, could take a central role in identifying areas needing evaluation. Evaluation will only be successful if it focuses on holistic issues identified by women themselves. Once data has been collected, findings should be summarized, disseminated to staff and other relevant personnel, and potentially published in practitioner journals. The dissemination of this information within practice and professional circles will facilitate ongoing discussion within the oncology community. Sharing the information within these forums can only serve to enhance the care received by women with cervical cancer.

### *Thinking about implementation*

From this research, it is evident that the personnel who provide direct patient care to women with cervical cancer are aware of gender-specific needs. However, there was limited, incorporation of gender-based strategies taking place at the clinic. While this is a case study of only one clinic, other research demonstrates that it is likely the rule and not the exception. For example, a report released by the Prairie Women's Health Centre of Excellence,[6] "Invisible Women: Gender and Health Planning in Manitoba and Saskatchewan and Models for Progress," indicates that gender-based analysis and planning is absent in most regional and provincial health authorities. The report recommended that regional health authorities move away from a reproductively focused view of women's health, and consider broader gender specific care for women. Proposed in 1999, this recommendation is still pertinent nearly ten years later. Arguably, a strength of the researched clinic is the recent consolidation of services in the province, which makes cancer care more centrally managed and distributed. Implementation of gender-based analysis could be done province-wide and each centre could pilot gender-based analysis in one specific treatment.

If GBA strategies were to be implemented into practice at the clinic, it would be important to incorporate evaluation as a way of measuring the success or failure of the program. As per the guidelines laid out above, women should be directly involved in the evaluation process. Moreover, if gender-based analysis strategies are to be implemented, it needs to be targeted at individuals providing patient care at all levels, including reception and volunteers.

### *Patients on the board*

Perhaps one major reason that medicalization is so pervasive

is the lack of women's input into treatment processes and clinic policies. Two participants mentioned the presence of a lay advisory board. This board is comprised of selected professionals from the clinic, as well as "lay people" from the community who have experienced treatment or are family members of those who have had treatment. This is a positive step toward incorporating patients into the development of patient care. To take this further, it could become clinic policy to incorporate women and men undergoing treatment into the development of policies that affect their care. This would provide patients and survivors with an active role, rather than being fixed in a passive role.

In keeping with the idea of inclusivity, it would also be advisable not to label non-healthcare professionals on the committee as "lay people," which suggests that they know little about the issues. People who have undergone treatment and join the board should be regarded as experts; perhaps not in the specifics of evidence-based treatment protocols, but definitely in the area of patient care.

### *Expert consultation*

In order to facilitate gender-based analysis, a position should be created to ensure the successful and continuous application of gender-based principles. The person filling this role could: serve as a liaison between patients and healthcare workers if gender-based concerns are identified; work with those conducting evaluations to come up with solutions to gender-based barriers/issues; participate in meetings within all departments of the cancer clinic; and act as an agent of change to promote more gender-based analysis at the clinic.

The duties of the proposed position would include raising the profile of women's health and gender-based analysis. This could include distributing literature to clients about the attempts at incorporating a WHA, public relations activities and putting up literature posters around the clinic.

### *Staff Education*

Many staff members identified their own knowledge gaps in a number of areas. In the discussions, there was a lack of knowledge about how to address women's health needs. Furthermore, it was evident that there was confusion at the clinic about who was responsible for certain patient education needs.

The issue of role confusion recurred in interviews, especially regarding women's need for sexual health education. In general, clinic leadership needs to identify knowledge gaps and determine who will address them. Rather than continuing

to be unsure about who should do what, a proactive approach should be adopted to address concerns affecting the care of women with cervical cancer. The clinic is clearly passive in identifying who should cover issues such as sexual health. This issue is probably thought to be 'mainstreamed', or part of everybody's role. Sexual health, due to its private nature, is not something patients generally bring up to the healthcare worker. This is a case where the organization needs to be very clear about who is responsible for sexual health, especially in a disease that is associated with HPV.

Rather than hiring new personnel to deal with the problem, program heads need to take the lead. Knowledge gaps first need to be identified. Staff committees should research best practices and present these to the staff to ensure unanimity. Education should be implemented into client care. It must be emphasized that this does not necessitate treating sexuality and other sensitive issues like "any other thing." Discussions about so-called "embarrassing" matters such as sexuality, intimacy and drug-use should be conducted in a value-free and sensitive manner.

When healthcare workers identify knowledge gaps, these gaps are often shrugged off due to cutbacks and politics. If a knowledge gap is identified, healthcare workers can act as advocates for patients. As powerless as healthcare workers often feel, they have access to resources and information that many patients are not privy to. Furthermore, if healthcare workers feel empowered to take an active part in patient education, it is plausible that they may find more satisfaction in their job. Past studies have shown that nurses satisfied with their job, are more likely to have satisfied patients.[36,37] Findings from these studies may be applicable to other caring professions working within the same healthcare system. These findings are important because they don't minimize the political and sometimes oppressive bureaucracy of the healthcare system, but instead suggest a road map to work within it.

### *Promotion of dialogue*

Healthcare workers should be encouraged to dialogue regarding the shortcomings identified in the case study and also to exchange concerns identified before this research took place. Providing a place to express concerns may well help to establish the recommendations already mentioned. A significant number of the ideas in the research came directly from those working in the clinic. Perhaps the research provided an outlet for the healthcare workers that they never had, or perhaps they never previously cared to share their ideas. Whatever the case, their ideas have the ability to

transform the clinic.

Time is the crucial factor in facilitating dialogue. Time needs to be allocated for healthcare workers to talk about significant issues related to patient care. They do not all have to engage in daunting academic work; they just need to dialogue regarding their concerns.

### *Psychosocial concerns*

Arguably the single most important finding from this study concerns the fact that more research needs to be done with women who have cervical cancer to investigate the disease's psychosocial implications. There is some overlap of this recommendation with others, but it does warrant a separate discussion because of its importance. Cervical cancer is less common than breast cancer, but it brings with it a unique set of challenges for women. Issues that seem to be pertinent are silence, stigma, sexuality and education. A great deal of work is being done in the area of cervical cancer, but much of it targets issues such as how to get more women into screening programs, non-attendees and the physiology of the disease. There are myriad other psychosocial issues that accompany all women with cancer. Notably, given its connection with HPV, the issue of social stigma affects many women. Such topics need to be studied in depth. Furthermore, guidelines for assessment of psychosocial needs in the adult patient were revised and released in 2009.[38] These guidelines suggest the need for comprehensive and focused assessment, screening for distress, education of health care providers, and the importance of considering the patients social context.[38] The point on social context emphasizes the significance of family life stage, and the need for healthcare workers to be aware of the far-reaching implications of a cancer diagnosis. In this study patients were aware of these issues, but seemed somewhat limited in their perceived ability to assess and implement psychosocial interventions.

Of similar importance would be research with women from rural and remote areas, as well as First Nations, Aboriginal and Métis women. Participants often identified these groups of women as having additional challenges regarding both screening and treatment, and labeled them as "high risk." Also, although not widely cited, research provides evidence regarding other barriers to treatment for Aboriginal women. One study assessed a group of minority women in Northern Ontario. The findings indicated that about 33% of Ojibwa and Cree women refused internal exams, compared to zero and 8% among other minority groups (39). Findings of this sort indicate the need for greater consultation with Aboriginal women to discuss strategies for creating and disseminating



culturally sensitive educational material.

At the clinic where the research was conducted, the experiences and opinions of women clients were not informing treatment in any way. This confirms the findings of Thomas-Maclean[40] that such settings divorce treatment of the disease from the self-perceived needs of the ill person. It also points to the fact that medicalization subverts resistance, or "resistance comes to look increasingly irrational since health—an intrinsic good—cannot reasonably be called into question".[18] The interviewees' perception of the program as doing fine without evaluation and their belief that patients are not interested in involving themselves illustrates the degree to which medicalization is firmly entrenched within the clinic.

### Limitations

Some of the limitations of the study pertain to those inherent to a qualitative approach. However, the goal of this study was to understand and explore rather than generalize findings, therefore a qualitative approach was the most design to answer the research question. In addition, owing to legal and ethical concerns, the clinic director had to approve the participation of the clinic personnel. This may have affected the demeanor of participants: if they participated only at the request of a superior, they may not have been sincerely interested in or comfortable taking part in the study.

### Conclusion

This study revealed that while a women's health approach was not specifically present, many healthcare workers identified constraints impeding their ability to attend to women's specific health needs. Further research is needed to explore these constraints specifically and their impact on implementing a women's health. More work is also required in the area of healthcare workers' understanding of a women's health approach and their capacity to implement such an approach. For example, it would be valuable to assess the capacity of oncology nurses to implement and manage women's health strategies into their practice with women undergoing cervical cancer treatment. Studies also need to be completed involving women receiving cancer treatment to understand their level of satisfaction with care approaches, their willingness to be involved in care, and their perceptions of the need to move towards a WHA in cancer care.

This research also emphasizes the need for knowledge translation on the part of researchers and practitioners working in the area of women's health and gender-based analysis.

There is scant literature available assessing WHA and how it affects care, how it is conceptualized by healthcare workers and patients alike. Given the pertinence of this topic and its ability to affect care it is important to emphasize the need for turning research findings into changes in clinical practice.

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