New Zealand Polynesian women’s access to information about cervical screening

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Introduction
Since the mid-1980s New Zealand governments of both left and right wing persuasion (Labour and National) have fostered ideologically-driven changes to a wide range of public services, including health. In the late 1980s the Gibbs report (1988) on the provision of health services identified the need for greater accountability in health management and drew attention to the importance of being able to meet shifts in health needs and preferences and in reallocating resources according to changing demand patterns. Since 1993 state-owned public hospitals, now known as Health and Hospital Services (HHSs) have been made more accountable and market-oriented. New fiscal management practices have been introduced, including some competitive tendering for health services. It may also be, as some commentators point out (Alam and Lawrence, 1994; Ashton, 1992), that an additional (or “real”) motive of the government in instituting reforms is to save money, reduce its exposure to increasing health expenditure, and to transfer more of the burden of health costs to individuals and the private sector.

Changes to the New Zealand health system have been attended by substantial debate from both supporters and opponents of reform. Questions have been raised, for example, as to how well reforms oriented to a model of individual responsibility are suited to subcultures within New Zealand (such as Polynesian cultures) that place greater emphasis on collective rather than individualistic solutions to problems. In the New Zealand context, critics of the reforms have sometimes been characterised as opposing progress, but the pace of changes in the direction of market-style reforms has been so rapid that there has been little opportunity to assess and evaluate the overall success of changes. In particular, little substantial research has yet been done on the present experience of people from more collectivist cultural orientations (such as Pacific Islands people) in an environment that is becoming geared to assumptions that it is now increasingly up to individuals to make their own provisions for health, retirement and social security.

The older, institutional model of health provision was allegedly monolithic and unresponsive. If so, it may be that a developing emphasis on flexibility in providing services according to customers’ stated preferences and needs contains new possibilities for improved services to distinctively different client...
groups. Health-care systems increasingly are being challenged to demonstrate that they are sensitive to the outcomes of decisions and that they are actively monitoring the quality of care, as perceived by health-service users. A local example of an attempt to be responsive was the 1996 appointment by the local HHS MidCentral Health, of a Pacific Island smear taker. Her role was to provide education to Pacific and immigrant women, as well as free cervical smears at women's homes or at her home (The Guardian, 1996).

Yet whether new models of health care do provide an opportunity for enhanced service to groups such as Pacific Island people is still open to speculation. As recently argued (Collins et al., 1994), the research has not yet been done on the appropriateness of applying health sector reforms designed for industrialised countries to people from developing countries. Nor is it necessarily the best outcome to move the provision of health care from public to private providers. In any event, learning at either organisational or systemic levels is highly dependent on both health care policy makers and providers finding out about actual successes and failures in locating health services where they are needed most.

If the proponents of a new order in health delivery are correct in their claim that a market model of health care is indeed more responsive to client demands, then research such as the present becomes particularly important in order to determine client needs and assess how well they are being met. This study set out to explore New Zealand Polynesian women's access to information about the availability of cervical screening services. According to Adams (1991) cervical cancer is the second most common cancer in women after breast cancer, with a New Zealand mortality rate of approximately 100 women per year (Ministry of Women's Affairs, 1989). The incidence and mortality rate is far higher in women of non-European descent (Ministry of Health, 1996) and in Pacific women (Cox and Skegg, 1989). Regular screening for abnormal cells is now recognised to be important since early detection can achieve reductions in mortality from cervical cancer (Adams, 1991).

Given that Pacific women have had disproportionately higher mortality from cervical cancer, specific attention is needed to research that is in harmony with Pacific cultures but which yields good quality data about people's health needs. The present study is a demanding one in that its subject matter, cervical screening, is viewed on Pacific cultural grounds as highly sensitive and, to some people, is virtually taboo in nature. Although the Pacific cultures (including Cook Island, Fijian, Niuean, Samoan, Tongan, etc.) are diverse in many ways, one common element is significant inhibitions about discussing human sexuality, reproduction, or diseases of the reproductive system. The taboo nature of the topic means that women are often very selective with whom they talk. It needs to be recognised that cervical screening is not a topic that is discussed easily and a trusting relationship must be established before this will take place.
Issues of quality are also relevant to this investigation. Assessing how patients or clients themselves react to the care or information they are receiving (Bull, 1994) is an element in the matrix of health care assurance methods. As this author also points out (Bull, 1995), “successful community care depends on a clear set of values and principles which take full account of the recipients’ views” (Bull, 1995, p. 37). In this study, the emphasis is on an intensive exploration of information users’ perceptions in an attempt to obtain an in-depth view of how users understand their barriers and gateways to enhanced knowledge about health services. This is in line with Calnan's argument (1995) about the benefits of understanding health care from the recipients’ perspective. He suggests several reasons for such an approach. These include the increasing role of patients’ families in managing chronic disease and disabilities, and the link between patient satisfaction with quality of health care and extent of recuperation from illness.

Since the early 1970s there has been significant Pacific Island immigration into New Zealand. In most cases, English is not the immigrants’ first language and their cultures of origin tend to be more oral than written in nature (Chong and Thomas, 1996). Both language and cultural factors may be significant impediments to Pacific women’s ability to acquire and understand documents written in formal English, and in their access to social services generally.

**Method**

The research was located in Palmerston North, a provincial city with a population of about 70,000. The aims of the research were to assess current levels of understanding about cervical screening, to identify the methods Pacific women use to obtain information and to identify ways to improve communication with Pacific women. Given the exploratory nature of the research, a qualitative approach was considered appropriate for, as Berg (1995) points out, the strength of qualitative research is its focus on the meanings that individuals assign to their experience, especially taking into account their perceptions and subjective understandings.

Data-gathering was carried out by interview, an approach considered congruent with the participants’ oral cultures. The research design was planned in association with Pacific women advisers and in consultation with those responsible for the local cervical screening programme. Participants were approached using the snowball or purposeful sampling technique, by which the researcher makes initial contact with a group of informants, asks them to contact people in their networks, recruits those persons as informants, and asks them in turn to assist the researcher to make further contacts (Minichiello et al., 1996). This approach was thought desirable in that it allowed the researcher to approach participants via their friends rather than have to approach them cold about a topic that is likely to be highly sensitive, if not virtually taboo, in many cultures (Macdonald, 1992).
Ultimately 20 interviews were conducted, some in the workplace, others in participants’ homes, and at a variety of times of the day. Interviews were tape-recorded and transcribed, and the transcripts content-analysed, first for general themes, then a second time for any trends relating to age, education and length of time in New Zealand. Cultures represented were Tongan, Fijian, Samoan, Tokelauan, Cook Island and Papua New Guinean. The sample included ten tertiary students, eight women in paid employment and two full-time mothers. Income level was considered comparable to that of the overall population of Pacific women in New Zealand, while educational level was higher, given the preponderance of students in the group. Time resident in New Zealand ranged from three months to 33 years, but 13 people had lived here for longer than 12 years. Further demographic details are shown Table I.

The interviewer was female but of European rather than Polynesian descent. The ethnic difference was not thought to be an impediment to the free expression of ideas. It may even have been an advantage, given the comment (reported below) from some participants that they felt more comfortable talking on sensitive issues with a person not of their immediate cultural group. A standardised question guide was used that explored: how participants found out about health issues, whether they had heard about the cervical screening programme, what is the purpose of cervical screening, how often do they need to have a smear, where they can go to get one, whether there is a cost, source of knowledge about cervical screening, method of receiving this information

<table>
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<tr>
<th>Participants</th>
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Table I. Characteristics of the participants
(interpersonal or print), factors that might stop them accessing this information, and demographic data.

Findings: current levels of understanding about cervical screening

Nature and frequency of screening

Out of the 20 women, 17 had heard of the local cervical screening programme and most had a reasonable knowledge of what the screening involved and that it was a test for cancer. Some linked cervical screening to a test for sexually transmitted diseases. The most accurate knowledge was possessed by women over 30 and those who had lived in New Zealand over five years. The desirable frequency of smears (three years) was most successfully identified by women in their 30s compared with the younger women and those over 40 years. Of the 20 women, 19 correctly identified that they could have a smear at the doctor's clinic or at the local public hospital. Half of the respondents knew that there were alternative venues available, but women who had been in New Zealand for less than five years were least likely to know this.

Methods to obtain information

Face to face communication

All of the women stated that they would prefer to use a face to face source for information about screening. The media were also considered to be useful but there was no strong preference for radio, newspaper or television. Talking with friends was of particular appeal to women of 25 years or younger and to those in New Zealand for less than five years, while women over 40 years did not express a preference for this source. Of the ten students, six said they would discuss health issues with friends, but the non-students were much less in favour of this option.

The women gained their knowledge about cervical screening in three main ways: visiting the hospital or a GP, a cultural group meeting, and talking with friends. Of the 20 women, 11 initially found out about cervical screening during a visit (sometimes antenatal) to their doctor or medical specialist. In some cases, the women were prompted to ask their doctor about cervical screening after seeing (English language) pamphlets in the waiting room.

Cultural group meetings

Four women gained their knowledge from a medical professional (usually a female Pacific nurse) invited to speak at a regular cultural group meeting. The mix of spoken information and pamphlets made available was appealing to the women. Generally the speaker would be unknown to most of those present, which was thought to be an advantage, as confidentiality and anonymity were assured.
Reactions to pamphlets

Four pamphlets were currently available in Palmerston North, all DLE (equivalent to A4 folded into three sections), using colour and professionally produced. One pamphlet, “Facts about cervical cancer” is available in six Pacific languages plus English and uses Pacific visual images (hibiscus flower and traditional woven mat). Two other pamphlets are in English only. One is in English and Maori.

The Pacific pamphlet had great appeal. The women made favourable comment on the colour, design, symbolism, the question and answer format and the simple language used. Being able to read the information in their own language was considered important, especially for understanding the medical terminology.

Ways to improve communication with Pacific women

Sensitivity of topic

All of the women, with one exception, agreed that Pacific women found cervical screening difficult to discuss. This sensitivity had some relationship to age and length of time in New Zealand, in that all women 25 years of age or younger (seven) and five out of the six women in New Zealand for less than five years had strong reservations about discussing the subject. Two students, who had been in New Zealand for less than five years, stated:

... it is embarrassing because it is something that in our custom is taboo ... I think it is, you know, sacred.

Yes I think it is a sensitive issue. It is a part of your body that you don’t want to discuss in front of anyone else. I think it is to do with your upbringing as well. In the Pacific it is a taboo subject and you don’t talk about this.

Confidentiality issues

Visiting a Pacific health professional was viewed with concern by some respondents, in that Pacific Island communities in New Zealand are small, everyone knows one another, and fears were expressed that personal matters would become community news. In the words of a 25 year old student:

Well if I walked into a clinic and there was a Polynesian woman working in the area I would be embarrassed to ask her for cervical information and that sort of thing. I would even be embarrassed to ask her about contraception if she looked Samoan ... I think ... the woman would probably know my mum and she would probably blab on to someone else ... whereas I don’t find it that embarrassing walking into a clinic and a European woman is there. I think it’s a cultural thing.

A key reason for confidentiality concerns was the perceived link between having had sex and having a smear. Since sex before marriage was culturally unacceptable, it was important for confidentiality to be maintained, so families did not discover unmarried women had had a smear and conclude they had also had premarital sex.
Religion
Some women referred to the effect of fundamentalist religious beliefs as being that God is in charge of their lives, so that it is not necessary to seek medical advice. That is, if you trust in God the disease will not spread but, if it does, then that is God's will. One respondent said:

... my values could be that although I'm 41 and ... needs to be prevented, but I have faith in the Lord of my safe journey where I go. You know I might be saying, you know, my prayers will cure me, so there is no need for me to go forward and ask for a miracle.

Discussion and conclusion
The sensitive nature of cervical screening imposed a significant barrier for most of the respondents, and this sensitivity was most immediately linked to age and length of time in New Zealand. The three main barriers facing the respondents were cultural background, confidentiality and embarrassment. Religious beliefs were also an issue for some women. Cultural background was perceived to have a significant influence on the ease with which the women felt they could access screening information. Cultural concerns were related to the taboo nature of discussing with anyone topics related to sexuality or the reproductive organs. Nearly all the participants expressed these concerns regardless of their age, length of time in New Zealand or education. Presumably, then, it is more difficult for Pacific women to find out information, let alone have a cervical smear, if it is not a topic that is discussed, even among themselves.

Concerns about confidentiality were raised by 15 of the participants. They were in part linked to the cultural expectation of no sex before marriage and the concern of unmarried women that their families should not know they were having a smear. Their concerns were also evident from the preference of many participants for a smear taker not from their culture, to ensure this person would not talk to others and that they would not meet socially. Most women would feel comfortable visiting a Pacific smear-taker only for education and information. This preference has implications for positions such as the MidCentral Health smear taker referred to above.

The participants strongly supported information provided in the Pacific languages and in a manner consistent with Pacific cultures. They also thought it desirable to recognise each Pacific culture individually rather than address them collectively. Participants used both formal and informal communication channels, with face to face communication preferred and visiting a health professional and talking with friends the most common sources of information. The media were not significant sources of information, but there was a preference for receiving additional written information in the form of pamphlets, when in a face to face meeting.

Holding meetings with a health professional present was recommended by the women as the most appropriate and successful way of conveying the message. Either the health professional should be able to speak the language, or else an interpreter should be present. Church and Pacific community networks
were seen as the key ways to reach Pacific women, though there were opposing views on the value of church networks, on account of the difficulties with discussing matters of an intimate nature.

**Designing a communication strategy**

A communication strategy designed to give Pacific women better information on cervical screening would need to differentiate between younger individuals (in this study, 25 years and under) as opposed to older; and between women in the country for less than five years, and those present for longer. At the heart of a communication strategy should be face to face meetings, with a health professional present. A person with a Pacific background would have an important role as an information provider but not as a smear-taker.

Probably the print, radio and TV media would not be especially effective ways of reaching these women, not least because of the sensitivity of the subject and the prohibitions about discussing it openly. It may also be that the media are of greater appeal to people socialised within an individualistic, Western-style cultural framework. Communication strategies designed for groups may be a better choice for cultures grounded in more collectivist assumptions.

The present study indicates the importance of effective cross-cultural research and communication in a country such as New Zealand which is increasingly moving away from previous, monocultural assumptions and coming to terms with its multicultural present and future. Moreover, in a national health system that says it has re-discovered the importance of determining clients' actual needs and then meeting them, research such as the present study is important as one way of giving voice to the particular needs of minority and at-risk groups.

**References**


