

ORIGINAL RESEARCH

Nurse Practitioners' Awareness of Existing Barriers Regarding Breast and Cervical Cancer Screening Among African American Women

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Abstract

Background and Significance: Despite availability of adequate screening protocols, African American (AA) women face increased incidence of breast and cervical cancer due to specific barriers to care. Nurse practitioners (NP) are perfectly positioned to identify and mitigate these specific barriers. **Study Purpose and Aim:** The purpose of this study was to explore NPs' awareness of existing barriers regarding breast and cervical cancer screening among AA women. The aim of the study was to promote NP awareness and understanding of existing barriers to care and the need for evidence-based breast and cervical cancer screening protocols tailored to the needs of AA women. **Methodology:** A qualitative descriptive design was utilized with use of individual semi-structured interviews. Guided by an essentialist/realist framework, Braun and Clarke's reflective thematic analysis method was used to analyze data with an inductive approach and use of semantic or explicit data driven codes. **Findings:** One overarching theme, *I'm Not Sure of Anything in Particular with African American Women as Far as Breast and Cervical Cancer Go*, and three key themes, *Multiple Screening Guidelines: Whatever It's Called, It's a Little Bit Too Late...Less Likely to Get Screening Done*, and *It All Just Comes Down to Awareness*, were generated as a result of the analysis of data. **Strengths and Limitations:** Strengths of this study included use of semi-structured individual interviews which yielded rich data that provided valuable insight into an under-researched area of NP practice concerning cancer screening in AA women. Limitations included study implementation during the Covid-19 pandemic, the data collection time frame, a small sample size, use of convenience sampling, and potential for participant bias. **Conclusion and Recommendations:** The disparity that currently exists within healthcare for AA women regarding breast and cervical cancer screening is alarming with a critical need to be addressed and mitigated. Improved outcomes of breast and cervical cancer screening for AA women may be achieved through NP and patient education, the creation of culturally sensitive and appropriate standardized breast and cervical cancer screening recommendations and guidelines, and increased provider diversity to promote representation.

Keywords: breast, cervical, cancer, screening, African American, nurse practitioner

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According to the American Cancer Society (ACS, 2019a), non-Hispanic Black or African American (AA) individuals have the highest death rate and shortest survival for most cancers of any racial/ethnic group in the United States (U.S.). Among AA women, breast cancer is the most commonly diagnosed cancer and is the second most common cause of death (18%) following lung cancer (20%) (ACS, 2019a). AA women are more likely to die from breast cancer at any age (ACS, 2019b). The rate of breast cancer among AA women is 126.7 per 100,000 (second to Non-Hispanic Whites (NHW) at 130.8 per 100,000) and AA women have the highest breast cancer death rate at 28.4 deaths per 100,000 (ACS, 2019b). Furthermore, almost 21% of breast cancers in AA women are triple negative, double the proportion of this cancer subtype in other racial/ethnic groups, which is a major contributor to the high breast cancer death rate (ACS, 2019b). In AA women, it is estimated that only half (54%) of breast cancers are diagnosed at a local stage compared to 64% in White women (ACS, 2019a).

Regarding cervical cancer, AA women have the second highest age adjusted incidence rate behind Hispanic women, and the highest mortality amongst all races and ethnicities (Belgrave & Abrams, 2016; National Cancer Institute Surveillance, Epidemiology, and End Results Program [NCI SEER], n.d.). AA women are more likely than NHW women to present with advanced stage cervical cancer with a mortality rate twice the rate found in NHW women (Siegel et al., 2014). Due to AA women being more likely to be diagnosed with regional or distant stage disease, they are 80% more likely to die from cervical cancer compared to NHW women (ACS, 2019a). Additionally, the overall 5-year relative survival rate for cervical cancer among AA women is 56% compared to 68% among white women (ACS, 2019a). Racial differences in stage at diagnosis for cervical cancer in AA women may be due to differences in screening quality, having less screening, lack of follow-up regarding abnormal screening findings, lack of insurance, and failure to receive surgery (ACS, 2019a).

Background and Significance

MacLaughlin et al. (2019) found that cervical cancer screening and HPV testing were less likely to be completed by AA women. In contrast, Ford et al. (2021) found that although AA women reported higher cervical cancer screening rates, they had lower levels of screening knowledge and fewer healthcare provider recommendations regarding follow up when an abnormal result was received. Recent cervical cancer screening estimates from the National Cancer Institute (NCI, 2021b) demonstrated that little difference exists regarding screening rates among AA women (74.8%) compared with NHW (75.4%). Interestingly, AA women had the best group rate for receiving a mammogram within the past two years (Office of Disease Prevention and Health Promotion [ODPHP], 2021). AA women also had the highest rate of mammography (79.1%), surpassing the overall mammography rate of 76.4% for the years 1987-2019 (NCI, 2021a). Regardless of these statistics, AA women continue to experience high

morbidity and mortality rates from breast and cervical cancers. The morbidity and mortality disparity may be attributed to ineffective screening guidelines, cost barriers, lack of education, lack of access to healthcare, and existing racial inequities for this particular population within healthcare (Bellinger et al., 2015; Haas et al., 2016; Penner et al., 2016; Radhakrishnan et al., 2017). Currently, a paucity of evidence-based literature exists exploring and examining nurse practitioner (NP) knowledge and understanding of barriers to care for AA women, in relation to breast and cervical cancer screening. With approximately 89% of NPs certified in a primary care specialty, they have the opportunity to investigate barriers to care for AA women to promote quality of care and life (American Association of Nurse Practitioners, 2021).

Despite the importance of and critical need for routine breast and cervical cancer screening among AA women, discrepancies exist among professional organizations suggesting screening guidelines, recommendations, and best practice for health care providers (Radhakrishnan et al., 2017; Zug & Grube, 2017). Currently, the two major discrepancies are when to initiate breast and cervical cancer screening and how often breast and cervical cancer screening should take place. The lack of consistency between screening guidelines may contribute to the delayed diagnosis and treatment of breast and cervical cancer in AA women. Through implementation of effective evidence-based screening protocols, cervical cancer is highly preventable, and breast cancer can be detected at an early stage when treatment is less extensive and more likely to be successful (ACS, 2019a). By providing trusting, cost-effective care and advocating to address barriers to healthcare access and screening, NPs are perfectly positioned to play a prominent and effective role in breast and cervical cancer screening efforts among AA women (Perks et al., 2018; Zug & Grube, 2017). A comprehensive review of nursing and health-related literature revealed that research is needed exploring NPs' awareness and proficiency in breast and cervical cancer screening and barriers to care for AA women.

Study Design and Method

The purpose of this qualitative descriptive study was to explore NPs' awareness of existing barriers regarding breast and cervical screening among AA women. According to Bradshaw et al. (2017), "The use of a qualitative descriptive approach is relevant where information is required directly from those experiencing the phenomenon under investigation..." (p. 1). The aim of the study was to promote NP awareness and understanding of existing barriers to care and the need for evidence-based breast and cervical cancer screening protocols tailored to the needs of AA women. Braun and Clarke's reflexive thematic analysis was utilized to analyze data (Braun & Clarke, 2006; Braun & Clarke, 2013; Braun et al., 2019). Approval for this study was granted from the University at Buffalo's (UB) Institutional Review Board (IRB).

Participant Recruitment and Setting

With permission and assistance from the UB School of Nursing's Director of Student Services, participants were recruited via convenience sampling through utilization of the UB Post-Masters Family Nurse Practitioner (FNP) and Adult-Gerontology Primary Care Nurse Practitioner (AGPCNP) Listserv. Participants were eligible to participate if they were a practicing NP, aged 18 years and older, English speaking, and working in a primary care, obstetrics-gynecology (OB/GYN), or oncology specialty practice. Five NP participants were voluntarily recruited. According to Braun et al. (2019), when determining sample size in research utilizing thematic analysis, the "rule of thumb is to have at least five or six interviews for a very small project, data that are rich, a relatively homogenous sample, a focused research question," and previously unpublished findings (p. 852). All five participants identified as female and their ages ranged from 34 to 53 (mean 43.5 years). The average number of years practicing as an NP was 9.4. Sixty percent (n=3) of participants identified as Caucasian, 20% (n=1) as Black, and 20% (n=1) as Hispanic. Settings included two oncology practices, two women's health practices, and one adult primary care practice.

Data Collection

A semi-structured interview questionnaire was used to collect data (see Table 1). The semi-structured interview questionnaire was developed by the authors guided by findings resulting from the literature review focusing on healthcare provider barriers and facilitators to cervical and breast screening practices for AA women, items found on the National Cancer Institute's (NCI, 2019) *National Survey of Primary Care Physicians' Recommendations & Practice for Breast, Cervical, Colorectal, & Lung Cancer Screening* (permission for adoption/adaption granted with citation), and Leininger's (2002) *Culture Care Theory*. Leininger's (2002) *Culture Care Theory* provided foundational and holistic grounding when creating the semi-structured interview questionnaire by helping the authors reflect on the importance of discovering and explaining diverse and universal cultural based care factors that influence the health and well-being of individuals and groups as well as the significance for using research findings to "...provide culturally congruent, safe, and meaningful care to clients of diverse or similar cultures" (p. 190).

Table 1

Semi-Structured Interview Questionnaire: Sample Questions

1. What published clinical guideline(s) for breast and cervical cancer screening do you currently follow, and why do you follow this organization as opposed to the others? Based on that guideline, how frequently do you personally screen or refer your patients for breast and cervical cancer screening?
2. Describe your stance on clinical breast exams for AA women. Do you perform them in your practice? Do you recommend that your patients do self-breast exams, and if so, how frequently do you recommend it is performed?
3. Tell me about your perceived level of proficiency when it comes to breast and cervical cancer screening and education for AA women.

4. Describe for me the information you provide to your patients concerning breast and cervical cancer screening, and how you present this information.
5. Do you think AA women are more likely to die from breast and cervical cancer? Why or why not?
6. Please explain why or why not you feel your current practice setting promotes or impedes your ability to screen AA women for breast and cervical cancer.
7. Please describe for me some common risks associated with breast and cervical cancer related to AA women.
8. Do you think AA women have a higher or lower incidence of breast/cervical cancer? Why or why not?
9. Do you think AA women are more or less likely to get their screening done? Why or why not?
10. Have you ever referred an AA woman who was at high risk for breast cancer for genetic testing? Why or Why not?
11. Explain to me your understanding of the term "medical mistrust." How do you think this term applies in the context of caring for AA women?
12. What resources are you aware of that you can provide to your female AA patients regarding information on breast and cervical cancer screening?
13. Does your EHR have a decision support feature that reminds you when patients are due for breast and cervical cancer screenings? If so, do you utilize this feature?
14. Do you discuss risk reduction and preventive measures for breast and cervical cancer with your AA patients? What are some of the topics you discuss?
15. How could you go about promoting positive health outcomes and increasing the screening rates for breast and cervical cancer for AA women?
16. What other factors do you feel impact the quality of care received by AA women and influences their breast and cervical cancer screening decisions?

Note. AA=African American; EHR=Electronic Health Record

Individual semi-structured interviews were conducted via a password protected Zoom video-conference meeting by author KB in a private and quiet location at the author's personal residence. Participants were free to choose a private and quiet location of their choice for the interview session. Participants were reminded that study participation was completely voluntary, that they could withdraw from study participation at any time without fear of penalty or reprisal, and that they had the right to refuse to answer any question asked of them. All participant questions were answered prior to interview session implementation and verbal consent was obtained. A scripted standardized introduction was read to all participants prior to interview session implementation. Interviews lasted approximately one hour and were audio-recorded, transcribed verbatim as de-identified by KB, and then were read and re-read by KB while listening to the audio recordings to ensure transcription accuracy, thoroughness, and quality (Braun et al., 2019). Data was stored as per the approved UB IRB protocol.

Data Analysis

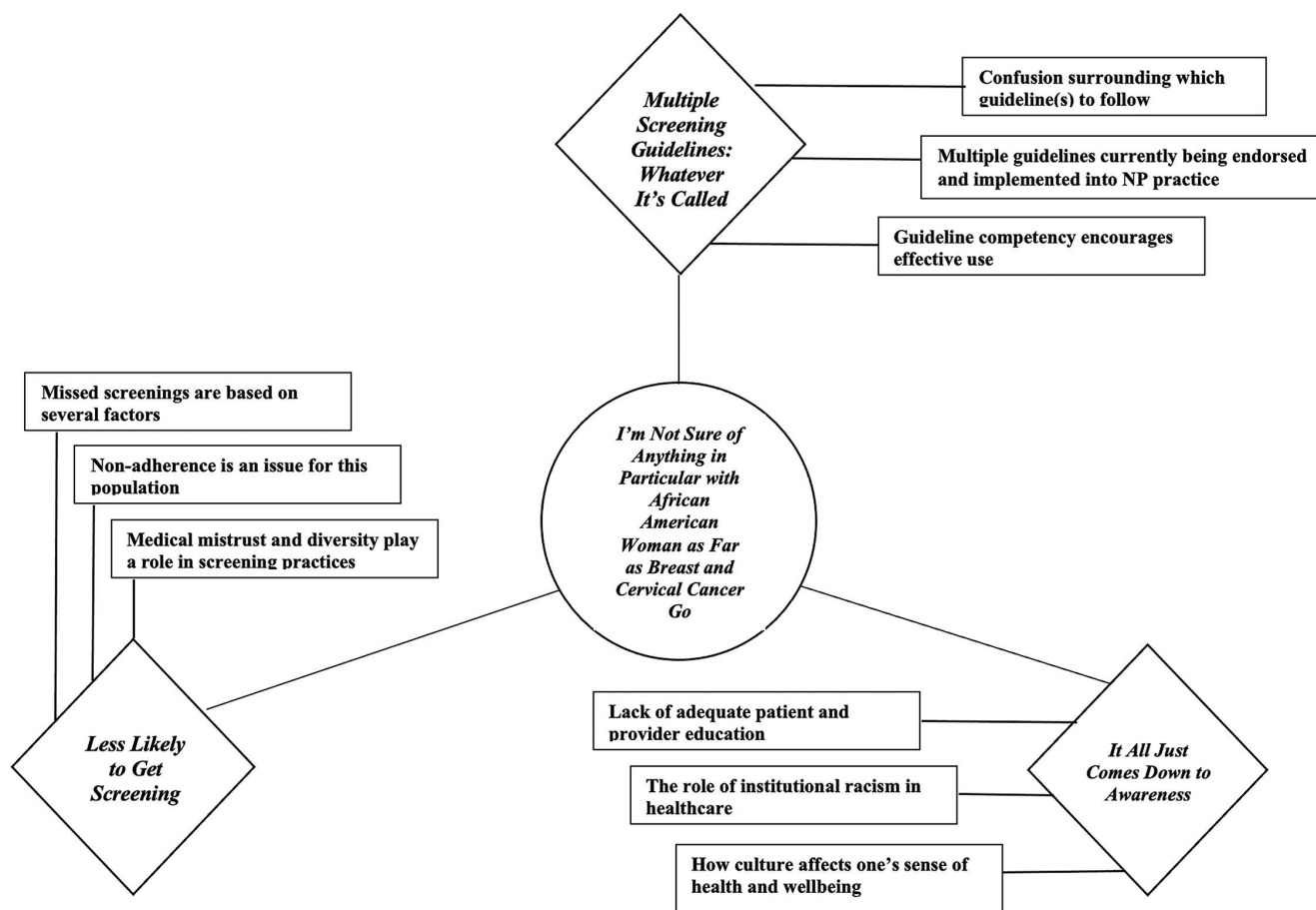
Guided by an essentialist/realist framework, Braun and Clarke's reflexive thematic analysis method was utilized using an inductive or 'bottoms up approach' and use of semantic or explicit data driven codes identified in the dataset (Braun & Clarke, 2006; Braun et al., 2019). According to Braun and Clarke (2006), an essentialist/realist framework supports exploring the experiences, meanings, and reality of the participants in a straightforward manner. Braun and Clarke's reflexive thematic analysis consists of the following six iterative and recursive phases: 1) becoming connected with the dataset through data transcription, familiarization, and immersion; making casual notes and being thoughtful and curious when reading the dataset; 2) generating initial codes across the entire dataset and collating codes to succinctly and systematically identify meaning throughout the dataset; 3) generating candidate or prototype themes; 4) revising and defining candidate themes; producing an early thematic map illustrating theme and subtheme relationships; 5) revising, refining, and defining final themes and theme names so they comprehensively represent the scope and core of each theme and concisely capture what is meaningful in the data related to the research question; and 6) finalizing the data

analysis by checking generated themes against the entire dataset to ensure that they remain close to the data, answer the research question, and tell the participant's story; writing up the final report and finalizing the thematic map (Braun & Clarke, 2006; Braun & Clarke, 2013; Braun et al., 2019).

According to Braun and Clarke (2019), practicing reflexivity is an essential component of the data collection, analysis, and reporting of findings process. Practicing reflexivity entails having each study team member reflect on how their role as a researcher and their personal and professional knowledge, experiences, and positioning may shape or inform the data collection and analysis process and writing the final report (Braun & Clarke, 2013; Braun et al., 2019). Throughout the duration of the study, while working both independently and together as a group, study team members practiced reflexivity. During the first two data analysis phases, study team members worked independently to document their initial notes and codes and then met on a weekly basis to discuss and revise codes and themes until final themes were generated, the final report was written, and the thematic map was finalized (Figure 1).

Figure 1

Thematic Map: Perceived Barriers and Facilitators of Breast and Cervical Cancer Screening for AA Women among NPs



Findings

One overarching theme, *I'm Not Sure of Anything in Particular with African American Women as Far as Breast and Cervical Cancer Go*, and three key themes, *Multiple Screening Guidelines: Whatever It's Called, It's a Little Bit Too Late...Less Likely to Get Screening Done*, and *It All Just Comes Down to Awareness*, were generated as a result of the analysis of data. The following presents the findings.

Overarching Theme:

I'm Not Sure of Anything in Particular with African American Women as Far as Breast and Cervical Cancer Go

The overarching theme captured the main idea threaded throughout the dataset and within the three key themes. Participant 2 voiced, "... I'm not sure of anything in particular with AA women as far as breast and cervical cancer go. Um, that I don't know... I did not know that AA women had higher rates of that [breast and cervical cancer]..." Several participants stated that they do not modify anything in their plan of care when treating and screening AA women for breast and cervical cancer. Participants commented, "... I don't remember if there's anything specific to AA women that the risk factors are different... I don't think there's anything specific...No...[screening is not different for AA women] (P3)"; "I don't have anything different for African American women...(P1)"; and "I educate everybody... you got a cervix and you got breasts [sic] and you need to go get yourself checked" (P2).

When asked about their breast and cervical screening practices and recommendations for AA women, all five participants stated that they base their practice and recommendations on personal experiences as a female receiving screening, on recommendations set forth by their chosen organizations, and that their screening practice was uniform for all women regardless of race or ethnicity. Participant 4 noted,

I guess I would say I would just go on myself...I would say all women should have, visit their GYN once a year and have a pap at least once every three years...I don't have a ton of knowledge about it...I think that being a female, I'm very aware of it [breast and cervical screening] um, so I think that is on my side versus a male colleague would be.

Participant 5 stated, "So we, basically, we do everyone, not only just AA women, we just follow the guidelines for everyone, white, Hispanics." Finally, Participant 3 reflected,

Uh, I think they have a higher incidence [breast and cervical cancer]....I mean, when I think about it, I really don't know if I have a specific plan of care that would be specifically for African Americans...I mean, I guess I talk to, again about you know, general screening. Do I do it in a different way? I don't, which is, I guess I should maybe, you know, start focusing on you know, some higher risk situations they have but honestly, I don't think I do.

Several participants acknowledged that the current state of health for AA women is not optimal and that there stands room to improve the health of this population. Participated 4 remarked, "Um, I would say that it [current state of health for AA women] needs to be improved upon...So I would say not good and it could be improved upon" and Participant 2 noted, "It's [current

state of health for AA women] not good. And the current state of this country unfortunately is making it harder for them to seek healthcare."

Theme 1: Multiple Screening Guidelines: Whatever It's Called

Theme 1, *Multiple Screening Guidelines: Whatever It's Called*, captured the NPs' confusion as to which breast and cervical screening guidelines they should be following. Participant 4 expressed, "Um, I guess I don't follow any in particular. I probably do the US, um, whatever it's called..." and Participant 1 noted, "It's AC...ACCC...I'm gonna [sic] cheat cause it's on my phone (laughing), it's ASCC something. It has the little, it gives you the algorithms, the ASCCP guidelines, the management and the screening guidelines because they are so confusing."

When participants were asked to identify what screening guidelines for breast and cervical cancer they used in practice, their answers revealed that the following multiple screening guidelines were being followed: American Cancer Society (ACS), American Society for Colposcopy and Cervical Pathology (ASCCP), American College of Obstetricians and Gynecologists (ACOG), U.S. Preventive Services Task Force (USPSTF), the American Academy of Family Physicians (AAFP), and an institution specific guideline. The USPSTF was cited as the most frequently followed guideline. All five participants discussed the importance of staying updated on current guidelines to promote best screening practices for their patients, regardless of the guideline followed. When asked how proficiency could be maintained regarding cervical and breast cancer screening, Participant 4 remarked, "I think I could brush up on my guidelines, of course...I think that would be something good to do in every aspect."

Theme 2: It's a Little Bit Too Late...Less Likely to Get Screening Done

Theme 2, *It's a Little Bit Too Late... Less Likely to Get Screening Done*, captured the participants' belief that AA women are less likely to get their cervical and breast cancer screenings done. Participant 5 stated, "There's a fair amount of them [AA women] that they don't come in at all and when they come in, it's a little bit too late... Less likely to get screening done." All five participants reported that although most of their AA patients get their breast and cervical cancer screenings done on a regular basis, many AA women miss screenings due to a lack of healthcare provider diversity and AA representation, medical mistrust, and non-adherence. With regard to the lack of provider diversity and AA representation, Participant 1, the only AA participant, reflected,

... 'cause [sic] usually myself, I'm the only brown face that I see at my job every day...I think it depends on presentation, um, and, representation. The few AA female patients that I have do all of their screenings. And this is where like I feel representation plays a role because they see a black face telling them that this is important and that they should do it, and they go do it....I think that if there was better representation...AA women would definitely get their screenings and that they probably don't at the level they should because they're not 1., going to the office to get any screening and 2., there's not enough, um, black and brown faces out there. There's just not enough representation.

Regarding medical mistrust, Participant 1's response was the only response that focused on why AA women may distrust their providers:

Medical mistrust...I think they're [AA women] certainly prone to it. Um, just they don't think they need screening, they don't trust what they read on the internet, they don't trust their doctor; um...I think it's hard to find a doctor you completely trust...You just have to find somebody you like.

Several participants either never heard of medical mistrust or incorrectly described medical mistrust. Participant 3 remarked,

Um, I never heard that term before, but it sounds very interesting...when they come in for a visit, they are coming in with a whole history of mistrust from other clinics...I guess that's what it would be is mistrust from...not being taken seriously, not having their problems addressed.

Participant 5 expressed,

Not trusting the care? Not trusting the...yeah, I guess the care? Not believing it...I'm sure there is a lot of patients [AA women] out there who do not trust, do not believe. They think that you know, nothing is going to happen or sometimes they just don't believe the system or you know, don't wanna [sic] come to the doctor as well because there is yeah, exactly, no trust in anybody. Yeah, I'm sure it plays a big role.

Screening non-adherence was another issue identified by all five participants as a breast and cervical cancer screening barrier among AA women. Factors contributing to screening non-adherence among AA women was described by participants as lack of transportation, trouble getting time off from work, limited access to childcare, misplacing their prescription, and not making an appointment. Two participants commented, "I would say transportation, getting time off work, and actually and uh, child care [factors influencing care]" (P3) and "That's because they never went so where they misplaced their prescription, where they didn't make the appointment, they didn't have any time or you know for multiple reasons I find that that's you know, goes into the cracks sometimes, just to get the mammogram" (P5).

Theme 3: It All Just Comes Down to Awareness

The final theme, theme 3, *It All Just Comes Down to Awareness*, captured the participants' perceptions of how the health of AA women could be improved on including how to increase their breast and cervical cancer screening rates. Participant 1 simply stated, "Um, I think it all just comes down to awareness." According to all five participants, breast and cervical cancer screening awareness encompassed the need for community outreach, use of smart phones and social media to promote screenings, improved patient education, acknowledging one's own implicit biases, understanding institutional racism and the role it may play in shaping healthcare outcomes for AA women, implementing shared decision making in the workplace, fostering a sense of healthcare provider trust and approachability, and recognizing the important role both faith and religion play in the lives of AA women. With regard to the need for community outreach, Participant 1 spoke about the cultural importance that word of mouth plays in AA

communities as well as the need to constantly remind AA women to get their screening done, commenting,

...when you do something ad nauseum...so maybe if we were overkill with awareness. Like maybe if there were commercials, if there were big hospitals in rural communities that went out and just went into the community, if people got so sick of hearing about 'Oh, I need to get my pap smear', 'Okay, ugh, I gotta [sic] go get my mammo [sic], oh God.' Like if they were put to the point where they were just sick of hearing about it, they would do it.

Most participants acknowledged having awareness of their implicit bias and how their biases impact the care they provide to patients. Participant 2 remarked,

....as much as I would like to sit here and say I don't have any [biases], that would be a lie because everyone has biases. I mean whether or not I think it's how we overcome our own biases and you know, we deal with it, makes us a practitioner...

Participant 3 reflected,

I almost feel like I get a little protective of my AA patients just because I feel like I don't know if they know how bad, you know, the prejudice is out there....I don't know if they really know...I'm sure they do but you know, these are my friends. So, I feel a little bit protective when I see my AA patients come in.

Participants had general knowledge regarding what institutional racism is but did not substantially understand its impact on their AA female patient population. Participant 2 stated, "You mean where Black people are treated like second class citizens just because of their color of their skin? [Chuckles]. It's still prevalent even though it's 2020. It sucks, but it's still there..." Participant 3 noted,

I wonder if patients really know how bad it [institutional racism] is 'cause [sic] I don't think they know. And it's just uh, and it's not something that's overt, it can be kind of under the radar, um, but I think it's just insidiously injected into everything.

Among all five participants, there was awareness of the need to be open, approachable, nonjudgmental, and honest to help foster trusting and constructive therapeutic partnerships with their AA patients. Participant 2 commented, "I try to...look approachable, I try to be approachable. I try to keep my mouth shut. I try not to judge" and Participant 4 noted,

I feel like I try to be, have a good relationship with my patients, you know I see them frequently so I, they know me by name and we talk all the time so I just try to be honest and I feel like that's the best way in healthcare is to be honest.

Finally, all five participants identified the important role that both faith and religion play in the lives of their AA female patients and how they help support promoting a deeper patient-provider connection. For the sake of building rapport and cultivating therapeutic and trusting patient-provider relationships, participants stated that they were comfortable praying with their AA patients, even if were not personally religious. Participant 5 remarked, "It's [prayer] cultural. So, you know, something they believe and they

feel more comfortable with and if you believe it then sometimes that helps. And it will make you feel more comfortable. That's fine, yeah" and Participant 3 reflected,

Oh! We've done that a few times. Yeah, I feel fine...I find that a lot of my AA patients are very faith-based. And you have, um, not that you have to, but if you're open to it as a provider, to talk to them on that level you know is, uh, it gives you that bond, it gives you that patient interaction. That deeper patient interaction.

Discussion

Throughout the entire interview process, all five NPs frequently commented that they learned something from participating in this study. Study findings revealed that although the NPs felt proficient in their care of AA women and the quality of their interactions with this population, they identified gaps in their clinical knowledge regarding utilizing available breast and cervical screening guidelines and protocols. Many participants felt inspired to write topics down that were being discussed during their interview for further personal reflection, stating that they were going to ask their specific organization and/or workplace why certain measures for promoting positive patient outcomes regarding breast and cervical screening for AA women were not in place.

Several participants stated that they do not modify anything in their plan of care when treating and screening AA women for breast and cervical cancer, that their breast and cervical cancer screening practice was uniform for all women regardless of race or ethnicity, and that they based their approach to care for AA women on personal experiences as a female receiving screening and/or on recommendations set forth by their workplace. All five participants admitted confusion as to which breast and cervical screening guidelines they should be following and had a difficult time verbalizing how the ethnicity and cultural beliefs and values of their AA patients could be incorporated into their plan of care and breast and cervical screening recommendations and practices. Current research is needed focusing on how to improve culturally sensitive and appropriate breast and cervical cancer screening guidelines, recommendations, and practices for NPs caring for AA women (Haddad & Sweeting, 2017; Kidd et al., 2015; Viens et al., 2017). To reduce confusion, further research is also needed examining and exploring best evidence-based approaches that can be implemented to foster and improve collaboration between NPs and their female AA patients to increase breast and cervical screenings and promote individualized patient-centered care (Haddad & Sweeting, 2017; Kidd et al., 2015).

Many AA individuals experience stigma, fear, socioeconomic and political disparities, and structural racism which have negatively impacted their health outcomes, quality of life, overall standard of living, and trust in the current healthcare system (ACS, 2019a; Bellinger et al., 2015; Gibson et al., 2019; Newman & Kaljee, 2017). According to Penner et al. (2016), patients will be suspicious of a system when they do not trust it. When healthcare providers express genuine interest and empathy with their patients, patients report feeling a sense of trust and comfort with the provider-patient interaction and relationship (Torres et al., 2016; Bellinger et al., 2015; Haas et al., 2016; Samuel et

al., 2018). Although many AA women rely on the expertise and opinion of their NP and/or healthcare provider to make decisions about their health care and routine screening practices, a level of medical mistrust continues to exist stemming from a long history of discrimination, racism, poor treatment, and socioeconomic and political disparities (Bellinger et al., 2015; Gibson et al., 2019; Head et al., 2017; Molina et al., 2015; Torres et al., 2016). Participants in this study acknowledged that the current state of health for AA women remains sub-optimal and deficient. To improve the health of this population, all participants recognized that a critical need exists for NPs to acknowledge their existing biases, to be educated about the root causes of medical mistrust, the existing fear and stigma among African Americans resulting from historical health care inequities and inequalities, and for NPs to promote AA representation both in their profession as well as in other health related disciplines. Among all five participants, there was awareness of the need to be open, approachable, nonjudgmental, and honest with their AA patients to help foster trusting and constructive therapeutic partnerships that emphasize empowerment, self-efficacy, and informed decision making while staying current on screening protocols, guidelines, and recommendations.

Finally, screening non-adherence was identified by all five participants as a breast and cervical cancer screening barrier among AA women. Interestingly, this discovery contradicted findings resulting from the literature review which indicated that AA women tend to have better breast and cervical screening rates than their counterparts. Factors identified as contributing to screening non-adherence among AA women were described by participants as lack of transportation, trouble getting time off from work, limited access to childcare, misplacing their prescription, and not making an appointment. Participants' perceptions of how breast and cervical cancer screening non-adherence could be improved included better community outreach, use of smartphones, use of social media platforms to promote screenings, and improved approaches to patient-provider education. Regarding the need for community outreach, Participant 1 specifically spoke about how word of mouth plays an important role for promoting breast and cervical cancer screening rates among AA women.

Study Strengths and Limitations

A strength of this qualitative descriptive study was use of semi-structured individual interviews to gain insight into breast and cervical cancer screening barriers for AA women among NPs working with this vulnerable population. Despite the small sample size, rich data resulted from the interviews. Findings resulting from this study strongly support the critical need for more research exploring and examining NP awareness of barriers to breast and cervical cancer screening among AA women as well as research exploring and examining breast and cervical screening facilitators and barriers from the voices of AA women themselves. A major study limitation was that this study was conducted during the 2020 Covid-19 pandemic. The pandemic may have contributed to the reason that only five NPs volunteered to participate. Many participants discussed how practicing during the pandemic greatly impacted their care and their patients' perceptions of seeking healthcare. Study limitations also included

use of convenience sampling, recruiting participants from only one school of nursing Listserv, a limited time frame for collecting data, the inability to generalize study findings due to the small sample size, and risk of participant bias due to the reporting of personal practice habits which may have been altered regarding true practice approaches. Further research should take place using mixed-methods approaches and larger sample sizes to advance evidence-based knowledge and understanding regarding care and breast and cervical cancer screening practices for AA women among NPs.

Conclusion and Recommendations

This study was timely in that it was conducted during a time in this country where there has been great movement and action regarding the need to address and bring more awareness to the importance of diversity and inclusion. Previous research supports that many AA patients prefer to work with healthcare providers that they can trust and relate to, especially providers 'who look like me'. This necessitates and supports the need for more diversity in the NP workforce (Penner et al., 2016). NPs strive towards positively impacting healthcare and improving health outcomes for their patient populations. As a critical first step toward change, advanced nursing degree programs need to actively work toward cultivating an ethnically diverse workforce that reflects and represents individuals from all walks of life. NPs, as well as other healthcare providers, need to be educated on culturally specific barriers and risk factors for AA women concerning breast and cervical cancer. Additionally, NPs and other healthcare providers need to be aware of the role HPV screening and prevention through vaccination plays in cervical cancer in order to adequately educate their patients. This topic was only briefly touched upon in the present study. NPs are in a unique position to guide AA women in their education and decision-making processes regarding breast and cervical cancer screening and prevention. To advocate and promote best care and practice, NPs need to be educated and well-versed on how to provide culturally appropriate and sensitive care to diverse patient populations.

Finally, to promote and support optimal health and well-being for AA women, future breast and cervical cancer screening guidelines and recommendations need to take ethnicity and cultural beliefs, practices, and values into consideration when making recommendations. It is known that AA women have unique cancer risk factors and that breast and cervical screening efforts need to take place at an earlier age than what is currently recommended. To the authors' knowledge, there are no screening guidelines available that are specifically tailored to the needs of AA women. Currently, the World Health Organization (WHO, 2021) recommends initiating cervical cancer screening at age 30 with a frequency of every 5-10 years when HPV DNA detection is used. This varies from guidelines and recommendations presently available in the U.S., further exemplifying differences in what is considered to be best practice. To reduce confusion among NPs and other healthcare providers caring for AA women, standardization of breast and cervical cancer recommendations and guidelines among professional issuing organizations is needed. Additionally, further research is needed exploring if a tailored breast and cervical cancer screening protocol would improve morbidity and

mortality rates among AA women. It is the authors' sincere hope that the knowledge and insight gained from findings of this study encourage and promote future evidence-based work and research aimed at improving the quality of health care provided to AA women to promote their quality of life.

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