

# CHAPTER 1

## Orientation

### 1.1 INTRODUCTION

The new democratic South African government has changed the focus of health care provision from curative to preventative health care through primary health care (PHC). The nursing fraternities in the new national health systems (NHS) are currently the sole providers of PHC and mainly in the public health care sector. The implementation of PHC in the public health sector is proven to be more effective. However, socioeconomic factors (such as affordability, accessibility and availability of private health care facilities) in Soshanguve, in the Gauteng Province of South Africa, have resulted in a situation in which those who can afford to pay and those who are insured by medical schemes find it more convenient to consult with a private medical practitioner even for cervical screening.

Considering the success the public health services has achieved in PHC provision, it is wise for private practitioners to consider it as the best approach in health care delivery. The situation in the private health sector is such that the private medical practitioner is the first in line to make contact with the patient. Since private medical practitioners concentrate mainly on curing diseases, patients who, in fact, need primary health care are disadvantaged. This makes it necessary for private medical care providers to offer PHC services as their first measure of service. Medical practitioners should assume the role of health promoter and educate patients about their illnesses, treatment, self-care activities and planning for continuity of care.

### 1.2 BACKGROUND TO THE STUDY

Cervical cancer is the second most common form of cancer among women in South Africa, with approximately 1 in every 41 women developing the lesions during their lifetime (Department of Health (DOH) 1999:1). Mqoqi, Kellett, Madhoo and Sitas (2003:18) report that cancer of the cervix is the leading cancer affecting women in South Africa and remains a leading cancer

among Black females. According to Mqoqi et al (2003:18), "in 1996, 4 835 new cases of cancer of the cervix were reported. The *crude incidence rate* (CIR) was 22,9 per 100 000 and the *age standardised rate* (ASR) was 29,5 per 100 000. In 1997, 5 318 new cancer cases were reported and these made a CIR of 24,5 per 100 000 and the ASP of 31 per 100 000. The *lifetime risk* (LTR) of developing cancer of the cervix in women aged 0-74 years was 1 in 31 in 1996 and 1 in 29 in 1997."

In developing countries, cervical cancer is the third most common women's reproductive health problem and a leading cause of death among women. It is the second most common cancer in women throughout the world, with approximately 500 000 new cases identified each year, many of them fatal (World Health Organization (WHO) 1988:1). It kills 200 000 women each year, 80% of whom are in developing countries. Rates are the highest in Central America and Sub-Saharan Africa. Each year, about 15 000 women in the United States learn that they have cancer of the cervix with a significant proportion of them not having had a Papanicolaou (Pap) smear regularly, thus resulting in 4 000 deaths (National Cancer Institute (NCI) 1994:1).

The epidemiology of cervical cancer shows wide geographic variation in occurrence as well as within local populations (Gray 1995:699). The geographic areas of underserved and under-screened women present with high incidence and mortality rates from cervical cancer. This could be due to the fact that women in these regions fail to access the screening facilities. Lack of knowledge, ignorance, unavailability of screening facilities, affordability, and cultural barriers are among the obstacles to receiving health care. According to Mqoqi et al (2003:18), cervical cancer was consistently the leader, comprising on average 18,5% of all female cancer cases in 1996 and 1997 while Black women constituted approximately 85% of all cervical cancer cases.

The risk factors associated with the development of cervical cancer are more common in teenagers and young women. These groups often engage in high risk sexual behaviours and lifestyles (for example, smoking) that predispose them to cervical cancer and are thus more vulnerable. According to Gray (1995:85), "*age-specific rates*, however, show an increase of cervical cancer cases in young women, particularly those aged 25-29". As a result, *screening* younger women can prevent cervical cancer from developing as *pre-cancerous* lesions could be more prevalent in this age group. Fitch, Greenberg and Cava (1998:442) state that most high-risk

women, elderly women and lower income women are not frequently included in the group receiving Pap smears, yet the incidence and mortality from cancer of the cervix are great among the poor and in some ethnic groups.

“Economic and social class factors are closely related. Research has shown that disease, disability and death are far more common in the lowest socio-economic classes and that rates decline steadily as one moves up the social class ladder” (De Haan 1996:26). Social class differences include poverty, low standards of education, and failure to access and utilise the health care services. The lack of such services for low social classes predisposes most poor Black women to the risk of developing cervical cancer. Cervical cancer is thus more common among women in developing than in developed countries.

The mortality rates due to cervical cancer are high in lower economic classes hence this is the type commonly found among the poor. Lack of resources and availability of treatment, low community awareness, poor quality of Pap smears and inadequate follow-up rates are foremost among the documented obstacles to successful cervical cancer screening (Smith, Moodley & Hoffman 2003:32). These constraints that affect cervical cancer screening programme implementation may result from financial concerns, cultural constraints, availability of follow-up and referral services and treatment facilities. However, McFarland (2003:167) argues that “in South Africa, infrequent use of Pap smear tests is attributed to factors such as lack of national cytology screening programmes, financial constraints, and lack of adequately trained health personnel”.

The participation of the targeted community may be affected partly by their experiences with other screening programmes. The means used to inform the women about the programme, the accessibility of the screening location, availability of transportation, convenience of the programme hours, cultural sensitivity of service delivery and the design of the programme may also discourage women from participating.

### 1.3 RESEARCH PROBLEM AND PROBLEM STATEMENT

In its Strategic Framework (1999-2004) the South African National DOH indicated their intention to improve women's health by strengthening and expanding national programme for cervical cancer awareness and screening. The screening programme targets women 30 years and older (DOH 1999:3). The goal is to screen at least 70% of the women in the target age group nationally within ten years. Although the programme was implemented in 1999 the target is difficult to reach despite the fact that women would receive three free Pap smears per lifetime.

In their study of barriers to cervical cancer screening in rural Mexico, Watkins, Gabali, Winkleby, Gaona and Lebaron (2002:475) report that mortality from cervical cancer has not declined in Mexico as greatly as in other countries despite having a national cervical cancer early detection programme for twenty-four years. They state that "in fact, from 1980-1990, cervical cancer mortality steadily increased in some age groups, suggesting that the early detection program has had little impact on the control of cervical cancer and that other factors than access to health care need to be addressed". In their study of knowledge of cervical cancer screening and use of cervical facilities among women in Durban, KwaZulu-Natal, Wellensiek, Moodley, Moodley and Nkwanyana (2002:376) state that "although screening facilities are available in certain parts of developing countries, the incidence of cervical cancer remains very high and many patients present with late stage disease".

The researcher is a registered cytotechnologist who practised privately in 1996, rendering cervical cytology screening services to private medical practitioners. The services were available to medical practitioners practising in Atteridgeville, Ga-Rankuwa, Soshanguve and Hammanskraal near Pretoria (Tshwane) in Gauteng. However, the researcher did not receive a substantial number of Pap smear specimens from those practices with the exception of a gynaecologist practising in Hammanskraal. The researcher was concerned that screening was not being conducted although women find it convenient to use the services of private medical practitioners. Perry and Burgess (2002:14) state that patients who show symptoms will often present to health services and most commonly to the general practitioner in the first instance. This emphasises the importance of PHC provision by private medical practitioners.

Private health care practices are highly concentrated in Soshanguve. Patients who can afford to pay and those on medical aid schemes thus find it convenient to use private medical practitioners for health care. Perry and Burgess (2002:14) maintain that the first contact with health professionals concerning a symptom that may indicate cancer is more likely to happen in the general practitioner's surgery. It is thus imperative that private health care providers educate patients, especially those at risk of cervical cancer. This should be done even if the patients' visits are for unrelated conditions.

The women using the private health care services were perhaps not having Pap smears because they were not aware of cervical cancer and the tool used for screening the condition. Another reason could be that the medical practitioners did not recommend a Pap smear. Fitch et al (1988:442) state that the efficiency of cervical cancer screening is affected by factors such as women's knowledge about the Pap smear and its purpose, understanding of the benefits of the test and early detection, and access to information by means of education as well as whether the physician recommended or did not recommend the Pap smear.

The researcher realised that most of the private medical practitioners in Soshanguve and other townships are men and assumed that the women probably felt uncomfortable about being screened by male service providers. Watkins et al (2002:476) state that for rural Mexican women, the primary barrier to obtaining a Pap smear was anxiety regarding physical privacy. In their study they determined the level of participation by measuring *pena*, which means embarrassment and anxiety about showing one's private parts. They go on to say that this feeling could be lessened if a female health care provider conducted the Pap smear.

There are factors that prevent cervical cancer screening programme implementation from being effective. There is, however, no data available about these factors. A qualitative study was therefore undertaken to determine the factors in private health care provision in Soshanguve which influenced the implementation of a cervical cancer screening programme, in order to provide suitable guidelines for a successful screening programme.

## 1.4 AIM OF THE STUDY

The aim of the study was to describe the factors that influence cervical cancer screening programme implementation in private health care services in Soshanguve.

## 1.5 RESEARCH OBJECTIVES

The following research objectives were formulated in order to guide the researcher. The study wished to

- (1) explore and describe factors influencing cervical cancer screening programme implementation in private health care services in Soshanguve
- (2) formulate guidelines for a cervical cancer screening programme in private health care services

## 1.6 SIGNIFICANCE OF THE STUDY

The study determines factors which contribute to the efficiency and inefficiency of the cervical cancer screening programme among private medical practitioners in Soshanguve. The findings will lead to the formulation of guidelines for a successful screening programme that can be implemented by private medical practitioners. This will promote and encourage cervical screening in private settings thereby increasing the targeted coverage proposed by the government in its strategic planning. The increased coverage will also reduce the impact of cervical cancer on women as lesions will be detected sooner and treatment administered in time.

## 1.7 DEFINITIONS OF TERMS USED IN THE STUDY

### ◆ Cancer

Perry and Burgess (2002:9) define cancer as a collection of over two hundred diseases which have the potential to spread or metastasise.

### ◆ **Cervical screening**

The utilisation of smears obtained from the female genital tract (cervix, vagina) of patients that do not show any symptoms of cervical cancer so as to detect early non-cancerous lesions that are treatable, thus preventing cervical cancer from developing.

### ◆ **Private health care sectors**

In this study private health care sectors are consulting rooms that are owned and serviced by independent medical practitioners who are registered as private practitioners with the Health Professionals Council of South Africa (HPCSA) and offer medical services at a cost.

## **1.8 RESEARCH DESIGN AND METHODOLOGY**

The study was explorative, descriptive and contextual, adopting a qualitative approach. The researcher used interviews, field notes taken and observations as data collection techniques.

## **1.9 OUTLINE OF THE STUDY**

Chapter 1 introduces the study and discusses the background to the problem as well as the purpose and significance of the study.

Chapter 2 discusses the literature review undertaken by the researcher.

Chapter 3 describes the research methodology used in the study.

Chapter 4 presents the findings of the study.

Chapter 5 concludes the study, discusses the guidelines on the implementation of a cervical cancer screening programme together with the limitations of the study, and makes recommendations for further study.

## 1.10 CONCLUSION

This chapter discussed the background to the problem that led the researcher to conduct the study, stated its purpose and objectives, defined terms used in the study and outlined the study.

Chapter 2 covers the literature review undertaken by the researcher.