

CHAPTER 4

Research findings

4.1 INTRODUCTION

This chapter discusses the findings from the interviews (qualitative data). The data was manually transcribed, sorted into meaningful segments, and categorised into themes in order to answer the set objectives. The data analysis was labour intensive and time consuming. The research question was: "What factors influence the implementation of a cervical screening programme among private medical practitioners?"

4.2 SAMPLE DESCRIPTION

During the study, six medical practitioners were interviewed. The semi-structured interviews took place in their consulting rooms and demographic data was obtained by means of a structured questionnaire.

4.3 DEMOGRAPHIC DATA

The respondents' demographic data was obtained by means of a structured questionnaire. Table 4.1 represents the characteristics of the sample and their frequencies.

Table 4.1 Demographic information about the respondents (sample description (n=6))

Characteristic	Frequency (n)
Sex	
Female	1
Male	5
Qualifying institution	
Medical University of South Africa (Medunsa)	5
University of the Witwatersrand (WITS)	1
Year of qualification	
No response	1
1991	3
1995	1
2000	1
Length of internship/service in gynaecology clinic	
No response	1
3 months	1
6 months	1
7 months	1
12 months	1
6 years	1
Duration in private practice	
No response	1
3 months	1
1 year	1
6 years	1
11 years	1
12 years	1
Location of private practice	
Block F	1
Block GG	2
Block L	1
Block LL	1
Block M	1

Of the respondents, five were males and one was female. However, one respondent did not complete the demographic questionnaire. All the respondents were Black, and their ages ranged from 38 to 44 years, with only one respondent not indicating his age. The respondents' medical practices were located in the following sections of Soshanguve: blocks F, GG, M, L and LL.

Five of the respondents qualified at the Medical University of South Africa (Medunsa) and one qualified at the University of the Witwatersrand (WITS). Three qualified in 1991, one in 1995 and one in 2000. Two of the respondents served in the public sector for one year, one for two years, one for about three years, one for nine years and one respondent did not furnish the researcher

with the information. Of the respondents, one had spent three months, one had spent six months, one had spent seven months, one had spent twelve months, and one had spent six years in a gynaecological ward/clinic during internship and community service while one did not answer the question. With regard to how long the respondents had been in private practice, one gave no response, one had been in private practice for three months, one for one year, one for six years, one for eleven years and one for twelve years.

4.4 FIELD EXPERIENCE

During data collection the researcher made and noted observations of settings. The waiting rooms had adequate seating and a television set that was turned on and facing the patients. The temperature in the waiting rooms was controlled with fans and air conditioners and the consulting rooms kept warm with heaters. No posters informing patients about cervical cancer, cervical cancer screening or Pap smears were displayed in the waiting rooms. In some waiting rooms there were price lists showing the cash price for a Pap smear. Most of the patients found in the waiting rooms were mainly women of childbearing age (carrying small babies), some middle aged women and some older women.

In one practice, consultation was done by two medical practitioners in separate examination rooms. Patient consultations lasted about ten minutes on average. In most of the consulting rooms, the examination bed was not in a separate room, but was just opposite or next to the medical practitioner's desk. In all six practices, two or three people worked at the reception desk. One had one female and one male receptionist, one had two female and one male receptionist, one had two male receptionists, and the last two practices had one and three female receptionists respectively.

To interview a medical practitioner, the researcher made appointments; however, she had to wait in a queue with patients. On one occasion the researcher was allowed in by the receptionist and when the medical practitioner realised there were still patients in the waiting room, she asked that the patients be allowed to come in first. On one occasion the researcher was allowed in after queuing for about ten to fifteen minutes, and the medical practitioner told the researcher she had to come back for the responses as she wished to prepare herself for the interview. However, the

researcher did not go back to that particular medical practitioner as she was always too busy for the researcher to make an appointment. One medical practitioner did not allow the researcher in and requested that an appointment be made before the medical practitioner could be interviewed. However, the respondents whom the researcher interviewed were very cooperative and keen to participate in the study. The medical practices were accessible as the roads were in excellent condition. Most of the practices were located in residential areas and close to the taxi and bus routes. They were also identifiable by advertising boards, indicating the nature of the practice, at the entrances. Some of the boards also indicated the name of the medical practitioner. One medical practice had a clinical pathology laboratory owned by a medical technologist in the complex (medical centre).

4.5 RESEARCH FINDINGS

Two main themes emerged as the data was categorised:

- (1) barriers to the implementation of a cervical cancer screening programme among private medical practitioners in Soshanguve
- (2) factors that facilitate the implementation of a cervical cancer screening programme among private medical practitioners in Soshanguve

4.5.1 Theme 1: Barriers to the implementation of a cervical cancer screening programme among private medical practitioners in Soshanguve

Barriers to the implementation of a cervical cancer screening programme were identified among medical practitioners as well as the patients (table 4.2).

Table 4.2 Barriers to the implementation of the cervical cancer screening programme (n=6)

Factors	Frequency (n)
Lack of awareness among medical practitioners	1
Lack of awareness among patients	4
Age of both medical practitioners and patients	1
Gender of medical practitioners	2
Lack of interest on the part of medical practitioners	2
Patients' refusal to have a Pap smear done	2
Failure of medical practitioners to inform patients	3
Cost of doing a Pap smear (affordability)	4

4.5.1.1 Lack of awareness

Lack of awareness was identified as a barrier to screening on the part of both the medical practitioners and the patients.

4.5.1.1.1 Lack of awareness among medical practitioners

The medical practitioners reported several factors that hindered the efficient implementation of a cervical screening programme by them. The respondents emphasised a lack of awareness of cervical cancer as a barrier to screening. They indicated that as medical practitioners they lacked awareness of cervical cancer and the screening programme.

It was also evident that the private medical practitioners lacked knowledge about cervical screening and the purpose of a Pap smear. One respondent mentioned that a Pap smear was evaluated by a microbiologist and another indicated that Pap smears are sent to a histology

laboratory for evaluation. One respondent stated that he did not need a Pap smear to diagnose a STD, unless if what he was treating was resistant to treatment then he would do a Pap smear to check for drug sensitivity. The findings were in line with McFarland's (2003:174) statement that Pap smear tests were used mostly as diagnostic rather than a screening test. One respondent commented:

But to go back to the issue of awareness, I don't think much has been done especially, you know, in our settings. So I think there is also lack of awareness from service providers or health providers to, like, voluntarily suggest to the patient to go for that.

4.5.1.1.2 *Lack of awareness among patients*

The respondents indicated that women were not that much informed and aware of a Pap smear either. They reported that patients did not know about cervical cancer and its predisposing factors. The medical practitioners felt that the awareness campaign about cervical cancer screening was not effective. This concurs with Wellensiek et al (2002:381) who indicate that most women who have heard the term "Pap smear" do not understand the purpose of the procedure. In their study in Durban, KwaZulu-Natal, South Africa, Wellensiek et al (2002:380) found that "the deficit of general education was paralleled by a lack of knowledge concerning cancer of the cervix and Pap smears". In this study, three respondents stated:

I think from my own personal experience, I would say, firstly, awareness. The awareness campaign, I don't think it actually reached the level where, you know, a lot of our people know the reasons why they are supposed to go for a Pap smear, if one has to put it that way.

There's lack of awareness. If that was not the case, one would be getting a lot of requests from patients.

The most important thing is that people are not very informed about cervical cancer, about the test Pap smear.

4.5.1.2 **Characteristics of both medical practitioners and patients**

Certain characteristics of medical practitioners and patients were identified as barriers to cervical

screening.

4.5.1.2.1 Age of both medical practitioner and patient

The ages of medical practitioners emerged as a barrier to screening. Young medical practitioners sometimes found it difficult to examine patients, even if they had problems with their genital tracts, because patients did not want young medical practitioners to examine their private parts. In their study Fitch et al (1998:443) describe embarrassment as one of the reasons why women do not participate in the screening programmes. When patients did not have any complaints about their genital tracts, young medical practitioners found it difficult, sometimes impossible, to recommend a cervical smear for screening purposes.

When a Pap smear is requested in the absence of symptoms, the patients concerned start thinking that medical practitioners want to play with their private parts. This concurs with Watkins et al's (2002:476) finding that anxiety regarding physical privacy would be the primary barrier to obtaining a Pap smear. Older women, especially those older than 50, even if they were at high risk, did not like their private parts to be examined, especially by young medical practitioners. However, the respondents emphasised that when it came to patients in the middle age group, that is, above 40, they preferred that a Pap smear be repeated more often than in 18 year-olds. One responded stated

One patient of about 60 years came to see me. She had been discharged from the hospital and she complained about a smelly vaginal discharge. I examined her and found a lesion. I referred her back to the hospital and she was very angry about that.

It was also evident that there was prevalence of STDs among teenagers, as they did not stick to one partner. Teenagers start having sexual relationships early in life, often not even using protection (unprotected sex). This behaviour resulted in increased risk of falling pregnant and also of being predisposed to STDs. This finding supports the statement made by Mqoqi et al (2003:18) that says women with high parity are more likely to develop cancer of the cervix. The respondents reported that this situation also predisposed teenagers to the precursors of cervical cancer. According to one respondent,

Another thing is that even the age can tell you. I mean, let's say a person is 30 years old and have 6 children. Obviously, she started coitus at an early age, that's why she has those kids at this point in time. And another thing is, unfortunately, you cannot ask them, the fathers of those kids, because if it's different fathers it's another risk factor. Such a person is liable to have a conglomeration of illnesses, in fact, one of which is HIV/AIDS which will actually predispose her to cervical cancer.

4.5.1.2.2 Gender of medical practitioner

Gender emerged as a characteristic of private medical practitioners that may interfere with the screening programme implementation.

◆ Male medical practitioners

As shown in the demographic data, most of the private medical practitioners are male in Soshanguve. Consequently, women did not like to be examined if they did not have any complaint about vaginal problems or if they did not present with any vaginal discharge. Older women, especially those older than 50, did not like to be examined by male private medical practitioners. This concurs with Fitch et al's (1998:442) finding that women did not want a male health care provider to do the Pap smear. At the same time, however, male private medical practitioners were blamed for being ignorant about the issue of cervical screening. They were accused of not seeing women as potential clients for a Pap smear as they only treated whatever the patient came with and forgot about other things. According to two of the respondents,

Sometimes it may just be a little bit of, maybe, an inconvenience or laziness, as we are lazy to take it.

I find it not really necessary to do it, probably because, you know, I find myself not going to benefit financially (laughter). I am trying to be fair.

◆ Female medical practitioners

The respondents indicated that, although the gender of the medical practitioner did not

discourage the participation of women in cervical screening, if a medical practitioner was a female, patients would be advantaged. In their study, Fitch et al (1998:442) found that women preferred female to male health care providers. Watkins et al (2002:476) state that embarrassment and anxiety about showing one's private parts could be lessened if a female health care provider conducts the Pap smear. When female medical practitioners examine female patients, they are also concerned about their reproductive health. The female respondent stated that this approach came naturally as they were of the same gender. According to her,

As a female, when I see a female, I see something else, you understand, and I am also a female and I am also a mother. When I see my patients, I see them holistically as females.

4.5.1.2.3 *Lack of interest on the part of private medical practitioners*

During the interviews, lack of interest among medical practitioners was indicated. The respondents indicated that in private practice cervical cancer was not something that one would see on a regular basis, unless one was looking for it. Perry and Burgess (2002:48) found that health professionals' roles are influenced by their responsibilities and competences to deal with issues. This, in turn, influences their response to the issue concerned. Most of the respondents do not find necessary to do Pap smears. They sometimes even forget that it exists in medicine because to them, in private practice settings, not doing a Pap smear does not have any impact as it was not common to find somebody presenting with cervical cancer. One respondent stated,

I last saw a patient with cervical cancer ten years ago.

The situation has led to their not requesting a Pap smear unless the patient does so. One respondent indicated that he did not screening the women as much as he was supposed to, as he was not going to benefit financially. The respondents gave lack of interest in doing a Pap smear, laziness (as they are lazy to do it), and that it was an inconvenience for them to do a Pap smear as reasons for not requesting Pap smears. Some of them indicated that they would only carry out an investigation once it was clear to them that the patient was in danger. Deeley (1979:37) found that not all medical practitioners are convinced about the use of detection methods such as a Pap smear. One respondent stated,

For me to diagnose an STI, I don't need a Pap smear. The majority of people that I see who have got STIs, I normally don't do any investigation. I just treat them and the response is good.

4.5.1.2.4 *Patients' refusal to have a Pap smear done*

The respondents indicated that when they tried to encourage patients to take a Pap smear, the patients often made excuses. The patients would make excuses and say that they would take a Pap smear on their next visit. Sometimes patients said they could not take a Pap smear as they were in a hurry. This concurs with Fitch et al's (1998:442) finding that despite the known benefits of cervical screening, most women do not avail themselves of the procedure. The respondents reported that older women and even young women did not like Pap smears to be done on them, especially if they were not complaining about any vaginal problems. As a result, the respondents ended up treating whatever the patient came with and left other things unattended. According to some of the respondents,

They will tell you that I came for a cough; I don't want my private parts to be examined.

How can you start talking about things that are not related to my illness?

You know, that other doctor makes you undress when you say you have flu.

4.5.1.3 *Poor communication between medical practitioners and patients*

Communication between medical practitioners and patients was a barrier to cervical cancer screening programme implementation.

4.5.1.3.1 *Failure of medical practitioners to inform patients*

According to Alali and Jinadu (2002:81) in developing countries like South Africa, health communication was encouraged as a result of growing policy interest in health promotion and disease prevention. Accordingly, the PHC approach capitalises on the shift from treating infectious diseases to preventing chronic ones, like cancer. This can only be achieved by

enhancing prevention and changing life-styles to adopt healthy behaviours. According to Alali and Jinadu (2002:82), health communication plays the following roles:

- determining and assessing health outcomes
- guiding effective health care
- guiding health promotion
- gathering and disseminating health information
- providing social support
- coordinating health care, treatment and activities of various interdependent providers and consumers

In this study, the researcher found that women were not informed by medical practitioners about the issue of cervical cancer and its predisposing factors as most doctors did not provide or hand out information to patients. Most of the respondents did not tell female patients what was expected of them or even mention the word "Pap smear" to them during consultation. The respondents did not think about illnesses other than what the patient presented with. PHC provision in the form of preventative health care is not currently on the private medical practitioners' agenda. This concurs with Perry and Burgess' (2002:48) finding that medical practitioners have been trained that their function is to identify medical signs and symptoms and provide solutions to them. However, McFarland (2003:172) found that private medical practitioners in Botswana provided adequate information about cervical cancer and Pap smear testing to women. According to some of the respondents,

The thing that seems somehow to discourage them from taking another one is, like, they are not much informed about the issue, that the changes that may take place at the end of the day may lead to cancer.

We normally screen them based on some sort of evidence, when we think that somebody is threatened, whereas, in fact, it would be nice at least to screen them even when they are not complaining of the symptoms.

4.5.1.4 Cost of doing a Pap smear (affordability)

The respondents indicated that the cost was becoming a barrier to screening for patients who paid cash. These patients found a laboratory fee for a Pap smear to be an extra expense (cost). They could not afford to pay both consultation and laboratory fees as they came from disadvantaged backgrounds, with most of the women being unemployed. Their source of income was social grants from the government. Therefore, if the price of a Pap smear was too high, they could not afford to take it. Some of the respondents indicated that they often had to cut the consultation fee to make it possible for impoverished patients to be screened, and paid the laboratory fees on their behalf. Some of the respondents mentioned that patients who could not afford the laboratory costs were referred to a clinic for free screening.

The respondents indicated that the cost could be reduced by using the laboratory services of medical technologists in private practices as their prices were far less than those of private pathologists. On the other hand, they indicated that prices could be negotiated with private pathologists for cash paying patients. Women to whom the issue of screening was communicated often agreed on screening, especially when they were able to afford the laboratory costs. This concurs with Hewitt, Devesa & Breen's (2002:667) finding that the lack of health insurance and poverty were associated with lower rates of Pap test use. If the Pap smear was an affordable procedure, women would agree to be screened. One respondent stated:

What we have seen from our community is that there are some of them who actually, due to finances, you find that they don't do the Pap smear as often as they should.

4.5.2 Factors facilitating the implementation of a cervical cancer screening programme among private medical practitioners in Soshanguve

The study identified factors that facilitated the implementation of a cervical cancer screening programme. Table 4.3 below represents the facilitating factors.

Table 4.3 Enhancers to the implementation of the cervical cancer screening programme

Factors	Frequencies (n)
Accessibility of the test	3
Health education	3
Identification of patients at high-risk	3

4.5.2.1 Accessibility of test

The respondents reported that most women, when asked when last they took a Pap smear, said during their last pregnancy. They did that as part of their screening during pregnancy. However, the respondents indicated that it would be nice at least to screen them even when they did not complain of the symptoms of cervical cancer. The respondents maintained that the test should be accessible and affordable, which was not the case in Soshanguve. This supports Hewitt et al's (2002:669) finding that to improve Pap test use increased support for programmes that expand access to Pap test should be provided.

4.5.2.2 Role of private medical practitioners in screening programmes

Medical practitioners play a major role in encouraging the women to participate and make themselves available to cervical screening programmes.

4.5.2.2.1 Health education

The respondents were of the opinion that ways to make people aware of cervical cancer and the screening programme needed to be explored. Women must be made aware of the advantages of knowing the status of their cervix. Hewitt et al (2002:669) maintain that educational campaigns that inform women of cervical cancer risk factors and encourage screening could improve Pap test use. The respondents agreed that it should be the health care provider who talks to the patient about the test. They indicated that the moment they explained the purpose of a Pap

smear investigation, the women did it. The respondents stated further that, although they talk to their patients from time to time, another way could be to use flyers or pamphlets with information about cervical cancer, its predisposing factors, symptoms and detection tool (Pap smear). The flyers or pamphlets could be placed in the reception area so that patients could access and read them in their own time.

Another way could be to talk to the patients to encourage them to participate in screening. The respondents stated that it was better to encourage any woman between the ages of 30 and 45 to do a Pap smear once every three years. Other stakeholders, such as the community radio stations, the church and the schools, could also be involved in the awareness campaign. The respondents' general feeling was that patients had to be provided with information in order to encourage them to go for screening. The respondents indicated that they often tried to encourage women to participate in screening by talking to them and interviewing them on issues of cervical cancer. In their view, a Pap smear was a good tool if taken correctly in diagnosing cervical cancer and its precursors early enough to permit treatment.

4.5.2.2.2 Identification of patients at high-risk

Hewitt, Devesa and Breen (2002:667) state that "high-risk women might have enhanced opportunities for screening because of greater exposure to health care providers". The respondents indicated that they looked out for the following symptoms to identify women who were at risk of developing cervical cancer:

- a patient coming with pelvic inflammatory disease
- STDs in the teenage age groups
- middle age, say above the age of 30 and 50
- a patient who had not had a Pap smear for the past eight years
- a patient coming with PV bleeding post-menopausal
- a patient with serious symptoms
- the number of children a patient has in relation to her age

These signs accorded with those indicated by Haagedoorn et al (1994:239) as symptoms of cervical cancer. The respondents identified the following as predisposing factors to cervical cancer and its precursor lesions:

- early engagement in sex (coitus at an early age)
- engaging in unprotected sex
- number of pregnancies
- number of children
- promiscuity (teenagers not sticking to one partner in a relationship)

The factors were in line with Mqoqi et al's (2003:18) finding that women who engaged into sexual intercourse at an early age, have a history of multiple male sexual partners, engaged in sexual intercourse with a male partner who has had multiple sexual partners, and have a history of STDs, are at risk and should be screened. The respondents indicated that they normally screened the women based on some sort of evidence. For example, if a patient presented with serious symptoms of cervical cancer, they would consider screening them. This supports Perry and Burgess' (2002:48) finding that medical practitioners have been trained that their function is to identify medical signs and symptoms and provide solutions to them.

The respondents stated that they normally preferred a Pap smear to be repeated more often in women between the ages of 30 and 50, which they maintained was the common age for the development of cervical cancer, than in younger ones (18 year-olds). The respondents also stated that many women were not screened as precursor lesions of cervical cancer were not showing any symptoms (asymptomatic). This led to patients seeking advice only when they suspected there was something wrong with their genitals and consulted a medical practitioner to find out what was causing their vaginal discharge. Once a Pap smear was done, it was discovered that there was a problem as the cancer was already advanced.

Table 4.4 Application of the health services evaluation model to the findings

INPUTS	PROCESSES	OUTPUTS
<ul style="list-style-type: none"> • Awareness • Interest • Absence of disease and symptoms • Gender of medical practitioner • Age of medical practitioner and patient • Cost of doing a Pap smear 	<ul style="list-style-type: none"> • Health education • Identification of high-risk patients • Communication 	<ul style="list-style-type: none"> • Patient refusing to be examined. • Interest • Absence of disease and symptoms • Awareness • Availability and accessibility of services

4.6 CONCLUSION

This chapter discussed the findings with reference to the literature reviewed. The data analysis revealed two themes, namely

- barriers to the implementation of a cervical cancer screening programme among private medical practitioners in Soshanguve
- factors facilitating the implementation of a cervical cancer screening programme among private medical practitioners in Soshanguve

The research findings were also reflected within the health services evaluation model.

Chapter 5 concludes the study and presents guidelines for a cervical cancer screening programme that could be implemented within private health care services.