

# **BARRIERS TO CERVICAL CANCER SCREENING WITHIN PRIVATE MEDICAL PRACTICES IN SOSHANGUVE, SOUTH AFRICA**

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## **ABSTRACT**

A qualitative, explorative, descriptive and contextual study, using interviews and field notes, investigated the implementation of cervical cancer screening by private medical practitioners in Soshanguve, South Africa. Four barriers to the implementation of cervical cancer screening programmes among private medical practitioners were identified: age and gender of medical practitioners and the patients' ages; few opportunities for private medical practitioners to conduct cervical screening tests; failure of medical practitioners to inform patients; the high cost of screening.

Programmes promoting awareness about cervical screening and information and education materials on cervical cancer (and its predisposing factors) should be supplied to women. The utilisation of less expensive laboratory service providers could make cervical screening more affordable and accessible.

**KEYWORDS:** Barriers to cervical cancer screening, cervical cancer, private medical practitioners in South Africa, screening for cervical cancer

## **INTRODUCTION**

The South African government changed the focus of health care provision from curative to preventive health care through adopting a primary health care (PHC) approach. The nursing profession in the national health system (NHS) is the major provider of PHC in the public health care sector. Socio-economic factors in Soshanguve, South Africa, enable some people to consult private medical practitioners.

According to Wellensiek, Moodley, Moodley and Nkwanyana (2002), cancer screening programmes are successful in decreasing the incidence of cervical cancer in developed countries by 80%. This view is also supported by Hoffman et al. (2003:573), who indicate that odds ratios (OR) of cervical cancer decrease with the number of smears women had done. It is thus wise for private practitioners to consider various screening approaches in the prevention of invasive cervical cancer.

## **BACKGROUND**

In South Africa, cancer of the cervix is the most common malignancy in African women, and the fourth most common in white women, with an overall age standardised incidence rate of 22 per 100 000 per year (Hoffman et al., 2003:573). According to the Alliance for Cervical Cancer Prevention (2007:2), *“every woman has the right to cervical screening at least once in her lifetime”*. Although cytology-based screening programmes are successful in developed countries, quality cytology programmes are difficult to sustain (Alliance for Cervical Cancer Prevention, 2007:2). They support the use of the most efficient and effective strategy for secondary prevention of cervical cancer in low-resource settings, by utilising either HPV (human Papilloma Virus) DNA testing or VIA (visual inspection with acetic acid) and treatment of precancerous lesions using cryotherapy (freezing). This could be done in a single visit and could be carried out by physicians, nurses or midwives.

Cervical cancer screening, using cytology and multiple visits for diagnosis and treatment, prove challenging for low-resource settings. Blumenthal, Lauterbach, Sellors and Sankaranarayanan (2005:S30) argue that training should be competency-based combined with didactic and hands-on approaches and done in clinical settings that resemble the service delivery conditions at the programme site. Perry and Burgess (2002:48-49) argue that *“there are two main sorts of relevant beliefs: about the professionals’ role (including what they are responsible for, and their competence to deal with issues), and about the patients and their role (such as being active or passive in the relationship)”*.

The implementation of screening programmes is influenced by medical practitioners and nurses. In Durban, South Africa, Wellensiek et al. (2002:376) reported that 87% of women from higher social and educational backgrounds did not use available cervical screening services because healthcare providers failed to disseminate this information. In the Eastern Cape, Smith, Moodley and Hoffman (2003:32) reported that barriers within the health services were not identified. In Botswana, McFarland (2003:172) found that clients lacked knowledge about cervical cancer and its screening. In Canada, Fitch, Greenberg & Cava (1998:442) found that some women were not screened because their physicians had not recommended the procedure. Beliefs about cancer screening and the characteristics of service delivery to women present obstacles. In South Africa, Bingham et al. (2003:S410) revealed the belief that cervical cancer screening was related to sexually transmitted infections (STIs). Some women equated a positive Pap

smear result, with AIDS (or a positive HIV test result). Bingham et al. (2003:S410) identified additional obstacles to cancer screening programmes' implementation such as the location of the service, structure of the service delivery system and women's needs for social support.

In Ontario, Canada, Ahmad, Stewart, Cameron and Hyman (2001:201) revealed that over 90% (out of 191 physicians) were likely to conduct Pap tests and clinical breast examinations during health examinations, and they were confident to perform these procedures. Male physicians were often asked by patients to refer them to female physicians to perform these tests. Male physicians perceived patients' embarrassment as a stronger barrier to Pap tests than female physicians (Ahmad et al., 2001:207).

Apart from the gender of the physicians, cervical cancer screening reportedly limits the provision of contraception. In San Francisco, Schwarz, Saint, Gildengorin, Weitz, Stewart and Sawaya (2005:179) found that balancing the need for contraception and cervical screening was challenging for clinicians. Only 3% out of the 185 responding obstetricians/gynaecologists, would prescribe 12 months' oral contraceptives without performing Pap tests, but 11-16% would refuse prescribing emergency contraceptives to women deemed to require Pap tests.

Detection of cervical cancer in the early asymptomatic stage allows treatment when the course of the disease can be altered significantly. Cervical cancer is preceded by a precancerous stage, when risk factors are building momentum toward manifestation of the malignant stage of the disease. Screening takes advantage of the early pathologic state of the disease during which high-risk women can be identified. This provides a way to direct the health care provider in assessing the individual's chance of developing cervical cancer (Edelman & Mandle, 2002:228), and to recommend appropriate treatment. According to Edelman and Mandle (2002:228), cervical screening also reduces the cost of treating the disease by avoiding the more vigorous interventions required during its later stages. The more advanced lesions may require histological techniques, radiation therapy and chemotherapy in addition to surgery. Some procedures may require hospitalisation, which increased costs. Therefore, screening of patients is a cost-conscious approach to health care. Cervical cancer screening is adaptable to all levels of health care and delivery systems owing to its relatively low cost and flexibility.

However, cervical cytology is only a fraction of the complete system required for cervical cancer control. It only identifies cases that need appropriate follow-up and treatment. Therefore, it is useless without adequately integrating diagnostic and treatment services essential for patients with abnormalities. Fitch et al. (1998:443) maintain that perceived social support both within the individual's environment and the physician's office contributes to regular Pap smear utilisation. Patients should be informed about the procedures being performed during consultation. Perry and Burgess (2002:16) state that "information about procedures can be provided both about the events which the patient will undergo and also about how the patient will feel as a result of a particular stressful

medical procedure”. According to Perry and Burgess (2002:14), individuals must be convinced that the recommended actions will benefit them. Therefore, the reliability and validity of the tests are critical. False negative screening results may cause failure to provide early treatment. A negative screening result is not always a guarantee that precancerous changes are absent (Perry & Burgess, 2002:14). False positive results may cause unnecessary frustration. Perry and Burgess (2002:14) state that “*at times there has been great concern about the emotional effects of screening. Firstly, unnecessary distress may be caused by telling the patient that a cancer might be present when in fact this turns out not to be the case (false positive)*”. The cervical cancer screening programme must be safe, cost-effective and accurate.

## **PROBLEM STATEMENT**

In its strategic framework (1999-2004), the South African National Department of Health (DOH) indicates its intention to improve women’s health by strengthening and expanding the national programme for cervical cancer awareness and screening. The screening programme targets women 30 years and older (DOH, 1999:3). The goal was to screen at least 70% of women in the target age group nationally within ten years. Even though the programme was implemented in 1999, offering women three free Pap smears per lifetime, this goal has not been attained.

In Durban, KwaZulu-Natal, Wellensiek et al. (2002:376) reported 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*”. Factors preventing the implementation of effective cervical cancer screening programmes include limited access to health facilities, financial constraints, ignorance about cervical cancer screening and mistrust of healthcare providers (McFarland, 2003:167; Markovic Markovic & Henderson 2005:2531). Therefore, a qualitative study was undertaken to identify barriers to the implementation of cervical cancer screening programmes by private medical practitioners in Soshanguve.

## **DEFINITIONS OF KEY CONCEPTS**

**Cancer** refers to a class of diseases in which a group of cells display the traits of *uncontrolled growth* (growth and division beyond the normal limits), *invasion* (intrusion on and destruction of adjacent tissues), and sometimes *metastases*, spreading to other locations in the body via lymph or blood (Canadian Cancer Society, 2007).

**Cervical cancer** implies cancer that starts in the cervix, the lower part of the uterus (Canadian Cancer Society, 2007). Cervical cancer is a disease in which the cells of the cervix become abnormal and start to grow uncontrollably, forming tumours.

**Cancer screening** is the utilisation of smears obtained from the female genital tract (cervix, vagina) of patients so as to detect early non-cancerous lesions that are treatable, thus preventing cervical cancer from developing.

**Private medical practice** encompasses consulting rooms that are owned and serviced by independent medical practitioners who are registered as private practitioners with the Health Professional Council of South Africa (HPCSA) and offer medical services at a fee-for-service basis.

## **PURPOSE OF THE RESEARCH**

The main purpose of this research was to explore and describe barriers to cervical cancer screening encountered by private medical practitioners in Soshanguve.

## **RESEARCH DESIGN**

In line with the research purpose, a qualitative, explorative, descriptive and contextual study was conducted in order to gain a rich understanding of the phenomenon as it existed in the real world (Polit & Beck, 2004:247).

## **RESEARCH METHODS**

A qualitative approach was adopted using semi-structured interviews and field notes as data collection techniques (Polit & Beck, 2004:253).

### **Population**

The population comprised private medical practitioners registered with the HPCSA in Soshanguve. The accessible population comprised all eligible private medical practitioners who offered cervical screening services.

### **Sampling and sample size**

Purposive sampling was used to select participants who were providing cervical screening services (Streubert-Speziale & Carpenter, 2007:29). The requirement for each participant was practising as a private medical practitioner for at least two years in Soshanguve, and conducting cervical screening in their practices. Data saturation occurred after six interviews (Polit & Beck, 2004:312) when repetitions and confirmations of previously collected data, rather than new information, were obtained during interviews.

### **Data collection**

Individual semi-structured interviews were conducted with participants in their own settings. The participants were asked a broad question relating to the research topic: *“What are the barriers to cervical cancer screening programme implementation within*

*private medical practices in Soshanguve?*” The interviews were audiotaped and detailed field notes were taken. Each interview was expected to last approximately 45-60 minutes, but took less time because the practitioners were very busy. The audio recordings were transcribed immediately after the interviews and carefully labelled. Demographic information was obtained by asking structured questions, such as the gender of the medical practitioner, and the location of the private practice in Soshanguve.

## **Data analysis**

The audio recordings and field notes were transcribed verbatim for analysis (Polit & Beck, 2004:572). The information was read to identify meaningful segments and units and then the segments were reviewed. Finally, themes and categories were identified. The analysis of data followed a six-step approach proposed by LoBiondo-Wood and Haber (2005:172). This approach emphasises a general pattern of moving from participants’ descriptions to the researcher’s synthesis of all participants’ descriptions. The steps followed in this study included the following:

- Thorough reading of the entire transcription of the participants’ description
- Identification of shifts in participants’ thoughts, resulting in division of the transcription into thought segments
- Specification of the significant phrases in each thought segment, using the words of the participant
- Distillation of each significant phrase to express the central meaning of the segment in the words of the researcher
- Grouping together of segments that contain similar central meanings for each participant
- Preliminary synthesis of grouped segments for each participant with a focus on the essence of the phenomenon being studied and
- Synthesis of the essences that surfaced in all participants’ descriptions, resulting in an exhaustive description of their lived experiences.

## **ETHICAL CONSIDERATIONS**

Burns and Grove (2001:200-209) state that the participants’ rights as well as the rights of others involved in the study are to be protected. In this study the participants were informed that participation was voluntary, confidentiality was guaranteed and written consent was obtained. The research was approved by the Research and Ethics Committee of the Department of Health Studies, University of South Africa. All participants read and signed letters of consent granting permission to conduct the interview and to use

an audio recorder. The following ethical principles were maintained as proposed by LoBiondo-Wood and Haber (2005:123):

- **Respect for persons:** the right to self-determination and treatment as autonomous agents, and the freedom to participate or not to participate in research.
- **Beneficence:** the obligation to do no harm and to maximise possible benefits.
- **Justice:** the fair treatment of human subjects.

## MEASURES FOR ENSURING TRUSTWORTHINESS

Polit and Beck (2004:430) refer to Lincoln and Guba's four criteria for establishing the trustworthiness of qualitative data, namely credibility, transferability, dependability and confirmability. Table 1 reflects the application of this model of trustworthiness to this study.

**Table 1: Measures for ensuring trustworthiness**

Strategy	Criteria	Applicability
Credibility	Protracted and various field experience	The researcher, a qualified cytotechnologist, was a lecturer at the Tshwane University of Technology and had thirteen years' experience in the field. The researcher also offered a private cytology practice.
	Researcher's authority	The researcher participated in research capacity building projects and attended a one-month course in health systems research.
	Structural coherence	The study focused on medical practitioners in private practice. The health services model was used to provide structure to the findings.
	Peer group evaluation	The work was sent to the research capacity building participants, and to the study's supervisors for criticism, corrections and comments.
	Interviewing technique	The interviews enabled interaction between the interviewer and participant during data collection.
	Triangulation	The interviews enabled interaction between the interviewer and participant during data collection.
	Nominate sample	The researcher used triangulation of data collection techniques and research designs. Data were collected through semi-structured individual interviews, and field notes.

Transferability	Comparison of sample with demographic data Thick description Dense description	A purposive sample of private medical practitioners was used.  The demographic data of participants were collected through structured questions. The researcher provided sufficient descriptive data to allow comparisons.
Dependability	Coding-recoding procedure	The research methodology of this study has been described in detail.
Confirmability	Confirmation audit	The researcher sent the analysed data to the supervisors for their comments.  The tape recordings, transcriptions, field notes, forms, letter of consent and a demographic questions were preserved for future auditing.

## RESEARCH FINDINGS

Barriers to the implementation of a cervical cancer screening programme among private medical practitioners in Soshanguve revealed four themes: age and gender of medical practitioners and the age of patients; few opportunities for private medical practitioners to conduct cervical screening tests; failure of medical practitioners to inform patients; and the affordability of screening.

### **Theme 1: Characteristics of both medical practitioners and patients**

The age of both the medical practitioner and patient and the gender of the doctor were identified as barriers to the utilisation of cervical cancer screening services.

#### Age of both medical practitioner and patient

Older women were less accepting of cervical screening than younger ones. Young medical practitioners reportedly found it difficult to examine patients, even if they had gynaecological problems. Patients did not want young medical practitioners to examine them, especially when they had no gynaecological complaints. When medical practitioners requested to conduct a Pap smear in the absence of symptoms, the patients were concerned that medical practitioners were examining them needlessly. Older women, particularly those over 50, even if they were at risk, were uncomfortable with vaginal examinations, especially by younger medical practitioners. These results concur with the findings of Watkins, Gabali, Winkleby, Gaona and Lebaron (2002:476) that anxiety regarding physical privacy is a barrier to obtaining a Pap smear. In their study

Fitch et al. (1998:443) described embarrassment as one of the reasons why women did not participate in cervical screening programmes.

Some participants emphasised that middle-aged patients (older than 40) preferred that a Pap smear should not be repeated often. One participant said: *“One patient, about 60 years old, 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.”*

### Gender of medical practitioner

Apart from age, the gender of the private medical practitioners emerged as a factor that might interfere with the screening programme’s implementation. Most private medical practitioners in Soshanguve were males. Female patients preferred not to have vaginal examinations if they did not have any gynaecological complaints. They also reported that older women, especially those over 50, were uncomfortable with being examined by male doctors. This is in line with Fitch et al.’s finding (1998:442) that women did not want male healthcare providers to do their Pap smears. One participant said: *“I mean I’ve seen patients who would say, no that other doctor makes you undress when you say you have flu... he makes you undress the whole body. So I mean they are feeling uncomfortable with the whole situation.”*

Patients might be more comfortable to have Pap smears done by female doctors, as stated by one informant: *“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”*. Watkins et al. (2002:476) stated that embarrassment and anxiety about gender could be reduced if a female healthcare provider conducted Pap smears.

## **Theme 2: Few opportunities for private medical practitioners to conduct screening tests**

In private practice cervical cancer was not seen on a regular basis. Consequently, most participants did not find it necessary to conduct cervical cancer screening tests. Some participants were unaware of the necessity of the procedure because, in private practice few patients present with cervical cancer. The situation existed where a Pap smear was only conducted if the patient requested it, unless the patient was at risk of cervical cancer. This is what participants had to say: *“I last saw a patient with cervical cancer ten years ago.”* *“For me to diagnose an STD, I don’t need a Pap smear. The majority of people that I see who have got STDs, I normally don’t do any investigation. I just treat them and the response is good.”*

Perry and Burgess (2002:48) found that health professionals’ roles are influenced by their responsibilities and competence levels.

### **Theme 3: Failure of medical practitioners to inform patients**

Most medical practitioners did not provide information to patients about cervical cancer and its predisposing factors and did not even mention the term “Pap smear” during normal consultations. The participants attended to their patients; complaints, preventive health care was not on the private medical practitioners’ agenda. Verbatim quotes in this regard included: *“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.”*

This concurs with Perry and Burgess finding (2002:48) that medical practitioners’ major function is to identify medical signs and symptoms and provide solutions for them. Furthermore, McFarland (2003:174) argued that Pap smear tests are used mostly as diagnostic rather than screening tests. Contrary to practices in South Africa, McFarland (2003:172) found that private medical practitioners in Botswana provided adequate information about cervical cancer and Pap smears to women.

### **Theme 4: Cost of a Pap smear (affordability)**

The participants indicated that the cost was a barrier to screening for patients who paid cash. Patients from disadvantaged backgrounds found the consultation and laboratory fees for a Pap smear to be an extra expense that they could not afford. Some participants indicated that they often had to reduce the consultation fee to make it possible for impoverished patients to be screened, and paid the laboratory fees on their behalf. Alternatively, some doctors referred patients to clinics where free screening was available. The participants indicated that the cost could be reduced by using the laboratory services of medical technologists in private practices, as their prices were lower than those of private pathologists. Women agreed to screening more readily when they were able to afford the laboratory costs. One participant 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.”* This is in line with Hewitt, Devesa and Breen’s finding (2002:667) that the lack of health insurance and poverty were associated with lower rate of Pap test utilisations. If the Pap smear were an affordable procedure, more women would agree to be screened.

## **LIMITATIONS**

In line with qualitative research generalisation is not appropriate, but findings could be contextualised within the setting where they were obtained. Another limitation might be the fact that the sample of participants in this study did not consist of regular users of the cervical cancer screening tests. As a result the private medical practitioners did not have adequate exposure to cervical cancer screening. No interviews were conducted with women who did or did not use cervical screening services.

## CONCLUSIONS

The results indicated barriers to the implementation of the cervical cancer screening programme in Soshanguve, South Africa. These included the age and gender of medical practitioners and the age of patients; few opportunities for private medical practitioners to conduct screening tests; the failure of medical practitioners to inform patients about cervical screening; and the high cost of screening.

## RECOMMENDATIONS

Medical practitioners should inform patients about the benefits of regular cervical screening for the prevention of cervical cancer. As the male medical practitioners found it challenging to encourage women to have Pap smears, it is recommended that female nurses should provide these services, also in the private sector. As the cost of such tests is often a prohibitive factor, private practitioners should refer disadvantaged patients to existing free clinics where free screening is available. A quantitative study should be conducted with a larger sample of private medical practitioners in order to generalise the findings to a larger population.

A future study should include the views of women who used and women who failed to use cervical screening services in order to identify barriers encountered by the women themselves.

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