CERVICAL SCREENING IN HLABISA DISTRICT: WOMEN'S EXPERIENCES AND BARRIERS TO UPTAKE

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April 1996

ACKNOWLEDGEMENT

This report would not have been possible without the kind assistance of the staff of Mtubatuba clinic in Hlabisa District; the women from Hlabisa and Mtubatuba who agreed to talk to us; Pethie who worked with me as interpreter and adviser; Neli for her help; and Jabu who helped with the transcription of the tapes.

EXECUTIVE SUMMARY

Cervical cancer is the most common cancer of women in South Africa, and there is considerable current debate about the development of a national screening programme. This report presents the results of research undertaken in Hlabisa District in KwaZulu-Natal, with the aim of exploring women's knowledge and experience of cervical screening, and barriers to the uptake of the service. The study used qualitative methodology: in-depth interviews were held with screened and non-screened Zulu women, and health workers involved with the clinic cervical screening service. In addition, a limited clinic record review for 1994 was done to ascertain the ages of screened women, in order to consider some issues raised by the proposed national screening policy.

All but two of the twenty women interviewed had heard of the smear test and linked it to the 'womb'. The women did not recognise the womb as having separate parts which might be at more or less risk of developing cancer. Most of the women regarded the smear as "checking" and "looking for" "womb" cancer. The majority who had undergone a smear had ultimately done so because the clinic nurses told them to have one, and they trusted the healthworkers' authority even when their knowledge about what the smear was for was limited. Many women who had heard of 'womb' cancer associated it with having multiple sexual partners which was said to cause "dirtiness" in the womb, and expressed the perception that it is a terminal illness. Awareness of the possibility of prevention was low. Nurses described several constraints to uptake of the screening service by patients, including women's problems with vaginal exposure, and the common equation of absence of symptoms with healthiness, among others.

Important implications of this research are that health education programmes designed to increase uptake should focus on promoting the smear by using words which Zulu women themselves use, and emphasising that women are not to blame for "womb" cancer through "low morals", and that the illness is curable if found in the early stages.

Strategies for increasing uptake and changing the target group in line with the new recommendations should be primarily based on health workers formally or informally inviting women for screening. Every effort should be made to ensure that screening takes place in an environment where patient discomfort and fear can be minimised. Women who have been screened should be encouraged to share their experiences with other women who are yet to be screened. The report concludes with recommendations for the Provincial Authority of KwaZulu-Natal, and the healthworkers and managers of Mtubatuba.

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1.0 INTRODUCTION

1.1 Background, aim and objectives

Cervical cancer is the most common cancer of women in South Africa (Wynham 1986). The disease has been shown in other countries to be preventable with effective cervical screening (Johannesson 1978), and accordingly there has been considerable debate about the development of a national screening programme in South Africa. Although various forms of cervical screening have been undertaken for almost 30 years, there is still comparatively little data on the operation and effectiveness of screening, particularly outside Cape Town, Johannesburg and Durban, and very little is known of women's views and perspectives on the area.

The **aim** of the research was to investigate cervical screening in the rural area of Hlabisa District in KwaZulu-Natal, and to make recommendations for the improvement of the effectiveness of the service. This report is the second part of a tripartite study, investigating cervical screening in three rural areas: Hlabisa District, KwaZulu-Natal; Montagu District, Western Cape; and Ngqeleni District, Eastern Cape.

There were three **objectives:**

1) to explore women's knowledge and experiences of cervical screening and barriers to uptake;

2) to explore nurses' views on the screening programme;

3) to carry out a limited clinic record review for one year to ascertain age of women screened

1.2 Who gets cervical cancer in South Africa?

Cervical cancer is a disease of early to late middle age, found rarely in women between

the ages of 20 and 30 years. It starts to be more common between the ages of 30 and 40 and is most likely to occur in women of 40 and 70 years, after which time few cases are diagnosed (Bailie 1995). Eighty-seven percent of cases occur in women over 35 years (Sitas 1994). The disease is a much more common cause of death in Coloured and African women than in White and Asian women (Bradshaw 1985).

1.3 Cervical screening

The development of cervical cancer is thought to be preceded in most cases by pre-malignant phases which can be detected by cervical screening, and at which stage progression of the disease to cancer can be arrested. The focus of cervical screening is to detect these pre-malignant phases and to follow up and treat women who have them. The pre-malignant phases are of mild (CIN I), moderate (CIN II) and severe dysplasia (CIN III). One in ten women who have CIN I and CIN II will develop more severe disease (Miller 1992). For women with carcinoma-in-situ (a pre-invasive stage), between one half and one fifth of women will eventually develop invasive cancer (Sherris 1993). Some women's smears are reported as showing 'atypia', a broad name given to a group of problematic smear which include infection, inflammation, condylomata changes and atypical smears. These are indications of smear abnormalities, but are not pre-cancerous stages.

At present there is no national screening policy in South Africa; provinces have their own policies and these vary considerably. Most screening is focusing on family planning attenders and women using antenatal services. A recent workshop on cervical screening recommended that women be screened three times only in their lifetime, at ten-yearly intervals, with the first screen commencing after the age of 30 and the last screen before the age of 56 (Fonn 1994). The aim is to try to screen larger numbers of women, but to screen each one less frequently. The aim of this research is to examine current practices and barriers to screening more women, in order to assist service providers to implement and organise the new programme effectively.

2.0 SCREENING IN HLABISA DISTRICT

No routine screening programme exists at Hlabisa Hospital. Opportunistic screening,

mostly with women using family planning and child health services, takes place 50 kms to the south at the [former Natal Provincial Administration] clinic in Mtubatuba.

3.0 RESEARCH METHODS

In-depth interviews were held with twenty women of different ages, and included those who had been screened before, as well as those who had not. The interviews explored women's knowledges of their reproductive system and "womb" cancer, their interpretation of gynaecological symptoms, and their understanding of the cervical screening procedure and views on barriers to screening. In a similar manner, in-depth interviews were held with two health workers from the clinic: the Head Nurse and the Head of Services. They were asked about their perceptions of problems with the screening service, and barriers to patient acceptance of screening.

The study was conducted from 4-15 September 1995. The interviews were conducted by the main researcher [KW], who is a female medical anthropologist, in the women's first language, with the help of a Zulu woman who acted as interpreter and co-interviewer. The interviews were tape-recorded after consent was obtained. Some of the interviews were conducted at Mtubatuba clinic [with screened women], and some in women's homes around Hlabisa [with non-screened women]. The data was fully transcribed, translated into English and analysed using grounded theory.

4.0 FINDINGS

4.1 The organisation of cervical screening and recruitment of women in Mtubatuba clinic

Clinic services at Mtubatuba consist mainly of family planning and child health services. The cervical screening service is opportunistic; when a woman attends for the first time she is encouraged to have a smear. Thereafter a smear is done every two

years if the initial result is normal. Cytological specimens are sent to Durban for analysis, and the results come back within two or three weeks.

4.2 Women's knowledge and experiences of cervical screening and barriers to uptake; and nurses' views on the screening programme

4.2.1. Women's knowledge of the smear

What do women perceive the smear to be for?

All of the women recruited in Mtubatuba Clinic, and all but two of those recruited around Hlabisa, had heard of the smear test. All those [except one] who explained its purpose mentioned cancer unprompted, saying it "checks for" or "looks for" "womb" cancer, or in the words of one woman, for "a sore inside the womb which does not heal." The consensus was that it could "find out" whether "you have developed cancer."

One informant stated that it additionally checked for the "AIDS germ." Another informant expressed the purpose in terms of "to check if my womb is alright or not" and continued by specifying that she had been told that the nurses wanted "to check for any infection", though she was unclear as to what infection they were referring to; when probed about whether there was in any way a connection between the smear test and cancer, she said she had no idea.

A couple of informants said that the smear had a cleaning function. One woman for example said "they put in their fingers, examine it with a light, and then insert a plastic instrument which comes back out with the dirt from inside you." Another informant clearly associated the smear test with the D&C procedure, saying that women who had

their wombs "cleaned" included those "who want to check if they have cancer or not."

Why and how did women come to have a smear done?

Since no routine screening programme exists at Hlabisa Hospital itself, only one of the eleven women recruited around Hlabisa had had a smear test; this she said was when she presented with "pain in my womb" and was told that "they should check that I did not have cancer."

At Mtubatuba Clinic purposive sampling was conducted at the clinic specifically to find screened women. The majority of these informants had been screened because they had been told about the smear by the clinic nurses. One woman for example explained that "they said at the clinic that anyone who is on contraception needs to be tested, so whenever I came they told me about it", and another said that she had been told to come for "a breast examination and to check whether my womb is alright or not." One informant said she had come to the clinic for a pregnancy test but asked for a smear to be done because her sister had told her that its purpose was "to check the womb"; she also expressed the view that cancer could be stopped by "doing smears often."

Another woman explained that she had responded to the nurse's offer of a smear because she had symptoms at the time; "I wanted to be checked because I felt uneasiness in my womb and had headaches-my womb was painful." This corresponds to what nurses involved with screening both in Mtubatuba and elsewhere say: that women accept the smear more readily when they are symptomatic.

Other than clinic nurses, "people talking about it" [mother and sister were two such sources] was a common source of knowledge about the smear test. Through such informal networks women had heard of its existence, that doctors were able to do it, that certain individuals [neighbour/sister/others] had had a smear done, and that it was painful. One informant had heard on the radio that doctors test for cancer, and then tell you that you must "eat whatever you have because you will die."

Perceptions of the smear procedure

Women explained that they lay on their backs and "spread [my] legs", and in most cases had their breasts "checked" or "felt." Many informants described how "a hand is inserted into you" and "an instrument" [which one woman said was "metallic"] was "pushed inside the vagina" or "inserted." One woman explained that "you can feel the instrument moving inside you, but it is not very painful." One informant said she had "no idea what it was for or what it does." This was said to have "pulled something out."

Several informants said they had been "scared" beforehand and had not known what to expect, although some nevertheless expressed willingness to go through the procedure again [one woman said she would not re-do it]. One woman specified that she was "scared and uncomfortable with the opening of the legs."

Women said they understood they had to return in two or three weeks to collect the results, explaining that it [the "something" taken out during the procedure] had to be sent away "for tests."

4.2.2 Women's perceptions of "womb" cancer

Informants had much to say on the subject of cancer. Using the Zulu terms for "womb" [*isibeletho*] and "bladder" [*isinye*: used by some women to refer to the womb], women described their perceptions of the effects, causes and outcome of cervical cancer. It would appear that these women do not distinguish the womb as having separate parts which are more at risk of developing cancer. In the following section the term "womb" cancer is used because this is what the women said.

Women's perceptions of the process of "womb" cancer

Women used various expressions to describe how the womb is affected by cancer, most frequently using the phrase "sores in the womb", with other informants saying it consisted of a "sore inside which does not heal", "holes in the womb", "a sore or a lump, I am not sure which". One informant expressed the process graphically, saying

that "[the womb] first gets tired and then becomes loose/thin [lula], and then it gets eaten."

Women's perceptions of symptoms associated with "womb" cancer

Some informants explained that symptoms revealing the presence of womb cancer included "terrible pains in the womb", "uncontrolled bleeding, "bleed[ing] for a long time non-stop", "excessive bleeding", "swollen glands", and "problems with the kidneys." Two other informants associated symptoms of vaginal infection, "itchiness in the vaginal area" and "itchy discharge", with "being sick with cancer." Speaking of cancer in general, one woman said that body parts became "infected" and sometimes had to be "cut off." One informant described how "it eats away at your insides." One informant said that "with some people you can't see they have it."

Women's perceptions of the outcome of "womb" cancer

The majority of informants who discussed outcome expressed the view that in the end people diagnosed with womb cancer will "eventually die." Some told stories about individuals whom they had heard about, such as a woman "who has womb cancer and was discharged from the hospital because they couldn't help her any more, and she is just waiting for her death."

Significantly, some women however appropriated a biomedical construction of cancer as a disease of stages in time, saying that it could be cured/treated "in the early stage", "if it is discovered and treated in time." Two women said specifically said that it could be "stopped" by having smear tests frequently. One informant stated that "some people say it is curable, and some that it is incurable, especially inyangas." Another woman related prevention to her own concepts of cause of "womb" cancer, saying that it was preventable by avoiding long-term contraceptive use.

The widely held view that womb cancer entailed eventual death powerfully influenced women's concepts of self-risk. Importantly, the majority of informants who were asked whether they were ever worried for themselves, replied in the affirmative, giving

various reasons. Women frequently qualified their answer by saying that "if I had it I would die." Other individuals explained their worry about cancer by mentioning their symptomatic experiences; "I have problems with my womb", or "I once had an abcess and thought I had cancer", or "now I have a lump." Another woman said her mother had died of breast cancer and was worried for herself as a result. Other informants said that "there are many diseases around", saying that it was now common to find people with cancer, and that "anybody can get it." Another woman related her worry to her perception of its cause, explaining that she was not sure what her husband was "doing."

Women's perceptions of the causes of "womb" cancer: sex and "dirtiness"

Many women made an explicit connection between sexual activity and "womb" cancer. Occasionally it was said to "just happen." However it was more commonly said to be women with many sexual partners who ended up with the illness: in the words of various informants "young women with boyfriends", women who "sleep around", "women with many sexual partners who keep changing, and "if [a woman] has sexual encounters with more than one person at one time." Despite the connection with sexual activity, one woman emphasised that the internal sore which signified cancer was not itself transmissible, and so distinguished it from an STD . [Similarly another reported that she had heard of a person who had died of cancer but whose partner was "still alive", which she said demonstrated that it was non-transmissible].

The connection was often expressed in terms of cancer being caused by the womb being "dirty", the dirtiness being acquired through sex. There is a link between dirt, which is sometimes referred to with the term "germs" [igciwane], and sexually transmitted disease, such as one woman saying the womb became dirty "if your partner is misbehaving and he brings an *isifo socansi* to you", and another saying this happened "if you don't know your sexual partner infected you with a certain disease, and therefore you do not go for treatment." Informants used the words "infected sperm from your partner", and "waste from men." Symptoms of a dirty womb were said variously to be "when you feel you are unwell, when you feel there is something wrong in the womb", pain in the womb area, [smelly] vaginal "water", sores externally or

"inside the womb", heavy bleeding, and infertility.

For some informants, issues about disclosure of a diagnosis were closely related to the perceived sexual aitiology of womb cancer; in the words of one woman for example, "they say it is like AIDS-if I were to get AIDS I wouldn't tell anyone, because if you have it you are a disgrace." She explained that it is a disgrace because it is more common among "promiscuous people" just like AIDS was. Echoing this, another informant said "it is a disgrace because people have a tendency of sleeping with anyone, and they are afraid that it might have occurred because of that, so they can't tell other people." Others explained that the disgrace exists because cancer is a terminal illness. In addition to this, one woman said it was a disgrace for young people specifically to have cancer, saying "cancer affects old people, I am too young". A few women, however, said there was no stigma attached to womb cancer.

Other causes of womb cancer mentioned by three informants were said to be drug-use [oral and smoked], use of "snuff put in the vagina for sexual enjoyment", smoking, and alcohol consumption. One informant said that cancer was hereditary. Another woman said that long-term contraceptive use caused women to become infertile, and that such women got "womb" cancer, because their wombs were "dirty" from the contraception.

4.3. Nurses' views on the screening programme

What are the barriers to providing a more effective cervical screening service?

Accessibility

Healthworkers interviewed expressed the view that lack of accessibility-the lack of transport for women to come to the clinic-was "one of the biggest struggles."

Lack of staff

Lack of available nursing staff to provide women with health education, including explanations about smears, was said to be a problem. This was seen as a priority need for the clinic to operate more effectively.

Women's reluctance and fear

Healthworkers mentioned as problems women's misunderstandings about the smear test and lack of motivation to have them done. They made the point that even having a vaginal examination performed was a major problem for many women: "they need a lot of encouragement to expose themselves, for whatever reason." One healthworker explained as an example of misunderstanding that women "jump to conclusions", thinking that if nurses are screening women who come for FP services, then it is because "their [FP] methods" are giving them cancer.

Healthworkers also said that many women do not return for their smear results, and that although previously the clinic posted results, this practice had been discontinued on the grounds that the administration involved was too much for the clinic staff. Some patients had told them that they could not afford to come specially to the clinic to collect the results, and so the healthworkers said that they could just collect them at their next FP visit. Healthworkers did however mention that women were more likely to return for their results if they were given an appointment card with a date written on it.

Healthworkers also mentioned that some patients had a problem with the concept of asymptomatic disease, saying for example "I don't have anything wrong with me so why should I have the test?"

It was also said that women express a certain resignation about serious illness, that "they want to live with whatever they have", saying "if I die, I die."

No charge for the smear: a problem for some?

Healthworkers suggested that the fact that smears are done free of charge *may* be a problem for some patients, who may associate this with poor quality service. A parallel example given was that some clinic-attenders asked the nurses to give them FP brands which the nurses personally used, to avoid being given "cheap stuff."

Communication problems with other clinicians

Healthworkers expressed disappointment that they continued not to receive feedback from hospital specialists to whom they referred women found to have CIN or atypias which merited further clinical investigation, saying that when such women returned to the clinic at a later time, the clinic staff were not in a position to know what had happened diagnostically or curatively, and so were unsure as to how to act in the patients' best interests.

Problems with follow-up

Healthworkers described how some women who are found to have CIN refuse to go to the hospital when referred there. Reasons they suggested included that women think that inyangas are able to cure cancer, and that they associate hospitals with terminal illness and death.

5. DISCUSSION

In the following section the term "womb" cancer is used to refer to cervical cancer, since these are the words used by the patients interviewed.

5.1 Women's knowledge of their body

It was clear from the study that women neither recognised the word "cervix", nor distinguished separate parts of the womb. Informants used the Zulu terms *isibeletho* and *isinye* to refer to the womb. There are important implications for the development of health educational strategies and materials, since those which do not make use of the terms used by women themselves will be ineffective. Healthworkers are usually aware of these issues; however, it constitutes a useful reminder of how different ordinary people's understandings of their bodies and medical techniques can be from that of biomedical practitioners. Educators could for example talk about "the mouth of the womb" [as they may already], and this would make sense to women, as well as reassuring healthworkers and others who are worried about biomedical accuracy in terminology.

5.2 Smears, "womb" cancer and "promiscuity": a problematic association

Several important perceptions of "womb" cancer, which may contribute to low screening uptake, were raised in the interviews conducted with women. Primarily, informants associated "womb" cancer with having multiple sexual partners, which was commonly said to cause "dirtiness" in the womb, often through acquisition of a sexually transmitted disease [*isifo socansi*]. Significantly, informants predominantly placed the emphasis on *women* having multiple sexual partners as a primary cause of "womb" cancer, rather than on their male partners, as was the case when discussing sexually transmitted diseases rather than cancer.

There is evidence from this data, and from that collected at the other two sites in the study, that women are more willing to undergo a smear test if they are experiencing gynaecological symptoms, that it makes more sense to them. The association between smears and reproductive tract infection has appeared as a major discussion point, whose positive and negative consequences need to be considered. On the positive side, women presenting with infection may be an easy group to invite for a smear opportunistically, particularly if they are being examined anyway, given also that they at higher risk of contracting cervical cancer. On the negative side, the stigma which is already associated with "womb" cancer through its perceived sexual cause may be aggravated if the smear is further promoted as an STD diagnostic tool, and so may constitute a serious barrier to uptake of screening services. The danger is that women may be reluctant to attend for smears for fear of being found to have a stigmatised condition, or being regarded as having low morals.

It is not clear how much these associations constitute a problem, and it must be noted that all types of cancer may be stigmatised; however it is important for healthworkers to be aware of them, and to consider strategies for changing perceptions in this area. The situation may be improved if nurses, when educating about cervical cancer, emphasise the important role that *men* who have multiple sexual partners play as a risk factor for cervical cancer. Similarly, rather than explaining to patients that the smear test can detect infection, as many nurses do, perhaps it would be of more benefit to de-

centralise the sexual association, and emphasise that the smear acts as a "check-up" [which the researchers recognise that the clinic staff frequently do].

5.3 "Womb" cancer as a terminal illness

Although some women interviewed said that "womb" cancer was a disease of stages which could be halted if discovered in time, many women stated that "womb" cancer entailed eventual death, telling stories of individuals who had been diagnosed and who had subsequently died. This picture could derive from epidemiological patterns of cervical cancer, which demonstrate that black African women have a higher prevalence rate of the illness, and from barriers to health-seeking practices affecting them which means that they present later, and consequently are diagnosed later than other sectors of the South African population.

The researchers are aware of the efforts of clinic staff to explain the preventative potential of the smear test to their patients. In health education emphasis needs to be continually placed on explanation that cancer may be treated if found early, with the outcome that the smear test may be perceived more as a *preventative* procedure than a diagnostic one. International literature also documents the perception that the smear "tells you that you have cancer", and that such an association is damaging to efforts aimed at increasing screening uptake. Within this context it may further be opportune to explain the concept of asymptomatic disease which many women have difficulties with.

5.4 Fear of pain and difficulty with vaginal exposure

One of the most commonly raised barriers to the uptake of smears was fear of pain., and shyness about vaginal exposure. One apparently successful strategy that health workers have used in other clinics to overcome the fear barrier is to ask women to speak to someone who has previously had a smear, since most women find that the experience does not turn out to be as bad as expected. This strategy could be used more widely. It is important that all healthworkers are aware of these problems, as those interviewed at Mtubatuba Clinic were, and to ensure that smears are undertaken in

situations where utmost privacy exists, explanations by nurses of their actions are given, and good technique is followed, whereby women are sufficiently draped and are asked to lie on the examination table with their heels together [thereby lessening tension and reducing exposure].

5.5 Why do women come for smears?

Despite some variety in knowledge and explanations of the purpose of the smear test, many women interviewed indicated that they had undergone screening because the nurses had strongly advised it. There was considerable evidence that women trusted in the healthworkers' authority, even when they were asymptomatic and had limited understanding of the purpose of the smear.

Although ultimately it is desirable that women are educated more about their bodies, relying on education alone to improve screening uptake in women, particularly where staff nurses feel their time to be engaged in such activities to be limited, may not be enough. It could be suggested that the role of the healthworker in identifying suitable women for screening and asking them to attend may be expanded, for example using the TB and mobile clinic service to target older women, who are the focus of the proposed new screening policy [see below]. In addition to enhancing opportunistic screening, a small town such as Mtubatuba may be in a position to pilot a systematic approach through a simple household register, with invitations issued to women of the right age [for the new proposed policy-see below] in particular households each year, such that everyone is invited once in ten years. The technology and time for this in a small town would not be great.

5.6 Operation of the new proposed government screening policy

A review of Mtubatuba clinic records for the year 1994 found that a total of 413 smears were done. The ages of 398 patients were recorded. As noted in the Introduction to the document, cervical cancer starts to be more common between the ages of 30 and 40, with 87% of cases occurring in women over 35 years [Sitas 1994]. Although the details of the new national screening protocol have not been finalised, it is likely to target

women between the ages of 30-55 years [Fonn 1994]. This age group represents only 38 % [n=153] of the women screened at Mtubatuba Clinic in 1994. In other words, 62% of the women currently being screened at the clinic *will not be eligible* for screening in the national programme. Obviously the fact that 62% of women being screened are less than 30 years old, and so would not fit in with government guidelines for screening, directly reflects that the clinic overwhelmingly provides family planning and child health services, and so inevitably has younger women as its main patient group.

When the new policy is established, clinics will have to reconsider their screening programme. The challenge for Mtubatuba clinic, as for the others, will be targetting and successfully recruiting older women, between the ages of 30 and 55 years, for cervical screening. Possibilities of how this may be achieved given limited resources and time will need to be given a great deal of thought and discussion in the near future. There will be a need for management to develop strategies to communicate effectively with their staff, and answer their queries as soon as the new policy is agreed upon.

6. RECOMMENDATIONS

6.1 Recommendations for Provincial Administration KwaZulu-Natal Department of Health

From the findings of this study we recommend:

1. That the new cervical screening policy be agreed as soon as possible and communicated to staff effectively, providing them opportunities to clarify areas of concern;

2. That consideration be given to the extent to which the findings of this Mtubatuba study are generalisable to other parts of KwaZulu-Natal;

6.2 Recommendations for Mtubatuba clinic staff and their managers

The researchers fully recognise the efforts of the staff at the clinic to provide an effective and efficient screening service, and the multiple constraints under which they work.

From the findings of this study we recommend:

1. that clinic staff and managers give careful consideration to the implementation of the new screening policy, since considerable changes in the demographic characteristics of women screened will be required;

2. that managers recognise and discuss nurses' constraints and motivational problems in providing a screening service;

3. that careful consideration be given by managers to ways of expanding the role of nurses in pro-actively recruiting women for screening, as this is clearly successful, possibly through the use of a register;

4. that health education efforts aim primarily to use the language of the women, such as by discussing the "mouth of the womb";

5. that efforts be made to emphasise that cervical cancer is not a disease of 'low morals', and in particular to stress the role of *men* who have many sexual partners as a risk factor;

6. that continued efforts be made to emphasise that when regularly employed the smear test may act as a *preventative* measure, reflecting the probability that cervical cancer may be stopped if intercepted early;

7. that consideration be given to further efforts to enhance privacy and comfort during the smear, and to reduce women's shyness and fear of pain through encouraging women who have had smears to share their experiences with others;

8. that continued efforts be made to ensure that all those who have a smear can be informed of their results and can have any necessary further action explained and followed through

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