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Expressions of cervical cancer-related signs and symptoms

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ABSTRACT

Background: Cervical cancer is the second most common cancer in women worldwide. Although developing countries are the hardest hit by cervical cancer, women living in Europe are also at risk for this disease.
Purpose of the study: The purpose of the study was to explore how women treated for cervical cancer at an academic hospital in Tshwane, South Africa, expressed their cervical cancer-related signs and symptoms during the initial consultation with health care professionals.
Methods and sample: A qualitative, exploratory and contextual research design was used. The sampling method was purposive and convenience. Self-reported data were gathered using semi-structured interviews. Diekelmann's hermeneutical analysis approach was used to analyze the data. The sample size totaled 12 ($n = 12$).
Results: Four themes emerged from the data – ignorance, communication, delayed diagnosis and expectations. All participants lacked knowledge and awareness of the signs and symptoms of cervical cancer. The majority failed to communicate the real nature of their signs and symptoms and was only diagnosed after several visits to the primary health clinic.
Conclusion: Nurses should use every opportunity to screen women for cervical cancer as the woman might not be able to express her cervical cancer-related signs and symptoms.

Background

Cervical cancer is the second most common cancer in women worldwide. In 2002 cervical cancer was the cause of death in 273 000 women, whilst an estimated 493 000 were newly diagnosed. Developing countries are the hardest hit by cervical cancer as 83% of newly diagnosed and 85% of related deaths occur in developing countries (Sankaranarayanan and Ferlay, 2006). Cervical cancer is the most common cancer in women living in sub-Saharan Africa (World Health Organization and International Union Against Cancer, 2005) and is also the most common cause of cancer morbidity and mortality in South African women (Cooper et al., 2007; South African Medical Research Council, 2008). However women living in Europe are also at risk for this disease as according to Todorova et al. (2009) the incidence of cervical cancer in Eastern Europe is on the rise in contrast with that of Western Europe.

Preventing cervical cancer is not simple. It seems as if ethnicity, low socio-economic status and low levels of education lead to not being screened in both developed and developing countries (Moser et al., 2009; Todorova et al., 2009; Denny et al., 2006; Bessler et al., 2007). All South African women have access to cervical cancer screening at primary health clinics however the screening uptake is only approximately 20% (Gakidou et al., 2008). No wonder most women present with late cervical cancer.

Women are however not solely to be blamed for late presentation. In a study conducted by Van Schalkwyk et al. (2008) it was found that women were willing to be diagnosed but were failed by the health care system. Their first contact with the health care system did not result in prompt diagnosis or treatment and they repeatedly had to go back before being diagnosed. Van Schalkwyk (2007) suggested that women might not necessarily report their real problems during the consultations resulting in advanced cancer when they were eventually diagnosed. The current study focuses on how women express their cervical cancer signs and symptoms and will therefore add to the body of knowledge on why women even if screening is available are still being diagnosed with late cervical cancer.

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Purpose of the study

The purpose of the study was to explore how women being treated for cervical cancer at an academic hospital in Tshwane, South Africa expressed their cervical cancer-related signs and symptoms during the initial consultation with health care professionals.

Method

Theoretical foundation

The study was underpinned by Orem's Self Care Deficit Theory. Orem's Theory consists of three basic nursing systems namely the wholly compensatory system, the partly compensatory system and the supportive-educative system (Berman et al., 2008:45). The partly compensatory system applied to the study as both nurse action and patient action are required to enable prompt diagnosis of cervical cancer.

Research strategy and context

The study was exploratory and contextual. An exploratory strategy was applicable as the way in which women expressed their cervical cancer-related signs and symptoms was explored. The context of the study was an academic hospital in Tshwane, South Africa. Tshwane forms part of the Gauteng Province, has a total population of approximately 2.1 million people with Afrikaans (21%) and Sepedi (21%) the languages spoken by the majority. The female population of Tshwane totals 1.03 million, with 667652 women older than 20 years (City of Tshwane Metropolitan Municipality, 2006). Unfortunately the number of women living in Tshwane suffering from cervical cancer is not known.

The academic hospital is a tertiary health care institution where patients from all over South Africa are treated. Patients with cervical cancer are treated at the Department of Radiation Oncology which was established in 1958 (Alberts, 2003). Most patients are treated as outpatients. Patients also come from satellite hospitals as they are transported by bus to the Department for treatment. Food and medicine are provided for these patients as they remain at the Department the whole day. Patients who are unable to travel due to their disease, physical disabilities or old age are admitted to the radiation oncology in patient unit at the academic hospital.

Research design and recruitment strategy

A qualitative research design was selected for the study (Brink, 2006). The qualitative research design allowed the researcher to talk to women with first hand experience about how they expressed their cervical cancer-related signs and symptoms to health professionals during their initial consultation with them.

A purposive and convenience sampling design (Brink, 2006; Burns and Grove, 2005) was used to recruit participants for the study. Using a purposive and convenience sampling design was applicable to the study as the sample assumed to be typical of the population of interest were fortuitously gathered. Women 18 years and older, being treated for cervical cancer at the specific academic hospital and willing to participate were recruited. The sample size, determined by data saturation, totalled 12 ($n = 12$).

Data gathering and analyses

Self-reported data were gathered by means of semi-structured interviews (Polit and Beck, 2008). To enable data gathering, a topic guide was developed. The topic guide consisted of two sections. In Section A, data pertaining to the general characteristics of the sample were gathered. In Section B data pertaining to cervical cancer-related topics were gathered. Key questions explored what the participant told the health care professional was wrong with her, how this was expressed, why the specific information was given and what her expectations were after saying what was said.

Women meeting the inclusion criteria were approached by the researcher and asked if they would be willing to participate in the study. One participant was used to pre-test the topic guide. As the questions contained in the topic guide were clear and easy for the participant to understand, no changes were made to the topic guide and the data collected in the pre-test were included in the analysed data.

Participants were interviewed in a private room with only the researcher, an interpreter and participant present. Interviews were conducted in English with the assistance of the interpreter. A voice recorder was used to record the interviews and the researcher also made notes with the consent of the participants. The duration of the average interview was 1 hour. Data were saturated after 10 interviews; however an additional 2 interviews were conducted to ensure redundancy. Data were gathered during May and June 2009.

The data were analysed by means of content analysis using Diekelmann's hermeneutical approach as described by Polit and Beck (2008). First the researcher transcribed all the interviews verbatim after which the interviews were read for an overall understanding. Interpretive summaries of each interview were written. The transcribed interviews were then analysed with the assistance of a co-investigator and disagreement regarding the interpretation of the interviews were resolved by going back to the transcribed data. Common meanings and shared practices were identified by comparing and contrasting the text to allow themes to emerge.

Trustworthiness

Trustworthiness was established according to the strategies promoted by Lincoln and Guba (1985). Various measures were implemented to ensure credibility, transferability, dependability and confirmability.

Findings

Except for the general characteristics, four themes emerged from the data. The themes were ignorance, communication problems, delayed diagnosis and expectations. Narratives of some of the participants are reflected in the findings. Pseudonyms are used. The general characteristics of the participants are reflected in Table 1.

The most common age group (4 of 12) was the 51–60 years group. This finding supports the evidence of Mqogi et al. (2003) who reported that in South Africa, cervical cancer was most commonly diagnosed in women between the ages of 55 and 64 years.

With regard to the marital status of the sample, the participants were mostly (5 of 12) in a co-habitual relationship. The fact that the sample were mainly unmarried but had children, is supported by a study conducted by Dennis in 2006. Dennis (2006) found that the percentage of black South African women between the ages 15 and 49 who were married during the period 1995–1999 was significantly below 30%. Many black people in South Africa have co-habitual relationships due to the fact that bride price which predates marriage is too high for the men to afford (Dennis, 2006).

The majority of the participants (10 of 12) were functionally illiterate. According to the South African Department of Health (2007) a significant 4.57 million of the population aged 20 years and older had no formal education with an additional 4.1 million having had some primary school education. This group would therefore not benefit from health promotion material. The level of