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Cervical cancer in Bangladesh: community perceptions of cervical cancer and cervical cancer screening

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Summary We investigated the awareness of, and the attitude towards screening for, cervical cancer in Bangladesh. We performed a qualitative study using focus group discussions (FGD). The framework approach to qualitative analysis was used. The study was performed in the catchment areas of Addin Hospital, Jessore, Southern Bangladesh (peri-urban) and LAMB hospital, Parbatipur, North West Bangladesh (rural). A total of 220 men, women and adolescents participated in 28 FGDs. Awareness of cervical cancer was widespread. Knowledge about causes was often inadequate. The perceived consequences of cervical cancer were numerous and awareness of the need for cervical cancer treatment was present. Barriers to accessing care include: low priority for seeking help for symptoms, limited availability of health services and cost. Most women were unaware of the possibility of screening via speculum examination, which was considered acceptable to women (and men), as long as the examination was done by a female healthcare provider in an environment with sufficient privacy. In conclusion, adequate gynaecological services are not available or accessible for most women in rural and peri-urban Bangladesh. However, awareness of cervical cancer is widespread. Screening for cervical cancer in these communities is acceptable if done by a female healthcare provider under conditions with sufficient privacy.

1. Introduction

The worldwide annual incidence of cervical cancer is estimated at 493 000 cases and more than 270 000 women die

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of cervical cancer each year. At least 80% of cases occur in developing countries (Parkin, 2006) and in these countries it is the most common cancer in women.

Cervical cancer screening is relatively inexpensive and there is worldwide agreement that screening programmes for cervical cancer are a necessity (Ngoma, 2006). Furthermore, there are clearly defined management approaches, even in resource-poor environments, to diagnose and treat gynaecological diseases, including irregular bleeding and cancers of the genital tract, in particular cervix cancer (ACCP, 2004).

Programmes that use technically simple screening tools such as visual inspection with acetic acid (VIA) are the recommended screening approach (ACCP, 2004; Goldie et al., 2003; Nene et al., 1996; Sankaranarayanan et al., 2007; University of Zimbabwe/JHPIEGO Cervical Cancer Project, 1999). However, the uptake of screening in many developing countries is still poor (Royal Thai College of Obstetricians and Gynaecologists (RTCOG) and the JHPIEGO Corporation Cervical Cancer Prevention Group, 2003; Sangwa-Lugoma et al., 2006) Reasons for this are not well documented. A few studies have suggested that there is a lack of knowledge and awareness among women with regard to cervical cancer in general and screening opportunities in particular (Gichangi et al., 2003; Kidanto et al., 2002; Soew et al., 1995). Lack of knowledge among men (as key decision-makers) and a negative attitude of men towards screening or treatment of cervical cancer are thought to be other key factors contributing to poor uptake of services (Singh et al., 1998).

In Bangladesh, cervical cancer is the most frequent cancer among women of all ages and is the leading cause of cancer death among women (WHO/ICO, 2007). There are currently no population screening programmes for cervical cancer in Bangladesh. Furthermore, there is a lack of information about what Bangladeshi women know about cervical cancer, and what approach to screening for cervical cancer is feasible and acceptable to both men and women. Bangladesh has an estimated population of 136 million people. It is one of the most densely populated countries in the world. The annual income per capita is US$1770. Life expectancy is 61.7 years for women and 62.3 years for men. About half the population consists of children less than 18 years of age. The adult literacy rate is 50% for men and 31% for women. The fertility rate is 3.1 children per woman. The main religion is Islam (83%) (UNDP, 2007).

In this study, we assessed perceptions and understanding of cervical cancer symptoms, prevention and treatment options, as well as the acceptability of a cervical cancer screening programme. To obtain this information we used focus group discussions (FGD) in two Bangladeshi communities to derive understanding based on group discussion from the community rather than testing a preconceived hypothesis or theory (Pretty, 1993).

2. Materials and methods

The study was carried out in two different areas in Bangladesh. FGDs were held in the catchment populations (about 500 000 per facility) of two health facilities; LAMB Hospital (Parbatipur) in rural northern Bangladesh and Addin Hospital in Jessore (urban/peri-urban). Both hospitals provide community primary care with a focus on poor women and children. They do not currently provide any form of screening services for cervical cancer.

Topic guides and questions were developed with healthcare providers during a one-week multidisciplinary workshop in Bangladesh. These were tested using groups of non-healthcare providers (both men and women) and adapted using correct local terminology. Community healthcare workers were trained in the conduct of FGDs and at each site five pilot FGDs were conducted. The topic guide was revised (simplified) and further training provided. The topic guide included questions exploring the concepts of gynaecological (or women's) disease, cervical cancer, anatomy of the female genital tract, experience of, knowledge about and acceptability of gynaecological examination (bimanual pelvic examination) and speculum examination in general as well as the concept of speculum examination as a way of screening for cervical cancer.

FGDs were conducted in the two communities. During other community health-related activities in the month preceding this study, both communities were informed about planned FGDs and invited to participate. All participants were self selected from within the community and did not receive any payment or other incentive. Participants in the groups attended independently of each other, i.e. adolescents were not specifically invited as a result of other family members participating; similarly men were not invited specifically if wives attended etc. Groups were constituted such that they were culturally acceptable and to obtain the maximum amount of information from both men and women in the community. All discussions were held in an appropriate local setting in the community and conducted in the local language. FGDs generally took place in the shade outside or on the veranda of a health facility but never in a space that could be perceived as intimidating or uncomfortable. Each group had two moderators who were of the same gender as the participants. No specific information was recorded with regard to position, educational level, number of children or employment status.

Over a period of about six months (March to August 2005), a total of 18 FGDs were conducted with married women in the age range 20—49 years (eleven), postmenopausal women (three) and teenage girls (four). The opinions of men as key decision-makers were also sought and FGDs held separately with married men (five) and teenage/unmarried men (five). Informed consent was sought from all individuals participating in group discussions, after the purpose of the research and the specific activity for which participation was being solicited was explained. The names of participants were not recorded to protect privacy and confidentiality. Adolescents were all of reproductive age (>15 years) and gave their own consent. For the purposes of recording and analysis, each FGD received a code (either 'a' or 'L' followed by a number).

In general, each FGD consisted of between eight and twelve participants; in four cases there were larger numbers of people participating (up to 18). A large number of people in each community showed an interest in joining the groups and the team felt it would be counterproductive to refuse them the opportunity to participate.

The slight limitation of the larger group size was considered less important than ensuring the credibility of the data (Pretty, 1993). All discussions were taped, transcribed