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**CULTURAL BELIEFS INFLUENCING THE UPTAKE OF CERVICAL
CANCER SCREENING AMONG WOMEN IN A COMMUNITY
HEALTHCARE CENTRE**

by

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DEDICATION

I dedicate this dissertation to my two beloved grandmothers: Modjadji Chabalala and Mthavini Nkwinika who passed away due to breast cancer and cervical cancer respectively.

DECLARATION

Student Nr 991 105 30

I Cecilia Moeti declare that this dissertation has not been previously submitted to this University or any other University for the award of any degree, diploma or other similar titles of recognition and that the work contained in this dissertation is my own except those, which have been duly identified and acknowledged.

Signature

Date

ABSTRACT

Cultural beliefs influencing the uptake of cervical cancer screening among women in a community healthcare centre.

1.1 INTRODUCTION AND BACKGROUND

Globally cervical cancer was found to be the fourth most common cancer among women in 2012. There were an estimated 528,000 new cases and approximately 266,000 female deaths of cervical cancer in 2012 worldwide. The Human Papilloma Virus (HPV) was being associated with about 70 percent of all cervical cancers (World Health Organization [WHO] 2015:43). In South Africa, cervical cancer is still the most common cancer diagnosed in women. Despite this fact, the uptake of cervical cancer screening in a designated community centre in the Tshwane district in the Gauteng Province of South Africa (SA) is low.

1.2 PURPOSE OF THE STUDY

The purpose of the study was to explore and describe cultural beliefs influencing the uptake of cervical cancer screening among women in a designated community healthcare centre.

1.3 METHOD

A qualitative descriptive design was used, as the researcher was interested in exploring and describing whether cultural health beliefs influence the uptake of cervical cancer screening. The study was conducted at a designated community healthcare centre, which is situated in a Pretoria West suburb in the Tshwane Metropolitan Municipality of the Gauteng Province in South Africa. The population were women who were 35 years and older who have not made use of cervical cancer screening services before, and who attend the selected departments for other reasons than for screening for cervical cancer.

Purposive sampling was used to select participants as they visited the community health

centre's chronic as well as maternal child and women's health services (MCHW) at mother and child healthcare departments. The researcher handed out fliers to all women patients of the departments. The fliers contained information about the study and the inclusion criteria for the sample. The researcher's contact number was also included on the flier in order for interested women to make contact with her once they have decided to participate, or to get more information about the study.

Focus group interviews were conducted at the designated community healthcare centre. Consent was obtained for participation as well as for the use of audio recording beforehand. The interviews were conducted in the English and Sesotho language. The same group of participants were interviewed until data saturation was reached, meaning that no new information was to be obtained. The researcher and co-coder (who both understood Sesotho and English) organised data and translated it. The researcher then interpreted and discussed the findings in a 'dialogue' between it and the existing knowledge base related to the studied phenomenon.

1.4 FINDINGS

The following four categories emerged from this study; Fear of cervical cancer results, cervical cancer is perceived to be caused by sacred or indecent behaviour, spousal approval needed for cervical cancer screening and women should address gynaecological health issues with women. Furthermore nine sub-categories emerged from the categories.

The study found that cultural beliefs played an important role in influencing the uptake of cervical cancer screening in the designated community healthcare centre. Most families in this study were led by males, and participants reported that these males lack knowledge of cervical cancer-related issues. Women were expected to be submissive to their husbands and were not allowed to proceed with health-related procedures without the consent of their husbands. Participants verbalised that they lacked spousal support when it came to cervical cancer screening. Husbands could not approve of their wives having cervical cancer screening performed on them, as the disease was stigmatised. Participants in this study did not consider it necessary to seek cervical cancer screening, as they did not present any symptoms. Participants were most fearful of being diagnosed with the disease and feared losing their husbands due to the treatment procedure that entailed the removal of the uterus, and therefore preferred to remain in denial.

Fear of contracting other diseases such as Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome while performing cervical cancer screening was also reported. The community believed that women with cervical cancer were promiscuous or had abortions and hence women in this study refrained from screening for the disease for fear of being judged. It was also believed that the disease affected widows who failed to adhere to cultural rituals performed to the following the death of their husbands. The study found that cultural restrictions did not allow women's bodies to be viewed by men other than their husbands. The disease was regarded as a taboo, and it was never communicated within families and the community. In the families, women were not expected to talk about women health issues to their husbands as it was regarded as disrespectfulness. They were expected to discuss such issues with elderly female structures within the families. This also created a barrier as most participants reported that they did not get along with these elderly female structures.

1.5 CONCLUSION

It was evident that cultural beliefs played an important role in cervical cancer screening. The community, including men, need to be educated about cervical cancer-related issues while remaining culturally sensitive. Women had to be given a choice of gender preference at the designated healthcare centre when seeking cervical cancer screening.

Keywords: cervical, cancer, screening, uptake, culture, beliefs, Pap smear, Human Papillomavirus, barriers and symptoms.

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TABLE OF CONTENTS

TOPIC		PAGE NR
Dedication		I
Declaration		li
Abstract		lii
Acknowledgement		Vi
Table of contents		Vii
List of Abbreviations		Xii
CHAPTER 1 ORIENTATION TO THE STUDY		
NUMBER	TOPIC	PAGE NR
1.1	INTRODUCTION AND BACKGROUND	1
1.2	RATIONALE	2
1.3	PROBLEM STATEMENT	3
1.4	SIGNIFICANCE OF THE PROPOSED STUDY	4
1.5	RESEARCH QUESTION	4
1.6	OBJECTIVE OF THE STUDY	4
1.7	CONCEPT CLARIFICATION	4
1.8	PHILOSOPHICAL ASSUMPTIONS	5
1.8.1	Ontological Assumptions	5
1.8.2	Epistemological Assumptions	5
1.8.3	Methodological Assumptions	6
1.9	DELINEATION	6
1.10	RESEARCH DESIGN AND RESEARCH METHODS	6
1.11	CONCLUSION	7

CHAPTER 2 RESEARCH METHODOLOGY		
NUMBER	TOPIC	PAGE NR
2.1	INTRODUCTION	8
2.2	RESEARCH STRATEGY	8
2.3	THE RESEARCH METHOD	8
2.4	RESEARCH APPROACH	9
2.5	DATA COLLECTION METHODS AND TOOLS	9
2.6	SAMPLE SELECTION	9
2.7	STUDY CONTEXT	10
2.8	RESEARCH PROCESS	11
2.9	DATA ORGANISATION	12
2.10	DATA ANALYSIS	12
2.11	DATA INTERPRETATION	13
2.12	TRUSTWORTHINESS	13
2.13	ETHICAL CONSIDERATIONS	14
2.14	CONCLUSION	15
CHAPTER 3 FINDINGS		
NUMBER	TOPIC	PAGE NR
3.1	INTRODUCTION	16
3.2	FINDINGS	17
3.2.1	Category: fear of positive cervical cancer results	19
3.2.1.1	Subcategory: Wait for symptoms	19
3.2.1.2	Subcategory: Prefer denial	21
3.2.1.3	Subcategory: Do not want to lose their husbands	22
3.2.2	Category: Cervical cancer is perceived to be caused by sacred or indecent behaviour	24
3.2.2.1	Subcategory: Widows who do not adhere to cultural rituals get cervical cancer	24

3.2.2.2	Subcategory: Multiple sexual partners cause cervical cancer	25
3.2.2.3	Subcategory: Cervical cancer is a punishment	26
3.2.3	Category: Spousal approval needed for cervical cancer screening	28
3.2.3.1	Subcategory: Spousal disapproval causes women to delay cervical cancer screening	28
3.2.4	Category: Women should address gynaecological health issues with women	30
3.2.4.1	Subcategory: Concern to be discussed with female family members	30
3.2.4.2	Subcategory: Avoid male health workers	32
3.3	SUMMARY	33
CHAPTER 4 DISCUSSION OF THE FINDINGS		
NUMBER	TOPIC	PAGE NR
4.1	INTRODUCTION	35
4.2	CATEGORY: FEAR OF POSITIVE CERVICAL CANCER RESULTS	36
4.2.1	Subcategory: Wait for symptoms	36
4.2.2	Subcategory: Prefer denial	38
4.2.3	Subcategory: Do not want to lose husbands	39
4.3	CATEGORY: CERVICAL CANCER IS PERCEIVED TO BE CAUSED BY SACRED OR INDECENT BEHAVIOUR	40
4.3.1	Subcategory: Widows who do not adhere to cultural rituals get cervical cancer	40
4.3.2	Subcategory: Multiple sexual partners cause cervical cancer	41
4.3.3	Subcategory: Cervical cancer is a punishment	42
4.4	CATEGORY: SPOUSAL APPROVAL NEEDED FOR CERVICAL CANCER SCREENING	42
4.4.1	Subcategory: Spousal disapproval causes women to delay cervical cancer screening	42
4.5	CATEGORY: WOMEN SHOULD ADDRESS	44

	GYNAECOLOGICAL HEALTH ISSUES WITH WOMEN	
4.5.1	Subcategory: Concerns to be discussed with female members	44
4.5.2	Subcategory: Avoid male health workers	44
4.6	CONCLUSION	45
CHAPTER 5 CONCLUSIONS, IMPLICATIONS FOR PRACTICE RECOMMENDATIONS AND LIMITATIONS		
NUMBER	TOPIC	PAGE NR
5.1	INTRODUCTION	46
5.2	SUIMMARY OF FINDINGS	46
5.2.1	Fear of positive cervical cancer results	47
5.2.2	Cervical cancer is perceived to be caused by sacred or indecent behaviour	47
5.2.3	Spousal approval needed for cervical cancer screening	48
5.2.4	Women should address gynaecological health issues with women	48
5.3	LIMITATIONS OF THE STUDY	48
5.4	RECOMMENDATIONS	49
5.5	CONCLUSION	51

LIST OF REFERENCES

LIST OF REFERENCES	
TOPIC	PAGE NR
References	52-57

LIST OF TABLES

LIST OF TABLES		
TABLE	TOPIC	PAGE NR
Table 3.1	Demographic data of focus group participants	16

x

Table 3.2	Categories and subcategories regarding the influence of cultural beliefs on the uptake of cervical cancer screening	18
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LIST OF ANNEXURES

LIST OF ANNEXURES		
ANNEXURE	TOPIC	PAGE NR
Annexure A	DECLARATION TO PLAGIARISM	58
Annexure B	RESEARCH GUIDE	60
Annexure C	LETTER OF APPROVAL	62
Annexure D	RESEARCH DECLARATION	65
Annexure E	PARTICIPANT'S INFORMATION & INFORMED CONSENT DOCUMENT 2	67
Annexure F	LETTER OF APPROVAL FROM DEPARTMENTAL IN-HOUSE	70
Annexure G	LETTER OF APPROVAL FROM RESEARCH ETHICS COMMITTEE	72
Annexure H	LETTER OF CLEARANCE FROM TSHWANE RESEARCH COMMITTEE	74

LIST OF ABBREVIATIONS

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ABBREVIATION	MEANING
DHIS	District Health Information System
HPV	Human Papillomavirus
Pap Smear	Papanicolaou Cytological Testing
WHO	World Health Organisation
MCWH	Maternal Child and Women's Health
DoH	Department of Health
HIV/Aids	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
PEER	Participatory Ethnographic Evaluation and Research
VIA	Visual Inspection of the cervix with acetic acid
WBOT	Ward Based Outreach Team
DNA	Deoxyribonucleic acid

CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION AND BACKGROUND

According to Globocan (2012:5), cervical cancer was the fourth most common cancer among women in 2012, with an estimated 528,000 new cases and approximately 266,000 female deaths worldwide. Globocan (2012:6) further maintains that in South Africa it is the second most common cancer. Statistics South Africa (Stats SA 2014:14) estimates roughly eight female deaths from this cancer daily. The Human Papillomavirus (HPV) is associated with about 70 percent of all cervical cancers (World Health Organization [WHO] 2015:43). In South Africa, the Department of Health (DoH) has established a screening policy in an attempt to reduce the incidence of cervical cancer. However, implementation of the policy remains a challenge, as the estimated screening coverage in South Africa is as low as 13 percent (Snyman 2013:1).

The prevalence of HPV infection in Southern Africa varies per district, age group, and level of immune-competence (Ebrahim et al 2016:2). The WHO (2015:44) warns that the prevalence rate of cervical cancer could rise with time if measures for prevention and early diagnosis are not implemented. Two primary methods of cervical cancer prevention are endorsed by the WHO (2016:15), namely vaccination against HPV and regular screening for cervical cancer. In South Africa, Grade 4 girls attending public schools aged 9-13 years are offered vaccination against HPV as a form of primary prevention of cervical cancer (Botha & Richter 2015:33-34).

According to the guidelines of the WHO (2015:45), women older than 30 years need to be screened for precancerous cervical lesions to prevent it from progressing to invasive cancer. The national guidelines for cervical cancer screening in South Africa (DoH 2014:16) recommend at least three screenings for cervical lesions through Papanicolaou Cytological Testing (Pap smears) in a woman's lifetime, with a ten-year interval from the age of 30 years. As precancerous cervical lesions can be treated before progressing into cancer, regular screening for such lesions can

contribute to a decrease in the mortality rate of cervical cancer (Pegu et al. 2017:907). Unfortunately, the majority of cancers are diagnosed only once symptoms appear (Ellis-Brookes et al. 2013:1220-1226). In South Africa, the low uptake of cancer screening is evidenced by the few available statistics (Ebrahim et al. 2016:5).

Whether cultural beliefs influence the uptake of cervical cancer screening among women, should be considered. In Ghana, also an African country, similar low cancer screening trends are identified which, according to Lim and Ojo (2017:112), and Williams et al. (2013:231) may be associated with cultural beliefs. South Africa is a culturally diverse country, and people may have different cultural beliefs regarding cervical cancer screening, resulting in the differences that are experienced in the uptake of cervical screening in specific districts and provinces (Ebrahim et al. 2016:2).

Reasons cited for the low rates of cervical cancer screening in Sub-Saharan Africa such as stigma and shame of the disease, embarrassment for exposing private parts to others (Lim & Ojo 2017: 35), the occurrence of abortions, excessive sexual intercourse, the presence of environmental pollutants, and spiritual reasons (Williams et al. 2013:233) can be linked to cultural beliefs. According to Schleicher (2013:126), some women, due to their cultural beliefs, assume that cervical cancer cannot be prevented or identified early and treated as it occurs due to fate or predetermined forces that they cannot control.

Cultural beliefs play an important role in cancer as a disease. In Africa, including South Africa, the majority of people possess a variety of cultural beliefs influencing cancer diseases. In South Africa, very little literature could be found on the influence of cultural beliefs on cervical cancer screening by women. This study seeks to explore and describe whether cultural beliefs influence the uptake of cervical cancer screening among women in a community healthcare centre.

1.2 RATIONALE

In South Africa routine screening for cervical cancer is associated with the success rate of treatment of such cancers (DoH 2017:12). It is thus necessary to explore and describe why women prefer not to be screened for the early detection of cervical cancer. The researcher determined that cultural beliefs can be associated with the low screening percentage at the healthcare centre. The

healthcare centre has been unable to reach the South African Department of Health's annual target of 60 percent since 2014 (Districts Health Information System [DHIS] 2014-2015:12).

1.3 PROBLEM STATEMENT

Despite the involvement of governmental and non-governmental organisations in mitigating the morbidity of cervical cancer in South Africa, the uptake of cancer screening is below 45 percent (DHIS) 2014-2015:12). It is evident that there could be cultural reasons preventing women from screening for cervical cancer. South African health institutions are not able to screen at least 60 percent of the annual target as set by the South African Department of Health (DoH 2016:10), which could be attributed to reasons related to cultural beliefs. According to the DHIS (2016:22), an estimated coverage of cervical cancer screening in the district was around 25-30 percent between 2012 and 2016.

The community healthcare centre that the researcher selected for the research offers a free cervical cancer screening service. According to DHIS (2016-2017: 04), cervical cancer coverage was at 30 percent between April 2016 and March 2017 at this selected healthcare centre. The centre renders comprehensive health services to a culturally diverse population, and the researcher found it necessary to describe and explore cultural beliefs that could be associated with cervical cancer screening.

The researcher has been working at the selected community healthcare centre for more than 13 years. She observed that most of the women who come for cervical cancer screening are those referred to the centre because of the occurrence of sexually transmitted infections and lower abdominal pains (Community healthcare centre statistics 2016-2017:03). Based on the records on cervical cancer screening, an estimation of 30 percent of women aged 35 years and above make use of the service. According to the DHIS statistics (2014-2015:12) 55,943 women aged 30 years and above reside near the community healthcare centre; hence, the above statistics are worrisome.

As Schleicher (2013:6) argued, people from many cultures believed that poor genital hygiene and sexual activity caused cervical cancer. Schleicher (2013:6) further stated that in many cultures, women did not want to have their private parts checked by doctors unless there were symptoms present, as it was private. Therefore, in this study, the researcher sought to explore and describe

whether cultural beliefs influenced the uptake of cervical cancer screening among women in a community healthcare centre.

1.4 SIGNIFICANCE OF THE STUDY

The findings of this study brought new information about cultural beliefs regarding cervical cancer screening in the specific geographical area around the designated community healthcare centre, which could be associated with a low uptake of screening services. The information served as a basis for increasing cervical cancer screening awareness. It also addressed gaps that existed in the literature regarding reasons for the low uptake of cervical cancer screening in South Africa.

1.5 RESEARCH QUESTION

What are the cultural beliefs influencing the uptake of cervical cancer screening?

1.6 OBJECTIVE OF THE STUDY

The objective of the study was to explore and describe cultural beliefs influencing the uptake of cervical cancer screening.

1.7 CONCEPT CLARIFICATION

In this study, the following concepts were applicable:

Karma: According to the Oxford English Dictionary (2007:83), Karma refers to the sum of a person's actions in this and previous states of existence, viewed as deciding their fate in a future existence.

Human Papillomavirus: It is referred to as the causative organism of carcinoma of the uterus (DoH 2016:3) in South Africa). For the purpose of this study, the Human Papilloma Virus was referred to as the virus responsible for causing 70% of cervical cancers.

Cervical cancer screening: It is regarded as the process of detecting abnormal cells or tissues in the cervix before cervical cancer develops (WHO 2015:47). In this study, cervical cancer screening

was referred to as the detection of abnormal cells or tissue in the cervix. Papanicolaou smears are used. The method referred to cervical smear that was taken in the health centre and analysed in a laboratory.

Cultural beliefs: According to the Oxford English Dictionary (2007:72) ideas, customs and social behaviour of a particular group of people or a society. In this study, cultural beliefs were referred to as the knowledge that was held in the woman's culture that could have influenced her from screening for cervical cancer.

Uptake: The Oxford English Dictionary (2007:183) refers to uptake as an activity. In this study uptake refers to an activity meant to increase cervical cancer screening.

1.8 PHILOSOPHICAL ASSUMPTIONS

Philosophical assumptions are the researcher's beliefs that were accepted as truths, but with no evidence (Creswell 2014:12). The researcher of this study supported a constructivist paradigm. She thus assumed relativist ontology, a subjectivist epistemology and used a naturalistic research methodology (Denzin & Lincoln 2003:35).

1.8.1 Ontological Assumptions

Ontological assumptions are referred to as the nature of reality (Creswell 2014:11). In this study, the researcher believed that relativist ontology was applicable, as multiple realities regarding cultural beliefs and low uptake of cervical cancer screening existed. Different people had different views regarding whether cultural beliefs influenced a low uptake of cervical cancer screening. It was assumed that a variety of cultural beliefs were involved in the decision of women to consult community healthcare centres for cervical cancer screening.

1.8.2 Epistemological Assumptions

Epistemological assumptions refer to how researchers know what they know by engaging with participants (Creswell 2014:110). In this proposed study, the researcher interacted with participants to be able to explore and describe whether their cultural beliefs related to cervical cancer screening influenced them to not present themselves at the designated community healthcare centre for screening. The participant's views were also respected.

1.8.3 Methodological Assumption

Methodological assumptions are regarded as rules and procedures or the methods that the researcher needs to follow during the process of research. Moule and Goodman (2014:461) stated that researchers adopted the role of being facilitators during interviews to enable participants to share their perceptions and knowledge about the studied phenomenon. In this study, the researcher facilitated the interpretation of the participant's views on cultural beliefs regarding cervical cancer screening and how it was going to influence their decisions to not get screened. This was done by quoting the exact words of the participants to substantiate the findings of the study.

1.9 DELINEATION

This study focused on women who were older than 35 years, but haven't had cervical cancer screening in their lifetime. Although it was expected that all women older than 30 years should regularly be screened for abnormal cells in the cervix, the researcher decided to focus on women older than 35 years. Women who had just turned 30 years still had time to go for cervical cancer screening, but those who were already 35 years should already have been screened. According to American Cancer Society (2020:7) cervical cancer is most frequently diagnosed in women between the ages of 35 and 40 with the average age at diagnosis being 50.

1.10 RESEARCH DESIGN AND RESEARCH METHODS

In this study, a qualitative descriptive design was used. In qualitative research design, the researcher aimed to explore and understand the meaning of a person or people ascribed to social or human events (Creswell 2014:4). The researcher was interested in exploring and describing the influence of cultural beliefs on the uptake of cervical cancer screening in the designated community healthcare centre. It was by implementing a qualitative approach that the researcher was able to interact with participants and understand them. It allowed the researcher to explore and describe cultural beliefs that influence the uptake of cervical cancer screening. Polit and Beck (2017:743) stated that the purpose of a descriptive study was to observe, describe and document events as they naturally occur.

1.11 CONCLUSION

This chapter entailed the background of the study; the research questions, the rationale behind the study and its significance. It also outlined the problem statement and the objective of the study. Concepts were clarified; delineation and philosophical assumptions used were discussed. The detailed research design and research methods will be discussed in Chapter 2.

CHAPTER 2

RESEARCH METHODOLOGY

2.1 INTRODUCTION

In Chapter 1, the background, purpose, objectives, research question and significance of the study were described. This chapter describes and explains the research methodology of the dissertation. In this section, the researcher outlines the strategy, research method, research approach, methods of data collection, selection of the sample, research process, type of data analysis and ethical considerations.

2.2 RESEARCH STRATEGY

An applied research approach is relevant to this dissertation. Various pieces of previous academic research exist regarding cultural beliefs influencing cervical cancer screening, though not for the designated community healthcare centre, but for other destinations in African countries and other places in the world. As such, the dissertation took the form of new research but on an existing research subject.

2.3 THE RESEARCH METHOD

To satisfy the objectives of the dissertation, qualitative research was conducted. This was simply because it was appropriate for a smaller sample, while the outcomes were not measurable and quantifiable. It offered a complete description and analysis of a research subject, without limiting the scope of the research and the nature of participant's responses.

2.4 RESEARCH APPROACH

The research approach that was followed for the purpose of this study was a qualitative descriptive design. Based on this approach, the researcher aimed at exploring and understanding the meaning that a person or people ascribe to social or human events (Creswell 2014:4). The researcher was interested in exploring and describing cultural belief's influence on the uptake of cervical cancer screening in the designated community healthcare centre. It was through a qualitative approach that the researcher was able to interact with participants and understand them. It allowed the researcher to explore and describe the influence of cultural beliefs on the uptake of cervical cancer screening. Polit and Beck (2017:743) stated that the purpose of a descriptive study was to observe, describe and document events as they naturally occur.

2.5 DATA COLLECTION METHODS AND TOOLS

In this study, in-depth interviews through focus groups were used. Four focus group interviews that consisted of six participants were conducted at the designated community healthcare centre. Focus group interviews lasted between 45 and 60 minutes. The researcher played the role of a moderator/interviewer and was assisted by a colleague who functioned as the co-moderator. Consent for participation as well as the use of an audio recorder was obtained before the interview. Participants in each focus group were interviewed once using the same research guide. The focus groups were arranged according to the participant's language preference. There were two focus groups conducted in the English language and the other two in the Sesotho language. Data saturation was reached at the end of the fourth focus group. There was no separation of cultural groups because the researcher aimed to explore and describe cultural beliefs influencing their decisions to not use cervical cancer screening services.

2.6 SAMPLE SELECTION

The method of purposive sampling was used to develop the sample of the researcher under discussion. According to this method, which belongs to the category of non-probability sampling techniques, sample members are selected based on the researcher's own judgement about which participant she thinks will provide the information needed (Polit & Beck 2017:743). In this study, the researcher purposely selected participants as they visited the community healthcare centre's chronic and maternal child and women's health services (MCWH), specifically at the mother and

child department. Information about the study was made available to patients through a flier. With the permission of the management of the community healthcare centre and the professional nurses in charge of chronic and mother and child departments, the researcher handed out 80 fliers to all women who visited these departments on a specific day. The fliers contained information about the study as well as the inclusion criteria for the sample. It also contained the researcher's contact number for interested women to make contact with the researcher through a 'please call me' method once they have decided to participate or to request more information about the study. The researcher then returned their calls. A total of 67 women showed interest and responded. They were invited to the initial briefing meeting. Fifty-five women turned up for the meeting, and only 42 of them met the inclusion criteria. Thirteen women did not qualify due to the language barrier and age. Out of the qualifying 42 women, a total of 18 women failed to turn up for their appointment; hence, each focus group had 6 participants.

Inclusion criteria:

- Women who were 35 years and older.
- Never had a Pap smear done previously.
- Women who were able to express themselves in the Sesotho or English language.

2.7 STUDY CONTEXT

Polit and Beck (2017:743) referred to the context as the actual location where data is going to be collected. The study was conducted at the designated community healthcare centre. It is situated in a suburb in the south-west of Pretoria central, in the Tshwane Metropolitan Municipality of the Gauteng Province in South Africa. It is a provincial primary healthcare centre facility rendering 18 services which include chronic, maternal child and women's health services, physiotherapy, acute, emergencies, crisis centre, dental, sonography for pregnant women, radiology services, etc. All services are free of charge. It is situated in the Indian community, but it is predominantly used by the African community in the neighbouring areas. It has a total of 38 consulting rooms, one treatment room for Rehabilitative services and three theatre rooms for procedures such as termination of pregnancy and medical male circumcision. The two referral hospitals are approximately 10km away. It is open 24 hours a day, seven days a week, including weekends and holidays though the services that open at 24 hours are only emergency services, crisis centre and maternal obstetric units. However other services offered at an 8-hour service are rendered if needs

arise. It has a total of 150 staff members, which includes professionals and non-professionals. The total number of patients seen monthly range from 14000-14500.

2.8 RESEARCH PROCESS

Meetings were held between June and July 2018 with selected participants subsequent to their acceptance of participation in the research. The nature of the study was explained to participants and they were willing to participate in the research. The participants were given a paper to write their preferred language of the study. The researcher then arranged four focus groups which consisted of ten participants each to ensure that at least a minimum of six participants would be present should other participants fail to take part. This was based on the participant's language preference and appointments (date, time and venue) were made for them. They were also given a contact number where they can use a 'please call me' method to the researcher should they want to cancel their appointment. This enabled the researcher to rearrange the focus groups and appointments ensuring that each group had no less than six participants. The interviews were conducted between September and November 2018 at the designated community healthcare centre at 16:15 while the 8-hour shift services were closed.

On the day of the interview, participants in each of the focus groups were introduced to one another. The ground rules were set, the interview guide was made available to everyone before the onset of the interview, probing questions were used to clarify issues and they were encouraged to ask questions and comment on each other's experiences or points of view. At the end of each interview, an appointment for the next focus group was confirmed.

Each focus group was audio-recorded and lasted 45 to 60 minutes. There were two focus groups for participants who were comfortable with the Sesotho language and the other two focus groups were for those who were comfortable with the English language. Before the interview, participants were each given a piece of paper to fill in the requested demographic data. Participants who could not read and write were assisted by the moderator by asking them the required data and writing it on the piece of paper. During the interview, participants were free to express their views and kept to the agreed ground rules. As far as data collection tools were concerned, conducting the research involved the use of semi-structured questions that were used as an interview guide by the researcher. The questions were prepared for the researcher to guide the interview towards the satisfaction of the research objectives. No additional questions were compiled during the interview

(a detailed form of the research guide is presented as Annexure B). At the end of the interview, all participants were thanked. Descriptive field notes were compiled during and immediately after the focus group interviews to ensure that data that could not be captured in the audio-recordings was not lost.

Participants were fully informed regarding the objectives of the study, while they were also reassured that their responses would be treated as confidential. Participants were not harmed or abused, both physically and psychologically during the conduction of the study.

2.9 DATA ORGANISATION

According to Polit and Beck (2017:728), the researcher ensured that the transcriptions were accurate and reflected the phenomenon of interest of the participants. The interviews were thus transcribed verbatim and subsequently compared with the audio-records to ensure that no data was omitted. The field notes were typed. The researcher read and re-read the transcriptions to ensure that no gaps in the data existed. The transcriptions and field notes were stored in labelled folders, protected with passwords. Hard copies of the transcripts and field notes were also kept in locked cupboards.

2.10 DATA ANALYSIS

According to Creswell and Poth (2018:44), the analysis of data in qualitative research involves text analysis and understanding. This research followed the data analysis steps provided by Tesch (1990) in Creswell (2014:174) cited from Botma et al. (2010:224).

Demographic data were manually analysed. All pieces of paper were counted and sorted as per the research guide. Both the researcher and the co-coder listened to the audio-tapes and read the interview transcriptions as well as descriptive field notes. The researcher translated research texts from the source language (Sesotho) into the target language (English) while the co-coder translated from the target language to the source language. Finally both versions were compared to check accuracy and discrepancies. Any discrepancies were then negotiated between the two bilingual translators to achieve equivalence in meanings between two different languages. That was to gain a general sense of the data and to reflect on its overall meaning without distorting the

meaning of participant's cultural beliefs information. Thereafter, notes and general thoughts about data were written in the margins. A list of topics that came to the researcher's mind was to be compiled. Where possible, phrases from the transcriptions were used to ensure that the researcher stayed as close as possible to the information obtained from the participants. The co-coder compared topics with one another and labelled them as codes. In the next step, the codes were grouped into categories based on similarities and differences. Themes were developed from the categories that were used as headings in the description of the findings. The latter was substantiated with excerpts from the transcripts.

2.11 DATA INTERPRETATION

The researcher interpreted the findings after comparing it with the existing knowledge-based related to the studied phenomenon.

2.12 TRUSTWORTHINESS

According to Polit and Beck (2017:747), trustworthiness can be referred to as the degree of confidence the researcher has in their data and its analysis using the following strategies: credibility, dependability, transferability, conformability as well as authenticity to strengthen it.

Credibility is referred to as confidence in the truth of the collected data and the interpretation of data by the researcher (Polit & Beck 2017:559). To ensure credibility in this study, prolonged engagement was achieved by conducting more than one focus group. In addition, an independent coder verified that the collected data were coded and analysed correctly. Dependability referred to as the reliability of data over time and conditions (Polit & Beck 2017:559). In this study, the researcher asked the same questions, as reflected in the interview guide in all focus groups. The involvement of an independent coder was to strengthen the dependability of the study.

Transferability is referred to as how the study's outcomes could be transferred or applied in other settings or groups (Polit & Beck 2017:560). In this study, transferability was attained thorough description or discussions of the research setting, context, methodology, data obtained as well as interpretations of the findings

According to Polit and Beck (2017:560), conformability can be referred to as the objectivity or the potential between one or two independent individuals about the relevancy, accuracy and meaning of data. In this study, conformability was done through a thick description of the process followed.

Authenticity is referred to as how the researcher truly and fairly showed a variety of realities Polit and Beck (2017:560). In this study, it was achieved by quoting the participant's views, thoughts and beliefs without altering what they said to suit the researcher.

2.13 ETHICAL CONSIDERATIONS

Creswell (2014:52) argues that ethical consideration is referred to as a set of moral principles determined by one or more people and accepted by them. In this study, the following ethical principles, namely: beneficence, respect for human dignity and justice as outlined in Polit and Beck (2017:139) was applied (refer to Annexure E).

Permission to conduct the study: In this study, the researcher sought approval from the University of Pretoria ethics committee, National Department of Health Research Ethics Committee as well as the facility manager of the selected community healthcare centre.

Informed consent: The participants were requested to give informed consent for participation and the use of audio-recorder. They were reassured that should they decide to refuse, their decisions were not going to be held against them when they wanted to make use of the services as the selected community healthcare centre. The participants were also reassured that the provided information was not going to be used against them. The researcher adhered to all information that appeared on the informed consent form such as the sessional times and the number of contacts.

Respect for human dignity: It refers to the participant's right to self-determination which Polit and Beck (2017:140) referred to it as the participant's right to voluntary partake in the study and withdraw from it at any given point without being punished or prejudiced. For the purpose of this study, participants were given information about their right to voluntarily take part in the study without being coerced. It was emphasised that signing the informed consent form did not take away their right to withdraw from the study at any given point without fear of being penalised or prejudiced (Annexure E). They were also offered an opportunity to ask questions. Interested participants signed the informed consent forms where there was full disclosure of the nature of the

study, the rights to withdraw from the study or decline to participate, the potential risks, benefits and the researcher's responsibilities.

Beneficence: According to Polit and Beck (2017:139) beneficence refers to an obligation imposed on the researcher to protect the participant from harm and maximise benefits. There are two principles of beneficence namely; the right to freedom from harm and discomfort as well as the right to self-determination. In this study, the researcher ensured that participants were well informed and fully understood the research process and how it would benefit them.

Justice: According to Polit and Beck (2017:141), this principle refers to the right to fair treatment and the right to privacy. In this study, the participants were selected based on the study inclusion criteria. All participants were equally treated and not discriminated against. Should participants wished to decline to participate or withdraw at any point; they would not be treated in a non-prejudicial manner. The researcher further demonstrated sensitivity towards the participant's views on cultural beliefs. The collected data was stored in a locked cabinet. Confidentiality was maintained and emphasised but not guaranteed as other members of the focus groups could have leaked information to non-participants which the researcher had no control over. To maintain confidentiality, no personally identifiable information such as name was asked or associated journal reflections. Codes rather than participant's names were used to provide and maintain privacy.

2.14 CONCLUSION

In this study, data was collected at the designated community healthcare centre situated in the south western suburb of Pretoria central. The study population were women who are 35 years and older who had not made use of cervical cancer screening services and who were able to express themselves in the Sesotho or English language. Participants were purposely selected as they came to the community healthcare centre's chronic and maternal child and women's healthcare departments. Four focus group interviews that consisted of six participants were conducted at the community healthcare centre. The interviews were thus transcribed verbatim and later compared with the audio-records to ensure that no data got left out. The research findings will be presented in Chapter 3.

CHAPTER 3 FINDINGS

3.1 INTRODUCTION

This study aimed to explore and describe whether cultural beliefs influence the uptake of cervical cancer screening. Four groups of six participants were interviewed, and the data was analysed. In this chapter, the findings are described and substantiated with excerpts from the transcripts of the interviews.

The participants had different cultural beliefs and came from diverse cultural groups. The age of the participants ranged from 35 to 63 years. More than half of them (52% of 24 participants) were married. The rest were unmarried, widowed or engaged. Almost all the participants (90% of 24 participants) stayed with their husbands and partners. Refer to Table 3.1 below for more demographic information.

Table 3.1: Demographic data of focus group participants

PARTICIPANTS	AGE	MARITAL STATUS	PARITY	LIVING ARRANGEMENTS
P1	36	Married	01	Husband and children
P2	45	Single	04	Boyfriend
P3	53	Married	05	Husband and children
P4	37	Engaged	02	Partner and children
P5	45	Married	02	Husband and children
P6	38	Married	05	Husband, grandmother and children

P7	46	Married	03	Husband and children
P8	52	Married	05	Husband
P9	47	Single	01	Mother, child and siblings
P10	39	Single	02	Both parents, sister and Children
P11	40	Engaged	04	Fiancé and children
P12	37	Engaged	02	Fiancé, children and grandfather
P13	44	Married	03	Husband and children
P14	36	Single	01	Child and brother
P15	38	Married	03	Husband and children
P16	63	Married	06	Husband, children and father-in-law
P17	47	Single	04	Children
P18	51	Married	04	Husband and children
P19	40	Married	02	Husband and children
P20	53	Single	04	Boyfriend and children
P21	35	Widow	02	Children
P22	40	Married	03	Husband and children
P23	38	Single	03	Boyfriend
P24	36	Married	02	Husband, uncle and children

3.2 FINDINGS

The analysis of the data revealed four main categories namely “Fear of positive cervical cancer results”, “Cervical cancer perceived to be caused by indecent behaviour”, “Spousal approval

needed for cervical cancer screening” and “Women should talk about gynaecological health issues with women”. The categories consist of sub-categories as shown below in Table 3.2

Table 3.2: Categories and subcategories regarding the influence of cultural beliefs on the uptake of cervical cancer screening

CATEGORY	SUB-CATEGORIES
Fear of positive cervical cancer results	Wait for symptoms Prefer denial Do not want to lose their husbands
Cervical cancer perceived to be caused by sacred or indecent behaviour	Widows who do not adhere to cultural rituals get cervical cancer Multiple sexual partners cause cervical cancer Cervical cancer is a punishment
Spousal approval needed for cervical cancer screening	Spouse’s disapproval causes women to delay cervical cancer screening
Women should address gynaecological health issues with women	Concerns to be discussed with female family members Avoid male health workers

3.2.1 Category: Fear of positive cervical cancer results

Fear of a positive result can accompany any health screening test. In the current study, some participants mentioned that they refrained from cervical cancer screening, fearing a positive cervical cancer result following a screening test. Three subcategories emerged from the category.

3.2.1.1 Subcategory: Wait for symptoms

The participants preferred to wait for symptoms of cervical cancer than being precautionary screened. They were also convinced that it was not necessary to consult healthcare professionals for screening for the disease while they believed they were healthy. To them, the absence of symptoms such as vaginal bleeding and lower abdominal pain meant that women were free from gynaecological diseases. They preferred to continue with their lives until symptoms appeared:

“I will wait for the signs like too much bleeding from my private part, and I will go to the clinic; otherwise, I just have to enjoy my life with my husband.”¹ (Participant 19)

The participants felt that they needed first to have symptoms such as vaginal bleeding before they could think of getting screened for cervical cancer and in the meantime, they would continue living their lives as usual:

“I see no point going to check for womb cancer when I am not bleeding from my vagina, and my womb is not painful, and my life is fine now.” (Participant 12)

According to the participants, there was no need for cervical cancer screening when no symptoms such as vaginal bleeding and no lower abdominal pains were present.

“I don’t have any bleeding or discharges from my vagina; my womb is not painful, so why should I go to the clinic. If I go to test for this cancer and they tell me I have the disease what will happen to my life, I will not enjoy myself because my life will be a mess.” (Participant 20)

¹ In the interest of authenticity, all quotes are presented verbatim and no changes were made to language and grammar.

With the absence of vaginal bleeding or discharges, the participants believed that they had no reason to get screened for cervical cancer. They feared that the possible positive cervical cancer results would disrupt their lives. The participants also mentioned that they preferred to wait for symptoms for cervical cancer rather than undergoing cervical cancer screening. They distrusted the healthcare system as they were afraid that they could contract infections from cervical cancer screening:

“I am not sick, so why do I go to the clinic, the next thing I will have diseases that I don’t know where they come from.” (Participant 03)

The participants believed that one has to visit the healthcare facilities only when one is ill. Regular visits may cause problems as infections could be diagnosed:

“That is why there are so many diseases. It is because people go to the clinic even if they are not sick; doctors will tell you that you have AIDS”. (Participant 23)

The participants were convinced that the presence of many diseases was because people visit healthcare facilities while they are asymptomatic. They reported that during physical examinations and cancer screening procedures, patients could be exposed to microorganisms that could cause infections. They feared that they could contract AIDS during such unnecessary visits:

“People say doctors at the hospital will put all sorts of diseases to us when we do Pap smear and next thing; they will say they find that you have HIV”. (Participant 04)

The participants wrongly believed that they could get infections when doctors and nurses perform cervical cancer screening procedures. They also feared that they could be diagnosed with HIV infections:

“I once talked to him, my partner about Pap smear and he said I like inviting trouble into our lives. He said I want nurses to tell me that I have HIV”. (Participant 10)

Often the partners of the participants warned them to not go to the clinic for screening procedures, but to rather wait until symptoms appear.

In the subcategory wait for symptoms, it was evident that the participants preferred to wait for symptoms such as vaginal bleeding and lower abdominal pains before they could go for cervical cancer screening. They also feared that through cervical cancer screening without symptoms, they could in the process be diagnosed with infections such as HIV. Participants preferred to continue enjoying their lives as they feared positive cervical cancer results could disrupt their lives.

3.2.1.2 Subcategory: Prefer denial

Some of the participants indicated that the community preferred denial of the realities surrounding cervical cancer. They displayed fear in discussing cervical cancer-related issues amongst themselves as the community perceives the illness to be a taboo. Some of the participants affirmed that women who were rumoured to suffer from cervical cancer were rejected by their communities, including their own families:

“One woman was even called the devil as she told her mother in law that she has cancer of the womb. The women in her community stopped being her friend because you don’t want to be seen with the devil or witch otherwise you will be accused to be one, and it will affect your marriage because your husband\boyfriend will run away.” (Participant 05)

Communities and families attached a stigma to the disease, and the participants feared that they would lose their partners/husbands due to the attached stigma:

“I cannot do pap smear now because I am scared to know the results. If they tell me I have the disease, it's fine, and there is nothing I can do now. I am afraid people will stop buying my cakes I am selling.” (Participant 23)

The participants delayed screening for the disease as they were not ready to deal with positive results which could affect their businesses. They expressed that whenever they were to be diagnosed with the disease, they will deal with the consequences:

“With my culture, it is a taboo for a woman to have cancer of the womb, so we cannot do Pap smear”. (Participant 17)

The participants believed that cervical cancer was a taboo, and therefore, they could not seek screening for the disease. They further reported that cervical cancer-related deaths which occurred within their communities had been swept under the carpet because the community preferred denying the existence of the disease and that it was claiming the lives of women:

“Women die in silence, and the reason why they die is not told to outsiders. It is a shame to die of cancer of the womb in my culture.” (Participant 04)

The participants felt that women should not be talking about issues surrounding cervical cancer as it was regarded as a shameful disease. A death which occurs as a result of the disease would not be discussed within families or communities:

“Ja! Even when a person dies of it, they will not tell you. They will tell you something else. You don’t find people talking about Pap smear except when you go to the clinic, sometimes.” (Participant 17)

According to the participants, the community does not talk about cervical cancer-related issues except at the healthcare facilities. This was to such an extent that even when the disease claimed the lives of women, other diseases are said to be responsible for the deaths:

“Even when a person is sick about this cancer, it is kept as a secret. They will tell you that she had pains on the stomach or something else.” (Participant 14)

People living with cervical cancer also remained silent about the cause of their ill health and blamed other diseases. This subcategory revealed that the community regards cervical cancer as a taboo and a shameful illness. The participants preferred to live in denial that cervical cancer does exist and was responsible for some of the deaths of women in their community. This was because they feared that positive cervical cancer results could lead to them being discriminated against and judged by their own community/families. They then preferred not to be screened for the illness.

3.2.1.3 Subcategory: Do not want to lose their husbands

Some of participants reported that they did not want to lose their husbands, should they be diagnosed with cervical cancer. They feared positive cervical results as they were worried about

the treatment process, which entails the removal of the uterus. The participants were concerned that the treatment procedure could compromise their sexual activities and they would not be able to bear children anymore. This could result in their husbands, leaving them for other women:

"I am scared to do the test. What if the results say I have this cancer? He will leave me for another woman." (Participant 10)

The participants feared that their husbands would leave them for other women should they receive positive cervical cancer results:

"My friends say they will not do the test because they heard that if the results say you have cancer then they are going to take out your womb and your husband will not enjoy sex, and he will run away because it is like you are a man and not a woman". (Participant 24)

The participants were worried that the cervical cancer treatment process entailing the removal of the uterus could disrupt their sexual lives leading to their husbands leaving them for other women:

"If you have cervical cancer, then you will not be able to have children because they remove your womb, so your husband will leave you and get another woman". (Participant 20)

The participants were also worried that by having their uteruses removed as part of the treatment, they would not be able to bear more children. This will lead to their husbands leaving them for other women. Some participants verbalised that they saw the need to be screened for the illness, but they feared to lose their husbands/partners should they be diagnosed with cervical cancer:

"I have decided to go for Pap smear, but my boyfriend told me when I come back with cancer, then it is over with us because he said having no womb will be like I am a man, so I didn't go because I am afraid he will leave me". (Participant 23)

The participants delayed cervical cancer screening due to fears that should the tests indicate cervical cancer, their husbands may leave them. Men did not regard a woman who had her uterus removed as part of the treatment of cervical cancer as a woman anymore.

From this sub-category, it emerged that the participants feared that positive cervical cancer screening results could disrupt their families. This was because they would not be regarded as women due to the treatment process whereby their uteruses could be removed. With that said they preferred delaying screening for cervical cancer and rather wait for symptoms to appear as they feared losing their husbands to other women.

3.2.2 Category: Cervical cancer is perceived to be caused by sacred or indecent behaviour

Sacred or indecent behaviour was perceived as behaviour that was unacceptable to the community such as prostitution, having abortions or more than one sexual partner. It also included cultural rituals that were not adhered to as expected by a widow following the death of her spouse. The participants believed that only women with sacred or indecent behaviour were prone to cervical cancer. Three sub-categories emerged from this category.

3.2.2.1 Subcategory: Widows who do not adhere to cultural rituals get cervical cancer

The participants referred to cervical cancer as 'makgome'. According to them 'makgome' affects widows who failed to adhere to cultural rituals performed by an 'inyanga' upon the death of their husbands. They emphasised that cervical cancer was the result of 'bad blood from the deceased'. They further explained that makgome presented with swelling of the face and lower extremities. Excessive vaginal bleeding also occurs. The participants were convinced that only widows who failed to adhere to cultural rituals could be susceptible to cervical cancer:

"This cancer of the womb is also seen as makgome in our culture, bad blood of the wife's late husband and my husband is still alive, so I will not get it". (Participant 10)

The participants who were not widows regarded themselves as immune from contracting the disease. Screening for cervical cancer was not necessary for them as their husbands were still alive:

"With us, it is like when you have this cancer, you once had a husband or partner that passed away, and your family didn't get you a proper inyanga or traditional healer to cleanse you. This is somebody who has been trained to use herbs to cure diseases. It is called "makgome". And when

you sleep with another man, that man is also going to die (whisperings in the room.” (Participant 10)

The participants believed that cervical cancer could only be prevented by adhering to the cultural rituals performed by an ‘inyanga’ or traditional healer. The participants described an ‘inyanga’ or traditional healer as a person who underwent training to cure ailments using herbs. They added that should a widow get cervical cancer, it can also be cured by traditional herbs and not by western medicine:

“Yes, they say when you go to the doctor; they won’t see anything until you go to the sangoma because it’s a disease of us blacks.” (Participant 08)

As the participants believed that only ‘inyangas’ or traditional healers were capable of curing cervical cancer, there was no reason for them to consider visiting the clinics for cervical screening. They reported that should they develop symptoms of cervical cancer, they would consult the traditional healers for treatment instead of medical practitioner. The widowed participants mentioned that they have adhered to the cultural rituals upon the deaths of their spouses and they were convinced that they were immune from the disease.

“I agree with what she says, even with my culture makgome is real. She needs a good inyanga to bath her with muthi to take out the husband’s dirty blood and not a doctor because she will die, doctors don’t know these things, they will tell you it’s cancer and treat it as cancer.” (Participant 12)

The participants believed that cervical cancer could only be treated by traditional healers with herbal baths to ‘take out the deceased dirty blood’. They were convinced that western medicine could not treat cancer. According to them, there was no reason for them to visit the clinic for screening for the disease as western medicine had no place in treating cervical cancer. Participants further verbalised that doctors and nurses were not capable of treating a disease that was caused by indecent behaviour. According to the participants, only widows were prone to get cervical cancer and the only way to prevent it was to participate in cleansing therapy that traditional healers would offer upon death of spouse.

3.2.2.2 Subcategory: Multiple sexual partners cause cervical cancer

The participants revealed that their communities perceived a woman with cervical cancer as a promiscuous woman. Women who had multiple sexual partners would contract cervical cancer. It

was believed that it was caused by the 'dirt' that the men leave in the vagina of the involved woman:

"In my culture, it is believed that when a woman has cancer of the cervix, that woman is sleeping around. It is the dirt of different men that caused cancer". (Participant 03)

The participants believed that cervical cancer was caused by sexual intercourse with multiple sex partners. Participants were convinced that should a woman have only one sex partner, she would not get cervical cancer:

"Cancer of the womb is seen in women who sleep around with different men. We don't want to look like those women, too". (Clapping her hands) (Participant 17)

According to the participants, cervical cancer tends to affect women with multiple sexual partners, and no woman wanted to be associated with them. Women with cervical cancer got isolated from others. To further support this sub-category, some participants expressed that they did not see themselves as susceptible to cervical cancer because they did not have multiple sexual partners:

"I don't think it is necessary for me to do Pap smear because I have only one boyfriend". (Participant 12)

The participants who remained faithful to one partner did not regard themselves susceptible to the disease; hence, they did not see the need for screening.

"Why should I go to the clinic to check this cancer of the womb when I sleep with my husband only". (Participant 22)

The participants were convinced that only women who have multiple sexual partners should be screened for the disease as they were susceptible to it:

"Married women will not get this cancer because it is only for the ones who don't have husbands because they sleep with many boyfriends". (Participant 25)

Participants reported that married women who were faithful to their husbands did not need cervical screening as they would not develop cancer. These women were perceived to be not at risk of developing the disease.

The participants associated the illness with promiscuity and prostitution. They believed that since they did not engage in indecent behaviour such as having multiple sexual partners, they were free from getting the illness. They then felt that they didn't need to be screened for the illness.

3.2.2.3 Subcategory: Cervical cancer is a punishment

The participants stated that cervical cancer was, according to them, a punishment for indecent behaviour or what they referred to as bad behaviour. They mentioned that women with cervical cancer were either punished by God or the ancestors.

“My culture believes that when a woman has cancer of the womb, she has bad things that she did, and it is a punishment from the Ancestors or God. I don't believe in that, but this is what my culture says, so lots of women end up not going for the pap smear because they are afraid that they will be seen as bad people”. (Participant 02)

According to participants women who are thus diagnosed with cervical cancer were considered to have been punished for their sins or bad behaviour. Abortion and adultery are examples of bad behaviour. Women feared cervical cancer screening as a positive result would stigmatise them:

“In my culture, cervical cancer is believed to be a punishment of sins you have committed or something bad that you did. I am afraid of doing pap smears because if my results come back that I have cancer, then I will be seen as a bad person”. (Participant 07)

The participants also revealed that their culture perceived cervical cancer as a punishment from God for abortions:

“...in my culture, a woman with cancer of the womb means you had abortion somewhere in your life, so it is pay-back time, like a punishment from God”. (Participant 09)

The association of cervical cancer as a punishment made women refrain from cervical cancer screening procedures, as they feared possible positive results could label them as bad people or sinners:

“Me too, we see these women who have cancer as evil and are getting what they deserve. It is the punishment from the Ancestors or God”. (Participant 18)

Women who had cervical cancer were regarded as evil and deserving of punishment by the ancestors and God. It was evident that women who perceived themselves as ‘having good behaviours’ were not seeking cervical cancer screening. According to them, these women with ‘good behaviour’ were not prone to the disease. The participants refrained from cervical cancer screening procedures even though they wanted to. They feared positive cervical cancer results could mean that they once behaved indecently and were also being punished.

3.2.3 Category: Spousal approval needed for cervical cancer screening

The participants expressed that they needed spousal approval to proceed with cervical screening. They further reported that it was culturally seen as being disrespectful for a woman to undergo cervical cancer screening without the approval of her spouse. Unfortunately, their spouses would not approve of the participants to get screened for cervical cancer as they lacked knowledge about the need for screening for the disease.

3.2.3.1 Subcategory: Spousal disapproval causes women to delay cervical cancer screening

The participants reported that their partners disapproved of them being screened for cervical cancer. They further mentioned that it was because their spouses did not have sufficient information or knowledge on the causes of cervical cancer. Some participants were interested in cervical cancer screening, but they could not undergo the screening as their spouses did not permit them to be screened. They verbalised that they felt helpless:

“We just suffer in silence because our husband doesn’t approve as they don’t understand this disease. You cannot do anything that your husband doesn’t approve”. (Participant 18)

The participants' spouses refused to permit cervical cancer screening as they believed that it was not necessary to be screened for a disease when one was not ill. One of the participants' aunts passed away due to cervical cancer, and the participant saw the need to be screened. However her husband refused to give her permission to get screened and she had no other option but to obey him by not getting screened:

"After I lost my aunt because of cancer of the womb, I talked to my husband about pap smear and cancer of the womb. He doesn't allow me to do the test because he says I am not sick".
(Participant 01)

The participants did not consider getting screened for cervical cancer without their spouses' permission. They knew that the spouses would experience such anger that they could be chased away:

"My husband does not want me to do Pap smear so I will not do it; otherwise he will chase me out of the house". (Participant 07)

The husbands did not want their wives to be screened for the disease, and the participants were not prepared to defy that as they feared being chased out of their houses. The participants' spouses believed that when a woman had cervical cancer, she was also HIV positive and had several sexual partners. Their husbands warned the participants that positive cervical cancer results could mean that they also had HIV infections and that confirmed that they were promiscuous. They were thus scared to be screened for cervical cancer as a positive outcome might cause tremendous problems:

"My husband told me straight that if you go and come back and tell me you have cancer of the womb, it means you have HIV, so it simply means you are sleeping around." (Participant 24)

Due to rumours that cervical cancer can be caused by witchcraft, some of the participants' husbands were convinced that a woman who died of cervical cancer, was bewitched:

"There was a rumour in the community that one woman died of cervical cancer, but my husband said it was not cervical cancer but witchcraft". (Participant 3)

Some of the participants were financially dependent on their husbands. When they wanted to visit the clinic, they had to ask their husbands for the money for transport. One of the participants asked her husband to pay for the trip to the clinic. Instead of assisting her, he shouted at her:

“With me, my husband is very strict and old fashioned. I once asked his money to go to the clinic for a pap smear. He shouted at me to say he doesn’t want to hear that word of Pap smear in his house. So, I never went till today”. (Participant 16)

From this subcategory, it was clear that participants were willing to be screened for the disease but were bound by culture as they had to seek spousal approval. Most spouses refused to approve for their partners to be screened. This was because spouses lacked knowledge on cervical cancer as some associated the disease to HIV, prostitution, witchcraft, etc. The participants relied on their husbands for transport fees to be able to reach the healthcare facilities, and were often denied. They preferred to delay screening for the disease for fear of being regarded as disrespectful towards their husbands.

3.2.4 Category: Women should address gynaecological health issues with women

The participants reported that their cultures did not permit them to address gynaecological health-related issues with their spouses. They were expected to talk about it with the elderly female members of the extended family. Only with the permission of these ladies could they visit clinics to consult female healthcare providers. Two subcategories emerged from this category.

3.2.4.1 Subcategory: Concerns to be discussed with female family members

The participants reported that they could not discuss cervical cancer concerns with their husbands as their culture regarded it as being disrespectful. They further reported that such issues were to be discussed with elderly female structures within the paternal families:

“My husband is very stubborn, and he is strict. He doesn’t allow me to discuss women’s topics with him. He says I must talk to his mother when I want to talk about women’s issues. Now I cannot discuss it with him and convince him”. (Participant 06)

The participants felt defeated as they believed that their mothers-in-law could not convince their sons to support their wives to get cervical cancer screening. The older women were conservative and believed that cervical cancer screening was not necessary. The participants had to convince at least two people to support them to be screened for cervical cancer. They could not decide to undergo screening on their own:

“We never discuss things like a pap smear. In my culture, a woman does not talk to her husband about women’s illnesses or problems. I can speak to my sister in law or mother in law, and I feel maybe they are not trying their best to make him see that I want to test for cervical cancer”. (Participant 01)

Some of the participants did not get along with the elderly female family members, and felt that they had no chance of getting their husbands’ permission to be screened for cervical cancer:

“My mother in law is not friendly and does not like me so I just keep quiet because she won’t help me or tell my husband” (Participant 32)

The participants opted to delay screening for the disease due to poor relationships with family members:

“The only female person in the family is my sister in law that one will disagree with everything I say so it’s better just to close my mouth”. (Participant 16)

The participants felt that they shouldn't have to be directed to request screening approval through these female structures, because the same female structures disagreed with everything they say. They felt helpless and preferred to postpone screening. Some of the participants had good relationships with their mothers-in-law who tried to convince their sons to allow them to be screened for cervical cancer. Unfortunately, their sons (who were the deciding factor) were not convinced to approve for their wives to visit the clinic for cervical screening:

“I once asked my mother in law about getting screened for cervical cancer and asked her if it was ok for me to go to the clinic. She told me she has to first hear from my husband, and I was told he declined my request.” (Participant 19)

Some of the participants distrusted the female structures within their families. Upon husbands declining to give them permission for screening, the participants were unsure if the message was indeed conveyed or not:

“My sister in law told me when she asked my husband to approve me to get screened; he told her he will take me to the clinic the following month. Till today I haven’t got screened”. (Participant 11)

In this subcategory, participants were bound by culture not to discuss female health-related issues with their husbands but to speak to the paternal elderly female structures within the families. These structures were to convey the requests to the husbands on behalf of the wives. Participants were convinced that were they directly allowed to speak to their husbands, they would have managed to convince them to approve screening. The participants had doubts that these female structures did enough to convince their husbands to consent for the cervical screening. Some participants were promised by their husbands to accompany them to the healthcare centres for screening, but the promises were not honoured. For some participants, relating their concerns to the elderly female structures within the family was an obstacle, as they were not getting along. They opted to keep it to themselves and delayed cervical cancer screening.

3.2.4.2 Subcategory: Avoid male health workers

The participants stated that according to their cultures, it was a taboo for females to expose their bodies to males (who were regarded as strangers) other than their own husbands. They added that their husbands preferred to take them to the female family healthcare practitioners of their choices at private practices than to allow them to visit public facilities such as the community healthcare centre. At the centre, nurses and doctors of both gender performs the screening for cervical cancers. For that reason, some participants were not allowed to make use of the services offered by the community healthcare centre:

“He told me I am not supposed to undress to strangers to see my private parts unless if those strangers are my boyfriends”. (Participant 15)

Male healthcare providers were regarded as strangers, and the husbands of some participants did not allow these strangers to view their spouses’ genital areas. Should that take place, spouses were accused of being in a sexual relationship with strangers:

"I cannot have a stranger look into my private parts, no ways". (Participant 01)

Their husbands promised participants that they would take them to their family doctors but due to financial constraints, it was not done:

"He said if I am sick, he will take me to our family doctor because I cannot go to the clinic and take out my clothes for male doctors, but he had not taken me there until today". (Participant 19)

The participants were restricted from visiting public healthcare facilities, as they could be attended to by male doctors and nurses. It was culturally unacceptable for the participants to have a male person other than their husbands view their bodies.

From this subcategory, it was evident that participant's cultural beliefs prohibited women from males other than their husbands to view their genitalia, even if it was for health reasons. The participants were also expected to address their health-related concerns with a female healthcare provider. Husbands opted to take their wives to their female private healthcare practitioners for screening, but they could not always be taken due to financial constraints. As a result, the participants delayed cervical cancer screening.

3.3 SUMMARY

The findings of this study provided insight and an understanding that cultural beliefs influenced the uptake of cervical cancer in the designated community healthcare centre. Most families in the communities were patriarchal. Husbands played a major role in cervical cancer screening and yet they were found to lack knowledge of the disease. The participants had no say over their own health issues and were found to be submissive towards their husbands/partners. They were not provided with any form of support from their spouses concerning cervical cancer screening. Cultural customs were adhered to and were unquestionable. Financial challenges were seen to not deter husbands from defying their cultures.

Cervical cancer was also linked to human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS). Husbands believed that through cervical cancer screening, their wives could contract other infections. The participants preferred to wait for the presence of symptoms before

they could seek medical attention as they believed the absence of symptoms meant they were free from the illness. Cervical cancer was also associated with what they call 'makgome'. The participants believed that cervical cancer could only affect a certain individual with indecent behaviours and they also saw it as a punishment. Communities could not accept the realities of cervical cancer deaths that were occurring within the community.

The participants were also not allowed by culture to speak to their husbands about female health-related issues but were referred to the patriarchal elderly female structures within the family. This created doubt as women felt these females did not do enough to convince their husbands, and participants felt it would have been better if they were to speak to their husbands directly. Some participants did not get along with these elderly female structures, and they then decided to keep it to themselves and delayed screening.

These findings will be discussed with the literature review in the next chapter.

CHAPTER 4

DISCUSSION OF FINDINGS

4.1 INTRODUCTION

This study found that women using the designated healthcare centre delayed cervical cancer screening due to cultural beliefs. Some women lived in patriarchal led families, whereby men are the sole decision-makers. The study revealed that some women financially dependent on their husbands to be able to reach the healthcare facility for screening procedures. They also required their husbands' permission to get screened for cervical cancer. According to their cultural beliefs, it was unacceptable for them to get screened for cervical cancer without the permission of their husbands. The participants voiced fear of losing their husbands due to positive cervical cancer results and getting screened without spousal approval during the focus group interviews.

This study also revealed that cervical cancer was called 'makgome' by the participants. In some cultural groups, cervical cancer was caused by failure to adhere to cultural rituals performed by traditional healers following the death of a spouse. The disease was also said to affect promiscuous women and those who have had abortions. Cervical cancer was thus viewed as a punishment for having done bad things in one's life. According to cultural beliefs, women who fell outside the afore-mentioned categories perceive themselves as free from getting cervical cancer. Through this study, it was revealed that women would wait for symptoms such as excessive vaginal bleeding and lower abdominal pains to get screened. Without such symptoms, the participants believed that screening for cervical cancer was not necessary.

It was also found out that community and families preferred denial of the disease; hence, a death occurring as a result of cervical cancer was not communicated, and other diseases took the blame. The only place where women could get information about the disease was at the healthcare centre. This was because cervical cancer was regarded as a shameful disease. This study found that women were barred by culture not to directly speak to their husbands regarding gynaecological issues as it was regarded as being disrespectful. They were referred to the elderly female structures within the patriarchal families who would convey the messages on their behalf to

their husbands. Women were also advised to avoid male healthcare provider as it was culturally a taboo for men other than a husband to view their genital parts. Husbands preferred taking their spouses to the female family doctors in the private sector whenever they wanted to be screened. This study found that of some women who participated in the study were promised to be taken to these family doctors, were not taken due to financial constraints.

In this chapter, the findings are discussed with reference to the aim of the study, which is to explore and describe whether cultural beliefs influence the uptake of cervical cancer screening in light with existing literature.

The following four categories emerged from the study: Fear of positive cervical cancer results, cervical cancer perceived to be caused by indecent behaviour, spousal approval needed for cervical cancer screening and women should address gynaecological health issues with females.

4.2 CATEGORY: FEAR OF POSITIVE CERVICAL CANCER RESULTS

Fear of a positive result can accompany any health screening test. In the current study, some participants expressed that they feared a cervical cancer screening result following a screening for cervical cancer. Three subcategories emerged from the category.

4.2.1 Subcategory: Wait for symptoms

Participants said that they wanted to wait until they have symptoms such as excessive vaginal bleeding before they can seek medical attention. The absence of symptoms meant that they were free from contracting the disease.

Lee (2015:87) reviewed 22 current studies associated with breast and cervical cancer in Korean American women, and in 11 of the studies they found that lack of symptoms was the reason why Korean American women did not screen for cervical cancer. Chidyaonga-Maseko, Chirwa and Sinjani-Mvula (2015: 231) conducted an electronic search using keywords such as cervical cancer, HPV vaccination, etc. using the Garrard Matrix method approach. Thirty-one articles that were published between 2001 and 2014 were yielded from the search. In one of the studies searched, they found that most women did not view cervical screening as important or necessary, because they did not believe they were at risk for the disease. Rather, they believed that they were healthy as they had no gynaecological symptoms that warrant screening. Jradi and Bawazir (2019:532)

conducted a study in Riyadh city in Saudi Arabia which included 77 women between the ages of 18 and 45 years old in 9 focus groups. They found that women were convinced that it was not necessary for them to get screened while asymptomatic and considered themselves not at risk of contracting the disease. Conversely, Khan and Woodlands (2015: 255) recruited six South Asian women and seven Emirati women living in Dubai, and found that women in their study believed that it was possible to have cervical cancer without symptoms and that symptoms will become noted at an advanced stage.

Participants reported that they did not trust the health system, and they have a fear of contracting other diseases like HIV/AIDS during cervical cancer screening. This study is similar to the one conducted by Lim and Ojo (2017: 13) who electronically searched on MEDLINE EMBRACE.etc and studied eight studies exploring reasons women did not utilise cervical cancer screening in Sub Saharan Africa. Williams et al (2018: 587) also conducted their study on 42 nurses at two hospitals in Ghana, assessing their knowledge on cervical cancer screening and prevention. They found that participants reported distrust in the health system, where they feared contracting diseases such as HIV/AIDS. Modibbo et al. (2016:7), in their study conducted in 2 Nigerian hospitals on 27 Christian and 22 Nigerian Muslim women, explored barriers to cervical cancer screening. They focussed on religious and cultural factors and reported that women feared contracting other illnesses in the hospital during screening procedures.

A study by Hasahya et al. (2016:5) that included 36 women from Uganda consisted of 36 women aged 25 to 49 years old with no previous history of cervical cancer symptoms or diagnosis. They aimed at exploring beliefs, attitudes and perceptions in relation to cervical cancer and they mentioned that the reluctance to go for screening and the fear of contracting infections or diseases when being screened for cervical cancer reflected a lack of knowledge about cervical cancer screening. In a study conducted by Gherbre et al. (2015: 86) examining barriers of cervical cancer screening among Somali women, also reported a lack of trust in the health system, as women reported that they would not follow the doctors' instructions without asking for validation from fellow women in the community. Black, Hyslop and Richmond (2019:9) reviewed 14 studies that included the views of 4386 women and 350 healthcare workers published between 2006 and 2019 in Uganda to evaluate barriers and facilitators to accessing cervical cancer screening, and they found that women indicated that cervical cancer screening could reveal one's HIV status.

4.2.2 Subcategory: Prefer denial

Some participants in this study reported that they did not discuss cervical cancer-related issues in their community or families, as the illness was perceived to be taboo and shameful. Gherbre et al. (2015: 84) found that Somali women would discuss any health-related issues with family and friends, but not sexually related topics. They feared being judged by their communities and families as being bad people. These studies are concurrent with the study conducted by Madhivanan et al. (2016:715) amongst 35 Hispanic women in Miami, exploring their knowledge and beliefs on cervical cancer screening, found that women did not discuss cervical cancer for fear of making family members apprehensive and prefer to keep it as a secret.

Nyblade et al. (2017:10) conducted a study where 147 respondents were interviewed including husbands, healthcare providers and community leaders. They also found that women with cervical cancer will be talked about by husbands, families and the community as the disease bore a stigma. In a study conducted by Nattembo and Schumacher (2018: 5), 79 students of Makerere University aged 20 to 35 years old expressed that there was no sufficient communication regarding matters of cervical cancer within their community.

In this study, participants reported that they prefer to delay screening for the disease as they feared positive cervical cancer results which could disrupt their families. This is similar to the findings from other studies carried out in Nigeria and Southeast Georgia by Modibbo et al. (2016:9) and Luque et al. (2010:98) respectively, where both studies found that participants feared positive cervical cancer results as it could lead into broken homes. Luque et al. (2010: 98) study included Latinas and Anglo-American women as well as Latina healthcare workers between the ages of 18 to 55 years old in Southern Georgia. Williams et al. (2018:588) found that women feared positive cervical cancer results as they view it as a death sentence and feared being rejected by the community and families. McFarland, Gueldner and Mogobe (2016:496) conducted a similar study by searching databases whereby 17 reviewed studies published between 2006 and 2015 from sub-Saharan countries and revealed that positive cervical cancer results were an indication of death.

Nattembo and Schumacher (2018:4) also reported similar findings with the previous researchers. They preferred to be in denial of their cervical cancer status and continue with their lives as normal for fear of being victimised and rejected. Kwong (2016:138), in his study aimed at exploring the views of cancer among Chinese immigrants, assessed their health beliefs and attitudes towards

the causes and prevention of cervical cancer. He reported that female Chinese immigrants mentioned that when cervical cancer strikes, it was an unfortunate event and that women should try her best to remain positive and leave the outcome to God.

It has been noted from this study that the cause of a death occurring as a result of cervical cancer was kept as a secret as the disease was regarded as a shame, which is similar to the study conducted by Luque et al. (2010: 92), who also found that the disease was regarded as shameful. In a qualitative study by Asawapornmongkol (2017:43) conducted with 12 Thai American women, the findings emerged that despite having had a family member suffering from the disease, there was still avoidance of talking about the disease. In contrast with the later findings, Black, Hyslop and Richmond (2019:10) indicated that women who knew someone who had cervical cancer or died of the disease would motivate other women to seek screening procedures.

4.2.3 Subcategory: Do not want to lose husbands

In all focus groups, participants said they feared to lose their husbands due to positive cervical cancer results, as their husbands were unsupportive. This was attributed to the fact that they will not be able to bear them more children following treatment procedure which entails the removal of the uterus. Bateman et al. (2019:73) conducted a study on HIV infected women and clinicians in Tanzania, where they mentioned that men deserted their wives as they believed that the diagnosis of cervical cancer meant that the wives have been unfaithful to them or they could infect them with the disease through sexual engagement. They further mentioned that the women were stigmatised and isolated.

Nyblade et al. (2017:7) further mentioned that when a married woman has cervical cancer, the mother-in-law would start looking for another wife for her son, as it is believed that the woman will no longer be capable of performing her duties/roles of a wife due to the disease. They also believe that since the disease was incurable, death was unavoidable. Therefore, women ended up hesitating to get screened for the disease fearing the consequences of positive cervical cancer results.

In their studies, Onyenwenyi and Mchunu (2018:24) whose study included 28 rural men and women from Nigeria and Nardi, Sandhu and Selix; (2016:677), whose study was conducted amongst Hispanic, Asian American and African women, also found that women expressed fear of

undergoing hysterectomy if they were to be diagnosed with cervical cancer, which will make them feel less of a woman resulting in the fear of losing their husbands to other women. Black, Hyslop and Richmond (2019:9) further indicated that Ugandan women were also concerned that irrespective of the support their spouses provide them, upon diagnosis of cervical cancer, they will leave them.

4.3 CATEGORY: CERVICAL CANCER IS PERCEIVED TO BE CAUSED BY SACRED OR INDECENT BEHAVIOUR

Sacred or indecent behaviour was regarded as behaviour that was unacceptable to the community such as prostitution, abortions and having more than one sexual partner. It also included cultural rituals that were not adhered to as expected by a widow following the death of her spouse. Participants further expressed that only women with indecent behaviour were susceptible to cervical cancer. Three sub-categories emerged from this category.

4.3.1 Subcategory: Widows who do not adhere to cultural rituals get cervical cancer

Participants expressed that they believed that widows who failed to adhere to cultural rituals after the death of a spouse would get cervical cancer or 'makgome' as it was known in the community and that the disease cannot be cured by western medicine but by an 'Inyanga'. Some participants in this study were convinced that they were not at risk of contracting the disease since they were not widows. This is in contrast with the study conducted by Lee (2015:86) that reported that widows did not need to be screened for cervical cancer as they are no longer sexually active.

In the study conducted among men and women aged 18 to 59 years old and with ten key informant interviews with persons aged above 60 years old at two sites in the Gulu district between May and June 2012, Mwaka et al. (2014:7) reported that women preferred traditional medicine to treat cervical cancer as some of the healthcare workers demand bribes, disrespect them and uses a language that was understood by them only. The latter was aimed at exploring community perceptions, beliefs and knowledge about local names, causes and symptoms, cause, treatment and prognosis of cervical cancer. Furthermore, Black, Hyslop and Richmond (2019: 5) reported that in their study done in Uganda; women seek the advice of traditional healers first, as the disease was perceived to be caused by witchcraft. However, Khan and Woolhead (2015:253)

illustrated that women preferred treating cervical cancer using western medicine over traditional medicine.

4.3.2 Subcategory: Multiple sexual partners cause cervical cancer

Participants said that multiple sexual partners were perceived to be the cause of cervical cancer. This is concurrent with the study conducted by Heslop and Banda (2013:229) amongst males and females between the ages of 16 to 29 years old who were interviewed based on the Participatory Ethnographic Evaluation and Research (PEER), a method whereby multiple sexual partners was found to be a risk factor to cervical cancer. However, in their study, Mwaka et al. (2014:5) found that the prolonged use of condoms caused cervical cancer as a result of adverse reactions to the oils or lubricants on the condom. The study also revealed that women feared to attend the screening as they feared being accused of being bad people. Furthermore, Ogbonna (2017:20) in a cross-sectional study of African female students attending a United Kingdom university explored the knowledge, attitude and experience of cervical cancer screening. He indicated that women thought their Christian religion might not allow young women to talk openly about a Pap smear, because church members might see them as not being virgins or as being sexually promiscuous. Similar findings were noted in studies conducted by Modibbo et al. (2016:9) and Madhivanan et al. (2016:715), where women were reluctant to seek screening procedures because they did not want to be considered promiscuous.

Chavez et al. (2001:1116) examined the differential effects of knowledge, attitudes and beliefs on cervical cancer among US-born Latinas, Mexicans, Anglo Americans, Salvadorans and physicians in California. They found that multiple sexual partners were linked with risky bad or immoral behaviour, which increases a woman's chances of acquiring the disease which is consistent with this study. Williams et al. (2018:584) revealed that, in their study, women who had one life-time partner did not perceive themselves as susceptible to cervical cancer which is in line with the findings in this study.

However, Chavez et al. (2001:1119) and Lee (2015:5) found that Latina and Korean women reported that they did not need cervical cancer screening as they were not engaging in sexual activities, which is also similar to the study conducted by Szalacha, Kue and Menon (2017:423) amongst Latinas in Phoenix, Arizona. Gherbre et al. (2015:725) found that Somali women that were older and divorced had the perception that they were not at risk of cervical cancer, which

created a stigma in the community, resulting in some women delaying screening fearing that the community will accuse them of being sexually active. Khan and Woolhead (2015:254) found that Islamic culture and religion permitted polygamous marriages; thus, Islamic women did not perceive polygamous relationships to be a risk factor to the disease, as the relationships were legally binding and not considered to be promiscuous.

4.3.3 Subcategory: Cervical cancer is a punishment

Participants reported that cervical cancer was seen as a punishment from God or the ancestors for bad behaviour. The findings were similar to the study conducted by Mesafint, Berhane and Desalegn (2018:113) among 12 cervical cancer patients admitted at Tikur Anbessa Hospital in Addis Ababa from October 2013 to April 2014. The bad behaviour in the latter study ranges from abortions to promiscuity, and it is consistent with the findings in this study. Nyblade et al. (2017:6) also found in their study that cervical cancer was seen as a punishment for the bad deed a woman or her family may have done, which was also associated with the curse. This is consistent with the findings of Kim et al. (2016:3), who in a descriptive and cross-sectional face-to-face survey conducted among Cambodian American women found that cervical cancer was seen as Karma.

In contrast to this study, Khan and Woolhead (2015:253) revealed that the study conducted amongst Muslim women found that they did not deem cervical cancer as a punishment by God, even though they believe that God has final control over life and death.

4.4 CATEGORY: SPOUSAL APPROVAL NEEDED FOR CERVICAL CANCER SCREENING

Participants reported that they needed spousal approval to proceed with cervical screening. They further mentioned that it was culturally regarded as being disrespectful for a woman to proceed with cervical cancer screening without spousal approval. Participants further mentioned that their husbands lacked knowledge of cervical cancer.

4.4.1 Subcategory: Spousal disapproval causes women to delay cervical cancer screening

In this study, some families practiced patriarchy and husbands were the sole decision-makers. Culture did not allow women to seek screening procedures without their husband's approval. Similar to what was reported in other studies; women have to obtain approval from their husband's

prior screening. Chidyaonga - Maseko, Chirwa and Sinjani - Mvula (2015: 235) reported that women participating in cervical cancer screening should get the approval of their husbands/partners, suggesting that if the husband/partner does not approve of the test, a woman may not go against the cultural expectations and values.

The study also indicated that the women believed their husbands could not support and approve of them undergoing screening procedures due to lack of knowledge, which is in line with a study done by Chidyaonga - Maseko, Chirwa and Sinjani - Mvula (2015:232) that added that lack of knowledge to cervical cancer screening was a significant barrier to screening. A recent study conducted in Saudi Arabia by Jradi and Bawazir (2019:534) supported these studies as they also found that women expressed that they were not able to make decisions on their own health, but their husbands have to decide for them.

Teng et al. (2014:7783) conducted a study among women aged 30 to 60 years of age with the purpose of defining embarrassment and developing an understanding of the role of embarrassment in relation to cervical cancer screening and self-collected HPV DNA testing in Uganda. Allen, Lee and Pratt (2018:57) also conducted their study on 31 Somali refugees on women from the age of 23 to 64 years old to explore facilitators and barriers to cervical cancer screening and HPV vaccination. Both studies illustrated that women did not see this as a barrier as they believed that their health was important with or without their spousal approval.

Furthermore, Emirati women preferred their husbands to accompany them for screening procedures even though approval from their husbands was desirable, but it was not considered to be a barrier (Khan and Woolheads 2015: 254). Teng et al. (2014: 4785) also indicated that women mentioned that they would seek cervical screening with or without their husband's approval as it was not considered a barrier. A study done among men in Ghana pointed out that most men reported their willingness to offer spousal support for cervical cancer screening if they were knowledgeable about the disease (Williams and Amoateng 2012: 3).

The study also found that women are financially dependent on their husbands, and therefore husbands were reluctant to give them transport fees to access screening procedures, which were similar to the study performed by (Alemayehu and Mariam 2013:6).

4.5 CATEGORY: WOMEN SHOULD ADDRESS GYNAECOLOGICAL HEALTH ISSUES WITH WOMEN

Some participants mentioned that culture did not allow them to address female health-related issues with their husbands but with the elderly female structures within their families. This was also a case when they visited the healthcare centres where they needed to consult female structures. Two subcategories emerged from this category: concerns to be discussed with female family members and avoiding male health workers.

4.5.1 Subcategory: Concerns to be discussed with female members

Women in this study were prohibited by culture to discuss their health-related concerns with their husbands. They are expected to address their concerns with elderly female structures within the patriarchal families, who will then convey their concerns to the husbands on their behalf. This was similar to a study by Mutyaba et al. (2007:10) who found that in African culture, men are not expected to get involved with reproductive health issues and therefore would not discuss women's health. The difference between the two studies is that in this study, concerns were conveyed to the husbands through the elderly female structures, whereas in the other study husbands were not expected to be informed about the women's concerns. In both studies, women were not expected to speak to their husbands regarding their health-related concerns. Yaya et al. (2019:6) conducted an analysis of data collected from community conversations with male elders between the ages of 50-101 years old on perceptions of maternal use of skilled care in Nigeria. Their findings indicated that traditionally, women's health-related issues were considered to be their responsibility and not that of a man. However Black, Hyslop and Richmond (2019:8) found that women who discussed cervical cancer screening with their families, especially with their husbands, were more likely to seek screening procedures.

4.5.2 Subcategory: Avoid male health workers

In this study, women said that their culture barred them from exposing their private parts to males other than their husbands. White et al. (2012:94) conducted a qualitative study on 60 women aged 18 to 49 years of age who were able to undergo visual inspection with acetic acid-based (VIA) approach and separate interviews with 10 screening nurses and 11 peer educators from Lusaka. The study aimed at clarifying relations among motivations for cervical cancer screening

experiences and social influences on the decision for cervical cancer screening. Both Williams et al. (2018:12) and White et al. (2012:94) had similar findings to the study, as they reported that women are very conservative in exposing their private parts to the opposite sex other than their husbands. This is consistent with a study conducted by Chidyaonga - Maseko, Chirwa and Sinjani - Mvula (2015:5) who indicated that cultural values and beliefs did not encourage women to expose their bodies to men other than their husbands. A cross-sectional survey with a sample of 254 women aged 21 to 62 years old from 22 African countries (144 refugees and 110 non-refugees) was conducted by Anaman, Correa-Velez and King (2017:219), which expressed that the female genital area was referred to as a "sacred" area and should not be seen or touched by any other person apart from their sexual partners. They further added that women believed the preference for a female health professional during the vaginal examination was usually due to cultural beliefs and individual choice among Christians. Ogbonna (2017:18) found that women were discouraged from talking about their reproductive organs to anyone, especially male health workers.

In contrast with these findings is a study conducted by Mutyaba et al. (2007:12) who found that women preferred male health workers because they were found to be politer than their female counterparts. Khan and Woolhead (2015:6252) also found that women did not believe that gender mattered. In actual fact, participants had greater faith in male health workers than their female counterparts, as they believed that they were more competent. In the study conducted among Islamic women (Khan and Woolhead 2015:6), it was reported that Islamic religion and culture encouraged women to take care of their health, even if it meant exposing their private parts. Participants in the latter study were certain that even exposing their private parts to males for the sake of health were not prohibited.

4.6 CONCLUSION

In this chapter, the findings were summarised and discussed with reference to existing literature. In the next chapter summary of findings, limitations, recommendations of the study and conclusions will be presented.

CHAPTER 5

SUMMARY OF FINDINGS, LIMITATIONS, RECOMMENDATIONS AND CONCLUSION

5.1 INTRODUCTION

In this chapter, the findings of the study are summarised, limitations of the study revealed, recommendations and conclusions presented. This study was conducted at the designated community healthcare centre in Gauteng which experienced poor cervical cancer screening.

The research question to be answered was “What are the cultural beliefs influencing cervical cancer screening”? Waiting for symptoms before they could seek cervical cancer screening, women barred from discussing female health-related issues with their husbands, and cervical cancer perceived to be caused by sacred or indecent behaviour were among others influencing cervical cancer screening.

A qualitative contextual descriptive design was used. The objective of the study was to explore and describe cultural belief's influence on the uptake of cervical cancer screening in a community healthcare centre. The study focused on women older than 35 years who have not had cervical cancer screening in their lifetime and were able to express themselves in Sesotho or English language. Participants were purposely selected as they came to the community healthcare centre's chronic and mother and child health care departments. Four focus group interviews that consisted of six participants each were conducted at the community healthcare centre. The interviews were thus transcribed verbatim and thereafter compared with the audio-records. The collected data was stored in a locked cabinet. The findings of the study are outlined below.

5.2 SUMMARY OF FINDINGS

The summary outlines the subcategories of the findings of the study per category of cultural beliefs influencing cervical cancer screening.

5.2.1 Fear of positive cervical cancer results

Participants preferred to delay cervical cancer screening and wait for symptoms such as excessive vaginal bleeding. They did not see any reason to get screened for the disease during the absence of symptoms. It was clear that participants did not see screening as necessary prior to the presence of symptoms, which to them was alarming.

Participants reported that they preferred not to talk about the disease and live in denial. This was because the community perceived the disease as taboo and shameful. Those who were rumoured to suffer from the disease were isolated or rejected by the community, including their own families.

Participants feared to get screened for cervical cancer as they feared positive cervical cancer results. They were more worried about losing their husbands to other women due to positive results. This emanated from the treatment procedure following positive result that entailed the removal of the uterus, which they believed makes them less of a woman.

5.2.2 Cervical cancer is perceived to be caused by sacred or indecent behaviour

Participants believed that cervical cancer affects widows who did not adhere to cultural rituals performed by an 'inyanga' which they also call 'makgome'.

They also mentioned that the disease was caused by sacred or indecent behaviour such as abortions, promiscuity, etc. Therefore, women with multiple sexual partners are seen as risk factors for the disease. Participants mentioned that they delayed screening for cervical cancer as they did not want to be regarded as promiscuous.

Cervical cancer was again seen as a punishment from God or the ancestors for the bad thing women did during their lifetime. The community believed that women who suffered from the disease were deserving of it. In case of death due to the disease, families preferred to keep the cause of death a secret as cervical cancer was regarded as a shame.

In this study, the symptoms of cervical cancer were referred to as excessive vaginal bleeding, which is in line with the risk factors of the disease in the medical fraternity. Women who were not widows, sexually inactive, or had one sexual partner delayed screening as they believed that they were not susceptible to the disease.

5.2.3 Spousal approval needed for cervical cancer screening

Participants stated that they needed approval from their husbands to be screened for the disease. This was because culture expected them to seek permission to do procedures such as cervical cancer screening. Being screened for the disease without obtaining spousal approval was regarded as disrespectful. According to participants, their husbands did not approve as they also lacked knowledge.

It was noticed that men headed most families; therefore, women could not do anything without the approval of their husbands. Participants also mentioned that they had to request money for transport to visit the designated healthcare centre for cervical cancer screening, and their husbands could not provide them with the money for such a test.

5.2.4 Women should address gynaecological health issues with women

Participants also reported that according to their culture it was a taboo to discuss female health-related matters with the males including their husbands. They are expected to speak to the elderly female structures within the patriarchal families who have to convey the message to their husbands. This was reported to be ineffective, as some of them were not getting along with these female structures.

Participants also reported that culture did not allow them to expose their private parts to men other than their husbands. They referred to their bodies as a sacred place that cannot be viewed by men other than their husbands even for health-related reasons. Husbands preferred to take their wives to their preferred male private doctors for cervical cancer screening. However, most women reported that due to financial constraints, they were never taken to the private doctor to be screened for the disease. Screening for the disease was then delayed due to these cultural beliefs.

5.3 LIMITATIONS OF THE STUDY

The findings of this study may not be generalised to other areas due to diverse cultures, small sample size and the qualitative nature of the study, however, the researcher feels that this is an important contribution and a step in understanding the cultural belief's influence on cervical cancer

screening. Qualitative research does not allow the measurement of the examined problem. Limited funding restricted the study to the designated healthcare centre. Some of the responses were based on hypothetical experiences as opposed to real life. Although the researcher was fluent in the Sesotho and English languages, translation of transcripts from Sesotho to English might have diluted the meaning of the participant's perception.

5.4 RECOMMENDATIONS

Lack of knowledge and cultural beliefs has negatively impacted on cervical cancer screening uptake at the designated community healthcare centre. To address the identified challenges, the following are recommended:

Nursing education

- Cultural leaders and prominent figures in the community to be educated about cervical cancer without infringing their cultural beliefs.
- Negotiate with church leaders to be given a slot to address the congregation about cervical cancer screening at least on a 6-monthly basis.
- Education through frequent radio or television programs and through local women seminars about the disease in the local language.
- Spousal involvement including prominent leaders (political and religious) in cervical screening should be encouraged.
- Ward Based Outreach Teams (WBOT) and health promoters to educate the community on matters surrounding cervical cancer through community seminars or door to door campaigns, to be able to reach the elderly persons as well.
- Involvement of the clinic committee members to relay the messages to the community.

Nursing practice

- The need for culturally sensitive health education during health encounters is crucial to enhance community awareness and knowledge about cervical cancer screening.
- An understanding of cultural barriers to cervical cancer screening among healthcare providers is also necessary as it could lead to effective interventions.
- Mobile services should have adequate resources to be able to offer cervical cancer screening services.
- Patients have to be provided an option of gender preference on cervical screening.

Nursing research

- More research needs to be conducted on cervical cancer-related issues exploring the barriers of cervical cancer screening amongst healthcare providers.

Policy development

- Development of policies on the provision of counselling units that could support women to allay their fears and clarify myths surrounding cervical cancer screening is crucial.
- The government should subsidise the cost of cervical cancer screening services to private practices to make it free to encourage women to utilise the service.
- Cervical cancer screening should also be mandatory to all women aged 30 years and older recruited for new jobs and social grant applications.

5.5 CONCLUSION

In this study, cervical cancer is known by the local name that is descriptive of the main symptom of the disease. The understanding of the community on cervical cancer overlaps with biomedical knowledge of cervical cancer particularly with regard to symptoms and risk factors. The study also provided important insight regarding cultural beliefs on cervical cancer screening. It also highlighted the impact cultural beliefs have on cervical cancer screening. The need for husbands/partners, including male community leaders, priests, etc. to be educated so that they can be involved in encouraging and supporting their partners and female family members was identified. Women should also be educated about the benefits of cervical cancer screening to improve its uptake.

The study pointed out that the community lacked information regarding cervical cancer and cultural beliefs also played a role in the poor uptake of screening for the disease. It was also evident that husbands were making decisions for their partner's health-related issues and women respected that regardless of how they felt about the disease. Risk factors for the disease were found to be in line with that of the medical view.

The study also tinted the importance of health care providers to be culture-sensitive to enhance cervical cancer screening. It also found a relatively low knowledge of cervical cancer amongst the community. There is also a need for awareness campaigns to provide comprehensive information about cervical cancer screening and clarify perceptions while being culture-sensitive. A community-based study should assess private practices if they are educating women about cervical cancer and if cervical cancer screening is being offered to eligible women who consulted them for any other health problem. A culturally appropriate intervention to increase cervical cancer screening is needed. Cultural beliefs do have a negative impact on cervical cancer screening and should not be underestimated.

The results suggested that cultural beliefs do influence the uptake of cervical cancer screening. The findings may be a step forward in assisting researchers in focusing their research on exploring other barriers to cervical cancer screening in the designated community healthcare centre. Cultural factors associated with cervical cancer screening should be considered for practical implications and future research with women of various cultural groups. There was also a need for community-based studies to explore the barriers of cervical cancer screening amongst healthcare providers.

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ANNEXURE A**DECLARATION TO PLAGIARISM**

ANNEXURE A

DECLARATION TO PLAGIARISM

Full names	Cecilia Moeti
Student number	99110530
Topic of work	Cultural beliefs influencing the uptake of cervical cancer screening among women in a community healthcare centre.

Declaration

I understand what plagiarism is and am aware of the University's policy in this regard.

I declare that this Research Proposal is my own original work. Where other people's work has been used (either from a printed source, internet or any other source), this has been properly acknowledged and referenced in accordance with the requirements as stated in the University's plagiarism prevention policy.

I have not used another student's past written work to hand in as my own.

I have not allowed, and will not allow anyone to copy my work with the intention of passing it off as his or her own work.

Signature:

ANNEXURE B

RESEARCH GUIDE



ANNEXURE B

RESEARCH GUIDE

A. Demographic /Descriptive background

Age

Ethnic group

Number of children

Living arrangements, e.g. Is there an extended family member such as a grandmother?

B. Research questionnaires

How do male counterparts within your family/community influence your decision to have a Pap smear?

What discussion do you have about Pap smear within your family?

What is the information shared about Pap smear within your community?

What cultural beliefs influence your decision to have Pap smear?

ANNEXURE C

LETTER OF APPROVAL



ANNEXURE C
LETTER OF APPROVAL

To: Facility manager
Ladium community health centre
N.G. Nkopane

From: The Researcher

C. Moeti

Re: Permission to do research at Ladium community health centre

I am a researcher working at Ladium community health centre in acute department. I am currently studying MCur at the University of Pretoria. I therefore request permission to conduct a study on the Ladium community health centre grounds. The title of the study is: CULTURAL BELIEFS INFLUENCING THE UPTAKE OF CERVICAL CANCER SCREENING AMONG WOMEN IN A COMMUNITY HEALTHCARE CENTRE.

I intend to publish the findings of the study in a research journal and be made available to the management of Ladium community health centre. I also intend to protect the personal identity of the patients by assigning each patient a random code number. I undertake not to proceed with the study until I have received approval from the Faculty of Health Sciences Research Ethics Committee, University of Pretoria.

Yours sincerely

Signature of the Principle Investigator

Permission to do the research study at this hospital and to access the information as requested is hereby approved.

Facility manager

Cecilia Moeti

HOSPITAL OFFICIAL

STAMP

Signature:

Laudium community health centre

Date:

ANNEXURE D

RESEARCH DECLARATION



ANNEXURE D

RESEARCHER DECLARATION

Hereby I Cecilia Moeti in my capacity as a MCur student declares that:

1. Research participants will be informed, information will be handled confidentially, research participants reserve the right to choose whether to participate and, where applicable, written permission will be obtained for the execution of the project (example of permission will be attached).

2. No conflict of interests or financial benefit, whether for the researcher, company or organisation, that could materially affect the outcome of the investigation or jeopardise the name of the university is foreseen.

3. The information I furnish in the application is correct to the best of my knowledge and that I will abide by the stipulations of the committee as contained in the regulations.

Signed: C Moeti

Date: 16 October 2017

ANNEXURE E**PARTICIPANT'S INFORMATION &
INFORMED CONSENT DOCUMENT****2**

ANNEXURE E

PARTICIPANT'S INFORMATION & INFORMED CONSENT DOCUMENT 2

PARTICIPANT'S INFORMATION & INFORMED CONSENT DOCUMENT

Study title: Cultural beliefs influencing the uptake of cervical cancer screening among women in a community healthcare centre.

Dear Participant

1) INTRODUCTION

You are invited to volunteer for a research study. This information leaflet is to help you decide to participate in the study. You must understand this fully, before you agree to take part. If you have any questions regarding this study, do not hesitate to ask the researcher. You should not agree to take part unless you are completely happy about all the procedures involved. If I have any questions concerning this study, contact Ms C. Moeti: 012 374 9978(D) or 0724791353(D/N)

2) THE PURPOSE OF THE STUDY

The purpose of this research is to explore and describe whether cultural health beliefs influence the uptake of cervical cancer screening.

3) EXPLANATION OF THE PROCEDURES

The study will use focus group interviews of about 6-10 women as well as audio recording methodology.

The minimum requirements for you as a participant include:

- Participants must be 35 years and older to participate.
- Women who have not had a Pap smear done previously in their lifetime.
- Women who are not able to express themselves in one of the South African official languages.

All interviews will be recorded using a voice recorder and a note-taker will be present so as not to miss any pertinent information discussed. You also have the right not to answer any questionnaire you choose. Each recording will be transcribed into a written form (transcript). Recordings and transcripts will be kept in a locked file cabinet, and your identity will not be disclosed. In order to

maintain confidentiality, no personally identifiable information such as name will be asked or associated journal reflections. Only the researcher will have access to the files collected. All data files will be destroyed at the end of the study. The results of this project will be presented in conferences, published articles and also be given to the facility manager of the Laudium community health centre. Participation in the study is voluntary, and you may withdraw at any time without penalty, prejudice or loss of benefits.

4) BENEFITS

There are no direct benefits for taking part in the study. You may help the researcher to understand best ways to address cultural health beliefs so that women can screen for cervical cancer thus save their lives.

5) RISKS

There may be some minor risks to taking part in the study. You may feel uncomfortable when answering some of the questions which address sensitive topics about your culture.

6) CONSENT TO PARTICIPATE IN THIS STUDY.

I have read the above information or had read to me in a language that I understand before signing the consent form. The researcher explained the content and meaning of this information. I had an opportunity to ask questions and they were answered satisfactorily. I understand that my failure to participate in this study will not affect me negatively in any way.

I have received a signed copy of this informed consent agreement.

Participant's name:

Signature

Date

Researcher's name: C. Moeti

Signature:

Date: 16/10/2017

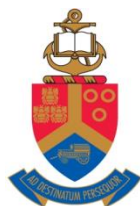
Witness's name:

Signature:

Date:

ANNEXURE F**LETTER OF APPROVAL FROM
DEPARTMENTAL IN-HOUSE**

ANNEXURE F



UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Denkleiers • Leading Minds • Dikgopolo tša Dihlalefi

DEPARTMENT OF NURSING SCIENCE

PRIVATE BAG X323, ARCADIA, 0007

TEL: (012) 356-3173

Fax: (012) 354-1490

e-mail: isabel.coetzee@up.ac.za

10 December 2017

The Chair: Post Graduate Committee

Dear Prof,

Letter of approval from Departmental In-house committee

The proposal of MCur student, C Moeti student number 99110530 served before the In-house committee of the Department of Nursing Science and was approved for submission to the Post Graduate School Committee.

Internal reviewers: Prof Peu and Dr Rikhotso

Yours sincerely

A handwritten signature in cursive script, appearing to read 'Coetzee'.

Dr Isabel Coetzee

Senior Lecturer

Department of Nursing Science

University of Pretoria

Cell phone: +2711 589 045

Office: (012) 354-2125

Email: isabel.coetzee@up.ac.za

Fax: (012) 354-1490

ANNEXURE G**LETTER OF APPROVAL FROM
RESEARCH ETHICS COMMITTEE**

The Research Ethics Committee, Faculty Health Sciences, University of Pretoria complies with ICH-GCP guidelines and has US Federal wide Assurance.

- FWA 00002567, Approved dd 22 May 2002 and Expires 03/20/2022.
- IRB 0000 2235 IORG0001762 Approved dd 22/04/2014 and Expires 03/14/2020.



UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences Research Ethics Committee

28/06/2018

Approval Certificate
New Application

Ethics Reference No: 310/2018

Title: Cultural beliefs influencing the uptake of cervical cancer screening in a community healthcare centre

Dear Miss Cecilia Moeti

The **New Application** as supported by documents specified in your cover letter dated 19/06/2018 for your research received on the 19/06/2018, was approved by the Faculty of Health Sciences Research Ethics Committee on its quorate meeting of 27/08/2018.

Please note the following about your ethics approval:

- Ethics Approval is valid for 2 years
- Please remember to use your protocol number (310/2018) on any documents or correspondence with the Research Ethics Committee regarding your research.
- Please note that the Research Ethics Committee may ask further questions, seek additional information, require further modification, or monitor the conduct of your research.

Ethics approval is subject to the following:

- The ethics approval is conditional on the receipt of **6 monthly written Progress Reports**, and
- The ethics approval is conditional on the research being conducted as stipulated by the details of all documents submitted to the Committee. In the event that a further need arises to change who the investigators are, the methods or any other aspect, such changes must be submitted as an Amendment for approval by the Committee.

We wish you the best with your research.

Yours sincerely

Dr R Sommers; MBChB; MMed (Int); MPharm, PhD

Deputy Chairperson of the Faculty of Health Sciences Research Ethics Committee, University of Pretoria

The Faculty of Health Sciences Research Ethics Committee complies with the SA National Act 61 of 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 and 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes, Second Edition 2015 (Department of Health).

☎ 012 356 3084

✉ gleeneka.bahari@up.ac.za / irseethics@up.ac.za

🌐 <http://www.up.ac.za/healthethics>

📍 Private Bag X323, Arcadia, 0007 - Tswelopele Building, Level 4, Room 60 / 61, 31 Bophelo Road, Gezina, Pretoria

ANNEXURE H**LETTER OF CLEARANCE FROM
TSHWANE RESEARCH
COMMITTEE**



GAUTENG PROVINCE
REPUBLIC OF SOUTH AFRICA

Enquirer: Mpho Mashimo-Shateqi
Tel: 97 12 491 8038
Email: Mpho.Mashimo@gauteng.gov.za

TSHWANE RESEARCH COMMITTEE: CLEARANCE CERTIFICATE

MEETING: 06/2018
PROJECT NUMBER: 57/2018
NHRD REFERENCE NUMBER: GP_201807_052

TOPIC: Cultural beliefs influencing the uptake of cervical cancer among women in a community healthcare centre

Name of the Researcher: Ms. Cecilia Moeti
Name of the Supervisor: Dr V. Bhana-Pema
Name of the co-supervisor: Prof N. van Wyk
Facility: Laudium CHC
Name of the Department: University of Pretoria

NB: THIS OFFICE REQUEST A FULL REPORT ON THE OUTCOME OF THE RESEARCH DONE AND

NOTE THAT RESUBMISSION OF THE PROTOCOL BY RESEARCHER(S) IS REQUIRED IF THERE IS DEPARTURE FROM THE PROTOCOL PROCEDURES AS APPROVED BY THE COMMITTEE.

DECISION OF THE COMMITTEE: APPROVED

Mr. Peter Silwimba
Deputy Chairperson: Tshwane Research Committee

Date: 6/08/18

Ms. Lorraine Malebo-Moru
Acting Chief Director: Tshwane District Health

Date: 02/08/18