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## GYNAECOLOGY

# Cervical cytology service in Nigeria: providers' perspective

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### Summary

It has been noted that efforts to organise an effective screening programme in developing countries will have to find adequate financial resources, develop the infrastructure, train the necessary manpower and elaborate surveillance mechanisms. In our study, we set out to determine (a) just how frequent is cervical cancer, to warrant the investment of funds in screening programmes; (b) what proportion of surveyed health facilities offer a cervical cytology screening programme; and (c) what basic facilities are currently available where such programmes exist? A pretested, self-completed questionnaire was sent to heads of department of obstetrics and gynaecology in public tertiary and secondary care hospitals in Nigeria as well as major mission hospitals. The response rate was 63%, monthly consultations included a mean of 114 ( $\pm 11.7$ ) new gynaecological patients and an average of 5 ( $4.7 \pm 0.8$ ) cervical cancer cases. One-half of the institutions had a hospital-based cervical screening programme with an average of 27 patients being screened monthly. Finance was the main difficulty encountered in maintaining a screening service. Only four had a certified gynaecological oncologist. In conclusion, there is dismal utilisation of available services and a dearth of trained specialists should any cervical cancer screening programme be considered.

### Introduction

At the turn of the century, it is gratifying to note that screening for the preinvasive stages of cervical cancer has been shown conclusively to reduce death from the disease (Miller, 1992). Even though the impact of cytology screening has never been proved through randomised trials, it has been shown to be effective in reducing the incidence and mortality from cervical cancer in developed countries (Hakama *et al.*, 1985; Miller *et al.*, 1990). The incidence of cervical cancer can be reduced by as much as 80% if the quality of coverage and follow-up of screening are high. In most developed countries women are advised to have their first smear soon after becoming sexually active and subsequently once every 1–5 years (Sankaranarayanan *et al.*, 2001).

In Nigeria cervical cancer is the most common gynaecological tumour (Nnatu and Durosinmi-Etti, 1985). Patients often present in hospital when they can be offered only palliative care (Nnatu and Durosinmi-Etti, 1985). Sixty to eighty per cent of cases are seen in advanced clinical stages (III and IV), if diagnosed at all, with a low probability of long-term survival (Sankaranarayanan *et al.*, 1998). In Nigeria, as in most other developing countries,

the concept of screening and pre-emptive therapies is generally alien (Haran *et al.*, 1990). Other, more virulent, disease conditions have effectively shifted policy-making decisions away from cancer screening. This is made worse by the depressed economy experienced by many of these countries. Until cervical cancer screening programmes become entrenched in our health-care delivery we will continue to see most women with cervical cancer presenting in the advanced stage of the disease.

It has been noted that efforts to organise an effective screening programme in developing countries will have to find adequate financial resources, develop the infrastructure, train the manpower and elaborate surveillance mechanisms for screening, investigating, treating and following-up the target population of women. In addition, programme conceptualisation, planning and execution require the involvement of a good number of stakeholders in certain aspects of need assessment. This would enable a balance in goal-setting and specific problem identification.

In this study, we set out to answer four main questions:

- Is cervical cancer frequent enough to warrant the investment of funds in screening programmes?
- What proportion of health facilities surveyed offer a cervical cytology screening programme?
- What basic facilities are currently available where such a programme exists?
- From experience, would charging user fees be acceptable to clients?

### Methodology

A pretested self-completed questionnaire was sent to heads of department of obstetrics and gynaecology in public tertiary and secondary care hospitals in Nigeria as well as major mission hospitals. Where feasible, one of us (IAB) conducted an on-site interview. In one instance, the interview was conducted over the telephone.

The questionnaire was semi-structured and contained questions related to the proportion of gynaecological consultations related to cervical cancer, the presumed willingness of patients to pay for cervical cancer screening services and the implied value of such a measure.

## Results

It was surprisingly difficult to obtain responses. In some instances, the questionnaire was sent four times. Overall, a 63% response rate was finally achieved. Twenty-two institutions responded to the questionnaire. Eight of the institutions (36.4%) were in the Southwestern region, although all the six geographical regions of the country were represented.

New gynaecological consultations per month ranged from one to 250 patients with a mean of 114 ( $\pm 11.7$ ) patients. Cancer of the cervix was identified as the most common cancer managed by 85.7% of the respondents. An average of five cases ( $4.7 \pm 0.8$ ) were managed each month and a mean of 45 cases ( $\pm 10.8$ ) annually.

Eleven (50.0%) of the institutions studied had a hospital-based cervical screening programme; only two (9.1%) had a community-based cervical cancer screening programme. Of the 11 institutions with screening programmes, data were available only on the number of women screened each month and each year in eight (72.8%). From the eight institutions, an average of 27 patients were screened each month. In 2000, 276 women were screened, while in 1999, 224 had the Pap smear.

The difficulties encountered in maintaining service in institutions with the screening programme were mainly financial (11; 100.0%). Other sources of difficulties are shown in Table I.

However, 17 (77.3%) respondents felt that with their present resources their institution could cope with any form of gynaecological screening, such as screening for cervical, ovarian and endometrial cancers. Only four (18.2%) institutions had a certified gynaecological oncologist and only five (22.7%) had nursing staff trained in taking and making a Pap smear. Almost all (20; 90.0%) had a cytopathologist in residence or a visiting pathologist.

Presumed attitudes of the patients towards payment for the screening test were also assessed. About a third (seven; or 31.8%) felt their patients would be willing to pay for cancer screening. One-half of respondents did not envisage any problem with instituting or improving the gynaecological screening programme in their centre. The problem envisaged by the other half were funding (seven; 63.6%), inadequate manpower and material resources (three; 27.3%) and absence of a laboratory (one; 9.1%).

**Table I.** Difficulty in maintaining screening programme and attitude to user fees

	Number (n = 11)	Percentage
<b>Difficulty</b>		
Funding	11	100
Patient recruitment	8	72.7
Lack of infrastructure	6	54.6
Lack of manpower	5	45.5
Others	3	27.3
<b>Attitude</b>		
Readily	7	31.8
Reluctant	14	63.6
Not at all	1	4.6
Total	22	100.0

## Discussion

A statement which probably best describes the problem of cervical cancer in developing countries mentions lack of knowledge among women of the symptoms of the disease and a fatalistic attitude towards cancer and disease generally. Other factors, include a lack of awareness of the possibility of a cure, lack of organised screening programmes and a lack of health-care facilities in the rural areas, combined with low priority for women's health issues (Planning Appropriate Cervical Cancer Programs, 1997).

Owing to their limited health-care resources, developing countries cannot afford the models of frequently repeated screening of women over the wide age range that are used in developed countries. Many low-income developing countries, including most in subSaharan Africa, have neither the resources nor the capacity for their health services to organise and sustain any kind of screening programme. It has been suggested that a realistic and effective goal is to target the screening of high-risk women once or twice in their lifetime using a highly sensitive test, with an emphasis on high coverage ( $> 80\%$ ) of the targeted population.

Cervical cytology is considered to be a specific test for high-grade precancerous lesions or cancer, but even if the quality of collection and spreading of cells, fixation and staining of smears and reporting by well-trained technicians and cytopathologists are good, its sensitivity is only moderate (Sankaranarayanan, 2001). Choosing a suitable screening test is only one aspect of a screening programme. A more fundamental and challenging issue is the organisation of the programme in its totality. The aim should be to set up a rational nationally organised screening programme (Hakama, 1985). Having to undertake repeat smears to make up for lack of quality of the first smear is costly. Therefore, investing in a system that ensures high-quality smear-taking and smear-reading is highly recommended (Miller *et al.*, 1999). The choice of a screening test in countries/regions that plan to initiate new programmes should be based on the comparative performance characteristics of cytology and its potential alternatives such as VIA, their relative cost, technical requirement, the level of development of laboratory infrastructure and the feasibility in a given country/region. Because programmes cannot afford the luxury of frequently repeated testing of women, a highly sensitive test should be provided (Sankaranarayanan, 2001).

This study has attempted to define the problems perceived by providers. The two important impressions are (1) a clientele probably willing to pay for the Pap smear and (2) a currently dismal utilisation of the services available. Another striking finding was the dearth of gynaecological oncologists (at least 2–4 years subspecialty training with a post-examination certification) in Nigeria.

Clearly, there is no form of organised cervical cancer screening in Nigeria. This is not surprising, considering that even in the United Kingdom cervical cancer screening only began haphazardly some 40 years ago (Haran, 1990). In assessing the provider views related to cervical cancer screening, this study has attempted to appraise (at least superficially) some basic technology and manpower realities. The increasing incidence of cervical cancer and lack of control strategies prompted our interest.

Should any cervical cancer screening programme be considered on a national basis, it is clear that there is little funding, personnel or patient appreciation of the problem.



Is Nigeria ready for any organised screening programme for cervical cancer? There is no evidence to suggest so. The success of cervical cancer screening will depend upon the programme, from education to screening to acting on results and its being acceptable to women themselves (Miller, 1999). To have an impact on cervical cancer incidence and mortality, efforts must be focused on the following: increasing the awareness of women about cervical cancer and preventive health-seeking behaviour, planned investment in order to improve the capacity of the health services to diagnose and treat cervical precancer, especially early invasive cancers, before expanding the services and providing repeated screening (e.g. once every 10 years). A machinery to monitor programme inputs and evaluate the outcomes must also be put into place.

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