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BARRIERS OF CERVICAL CANCER SCREENING IN PRESENTED TO GYNECOLOGY OUTPATIENT CLINIC IN BAGHDAD CITY

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ABSTRACT

Introduction: In terms of cancer incidence, cervical cancer ranks fourth among women and seventh overall; most cases (85%) are diagnosed in poor and middle-income nations. The study's overarching goal is to determine what factors prevent women with cervical cancer from receiving necessary follow-up care. **Method:** Cross-sectional study of 150 females will be conducted gynecology outpatient clinics in period between June 2021 and October 2021 in three hospitals in Baghdad city including al-emamainAlkadhemain teaching hospital, AL-yarmook teaching hospital and AL-karh hospital. Target population will be the patients attending gynecology clinics and health care providers working in these gynecology clinics of the selected hospitals.Data will be collected by interview with the patients who attend gynecology clinics and health care providers working in these clinics using pretested structured questionnaire after taking their consent to participate in the study.**Results:** Cross sectional study of 150 females, [36%] of them at age group 31-40 years while [28.7%] of females at age group 41-50 years. [86.7%] of females are married, [72.7%] of females are unemployed and [58%] of them have primary education just. [45.33%] of females have screening and [54.67%] have no screening before. There is significant impact of occupation that influence the decision to have screening, [68.3%] of Employed females have screening, also education significant impact on influence the decision to have screening, [50%] of Postgraduate females have screening. Significant association between recommendation of females for screening and doing screening, [74.1%] of females twice recommended have screening before while [39%] of females once recommended have screening before. **Conclusion:** Most of females have no screening before, occupation and education considered as important and significant barriers for females to have cervical screening, postgraduate females have more screening and also employment females get more cervical screening.

KEYWORDS: Prevalence, Barriers, facilitators, cervical cancer screening, gynecology outpatient clinic, Baghdad city.

INTRODUCTION

Eighty-five percent of the world's cervical cancer burden is concentrated in low and middle-income nations, making it the fourth most frequent malignancy in women worldwide.[1] In 2012, there were 528,000 new instances of cervical cancer and 266,000 deaths related to the disease.[2] Almost 90% of these fatalities happened in nations with poor or moderate incomes.[2] In Iraq, women between the ages of 15 and 44 have a cervical cancer incidence rate that ranks in the top 10 worldwide. There was a 1.7% annualised crude incidence rate among every 100,000 females.[3] Both the incidence and fatality rates are highest in Eastern Africa.[4] There are an estimated 5,250 new instances of cervical cancer and 3,286 deaths from the disease each year in Kenya.[5] It was predicted in 2012 that there would be 4,261 new cases of cervical cancer per year by 2025.[6] The only gynaecological cancer for which universal screening is suggested is cervical cancer.[7] Changes that, if left untreated for 10–15 years, could result in invasive cervical disease can be detected through screening. This is a once-in-a-lifetime chance to stop these premalignant lesions from developing into full-blown cancer. Screening for cervical cancer has been demonstrated to lower both new cases

and deaths from the disease by over 70 percent.[8] From over 80% in Austria and Luxembourg to 1% or less in Bangladesh, Ethiopia, and Myanmar, there is a considerable range in the effective coverage of cervical cancer screening among countries. The percentage of women who are screened for cervical cancer is significantly lower (19%) in poor nations than it is (63%) in wealthy countries.[9] Only 3.2% of Kenyan women had their cervical cancer checked in 2010, with only 4.0% of urban women and 2.6% of rural women being screened.[10] Cervical cancer is most prevalent in low-income regions, yet there has been little progress in organising screening programmes there. Lack of infrastructure and resources (technical, medical, and financial) as well as a lack of awareness and education about cervical cancer among women and health-care providers are major barriers to cervical cancer screening in resource-poor countries.[8] HIV/AIDS, malaria, TB, and high rates of newborn and maternal mortality are just some of the many health issues vying for attention in Africa.[11] Furthermore, there is a deficiency in both skilled doctors and enough laboratory supplies, employees, and treatment facilities. The aim of study is to identify the obstacles to cervical cancer screening related to both patient and care providerand to improve the use of preventive strategies against cervical cancer include HPV vaccine and cervical cancer screening.

METHOD

Cross-sectional study of 150 females will be conducted gynecology outpatient clinics in period between June 2021 and October 2021 in three hospitals in Baghdad city including al-emamainAlkadhemain teaching hospital, AL-yarmook teaching hospital and AL-karh hospital. Target population will be the patients attending gynaecology clinics and health care providers working in these gynecology clinics of the selected hospitals. Data will be collected by interview with the patients who attend gynaecology clinics and health care providers working in these clinics using pretested structured questionnaire after taking their consent to participate in the study. After obtaining the official approvals and task facilitating documents from scientific committee of Arabic counsel of family medicine, the researcher contacted the offices of directors of each selected hospital to explain the objectives and rationale of the study and get the approval for data collection. Examining the Numbers participants were given unique identity numbers. The information was analysed with the help of SPSS (Statistical Package for the Social Sciences) version.[22] The tabular presentations of percentages and frequencies of the categorical data. The average, median, and standard deviation for the continuous variables were shown. The correlation between the category variables was analysed using a Chi-square test. Lower than a 5% probability

RESULTS

Cross sectional study of 150 females, [36%] of them at age group 31-40 years while [28.7%] of females at age group 41-50 years. [86.7%] of females are married, [72.7%] of females are unemployed and [58%] of them have primary education just. As show in table 1.

Table 1: Sociodemographic characteristics of all females included in study.

variables		frequency	percentage
	30 less	38	25.3
Age	***31-40***	54	36.0
	41-50	43	28.7
	>50	15	10.0
Marital state	***divorced***	20	13.3
	married	130	86.7
Occupation	***employed***	41	27.3
	unemployed	109	72.7
	postgraduate	2	1.3
Education	***primary***	87	58.0
	secondary	61	40.7

As table 2 show, [79.3%] of females have nofear from procedures, [77.3%] of females have infection as complications after procedure, just [16.7%] of females have family history of CC, [83.3%] of females have just one recommendation, all females have no HIV infection. As show in table 2.

Table 2: patient's barriers.

variables		frequency	percentage
Fear from procedures	***no***	119	79.3
	yes	31	20.7
Complications after procedure	***bleeding***	34	22.7
	infection	116	77.3
Family history of CC	***negative***	125	83.3
	positive	25	16.7
No. of recommendation	***once***	123	82.0
	twice	27	18.0
HIV infection	***no***	150	100.0

As show in table 3, [17.3%] of females havematerials out of stock, and [58%] of females have Queue was too long, only [7.3%] of females have Charges were too high, and all female said that Clinicians were not available. As show in table 3.

Table 3: health care provider's barriers.

variables		frequency	percentage
Materials out of stock	***no***	124	82.7
	yes	26	17.3
Queue was too long	***no***	63	42.0
	yes	87	58.0
Charges were too high	***no***	139	92.7
	yes	11	7.3
Clinicians were not available	***no***	150	100.0

As fig 1 show, [45.33%] of females have screening and [54.67%] have no screening before.

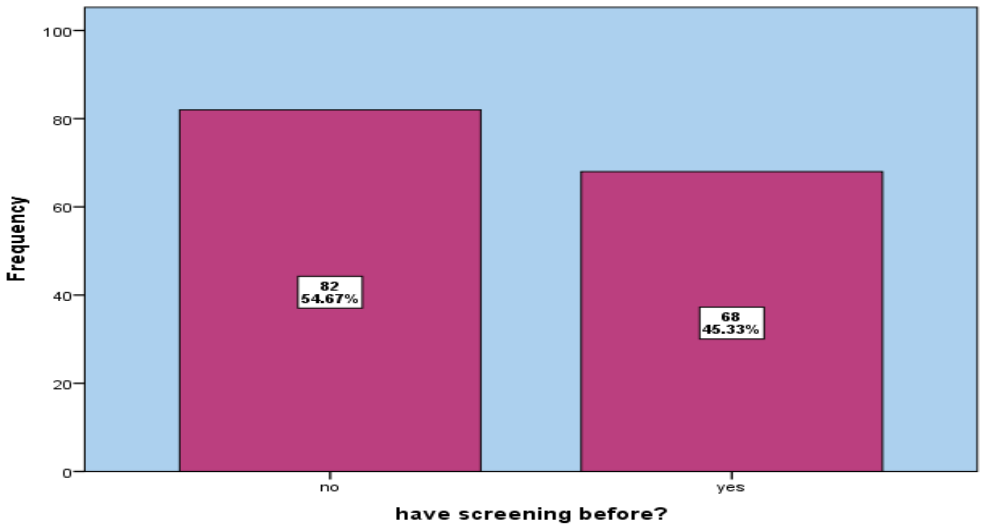

Fig 1: distribution of females as having screening before.

There is significant impact of occupation that influence the decision to have screening, [68.3%] of Employed females have screening, also education significant impact on influence the decision to have screening, [50%] of Postgraduate females have screening. Other sociodemographic factors have no significant impact. As show in table 4.

Table 4: impact of sociodemographic factors on screening before.

variables			Have the test done before?		P-value
		no	yes	Total	
	Divorced	10	10	20	
		50.0%	50.0%	100.0%	
Marital state	***Married***	72	58	130	0.8
		55.4%	44.6%	100.0%	
	Employed	13	28	41	
		31.7%	68.3%	100.0%	
Occupation	***Unemployed***	69	40	109	**0.001**
		63.3%	36.7%	100.0%	
	Postgraduate	1	1	2	
		50.0%	50.0%	100.0%	
Education	***Primary***	57	30	87	
		65.5%	34.5%	100.0%	**0.007**
	Secondary	24	37	61	
		1	1	2	
	30 ≥	23	15	38	
		60.5%	39.5%	100.0%	
	31-40	31	23	54	
Age groups		57.4%	42.6%	100.0%	
	41-50	22	21	43	0.5
		51.2%	48.8%	100.0%	
	>50	6	9	15	
		40.0%	60.0%	100.0%	

P-value ≤ 0.05 (significant).

Significant association between recommendation of females for screening and doing screening, [74.1%] of females twice recommended have screening before while [39%] of females once recommended have screening before. As show in table 5. Other barriers have no significant association.

Table 5: association between female's patient's barriers and screening before.

variables			Have screening before?	Total	P-value
		No	**Yes**		
	No	61	58	119	
		51.3%	48.7%	100.0%	
Fear from procedures	***Yes***	21	10	31	0.1
		67.7%	32.3%	100.0%	
Complications after	***No***	16	18	34	
		47.1%	52.9%	100.0%	
procedure	***Yes***	66	50	116	0.3
		56.9%	43.1%	100.0%	
	Negative	70	55	125	
Family history of		56.0%	44.0%	100.0%	
	Positive	12	13	25	0.5
procedure		48.0%	52.0%	100.0%	
	Once	75	48	123	
No. of recommendation		61.0%	39.0%	100.0%	
	Twice	7	20	27	**0.001**
		25.9%	74.1%	100.0%	

P-value ≤ 0.05 (significant).

As show in table 6, there is no significant association between health care provider's barriers and screening before.

Table 6: association between health care provider's barriers and screening before.

variables			Have screening before?	Total	P-value
		No	Yes		
	No	70	54	124	
Materials out of stock		56.5%	43.5%	100.0%	
	Yes	12	14	26	0.39
		46.2%	53.8%	100.0%	
Queue was too long	*No*	35	28	35	
		55.6%	44.4%	55.6%	
	Yes	47	40	47	0.8
		54.0%	46.0%	54.0%	
	No	75	64	139	
Charges too high		54.0%	46.0%	100.0%	
	Yes	7	4	11	0.7
		63.6%	36.4%	100.0%	

P-value ≤ 0.05 (significant).

DISCUSSION

Although of clear importance of cervical cancer screening in detection and treatment of precancerous lesions, no activities are carried out to implement national screening program for screening of cervical cancer.[12] however Pap Smear is the usual clinical practice for needed patients, this study was carried out to identify the barriers for Pap smear. The study revealed that barriers for cervical cancer screening were from both patient and care provider, this finding is similar to that reported from.[13,14] this is a surprising finding as the mentioned countries are low income countries like (Afghanistan, Guinea, Rwanda, etc..).[15] Iraq of middle income countries i.e. relatively high income country especially after redistribution of wealth after change of regime.[16] Work overload was identified as a barrier for doing pap smear among physicians 58% in tertiary centers. This feeling of overload attributed to mal distribution of human resources in health system.[17] this also reflects the defects in health system as the health system was not reformed since 1981 (low of public health was legislated in 1981). Financial status was observed as barrier for carrying out cervical cancer screening. It seems logic as the health system combines both public and private sectors, this status is in contrast with Iraqi constitution that stressed on free treatment of charges.[18] It could be challenging for such women to keep spending family resources on follow-up when they feel quite healthy but have other urgent financial needs to be attended [18]. Fear from the procedure and its complications that might be expressed in lack of awareness stated by high percentage of women (77%), this reaction similar to findings were reported from relevant studies.[15] Low education was a prominent barrier to cervical screening, it was said that illiteracy was defeated by the previous regime.[16] however low literacy was barrier to cervical cancer screening, furthermore Lower levels of education are usually associated with unemployment and lower paying jobs. Coupled with the fact that adherence to follow-up entails good comprehension of the condition, these women become vulnerable to poor adherence to follow-up. After two requests, the Iraqi women carry out the screening test Pap smear, this finding might reflect the hesitant nature of Iraqis.[18] mostly loss of trust in health system behind this phenomenon. Studies on satisfaction in health system showed low satisfaction.[17]

CONCLUSION

Most of females have low interest in carrying out cervical cancer screening, barriers were identified for this finding which include education and fear from the procedure as important and significant barriers for females to have cervical screening.

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