

HIV-Positive Women's Perceptions, Awareness, and Knowledge about Cervical Cancer Screening in Malawi: A Qualitative Study

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Abstract

Background

Malawi is among countries with highest rates of cervical cancer and HIV in the world. Evidence has shown that HIV-positive women have a higher risk of having abnormal cervical cells caused by human papillomavirus (HPV) than in HIV-negative women due to compromised immune system. However, there is a gap in the literature relating to cervical cancer and screening rate, knowledge, and behavior among Malawian HIV-positive women.

Objectives: To explore factors influencing cervical cancer screening among Malawian women living with HIV infection.

Methods:

This qualitative study was conducted in one of the Christian Health Association of Malawi (CHAM) health facilities. Data were collected through an in-depth interview with 13 HIV positive women who were purposely selected to participate. Data were analyzed using content analysis.

Results:

The study identified four major themes influencing screening which include 1) knowledge and attitudes; 2) social support networks; 3) socio-cultural factors; and 4) access to screening services.

Conclusion:

The findings of the study should further be explored in a larger population based survey to develop specific and targeted interventions for promoting cervical cancer screening among Malawian women living with HIV infection.

Keywords:

HIV; Cervical cancer screening; Perceptions; Awareness; Knowledge; Malawi

Background: Globally, health disparities exist in access to health care and disease burden. Almost nine out of ten (87%) cervical cancer deaths occur in the less developed regions [1].

Malawi has the highest rate of cervical cancer in the world [2,3]. Human papillomavirus (HPV) infection favors HIV acquisition, and HIV-infected individuals encompass a heavier burden of HPV and cervical cancer due to a compromised immune system [4]. HIV-positive women have a higher risk of having abnormal cervical cells caused by HPV than in HIV-negative women. In a study conducted recently in Malawi, the prevalence of a visual inspection with acetic acid (VIA) positive result was 7% among HIV-negative women and 33% among HIV-infected women [5]. Malawi's HIV prevalence is one of the highest in the world with women aged 15-49 years estimated at 10.8% [6]. Women account for more than half of all adults infected with HIV/AIDS. The use of antiretroviral therapy (ART) has extended survival for persons living with HIV/AIDS and allows them to live a longer healthy life. But HIV-infected individuals are prone to opportunistic and other sexually transmitted infections [7]. Lack of early diagnosis of HPV in HIV-infected women is linked to higher mortality from cervical cancer than from HIV/AIDS [8]. Malawi is the second poorest country in the world and women do not have access to the same methods of cervical cancer screening as women in developed countries [2]. In addition, more than 80% of cervical cancer in sub-Saharan Africa is detected at a later stage due to lack of awareness and resources to implement effective screening programs to identify and treat a pre-cancerous lesion or early stages of cervical cancer [9,10]. Cervical cancer is preventable and curable if detected at an early stage using VIA [3]. The VIA has demonstrated to be feasible, safe, accurate, affordable and an effective way of reducing the cervical cancer burden [10]. Cervical cancer screening is effective in the prevention of cervical cancer in developing countries where this testing is available [3]. Despite the availability of screening services in Malawi, the WHO report indicated that the cervical cancer screening coverage for all women aged 18 and above in Malawi was as low as 2.6% [10]. Regardless of the risk and vulnerability of a high percentage of the population, cervical cancer screening studies have not been conducted among Malawian women with HIV to explain and understand the determinants of cervical cancer screening. The purpose of this qualitative study was to explore sociocultural, knowledge, attitudes, and health belief about HIV and HPV infection and cervical cancer screening among Malawian women living with

HIV infection. The specific objectives include exploring HIV-positive women's perceptions, awareness, knowledge and health beliefs about cervical cancer; socio-cultural factors that influence cervical cancer screening; HIV-positive women's perceptions of stigma about HIV and cervical cancer.

Methods:

A descriptive qualitative study was conducted at a Christian Health Association of Malawi (CHAM) hospital in Malawi. The study targeted HIV-positive women aged 18 or older. Data collection commenced after obtaining local IRB approval, in addition to IRB approval from University of Massachusetts Boston. Participants' decision to take part in the research study was voluntary. Subjects were recruited using notices posted at strategic sites and through health talks at the clinics. Volunteers who showed up and gave written informed consent for participation were recruited consecutively. Saturation point was reached after interviewing 13 respondents.

Discussion:

The purpose of the study was to explore factors influencing cervical cancer screening among Malawian women living with HIV infection. Some respondents had limited knowledge on the use of screening services as a means of preventing cancer in HIV positive women. For example, a woman stated, "Government should advocate cervical cancer screening for all women. All women are equally at risk of having cervical cancer not just HIV positive women" (Respondent 7). Health beliefs could mean lack of knowledge regarding the increased risk of developing cervical cancer. On the other hand, HIV/AIDS is viewed as a stigmatized disease among the community and by advocating for cervical cancer screening for HIV positive women, it would also bring stigma to this preventive effort. Health beliefs could mean that HIV positive participants had limited knowledge that having HIV increases the risk of having cervical cancer. Cervical cancer can be prevented by screening and that the disease can be treated if diagnosed at an early stage. In addition, HIV positive women have low knowledge regarding cervical cancer and screening as any other women. Health beliefs are evidenced by the narrations from the participants that indicated that women did not have accurate knowledge about the disease. Women were asked what they had heard about cervical cancer and screening. Most women stated that they had heard that cervical cancer was a dangerous disease, but they could not state the signs and symptoms of the disease. Also, those who stated how the procedure was done indicated that the screening procedure was painful. Such knowledge deficits might explain why most of the participants did not go for screening as they thought the procedure was painful despite being aware of its usefulness. In addition, it might also indicate lack of information, education and communication of health

awareness and promotional messages about cervical cancer and screening in the community. In the absence of adequate knowledge on the procedure, women are not likely to undergo for screening or may do so when the disease has reached an advanced stage as indicated by Maseko and colleagues [10]. Due to lack of knowledge about cervical cancer few participants accessed the services. Health beliefs are in line with the WHO's report which indicated that few women (2.6%) have had cervical cancer screening in Malawi [10]. Therefore, the health care system should create health awareness day for cervical cancer and screening in the community. The awareness will increase women's knowledge about cervical cancer and screening services. The knowledge gained will also help to address women's misconceptions about the cervical cancer screening procedure. Health care workers have a crucial role in sensitizing the community and educating women about cervical cancer and screening procedure in Malawi. Women got information about cervical cancer and screening from their friends or relatives. The decision to go for cervical cancer screening was influenced by their social network members' information. One participant shared this: "The doctors told my friend not to have sex for one week after the procedure. Some husbands cannot stay without sex for one week" (Respondent 11). Health beliefs can mean that the friends are a source of information that influences behavior. On the other hand, it may mean that information is not correctly shared among the community. Another woman also stated that "The procedure of cervical cancer is painful" "Since I have never heard from doctors talking about cervical cancer screening, I have no information about it". Therefore, incorrect information that women share about screening procedure may be a barrier to cervical cancer screening among Malawian women. On the other hand, Women who reported that they underwent screening, reported that a family member or a health care provider motivated them to undergo the screening as shown through narrations from two women as follows: "My daughter-in-law told me that the procedure is not painful and encouraged me to go for testing" (Respondent 1). "The doctor told me that the screening helps to prevent cancer and for early care if you are found with cancer" (Respondent 4). Health beliefs suggest that the type of social networks of women living with HIV-infection interacts and the type of information shared facilitates and hinders screening uptake. Most respondents reported on indirect costs of screening such as lack of availability and accessibility of the screening services. The cervical cancer screening services were offered at a hospital level, and some clinics refer cases to hospitals that are situated very far away. Money for transport to go to a hospital to receive cancer services was a significant barrier to receiving care when the cancer was treatable. Although there are no user fees to access cancer services in public health facilities, there was indirect cost as the women were required to travel long distances and purchase health passports if they did not have one. In addressing this problem, training more service

providers and procurement of resources may help to open more cervical cancer screening centers and improving access cervical cancer services. All the participants were aware that both male and female health workers perform cervical screening. Some women were not comfortable to be screened by a male service provider. HLs indicated that the gender of the healthcare provider performing the cervical cancer screening appeared to be a barrier to access screening services for some of the participants. Refusing to be screened by men reflects cultural unacceptability of reproductive health services like cervical cancer screening to be provided by male service providers. Likewise, age of service providers is a critical component of secondary prevention of cancer in a culturally sensitive environment when women have no signs and symptoms of the disease to undergo screening. Women also added that fragmentation of the HIV and cervical cancer services was a barrier to cervical cancer screening. One woman shared this: "It is better if doctors screen us as we are starting ARV as part of our care package and follow up within our ARV appointment dates rather than going to cervical cancer screening clinic to save transport money and time" (Respondent 9). Herefore, access to screening services was a barrier to screening rather than the socioeconomic factors.