

As mentioned in our 'Opinion', the arguments that we present against a nationwide cytological screening programme for cervical cancer can and should also be applied to many other forms of health expenditure which also have a detrimental effect on the development of effective primary health care and the overall health and well-being of women.

It is clear that we share Dr Fonn's vision and hopes in this regard, but differ in the way we think that this can be achieved. We simply favour a more incremental approach to the development of good-quality, cost-effective primary health care based on a more rigorous assessment of the relative costs and benefits.

Feasibility of universal screening for cervical cancer in rural South Africa

To the Editor: The feasibility of a universal screening programme for cervical cancer in South Africa is currently being debated. Perhaps the two extremes of opinion are represented by McCoy and Barron¹ and the Centre for Health Policy.² McCoy and Barron argue that 'cervical cancer . . . [should be] . . . kept off the policy and planning agenda'. They believe that cervical cancer screening is not feasible, and that it is not desirable given more pressing health needs. The Centre for Health Policy considers that the need is great, and a plan of action to implement national screening is proposed.

How feasible would the implementation of universal cervical cancer screening be in rural South Africa? It is too easy to be nihilistic about apparently overwhelming health issues. We perceive our resources to be inadequate and our problems to be insurmountable, but this is not necessarily true. Our experience at Hlabisa is that much can be done.

We have shown that 85% of patients with tuberculosis complete treatment through an innovative community-based programme.^{3,4} Similarly, through a simple and focused approach to perinatal care we have virtually eliminated avoidable perinatal deaths in our health district and perinatal mortality has fallen as a result.^{5,6} We are currently developing an integrated district-wide sexually transmitted disease control programme that involves public, private and traditional sectors. Our goal is to reduce the incidence of HIV infection. Fanciful? We think not.

It is, however, the opinion of the practitioners at Hlabisa that universal cervical cancer screening, while ultimately desirable, is not feasible within the current — or likely future — resources of our health service. There is no slack, and demand is rising while our ability to supply is falling, in part due to the HIV epidemic.⁷

Barriers to a universal screening programme are outlined by McCoy and Barron. The skills and capacity to take smears do indeed not exist, but they could be developed. Good coverage of the target population could probably be achieved; we do reach most children for immunisation and women for antenatal care.⁸ The health and management information systems currently in place are less than adequate; perhaps paradoxically we know more about how money is spent in our district health system than about

where it *should* be spent. The cytology and referral services would need to be considerably strengthened and expanded. Even were they to be in place, our experience is that getting results back and to the patient is very difficult. Only 22% of patients undergoing biopsy (for any reason) in Hlabisa ever received their results.⁹ Similarly, only 17% of patients who had an HIV test ever received their result.¹⁰ We may have systems in place, but making them work is another story.

However, even if universal screening were feasible it would not be desirable in our setting. There are many more urgent priorities for which cost-effective interventions exist.¹¹ McCoy and Barron are right: the opportunity costs of a universal cervical cancer screening programme preclude its feasibility and desirability.

David Wilkinson

Hlabisa Hospital
Hlabisa, KwaZulu-Natal

1. McCoy D, Barron P. Cytology screening for cervical cancer — what are the opportunity costs? (Opinion). *S Afr Med J* 1996; **8**: 935-936.
2. Fonn S, Klugman B, Dehaeck K. *Towards a National Screening Policy for Cancer of the Cervix in South Africa* (Paper No. 31). Johannesburg: Centre for Health Policy, University of the Witwatersrand, 1993.
3. Wilkinson D. High-compliance tuberculosis treatment programme in a rural community. *Lancet* 1994; **343**: 647-648.
4. Wilkinson D, Davies GR, Connolly C. Directly observed therapy for tuberculosis in rural South Africa, 1991 through 1994. *Am J Public Health* 1996; **86**: 1094-1097.
5. Wilkinson D. Statistics of perinatal mortality due to error or omission: a suggestion of how to improve care. *Trop Doct* 1993; **23**: 119-121.
6. Wilkinson D. Avoidable perinatal deaths in a rural hospital: strategies to improve quality of care. *Trop Doct* 1995; **25**: 16-20.
7. Gilks CF, Haran D, Wilkinson D. Coping with the impact of the HIV epidemic — the Hlabisa-Liverpool Link. *S Afr Med J* 1996; **86**: 1077-1078.
8. Wilkinson D, Cutts F, Ntuli N, Abdool Karim SS. Maternal and child health indicators in a rural South African health district. *S Afr Med J* 1996; **87**: 456-459.
9. Kettle H, Wilkinson D. Histopathology services in a rural African hospital: how audit can improve service. *Trop Doct* 1997 (in press).
10. Wilkinson D, Wilkinson NF, Lombard C, Martin D, Smith A, Floyd K, Ballard R. On-site HIV testing in resource-poor settings: is one rapid test enough? *AIDS* 1997; **11**: 377-381.
11. World Bank, Jamison DT, Mosley WH, Measham AR, Bobadilla JL, eds. *Disease Control Priorities in Developing Countries*. Oxford: Oxford University Press, 1994.

Screening for cancer of the cervix in South Africa

To the Editor: The National Cancer Registry (NCR) collects information on histologically diagnosed cancer via a network of all the country's histopathology, cytology and haematology laboratories. Data for 1990 - 1991 have been collated and analysed using standard methods¹ and published elsewhere,² but because of an 'Opinion' article³ by McCoy and Barron we felt it important to publicise the enormous burden of cancer and cancer of the cervix in South Africa and the possible benefits of a screening programme.

A total of 111 207 new cases of cancer were reported for the two years of 1990 - 1991, i.e. about 50 000 per year. If one assumes that current cancer incidence trends continue (a common assumption¹), at least 1 in 6 women will develop a cancer of any kind in their lifetime, i.e. between 0 and 74 years. These are minimal incidence rates because clinical diagnoses of cancer are unfortunately not included by the NCR. If we adjust for underreporting, about 1 in 4 South Africans will develop a cancer in their lifetime.²

Despite underreporting, about 5 000 new cases of histologically diagnosed cancer of the cervix are recorded annually by the NCR (Table I) and about 1 500 deaths (after