Integrating cervical cancer screening within family planning service provision in peri-urban Zambia

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Significance/Background

Cervical cancer is the leading cause of cancer-related deaths in developing countries. Second to breast cancer, it is the most common cancer in women worldwide and primarily affects women aged 30 years and older (1). In Zambia, cervical cancer (CACX) screening was introduced in 2006. Since then over 189,500 women have been screened for CACX (2). While incidence and mortality rates of cervical cancer have fallen significantly in developed countries, 85% of all new cases that occur annually and 85% of all deaths from the disease occur in developing countries (2,3).

Family planning (FP) services in Zambia have traditionally been offered routinely in maternal and child health (MCH) settings. The Society for Family Health (SFH) provides FP services using a dedicated provider model in high volume public sector health facilities since 2008 (4). The model emphasises long-acting reversible contraception (LARC), while assuring method choice. Historically FP and CACX services have been offered in parallel. Previous integration of cervical cancer screening programs was mainly conducted within HIV programs because of the strong demonstrated association between CACX and HIV (3). An integrated FP-CACX program aims to efficiently reduce unmet need for critical sexual and reproductive health (SRH) services and implemented an integrated FP and CACX service delivery model to determine the feasibility of integration and whether an integrated model would result in increased demand for both services by clients.

Program Implementation/Activity Tested

The integrated model was implemented in 3 high-volume public sector health facilities in Zambia’s Copperbelt Province. Each facility had one SFH healthcare provider trained in CACX screening and treatment and provided both FP and CACX services from the same facility. CACX screening used visual inspection with acetic acid (VIA) and digital Cervicography. Each facility had one SFH healthcare provider trained in CACX screening and treatment and provided both FP and CACX services from the same facility. CACX screening used visual inspection with acetic acid (VIA) and digital Cervicography. Services were offered concurrently.

Methodology

The intervention was conducted between February 2012 and September 2014. Prospective clients who attended MCH clinics were offered information on these services during routine group education. Clients seeking either service were referred to an integrated FP-CACX screening room within the facility. Women seeking FP services were offered CACX screening and those seeking CACX screening were offered FP services by the same provider. CACX screening was done using VIA and digital Cervicography. Clients with positive VIA results were treated immediately with cryotherapy if they had minor lesions. Clients with complex lesions were referred to external specialized facilities for further evaluation. Minor lesions are lesions that affect the superficial cells of the cervix and the complex ones affect the deeper cells. All clients were routinely offered HIV testing.

Client level data was routinely collected using public sector registers and SFH data collection tools. Program data was submitted centrally to SFH for management and analysis.

We analyzed data during the period of July-August 2014.

Results & Key Findings

Among 819 clients desiring FP or CACX services in MCH clinic in the three facilities, a total of 544 (66%) opted to solely receive an FP service. CACX screening services were received by 256 (31%) of clients who came in desiring FP or CACX services in MCH. The majority of all clients seen, had attained secondary education (47%), were married (83%) and were HIV negative (86%)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
<th>Clients who received FP only</th>
<th>Clients who received CACX screening only</th>
<th>Clients who received both FP and CACX screening</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education Status</td>
<td>No. (n=552)</td>
<td>No. (n=229)</td>
<td>No. (n=11)</td>
<td>No. (n=742)</td>
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<tr>
<td>Primary</td>
<td>27%</td>
<td>17%</td>
<td>4%</td>
<td>38%</td>
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<tr>
<td>Secondary</td>
<td>59%</td>
<td>37%</td>
<td>46%</td>
<td>61%</td>
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<tr>
<td>Tertiary</td>
<td>5%</td>
<td>45%</td>
<td>9%</td>
<td>16%</td>
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<tr>
<td>Marital status</td>
<td>No. (n=469)</td>
<td>No. (n=238)</td>
<td>No. (n=10)</td>
<td>No. (431)</td>
<td></td>
</tr>
<tr>
<td>Unmarried</td>
<td>9%</td>
<td>32%</td>
<td>10%</td>
<td>47%</td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>90%</td>
<td>68%</td>
<td>86%</td>
<td>83%</td>
<td></td>
</tr>
</tbody>
</table>

Of the 819 clients desiring FP or CACX services in the three facilities, a total of 544 (66%) opted to solely receive an FP service. CACX screening services were received by 256 (31%) of clients who came in desiring FP or CACX services in MCH. The majority of all clients seen, had attained secondary education (47%), were married (83%) and were HIV negative (86%)

Lessons/Program Implications

We evaluated an integrated CACX FP program designed to create efficiencies and increase demand for both FP and CACX services. In this setting, offering integrated HIV testing was relatively successful. We demonstrated that even though services are provided by one health care worker in the same facility, it appears that uptake for both services is low. This may be because clients come expecting to receive a single service, and additional services may be less desirable within a single visit. Time and motion studies are warranted to elicit specific time associated with offering both services at once.

This program demonstrates that an integrated model is feasible, though client uptake of combined FP-CACX services remained relatively low in this setting. Health education models to encourage women to seek both services should be explored. There is a need to further investigate approaches, barriers and facilitators of dual service provision across a variety of client demographics to refine integrated SFH service delivery strategies for women in need.

References