Integrating Cervical Cancer Screening and Preventive Therapy with Other Reproductive Health Services:

An Entry Point to a Wider Range of Service Offering

CASE STUDY 2

IPPF
Africa Region

Contents

Background

Cervical cancer is the second most common cancer among women (WHO, 2012). It is estimated that over a million women worldwide currently have cervical cancer, and more than 260,000 women die every year because of the disease (WHO, 2014). Although cervical cancer is highly preventable and easily treatable if detected early, it remains one of the leading causes of cancer-related death in the world. Nearly 90% of cervical cancer-related deaths occur in developing countries (WHO, 2014). **Although rates of cervical cancer have fallen in most of the developed world in recent decades, rates in most developing countries have risen or remain unchanged** (WHO, 2014).

To address these challenges, the International Planned Parenthood Federation (IPPF), Marie Stopes International (MSI) and Population Services International (PSI), with support from the Bill and Melinda Gates Foundation, initiated the Cervical Cancer Screening and Preventive Therapy (CCS&PT) Programme. The programme was implemented from late 2012 to 2017 with the participation of IPPF Member Associations in Kenya, Nigeria, Tanzania and Uganda[1] and the collaboration from the respective Ministries of Health and key stakeholders at the local level. **The purpose of the initiative was to institutionalize and scale up CCS&PT services through existing Reproductive Health Networks (RHNs). The programme utilized Visual Inspection with Acetic Acid (VIA) for screening – an evidence-based, affordable, non-invasive method that can be performed in a low-level health facility with instant results – and cryotherapy for treatment** – a procedure that uses freezing gas to destroy precancerous cells on the cervix.

Since its inception in late 2012 through July 2017, the **CCS&PT Programme has delivered screening services to over 2 million women and treatment and preventive therapy to over 32,000 women in the four target countries.** It has become the largest effort against cervical cancer being implemented in the developing world. The programme has reached poor, marginalized and underserved women 30 to 49 years old through mobile units, outreach teams and fixed facilities.

A key driver – and outcome – of this initiative has been the integration of cervical cancer prevention with other sexual and reproductive health services.

This document describes how the integration of cervical cancer prevention with other services has the potential to increase family planning

[1] *Family Health Options-Kenya, Planned Parenthood Federation of Nigeria, UMATI-Tanzania and Reproductive Health Uganda*

uptake and access to other sexual and reproductive health services. By providing information on the implementation of this approach and its relevance within the **CCS&PT Programme**, we hope to share useful information and advice sexual and reproductive health organisations, public authorities, practitioners and other stakeholders concerned with women's health and sexual and reproductive rights.

What is integrated service delivery and why is it necessary?

Integrated service delivery (ISD) is defined by the World Health Organization (WHO) as ***"the management and delivery of health services so that clients receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health system"*** (WHO, 2008). Supporting integrated services does not mean that everything has to be integrated into one package. In reality, there are many possible permutations. Integration may occur when the same provider offers various services during the same consultation (provider-level integration), or when different services are available at the same facility but are not necessarily offered by the same provider (facility-level integration). Ultimately, integration is about efficient use of the limited resources available and the effective organisation of various services to meet the needs of a population and ensure their right to the highest standard of health.

IPPF has long understood the importance of integrated service delivery. Since 2011, IPPF has been promoting the delivery of an Integrated Package of Essential Services (IPES) through its Member Associations around the world. The IPES seeks to meet the most pressing sexual and reproductive health needs of the population, placing the client at the very centre of everything we do and ensuring that we deliver quality integrated services to every individual. The IPES includes eight sexual and reproductive health (SRH) service categories: ***counselling, contraception, safe abortion care, sexually transmitted infections/reproductive tract infections, HIV, prenatal care, gender-based violence and gynaecology, which is focused on cervical cancer prevention and breast cancer prevention.***

IPPF has also led the Integra Initiative, a research project implemented in Kenya, Malawi and Swaziland that analysed the benefits and costs of a range of models for delivering integrated HIV and SRH services in high and medium HIV prevalence settings aimed at reducing HIV infection (and associated stigma) and unintended pregnancies (Integration Initiatives, 2014). The study demonstrated that integrating services has the potential to increase the uptake and range of services available, make efficient use of resources, and respond to client needs, improving overall client satisfaction and service quality (Ibid.).

Integrating HIV and family planning services with cervical cancer programmes is recommended as a good practice that reduces the number of client visits to access services and increases the long-term benefits of comprehensive care (WHO)

Rationale for integration in the CCS&PT Programme

Integration has been part of the CCS&PT Programme from its design phase; the intent of the initiative was to institutionalize and scale up CCS&PT services through existing RHNs. The idea was to take advantage of the installed capacity of these organisations – human resources, facilities, services, geographical coverage, awareness programmes at the community level, etc. – to accelerate progress in cervical cancer prevention and, simultaneously facilitate access to other more stigmatized sexual and reproductive health services using cervical cancer prevention as an entry point. From the beginning, the expectation was that the programme could help increase the demand for services such as family planning and STI counselling, testing and treatment (including HIV). While the reaction to the goal of integration was initially lukewarm due to concerns about service delivery capacity, the funding provided under the CCS&PT Programme allowed IPPF to experiment with different models and practices that showed that the approach resulted in significant benefits.

The benefits of integration in the CCS&PT Programme

During the 2015-2016 project year, the CCS&PT Programme commissioned operational research to better understand how and how well cervical cancer screening services were being provided within the existing sexual and reproductive health service delivery channels. The study, conducted in Uganda, confirmed the value of service integration in improving access, demand and use of sexual and reproductive health services, including CCS&PT. The results showed that a) integrating CCS&PT into sexual and reproductive health care appeared to increase demand for other services; and b) that integration was an opportunity to bring cervical cancer prevention to new segments of the population, as demonstrated by the fact that a high proportion of the clients reached by the programme had never been screened before.

In the research implemented in Uganda, interviewees confirmed that although the main reason for their presence at the facility was cervical cancer screening (34% of all clients arrived with the intention of being screened), as many as 78% of interviewees accessed other services during their visit, mostly long-acting reversible contraception or family planning counselling. The number of implant and intra-uterine device (IUD) services increased substantially following the introduction of CCS&PT, as seen in Figure 1. Similar results were found in other countries. The implementing partners in Kenya found that during 116 cervical cancer screening and family planning integrated outreach sessions in 2015, approximately 40% of clients who received cervical cancer services also accessed family planning methods (Marie Stopes International, 2017).

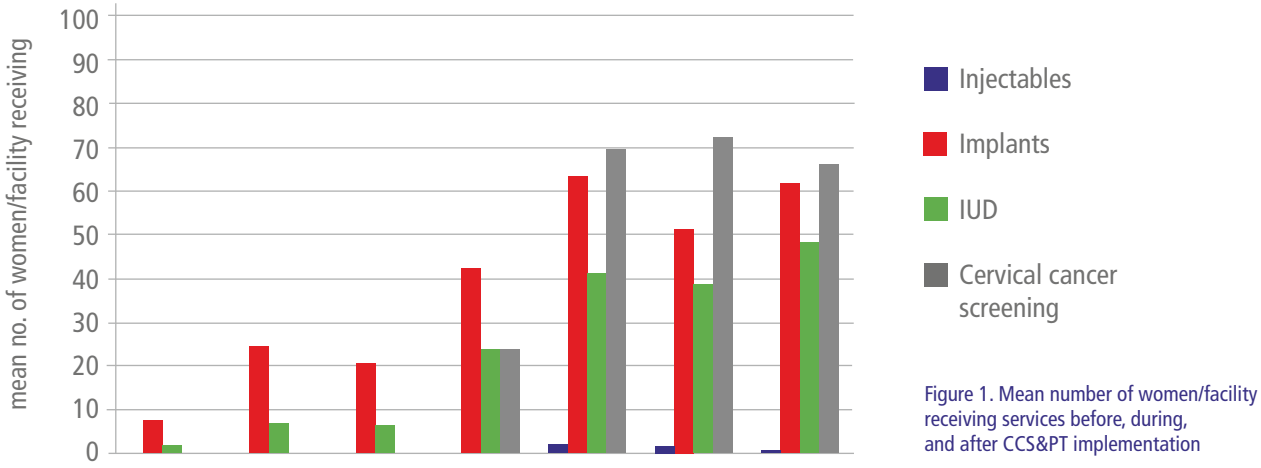


Figure 1. Mean number of women/facility receiving services before, during, and after CCS&PT implementation

Lessons from the field

Over the years, we have gathered the following lessons learned about the impact of integration:

1. Integration places the clients at the centre of service delivery: Integration focuses on clients' needs, leading to higher client satisfaction and resulting in better health outcomes due to easier access to more services. Our partners in Uganda, for instance, have developed outreach sessions in refugee camps that very few providers are able to reach and where women have limited access to services.

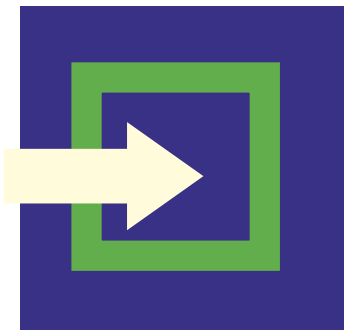
2. Integration creates opportunities for learning: Health providers are able to acquire knowledge and skills through training on CCS&PT, shared reading materials (such as protocols and guidelines), mentorship and the practice of clinical services delivery.

3. Integration improves access, demand and use of sexual and reproductive health services: This is particularly true for the administration of IUDs, implants and services related to sexually transmitted infections. This is especially important for the most vulnerable populations, including women living in remote areas served through community-based outreach.

4. Integration allows women to access stigmatized reproductive health services in conservative contexts: The programme has become an entry point for women to access services that would otherwise be difficult to get due to social stigma, including contraception and HIV testing. For example, many women in Uganda lack support from their spouses and partners for family planning and other reproductive health services, but are much more likely to get support from them when they mention they are going for cervical cancer screening.[2]

5. Integration is a time and cost-efficient means for delivering services, both for the client and the provider: Reproductive health integration allows the provider to address the client's needs in one visit, optimizing use of time and supplies and reducing the gap of missed opportunities. For example, the clinical procedures for IUD insertion and cervical cancer screening are very similar and can be performed in conjunction with each other. Similarly, clients who had sexually transmitted infections but were not aware of the infection received diagnosis, treatment and further counselling.

6. Integration opens opportunities for income generation: As some of the services offered as part of the package have a fee, integration opens the possibilities for providers to increase their income, ensuring a sustainable way to continue to provide CCS&PT services.



"Integrating family planning with CCS&PT has been of significant help in our work. In Tanzania, we have very conservative regions where local leaders reject family planning outreach. In such communities, you cannot openly mobilize people around family planning because you put your sustainability as an organization at risk. However, cervical cancer screening is a service people normally accept, even in the most conservative settings. With the Integrated Service Delivery approach, you can publicize cervical cancer screening as your core service but use the visit to address other unmet needs, mostly family planning".
Representative from UMATI, IPPF's Member Association in Tanzania

[2]*Testimony from Reproductive Health Uganda staff, IPPF's member association in Uganda*

Some challenges were also noted during the programme:

1. Increased workload for providers: Providers' workload increased due to the extra needs of clients added to their regular responsibilities.

2. Longer waiting times and some clients not being seen: This was an issue during the programme, particularly during outreach activities, where the volume of clients was very high in relation to the number of service providers. Longer waiting times were mainly due to the provision of several services to a single client, particularly services involving time-consuming procedures such as IUD insertion, counselling in several areas, and completing data forms. Consequently, integrated services require additional resources and supplies, including HIV test kits, instruments, technologists and counsellors, etc. In order to address these issues, service providers are encouraged to strategically plan to increase staff members and skills at mobile outreach clinics (where a higher demand is observed), carefully managing the high client flow and establishing good information systems, supervision and logistics.

"Many women are not aware they have pre-cancerous lesions. They come for other services, such as family planning and sexually transmitted infection management, including HIV testing or care. However, when we offer the option to be screened, they accept and we find lesions, and they can receive treatment and save their lives. In other cases, it is the contrary, they come for cervical cancer screening, and we take the opportunity to offer other services, for example, family planning or HIV testing. It may also happen that, during the examination we find STI or other abnormalities that we can treat immediately".
Representative from Reproductive Health Uganda, IPPF's member association in Uganda.

Recommended steps to implementing integrated service delivery

Implementing integrated service delivery in cervical cancer prevention efforts require a high level of assessment, planning and coordination. Here are some recommended steps for its implementation:

- **Coordinate and advocate with policy makers and administrative entities:** Enable implementers to identify the gaps and opportunities in policies and national strategies, optimising resources and increasing access to integrated services.
- **Analyse the existing service package that your organisation offers:** Define which existing services (if any) might be entry points to CCS&PT or if, by introducing CCS&PT, clients will be able to access existing services more easily.
- **Check available resources and capacities:** This might include supplies, infrastructure, personnel shortages or surpluses, service allocation within a facility, information, monitoring and evaluation management systems, etc. Consider if internal referral systems are in place to facilitate the flow of clients between services and if coordination is needed to ensure providers have access to all the necessary supplies for the provision of integrated care, e.g. a provider offering cervical cancer screenings may require flipcharts to offer counselling in contraceptive use.
- **Identify the implications on the internal operation of the organisation:** For example, the provision of integrated services may require changes to the client registration/medical history form to better capture the comprehensive care being accessed by the client, or adaptations to the infrastructure to facilitate the flow of clients from one service to the other. Facilities should explore the possibility of re-organizing the available rooms

to improve strategic and discrete flow from one room to another.

- **Identify the implications for service providers:** Make sure that providers actively participate in the design process to ensure that management of the integration process reflects the on-the-ground needs of the facility. Broadening services may require additional time per client, causing longer waiting times, impacting the number of clients served and the provider's schedule. This element is crucial for planning itineraries, especially for mobile units or outreach services, as it might now be necessary to stay a few extra days or return to a community on a more regular basis.

- **Improve health providers' skills through training and mentorship:** Provide training, as well as guidelines and protocols on multiple services. Strong mentorship and training have the potential to address staff shortage issues by increasing and transmitting skills among existing personnel. This might require a certain level of multi-task and task sharing among staff members.

- **Define costs and fees:** Identify whether services will be free of charge and how clients will be informed about the potential cost of additional services during a single visit. Implementing organisations should plan for unforeseen costs or internal management issues, which may be reflected in the cost of services.

- **Create an action plan to create awareness on multiple issues at the community level:** CCS&PT can be an excellent entry point to dispel myths about other sexual and reproductive health topics and address stigma.

- **Monitor the process:** Ensure reliable and regular data collection to assess the programme's performance and identify areas that may require quality improvement, e.g. Is integration being captured? Is it possible to identify services that may be underreported? What are the main bottlenecks impacting client flow from one service to another? It is important to regularly assess the model and readjust according to each facility's needs and abilities.

- **Evaluation, learning and improvement** should form part of a continuous process that must be constantly supported and realigned to assess the acceptability, efficiency and effectiveness of the integrated services offered.

Remember...
The integration of cervical cancer prevention with other services has the potential to accelerate results as well as increase contraceptive uptake and access to other sexual and reproductive health services. Implementing organisations can take advantage of their capacities, including human resources and facilities.

Want to know more about other successful practices to increase access to CCS&PT? Access our case studies on service integration, referral systems and performance-based funding.

REFERENCES

Integration Initiatives, 2014. Overview and Objectives. [Online]
Available at:
http://www.integrainitiative.org/projects/integrainitiative/overview-and-objectives/
[Accessed 23 Oct 2017].

IPPF Africa Region, n.d. From choice, a world of possibilities: IPPF Cervical Cancer Screening and Preventive Therapy in Africa, Nairobi: IPPF Africa Regional Office.

Khulisa Management Services, 2016. Cervical Cancer Screening and Preventive Treatment (CCS&PT) Results Verification Yr 2: IPPF, Johannesburg: unpublished.

Marie Stopes International, 2017. Cervical Cancer Screening and Preventative Therapy via Reproductive Health Networks: Global health progress report - Bill & Melinda Gates Foundation, London: unpublished.

Martin, C. et al., 2014. Evaluation of a single-visit approach to cervical cancer screening and treatment in Guyana: feasibility, effectiveness and lessons learned. J Obstet Gynaecol Res, 40(6), pp. 1707-1716.

Plotkin, M. et al., 2014. Integrating HIV testing into cervical cancer screening in Tanzania: an analysis of routine service delivery statistics. BMC Women's Health, 14(120).

PSI, 2017. Cervical Cancer Control and Prevention. [Online]
Available at: http://www.psi.org/program/cervical-cancer-control-prevention/
[Accessed 10 10 2017].

Qiagen, 2017. careHPV Test Kit. [Online]
Available at: https://www.qiagen.com/au/shop/detection-solutions/hpv-testing/carehpv-test-kit/#orderinginformation
[Accessed 16 10 2017].

Shiferaw, N. et al., 2016. The Single-Visit Approach as a Cervical Cancer Prevention Strategy Among Women With HIV in Ethiopia: Successes and Lessons Learned. Glob Health Sci Pract. , 4(1), p. 87–98.

UNFPA, 2011. Comprehensive Cervical Cancer Prevention and Control: Programme Guidance for Countries, s.l.: UNFPA.

White, H. L., Megioli, A., Chowdhury, R. & Nuccio, O., 2017. Integrating cervical cancer screening and preventive treatment with family planning and HIV-related services. International Journal of Gynecology & Obstetrics, 138(S1), pp. 41-46.

WHO, 2008. Integrated Health Services - What and Why? Technical Brief No.1. [Online]
Available at:
http://www.who.int/healthsystems/service_delivery_techbrief1.pdf

WHO, 2012. Prevention of cervical cancer through screening using visual inspection with acetic acid (VIA) and treatment with cryotherapy. A demonstration project in six African countries: (Malawi, Madagascar, Nigeria, Uganda,the United Republic of Tanzania, and Zamb, Geneva, Switzerland : World Health Organization.

WHO, 2013. WHO guidelines for screening and treatment of precancerous lesions for cervical cancer prevention, Geneva, Switzerland: World Health Organization.

WHO, 2014. Comprehensive Cervical Cancer Control: A guide to essential practice. Second Edition, Geneva, Switzerland: World Health Organization.

IPPF
Africa Region

Photo credit: IPPF/Tommy Trenchard