



# Strengthening Referral Systems for Improved Cervical Cancer Prevention Outcomes

## CASE STUDY 3





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## 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<sup>1</sup> 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, reaching poor, marginalized and underserved women 30 to 49 years old through mobile units, outreach teams and fixed facilities.

**The programme, however, have also had great challenges during its implementation. Before it started, there were no referral systems in place. Therefore, during Project Years 1 and 2, Member Associations struggled with very low treatment rates and emerging referrals in most countries. There were a significant number of losses to follow-up due to incipient systems. As a result, IPPF and its partners started looking for models to reinforce referrals and for practices that minimized the need for referrals.**

<sup>1</sup> Family Health Options-Kenya, Planned Parenthood Federation of Nigeria, UMATI-Tanzania and Reproductive Health Uganda



This document provides an overview of the challenges of establishing an effective referral system in CCS&PT initiatives and key recommendations for improved action. We hope to provide useful information and advice to sexual and reproductive health organisations, public authorities, practitioners and other stakeholders concerned with women's health and sexual and reproductive rights.



## Challenges in the implementation of referral systems in the CCS&PT Programme

Although providing universal access to high-quality screening is the first step to prevent women from dying from cervical cancer, little can be achieved if positive screening of pre-cancerous lesions are not properly linked to preventive therapy and to other essential services. Acknowledging this, **during the planning stage**, the CCS&PT Programme identified two mechanisms to ensure access to treatment: setting up a hub-and-spoke model in which several screening sites were serviced by a single cryotherapy site with equipment and trained staff; and strengthening referral systems to government hospitals or clinics from other non-governmental organisations – either for access to preventive therapy (cryotherapy or LEEP) or for access to more complex care (e.g. oncology services).

In practice, however, these mechanisms were insufficient to ensure high treatment rates:

- Facilities with cryotherapy machines did not always offer treatment immediately after screening<sup>2</sup>. This, according to country-programme reports, was due to multiple factors, such as availability of trained staff, shortage of instruments, broken equipment, and lack of gas, among others.
- Referred women faced challenges to access the services, including geographical barriers, service charge, long waiting lists for planned procedures, and the factors described above in relation to facilities.
- High-level treatments – e.g. for women with cancer – posed an even greater challenge, as

<sup>2</sup>Namely, *Single Visit Approach* – a cervical cancer prevention practice that offers screening services with instant results followed by immediate treatment for women who screen positive for pre-cancer.



there were usually very few specialized facilities in the country or sometimes just one (often located in the capital city) and such places experienced high demand. As a result, there was a greater possibility that women would need to move to a different city for their treatments.

Within this context, the CCS&PT partnership implemented two key actions:

- a. An **intensification strategy** that focused efforts on strengthening the implementation of the single visit approach, i.e. reducing the number of screening sites to those that yielded better results, increasing the number of treatment sites, acquiring additional cryotherapy machines and training more providers (To learn more, access the “Single visit approach” case study); and
- b. **Corrective measures to improve the referral systems** using the findings from operational research commissioned in 2015 as a starting point. This research sought to analyse the modes and effectiveness of referral methods for further treatment for women that screened positive. The study, implemented in Uganda<sup>3</sup>, showed that few of those with positive screens had cryotherapy at the same time (24%). Almost half of respondents had been referred to another facility for cryotherapy (44%). A further 27% were referred for other higher-level treatment.

The operational research demonstrated that the greatest barrier to referral treatment completion was cost and geographical distance:

- **Clients who obtained referral treatment travelled for a median of 120 minutes to reach the referral facility, most commonly by car, taxi or mini bus. Seeking referral treatment cost a median of approximately \$20, including transport, service charge, meals and telephone costs.**
- **Of the 19 respondents who did not attend referral treatment, the most common reason given was lack of money.**

- **44% of respondents received some kind of motivational support to obtain referral treatment, most commonly a financial incentive (26%).**



Other barriers identified by implementing partners during the operational research included factors inherent to the referral facility, such as non-functional cryotherapy machines at the referral sites; low numbers of trained providers; and long wait lists. From the provider's perspective, tracking down clients who were unable to receive same day treatment was commonly mentioned as an expensive and time-consuming task. Not only were phone calls and in-person follow up by community health workers or village health teams expensive, but contact numbers provided by clients were also often invalid or inactive.



<sup>3</sup>The study included analysis of routine data, quantitative cross-sectional surveys with 542 CCS&PT clients, in-depth interviews with 22 providers and 10 clients, and a referral assessment survey of 76 facilities. Data were collected across all three service delivery partners: MSI, PSI, and IPPF.



## How we improved referral systems in the CCS&PT Programme

The following actions were implemented to strengthen the referral systems. However, it is important to acknowledge that the single visit approach was the mechanism that yielded the best results to improve treatment rates.

**1. Set up stronger referral protocols:** Efforts were made to agree on referral protocols, produce referral site directories and, in some cases, offer incentives such as discount vouchers or transportation to the referral facility. The Planned Parenthood Federation of Nigeria implemented a [cluster model](#) where several facilities referred clients to a single larger facility within an area of 20 Km for treatment. This model is a good example of how communication and joint planning can strengthen the effectiveness of referral systems.



**2. Improve communication and relations with referral facilities:** Even with a larger number of facilities offering a single visit approach, some cases needed to be referred, including clients needing high-level treatment. In these cases, some implementing partners successfully established close communication with the providers at the referral facility. Reproductive Health Uganda (RHU), the implementing partner in Uganda, affirmed that having direct phone access to the person in charge at the National Hospital (high-level treatment provider) allowed them access to information regarding the days when their clients were more likely to be seen and helped them confirm whether the client was treated or not.

Additionally, relations with providers at the referral sites were improved by inviting them to data review meetings, sharing relevant information with them on a regular basis, making them part of outreach activities, offering training opportunities and visiting them in-person to compare referrals made and referrals received, among others.

**3. Testing other mechanisms for follow-up:** Family Health Options - Kenya provided transport incentives to women who had difficulties to attend referrals for treatment and follow-up appointments due to inability to pay for transport. With the help of community health volunteers, Family Health Options - Kenya identified and called women that were eligible for cryotherapy but had not received treatment and paid for their transport to ensure attendance. While transport incentives have contributed to an increased follow-up rate, it is important to highlight that other factors in Kenya continue contributing to loss to follow-up, such as fear, use of traditional medicine, and spousal consent, among others.

*“Strong collaboration with the doctor from the Uganda Cancer Institute improved referral linkages with Mulago National Referral Hospital for clients who needed high-level treatment. She was a call away! She advised us on the most appropriate days for clients to visit the Institute for care and she linked our clients to her colleagues for timely management. This collaboration reduced client waiting time. This allowed our service providers to make telephone calls to the obstetrician to define when the client was more likely to be treated without having to wait too long”.*

**Representative from Reproductive Health Uganda, IPPF Member Association in Uganda**



## The way forward – ongoing challenges

The CCS&PT Programme provided IPPF Member Associations with multiple opportunities to experiment with different partnership and capacity building models to strengthen referrals and follow-up procedures. Although methods such as the single visit approach contributed significantly to reducing referral processes, there is still a need to create and maintain strong partnerships and constant communication with other facilities and referral sites. Additionally, social support is necessary to encourage clients to complete

the referral. Research carried out in South Africa showed that loss to follow-up was reduced by enabling community health workers to visit women who had not attended their regularly scheduled appointments (Goldhaber-Fiebert, et al., 2005). There are still many other challenges that need to be overcome. High-level treatment in public hospitals continues to be a challenge, tertiary-level facilities are not always functional, and the cost of treatment is not affordable. This is in addition to the socio-economic, cultural and even religious aspects that may restrain women from continuing with follow-up treatment and that service providers should be aware of in order to provide support, including counselling and involvement of the client's family.

### Remember...

Robust referral systems play an important role in cervical cancer screening programmes. They may not always be in place at the start of the project, but this can be improved by establishing strict protocols, producing site directories and, in some cases, offer incentives such as discount vouchers or transportation to the referral facility. It is also important to create and maintain strong alliances and continuous communication with other facilities and referral sites.

*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.*





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