Report

Cervical and Breast Cancer Screening

Banda Health Center III

Namayingo District, Busoga Region

2-4 May, 2019

BACKGROUND

In the developed world, cervical cancer is a diminishing disease. With widespread PAP smear testing, precancerous lesions are diagnosed and treated early, and the HPV vaccine has the potential to eradicate the virus from future generations. Last year, the Director-General of the WHO called for elimination of cervical cancer, and the World Health Assembly in 2020 plans to draft a strategy to do so. A recent Lancet article describes a predictive model in which this is only achievable with immediate intensive screening and HPV vaccination.

In Uganda, cervical cancer accounts for 20% of all new cancers and 35% of all female cancers – eighty percent of these women present with advanced disease – and those are the women Rays of Hope Hospice Jinja (RHHJ) meet and work with every day. In February 2019 RHHJ had 95 women enrolled with cervical cancer, 49% of all the female cancers enrolled on programme.

These women have all the difficult and degrading symptoms of cervical cancer – not only pain, but also fistulas, incontinence, heavy bleeding and offensive-smelling discharge. Too poor to afford treatment and diapers, these women get isolated in dark rooms, ashamed and afraid of the foul discharge and stains on their skirts, dresses and beddings. RHHJ helps those women we have contact with – but there are many more out there, and many more will be doomed to the same fate, unless they are diagnosed and treated early for the cervical cancer.

Knowing the extent of the problem and the almost non-existent access to screening and early treatment for cervical cancer in Busoga Region, RHHJ started in 2018 a cervical cancer screening programme targeting the rural population and using the WHO recommended VIA test (Visual Inspection with Acetic Acid). Screenings were done at 14 different health centers. Two hundred and sixty-nine women were screened - 9.6% were VIA positive and 3% had other gynecological problems in need of treatment. Treatment support was given to those who tested positive at the screening.

The high interest and the results of the screenings done in 2018 called for expansion of the RHHJ screening programme in 2019. Also, information on the prevalence and extent of the cervical cancer among rural women in Uganda is much needed to support further advocacy for comprehensive cervical cancer prevention, early detection and treatment programmes on the regional and national level.

PLANNING AND PREPARATION

Choosing the site

Since July 2017 RHHJ has been working in Namayingo district. A team of clinicians visits the district every two weeks, and we work with government health staff and RHHJ-trained community volunteers.

Screening Camp for Cervical and Breast Cancer, Banda HC III, Namayingo 2-4 May, 2019

Over the months, RHHJ has developed a very productive and close relationship to staff and community volunteers at Banda Health Center (H/C) III in Namayingo.

Banda H/C III serves a very poor population in a geographically isolated location. Both health center staff and volunteers expressed a very high interest in hosting a screening camp for cervical and breast cancer. The community volunteers were very committed to do a sensitization and the health center ensured us that we could use their premises for the camp.

Sensitization

The sensitization started four weeks before the camp. Six mobilization strategies were used:

- The central community volunteer recruited a team of five **volunteers**. Over one month they went to churches and mosques worked with local government officials, went door-to door, spoke at funerals, markets – any place where people gather.
- **Radio**: In Lusoga and Samia (adverts 3x per day) on NBS and Jogo FM on the days leading up to the camp.
- **Banners**: Two hung at Banda trading center and at the H/C
- **Mobilization** by RHHJ staff during home visits – talking with families of patients on our route in the area.
- **Health center staff** informed patients during their out-patient visits.
- **Public address system** that went the day before the screening and during the days of the screening

Identifying partners

RHHJ has during all our screenings in 2018 worked with **NAWEC** (Nama Wellness Community Center) in Mukono, who has a clinic and facilities for cervical cancer screening and early treatment. NAWEC would provide four nurses/midwives experienced in VIA testing and cryo- and thermal treatment.

MOH Namyingo provided their cancer focal person, a nurse also trained in VIA testing and cryo- and thermal treatment.

Facilities were provided by **Banda Health Center III**

Composition of the team

A team of 20 people made sure that the screening was done smoothly and efficiently:

- Organizing number system and ensuring smooth and fair waiting line: 6 RHHJ community volunteers
- Pre-screening education and filling questionnaires: 2 RHHJ clinicians and 1 RHHJ social worker
- Cervical cancer screening and early treatment: 4 NAWEC nurse/midwives, 1 MOH nurse, 1 RHHJ nurse
- Support to screeners and continuing cleaning of screening space and utensils: 1 RHHJ assistant
- Breast cancer screening: 1 RHHJ clinician
- Organizing waiting area at screening and translation: 1 RHHJ community volunteer
- Moving with public address system and general support : 2 RHHJ drivers

In addition, the Banda H/C III staff was extremely supportive throughout the camp in all possible ways from cleaning to actually participating in the screenings.

On-site preparation for the camp

On May 1, 2019 the day before the camp, all staff participating in the camp travelled to Banda carrying all supplies and equipment including the cryotherapy and thermal treatment equipment.

The rooms for the screening, the waiting and education area and an extra tent were set up ready for an early morning start.

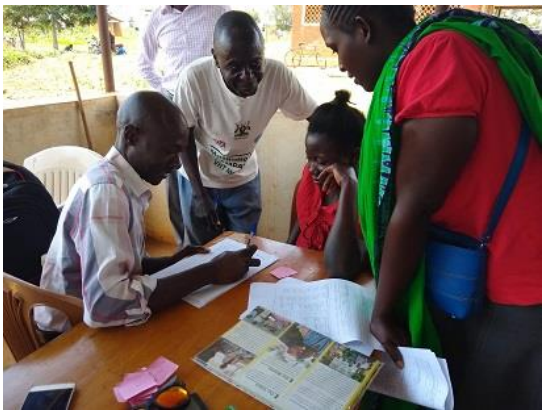
Flow of activities at screening site

Upon arrival, each woman was given a number, which indicated her place in the line for service.

When we arrived in the early morning the waiting room looked like this each of the three mornings.

A health education talk was given on cervical and breast cancer. The importance of testing and what to expect during the screening.

Thereafter each woman was registered, and a questionnaire was filled (see annex). The questionnaire follows the one developed, recommended and used by the MOH.



After registration screening for cervical cancer was done. If the woman tested VIA-positive, she was offered and given either cryo- or thermal treatment on site.

Screening Camp for Cervical and Breast Cancer, Banda HC III, Namayingo 2-4 May, 2019

Breast cancer screening was done using manual palpation. Each woman was at the same time shown how to self-examine and encouraged to do so monthly after each period has ended.

All 57 women testing VIA positive were treated on site with either cryo – or thermal therapy.

All HIV+ women and women who were VIA-positive and treated were advised to repeat screening in one year. Other women should come back in three years.

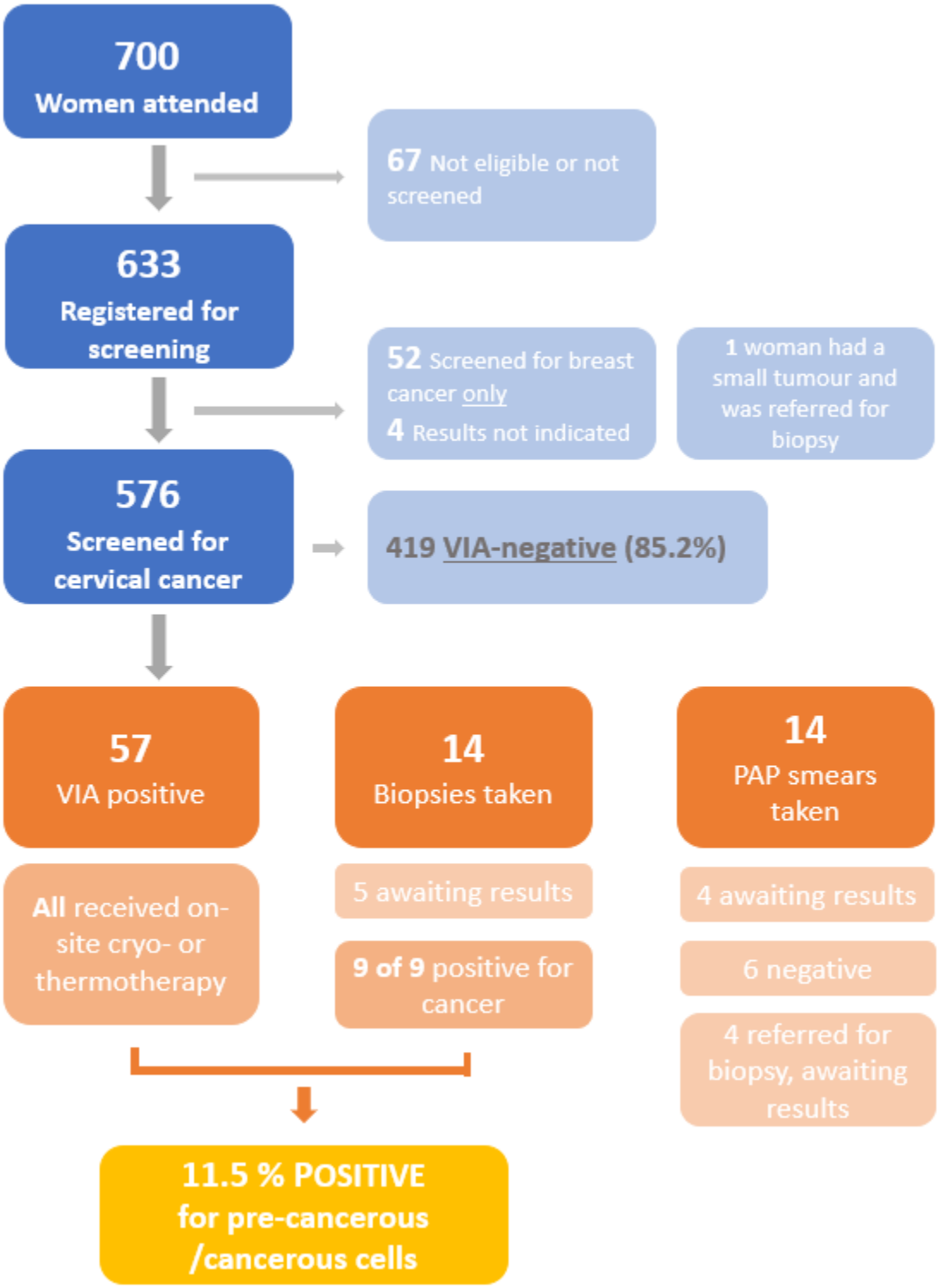
Women who needed biopsy or PAP smear were referred to gynecologist in Namayingo and RHHJ paid for the tests. The women were all given a paper with results of the screening and follow-up dates.

….and at the end of the day, it was time to put our feet up!

PROFILE OF SCREENING PARTICIPANTS

Characteristic	Data	Characteristic	Data
Age (median)	34	**Age at Sexual Debut, n (%)**	
Education, n (%)		< 14	12.1%
None	18.3%	15-17	49.0%
Primary	57.4%	> 18	36.3%
Secondary	17.9%	**Age at First Delivery, n (%)**	
Tertiary	1.6%	< 14	3.3%
Marital status, n (%)		15-17	31.4%%
Married	87.9%	> 18	60.6%
Single	3.8%	**Gravidity, n (%)**	
Widowed/divorced	8.2%	0	0.8 %
Marriage situation, n (%)		1-4	40.0%
Monogamous	51.2%	5-8	40.3%
Polygamous	48.8%	9-12	14.3
Self-reported HIV status, n (%)		13-20	2.7%
HIV-negative	87.9%	**Live births, n (%)**	
HIV-positive	5.5%	0	1.6%
HIV-unknown	6.6%	1-4	42.7%
Age at first menstruation, n (%)		5-8	39.4%
< 14	45.4%	9-12	12.7%
15-17	46.4%	13-15	1.4%
> 18	5.8%		

RESULTS


700
Women attended
67 Not eligible or not screened
633
Registered for screening
52 Screened for breast cancer only
4 Results not indicated
1 woman had a small tumour and was referred for biopsy
576
Screened for cervical cancer
419 VIA-negative (85.2%)
57
VIA positive
14
Biopsies taken
14
PAP smears taken
All received on-site cryo- or thermotherapy
5 awaiting results
9 of 9 positive for cancer
4 awaiting results
6 negative
4 referred for biopsy, awaiting results
11.5 % POSITIVE for pre-cancerous /cancerous cells

HIV status	Positive (VIA positive, confirmed biopsy or PAP smear)	Negative (VIA negative, confirmed biopsy or PAP smear)
HIV negative	12.1%	87.9%
HIV positive	12.1%	87.9%
HIV unknown	6.1%	93.9%

Observations on results

- Women were enthusiastic about attending the screening camp.
- The prevalence of 11.5% pre-cancerous and cancerous cell found among 576 women examined is very high and demands urgent action.
- There was no difference between HIV status and screening result, however it is important to note that most women reported an HIV status that was measured more than 6 months prior to screening.

Observations on practical arrangements

- The excellent and thorough sensitization ensured that 633 women were screened, the maximum number we could manage.
- The sensitization done in the community was done by six men, which proved that messages given by men on women's issues was not a problem.
- The interest of the women was almost overwhelming, and their gratitude inspiring.
- The support of the Banda H/C III staff was essential and wonderful
- The client flow from arrival to final screening was well set up and in spite of big numbers, all went smoothly.
- The team worked tirelessly from 7.30am - 7.30pm every day without break – it seems inspired by the gratitude of the women attending. However, breaks need to be catered for at future camps.
- It was excellent that all the women who tested VIA-positive could be treated on site with no delay.
- Of the women screened, 40% did not have a phone contact, making follow-up for challenging. While the village where they lived was recorded, this was not enough information to locate the women. Other contact possibilities like LC1 contact needs to be explored for future camps.

Conclusion

Women in Namayingo were enthusiastically attending the screening camp for cervical and breast cancer. There was no reluctance expressed to have pelvic exam. The screen-and-treat model is crucial, particularly in the rural setting where around 40% did not have phone contact.

The government health center staff was participating very actively and expressed strong interest in learning how to do the VIA testing and conducting screening and tests at the health center.

The high prevalence of VIA-positive calls for urgent action to provide free screening and testing for cervical cancer to the women in the rural areas. It also stresses the need for ensuring vaccination against HPV.

Let us work hard together to make cervical cancer a disease of the past – and not what it is now, a disease of the poor.