Author’s response to reviews

Title: Barriers and facilitators to uptake of cervical cancer screening among women in Uganda: a systematic review

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Reviewer reports:

Maggie McConnell (Reviewer 1): This paper offers a well-written systematic review on the literature surrounding barriers and facilitators of cervical cancer screening. I have some specific suggestions for improvements and clarifications to the manuscript:

1) It would be valuable to update the systematic review as the last search was done in 2017 and this is an active area of research.

We have rerun our searches as described in the Methods section of the paper and found no new publications meeting our search criteria. We have updated the date at line 126.

2) On page 7 the manuscript reports that "Only studies of reported barriers and facilitators were chosen; studies that inferred correlations based on statistical associations with demographic features were excluded.” However, in the results section the manuscript reports findings related to socio-economic and demographic conditions. It would be helpful to clarify the scope of the review and whether the intention is to discuss findings which may shed light on barriers and facilitators that are related to differences in take-up across socioeconomic and demographic characteristics.

We have removed this sentence as we can see it is confusing. In response to the reviewer’s comment: yes we did want to evaluate socioeconomic/demographic variables that might facilitate or act as barriers to screening, but we were careful to only include studies where this was one of the outcomes, and not just inferred. We did not include studies that weren’t
specifically evaluating barriers or facilitators in a structured survey or interview. However, we believe we have already adequately described this and have removed the confusing sentence at line 189-191.

3) I would in general be somewhat cautious about stating that anything can be concluded about the "most commonly reported barrier" -- does this mean reported by the greatest number of study participants? Reported in the greatest number of studies? Given the extraordinary range in methodologies, sample sizes and study scope it is bit difficult to support this kind of conclusion from the literature review at this point.

We have clarified that the most commonly reported barrier was by number of studies at line 259 and added further information at lines 266-270.

4) The manuscript overall focuses on barriers and facilitators from the point of view of interventions that could influence patients' behaviors, though some of the barriers at the health worker and facility level may be of more primary concern. For example, improving knowledge of screening will not improve screening rates if there are not trained health workers with adequate knowledge, materials and supplies to perform training.

We thank the reviewer for her comment which mirrors the comment made by reviewer 2(7) and we have altered our text to clarify this point. We agree that there is a need for more services and trained Health Care workers, but this is beyond this scope of this review. Our paper seeks to address issues that need to be taken into consideration in the provision of existing and future services to improve the likelihood of women utilizing these. We have revised our text at lines 35-37, 109-111 and 435-440 to clarify this and have altered the title of our paper to more accurately describe the aim of our review. We also draw the reviewer’s attention to our sentence at lines 182-183 where we describe why we have included studies that described the views of HCWs.

5) It is difficult to interpret the proportions of women screened in table 1 without also including the nature of stay recruitment (i.e. whether the sample is designed to be population representative). This should be added.

We thank the reviewer for raising this important point, and have to clarified the nature of stay recruitment at lines 213-219.

Eva Kantelhardt (Reviewer 2): Black and colleagues present a well written systematic review on barriers and facilitators to cervical cancer screening among women in Uganda. The topic is of
high relevance considering global efforts towards elimination of cervical cancer. Screening is a crucial element and access to screening essential. The authors found a considerable number of papers which focus on the topic. They have nicely extracted the important factors associated with uptake or non-uptake of screening service. I congratulate the authors to the thorough work.

I may suggest some ideas:

Background

1 The reader may not be familiar with the situation of health service and cancer service in Uganda. It would be helpful to minimally describe or outline the health system and National Cancer Control Plan and where screening is planned to be done in Uganda (which health service level?)

We believe we have described the health system and screening guidelines in Uganda at lines 70-85 and have added further details in lines 80-85.

2 Accessibility is crucial for any uptake of health service. Is there data on how many screening Units are active in Uganda? Who offers screening in public and private? Who is trained? What is the National screening strategy?

We thank the reviewer for her comment and agree that accessibility is crucial. However, an assessment of active screening units, training of HCWs and description of the screening strategy (beyond our description in lines 70-85) is beyond the scope and word limit of the paper. We have included the point that lifetime screening rates in Uganda are between 4.8-30% at line 89.

3 The authors repeatedly talk about HPV. Please clarify - are you referring to high risk types?

We have clarified this at lines 66-67.

4 Line 68-70; It is not clear why the poor follow-up and limited recall system is related to low sensitivity of cytology. To me I suppose that cytology screening is impossible due to lack of pathologists (since despite low sensitivity it has been successful in high resource countries). Of course additionally screening every 2-3 years is difficult - but this is true for all screening methods therefore a once or twice I a lifetime approach needs to be chosen.
We agree with the reviewer that lack of pathologists is an issue. However, even with sufficient pathologists, due to the low sensitivity of cytology, women need frequent screening. This is an unrealistic goal in the Ugandan context due to follow up/recall issues.

5 Line 78 Is there any HPV testing available in Uganda?

We are unaware of any HPV testing available in Uganda, outside of research projects, and we have mentioned the lack of availability in line 83-85. As of 2016, HPV testing in Uganda was “undergoing demonstration projects” https://hpvcentre.net/statistics/reports/UGA.pdf

Methods

6 Line 163 Why were reasons for non-attendance of HIV pts. excluded?

This is explained at lines 187-189

Of those women described as normal population, also a reasonable proportion will be positive and thus this group is among the population studied.

We agree with the reviewer’s comment that a reasonable population of the ‘normal’ population would have been HIV positive and that this group would have been among the population studied. We excluded studies that focused on women with HIV as many barriers faced by these women are related to the fact that they have a known HIV diagnosis. These barriers would not apply to those HIV positive women who are unaware of their HIV status. Had we included studies with HIV positive women, it would not have been possible to assume that the barriers they face apply to women without a known diagnosis of HIV. We would have needed to present the findings separately, which was outside the scope and word count of this review.

Results and discussion

7 The proportion of women screened seems very low. Was there any information weather at all the women had a chance to be screened? The authors focus on barriers and facilitators to screening much on the side of the women. But this closely links with the problem of service availability and efforts needed to use the service. This should be mentioned in limitations.

We thank the reviewer for her comment which mirrors the comment made by reviewer 1(4) and we have altered our text to clarify this point. We agree that there is a need for more services and trained Health Care workers, but this is beyond this scope of this review. Our paper seeks to address issues that need to be taken into consideration in the provision of existing and future
services to improve the likelihood of women utilizing these We have revised our text at lines 35-37, 109-111 and 435-440 to clarify this.

We have altered the title of our paper to more accurately describe the aim of our review.

8 table 3 "CCS not considered important" and discussion line 428 - the authors should critically discuss that indeed there could be more important issues which women need to consider even if they correctly received and understood health promotion messages on CCS.

We are limited by word count restrictions and cannot explore this more deeply, but have addressed this at line 468-469 and have acknowledged that perceived unimportance may be relative.

9 If possible, the authors could indicate weather the studies discussed actually measured reasons for a) attending/not attending screening or if they asked b) about perceived facilitators and barriers without assessing the actual behavior? In the case of a) it should be critically noted that possibly women are knowledgeable BECAUSE they went for screening and that it was not the reason for screening.

We thank the reviewer for this important point, and have included this at lines 286-288.