Improving The Quality of Reproductive Health Service Provision in Line with Emerging Hormonal Contraception and HIV/AIDS Related Cervical Neoplasms: Challenges for Zimbabwe's Reproductive Health Service Providers.

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SUMMARY

AIDS associated cancers are an emerging challenge in cancer epidemiology. Immune compromised people with AIDS have higher risks of developing cancer. Studies in Africa have demonstrated that following HIV+ diagnosis, the majority of hormonal contraceptive (HC) users continued on them while a quarter of non-users began using HCs. There are contradicting findings on the role of HCs on cervical intraepithelial neoplasia (CIN) development. A number of studies have however positively correlated HC use to CIN development. This paper seeks to discuss the need for an integrative approach in reproductive health delivery system in line with HC provision concurrently with HIV/AIDS screening. We envisage a plausible approach that would support clients to make informed decisions on contraceptive use against the risks of HIV infection and development of CIN. This paper will critically appraise reproductive health provision in Zimbabwe in line with current global trends on HIV and oral contraceptive related neoplasm. The implications of the observed trends will be discussed in line with professionalisation of service delivery for the Zimbabwe National Family Planning Council (ZNFPC) and partner organisations.

Key words: integrated, reproductive, HIV/AIDS, neoplasia, Zimbabwe

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Introduction

Cervical cancer screening is an issue of concern for the Zimbabwean government's thrust to improve women's reproductive health. At present only about 7.2 percent of Zimbabwean women at risk have access to appropriate cervical cancer screening programmes. Of about 1855 women who are diagnosed with cervical cancer in Zimbabwe each year, 1286 die from the disease [1]. The aim of cytology screening programmes in developing countries is to detect precancerous lesions hence resulting in a large decline in cervical cancer incidence and mortality [2]. Nanda et al[3] demonstrated that following HIV+ diagnosis, 98.5% of HC users in Sub-Saharan Africa continued on them while 25% of non-users began using HCs yet the correlation between long-term oral contraception and cervical neoplasia is well established[4]. In February

2012, the World Health Organisation (WHO) clarified the guidelines on HC use and HIV infection in Africa. Although the WHO reaffirmed the efficiency of hormonal contraception in preventing pregnancy, it stressed the importance of condom use to prevent HIV infection [5]. Such compounding factors necessitate the need to infer into whether it is necessary for the Zimbabwe National Family Planning Council (ZNFPC) to work in conjunction with voluntary HIV screening organizations in order to encourage HIV positive clients to use alternative forms of contraception such as barrier methods. Harris et al[6] substantiate this as they point out the need to empower women so that they make informed choices relating to their reproductive health choices.

Association of cervical intraepithelial neoplasia to HIV/AIDS and hormonal contraceptives

Aids associated cancers are an emerging challenge in cancer epidemiology. Immune compromised people who are HPV+ and HIV+ have higher risks of developing cancer [7, 8]. Some epidemiological studies have suggested a positive correlation between initiation of highly active antiretroviral therapy (HAART) and cervical intraepithelial neoplasia [9, 10]. Although no large-scale studies have been carried out in Zimbabwe, Moodley et al [11], have demonstrated a positive correlation between HAART use and abnormal pap smears among South Africans. Sirera et al [12] and Shrestha [13] suggest the need to carry out large-scale studies to evaluate HAART's effect over a long time. It has since been established that CIN is etiologically associated with human papillomavirus [14]. In this regard HIV infection and HAART drugs could therefore be acting as predisposing factors for CIN development. There is therefore need to advocate for a cervical screening program that safeguards women at risk of CIN.

There is contradicting literature on the role played by hormonal contraceptives on CIN initiation. Louv et al[15] are quick to point out that some combined oral contraceptives contain estrogen and progestin both of which potentially cause cervical ectopy (a condition in which cells that line the inside of the cervical canal extend outwards). This is suggested to be one way through which unfavourable transformations occur among HC users. Messiou et al [16] have suggested through observations that HC use promotes CIN. Such observations necessitate the need for an integrated cervical screening policy that incorporates reference to one's history of HC use and HIV status.

HIV screening in Zimbabwe

The Zimbabwe National Guidelines on HIV and Counseling highlight that the country is among the highly infected nations in Sub-Saharan Africa [17]. Voluntary counseling and testing (VCT) is the dominant mode through which most Zimbabweans access knowledge to their HIV status. This is however confounded by high levels of stigma and discrimination against HIV positive people. The voluntary testing centres known as New Start Centres are the predominant providers of free HIV testing and counseling services. These are widespread throughout the country and people approach them on a need to know basis. According to Murombedzi cited in allafrica.com, most Zimbabweans living with HIV are unaware of their status [18].

It is common practice that Zimbabwean hospitals have HIV testing facilities for patients presenting with symptoms suspicious of HIV/AIDS infection. In such cases the patient will be tested according to medical

guidelines. Whereas it is unethical to coherse people into submission for HIV testing, there is need to implement an approach which in addition educates the clients on the pros and cons of using different types of contraception. Inclusion of such testing and counseling services in ZNFPC reproductive health clinics seems a feasible approach. Most clients visiting ZNFPC clinics are concerned with reproductive health issues hence they are more likely to accept offers of voluntary testing and counseling services.

Cervical cancer screening in Zimbabwe

Zimbabwe has been using a selective opportunistic screening programme which could be either voluntary on the part of the patient/client or could be need based as patients are assessed by health practitioners on presentation with gynecological complications [19]. If CIN is detected at an early stage, then this can be treated hence preventing proliferation into cancerous cells [15]. In Zimbabwe, like other low resource countries, CIN screening programmes are small scale due to lack of technical skills [20]. This is compounded by lack of financial resources because the health delivery system has been predominantly donor dependent. Such challenges result in reduced opportunities to detect precancerous lesions. Most patients consequently present with high-grade metastatic disease. In the 1990s an attempt was made to implement visual inspection with acetic acid (VIA), which is relatively cheaper. This programme did not yield any positive effect as it was abandoned due to lack of funding. Two major cancer-screening facilities are in Harare and Bulawayo (the largest and second largest cities respectively). Although smears can be brought from all districts, most women in rural areas do not have access to screening facilities [19, 21]. Complementary screening services are provided by Mission Hospitals such as the Reformed Church in Zimbabwe, Salvation Army and Roman Catholic owned hospitals. In their research in rural Mashonaland province, Thistle and Chirenje [19] demonstrated that cervical cancer predominantly affects older women. This is thus suggestive of a screening policy whose emphasis targets vulnerable age groups in response to resource shortages.

On the contrary most developed countries have well defined cervical cancer screening programmes. For example in the United Kingdom, the National Health Service (NHS) screening programme specifies eligibility according to age. The first invitation for screening is done at the age of 25 years. This is because physiological and anatomical changes in the young cervix are normal. Unnecessary treatment could have consequences for child bearing. For the 25-49 years age group, screening is done 3 yearly. From 50 to 64 years, it is done 5 yearly. Women above 65 years are only screened if they were not screened at the age of 50. Such planned programmes ensure effective screening of women at risk.

Professionalisation of health services in low resource settings

With the support of international bodies such as the United Nations and WHO, evidence based practice is being implemented in most African countries, Zimbabwe included [22]. Such an approach may improve the professionalisation of poorly performing health systems in this region. Sekwat [23] has identified budgetary resources, upsurge in demand for conventional medicine and rising care costs as major challenges affecting the quality of service provision in low resource countries. This paper will also discuss

how the socio-political and economic dynamics have negatively influenced the professionalisation of reproductive health service provision by ZNFPC. It is also of paramount importance to discuss plausible change strategies that are necessary to improve the quality of cervical and HIV/AIDS screening in Zimbabwe. An inference will thus be made on the advantages of an integrated HIV/AIDS and CIN screening programme.

Professionalism and reproductive health service provision in Zimbabwe

According to the Department of Health (UK) [24], a professional is an individual who takes responsibility for his/her own action, meets competence standards and abides by ethical and moral principles. Reproductive nurses who work for the ZNFPC are required to be trained and registered by the Health Professions Authority of Zimbabwe. The Nursing Council regulates the registration and monitors the code of conduct of all nurses. ZNFPC clients are thus treated with dignity and client information is treated with strict confidentiality. Where necessary, the information can only be disseminated on a need to know basis. According to Carney [25], poor practice presents a risk to the public. Where there is poor practice, there is need for corrective action to be implemented by either the employers or regulating bodies. This explains why Mafuva et al [21] presented their results with recommendations suggesting the need to intensify cervical cancer screening in both urban and rural area.

Most other Mission hospitals' departments are facing closure due to brain drain and practitioners are increasingly frustrated with lack of resources. The government has also slashed the budgetary allocation for the Ministry of Health in response to the unfavourable socio-economic climate. This lack of financial resources for public health institutions affects the quality and efficiency of service delivery. It also de-motivates public health professionals hence impacting negatively on service delivery. There is thus need to advocate for all stake holder workshops elaborating on the need for interdependence of governmental institutions, non-governmental organisations (NGOs) and the private sector in a quest for an effective HIV/AIDS and CIN screening transition. Worldwide, not-for-profit organizations are vital drivers for efficient health services.

According to the NIHR Health Services and Delivery Research Programme [26], evidence based research is an important facet of professional practice. There is need to produce relevant evidence based research on the quality, access and organisation of health services. This helps to direct knowledge mobilisation. The Zimbabwe National Guidelines on HIV Testing and counseling seem to be dependent on evidence suggesting that most HIV positive Zimbabweans are unaware of their status. This necessitates the need to educate communities about the advantages of being aware of one's HIV status. Such an approach helps people to make informed choices on their lifestyle including choices on contraception. The public education initiative may reduce the spread of HIV among Zimbabweans. Introducing intensive HIV/AIDS counseling programmes at ZNFPC clinics parallel to the contraceptive distribution programmes will help to avert AIDS associated neoplasia as suggested by Moodley et al [11]. Not withstanding the current findings, there is need to incorporate rural area populations in CIN prevalence studies. This is

important if resources are to be allocated equitably in accordance to the needs for each province and district. Good practice also entails maintaining trust and minimising conflict among health providers. In the present scenario, there could be need to advocate for New Start Centres to work in collaboration with ZNFPC clinics. Since New Start Centres provide services free of charge (donor dependent). Another alternative would be for these centres to advise HIV positive women to routinely go for cervical smears so as to nip cervical neoplasia at its incipience. Similarly ZNFPCs could refer people with high-grade dysplasia for voluntary counseling at the New Start Centres. Such an approach will be cost effective while at the same time minimising conflicts of interest. It also endeavors to minimise risks of both CIN development and spread of HIV that has been suggested as a risk factor for cervical cancer development.

Organisational and quality issues in reproductive health

According to the Open University, three fundamental factors namely people, objectives and structure are common constituents for organizations. The interaction of people to achieve objectives forms the basis of an organization. A structured approach is needed for people's interactions to be focused. The ZNFPC is a not-for-profit organization at whose helm are the director, deputy director and the Chief Executive Officer who are all based at the head office in Harare. The provincial manager oversees the community based distribution (CBD) programme in each province. The service delivery coordinator (SDC) is a nurse midwife who in turn supervises the Sister-In-Charge Community (SICC). The SICC must hold postgraduate qualifications in community nursing and she supervises Group Leaders (GLs). GLs in turn supervise about ten community based distribution agents in each district [27]. If managed efficiently, such a hierarchical structure with highly qualified personnel is poised for efficient bottom to top as well as top to bottom trickle effect.

Westrum [28] maintains that organizational culture shapes performance as well as the strategy. Westrum [28] further defines a culture as a way in which an organization responds to problems and opportunities it comes across. In our scenario under discussion, the major problems of concern are HIV acquisition and increased incidences of CIN among Zimbabwean women. The ZNFPC's community distribution programme (CBD) is the major caterer for family planning services in Zimbabwe. Research findings have however indicated a steady decline in this contribution as CBD agents spend more time resupplying existing clients rather than recruiting more clients. The CBD programme also needs to address the AIDS pandemic in Zimbabwe. It has since been recommended that the ZNFPC reviews its recruitment process so as to incorporate professional counselors in their teams. Alternatively there could be need to design in-house courses in order to empower the current team with additional skills needed for HIV testing and counseling. With the current economic challenges, such an approach could be pragmatic as it does not demand a higher input of financial resources if compared to hiring new personnel with other desired skills. Whether this compromises the quality of service can be formatively evaluated as the services are disseminated to the community.

Before Independence, some African politicians perceived family planning as a tool used by

Europeans to reduce the African population while their own was increasing [19]. As the education system became liberalised through egalitarian policies, most African policy makers began to appreciate the need for birth control. The same applies to conspiracy theories that were coined to the origins of HIV. However the current global focus is on how to control the spread of HIV rather than on its origins. The Zimbabwe National Guidelines on HIV testing are a testimony of the government's commitment on paper. Experience has however shown that many excellent policy documents end up gathering dust in most developing countries. It is therefore important for non-governmental stake holders to organise consultative workshops on the way forward in pragmatically coming up with screening programmes that take into cognisance both CIN and HIV risks. According to Maggwa et al [26], the relationships between ZNFPC and the Ministry of Health and Child Welfare have been viewed as ad hoc. Where working relationships exist, these appear to be dependent on individual ZNFPC's managers, GLs and CBDs' individual commitments. Formalising these relations may empower the ZNFPC in a bid to avert a lot of bureaucratic tendencies typical of state controlled institutions.

Change strategies for reproductive health service provision in Zimbabwe

Carney [24] postulates that senior managers are more concerned with strategy development whereas middle managers are concerned with implementing such decisions. With reference to ZNFPC, senior management comprises of the provincial managers, chief executive officer, deputy director and the director. The service delivery coordinators and Sisters-In-Charge Community constitute the middle management. For middle management to understand the rationale behind the strategic plan, they must participate in the strategic process [28]. Thus there is need for resource mobilisation and organising national consultative workshops involving the Ministry of Health and Child Welfare, private sector and non-governmental organisations. Senior and middle management from stakeholders must be invited. As Drury [29] puts it, the training package should take into account the agenda for change. In the present case the theme of the workshops and training will be geared: "Towards the implementation of a CIN screening programme that incorporates HIV/AIDS screening in order to reduce AIDS associated CIN." Participants will be invited to deliberate on different change strategies before consultants come out with a draft-working document for consideration. Once adopted by the policy makers and regulators then the ZNFPC will initiate pilot implementation programmes.

For change to be achieved there is need to empower the rest of the personnel through training [29]. Middle managers will assume this role as it helps in creating a shared vision. This approach thus conforms to the three basic stages of change that consists of the present state, the transition state and the desired state. Zimbabwe being a low resource country might be faced with challenges to mobilize resources for this drive. There is need to work in cohort with international bodies that deal with global HIV and reproductive health issues. Examples are United Nations, Global AIDS Fund and World Health Organization just to mention but a few. Involvement of government departments may lead to government's intervention by channeling some of the resources for

this reproductive health initiative. This is in light of the fact that the recently established diamond mines are contributing a significant amount of revenue to the treasury. Once the programme is implemented there is need for community based health education so as to promote awareness and accessibility of screening facilities among Zimbabwean women.

Conclusion

The upsurge of HIV/AIDS related cervical intraepithelial neoplasia is of concern in Sub-Saharan Africa. With fewer women currently able to access national cervical screening centres in Zimbabwe, there is need to promote awareness for such. Programmes also need to be adopted that incorporate joint HIV testing/counseling and CIN screening. With increased support from the World Health Organisation the government of Zimbabwe now appreciates the need for concerted efforts in addressing the needs for HIV status awareness among Zimbabwean communities. There is thus need for collaborative efforts between the Ministry of Health and Child Welfare and the Zimbabwe National Family Planning Council in addressing these challenges. This entails running consultative forums leading to implementation of an integrated CIN and HIV/AIDS screening programme.

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