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Identifying barriers that prevent women with positive CIN2/3 LEEP margins from returning for a repeat LEEP and identifying strategies to address this low adherence to treatments

Zambia has the second highest incidence of cervical cancer (CC) in the world with an incidence rate 66.4 per 100,000 and third highest mortality at a rate of 44.5 per 100,000. In terms of prevalence, cervical cancer is also the most prevalent cancer among women in Zambia, accounting for almost 41.4% of all cancers in females, and 24.8% of all cancers in adults. A high prevalence rate of HIV in females has also contributed to an excessive cancer burden as women living with HIV (WLHIV) have a higher incidence of HPV infection and a faster progression to pre-cancerous lesions and invasive CC. The cervical cancer screening program in Zambia is one of the most successful screening programs in Africa having screened over 800,000 women since its implementation of the see and treat approach in 2006. Since then, Zambia has scaled up its program to all ten provinces across the country in 162 government clinics so far with nurses as the primary screening providers. The University of North Carolina Global Projects Zambia (UNC GPZ) conducts research in CC in partnership with the Ministry of Health. Among the 8 screening clinics located in Lusaka, 7 are nested within existing screening services at government first level hospitals. All women accessing the clinic are provided with free VIA screening services and free treatment services for pre-cancerous lesions using Loop electrosurgical excision procedure (LEEP), thermal ablation or cryotherapy.

In January 2021 as part of the UNC GPZ commitment to provide support to women accessing CC screening services in our research clinics, a Patient Navigation Unit was initiated to actively follow-up women seen and/or treated at our clinics who need treatments and referrals. One of the core responsibilities of this unit was to set-up a system following-up women with positive CIN2/3 LEEP margins and schedule appointments with them to have a repeat LEEP. The data generated so far shows that less than 50% of women have returned to our clinics for a repeat LEEP despite our follow-up efforts. In of women have returned to our clinics for a repeat LEEP despite our follow-up efforts. In addition, the majority of these women are living with HIV which increases their risk of cervical cancer especially when they have incompletely excised CIN2/3 pre-cancerous lesions (4,5). Women who have incompletely excised pre-cancerous lesions CIN2/3 on LEEP are considered as undertreated and are at increased risk of developing recurring lesions especially if they are living with HIV.

While LEEP treatment are provided at no cost at government LEEP clinics, less than 50% of women followed up by our patient navigation team have returned to complete treatment when more than 50% of these women are living with HIV putting them at high risk of lesion recurrence. There is a need to identify the barriers these women are experiencing to complete treatment and establish strategies to reduce the number of losses to follow-up.