‘I’m here for my women’s check up’: health promotion in the context of cervical screening

Genevieve Dally
Family Planning and Welfare, NT

Background

Australia celebrates its successful cervical screening program with a significantly low incidence of morbidity and mortality associated with cervical cancer[1]. Health promotion campaigns aligned with this biennial model are heralded globally as measures of effective recruitment and retention into a program with well understood health benefits[2]. In rural and remote Australia cervical screening is colloquially known as a ‘women’s check up ’ and occurs within a context of opportunistic screening, health assessment and education.

The ‘women’s check up’ provides clinical staff with the opportunity to address concerns in an environment where sexual and reproductive health is not often prioritised due to a lack of accessible and appropriate services, shame, embarrassment and cultural taboos. These barriers have significantly contributed to increasing rates of sexually transmissible infections (STIs) and unplanned, unwanted pregnancies. The most recent *Reproductive and Sexual Health in Australia (2013)* report indicates that the Northern Territory has the highest number of chlamydia notifications in Australia (1,142 per 100,000 population) and prevalence is greatest amongst Indigenous women. Opportunistic testing associated with cervical screening and health promotion activities directed at vulnerable populations are believed to be reflected in these rates[1].

It is estimated that in Australia each year, women experience almost 200,000 unplanned pregnancies[3]. While data collection is flawed, in 2004 the number of induced abortions of known pregnancies was 83,000[4]. Similar data collected in previous years indicates that for every four known pregnancies, one will result in an induced abortion in Australia. Unplanned pregnancies and abortions occur within a complex individual, social, cultural and political climate. Reasons why unplanned pregnancies occur include: misinformation, low self-esteem, use of alcohol and drugs, experiences of sexual violence and lack of access to contraception due to insufficient sexual and reproductive health education[3]. The ‘women’s check up’ provides a safe space for health practitioners to support women to avoid unwanted pregnancies and to assist them to make choices which improve their sexual and reproductive wellbeing.

Since the introduction of the National Cervical Screening Program (NCSP) in 1991 incidence and mortality rates of cervical cancer have more than halved[2]. *The circumstance in which cervical screening occurs has changed dramatically in recent years. Practitioners are now armed with new technology and screening tests; a well-established vaccination program and a better understanding of the natural progression of the Human Papilloma Virus (HPV), responsible for the majority of cervical cancers. With this evidence and information the* Medical Services Advisory Committee (MSAC) has recommended to the Australian Government that a new cervical screening test should replace the current Pap smear test[5]. This newer test detects HPV, which is now understood to be the first step in cervical cell changes which go on to progress to cancer. The MSAC also recommends changes to the screening schedule which would see testing occurring every five years in women aged between 25 – 70 years of age. Extensive review of economic and health benefits indicate that the HPV test can save more lives with fewer tests than the current program[5]. It is anticipated that, pending policy decisions, these changes to the NCSP will be implemented by 2017.

The change from a biennial to a quinquennial screening program will have widespread implications for sexual and reproductive health service utilisation. Health education, screening and promotion activities currently linked to the well-known and well accepted program will be diminished. In order to fully understand this reduction in health service utilisation a clinical audit was undertaken to determine the likelihood of additional women’s health issues being addressed as part of a cervical screening consultation. This data was able to be extrapolated to better understand what sexual and reproductive health care might look like after the renewed NCSP has been introduced and may serve as a guide for policy makers who wish to ensure the gap between service delivery and poor health outcomes does not widen in conjunction with the proposed changes.

Method

Data was collected from a Darwin sexual and reproductive health service, in the month of June 2014 and in November 2014. These months were chosen as representative of a 'typical' month for the service. Comparisons were made between June and November because in June 2014 there were a number of training clinics offered and due to the diligence of students; this difference had the potential to distort data. Trainee health practitioners were found to be more likely to offer and discuss additional health services, particularly in relation to 'lifestyle' issues, than clinical staff employed at the service.

Electronic software, "Medical Director" and "DME client" were used to extract the data and verify demographics, consultation details and reasons for attendance. Issues earmarked as being regularly identified included breast health, STI screening, contraception, management of menstrual symptoms, incontinence, fertility, pregnancy options and lifestyle issues.

Clinical audit details

Lists of clients were generated through Medical Director *'Pap test results search'* and caveats included – extrauterine, Low Grade abnormality, High Grade abnormality, inconclusive, Inflammatory, Atypia, CIN1, CIN 2, CIN 3 and Invasive Ca. This report generated the details of 70 eligible clients who attended the clinic during the month of June 2014 and 34 eligible clients who attended the clinic during the month of November 2014. Consultation notes, pathology requests and pathology results were compared to ensure the cervical screening consultation took place in only the allocated months. Occasionally practitioners were found to have entered incorrect information into the 'Pap test' section in the client file (i.e. date pap taken) which meant the client was included in the report but the cervical screening test was not taken during June 2014 or November 2014, or it had been taken at another service. Clients with missing notes (2) were excluded from the audit.

The following rules were followed to ensure consistency of audit and data collection:

- Must have written detailed notes regarding issues (i.e. *contraception discussion* must include additional details other than yes/no, using or type of contraception documented);
- *Lifestyle issues* includes smoking/alcohol/drug assessment;
- *Pregnancy* include pregnancy testing;
- *STI screening* – pathology must have been ordered;
- *Symptom management* must include prescription and/or referral to a specialist.

A total of 104 client files were audited and reviewed. Data was collected regarding the likelihood of the following issues being managed:

- BREAST health
- STI screening
- contraception discussion
- contraception commenced or dispensed
- management of menstrual symptoms
- incontinence and pelvic floor health
- lifestyle issues
- subfertility/fertility
- pregnancy
- pelvic pain/symptom management.

The data collected from the audit was then extrapolated to demonstrate a potential reduction in services accessible to Australian women through the NCSP once the renewed guidelines are introduced. Estimates generated from the MSAC economic and evidence reports and presented by Professor Karen Canfell at the *Australasian Sexual Health Conference* (2014)[6] were used, with permission, for this purpose.

Results

Of the total client visits in June and November 2014 (104), 236 issues were managed, in addition to cervical screening. On only seven occasions in June and two occasions in November was the Pap test the only service provided to the client (Figure 1).

Clients attending the service in June 2014 most commonly had least three other health concerns assessed, in addition to cervical screening

Clients attending the service in November 2014 most commonly had between one and three other health concerns assessed, in addition to cervical screening.

In June 2014 (70) and November 2014 (34) respectively, the most common additional service undertaken by the clients attending primarily for cervical screening was breast health (15.5%, 23.5%), STI screening (57.8%, 47.1%) and contraception discussion (57.8%, 61.8%) (Figure 2).

According to data provided by MSAC, it is estimated that there will be a ~46% decrease in numbers of cervical screening tests undertaken annually once the new guidelines have been introduced. This estimate was used to explore potential decreases in sexual and reproductive health services currently offered in conjunction with cervical screening. Utilising the audit data it was ascertained that there will be a potential reduction of 214,000 annual breast health consultations. There will be 580,000 fewer STI screens undertaken; contraception discussion consultations will be reduced by 660,000 a year and there will be 420,000 fewer opportunities for clinicians to manage lifestyle issues which impact negatively on health and wellbeing (Figure 3).

Figure 1

June 2014

0 Issues discussed	1 Issue discussed	2 Issues discussed	3 Issues discussed	4 Issues discussed	5 Issues discussed	Total visits
7	12	16	23	11	1	70

November 2014

0 Issues discussed	1 Issue discussed	2 Issues discussed	3 Issues discussed	4 Issues discussed	5 Issues discussed	Total visits
2	9	9	9	5	0	34

Figure 2

	Jun-14		Nov-14	
Appointments	70		34	
Breast Health	11	15.7%	8	23.5%
STI screening	40	57.1%	16	47.1%
Contraception Discussed	40	57.1%	21	61.8%
Contraception Commenced/ dispensed	8	11.4%	3	8.8%
Management menstrual symptoms	0	0%	3	8.8%
Incontinence/ pelvic floor health	13	18.6%	5	14.7%
Lifestyle issues	30	42.9%	11	32.4%
Subfertility/fertility advice	4	5.7%	5	14.7%
Pregnancy	5	7.1%	0	0%
Pelvic pain/symptom management	11	15.7%	2	5.9%
Total No. issues	162		74	

Figure 3

Consultations and New data extrapolation	Percentages	Current program annual Pap tests approx.	New program HPV tests approx.	Difference in # of annual consults with new HPV Program	Percentage less Consults
Current annual Pap tests vs new program HPV tests		2,400,000	1,300,000		
FPWNT data June/Nov 2014					
Breast health 19.5%* of consultations	19.50%	468,000	253,500	214,500	46%
STI screening 52.45%* of consultations	52.45%	1,258,800	681,850	576,950	46%
Contraception discussed 59.8%* of consultations	59.80%	1,435,200	777,400	657,800	46%
Lifestyle issues 38.05%*	38.05%	913,200	494,650	418,550	46%

* Average percentage taken June/November

Discussion

Of the seventy consultations which took place in June 2014 and the thirty four consultations which took place in November 2014, the vast majority included discussion, education, advice or referrals pertaining to one or more additional women's health issue. This occurred despite the reason for attendance being given as 'cervical screening' only. The clinical audit clearly demonstrated that women present for a 'check-up' as a result of raised awareness about cervical screening but are also then given the opportunity to manage other issues and conditions which could have significant negative health repercussions if not addressed in a timely and efficient manner.

There is significant demonstrated cost-saving associated with the renewed NCSP guidelines. According to MSAC implementing a quinquennial screening program that utilises HPV testing will result in substantial economic gains for the Australian Government. These savings could be well invested in rigorous evidence-based health promotion campaigns (similar to the current public awareness-raising 'Pap Smear Campaign'). It is imperative that an ongoing wellness approach to women's health be implemented as common practice. Offering formalised, regular sexual health reviews will acknowledge that women are more than the sum of their parts and wellness is achieved when inclusive collaboration is prioritised. Comprehensive sexual and reproductive health 'check up's' must become part of routine health assessments. An allocated Medicare benefit scheme (MBS) item number would enable practitioners to offer these health assessments and would support the financial viability of actively recalling women for practitioner- led sexual and reproductive health reviews. This, in the long term, will ensure critical health issues such as sexually transmissible infections, breast health, contraception and women's health education do not fall by the wayside. This would also

provide a long-term cost savings for the Australian Government as women's health issues are addressed and managed in their infancy and women are educated and empowered to be proactive in the management of their health care - rather than the ' the ambulance at the bottom of the cliff' approach.

Policy recommendations also include an MBS item number allocated to specific STI screening tests. This will ensure that effective monitoring and evaluation of any new programs is possible. Declines in health-seeking behaviours attributed to changes in the NCSP must be accounted for and ameliorated.

In a landscape of ever increasing advanced technology, HPV vaccination programs and sound evidence to support changes to cervical screening intervals, challenges exist for health practitioners addressing women's health needs in a timely, acceptable and ongoing manner. Health promotion campaigns will need to normalise health seeking behaviour and support women to access services outside current established recommendations.

References

1. Family Planning NSW. *Reproductive and Sexual Health in Australia.* Sydney : FPNSW, 2013.

2. Australian Insitute of Health and Welfare. *Australian Cancer Incidence and Mortality Books.* Canberra : AIHW, 2014.

3. Children by Choice. *Briefing paper: The sexual and reproductive health of Australian women*. Brisbane : Children by Choice, 2012.

4. Laws P, Grayson N, Sullivan E. *Australia's Mothers and Babies 2004.* Sydney : AIHW National Perinatal Statistics Unit, 2006. Perinatal statistics series. 18.

5. Australian Government, Department of Health. *National Cervical Screening Program : Medcal Services Advisory Committee Recomendations.* Canberra : Commonwealth of Australia , 2014.

6. *The impact of HPV vaccination on cervical screening in Australia: Update on new reccomendations for the national Cervical Screening Program*. Canfell, K. Sydney : Australasian Sexual Health Conference , 2014.

Presenter

Genevieve Dally is a decade long champion of the sexual and reproductive health sector. Cutting her teeth in a busy urban general practice, Genevieve developed a nurse-led sexual health clinic to address gaps in access to services for young people. Recognising early on the limitations of a diversified workforce Genevieve then moved into sexual and reproductive health education to strengthen the skill base and build the capacity of doctors, nurses and allied health professionals. Genevieve is a registered nurse with a Masters in Public Health and is currently employed by Family Planning and Welfare NT in the role of Manger for Education and Workforce Development. Genevieve is passionate about sexual rights being human rights and works tirelessly to promote safe, happy healthy and enjoyable sexual lives for all people.