Access to treatment in the Jujuy Demonstration Project

In their Comment (June, 2019) on our Article1 presenting results from the Jujuy Demonstration Project, Marc Arbyn and colleagues point out that access to treatment was not described. This observation is of high importance because it implies that to attain the high level of treatment obtained in the Jujuy project, specific activities must have been done to increase access to treatment for women. In effect, social and health system barriers are a main cause of the shortage of treatment for women with preneoplastic disease or cervical cancer in a variety of settings, which is one of the reasons why screening programmes from low-resource settings have failed. As Arbyn and colleagues2 have stated, access to effective treatment procedures is a crucial condition that must be met for a successful screening programme. Although some of the measures to assure access to treatment in the Jujuy demonstration project have been previously described,3 we agree with Arbyn and colleagues that such an important component should be explicitly and extensively described.

In the Jujuy project, a network of 15 treatment units in the public health sector were reorganised to assure provision of treatment. If deemed necessary, services were provided with equipment and consumables by the National Programme on Cervical Cancer Prevention (NPCC). Refresher training was provided to cervical pathologists. Further, treatment was free of cost to women. Women diagnosed with high-grade squamous intraepithelial lesions were supported by two navigators using Sistema de Informacion para el Tamizaje (SITAM), the national screening information system. Navigators scanned SITAM to identify women without treatment and contacted them, first by telephone if possible, then personally. The navigators asked about barriers to treatment faced by these women and, if possible, provided support (eg, by making arrangements to assure transportation using vehicles within the health system if the absence of transport was at the root of the problem). Navigators also connected with treatment services to assure appointment times and alert providers to any woman with special needs.

But the navigator’s programme did not come out of nothing. This programme was the result of extensive research to produce local evidence on the barriers faced by women in accessing treatment. In Argentina, pioneering work by Ramos and Pantelides4 showed that, in the 1990s, at least 25% of women diagnosed with high-grade disease abandoned treatment. In 2008, when the NPCC was relaunched, priority was given to continue this line of research. Several studies5 showed that the most important barriers faced by women relating to health-care system function included a shortage of providers, long waiting times, problems receiving results, and appointments during hours not suited for working women or for women taking care of their children (which is to say, the large majority of women). These problems are not exclusive to Argentina and are common among many low-resource settings. This local evidence has been widely disseminated and discussed in meetings and at management tables with decision makers, health authorities, head of services, and scientific societies.

Although a national cytology-based screening programme has been in place since 1998, at the time of the relaunching of the programme in 2008, no data existed on how many women with abnormal lesions had been followed up and treated.6 Full implementation of SITAM in 2010 was a turning point in cervical cancer treatment because daily and up-to-date information was available to closely monitor follow-up and treatment of women who had undergone screening. Moreover, during instances of work (ie, training) with provincial stakeholders, the NPCC staff began to use the concept of a screening–diagnosis–treatment programme, instead of just screening programme, to stress the fact that each one of these components was equally important to attaining the goal of reducing the burden of cervical cancer. Although it might seem a semantic subtlety, this change in the communication process was important for increasing the focus on the diagnosis and treatment aspects of the programme: components that had been long kept invisible.

All of these combined elements resulted in the high adherence to treatment that we reported in our Article,7 which were similar to those attained in the study by Sankaranarayanan and colleagues8 that showed that HPV-testing reduced mortality from cervical cancer.

To summarise, access to treatment was assured by considering it a high priority in the policy agenda of the NPCC, producing local evidence about the barriers faced by women to treatment, implementing an information system to monitor follow-up and treatment, establishing a navigator programme to provide support for women and reduce the barriers to treatment, organising a treatment network, and providing treatment free of cost to women.

I declare no competing interests.

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