Author's response to reviews

Title: Influences on Uptake of Reproductive Health Services in Nsangi community of Uganda: Implications for Cervical Cancer Screening

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Author's response to reviews: see over

Dr Regina Kulier, MD, MSc
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Manuscript 1851408151127028 "Influences on Uptake of Reproductive Health Services in Nsangi community of Uganda: Implications for Cervical Cancer Screening"

Dear Dr Kulier,

Thank you in advance for considering our revised manuscript for publication. We have responded to the reviewers' comments and included their suggestions in the attached manuscript. We hope that the changes we did will be satisfactory to you and to the reviewers. Please, find our point-by-point responses below.

With kind regards

On behalf of all authors
Elisabete Weiderpass

Response to comments by Dr Nuwaha.

Comments on Background:

Comment 1. Whether the other [health] indicators are responsible for the high maternal mortality ratio (MMR).
We agree that they are not. The other health indicators may be influenced by the same causes as maternal mortality, but we believe that they do not influence MMR independently. We changed the paragraph listing MMR as one indicator, not drawing particular attention to it.
We could identify only two previous studies – both hospital based - addressing uptaking of cervical cancer screening services, to which we could possibly compare our data.

Therefore we used the other reproductive health indicators from population-based surveys to explain the situation in the country. We have also pointed out in the discussion that Uganda has an integrated system of health services delivery, and how opportunistic cervical cancer screening could be integrated in antenatal care, postnatal care and family planning services. The relevance of use of the other reproductive health services to cervical cancer screening becomes clear as they are vital entry points for information, education and opportunistic screening.

Comment 2. What is opportunistic screening?

Opportunistic screening is the screening services offered to women when they come to a health facility for another reason, for example contraception. This is opposed to organised screening where there is a deliberate effort to reach and screen a defined population. We added a sentence in the text explaining what opportunistic screening is, since readers could ask themselves the same question.

Comment 3. The reviewer's comment was that the aim of the study appears to be blurred.
We would like to clarify that the aim of the study was to identify what influences uptake of cervical cancer screening services. We changed the paragraph in the very end of the introduction section clarifying this specific aim and the relevance of looking at the other reproductive health services (they are vital entry points especially in an opportunistic screening program). Previous Knowledge, Attitude and Practices (KAP) studies were hospital based and quantitative, and showed fairly good knowledge about cervical cancer among health workers and availability of facilities for opportunistic screening. In out study, using qualitative methods and including study subjects from the general population - we found that knowledge about cervical cancer and possibilities of screening among women was low. We had suspected this but had no sources to refer to. We therefore used the other reproductive health services as proxy variables, i.e. we assumed that what influences uptake of the other reproductive health services would similarly affect uptake of cervical cancer screening. We do hope that this makes the issue clear now, and we apologize to the reviewer for the lack of clarity in our previous version.

Comment on Methods:

In view of the above explanation it becomes apparent why focus group discussions were the best methodological method to be used, since it generates more data to understand or explain factors influencing health-seeking behaviour. We acknowledge there might be some limitations of this method, such as lack of generality, but still our findings inform planners about issues to consider for achieving maximum cervical cancer screening uptake.

Comments about the Discussion:

1. It is true we did not expect knowledge about cervical cancer to be high. Indeed we found it to be almost negligible. However we could not presume that it would be so as it might differ between different sections of society. We cite this lack of knowledge as one of the many influences that needs to be addressed by health planners for future cervical cancer screening programs.

2. We have included in the first paragraph of the background section including an additional explanation about disparity between high antenatal attendance for one visit only, and low usage of the other reproductive health services.

3. On the comment about the use of the research data: we believe that the findings of this study will be useful for public health planning of a cervical cancer screening program aiming to achieve maximum uptake. The population needs to be well informed about cervical cancer and the possibilities of early detection and treatment to feel motivated to seek the service. Apart from the usual channels of information, we bring to their attention the issue of authoritative knowledge sources on reproductive health issues in this population. We point out the difficult situation regarding public health delivery units, and the reasons for the loss of confidence by the women in these units. We highlight the reasons for the perceived reluctance of men to be involved in women reproductive health issues, and the power they wield on access to health services at domestic level. We have made suggestions about the involvement of male partners in the decision process of seeking screening. We have also suggested use of alternative service delivery systems, like outreaches or camps, which may be relatively effective for a strategy of a once in a lifetime cervical cancer screening for each woman. This strategy that might work for cervical cancer prevention though not for other reproductive health needs. Since the study was done in a single community, there is room for further research in other ethnic communities regarding reproductive health issues.

Finally, the reviewer asked us to comment about the disparity between antenatal attendance and delivery in health units in Uganda. It has been hypothesized that the women come for prenatal care services to get a card that facilitates access to hospital services in case any problem develops during pregnancy. Most women, however, have no intention to deliver in the health units in case the pregnancy is uncomplicated. This is possibly the reason why attendance to antenatal care (ANC) is high for at least one visit, but is low when one considers 4 visits, which is the WHO recommendation. Some of the reasons for loss of confidence in the health care units, which might explain this disparity, are outlined in our manuscript. We have included this explanation in the first paragraph of the background section.

Response to comments by Jeanette Lim.

Comment 2.
We agree that the findings cannot be generalisable for the whole country. The area that the study was carried out is close to Kampala, the capital city of Uganda, and it is prudent to assume that the population here would have relatively better access to health units, higher income and more access to information on diseases as compared to more remote areas. One would expect the performance of health units to be better the closer one is to the capital. Uganda being multi-tribal, the major differences would be in the cultural explanations of the disease and their influence on health seeking behaviour, namely on the decision on whether to go to the western model or the traditional model health care. We believe that tribal culture has a large influence on health seeking behaviour in Uganda, and as the Baganda are just one tribe out of many, we agree that we needed to acknowledge this fact in the title. Thus, we changed the title of the manuscript as follows:

New Title: Influences on Uptake of Reproductive Health Services in Nsangi Community of Uganda: Implications for cervical cancer screening.

Comment 3.
Though the Baganda are the largest tribe in Uganda, they make up only about 20 percent of the total population of the country. The representativeness was in respect to occupation and thus income. This has been corrected in the manuscript.

Comments 4-10: all have been corrected in the text according to the reviewer's suggestions.

Comment 11
There is no reference for field colposcopes. They are manufactured by DIVLABS, India and are smaller and could be carried in a mobile van. We added the name of the colposcope producer in the text.

Comment 12
The use of this was contextual. In Uganda since 1986, there is a practice of holding village meetings to deliberate on any issues in the communities. They are called Local Councils (LCs). To a researcher, they are quite close to focus group discussions. They choose acceptable leaders during their deliberations. We took advantage of this in our research so no references can be cited. A paragraph has been added to the text to explain this issue.

Comment 13: The sentence has been deleted

Comment 14: (and comments 7, 8: new references)
New references have been provided and are outlined below.

For comment 7

Alliance for Cervical Cancer Prevention (ACCP). The Case for Investing in Cervical Cancer Prevention. In Cervical Cancer Prevention Issues in Depth, vol 3, Seattle, ACCP; 2004:17.

Cuzick J: Human papillomavirus testing for primary cervical cancer screening. JAMA 2000, 283: 108-109.

For comment 8

Alliance for Cervical Cancer Prevention (ACCP). The Case for Investing in Cervical Cancer Prevention. In Cervical Cancer Prevention Issues in Depth, vol 3, Seattle, ACCP; 2004:15-19.

Denny L, Kuhn L, De Souza M, Pollack AE, Dupree W, Wright TC, Jr.: Screen-and-treat approaches for cervical cancer prevention in low-resource settings: a randomized controlled trial. JAMA 2005, 294: 2173-2181.

For comment 14

Kaleeba N, Kalibala S, Kaseje M, Ssebbanja P, Anderson S, van Praag E et al.: Participatory evaluation of counselling, medical and social services of The AIDS Support Organization (TASO) in Uganda. AIDS Care 1997, 9: 13-26.

Muyinda H, Seeley J, Pickering H, Barton T: Social aspects of AIDS-related stigma in rural Uganda. Health Place 1997, 3: 143-147.

Comment 15: the sentence has been deleted