Cervical Cancer Screening in Guatemala
Implementing a high-quality and sustainable program

Margaret M Sullivan[1,3], Dana D. Im[2], Lindsay Palazuelos[3], Dan Palazuelos[2,3]
[1]Boston Health Care for the Homeless, [2]Harvard Medical School, [3]Partners In Health

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Introduction

Cervical cancer is the third most common cancer among women worldwide[1]. Overwhelmingly a disease of the poor, approximately 530,000 new cases are diagnosed each year[1]. Nearly 80 percent of women who develop cervical cancer live in low- and middle-income countries (LMICs) and the vast majority (83%) of these deaths occurs in LMICs[1,2]. In Guatemala, cervical cancer is the leading cause of cancer-related deaths among women of reproductive age (15-44 years)[1]. The burden of cervical cancer in LMICs illustrates an enormous global health disparity of access.

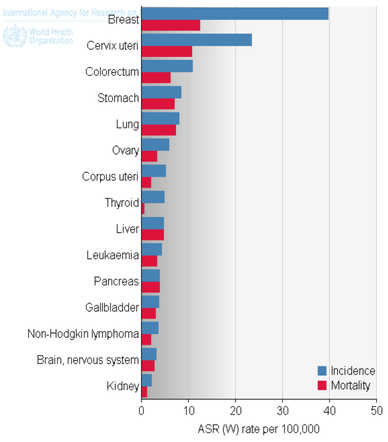


Figure 1. (left) Estimated age-standardized incidence and mortality rates for women in **Latin America and the Carribean**. GLOBOCON 2008

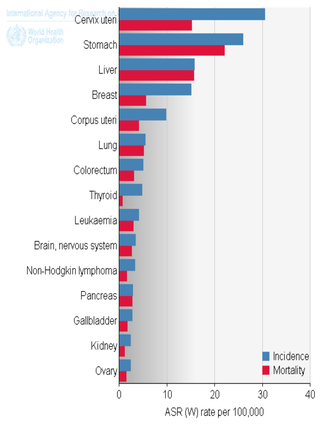


Figure 2. (right) Estimated age-standardized incidence and mortality rates for women in **Guatemala**. GLOBOCON 2008

Objectives

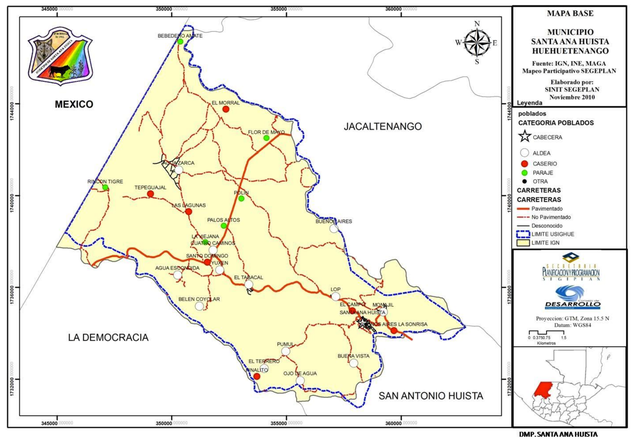
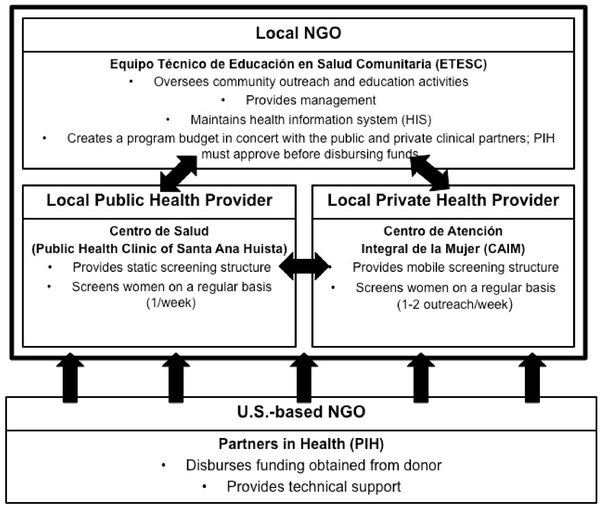


Figure 3. Santa Ana – Huista, Huehuetenango, Guatemala. Municipal Office.

In order to decrease mortality by at least 25%, we will need to screen at least 70% of eligible women[3]. Over the next three years, our goal is to screen all of the estimated 1,300 women aged 30-50 in the population of 11,000 in Santa Ana Huista, Guatemala, as well as up to an additional 3,000 women in surrounding municipalities. Secondly, we will establish a database for ongoing program evaluation and clinical monitoring.

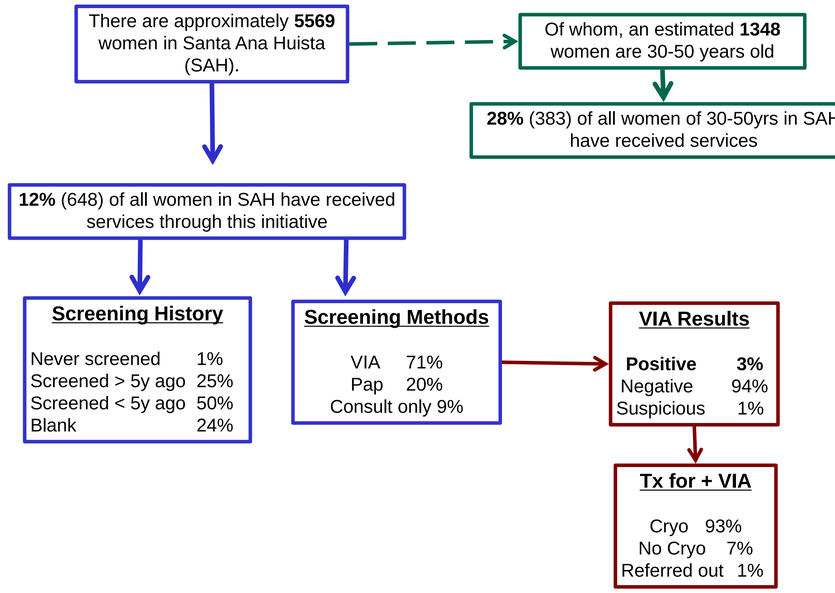
Description of the Project



To reach our goals, Partners In Health (PIH) collaborates with a local NGO, a private not-for-profit clinic and the government community health clinic to provide a combination of weekly screening clinics at the main health center as well as mobile outreach clinics. Screening is performed through the novel single-visit screen-and-treat approach, combining visual inspection with ascetic acid and cryotherapy.

6 Key Ingredients for Program Quality/Sustainability

1.	Rigorous clinical training, involving both nurses and physicians, spanning the course of a week with didactic and daily practicums. A curriculum based on an international standard of care[4,5].
2.	Follow-up training after several months of practice, again both didactic and practicums, with the original trainers.
3.	On-going clinical accompaniment, observation and re-tooling.
4.	Adapting the project to the specific needs of the community, which in our case meant including contraception, treatment for vaginitis/UTIs, including Pap smears with our VIA model and accompanying patients to the capital for diagnostic testing and curative/palliative treatment.
5.	Local champions who are invested in the project outcomes. Agreeing upon overarching project goals that overlap with the underlying objectives of our partner organizations. Funding to pay the full-time salary of a local nurse champion.
6.	Maintaining positive and constructive on-going relationships with our partners, fostering continued communication, and working to support their professional development.



Outcomes and Implications for Global Health Nursing

Since March 2011, a total of nearly 1000 women in the rural area of Santa Ana Huista have received services through this initiative. The provision of these services is by local Guatemalan nurses. The implication is that local nurses can be trained and capacitated to provide vital and necessary primary and secondary health services to hard-to-reach populations. Involving a variety of collaborators in a multi-provider public-private partnership allowed for a wider coverage of services, and holds promise for long term sustainability.

References and Key Resources

1. **Ferlay J, Shin HR, Bray F, Forman D, Mathers C and Parkin DM**. GLOBOCAN 2008 v2.0, Cancer Incidence and Mortality Worldwide: IARC CancerBase No. 10 [Internet]. Lyon, France: International Agency for Research on Cancer; 2010. Available from: http://globocan.iarc.fr/. Accessed on October 9, 2012.
2. **Lewis, Merle J.** A Situational Analysis of Cervical Cancer in Latin America and the Carribbean. Washington, DC. PAHO, 2004.
3. **Blumenthal, PD et al**. Cervical cancer prevention: safety, acceptability and feasibility of a single-visit approach in Accra, Ghana (2007). *American Journal Obstet Gynecology*.
4. **Blumenthal, PD**. Cervical Cancer Prevention Course Handbook. Jhpiego. Reprinted 2007.
5. **Basic Health International**, El Salvador. http://www.basichealth.org/medical_training.html#

"Just two cancers – breast and cervical – account for almost the same number of deaths among women in reproductive age in LMICs as maternal mortality." Closing the Cancer Divide, 2011.

"Over the last 40 years, cervical cancer mortality and incidence rates in Latin America and the Caribbean have not declined as significantly as in North America." PAHO, 2004

"Cervical cancer is fully preventable and curable, at low cost and at low risk, when screening to facilitate the timely detection of early precursor lesions in asymptomatic women is available together with appropriate diagnosis, treatment and follow-up." PAHO, 2004