Acceptability and feasibility of genital self-sampling for the diagnosis of female genital schistosomiasis: a cross-sectional study in Zambia [version 1; peer review: 2 approved with reservations]

Comfort Rutty Phiri¹, Amy S. Sturt², Emily L. Webb¹³, Namakau Chola¹, Richard Hayes³, Kwame Shanaube¹, Helen Ayles², Isaiah Hansingo⁴, Amaya L. Bustinduy², BILHIV study team

¹Zambart, Lusaka, Zambia
²Department of Clinical Research, London School of Hygiene & Tropical Medicine, London, WC1E 7HT, UK
³MRC Tropical Epidemiology Group, London School of Hygiene & Tropical Medicine, London, WC1E 7HT, UK
⁴Gynecology Department, Livingstone Central Hospital, Livingstone, Zambia

Abstract

Background: Female genital schistosomiasis (FGS) is a neglected and disabling gynaecological disorder that is difficult to diagnose and is part of the wider spectrum of urogenital disease caused by the waterborne parasite Schistosoma haematobium. Over 90% of human schistosomiasis cases are found in sub-Saharan Africa with 3.8 million people infected with schistosomes in Zambia. Reported FGS prevalence ranges from 33-75% of those with urinary schistosomiasis in endemic areas, suggesting a potentially high FGS burden in Zambia alone. The Bilharzia and HIV (BILHIV) study evaluated home self-sampling genital collection methods for the diagnosis of FGS.

Methods: Eligible participants included non-pregnant, sexually active women aged 18-31 who were previously recruited for the HPTN 071 (PopART) trial in Livingstone, Zambia. Household demographic and symptom questionnaires were administered by community workers. Participants were offered vaginal and cervical self-swabs and a urine cup. Cervicovaginal lavage (CVL) was performed in clinic by midwives. Information was collected from participants on the acceptability and feasibility of genital self-sampling.

Results: From January-August 2018, 603 women were enrolled, and 87.3% (527/603) completed clinic follow up. A high proportion of participants indicated that self-collection of specimens was "easy" or "very easy" on a 5-point Likert scale. A high proportion of women would be willing to self-collect all three specimens again in future: vaginal swab 96.7%
(583/603), cervical swab 96.5% (582/603), and urine 96.2% (580/603).
Home-based self-sampling was preferred over provider-based
sampling in the clinic due to greater privacy 58.5% (353/603),
convenience 46.3%
(279/603) and need for transportation 15.9% (96/603).

Conclusions: Home based genital self-sampling for FGS diagnosis is
highly acceptable. This scalable method may inform future efforts for
community-based diagnosis of FGS.

Keywords
female genital schistosomiasis, acceptability, feasibility, self-sampling,
self-collection, vaginal self-sampling, cervical self-sampling, genital
self-sampling
Introduction

Human schistosomiasis is a waterborne parasitic disease caused by blood flukes of the genus *Schistosoma* 1-3. It constitutes a significant public health problem causing the loss of 1.440 million years of full health worldwide, with approximately 659 million people at risk of acquiring infection4. More specifically, *Schistosoma haematobium* affects both the urinary as well as the genital tract. In female genital schistosomiasis (FGS), parasite egg deposition occurs in the genital tract and it is characterized by histologic vaginal or cervical mucosal inflammation4 and unique clinical findings5. FGS has been associated with infertility, a condition associated with negative social and psychological impacts in many low-income countries6. In addition, observational studies have suggested an association between FGS and prevalent HIV infection7,8, and HIV transmission and acquisition9.

Genital self-sampling has been described in the diagnosis of reproductive tract infections (RTI)10-12 in both adults and adolescents13 and has enhanced access to health services among hard-to-reach populations such as adolescents/young people14, and those who do not regularly access health screening services15,16. A high proportion of women, including those from resource-limited settings have been found to prefer vaginal specimen self-collection17,18 compared with clinic-based sampling. In addition to acceptability, two other factors make genital self-sampling advantageous; 1) the availability of vaginal self-sampling is effective for improving participation in specific RTI screening programmes and 2) the sensitivity of PCR-based assays on self-collected specimens compares favourably with physician-performed sampling16,18.

The Bilharzia and HIV (BILHIV) study’s primary aim was to validate home-based self-sampling for the detection of *Schistosoma* DNA with vaginal and cervical swabs against provider obtained cervicovaginal lavage in a clinic setting in an endemic area in Zambia. The BILHIV study previously found that *Schistosoma* DNA was more frequently detected in genital self-collected specimens compared to clinic-collected cervicovaginal lavage19. Here, we describe the acceptability and feasibility of genital self-sampling for the detection of *Schistosoma* DNA in the BILHIV study. In addition, this study also analyses the demographic predictors for participant’s preference of home-based self-sampling over clinic-based sampling.

Methods

Study setting and participants

The Bilharzia and HIV (BILHIV) study was a cross-sectional study nested within two of the 12 HPTN 071 (PopART) communities in Livingstone, southern province of Zambia10. HPTN 071 (PopART) was a trial to measure the impact of an HIV combination prevention package, including universal test and treat20. Non-pregnant, sexually active women aged 18–31 who had previously been recruited for the HPTN 071 (PopART) population cohort were eligible for inclusion in BILHIV.

Sample collection and questionnaire

Between January and August 2018, specially trained population cohort research assistants visited women during the population cohort 36-month end of study follow up and enquired regarding an “expression of interest” in the BILHIV study. At a subsequent home visit, BILHIV Community Workers (BCW) evaluated study eligibility, provided participants with study information in the language of their choice, along with FGS education, and obtained written informed consent.

At the home visit, the BCW provided participating women with instructions for urine collection and cervical and vaginal self-swabs using educational materials including an information sheet with diagrams of the female anatomy, model vagina, and test swabs. Photos in the World Health Organization’s “Female Genital Schistosomiasis Pocket Atlas” were also displayed as a visual aid. As shown in Figure 1, these educational materials were used to explain and demonstrate the procedure of self-collection of genital specimens. For swab self-collection, participants were instructed to hold a 6-inch vaginal swab (PrimeSwab, Longhorn Diagnostics, Texas, USA) at the 2 3/8-inch score mark and insert the swab vaginally until their fingers touched the labia minora. Participants moved the swab in a circular motion against the vaginal walls for a minimum of 15 repetitions. Similarly, for the cervical swab, participants were instructed to hold a 6 3/4-inch flocked swab (Miraclean, Shenzen, China) with a quadrilateral kite-shaped tip at the non-flocked end of the swab body and insert the swab vaginally until they met noticeable resistance. The participant then performed swab rotation as described above. The participant broke the shaft of each swab and placed the vaginal and cervical swabs in separate screw-capped microtubes (STARLAB, Hamburg, Germany). Both swab specimens and urine were placed in cool boxes for transportation to the laboratory.

Following written informed consent and specimen collection, the participants completed a questionnaire, with responses captured on hand-held tablets. The questionnaire assessed basic demographics, information regarding genital symptoms, sexual behaviour and also the participant’s assessment of the acceptability of self-sampling, through their responses to 15 questions (Extended data11; Table 1).

At a later date, participating women who were not currently menstruating attended Livingstone Central Hospital (LCH) cervical cancer screening clinic where a trained midwife performed a cervicovaginal lavage and images of the vagina and cervix were captured with a point-of-care colposcope (MobileODT, Tel Aviv Israel) (Sturt, A et al. paper under review).

Ethics and informed consent

All eligible participants providing written consent were recruited into the study. Participants who were unable to provide written informed consent were recruited in the presence of a witness with the participant placing their thumbprint on the consent form. The study was approved by the University of Zambia Biomedical Research Ethics Committee (reference number: 011-08-17), the Zambia National Health Research Authority and the London School of Hygiene and Tropical Medicine research ethics committee (reference number: 14506). Permission to conduct the study was given by the Livingstone District health office and the superintendent of the Livingstone Central Hospital.
Data management and statistical methods
Acceptability in our study was measured by the following outcomes: the proportion of women who rated home-based self-sampling to be “easy” or “very easy” (for each of urine, vaginal, cervical self-sampling), the proportion who didn’t experience “pain” while self-sampling (for each of vaginal, cervical self-sampling), the proportion who were willing to self-sample again “in the future” (for each of urine, vaginal, cervical self-sampling), and the proportion who would prefer to “sample at home” (versus sampling in the clinic).

Participant data were entered using Open Data Kit Collect22. Continuous variables were summarized by mean and interquartile range (IQR), and categorical variables by frequency and percentage. Participant characteristics were compared between the two communities using Wilcoxon-Mann-Whitney, chi-squared, and Fisher’s exact tests. The Mantel-Haenszel approach was used to obtain crude and age-adjusted odds ratios for the association of demographic variables with a participant’s preference for home-based versus clinic-based sampling.

Results
Of 1104 women screened for BILHIV eligibility, 54.5% (603/1105) were enrolled and all completed an initial home-based visit. Of those completing the initial home visit, 87.4% (527/603) completed clinic follow up (Figure 2). The median age was 24 years (IQR 22-28). More than half of participants, 60.4% (364/603), completed secondary school education and 59% (356/603) spoke primarily Nyanja (Table 1).

Acceptability and feasibility
Out of 603 women recruited, a high proportion indicated that self-collection of genital specimens was “easy” or “very easy” on a 5-point Likert scale for urine collection (96.2%; 580/603), vaginal swab (94.9%; 572/603), and cervical swab (86.6%; 522/603) (Figure 3; Table 2). Most participants indicated that they would be willing to self-collect again in the future: urine 96.2% (580/603), vaginal swab 96.7% (583/603) and cervical swab 96.5% (582/603). Substantially less than half of participants reported that it was “painful” to self-collect vaginal specimens (3.3%; 20/603) and cervical specimens (6.8%; 41/603).
### Table 1. Baseline characteristics of 603 Zambian women living in *Schistosoma haematobium* endemic areas near the Zambezi river by community.

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Overall (n=603)</th>
<th>Community A (n=319)</th>
<th>Community B (n=284)</th>
<th>p-value*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age in years – Median (IQR)</td>
<td>24 (22-28)</td>
<td>26 (23-29)</td>
<td>24 (21-27)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>258 (42.8%)</td>
<td>110 (34.5%)</td>
<td>148 (52.1%)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Married or Cohabiting</td>
<td>320 (53.1%)</td>
<td>193 (60.5%)</td>
<td>127 (44.7%)</td>
<td></td>
</tr>
<tr>
<td>Divorced or Separated</td>
<td>23 (3.8%)</td>
<td>15 (4.7%)</td>
<td>8 (2.8%)</td>
<td></td>
</tr>
<tr>
<td>Widowed</td>
<td>2 (0.3%)</td>
<td>1 (0.3%)</td>
<td>1 (0.4%)</td>
<td></td>
</tr>
<tr>
<td>Language spoken</td>
<td></td>
<td></td>
<td></td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Nyanja</td>
<td>356 (59.0%)</td>
<td>160 (50.2%)</td>
<td>196 (69.0%)</td>
<td></td>
</tr>
<tr>
<td>Tonga</td>
<td>127 (21.1%)</td>
<td>93 (29.2%)</td>
<td>34 (12.0%)</td>
<td></td>
</tr>
<tr>
<td>Lozi</td>
<td>86 (14.3%)</td>
<td>48 (15.1%)</td>
<td>38 (13.4%)</td>
<td></td>
</tr>
<tr>
<td>Bemba</td>
<td>30 (5.0%)</td>
<td>17 (5.3%)</td>
<td>13 (4.6%)</td>
<td></td>
</tr>
<tr>
<td>English only</td>
<td>4 (0.7%)</td>
<td>1 (0.3%)</td>
<td>3 (1.1%)</td>
<td></td>
</tr>
<tr>
<td>Education (highest level)</td>
<td></td>
<td></td>
<td></td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Any Primary School</td>
<td>167 (27.7%)</td>
<td>117 (36.7%)</td>
<td>50 (17.6%)</td>
<td></td>
</tr>
<tr>
<td>Any Secondary School</td>
<td>364 (60.4%)</td>
<td>173 (54.2%)</td>
<td>191 (67.3%)</td>
<td></td>
</tr>
<tr>
<td>Training in a Trade</td>
<td>59 (9.8%)</td>
<td>20 (6.3%)</td>
<td>39 (13.7%)</td>
<td></td>
</tr>
<tr>
<td>Degree or Higher</td>
<td>3 (0.5%)</td>
<td>3 (0.9%)</td>
<td>0 (0.0%)</td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>10 (1.7%)</td>
<td>6 (1.9%)</td>
<td>4 (1.4%)</td>
<td></td>
</tr>
<tr>
<td>Employment status</td>
<td></td>
<td></td>
<td></td>
<td>0.006</td>
</tr>
<tr>
<td>Working</td>
<td>408 (67.7%)</td>
<td>200 (62.7%)</td>
<td>208 (73.2%)</td>
<td></td>
</tr>
<tr>
<td>Not Working</td>
<td>195 (32.3%)</td>
<td>119 (37.3%)</td>
<td>76 (26.8%)</td>
<td></td>
</tr>
<tr>
<td>Current water contact</td>
<td></td>
<td></td>
<td></td>
<td>0.02</td>
</tr>
<tr>
<td>None</td>
<td>512 (84.9%)</td>
<td>263 (82.5%)</td>
<td>249 (87.7%)</td>
<td></td>
</tr>
<tr>
<td>At Least Weekly</td>
<td>18 (3.0%)</td>
<td>11 (3.5%)</td>
<td>7 (2.5%)</td>
<td></td>
</tr>
<tr>
<td>Every 1–2 Months</td>
<td>30 (5.0%)</td>
<td>24 (7.5%)</td>
<td>6 (2.1%)</td>
<td></td>
</tr>
<tr>
<td>Every 6–12 Months</td>
<td>43 (7.1%)</td>
<td>21 (6.6%)</td>
<td>22 (7.8%)</td>
<td></td>
</tr>
<tr>
<td>Childhood water contact</td>
<td></td>
<td></td>
<td></td>
<td>0.22</td>
</tr>
<tr>
<td>None</td>
<td>186 (30.9%)</td>
<td>96 (30.1%)</td>
<td>90 (31.7%)</td>
<td></td>
</tr>
<tr>
<td>At Least Weekly</td>
<td>381 (63.2%)</td>
<td>208 (65.2%)</td>
<td>173 (60.9%)</td>
<td></td>
</tr>
<tr>
<td>Every 1–2 Months</td>
<td>24 (4.0%)</td>
<td>12 (3.8%)</td>
<td>12 (4.2%)</td>
<td></td>
</tr>
<tr>
<td>Every 6–12 Months</td>
<td>12 (2.0%)</td>
<td>3 (0.9%)</td>
<td>9 (3.2%)</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>572 (94.8%)</td>
<td>294 (92.2%)</td>
<td>278 (97.9%)</td>
<td>0.006</td>
</tr>
<tr>
<td>Self-reported history of schistosomiasis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>25 (4.2%)</td>
<td>20 (6.3%)</td>
<td>5 (1.8%)</td>
<td></td>
</tr>
<tr>
<td>Maybe</td>
<td>6 (1.0%)</td>
<td>5 (1.6%)</td>
<td>1 (0.4%)</td>
<td></td>
</tr>
</tbody>
</table>

*comparison of Community-A vs Community-B

A high proportion of women (95.7%; 577/603) indicated that they would ‘recommend self-sampling to my friends’. Overall, most women preferred to collect specimens at home (90.0%; 543/603), compared with clinic-based sampling (10.0%; 60/603), (Table 3). Women from both communities preferred to self-collect specimens from home (Community A: 89.3%; 285/319; Community B: 90.9%; 258/284; p=0.5) compared with attending the health facility. Participants preferred “self-sampling at home” over provider-based sampling in the clinic due to greater privacy (58.5%; 353/603), convenience (46.3%; 279/603) and lack of transportation (15.9%; 96/603) (Table 3). Participants in Community B were more confident (99.3%; 282/284) than participants in Community A (91.5%; 292/319) (p<0.001) that they collected the specimens correctly.

Overall, there was little evidence that education, marital status, community of residence, employment status, language spoken, and age were associated with a participant’s preference for home-based sampling over clinic-based sampling (Table 4). Given that the preference for self-sampling was universal across the groups examined in the crude analysis, we did not undertake multivariable analysis.
Figure 2. The Bilharzia and HIV study enrolment and sampling flow chart.

FIGURE 3. Ease of self-sampling in 603 Zambian women by specimen type.
Table 2. Acceptability of genital self-sampling for women from the BILHIV study (n=603).

<table>
<thead>
<tr>
<th>Question</th>
<th>Very easy % (n)</th>
<th>Easy % (n)</th>
<th>Neutral % (n)</th>
<th>A little difficult % (n)</th>
<th>Very difficult % (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I found vaginal self-sampling to be</td>
<td>34.5 (208)</td>
<td>60.4 (364)</td>
<td>2.0 (12)</td>
<td>3.2 (19)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>I found cervical self-sampling to be</td>
<td>26.2 (158)</td>
<td>60.4 (364)</td>
<td>5.0 (30)</td>
<td>8.5 (51)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>I found collecting my own urine sample to be</td>
<td>56.2 (339)</td>
<td>40.0 (241)</td>
<td>1.7 (10)</td>
<td>2.0 (12)</td>
<td>0.2 (1)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question</th>
<th>Strong yes</th>
<th>Yes</th>
<th>Maybe</th>
<th>No</th>
<th>Strong no</th>
</tr>
</thead>
<tbody>
<tr>
<td>I would be willing to take a vaginal self-sample in the future.</td>
<td>42.1 (254)</td>
<td>54.6 (329)</td>
<td>2.2 (13)</td>
<td>1.2 (7)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>I would be willing to take a cervical self-sample in the future.</td>
<td>37.0 (223)</td>
<td>60.0 (359)</td>
<td>2.5 (15)</td>
<td>1.0 (6)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>I would be willing to take a urine self-sample in the future.</td>
<td>38.6 (233)</td>
<td>58.4 (352)</td>
<td>2.3 (14)</td>
<td>0.7 (4)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>I would recommend self-sampling to my friends.</td>
<td>29.0 (175)</td>
<td>66.7 (402)</td>
<td>1.8 (11)</td>
<td>2.0 (12)</td>
<td>0.5 (3)</td>
</tr>
<tr>
<td>Self-collecting a vaginal swab was painful.</td>
<td>0.33 (2)</td>
<td>3.0 (18)</td>
<td>3.7 (22)</td>
<td>77.1 (465)</td>
<td>15.9 (96)</td>
</tr>
<tr>
<td>Self-collecting a cervical swab was painful.</td>
<td>0.0 (0)</td>
<td>6.8 (41)</td>
<td>9.6 (58)</td>
<td>71.3 (430)</td>
<td>12.3 (74)</td>
</tr>
<tr>
<td>I am confident I collected the specimens properly.</td>
<td>29.0 (175)</td>
<td>66.2 (399)</td>
<td>2.7 (16)</td>
<td>2.2 (13)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>I feel confident I collected a sample from my vagina.</td>
<td>25.7 (155)</td>
<td>72.3 (436)</td>
<td>1.3 (8)</td>
<td>0.7 (4)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>I feel confident I collected a sample from my cervix.</td>
<td>24.5 (148)</td>
<td>71.6 (432)</td>
<td>3.5 (21)</td>
<td>0.3 (2)</td>
<td>0 (0)</td>
</tr>
</tbody>
</table>

Table 3. Results of the BILHIV study patient experience surveys for 603 women living in Schistosoma haematobium endemic areas in Livingstone, Zambia*.

<table>
<thead>
<tr>
<th>Question</th>
<th>Participant responses</th>
<th>% (n)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you prefer to take your samples at home, or would you prefer to take samples at the clinic?</td>
<td>Clinic</td>
<td>10.0 (60)</td>
</tr>
<tr>
<td></td>
<td>Home</td>
<td>90.0 (543)</td>
</tr>
<tr>
<td>I prefer doing samples at home because**</td>
<td>It is more convenient</td>
<td>51.4 (279)</td>
</tr>
<tr>
<td></td>
<td>I don’t have transportation</td>
<td>17.7 (96)</td>
</tr>
<tr>
<td></td>
<td>I don’t have childcare</td>
<td>2.6 (14)</td>
</tr>
<tr>
<td></td>
<td>I need to work</td>
<td>6.2 (34)</td>
</tr>
<tr>
<td></td>
<td>I have more privacy at home</td>
<td>65.0 (353)</td>
</tr>
<tr>
<td></td>
<td>It is easier to sample at home</td>
<td>66.3 (360)</td>
</tr>
<tr>
<td></td>
<td>Other reason</td>
<td>11.4 (62)</td>
</tr>
<tr>
<td>I prefer having samples performed in clinic because**</td>
<td>I don’t have privacy at home</td>
<td>26.7 (16)</td>
</tr>
<tr>
<td></td>
<td>I had discomfort with collecting my own samples</td>
<td>13.3 (8)</td>
</tr>
<tr>
<td></td>
<td>I was unsure if I did the sampling properly</td>
<td>30.0 (18)</td>
</tr>
<tr>
<td></td>
<td>I’d like more supervision</td>
<td>28.3 (17)</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>28.3 (17)</td>
</tr>
</tbody>
</table>

*Proportions for home-based testing have a denominator of 543, proportions for clinic-based testing have a denominator of 60
**Participants could choose more than one answer
Table 4. Factors associated with the choice of home-based sampling over clinic-based sampling, adjusted for age.

<table>
<thead>
<tr>
<th>Exposure</th>
<th>n (home-based sampling)/N (%)</th>
<th>Crude OR</th>
<th>95% CI</th>
<th>aOR</th>
<th>95% CI</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None or any primary school</td>
<td>166/177 (94%)</td>
<td>reference</td>
<td>reference</td>
<td>0.31</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any secondary school</td>
<td>323/364 (89%)</td>
<td>0.52</td>
<td>0.26 – 1.05</td>
<td>0.45</td>
<td>0.22 – 0.91</td>
<td></td>
</tr>
<tr>
<td>Trade training or a degree</td>
<td>54/62 (87%)</td>
<td>0.45</td>
<td>0.17 – 1.18</td>
<td>0.47</td>
<td>0.17 – 1.27</td>
<td></td>
</tr>
<tr>
<td>Language*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nyanja</td>
<td>328/356 (92%)</td>
<td>reference</td>
<td>reference</td>
<td>0.11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tonga</td>
<td>114/127 (90%)</td>
<td>0.75</td>
<td>0.37 – 1.50</td>
<td>0.75</td>
<td>0.38 – 1.52</td>
<td></td>
</tr>
<tr>
<td>Lozi</td>
<td>72/86 (84%)</td>
<td>0.44</td>
<td>0.22 – 0.88</td>
<td>0.44</td>
<td>0.22 – 0.88</td>
<td></td>
</tr>
<tr>
<td>Bemba</td>
<td>26/30 (87%)</td>
<td>0.55</td>
<td>0.18 – 1.71</td>
<td>0.55</td>
<td>0.18 – 1.70</td>
<td></td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>228/258 (88%)</td>
<td>reference</td>
<td>reference</td>
<td>0.49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>292/320 (91%)</td>
<td>1.37</td>
<td>0.79 – 2.37</td>
<td>1.58</td>
<td>0.85 – 2.95</td>
<td></td>
</tr>
<tr>
<td>Divorced or widowed</td>
<td>23/25 (92%)</td>
<td>1.51</td>
<td>0.34 – 6.77</td>
<td>1.61</td>
<td>0.31 – 8.34</td>
<td></td>
</tr>
<tr>
<td>District</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community A</td>
<td>285/319 (89%)</td>
<td>reference</td>
<td>reference</td>
<td>0.54</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community B</td>
<td>258/284 (91%)</td>
<td>1.18</td>
<td>0.69 – 2.03</td>
<td>1.14</td>
<td>0.66 – 1.97</td>
<td></td>
</tr>
<tr>
<td>Employment status</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not working</td>
<td>367/408 (90%)</td>
<td>reference</td>
<td>reference</td>
<td>0.91</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Working</td>
<td>176/195 (90%)</td>
<td>1.03</td>
<td>0.58 – 1.84</td>
<td>1.07</td>
<td>0.60 – 0.90</td>
<td></td>
</tr>
<tr>
<td>Age (years)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18–22</td>
<td>144/158 (91%)</td>
<td>reference</td>
<td></td>
<td>--</td>
<td>--</td>
<td>0.62</td>
</tr>
<tr>
<td>23–26</td>
<td>207/228 (91%)</td>
<td>0.96</td>
<td>0.47 – 1.95</td>
<td>--</td>
<td>--</td>
<td></td>
</tr>
<tr>
<td>27–31</td>
<td>192/217 (89%)</td>
<td>0.75</td>
<td>0.37 – 1.49</td>
<td>--</td>
<td>--</td>
<td></td>
</tr>
</tbody>
</table>

Discussion

FGS is a chronic gynaecologic condition that affects vulnerable women and girls in sub-Saharan Africa. Current diagnostic strategies are limited as they rely on resources that are seldom available in low-income settings. A self-collection method that minimises reliance on health care providers would represent a scalable alternative method for FGS community-based diagnosis in endemic resource limited settings, but only if it is an acceptable procedure to perform. Home based genital self-sampling for the diagnosis of FGS was highly acceptable among women aged 18 to 31 years of age enrolled in the BILHIV study in Zambia. All participating women provided all three self-collected specimens (urine, vaginal and cervical swabs), and a high proportion found vaginal self-sampling and cervical self-sampling "easy" or "very easy". Our study is in agreement with other studies in which self-swabs were acceptable to women in geographically and ethnically diverse target populations. In a study of Haitian immigrants living in the USA, the acceptability of unsupervised cervical HPV self-sampling using written instructions revealed that self-sampling was more acceptable to the majority of the women than clinician-administered sampling, and it increased screening coverage among female clinic non-attendees. Also in an Italian study, cervical self-sampling using either a brush or a self-lavaging device was acceptable and both modalities were preferred to clinician-sampling (n=117, 68%) . A systematic review on the acceptability of self-sampled screening for HPV DNA reported that self-sampling was highly acceptable among study participants in 37 studies from 24 countries across five continents. Despite heterogeneity in study design, the studies in this meta-analysis suggest that self-sampling is well accepted by participants regardless of education, marital status, community of residence, employment status, language spoken, and age. Supported by these data we can conclude that our findings are likely generalizable across geographic areas and among women of varying educational background, cultures, and ethnic groups.

Substantially over half of the women in the BILHIV study reported that self-collection of specimens was "easy" or "very easy" (urine 96.2%, vaginal swab 94.9% and cervical swab 86.6%). This is consistent with other studies that showed that study participants found genital self-sampling or the use of a self-sampling device easy to use. The proportion with this outcome was slightly lower for cervical than vaginal sampling. Swab length and more invasive technique may account for the lower proportion of women who found cervical self-sampling "easy" or "very easy", compared with vaginal self-sampling. As another measure of acceptability, over 96% of women in the BILHIV study indicated that they were willing to self-collect all three specimens again.
in the future, which is similar to proportions reported in HPV self-collection research using cervical swabs\(^{21,28}\) and curable STI research using vaginal swabs\(^{29}\). Our study, as others, further showed that a high proportion of the women indicated that they would recommend self-sampling to a friend\(^{22}\). This shows promise for the future use of peer-encouragement in the use of genital self-sampling procedures.

Our study also revealed that 90.0% of participants preferred self-sampling at home over provider-based sampling at the clinic. Our findings are similar to studies reporting a high preference for home self-sampling\(^{25,27,28}\). However, a recent meta-analysis found that the pooled estimate of women who preferred self-sampling to clinic based sampling was 59% (48 – 69%)\(^{11}\). There are some possible explanations for this. While a binary outcome was evaluated in the meta-analysis, the individual reasons for preferring home-based self-sampling to health-facility sampling vary across studies. In the BILHIV study questionnaire, the questions regarding preferences for home vs. clinic sampling included a comprehensive range of options that included ‘privacy’, ‘convenience’, ‘transportation’, ‘work conflicts’, ‘no child-care’, and ‘ease’ among others. Second, other report that some women preferred clinic sampling to home based self-sampling because they were not comfortable with touching their genital areas, they were unsure about the safety of self-testing, or they were concerned they would perform the test incorrectly\(^{20}\).

This study benefited from HPTN 071 (PopART) because HPTN 071 (PopART) staff introduced the BILHIV study to all prospective BILHIV participants that enabled them to be familiar with the study even before it began. Further, the BILHIV study was implemented in communities that were already familiar with the organization and the staff that worked under the HPTN 071 (PopART) study. In addition, former HPTN 071 (PopART) staff in the two study communities continued to work in the same communities under the BILHIV study. This enabled improved study performance because of the existing rapport between BILHIV staff and the community members. Standardized questionnaires were used to reduce observer bias and were performed at the time of self-sampling to minimize recall bias. However, it is important to note that the participation in the BILHIV study was limited to women who took part in the HPTN 071 (PopART) population cohort. In this scenario, bias may be related to a Hawthorne effect. This observer effect can occur as participants in a study alter their behaviour as a result of regular follow-up within a cohort\(^{11}\). The HPTN 071 (PopART) population cohort was selected through a random sampling of households and random selection of one individual within each household\(^{21}\). BILHIV study participants were selected by querying eligible members of the population cohort for an “expression of interest”. There may be selection bias, in that women who expressed an interest in participating in the study may not be representative of the population as a whole.

**Conclusion**

We have shown high acceptability and feasibility of genital self-sampling for the diagnosis of FGS in young women (18–31 years) in a schistosomiasis endemic area in Zambia. This practice has potential to increase FGS surveillance in other endemic populations. The majority of participants reported that specimen self-collection was “easy” or “very easy” with high willingness to participate in future home-based self-sampling. Results can inform future efforts for community-based diagnosis of FGS.

**Data availability**

**Underlying data**

**LSHTM Data Compass: BILHIV acceptability dataset, https://doi.org/10.17037/DATA.00001618\(^{22}\).**

This data is under restricted access due to the assurance given to participants that responses would be kept completely confidential. This is particularly important due to the sensitivity of the data produced. The data set can be accessed by completing the Request Form, which requires that the intended use for the data is specified. Data available under the LSHTM Data Compass Data Sharing Agreement.

**Extended data**

Figgshare: Extended data Figshare.docx, https://doi.org/10.6084/m9.figshare.12023382.v1\(^{21}\).

**Acknowledgements**

BILHIV study team: https://www.lshtm.ac.uk/research/centres-projects-groups/bilharzia-and-hiv

**References**


http://www.doi.org/10.6084/m9.figshare.12023382.v1


Reference Source


http://www.doi.org/10.17037/DATA.00001618
Open Peer Review

Current Peer Review Status:  ?  ?

Version 1

Reviewer Report 20 July 2020

https://doi.org/10.21956/wellcomeopenres.16935.r39268

© 2020 Odaibo A. This is an open access peer review report distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

Alexander Odaibo
Parasitology Research Unit, Department of Zoology, University of Ibadan, Ibadan, Nigeria

The authors intended to evaluate the acceptability and feasibility of genital self-sampling for female genital schistosomiasis in a given cohort in Zambia. The intention is good and the execution is appropriate but there are a few clarifications to be made.

Methods:
1. No information was provided on the number of participants recruited for the study.
2. It is not clear from the article if there was a common sample collection centre for all participants or sample collection was done at the residence of each participant.
3. What was the Schistosoma haematobium infection status of the participants at the time of study?

Results:
1. Figure 2 is superfluous and what is the relevance of the table under result?
2. No information on how the home-based sampling by the women compared with the clinic sampling done in this study, instead readers are referred a paper that is still under review.

Discussion:
1. The authors may need to rephrase the first sentence under discussion to avoid starting the sentence with an abbreviation (FGS).
2. Schistosomiases should be changed to schistosomiasis.

Is the work clearly and accurately presented and does it cite the current literature?
Yes

Is the study design appropriate and is the work technically sound?
Yes

**Are sufficient details of methods and analysis provided to allow replication by others?**
Partly

**If applicable, is the statistical analysis and its interpretation appropriate?**
I cannot comment. A qualified statistician is required.

**Are all the source data underlying the results available to ensure full reproducibility?**
Yes

**Are the conclusions drawn adequately supported by the results?**
Yes

**Competing Interests:** No competing interests were disclosed.

**Reviewer Expertise:** Epidemiology and control of schistosomiasis.

I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard, however I have significant reservations, as outlined above.

---

**Author Response 24 Aug 2020**

**Amaya Bustinduy**, London School of Hygiene & Tropical Medicine, London, UK

We thank Prof Odalbo for his helpful comments. To respond to his queries, this is a point by point response.

- No information was provided on the number of participants recruited for the study.

We apologize for any confusion, the information about total number of participants recruited can be found in the “Abstract” and also on page 6 under “Results” in the 1st and 3rd sentences in our final submitted manuscript. For convenience, we have highlighted this in the accompanying manuscript.

- It is not clear from the article if there was a common sample collection centre for all participants or sample collection was done at the residence of each participant.

Thank you for this input. We have added your point regarding sample collection was done on method section, sub section “Sample Collection and Questionnaire” line 6.

- What was the Schistosoma haematobium infection status of the participants at the time of study?

In the “Results” section we have now included the schistosome infection status of the participants in the study. We used both urine microscopy and Circulating Anodic Antigen (CAA). As the CAA is not species-specific, we have expressed infection status as “active schistosome infection”.

**Results:**

- Figure 2 is superfluous and what is the relevance of the table under result?
Thank you for your review. Figure 2 is the BILHIV Study Flow Diagram. We thought providing this information to readers might provide transparency regarding the included participants and enhance interpretation of the study's generalisability.

In terms of the tables in the “Results” section:
Table 1 describes the baseline characteristics of 603 study participants
Table 2 gives more information regarding experiences women had during self-sampling.
Table 3 describes the results of the patient experience surveys for 603 study participants
Table 4 describes the demographic factors associated with the choice of home-based sampling over clinic-based sampling. We feel these tables should be maintained.

- No information on how the home-based sampling by the women compared with the clinic sampling done in this study, instead readers are referred a paper that is still under review.

Thank you very much for bringing up this point and for any inconvenience. In the third paragraph of the “Introduction” we describe that “the BILHIV study found that Schistosoma DNA was more frequently detected in genital self-collected specimens compared to clinic-collected cervicovaginal lavage”. At the time this manuscript was originally submitted we had not yet published the main results for the BILHIV study, however the paper that was under review is now published and it is cited as reference number 19.

Discussion:
- The authors may need to rephrase the first sentence under discussion to avoid starting the sentence with an abbreviation (FGS).

Thank you for this input. We have rephrased the sentence starting with abbreviation FGS under “Discussion”, line 1.
- Schistosomiases should be changed to schistosomiasis.

Thank you for your observation. We have changed ‘Schistosomiases to schistosomiasis’ under “Conclusion” in line 2.

**Competing Interests:** No competing interests were disclosed.
with only minor discomfort/distress, if any. This approach of home sampling as an alternative to urogenital sampling in a clinical setting seems attractive by providing the women elements of individual convenience and privacy.

However, as also presented in the discussion, the study findings may not necessarily translate to the same extent into other communities in sub-Saharan Africa, mainly because a bias being potentially implicated due to previous study activities taking place in the populations before the self-sampling study. Therefore, another study should be performed, and preferable in different schistosomiasis endemic communities in Southern Africa to control for the potential bias.

Other comments:
- Inclusion criteria (e.g. age, non-pregnancy) are not stated in Methods.
- Why inform about a pending paper by Stuart et al.? More interesting to know about a probably pending paper presenting the lab findings (SH DNA).
- A 5-point Likert scale has been used. This information should be presented in the Methods and not in the Results.
- No information whether the questionnaire was performed anonymously or not, apparently not if one looks at the field image. Then there would have been a unique opportunity to uncover various reasons for reported lack of confidence, acceptance, comfort etc – even only reported in a minority of the women.
- Is information about the different dialects in Table 1 of interest for the reader?
- Interesting that 32.3% of women are given the status as “Not working”.
- Information about Childhood water contact seems not that relevant (recall-bias) in adult women.
- How has self-reported history of schistosomiasis been assessed?

Results
- N=603 stated 17 times. Should be adequate to mention once, the number of study participants.
- Confusing that the percentages in Table 3 (I don’t have transportation, I have more privacy at home) are different from those in the main text (17.7% vs 15.9%; 65.0% vs. 58.5).

Discussion
- FGS is a chronic gynaecological condition that afflicts vulnerable women... What is meant by “vulnerable”?
- Current diagnostic strategies are limited as they rely on resources that are seldom available in low-income settings. Self-sampling does not contribute significantly to solving this problem, only to minor extent, having the women to perform the sampling themselves instead of a health care provider (e.g. a nurse). Other major cost will remain, including lab technicians, equipment, reagents etc.
Participants should always be acknowledged.

Is the work clearly and accurately presented and does it cite the current literature?
Yes

Is the study design appropriate and is the work technically sound?
Yes

Are sufficient details of methods and analysis provided to allow replication by others?
Yes

If applicable, is the statistical analysis and its interpretation appropriate?
Yes

Are all the source data underlying the results available to ensure full reproducibility?
Yes

Are the conclusions drawn adequately supported by the results?
Yes

**Competing Interests:** No competing interests were disclosed.

I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard, however I have significant reservations, as outlined above.

---

**Author Response 20 Aug 2020**

**Amaya Bustinduy,** London School of Hygiene & Tropical Medicine, London, UK

In this manuscript, results from questionnaire in a urogenital self-sampling study are presented addressing schistosomiasis infection in women aged 18-31 living in Zambia. Overall, the conclusion is clear. Self-sampling is very well accepted by the women, and apparently with only minor discomfort/distress, if any. This approach of home sampling as an alternative to urogenital sampling in a clinical setting seems attractive by providing the women elements of individual convenience and privacy.

However, as also presented in the discussion, the study findings may not necessarily translate to the same extent into other communities in sub-Saharan Africa, mainly because a bias being potentially implicated due to previous study activities taking place in the populations before the self-sampling study. Therefore, another study should be performed, and preferable in different schistosomiasis endemic communities in Southern Africa to control for the potential bias.

**Thank you for this input. We have added your point regarding performing other studies in schistosomiasis endemic communities in different regions to the discussion. Lines 67-70 under discussion.**
Inclusion criteria (e.g. age, non-pregnancy) are not stated in Methods.

We apologize for any confusion. In the BILHIV study, women were eligible if they were sexually active aged 18-31 who were not pregnant and had previously been recruited for the HPTN 071 (PopART) population cohort were eligible for inclusion in BILHIV. In the on-line version (https://wellcomeopenresearch.org/articles/5-61) the inclusion criteria are stated in the first sentence of the abstract methods. In the main manuscript, the inclusion criteria are stated in the Methods section in the second sentence methods under “study setting and participants”. In the tracked-changes manuscript we have highlighted these areas for clarity.

Why inform about a pending paper by Stuart et al.? More interesting to know about a probably pending paper presenting the lab findings (SH DNA).

We agree that the section in question should be modified. In the section “Sample collection and questionnaire” in the final sentence, we have removed the wording “Sturt, A et al. paper under review” and instead we reference the BILHIV study manuscript. As you have suggested, this manuscript provides the full laboratory results.

A 5-point Likert scale has been used. This information should be presented in the Methods and not in the Results.

We apologize for any confusion, the information about the Likert scale was included in the methods section in our final submitted manuscript, but it seems not to have been uploaded into the online manuscript. We have highlighted this in the accompanying manuscript.

No information whether the questionnaire was performed anonymously or not, apparently not if one looks at the field image. Then there would have been a unique opportunity to uncover various reasons for reported lack of confidence, acceptance, comfort etc – even only reported in a minority of the women.

You are correct that the questionnaire was not performed anonymously. We have clarified this in the methods.

Is information about the different dialects in Table 1 of interest for the reader?

Thank you for this input, although we agree with the reviewer that dialects are not directly of importance to the study outcome, we would like to keep them in the table as they contribute to a more holistic appreciation of the study participants and their background. This may be of interest for certain readers.

Interesting that 32.3% of women are given the status as “Not working”.

We agree that this is interesting. The women were asked the question “are you
Currently working?” with yes/no answer. These data reflect their self-reported response to this question.

Information about Childhood water contact seems not that relevant (recall-bias) in adult women.

We agree that the variable regarding childhood water contact is subject to recall bias. However, we thought this information would provide the reader with information regarding the participant’s perceived level of exposure.

How has self-reported history of schistosomiasis been assessed?

The self-reported history of schistosomiasis was not further assessed beyond the participant’s self-report.

RESULTS

N=603 stated 17 times. Should be adequate to mention once, the number of study participants.

Thank you for this input. We have repeated the total enrollment number to clarify the denominator for many of the presented proportions.

Confusing that the percentages in Table 3 (I don’t have transportation, I have more privacy at home) are different from those in the main text (17.7% vs 15.9%; 65.0% vs. 58.5).

Thank you for catching this! Outcomes for this variable should be divided by the proportion of women in the sampling category (prefer to sample at home, n=543). In the abstract and the main text, these proportions were mistakenly reported out of 603. The correct proportions are reported in Table 3. This has now been updated in the manuscript.

DISCUSSION

FGS is a chronic gynaecological condition that afflicts vulnerable women… What is meant by “vulnerable”?

In the setting of environmental health emergencies, the WHO describes vulnerability as “the degree to which a population, individual, or organization is unable to anticipate, cope with, resist, or recover from the impact of disasters”. We feel this vulnerability also describes well the plight of women in sub-Saharan Africa in relationship to FGS, as an underreported neglected ailment. Thus, we suggest that the term could be maintained.

Current diagnostic strategies are limited as they rely on resources that are seldom available in low-income settings. Self-sampling does not contribute significantly to solving this problem, only to minor extent, having the women to perform the sampling themselves instead of a
health care provider (e.g a nurse). Other major cost will remain, including lab technicians, equipment, reagents etc.

Thank you for this input. We agree that many of the other costs will remain and we have attended to this in the manuscript discussion. However a full cost-effective analysis was beyond this pilot work.

Participants should always be acknowledged.

Thank you for bringing this oversight to our attention. We have acknowledged the participants.

**Competing Interests:** No competing interests were disclosed.