Implementing cervical cancer screening in Bulgaria: what are the health system-level constraints that should be addressed?

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Introduction

Bulgaria has experienced a dramatic rise in the incidence of cervical cancer, from 15.8 per 100,000 in 1988, to 27.3 in 2002, among the highest rates in Europe and the Former Soviet Union (HfA, WHO 2004). Mortality from cervical cancer in all ages has grown since the 1980s, and in 2001, it was twice the EU levels (6.4 per 100,000, compared to 2.5 EU average), although it started from a lower base during the 1970s. (Figure 1).

Figure 1. Standardised Mortality Rate, cervical cancer (0-64), per 100,000
A plausible hypothesis for these increases may be that the underfunding and transformation of the health care system has hampered the availability and affordability of routine cervical cancer screening in Bulgaria. Cervical cancer is being diagnosed at later stages and the previously ubiquitous mass screening is non-existent.

There is now an increased understanding that conditions, such as diabetes, tuberculosis, and cervical cancer, require complex health system response at different levels, integrating prevention and treatment, continuity of care and information flows across the health system. (Coker, 2004). We argue that a framework including a series of interlinked inputs, such as physical resources, human resources, intellectual resources; and social resources (McKee & Healy, 2002; Hopkinson et al, 2004), is useful in developing strategies to contain cervical cancer morbidity and mortality in Bulgaria.

Methods

The study was conducted in the framework of the “Psychosocial and Health Systems Dimensions of Cervical Cancer Screening in Bulgaria and Romania” project, a collaboration between the Health Psychology Research Center in Bulgaria, the Department of Psychology at the Babes-Bolyai University in Cluj-Napoca, Romania and EngenderHealth, USA.

Data were obtained through 20 (?ut of 50) semi-structured interviews and 6 focus group discussions with health care professionals in Bulgaria conducted in the spring and summer of 2004. Data were collected in the capital Sofia and in four regions, seeking to achieve a diverse representation of staff working at different levels of the system and types of facility. Key informants from major national and donor institutions with relevance to cervical cancer screening were also interviewed. Analysis is in progress, and the paper presents the preliminary findings.

Results

The study drew on a theoretical framework based on the premise that for a functioning screening system, a series of interrelated physical, human, intellectual and social resource inputs will be required. The results are presented following this logic.

Physical resources

The study found that the level of physical resources necessary to conduct cervical cancer screening is adequate. A large majority of respondents report that they have the equipment and consumables available at their health facility (brushes, slides, fixating agent etc.) to perform smear tests.

However, often there is a reliance on ad hoc arrangements for transportation of the slides, which could create inefficiencies or other problems. This is reported especially in the
small settlements, where physicians tend to use any available opportunity to send slides to the laboratory they work with, for example, using ambulances travelling to the district centre, occasional couriers, or delivery during personal travel. Transport infrastructure and links in most areas are appropriate, it is rather the arrangements that could create problems such as some delays of receipt of results, or potential damage to the slides due to inadequate protection of the sample. However, such occasions are rarely reported.

“We are taking these (the samples) in person. Either me, or the nurse, or the midwife … My practice is to take them to the lab once a month…It takes 20 days to month…If a person (patient) takes the sample by themselves, results could be available the next day … (GP, small town)

Effective laboratories are a major building block of any screening campaign. Findings showed that routine laboratory procedures are heavily dependent on the judgement of individual practitioners, with little use of peer review or quality control. Usually physicians choose to work with a designated laboratory if they are personally familiar with the lead cytologists working there, especially in the smaller towns. The relationship with a particular laboratory is stable over time.

“How could we question the test results given by our colleagues?… They are specialists… If we have doubts, we wouldn’t be sending the samples there!” (gynecologist, hospital, small town)

In some cases (mainly Sofia), where there are no close links or where the links with a certain laboratory are not established by staff themselves, but are externally enforced, or patients have access to different labs, confidence appears lower. In Sofia, the National Oncological Center is often perceived as the highest authority in analysis of smear tests. However, due to capacity limitation, the use of other (often private) labs is required, but considered a second best option.

Most respondents are satisfied with the work of the laboratories, based on whether they provide quick, reliable service or have sufficiently senior and experienced staff, and whether they trust the respective specialist.

Results are usually returned to the physicians’ office by courier, or by patients who collect and bring these back (a more typical scenario in Sofia). The length of time required for the results to be returned to the physician depends on the individual circumstances, distance to laboratory and type of transportation used.

Usually the patient is informed about the outcome of the test when the results are back. It is rare that women do not receive results. In cases, where the result is positive, most physicians report actively seeking to contact and inform the women. For example a nurse may ring them at home or in smaller towns, visit them. Some women receive their results by telephone.
“Usually we receive the results by post or by hand, in batches. It is rare, only when there is an expectation for a very problematic result, then we call the lab and an individual result could be sent by post or personally delivered… by relatives or else.” (gynecologist, hospital, small town)

“The result is given personally to the patient and she keeps it. It could also be given to her GP, it could be included in her personal file if any.” (gynecologist, hospital, small town)

One of the major problems is the lack of suitable arrangements related to cervical cancer screening. These include inconvenient working hours of referring physician, lack of appointment system at GPs, lack of specific clinics dedicated to smear test, etc.

“The GPs should hire a medical secretary. Even a high school student of an average intelligence could design the software... The software should show the ones who are due for a check-up. A month in advance a notice should be send ... And this should be regulated legally – that they will receive an invitation for a checkup...If they don’t show up, this should be recorded, and the next checkup should be paid...” (gynecologist, big hospital, Sofia)

Despite the apparently reasonably resourced system, there is a major problem with the lack of an unified patient information system. The GPs have information about their own patients, in hard copy and electronically. The insurance fund collects data on utilisation (a form is filled for each visit) for the services that it funds, with this data used mainly for financial management. The private obstetrician-gynecologists (not contracted by the National Health Insurance Fund (NHIF)) do not report or provide feedback to the patient’s primary health care (PHC) provider or to the Ministry of Health (MoH). The information for each patient is not integrated and accessible at one place and point in time, which leads to gaps and duplication in cervical cancer screening.

In addition, a sizeable proportion of women are either uninsured, not registered with a GP, or are hard to reach using conventional health service. The issue is complicated by the fact that women are able to access providers in different geographical areas and may have more than one PHC provider, in the public or private sector. Thus, within the health system there is no unified list of all women that are in need of smear test, based on which to introduce a call-recall system.

**Human resources**

The study suggests that there is a relatively good level of human resources, both in numbers and specialities (GPs, obstetrician-gynecologists, cytologists). The GPs receive a basic training in obstetrics and gynecology, which does not give sufficiently specific training to conduct cervical cancer screening. They are generally unwilling to take smears mainly due to the good supply of gynecologists and the lack of specific skills among GPs, but also due to persisting narrow specialisation in the health care system, and marked patient preference that smear test is better done by specialists. There is a strong view among most stakeholders (both GPs and obstetrician-gynecologists) that GP’s are not equipped to conduct smear tests.
“...I was very surprised when the GPs had to take smear tests. First of all, they were unwilling to do it, second, many of the more conscientious ones said ‘it is better for a specialist to do it. The patients also were surprised that the GP would do it, and prefer to go to gynecologists’” (gynecologist, focus group, Sofia)

“Despite the fact that they know I used to be a gynecologist, I have a problem ... convincing them that this is something that is important and has to be done... Usually the Bulgarian woman comes when she already has a problem...and by then cervical cancer is difficult to treat” (GP, small town)

The gynecologists have adequate training and are currently conducting almost all smear tests. According to a respondent, who works in a big hospital in Sofia and who is a certified trainer of GPs in reproductive health care, every obstetrician who works in the PHC institution is required to have a certificate for performing colposcopy and ultrasound scans. Nevertheless, there are concerns for the quality of training to conduct colposcopy (key informant, oncologist in a district dispensary), as well as limited experience with it.

It is a widely recognised that screening is valuable as a method to control cervical cancer, although there are some misconceptions. For example, there are contradictory views on who is more at risk (young or older women; those with risky behaviour; having children or not), and how often the screening should be conducted (many stated that the recommended (maximum) screening interval should be 6 month to 1 year). Others use simple visual assessment prior to smear test, whose effectiveness is not supported by evidence.

For the laboratory staff, pathologists who have specialised in cytology are seen to be most qualified to analyse smear tests. The general view is that there are sufficient numbers of cytologists in view of current demand. Moreover, due to the declining number of smear tests compared to the socialist period, some cytologists are becoming disqualified due to lack of sufficient practice. The basic training provided within the core medical training curricula is not up-to-date in view of the internationally accepted evidence and is not sufficiently specialised in cytology (according to a key informant). In order to receive qualification they have to undergo post-graduate specialisation and a course in cytology, which in many cases is financed out of pocket. The lab technicians have mainly assisting functions (due to the predominantly manual lab analysis), while the responsibility lies with the lab cytologist. Some cytologists provide specialised training for technicians at the workplace, but the latter still do not work independently.

According to the current regulations, biologists could also analyse smear tests, but with supervision from cytologists. However, cases of biologists working unsupervised were reported. The general view among health professionals is that the qualified cytologists are the only competent and reliable specialists to analyse smear tests.

“...smears should be interpreted by morphologists. In the West there are lab technicians, but they have higher qualification than our biologists...Biologists cannot make the
connection between the clinics of the illness, the pathology and cytology. Therefore I am absolutely against participation of any other specialists in analysis of smears.”

In order for the system to work, an informed female population, willing to attend screening, is also an essential resource. There are serious problems with access to information and awareness, which are indicated by the nationally representative survey in Bulgaria, discussed in another paper. It is important to understand the health system circumstances that obstruct access to information.

“...once a year every woman, who is sexually active or is 19-20 years old, has the right to a checkup, including a smear test, if the doctor decides to do it. These things exist but nobody is doing it. If you conduct a survey among the staff of this hospital, mostly women; and among the current inpatients...They will tell you that they go for (any) exam 3-4 times a year. If staff is not going for exams, what about the other people” (gynecologist in a hospital, Sofia)

Patients chose a GP but they do not view them as their personal physician and rely on them for information and advice. The GPs report that they are unable to allocate time and resources to preventive activities, even where they are aware of their importance.

“It is even not technically possible, because to do something like that (screening), you have firstly to check patients telephones from A to Z, so that the nurse could start calling them and explain. This is stressful, and when not paid, is a burden... But when they (women) come and seek care, it is much easier. (GP, big town)

The general pattern of health care seeking behaviour in Bulgaria is that medical care is sought only in case of serious or unusual symptoms, which could not be self-treated (Balabanova & McKee 2002). On the one hand, the prevailing attitude in the health care system is one of paternalism and lack of patient empowerment to take care of their own health. Patients are not encouraged to inquire about, demand smear tests, are often unclear about their rights to do so, and are not routinely informed about the need for screening and procedures. On the other hand, given the limited resources for health care currently, prevention is seen by many stakeholders as unrealistic, time consuming and associated with the old regime, and thus, not a central part of their activity.

The main thing is that the PHC starts to work properly, as it should, with a preventive orientation... On the one hand, there are patient’s rights... there are ten rules, accepted by WHO, by NGOs. They are about right to information, to equal access to care... But those working in the health care system also have rights. Until the population is not taught some rules ...with sanctions or other... to observe these rules, the situation will not improve. (gynecologist in a hospital, Sofia)

The policy-makers are an essential part of the HR requirements of a functioning screening programme. Although there is recognition of screening as the most effective strategy for cervical cancer prevention, there is uncertainty as to how to implement a working screening programme in the current situation in Bulgaria. Solutions are targeted to specific areas, instead of addressing the system as a whole and the way it operates.
Consequently, there is little collaboration between different stakeholders to address generic system issues, rather than a series of fragmented problems.

“So, there are inadequate linkages between different departments in the Ministry (of health). For example, I don’t know who is writing the programme and what is included in it. And because it is written by physicians and not by public health people, prevention is forgotten, or only the preventive checkups are included but not the health education… It was a similar situation with the programmes for mental health and for TB – there is very little about prevention, while it should be prioritised…because we need to reduce the number of people to be treated (key informant)

A significant number of stakeholders share the view that NGO could play a key role in informing the population, monitoring existing service and organising services for hard-to-reach groups. They are seen as flexible, not constrained by the existing institutional framework; and well placed to campaign for more effective action. However, there a significant share of pessimistic views as to what could be achieved as change of the health system at this point in time, and many see a critical need for external pressure (from patient/civil society groups) to change the situation.

Many respondents thought that there is no institution that could effectively enforce and control the application of the existing screening programme. A number of respondents suggested that a new institution involving a range of stakeholders should be made responsible for implementing and controlling the overall cervical cancer screening process and its linkages to other levels of care. Among many respondents, there is a definite lack of trust in the MoH as an institution able to implement screening programmes.

**Intellectual resources**

Currently, the former mass screening for cervical cancer organised through the workplace has been largely replaced with opportunistic or spontaneous screening. In the past, mass coverage was possible because a large majority of women were working and were concentrated in the state sector. Presently, screening is practiced on an ad hoc basis, with little formal guidance from national or district level institutions. In effect, the system is chaotic, with women obtaining smear tests in different circumstances, locations, and at different intervals. There is no effective call-recall system. Respondents who also worked under the old system, often believe that “it is better t? have a bad system than no system”.

“There is no organised prevention anymore… as it was 10 years ago. The orderly system for mandatory preventive checkups …where using financial and administrative methods women were driven to the gynecologist for smears once every 1-2 years, has disappeared. Unfortunately in recent years… the number of preventive checkups has markedly decreased” (gynecologist, Medical University, Sofia)

“For example, a patient living locally receives a result III B (PAP). However she is angry, can’t believe, and goes to five other places in a search for a good result...When
she applies to private facilities, she doesn’t give them information about previous results. This happens often.” (gynecologist, focus group, Sofia)

According to the providers interviewed, the typical case is a woman with some symptoms seeking health care. Another slightly less common case is when women seek preventive gynaecological examination, but these are women who had a problem in the past. Even less common are cases of women who are informed and actively seek preventive care.

The second major problem is that coverage with cervical cancer screening is not systematic enough. In 2003, the National Health Insurance Fund funded only 100,000 smear tests, compared to the 650,000 required according to the National Strategy for Preventive Oncological Screening commissioned by the MoH and prepared by a team of experts in various fields. Moreover, many health providers report that according to the existing regulations, every woman has a right to one Pap smear yearly. However, in practice there are limits to the number of smears that are conducted in different facilities due to the need to channel scarce resources to curative rather than preventive care.

“We have limited resources. Having 200 Leva per month for different tests, and given that a smear test is 3 Leva, not many tests could be covered. Care is financially rationed by the Health Insurance Fund. It’s a paradox: there is talk of prevention, caring for population health, but... those who would like a smear test are required to pay, which is not right because these people have insurance.” (gynecologist, big hospital, Sofia)

Recent estimates show that not an insignificant proportion of the population do not have health insurance, and many people are not registered with a GP. In addition, there are people registered with a GP who do not seek care there, but receive treatment in the private sector or self-treat. All this means that a there is a proportion of women who may not be in contact with a health professional on a regular basis and may not be offered a smear test. Moreover, there are gaps in coverage - groups that are either marginalised (minorities/ older women/ migrants/ seasonal workers abroad) or do not seek care as often as appropriate due to religious beliefs. Elderly and post-menopausal women, who have a higher risk of disease, are reportedly less likely to be offered or to seek smear test.

This shows that introducing mass screening is a relatively complex task given the serious coverage problems. However, the mass perception is that implementing it is relatively straightforward, subject to adequate resources, and that it should be obligatory for all. There is a strong support among most respondents interviewed, for sanctions to women if they avoid or not actively seek smear tests.

“It is not difficult to organise screening, not much money is required... Smear tests should be obligatory, otherwise women wouldn’t come. Women who are willing to have smear test just go for it. There is no screening, which could cover those people who do not feel like going to health facilities. So they should be forced somehow” (gynecologist, private health center, Sofia).

There are serious health system-level obstructive factors. These include complicated referral procedures favouring acute illness and funding packages not promoting
prevention at primary care level. The National Health Insurance Fund finances limited number of referrals to secondary care per month per GP, in effect rationing care. Having to allocate these according to most urgent need, the GPs refer patients with acute and chronic conditions, and are often forced to sideline cervical cancer prevention.

“There are a set number of free referrals for smear tests, and I have to play God, and decide who should get it and who shouldn’t – it is not right for me to determine this according to my own views” (GP, small town)

Many doctors were fully aware of the detrimental effect the chaotic access to screening has on mortality and morbidity. Some women are reportedly tested every 6 months, while others have never had a smear test, due to fatalism, inconvenience of obtaining a test or lack of information about the benefits of screening. There is a common perception among health care professionals that women do not understand the purpose of the smear test, do not ask for it and have “insufficient responsibility for their own health”.

“There should be great emphasis on mass screening… like in the West. Most importantly, women should be taking care of their health” (gynecologist in a hospital, small town)

“The role of the gynecologist is also important. Even a woman, who is seeking care for other reasons, should be told what is the purpose of a preventive check-up or at least asked when was the last time she had a smear test. … and for two minutes to explain why this needs to be done annually.” (gynecologist, University hospital, big town)

While until recently the GPs were responsible for organising (or in rare cases, performing) cervical cancer screening, it is now handled by gynecologists, working in the Diagnostic Consultative Centres (former policlinics). Sometimes GPs are not aware of the current regulations and are not being properly briefed. They know that PAP smears are not included in the annual preventive package any more but they do not know whether the policlinic gynecologists are obliged to perform preventive checkups.

While this development seems to be welcomed by most health care professionals interviewed, it has in many cases negatively affected continuity of care, providing little opportunity to the GPs to follow-up their patients. The inherited system of vertically organised dispensaries does not fit well with the rapidly changing health system, and there is tension between acute general hospitals and specialised oncological dispensaries about who is responsible for what type of treatment.

It is important to clarify how women obtain smear tests. GPs are required to conduct an annual preventive exam, obligatory from 2004. However, it is identical for men and women and monitors the general physiological status, and does not include a preventive gynaecological exam. The decision to refer women for preventive gynaecological exam at a higher level facility rests with the GP.

“I have observed that there are fewer women who are diagnosed with an early stage cervical cancer. But I am not sure whether the numbers are falling or they are not tested,
and go directly to the Oncological dispensary with more advanced forms of cancer”.
(gynecologist, big hospital, Sofia)

On the other hand, even those who are referred for preventive checkups are not always offered a smear test, contrary to what is envisaged in the newly enacted ‘Standard of gynaecological care’. Women who seek care because of particular symptoms are not always asked when they have had their last smear test.

PAP is the universally used classification system. Most physicians practice according to what they have learned in the medical school, and do not refer to clear rules and standards formulated either at national or facility level. There are no clear unambiguous practice guidelines for performing screening concerning screening interval, call-recall, or minimum level of information provided to users.

There are serious questions about who is (or should be) responsible for the cervical cancer screening. A system and institutions able and equipped to ensure and monitor coverage, and which could be held accountable for it, are absent. It was even suggested that institutions from outside the health care system should be heavily involved, for example NGOs informing the population. It is widely believed that women are currently responsible for looking after their own health, and in many cases this was seen as a logical result of the more limited state role in the health system. While the MoH has the expertise in preparing national level strategies, it does not have the resources (in contrast to the NHIF) or legitimacy required to conduct mass screening.

“The Ministry of Health has guidelines that smear tests should be taken once per year, but unfortunately this is not obligatory for women. We are the ones who should be actively influencing public opinion and women, to attend screening” (gynecologist, Sofia)

Social resources and networks

The major problem within the system for cervical cancer screening are the linkages between different levels of specialists. In practice, when a person has had a smear test, results are not always received by the referring physician. Often there is reliance on patients to bring their results back from the lab to the specialist, and to inform the GP. There is no formal procedure for communication between the GPs and the gynecologists. The GPs do not have formal mechanisms to follow-up and request information about their patients, and in many cases are not informed about subsequent stages of disease, unless the patient decides to do so. GPs can trace the patients if needed, but do not have a link with specialists, which leads to duplication and gaps in care.

There are also no linkages between financing and planning of smear tests. In general there is minimal collaboration between the main stakeholders in the health system. The Ministry of Health develops national strategies but with little resources to implement them; while the NHIF acts as the main purchaser of care, but has insufficient leverage to change clinical and organisational practice. The National Strategy for Oncological
Screening is not translated into practical activities or linked to designate funding. There is little dialogue and coordination between the two institutions to coordinate planned with actual activity. In effect, financing is insufficient, unsustainable and intermittent. The Bulgarian physicians union have little role in influencing provider practice.

There is a lack of clear and properly channelled communication and provision of health information within the health care system. Findings show that information about screening is often seen as an on-off campaign rather than a routine activity integrated with health services, similarly to the case of the breast cancer. In most cases, it is up to the health professional to provide the explanation, with little support.

“Society should be involved, mass media, films...The MoH should raise the profile of screening and initiate a wide debate.” (gynecologist in a hospital, small town)

“Every woman could be reached somehow, First, explanation, mass information – this is important. TV programmes, information leaflets about cervical cancer – there are examples from 20 years ago prepared and disseminated by Hygiene and Epidemiology Directions who had budget for such activities.” (gynecologist in a hospital, small town)

However, from the survey among women conducted as a part of this project, it is evident that around 50% of women are unsure about cervical cancer and its prevention, despite having relatively regular gynecological examinations. This indicates that providers often do not provide sufficient information. Usually provision of general information about screening is seen as peripheral to the essential care, and to be provided by institutions outside the health system. Physicians recommend that information is provided through the media, civil society or patient groups. The idea that prevention might require input by different actors (within or outside the health system) is not commonly mentioned.

There are also issues with the linkages between primary health care specialists (gynecologists working in polyclinics or GPs) and the secondary and tertiary levels of the system, as well as between gynecologists working at secondary care level and those working at the specialised oncological facilities. Oncologists working at dispensaries provide a service to those with some level of malignancy, with follow-up tests or procedures done at the same place. However, some oncologists reported that gynecologists do not immediately refer suspect cases to them, but attempt to treat them themselves (especially in the private sector) and the treatment is not as effective as it could be. In general there is confusion among the PHC providers on where to refer people with different level of positive results, where are smear tests available for free, and who should be tracing specific groups of patients. Thus, PHC staff would often refer to the secondary care hospital in their catchment area, or to a remote oncological dispensary, which may be less accessible for the patients.

Discussion & Policy recommendations
The study indicates that in most cases the physical capacity, human resources and skill base to perform smear tests are present in Bulgaria. Therefore, the reasons for the patchy screening lie in the dynamic reform state of the health system and the way it is funded and regulated. Important inputs that are currently problematic include: enabling responsive and evidence based screening programmes; as well as the ‘social inputs’ such as communication and linkages across different levels of care, as well as embedding ethos of empowerment of patients through raising health awareness.

There is clearly a need for a more consistent leadership from the national level, underpinned by financing, and commitment to implement the existing strategies to combat cervical cancer, with the involvement of a range of stakeholders – inside and outside the health system.

Providing integrated information for each patient aggregated by a specific institution (MoH or other) is necessary in order to start an effective screening procedure. Ultimately, there should be a list of all women eligible for smear tests. GPs and other PHC providers – if managing a mass-screening programme, must have feedback about subsequent treatment or patient status.

Ideally, there should be an integrated information system across facilities and levels of the health system. However, in the mean time, given the pluralistic provision and unrestricted access to a variety of providers, it could be suggested that people should have a personal health ambulatory card in which all major preventive care is recorded, and it is monitored by the GP.

The study findings suggest that there is a need for redesigning of the referral system. Currently, it is to some extent a financial instrument for reimbursement employed by the National Health Insurance Fund, and the doctor’s decision is severely constrained by the number of referral forms available. In a system traditionally oriented towards curative care, this means that preventive activities, including cervical cancer screening, are de-prioritised. Some possibilities include to separate the curative from preventive referrals, and to have an earmarked fund for prevention.

There is a great need for concerted action between stakeholders who plan screening strategies (MoH), and those who mostly finance care (NHIF, municipalities), and monitor preventive activities. There should be clear division of responsibility. There should be resources allocated for developing a (computerised) call recall system for cervical cancer screening.

Study findings show that many see provision of information as external to the health system, to be done by the civil society or other institutions. Clearly, a successful public health information campaign would require intersectoral action, to include providers, who are at the frontline of care. There is recognition that information should not be provided through campaigns, but should be part of the routine preventive and curative obstetrics and gynaecological care; and should become integral part of the screening procedure.
To increase access to cervical cancer screening different strategies could be required for different groups. For those employed, it could be through workplace and employer-organised examinations. In remote areas, travel clinics or visiting specialists organised through GP offices, could be applicable. To include other more problematic groups, support and advice from local leaders or opinion formers could be sought.

The study finds that most providers and key informants strongly support that the preventive gynaecological exam should be obligatory, and sanctions be levied to those who do not attend. Indeed, the new Law on Health (passed in 2004) envisages sanctions for those who do not attend general preventive exams, and there is a possibility that smear tests are included as well. Smear tests could possibly be included in the preventive package managed by the GP. However, clearly systems to provide mass screening are not effective currently, and there are women who would not be able to obtain free examination in the state sector. Clearly making screening obligatory, without improving accessibility and acceptability of services is a simplistic solution. In addition, there is no mechanism for complaints and providing feedback on the failure of the screening system. The issue is even more fundamental as it concerns the individual right to consent to a medical procedure.

The study shows that the existing National Strategy for Preventive Oncological Screening should be updated to include information on how the system should be managed, on information flows, and on overall responsibility for follow-up of the patient. This should cover the public and the private sector. It should be linked to necessary financial resources if it is to be meaningful.

References


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