IRISH FAMILY PLANNING ASSOCIATION

SUBMISSION TO THE

NATIONAL CERVICAL SCREENING PROGRAMME

November 2007

INTRODUCTION

The IFPA (Irish Family Planning Association) is a national voluntary organisation and registered charity which has been pioneering sexual and reproductive health and rights in Ireland since 1969. For the past 38 years, the IFPA has helped people make informed choices about their sexual and reproductive health (SRH) through high quality SRH clinical services, counselling, education, training and advocacy. Each year, over 30 000 people attend our medical and counselling centres and over 200 doctors, midwives and nurses from all over Ireland participate in our bi-annual professionally accredited family planning course. The IFPA is recognised as a source of expertise in the area of sexual and reproductive health and rights.

The IFPA welcomes the development of a national cervical screening programme and is pleased to participate in the submission process in advance of the national rollout. The IFPA has advocated for the implementation of a national cervical screening programme for over a decade as an essential component of a comprehensive sexual and reproductive health strategy, public health policy and preventative health care for women. IFPA doctors and nurses are trained and experienced smear takers, providing on average 7000 smear tests each year.

This submission outlines the ways in which the IFPA's experience can inform the practical implementation of the National Cervical Screening Programme.

CONTEXT

Annual Irish figures from the Women's Health Council (2006) report:

- Over 180 women are newly diagnosed with cervical cancer;
- Over 800 women are diagnosed with precancerous lesions of the cervix;
- 73 women die from cancer of the cervix;
- Trends in mortality from cervical cancer since 1978 show an increase of 1.5% per year.

Well organised and well resourced screening programmes have been proven to dramatically reduce the mortality rate of cervical cancer through early detection and prevention. In the UK, since the introduction of its national screening programme in 1988, it is estimated that the deaths of at least 5 000 women each year have been prevented at a cost per life saved of £36 000 (Peto, Gilham, Fletcher & Matthews, 2004). The World Health Organisation (WHO) vigorously recommends all countries to implement a national screening programme and states that scientific and medical advances in prevention and intervention methods (such as vaccines and screening programmes) have the capacity to eliminate cervical cancer as a killer of women. (Ullrich, Garwood & Clayes, 2007)

The IFPA promotes a holistic concept of sexual health that is not only defined by the absence of disease but also by complete mental, physical and social well

being. In this respect, the National Cervical Screening Programme (NCSP) and the IFPA have analogous objectives of ensuring the health and well being of women and of always developing policies and practices that are focused on delivering the best possible service to women.

SCREENING INTERVALS

The NCSP has announced that women between the ages of 25 – 44 will receive a free screen every three years and women aged 45-59 will receive a free screen every five years. The IFPA is in agreement with these screening intervals as they reflect best practice guidelines from the WHO's *Comprehensive Cervical Cancer Control: A Guide to Essential Practice* (2006) and are the most cost effective intervals that also prioritise the health and well-being of women.

RESULTS & FOLLOW UP

In order to reduce undue anxiety for women, the IFPA agrees with the target time of four weeks for women to receive their results.

It is unclear at this stage what roles the smear takers will have in relation to follow up of abnormal cell results. Clear demarcation of roles and responsibilities of smear takers and the NCSP is an essential element of a successful screening programme. The NCSP must also communicate these roles and responsibilities to women participating in the programme and registered smear takers to avoid duplication of tasks, confusion for women and most importantly to ensure no woman who needs treatment is omitted.

THE ROLE OF FAMILY PLANNING CLINICS

Family planning clinics (FPCs) play a critical role in national cervical screening programmes. As promoters of sexual health and providers of sexual health services, the IFPA advocates for regular cervical screens as part of a general women's health check up and an integral component of achieving sexual health. From a public health perspective, cervical screening in FPCs is especially valuable because it provides an opportunity for women to start a dialogue with experienced practitioners about other preventative sexual health measures such as contraception use or sexually transmitted infection (STI) screening. The reverse situation, where a woman attends an FPC for contraception or STI advice, for example, also provides the nurse or doctor with an opportunity to discuss the importance of having a Pap smear.

Informing women that they have a choice of smear takers has been found to directly impact women's decision to attend for a smear. A study conducted by the National University of Ireland, Galway (2003) found that 35% of women did not want to have a smear taken by a male practitioner. The Women's Health Council (2004) found that some women will not attend for a smear with their GP because their GP lived in their local area. The IFPA employs mostly female smear takers and provides a well established, trusted alternative to GP surgeries that provides women with the anonymity they seek.

PROMOTIONAL ACTIVITIES

Providing women with the information they need about cervical screening plays a vital role in ensuring participation in the programme. Many Irish women may not know what to expect when attending for a Pap smear, are not informed of their risk of cervical cancer, may be fearful and anxious about having the test, and/or may have had negative experiences in the past with Pap smears (Women's Health Council, 2004 & National University of Ireland, Galway, 2003). Therefore, promotional campaigns should emphasize the importance of the test, provide as much information as possible, assure women that they have a choice of smear taker and normalize as much as possible public discourse about preventative health for women.

As noted above, some women will not attend their regular GP for a smear and in an evaluation of the first phase of the NCSP women reported a lack of information about alternative smear takers as a reason for non-attendance (Women's Health Council, 2004). Any promotional material and invitation letters should make clear women's option to attend FPCs to avail of their free smear.

FINANCE

As the details of reimbursement for smear takers, grants for equipment and administrative costs are not yet available, the IFPA offers the following points for consideration:

- Organisations and smear takers will employ their own cost benefit analysis of participating in the programme and reimbursement must reflect the skills, time and equipment necessary to provide a sensitive, efficient service;
- Some women will need to see a doctor instead of a nurse, especially if they have never had a smear before, and reimbursement practice must reflect such circumstances;
- If smear takers are to have a role in the follow up care of women who have irregular cells, reimbursement needs to factor in the considerable administrative time involved in ensuring results are recorded, monitored and followed up.
- Once-off grants for computers, training and equipment may be necessary for large smear takers such as the IFPA who cannot access grants for such purposes through the HSE.

TARGETED INITIATIVES

The Women's Health Council (2006) has reported that the increased risk of developing cervical cancer is connected to a decrease in socio economic status which is further related to barriers to accessing health services. Women most likely to experience poverty and/or disadvantage can include disabled women, immigrant women, asylum seeking women, lesbian women, Traveller women and women from disadvantaged areas. In recent years, the experience of the IFPA has been that partnership with organisations run by and for specific groups of

women is the most successful way to reach marginalised women in a meaningful way and address barriers to access. Targeted initiatives (including dissemination of information) in partnership with local organisations must play a key role in the programme in order to maximise uptake.

FUTURE CONSIDERATIONS

Medical and scientific advances are currently underway to improve prevention and screening methods in order to halt the unnecessary deaths of women all over the world. It is imperative the NCSP implement these advances and continue to seek out best practice experiences from other countries. Two recent advances have affected the way many health systems implement screening and prevention programmes, these include HPV testing and HPV screening.

HPV TESTING

The majority of cervical cancer is caused by certain strains of the human papilloma virus (HPV). Recent studies report that DNA testing for the presence of high risk HPV strains in combination with Pap smears is more effective with regards to detecting precancerous lesions than the Pap smear alone for women over 30 (Mayrand, Duarte-Franco, Rodrigues, Walter, Hanley, Ferenczy, Ratnam, Coutlée, & Franco, 2007). The goal of HPV DNA testing is synonymous to the goals of the cancer screening programme: earlier detection, earlier treatment and reduced morbidity and mortality. The IFPA recommends the NCSP to explore the option of utilizing HPV DNA testing as a complement to the Pap smear.

HPV VACCINE

The WHO recommends both screening and prevention as part of a comprehensive cervical cancer control programme. The prevention aspect of the programme rests on two main areas: consistent condom use to reduce the sexual transmission of HPV and vaccination of pre adolescent girls. The IFPA urges the NCSP to investigate the benefits of integrating the HPV vaccine into its national screening programme as other countries such as Canada, the UK and Australia have now done. The HPV vaccine has been proven almost 100% effective in preventing certain types of the virus that cause cervical cancer and is expected to reduce the global cervical cancer burden by almost 70% (Ullrich et al, 2007).

Questions for the NCSP

1. Who has ultimate responsibility for monitoring the follow up of women who have abnormal smears?

2. What is the expected turn around time for initial smear results?

3. Which cytology labs have been contracted to process smear results and where will they be located?

4. Will the reporting of results be uniform across all contracted cytology labs, Irish and/or international?

5. What is the current capacity of colposcopy clinics in Ireland and will they be able to absorb an increase in referrals?

6. What is the planned Information Technology infrastructure for communicating data between the labs, primary care facilities and the NCSP?

7. Is the ISCP considering the use of the HPV vaccine and/or HPV testing as part of its programme?

8. Will there be a draw down fund whereby clinics can request grants for equipment, training, computers etc. and if so, how will this be accessed?

9. What is the level of smear taker discretion in relation to advising women to attend for smears outside the recommended intervals and/or age group?

10. Is there a system of checks and balances built into the NCSP that ensures no woman in need of treatment is omitted?

11. Will there be a space on the smear taker form for the clinic's number to facilitate filing of results?

12. What is the protocol for women attending for a screen without their PPS number?

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