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Assessment of Knowledge, Attitudes and Practices on Cervical Cancer Prevention in the Republic of Moldova – KAP Survey

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**The translation from Romanian into English was performed by Intart Design SRL, which took full responsibility for the accuracy of the translation.*
Translator – Martiniuc Ana.

Abbreviations

PHC – Primary Health Care
NBS – National Bureau of Statistics
CC – Cervical Cancer
CIN – Cervical Intraepithelial Neoplasia
NHIC – National Health Insurance Company
HPV – Human Papillomavirus
ICCPA – International Cervical Cancer Prevention Association
KAP – Knowledge, Attitude and Practice
LEEP – Loop Electrosurgical Excision Procedure
WHO – World Health Organization
SOP – Standard Operating Procedures
RM – Republic of Moldova
SDC – Swiss Agency for Development and Cooperation
UNFPA – United Nations Population Fund
N – Number of Respondents

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SUMMARY

Cervical cancer is one of the most commonly diagnosed form of cancer among women, and a major public health issue in the Republic of Moldova. In 2017, cervical cancer incidence was 17.4 cases per 100,000 population, while cervical cancer mortality was 9.1 cases per 100,000 population (data of the Oncology Institute and National Public Health Agency).

The following types of research were carried out to achieve the objectives of the survey: a national representative survey among 1,226 women representing the target segment (aged 25-61), group discussions with 51 women (half of whom did the Pap test), 40 in-depth interviews with doctors and nurses, and 15 in-depth interviews with public health policy experts.

Indicators. Measurement of four indicators across the target segment (women aged 25-61) was among the objectives of the survey.

Indicator name	Population	Unit of measurement	Indicator
a) Percentage of women who know about the cervical screening service	Total sample	%	24
b) Coverage of women with cervical screening services	Total sample	%	36
c) Coverage of women with follow-up services after cervical screening	Women who did the test, N=440	%	73
d) Integrated indicator: Women' satisfaction with accessibility and quality of cervical screening services	Women who did the test, N=440	%	73

One in two women (50%) believed that her health was good and very good. At the same time, 31% of the respondents said they had been diagnosed with a chronic disease.

Access to health care

- Most of the 25-61 year old women in Moldova are covered by the compulsory health insurance system (69%) and are registered on a family doctor's list (87%).
- In case of health conditions, 95% of women go to a health worker. Most often, women go to their family doctor (70%).
- When they go to a family doctor, most women go to the family doctor serving the sector where they live (90%).
- As much as 57% of women underwent a medical examination in the last 12 months, and 61% say they go to a gynaecologist once a year, or more often. For gynaecological examinations, women usually go the gynaecologist in district or municipal health care centers (44%).
- Interviews show that women are largely satisfied with gynaecological services, but they say that the latter could be improved if gynaecologists provide detailed explanations about the diagnosis and how to apply the treatment. In communities outside the capital city, women mentioned that sometimes they had to buy some of the supplies required for gynaecological examination because the offices are poorly equipped.

Satisfaction with health care

- Two-thirds of women say they are satisfied or very satisfied with the health care offered by the family doctor. During the group discussions, women said that the contradictory diagnoses and treatments offered by different professionals, the short consultations that seem to be superficial, or the negative attitude of health professionals had caused their dissatisfaction with health care. In addition, women were disappointed with the long waiting times until the appointment for the consultation of specialist doctors, but also with the fact that appointments do not guarantee that the consultation takes place at the time agreed.

Knowledge of cervical cancer prevention

- As much as 47% of the women aged 25-61 in Moldova said they heard about the Pap test. However, certain socio-demographic categories, such as young and middle-aged women, married women, women with higher education who are employed and who have an average financial status, are more likely to declare that they know about the cytology test.
- Women's knowledge of the test purpose, procedure, frequency, and the target group of cervical screening were assessed. Of these, the purpose of cytology test was the most well known. Thus, 82% of women correctly identified that the test prevents cancer and detects changes in cervical cells. At the same time, 52% indicated correctly that the test consists of collecting cervical cells, 42% said the test is recommended for women aged 25-61 and 34% noted that the test should be done every three years. Also, only 47% of women know that the Pap test is free of charge, if referred by the family doctor. The qualitative survey also shows that there are misperceptions about the cytology test. Therefore, many women were unaware that the test may also detect pre-cancerous stages, and they continued to believe that the test only detects cancer cells. Hence, certain women said the test was only recommended for women at risk of developing cancer or with cancer symptoms.
- Half of the women believe that they need to go to the office of the gynaecologist at the district or municipal health care centre to do the cytology test, and 19% know that they can do it at the family doctor.
- Only one-quarter of women know about the existence of cervical screening, and 46% believe that it is necessary to visit the gynaecologist at the district or municipal health care centres in order to benefit from these services. If they know about the cervical screening, it is most likely that the respondents heard of it from the family doctor (43%) or from the gynaecologist (36%).
- The qualitative survey indicates that many women are worried about cervical cancer. Most of the time, women worry because they perceive the increasing number of cases of cervical cancer, but also because they believe that currently there are more risks for cancer development, such as environmental pollution and food low quality. It is worth noting that few women are aware of the fact that HPV virus is one of the key risk factors for developing cervical cancer. Women worry because they think cervical cancer occurs suddenly and asymptomatically, but also because they believe the medical system is insufficiently developed to cope with the cervical cancer.

Cervical screening among the female population aged 25-61

- As much as 36% of the women aged 25-61 in Moldova reported having the Pap test at some point in their life. Statistical tests indicate that middle-aged women, women from urban areas, women who are in a marital or cohabitation relationship, those with higher education, who are employed and have a good financial status, are more likely to declare that they had the cytology test.
- Generally, 27% of women remember that the family doctor recommended them to do the cytology test. At the same time, 67% of the women who had the cytology test said that the family doctor recommended it.
- Most of the time, women contacted the gynaecologists to do the cytology test. Hence, 48% contacted the gynaecologist from the district or municipal health care centre, 17% went to the gynaecologist from a public hospital, and 9% went to a gynaecologist from a private health care facility.
- According to the women, they usually do the test every three years, or more often.
- When the cytology test was done, 41% of the women actually went to a routine gynaecological examination, while 22% – because they had certain gynaecological problems. At the same time, only 15% went to the doctor to do exclusively the cytology test. In addition, note that the initiative to do the test usually comes from gynaecologist (36%), family doctor (25%) or his/her nurse (15%). Only 22% of women said that they themselves have asked to do the test.
- As much as 70% of the women who had the Pap test did not pay for it.
- As much as 4% of the women who had the test said they had a positive cytology test (4% = 19 women). Of these, 15 women repeated the test, most often by reaching out to the gynaecologist from the district or municipal health care centre, or from a private health care facility. Also, 18 women were referred for colposcopy either at the Oncology Institute or at a gynaecologist from a public hospital.

Satisfaction with health care and its accessibility

- As much as 87% of women said they were satisfied and very satisfied with the services they received when doing the Pap test. More than 69% of the women who had the cytology test said they were satisfied or very satisfied with the accessibility of health care. As regards the aspects related to the accessibility of screening

services, women were most satisfied with the attitude of the family towards the decision to have the test (83% satisfied and very satisfied), ease in accessing the services (80% satisfied and very satisfied), and the waiting time for an appointment (74% satisfied and very satisfied). As far as the quality of medical services is concerned, the women who had the cytology test stated that they were highly satisfied with the attention and respect from behalf of health professionals (84% satisfied and very satisfied) and the way the examination took place (86% satisfied and very satisfied).

- When asked if they would do the test in the next three months, 70% of women responded that they would probably or certainly do the test. The best predictors of the intent to do the cervical screening are: perception of benefits, attitude towards the test, and knowledge of the test purpose.

The need to inform about the Pap test

- Most women would like to be invited to do the cervical screening via a phone call (51%) or a verbal invitation during a visit to the family doctor (34%). Women appreciated these ways of inviting because they are personalized, and could offer them answers to potential questions they might have.
- Only 36% of women showed interest in receiving more information about the cytology test. Women would highly trust the information about the cytology test offered/explained by the gynaecologist or oncologist. At the same time, they would show least trust in the information that would come from celebrities or priests.

Opinion on HPV vaccination

- As much as 4% of the women aged 25-61 state that they know about the HPV vaccine, most of whom hear about it on TV, radio (52%) or family doctor (33%).
- At the same time, 23% of women who have daughters about the age of 10 said they had vaccinated them against HPV, and 45% – that they were willing to vaccinate them.

Specialist opinion

- Though most of the specialists estimate that Moldova has appropriate services for addressing the cervical cancer problem, some shortcomings of the cervical screening services are present. The most important shortcomings mentioned were as follows: large use of the method of processing/staining the tests according to the Romanowsky-Giemsa technique, non-assurance of qualitative sampling of the cytology smear, long duration of obtaining the test results and insufficient equipment of the laboratories.
- The current regulatory framework on cancer prevention was assessed as being sufficient. All of the interviewed specialists described the documents that regulate cervical screening and HPV immunization as well-developed and compliant with international standards. Some documents are reportedly being reviewed in order to adjust and update them accordingly. At the same time, barriers to the implementation of these documents were mentioned. The shortage of health professionals, population's reluctance to seek preventive health care, insufficient financial resources to equip the laboratories and provide the necessary equipment/consumables for taking cytology smears at all health care centres offering services of cervical screening are the key difficulties.
- As regards the institutional framework involved in cervical screening, it was mentioned that from the point of view of the medical system all health care facilities and specialists that should be involved in the process are involved in it. To increase cervical screening coverage, most respondents said that institutions non-related to health care, such as educational institutions, local public authorities and media outlets, should also be involved. At the level of primary health care, the bureaucratic work done by family doctors needs to be simplified to give them more time to communicate with and counsel the women.
- There were no consistent views on the presence of optimal conditions for cervical screening in PHC facilities. Thus, although some respondents said they do have the conditions to perform the cervical smear sampling, other health workers said that it would be necessary to improve the conditions in the units where they work. The lack of equipment/consumables for cytology sampling was most often mentioned. In this regard, the specialists added that the provision of the equipment necessary for the cytology test was not yet standardized nationwide.
- Specialists believe that the number of cytological and histopathological laboratories in the country is enough. Even more, it was proposed to regionalise the laboratory and colposcopy services. This opinion is based on the fact that regional laboratories will have a greater assessment capacity, which will allow for a

greater number of qualitative investigations. It was mentioned that even the largest laboratories have insufficient equipment and well-trained staff.

- Medical workers consider the cervical screening as a routine procedure where family doctors take responsibility for monitoring the women who underwent the cervical screening. Certain specialists said that women's monitoring is not well-organised at the moment, because patient traceability is not ensured and there are no clear mechanisms for collaboration between the health professionals involved in the cervical screening. Hence, it was proposed to set up an information system that would ensure an effective monitoring of women and the communication between the links of the health care system involved in the cervical screening.
- As far as quality assurance is concerned, opinions were voiced that the normative framework is well developed, with protocols, standards and textbooks available for laboratories. Besides, insufficient monitoring of the implementation of these documents was noted. It was suggested to reintroduce the performance indicators for cervical screening in order to improve the quality of screening.
- All health workers and health care specialists positively appreciated that the Pap test is free of charge. A number of specialists indicated that the outpatient treatment should be free of charge to avoid situations where uninsured women cannot follow the treatment indicated.
- The cervical screening service was described as accessible, but not attractive and convenient due to inappropriate equipment of facilities.
- The need to organise a national information campaign with the support of the Ministry of Health, Labour and Social Protection and of the National Health Insurance Company was emphasized. In addition, it was suggested that such a communication campaign should be ongoing and combine all stakeholders' efforts.

Recommendations:

Recommendations meant to change the attitudes and behaviour of the target population

1. Develop effective mechanisms to motivate and raise women's awareness of the need to undergo regularly the screening, involving non-medical stakeholders, including life partners.
2. Develop ample information programs and campaigns focusing on specific target groups and taking into account the cultural, social and age-specific features of women.
3. Initiate some trainings on *communication meant to change health-risk behaviours* and *patients' rights.* These trainings need to focus on health professionals involved in the screening.
4. Promote amongst health professionals standardised messages on cervical cancer screening and HPV vaccination that should be disseminated uniformly in the society.

Recommendations meant to improve the organisation, access to and the quality of cervical cancer prevention services

5. Develop a procedure to monitor patients' journey all through the screening by creating an information system with a database on the whole process of women interaction with the health care system.
6. Review the monitoring and evaluation indicators of the National Cancer Control Program and of the National Cervical Cancer Screening Program and add new *progress indicators* to evaluate the involvement of all those involved in the cervical screening.
7. Organise certain programs to increase women's access to screening services in communities with a shortage of qualified health workers skilled in correct smear sampling.
8. Assess the current capacities of PHC facilities for cervical screening (endowment with equipment and health workers' skills) and develop an algorithm to organise the screening in the communities lacking adequate institutional capacities.
9. Standardise the mandatory screening procedure for all health care facilities.
10. Develop an action plan to strengthen the cytology laboratories and fit them out with the required equipment and to provide trainings for the staff.
11. Assess the capacity of colposcopy offices and of offices performing pre-cancer treatment procedures and develop a plan of measures to strengthen their capacity. Develop an algorithm to ensure women's access to colposcopy services.
12. Review the financing of the screening procedure at all implementation stages, including the second stage of cervical screening.

INTRODUCTION

Cervical cancer is a major public health issue in the Republic of Moldova and one of the most commonly diagnosed form of cancer among women. Thus, in 2017, cervical cancer incidence was 17.4 cases per 100,000 population, while cervical cancer mortality was 9.1 cases per 100,000 population (data of the Oncology Institute and National Public Health Agency).

Of all malignant diseases, cervical cancer is the most easily preventable. The available international evidence shows that the implementation of well-organised screening programs, with a recall in 3-5 years, with a quality control and adequate mechanisms of supervision and treatment for all women having positive screening results, may reduce by 80% both cervical cancer incidence and mortality. In parallel with the implementation of an effective and well-organised cervical screening program, the introduction of HPV vaccination during adolescence also contributes to the reduction of cervical cancer rate. As a whole, both services complement each other, providing highly effective protection against cervical cancer.

In 2014, an analysis of the situation and capacities to prevent cervical cancer in the Republic of Moldova was carried out nationwide with UNFPA's technical support, in collaboration with ICCPA; following the assessment, action plans were developed, approved and enforced in order to implement a well-organised cervical screening Republic of Moldova, in accordance with international best practices and recommendations (Action Plan Implementing the Cervical Screening in the Republic of Moldova for 2014-2015; Action Plan Strengthening the Capacities in Implementing the Cervical Screening in the Republic of Moldova for 2016-2018).

The organisation and implementation of national programs for screening of target population to prevent and early detect non-communicable diseases (including oncological diseases) are one of the medium-term strategic priorities provided by the National Strategy for Prevention and Control of Non-communicable Diseases for 2012-2020, approved by RM Parliament Decision No 82 of 12 April 2012. The implementation of cervical screening as a method to prevent cervical cancer is also one of the provisions of the National Cancer Control Program for 2016-2025, approved by Government Decision No 1291 of 2 December 2016.

The major achievements at national level during 2015-2018, including with the technical support provided by UNFPA, SDC and other development partners include the following: developed the National Standard Operating Procedures for Cervical Screening; introduced the indicators on the detection of precancerous lesions and cervical cancer in the early stages as performance indicators for family doctors; trained over 400 primary health care professionals in cervical screening, on the basis of the Irish model; trained 18 gynaecologists from Moldova in colposcopy and cervical cancer prevention under a regional program; assessed at national level the capacity of cytology and histopathology laboratories; assessed the technical performance of the equipment of the colposcopy offices; set up the Referral Centre in Colposcopy and the Unit Coordinating the Implementation of Cervical Screening at the Institute of Mother and Child; etc.

The success of the implemented interventions encourages further cooperation to support the efforts of the health care system in strengthening cervical cancer prevention services in the Republic of Moldova. In this context, under 'Cervical Cancer Prevention in the Republic of Moldova' Project – UNFPA, together with SDC and other partners, support the strengthening of cervical screening services provided by primary health care facilities, gynaecological cytology and histopathology services, colposcopy services; as well as the set up of the Cervical Screening Register to improve the referral system and to monitor and assess the impact of cervical screening. The project also envisages the development and implementation of a communication strategy for behavioural change (to increase the level of public awareness, in particular of the target group, on the importance of cervical cancer prevention, and to encourage more people to access cervical screening services).

Understanding the attitudes and behaviour of the population and the factors influencing the decision whether or not seek available cervical screening services is extremely important to successfully implement a communication strategy for behavioural change. In this context, the assessment of the knowledge, attitude and practice relevant to cervical cancer prevention in the Republic of Moldova – KAP survey – was conducted as a starting point (mainly focused on cervical screening features; at the same time, the questionnaire for data collection, and the interview guidelines also included questions about HPV vaccination, which supplemented the data on HPV vaccination, previously obtained at national level with WHO support).

The communication campaign for behavioural change will be evaluated by comparing the data obtained in the current assessment of the knowledge, attitude and practice on cervical cancer prevention in the Republic of Moldova – KAP survey – with the results of a similar KAP survey that will be repeated in 2020.

CHAPTER I: CERVICAL CANCER IN THE REPUBLIC OF MOLDOVA

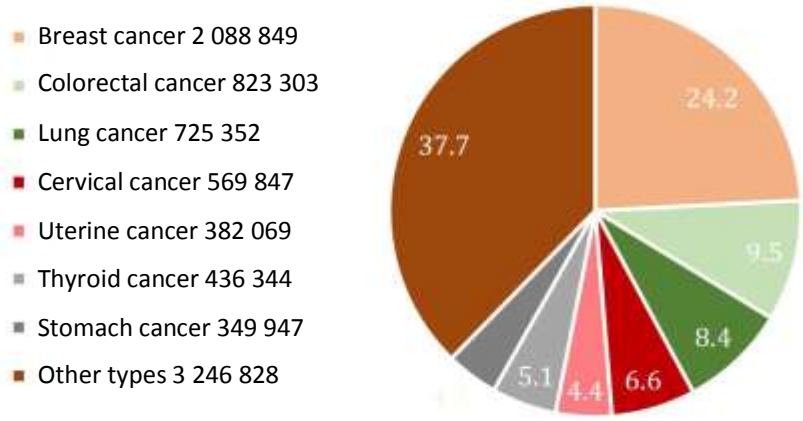
1.1 Cervical Cancer Burden

Cervical cancer (CC) is an oncological condition characterised by the appearance of cells that chaotically multiply in the cervix. Evidence show that the sooner the CC is diagnosed, the greater the chances of healing are. CC is a malignant tumour, the invasive cells of which can be prevented.

Incidence

Globally, cervical cancer ranks second in malignant tumours among women. Around 530,000 new cases and about 300,000 deaths are recorded every year.[1] Of the total deaths, 80% occur in the female population of developing countries, where there are no cervical cancer prevention programs. In Europe, about 60,000 women develop and 30,000 women die from cervical cancer every year.[2] Thus, cervical cancer ranks fourth among neoplastic locations in women in Europe and second among 15-44-year-old women.

Figure 1.1.1: Estimated number of new cases of cancer in 2018 worldwide, female population, all ages (% and absolute figures)[3].



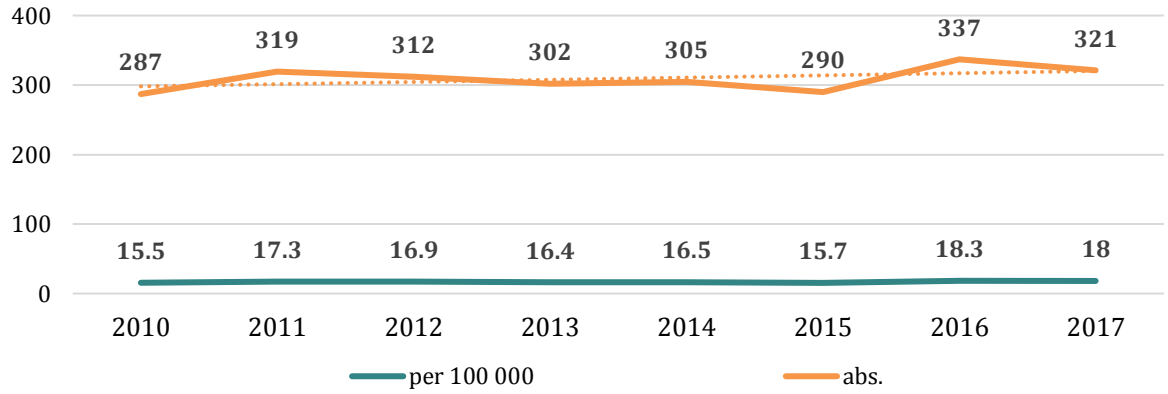
Compared to other types of cancer, cervical cancer affects younger women, most cases being recorded in women aged 35-60[4].

In the Republic of Moldova, almost every day a woman is diagnosed with cervical cancer, and one woman dies because of it every third day. Over the past five years, over 1,500 women were diagnosed with this disease, and more than 1,000 died[5]. Cervical cancer ranks third among women's cancers in our country and first among the cancers of women aged 15-44.

The number of new cases of cervical cancer diagnosed in the Republic of Moldova knew a slightly upward trend in recent years, between 287 and 337 women being diagnosed with this disease every year (Figure 1.1.2).

[1] https://moldova.unfpa.org/sites/default/files/pub-pdf/Cervical%20Cancer_Issue5.pdf
[2] https://moldova.unfpa.org/sites/default/files/pub-pdf/RM%20Cervical%20Cytology%20Assessment%20%20Recommendations_eng.pdf
[3] GLOBOCAN 2018. Global Cancer Observatory. http://gco.iarc.fr
[4] http://onco.md/news/Sptmna-de-Prevenire-a-Cancerului-de-Col-Uterin-
[5] https://msmps.gov.md/ro/content/cancerul-de-col-uterin-va-fi-prevenit-republica-moldova-prin-programe-de-screening-cervical

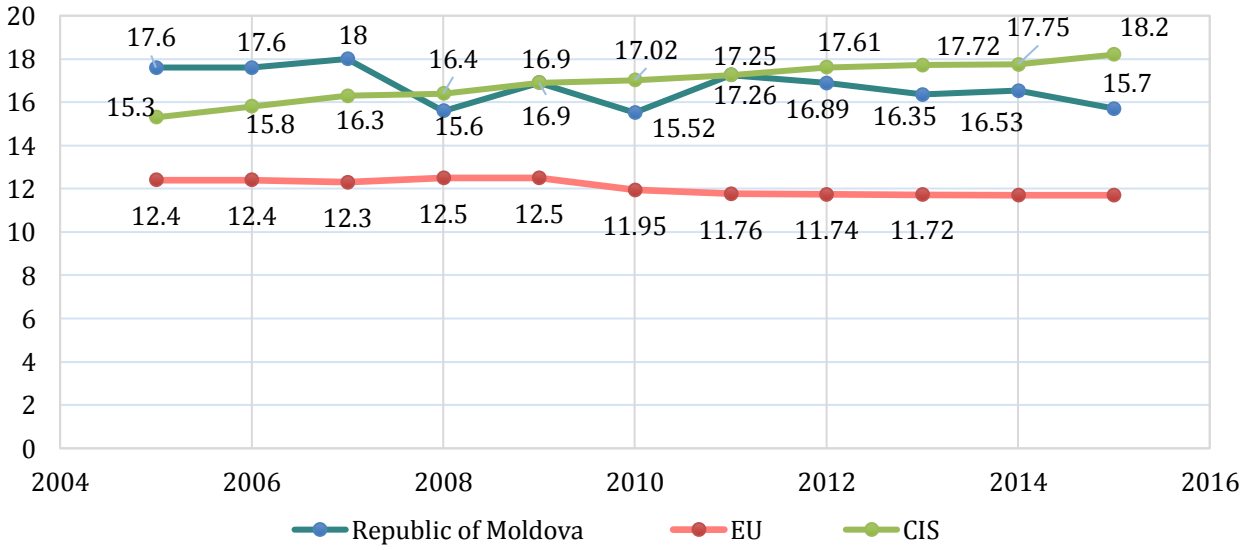
Figure 1.1.2: Number of cases and incidence of cervical cancer in RM during 2010-2017 (per 100,000 population and in absolute numbers)[6]



Note that, over the last 20 years, the incidence of cervical cancer shows an increase in time and remains high, without any improvement from a statistical point of view. For instance, the incidence per 100,000 population was 13 cases in 1996, and 14.4 cases in 2001. At the same time, the national CC incidence reporting system, which is still ineffective and with many gaps, should be taken into account. The cases started to be recorded in the National Cancer Register at the Oncology Institute only since 2016, which has allowed a much more accurate tracking and monitoring of the indicators in this field. Respectively, this indicator has increased over the last 2 years.

By comparing the rate of developing cervical cancer in the Republic of Moldova with the general picture of the region, one can note that, at international level, the situation is much worse in Moldova than in EU countries, and almost close to CIS average (Figure 1.1.3).

Figure 1.1.3: Comparative incidence of cervical cancer per 100,000 during 2005-2015[7]



By calculating the rate of this type of cancer to **100,000 women**, one can see that the situation in the Republic of Moldova is significantly worse (Table 1.1.1):

[6] Data for 2017 provided by the Oncology Institute and from NCHM Report on Health System of Moldova, 2016.
[7] European health for all database (HFA-DB) WHO/Europe https://gateway.euro.who.int/en/indicators/hfa_377-2360-incidence-of-cervix-uteri-cancer-per-100-000/visualizations/#id=19308

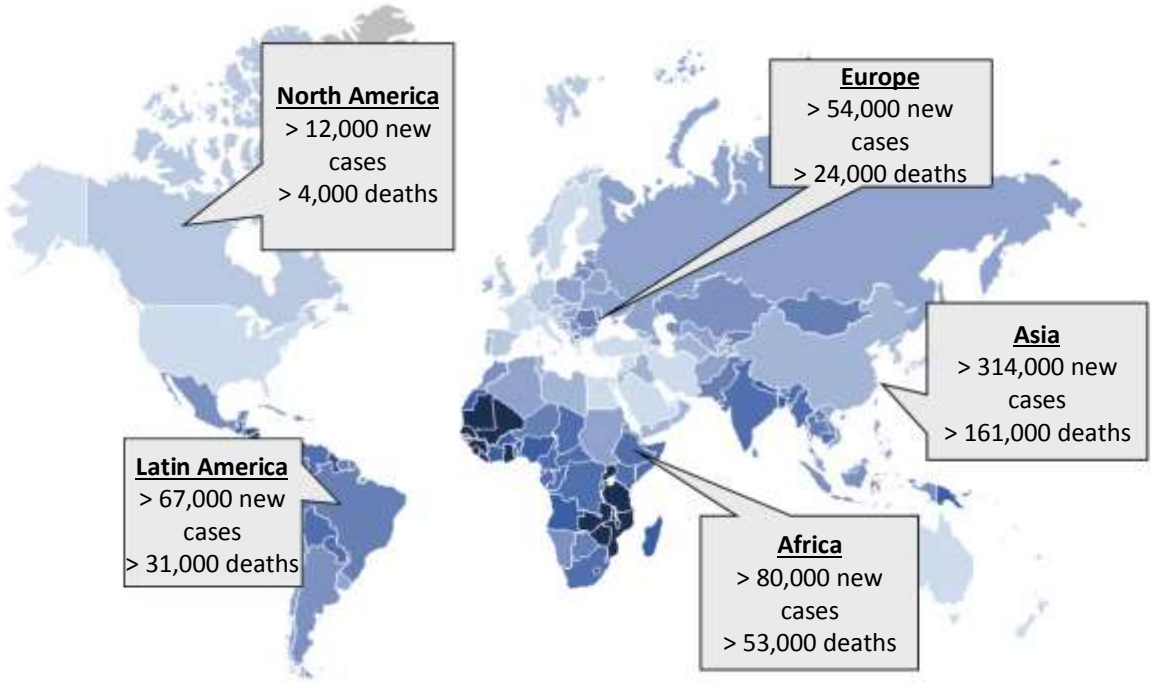
Table 1.1.1: Comparative situation of cervical cancer, 100,000 women, 2012[8]

Indicator	in RM	Eastern Europe	worldwide
Incidence per 100,000 women	25.7	21.7	15.1
Age-standardized incidence rate	19.6	16.3	14.0
Mortality rate per 100,000 women	11.4	9.9	7.6
Age-standardized mortality rate	7.9	6.2	6.8

Mortality

It is important to point out that worldwide mortality rates for cervical cancer are substantially lower than incidence, with an incidence – mortality ratio of 50.3%. Cervical cancer is the 7th cause of cancer mortality among European women, and second cause among 15-44-year-old women[9].[10]

Figure 1.1.3: Cervical cancer incidence and mortality worldwide, 2010[11]



In the Republic of Moldova, cervical cancer mortality is the second cause of death by cancer in women after breast cancer. Around 1,700 women died in the last 10 years due to the cervical cancer[12]. Most deaths were recorded in the central districts of the Republic of Moldova. The figure below shows, however, a slight decrease

[8] Bruni L, Barrionuevo-Rosas L, Albero G, Serrano B, Mena M, Gómez D, Muñoz J, Bosch FX, de Sanjosé S. ICO/IARC Information Centre on HPV and Cancer (HPV Information Centre). Human Papillomavirus and Related Diseases in Republic of Moldova. Summary Report 27 July 2017. [accessed on 29.09.2017] http://www.hpvcentre.net/statistics/reports/MDA.pdf

[9] Ferlay J, Soerjomataram I, Ervik M, Dikshit R, Eser S, Mathers C, Rebelo M, Parkin DM, Forman D, Bray F. GLOBOCAN 2012 v1.2, Cancer Incidence and Mortality Worldwide: IARC CancerBase No. 11 [Internet]. Lyon, France: International Agency for Research on Cancer; 2013. Available at: http://globocan.iarc.fr.

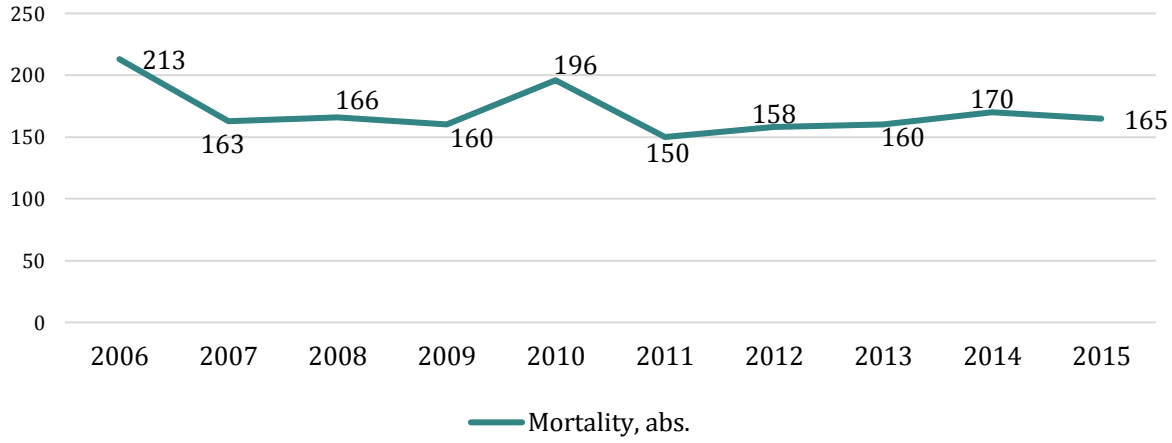
[10] SITUATION ANALYSIS. EUROPEAN CERVICAL CANCER PREVENTION WEEK. Available at http://insp.gov.ro/sites/cnepss/wp-content/uploads/2016/01/Analiza-de-situatie-SEPCCU-2017.pdf

[11] . Ferlay J, *et al. GLOBOCAN 2008, Cancer Incidence and Mortality Worldwide.* IARC CancerBase No.10; Lyon, France, 2010 Available at: http://globocan.iarc.fr.

[12] Data provided by the National Centre for Health Management/National Agency for Public Health

in the mortality rate over the past 10 years[13]. CC is increasing among young women, more of them being affected by this disease if compared with other types of cancer. The average age of patients diagnosed with cervical cancer is 50-51 years[14].

Figure 1.1.4: Cervical cancer mortality in the Republic of Moldova, 2006-2015 (absolute numbers)



The Republic of Moldova is among the top 5 countries in the WHO European Region with the highest cervical cancer mortality rates[15]. According to the latest WHO data published in 2017 cervical cancer deaths in Moldova reached 188[16].

The late detection of this disease, which also negatively affects the survival rate of women, is a major cause of high cancer mortality in the Republic of Moldova.

Early and late diagnosis rate (stage of the disease in primary diagnosis)

In the Republic of Moldova, though cervical screening, CC prevention and prophylaxis are a priority for health authorities, with a number of measures already taken, the mortality and morbidity rates continue to be alarming, with a tragic burden on the public health system and the population of the country. The rate of advanced stages of cervical cancer when it is diagnosed is alarming; hence, treatment success rate drops significantly. Over the past few years, one can see that the late diagnosis of cervical cancer (at advanced stages) is already a common phenomenon. Figure 1.1.5 shows that the rate of primarily diagnosed cancer in advanced stages (III and IV) accounts for more than half of the newly diagnosed cases.

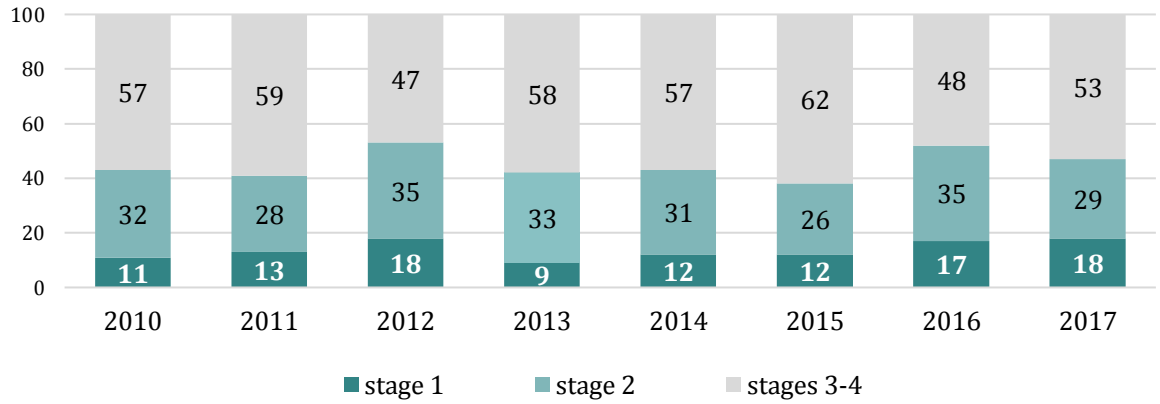
[13]Cervical Cancer. National Clinical Protocol 5 PCN-142, Chisinau, 2015 https://www.cidsr.md/wp-content/uploads/2016/07/Protocol-Clinic-National.pdf

[14] NCHM, 2015

[15] http://www.euro.who.int/en/countries/republic-of-moldova/news/news/2017/02/human-papillomavirus-vaccine-introduction-in-the-republic-of-moldova

[16] https://www.worldlifeexpectancy.com/moldova-cervical-cancer

Figure 1.1.5: Percentage of cervical cancer cases diagnosed at different stages, 2010-2017 (%)[17]



2.2 Prevalence of Cervical Screening/Coverage of Women of Eligible Age (25-61) with Cervical Screening Services

Cervical cancer screening is the testing for pre-cancer and cancer among women who have no symptoms and feel perfectly healthy. This screening aims to determine the presence or absence of abnormal cells in their initial stages, when they can be easily removed before they develop into cancerous (malignant) cells. The cervical cancer screening is done via the **Papanicolaou test** (Babes-Papanicolaou smear test) or the **Pap test.** The European directives currently recommend the Pap test every 3-5 years, starting at the age of 25 and ending at the age of 65. Depending on the target population and gynaecologist's indications, sometimes it is recommended more frequently. The screening can detect the cancer at an early stage, when treatment is highly likely to result in healing. A well-organised screening program, with a periodical recall, with a quality control and adequate mechanisms of supervision and treatment for all women having positive screening results, may reduce by 80% both cervical cancer incidence and mortality.

In many Western countries, where screening programs were implemented, cervical cancer mortality decreased even by 65% in the last four decades. For instance, mortality rates in Norway decreased from 6.3 per 100,000 population in 1970, to 1.5 in 2011. In the US, the cervical cancer mortality rate dropped by about 74% over the past 50 years due to the implementation of the population screening. At the same time, the study *'The end of the decline in cervical cancer mortality in Spain: trends across the period 1981-2012'* shows that the current prevention programs based on population screening are not able to further reduce the rates due to the lack of adjustments required by the availability of HPV testing and by the introduction of HPV vaccination into the publicly-funded vaccination program.[18]

A cervical screening is considered to be *opportunistic* when people undergo a medical examination at their own initiative or while visiting the doctor for other reasons, but there is no well-established system to recruit people, monitor their cases and further diagnosis and treatment procedures if needed, and to ensure that all component services are of the highest quality.

The opportunistic screening can substantially decrease the incidence of diseases, however this is possible only in countries where the population has a high level of health education, where a large proportion of the target population regularly interacts with the health care system, where patient referral mechanisms and surveillance measures are in place, and health services are all of high quality.

Under the opportunistic screening, women with good financial status are checked too often (e.g. annually), although they have a lower risk of developing cancer, while women from disadvantaged socio-economic groups, who are at a greater risk, are checked too rarely. This is important because every screening test has an optimal screening age-range and interval that has been set to maximise the benefits and minimise the harms. Therefore, too often screening offers little additional protection, but it increases the negative consequences (e.g. stress and needless expenses). The sub-screening clearly increases the rate of late detection of the disease.

[17] Data collected from the Statistical Report No 35, National Cancer Register, Oncology Institute.
[18] SITUATION ANALYSIS. EUROPEAN CERVICAL CANCER PREVENTION WEEK. Available at http://insp.gov.ro/sites/cnepss/wp-content/uploads/2016/01/Analiza-de-situatie-SEPCCU-2017.pdf

As a result, the opportunistic screening brings suboptimal reductions in disease incidence, perpetuates or increases health inequalities and scatters health system resources.

In contrast to opportunistic screening, *organised cervical screening programs* (also called *population screening*) are specifically designed to maximise the benefits while minimising the harms for the population being screened. The key element of a well-organised cervical screening program is a central administration with the budget and authority able to ensure:

- Wide and fair coverage of the target population.
- Observance of the age range and interval recommended for screening.
- Optimal quality and coordination of all the services involved in the screening program from recruitment to supervision, as well as cancer diagnosis of people having a positive screening test result and the treatment of the diagnosed disease.

As a result, organised (population) cancer screening programs provide the optimal balance between the benefits and harms, ensure the benefits are equitably delivered across all social strata and deliver the most cost-effective disease reductions. For these reasons, the *European Guidelines for Quality Assurance in Cervical Screening*[19] state that cervical screening should only be provided through organised (population) programs.

In the Republic of Moldova, the number of women at risk for cervical cancer (>=15 years) is 1.8 million[20].

Table 1.2.1: Female population in the Republic of Moldova (estimates by the UN for 2017, including Transnistria) [21]

YEARS OLD	Number of persons
80+	64,555
75–79	55,043
70–74	58,445
65–69	96,993
60–64	155,558
55–59	155,624
50–54	148,703
45–49	123,950
40–44	141,400
35–39	159,713
30–34	192,125
25–29	197,143
20–24	142,598
15–19	106,287
10–14	97,973
5–9	108,229
Under 5	103,426

Cancer epidemiological situation is largely determined by the access, quality and cost of cancer control services.

Cervical cancer prevention via screening in the Republic of Moldova is not yet fully completed and is provided unevenly in the country. Until 2011, cervical cancer screening was *opportunistic*.

Starting with 2011, Moldova introduced a national screening program for women over 20, every 2 years. In June 2011, cervical screening was launched in several districts of the country, being provided by primary health care facilities.

[19] https://publications.europa.eu/en/publication-detail/-/publication/f6d9b1fb-6404-49f2-a4ae-8763ee8b0c52

[20] Bruni L, Barrionuevo-Rosas L, Albero G, Serrano B, Mena M, Gómez D, Muñoz J, Bosch FX, de Sanjosé S. ICO/IARC Information Centre on HPV and Cancer (HPV Information Centre). Human Papillomavirus and Related Diseases in Republic of Moldova. Summary Report 27 July 2017. [accessed on 29.09.2017] http://www.hpvcentre.net/statistics/reports/MDA.pdf

[21] United Nations, Department of Economic and Social Affairs, Population Division (2015). World Population Prospects: The 2015 Revision, DVD Edition. Available at: https://esa.un.org/unpd/wpp/Download/Standard/Population/

Cervical screening tests should be provided by the facilities that are accessible and well known by the population being screened, with further referral to secondary or tertiary health care, depending on the screening test result.

In the Republic of Moldova, this means providing screening via PHC facilities representing the largest health care network in the country. At present, the Babes-Papanicolaou smear test is indicated for all women aged 25-61, being free of charge whether or not the women are registered with NHIC. At present, the test is recommended to be done every 3 years.

If the screening finds precancerous and cancerous cervix lesions, the family doctor refers the patients to the gynaecologist for colposcopy, to the district oncologist, or directly to the Oncology Institute[22]. It should be noted that at this point, the insured women benefit from free of charge further investigations for diagnosis, while the uninsured ones have to pay. Hence, the risk that uninsured women won't continue the necessary investigations due to lack of financial resources.

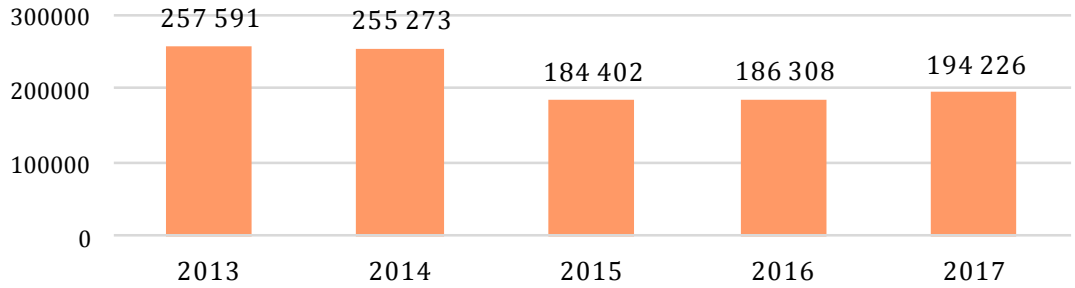
At the same time, many districts in the country have limited or no colposcopy services. Only one in three women diagnosed with cervical pathologies undergoes colposcopy and treatment. One of the causes is that the available functional medical devices are not being used due to the lack of qualified colposcopists.

A study in the field has shown that at this point screening features shows up, that young, rich, educated women from Chisinau (who are in risk group for HPV infection) screen every two years, but old, poor, less educated woman from countryside (who are in risk group for cancer development) do not do that at all[23].

According to the data provided by the National Health Insurance Company, the coverage with screening of the female population in the target group is not yet sufficient to ensure a high efficiency of this service.

It is worth mentioning that in 2011, cervical screening was launched at the population level, with the introduction of performance indicators for family doctors, who actively invited women from the target group to do the cytology test. In the beginning, the cervical screening test was recommended to be done once in two years, thus the annual target for coverage of women aged 25-61 with screening services was significantly higher over during 2013-2014 compared to the period when cervical screening was indicated to be done once in three years (since 2015). This explains the higher number of women who had the cytology test between 2013 and 2014 compared to the following period starting in 2015.

Figure 1.2.1: Number of women aged 25-61 who had the cytology test, 2013-2017 (absolute numbers)[24]



The analysis of the proportion of the target population covered with cervical screening services shows that this rate slightly increased over the time, but still remains lower than the recommended level of at least 75% to ensure a high effectiveness of cervical screening programs:

Table 1.2.2: Proportion of target population covered with cervical screening in RM, %

Year	Target population (women aged 25-61)	Proportion of the target population	Number of target population	Number of women aged 25-61 who had the cytology test	Coverage of target population, %	**Deficit**
2013	1,006,332	1/2	503,166	257,591	51.2%	**48.8%**
2014	1,014,195	1/2	507,098	255,273	50.3%	**49.7%**
2015	1,018,972	1/3	339,657	184,402	54.3%	**45.7%**

[22] Cervical Cancer. National Clinical Protocol – PCN-142. Chisinau 2015. Available at: https://www.cidsr.md/wp-content/uploads/2016/07/Protocol-Clinic-National.pdf
[23] Andrzej Jarynowski. HPV and cervical cancer in Moldova – epidemiological model with intervention's cost – benefit/effectiveness analysis https://arxiv.org/ftp/arxiv/papers/1504/1504.05383.pdf
[24] Data provided by the National Health Insurance Company

2016	1,023,737	1/3	341,246	186,308	54.6%	**45.4%**
2017	1,025,101	1/3	341,700	194,226	56.8%	**43.2%**

Though the proportion of the screened population increases annually, a number of reports revealed that cervical cancer incidence and mortality rates have flatlined in recent years and remained high. Hence the question related to the effective distribution and use of the resources allocated to screening services and the quality of the latter[25].

At the same time, the literature and international evidence also show that the attempts to implement cervical screening in developing countries did not deliver the expected result (decrease in CC incidence) due to insufficient control of smear quality, inefficient system of their transport to the laboratory, non-qualitative microscopy, etc.

This test requires the correct sampling of the smear, the laboratory research needing an adequate quality and quantity of squamous cells that cover the ectocervix, as well as cells from the transition area and the cervical canal (cylindrical epithelium). The samples are transported to the laboratory to be analysed and appreciated by a trained cytologist. The result of the cytology test must be sent to the doctor to decide on the further supervision or treatment[26].

The study on the quality of cytology services in the Republic of Moldova demonstrates that the quality of the cervical cytology is of serious concern as evidenced by large variations in the proportions of Pap test results between laboratories in the country, which means equally large variations in service quality. It was demonstrated that a substantial amount of high-grade preinvasive cervical diseases were not detected by certain laboratories, so they were not treated and many of these women will go on to develop invasive cervical cancer, even if they are regularly screened[27].

1.3 National and Institutional Frameworks Regulating the Cervical Screening

Structure

Cervical cancer screening is a complex multistep process that includes[28]:

- Identification and characterisation of the screening population.
- Education and promotion among the screening population to raise awareness about the benefits of screening and increase participation.
- Recruitment to screening.
- Personal counselling and risk evaluation, and taking the screening test.
- Processing of the screening test.
- Using the screening test result together with the woman's personal history and clinical profile to determine and plan subsequent care:
  - Periodic recall to screening,
  - Active monitoring,
  - Referral for follow-up.
- If referred for follow-up, re-assessment of the individual's risk based on the follow-up results with the screening test results, personal history and clinical profile to plan subsequent care:
  - Active monitoring,
  - Referral for local treatment,

[25] Philip Davies, Cesare Gentili, Diana Valuta and others. Assessment of Cervical Cytology Services in the Republic of Moldova and Recommendations for their Reorganisation to Comply with International Evidence-Based Standards. Chisinau, 2016 Available at https://moldova.unfpa.org/sites/default/files/pub-pdf/RM%20Cervical%20Cytology%20Assessment%20%20Recommendations_eng.pdf .

[26] NATIONAL GUIDELINES FOR THE PREVENTION OF CERVICAL CANCER. Ministry of Health. Available at http://old.ms.gov.md/_files/6534-CCU_office2003%255B1%255D%255B1%255D.docx.pdf

[27] Philip Davies, Cesare Gentili, Diana Valuta and others. Assessment of Cervical Cytology Services in the Republic of Moldova and Recommendations for their Reorganisation to Comply with International Evidence-Based Standards. Chisinau, 2016. Available at https://moldova.unfpa.org/sites/default/files/pub-pdf/RM%20Cervical%20Cytology%20Assessment%20%20Recommendations_eng.pdf

[28] National Standard Operating Procedures for Cervical Screening. Ministry of Health, Chisinau, 2015. Available at http://old.ms.gov.md/public/info/Ghid/standarte/procedurioperation/

- Referral for cancer treatment.

A frequent error while implementing cervical cancer screening programs is the excessive focus on the screening test, while neglecting the other elements of the screening. Therefore, it is paramount to collaborate and communicate permanently with the health care system stakeholders involved in the cervical screening: family doctors, gynaecologists, cytologists, histopathologists, and oncologists.

Services/Legal and regulatory frameworks

The services provided as part of the cervical screening and cervical cancer treatment are governed by the regulatory framework in force and are depicted in Table 1.3.1:

Table 1.3.1: Current provisions of the law, orders and clinical protocols of RM on cervical screening and treatment of cervical cancer (data collected by authors and taken from the available reports[29]).

Provisions	Laws/Regulations/Protocols
All women aged 25-61 should be screened for cervical cancer using ecto and endocervical cytology once in every 3-year period.	• NATIONAL Cancer Control PROGRAM for 2016-2025, Government Decision No 1291 of 2 December 2016. • Cervical Cancer. National Clinical Protocol – PCN-142. Chisinau 2015. • National Standard Operating Procedures for Cervical Screening, approved by Order of the Ministry of Health of the Republic of Moldova No 533 of 25 June 2015. • MoH/NHIC Order No 596/404-A of 21 July 2016 approving the Methodological Norms for the implementation of the Single Program of Compulsory Health Insurance.
All women of screening age are entitled to free cervical screening through PHC services whether or not they are registered with NHIC.	• MoH/NHIC Order No 1087/721-A of 30 December 2016 approving the Regulation on the registration of the individual with the family doctor from the health care facility providing primary health care under the compulsory health insurance. • MoH/NHIC Order No 596/404-A of 21 July 2016 approving the Methodological Norms for the implementation of the Single Program of Compulsory Health Insurance. • MHLSP/NHIC Order No 515/130-A of 13 April 2018 on the Performance Indicators in the Primary Health Care.
All PHC facilities in RM must provide cervical screening (Pap test).	• Cervical Cancer. National Clinical Protocol – PCN-142. Chisinau 2015. • MoH/NHIC Order No 247/125 A of 28 March 2017 on the Performance Indicators in the Primary Health Care. • MoH/NHIC Joint Order No 596/404-A of 21 July 2016 approving the Methodological Norms for the implementation of the Single Program of Compulsory Health Insurance. • National Standard Operating Procedures for Cervical Screening, approved by Order of the Ministry of Health of the Republic of Moldova No 533 of 25 June 2015.

[29] Philip Davies, Diana Valuta. Capacity Assessment and Recommendations for a National Cervical Cancer Screening Program in the Republic of Moldova. Chisinau, 2014. Available at https://moldova.unfpa.org/sites/default/files/pub-pdf/Assessment%26Recommendations_Cervical%20Cancer%20Screening%20Moldova%202014_EN.pdf

	• MoH Order No 252 of 1 April 2011 on the Intensification of Prevention in PHC. • MoH Order No 695 of 13 October 2010 on Primary Health Care in the Republic of Moldova. • MoH Order No 504 of 25 December 2008 on Prophylactic Medical Examination of the Population. • MoH Order No 144/65A of 12 April 2007 on Equipment for PHC Institutions.
All family doctors and nurses must know how to take samples for cervical screening, and have screening counselling skills.	• NATIONAL Cancer Control PROGRAM for 2016-2025, Government Decision No 1291 of 2 December 2016. • National Standard Operating Procedures for Cervical Screening, approved by Order of the Ministry of Health of the Republic of Moldova No 533 of 25 June 2015 • MoH Order No 695 of 13 October 2010 on Primary Health Care in the Republic of Moldova.
Clinical guidelines for taking cervical samples for cervical screening.	• Cervical Cancer. National Clinical Protocol – PCN-142. Chisinau 2015. • MoH Order No 722 of 16 July 2012 on Improvement of Cytological Pathomorphologic Services in the Republic of Moldova. • National Standard Operating Procedures for Cervical Screening, approved by Order of the Ministry of Health of the Republic of Moldova No 533 of 25 June 2015.
Guidelines for the referral and follow-up of women with an abnormal cervical screening test.	• 2015 – National Standard Operating Procedures for Cervical Screening, approved by Order of the Ministry of Health of the Republic of Moldova No 533 of 25 June 2015 • 2013 – Precancerous Conditions of the Cervix: Diagnostic Issues and Behaviour. Chisinau 2013. T. Rotari, D. Osadcii, N. Ghidirim and L. Rotaru. • 2012 – Methods of Instrumental Diagnostics in Gynaecology. Chisinau, 2012. O. Cernetchi and M. Stemerg. • 2009 – National Guidelines for the Prevention of Cervical Cancer.
All women registered with NHIC and a family doctor who have abnormal cervical cytology (clinical group 1A) are entitled to free outpatient follow-up services including colposcopy and biopsy conducted in specialised outpatient facilities. Uninsured women must pay for these services.	• MoH/NHIC Order No 596/404-A of 21 July 2016 approving the Methodological Norms for the implementation of the Single Program of Compulsory Health Insurance. • MoH Order No 627/163-A of 9 September 2010 approving the Regulation on the registration of the individual with the family doctor from the health care facility providing primary health care under the compulsory health insurance.
All women registered with NHIC and a family doctor who have abnormal cervical cytology (clinical group 1B) are legally entitled to free treatment in specialised outpatient facilities or inpatient services at the Oncology Institute. Uninsured women must pay for these services.	• MoH/NHIC Order No 596/404-A of 21 July 2016 approving the Methodological Norms for the implementation of the Single Program of Compulsory Health Insurance. • MoH Order No 627/163-A of 9 September 2010 approving the Regulation on the registration of the individual with the family doctor from the health care facility providing primary health care under the compulsory health insurance.
All women with histologically confirmed cervix malignant diseases (clinical group 2) are legally	• MoH/NHIC Order No 596/404-A of 21 July 2016 approving the Methodological Norms for the

entitled to free inpatient treatment at the Oncology Institute, whether or not they are registered with NHIC.	implementation of the Single Program of Compulsory Health Insurance.
All women registered with NHIC and a family doctor who have been successfully treated for a malignant disease (clinical group 3) are legally entitled to active monitoring by an oncologist/gynaecologic oncologist and by a family doctor on a quarterly, biannual or yearly basis. Uninsured women must pay for these services.	• MoH/NHIC Order No 596/404-A of 21 July 2016 approving the Methodological Norms for the implementation of the Single Program of Compulsory Health Insurance.
All women registered with NHIC and a family doctor who are living with malignant diseases (clinical group 4) are entitled to symptomatic palliative care and pain relief through the Oncology Institute and/or family medicine, as required. Uninsured women must pay for these services.	• MoH/NHIC Order No 596/404-A of 21 July 2016 approving the Methodological Norms for the implementation of the Single Program of Compulsory Health Insurance.
The Oncology Institute has responsibility for the provision and supervision of cervical cytology and pathology services.	• MoH Order No 722 of 16 July 2012 on Improvement of Cytological Pathomorphologic Services in the Republic of Moldova.
Cytology/cytopathology work limits.	• Cervical Cancer. National Clinical Protocol – PCN-142. Chisinau 2015. • MoH Order No 722 of 16 July 2012 on Improvement of Cytological Pathomorphologic Services in the Republic of Moldova.
Colposcopy services	• Cervical Cancer. National Clinical Protocol – PCN-142. Chisinau 2015. • MoH Order No 1239/253 of 19 December 2012 approving the Methodological Norms for the implementation in 2013 of the Single Program of Compulsory Health Insurance. • MoH Order No 695 of 13 October 2010 on Primary Health Care in the Republic of Moldova.
Performance indicators	• NATIONAL Cancer Control PROGRAM for 2016-2025, Government Decision No 1291 of 2 December 2016. • MHLSP/NHIC Order No 515/130-A of 13 April 2018 on the Performance Indicators in the Primary Health Care.

An analysis of the current situation, carried out with the support of international consultants[30], found a number of gaps in ensuring a regulatory framework to govern this field, namely:

- Republic of Moldova has no working practice recommendations for cervical cytology screening. In the past, Ministry of Health Order No 68 of 10 March 2005 set a limit of 67 Pap tests/cyto-screener/day. However, this Order was subsequently replaced by MoH Order No 722 of 16 July 2012 that did not specify any limit.
- Republic of Moldova does have standard operating procedures (SOPs) for cytology laboratories, but there are no mechanisms to monitor and evaluate laboratory performance or encourage laboratory staff to implement the SOPs, the provisions of which are not observed by most laboratories.

[30] Philip Davies, Cesare Gentili, Diana Valuta and others. Assessment of Cervical Cytology Services in the Republic of Moldova and Recommendations for their Reorganisation to Comply with International Evidence-Based Standards. Chisinau, 2016. Available at https://moldova.unfpa.org/sites/default/files/pub-pdf/RM%20Cervical%20Cytology%20Assessment%20%20Recommendations_eng.pdf

- Republic of Moldova has no quality assurance program, with performance indicators and standards for any component of the cervical screening. As a result, there is no mechanism to monitor and evaluate the quality of the cervical screening services or, more importantly, to identify sub-optimal performance so they can be improved.

Facilities providing cervical screening

MoH Order No 695 of 13 October 2010 states the following:

- All PHC facilities must provide cervical screening services.
- All family doctors and nurses must know how to take cervical samples/Pap tests.
- Colposcopy services for further investigation of women with abnormal Pap test result must be available in all TMA, FDC, and HC.

The National Standard Operating Procedures for Cervical Screening describes in detail the duties of PHC staff (PHC facility managers, family doctors and their nurses) while performing cervical screening activities.[31]

Although the network of PHC facilities in RM is vast and easy to access, the data in recent years show a serious staff shortage in this sector, especially in rural areas. This negatively influences the access of rural women to cervical screening services.

Note that in the Republic of Moldova the vast majority of cervical cytology tests are currently processed/stained using the Romanowsky-Giemsa technique. The use of this technique for cervical screening is largely restricted to the countries of the former Soviet Union, and the rest of the world uses mostly only the Papanicolaou technique. These two techniques use completely different processing/staining processes so the cytological interpretation is also completely different and laboratories specialised in one technique cannot train cyto-screeners to work in laboratories using the other. Thus, RM needs to urgently improve the quality of cervical cytology services. This can be effectively achieved by exchanging good practices in cervical cytology training with countries that have high quality cervical cytology, but all these countries use the Papanicolaou processing/staining technique. Therefore, continuing to use the Romanowsky-Giemsa processing/staining technique in RM will prevent cervical cytology laboratories here from achieving internationally recognised evidence-based standards.

Financing

According to GD No 1291 of 2 December 2016 on the National Cancer Control Program for 2016-2025, the financing of the services provided to the persons with cancer is guaranteed by the compulsory health insurance funds, which are the own resources of the health care facilities, obtained under the law in force, under the contracts entered into with the National Health Insurance Company (NHIC), within the limits of the available financial means.

According to WHO recommendations, RM law provides that cervical screening and cervical cancer treatment are offered free of charge to all women, whether or not they have compulsory health insurance. This is particularly important since the cervical screening targets women who are healthy, so they are motivated to participate in the cervical screening, preventing the cervical cancer to develop.

However, the follow-up of abnormal Pap tests to confirm cancer diagnosis is provided free of charge only to the insured women, while those uninsured encounter here a financial barrier. Therefore, imposing this condition tends to restrict participation in cervical screening only of the women who can financially afford it. At the same time, this situation seems to be in contradiction with Government policies on the fair provision of health care in RM.

Thus, some of the uninsured women are reluctant to make further investigations, or choose not to participate in the screening, generally because of the fears of the cost of these services.

[31] National Standard Operating Procedures for Cervical Screening, approved by Order of the Ministry of Health of the Republic of Moldova No 533 of 25 June 2015. Available at http://old.ms.gov.md/_files/15134-asa.pdf

The key objective of cervical screening is to identify pre-cancerous lesions and thus prevent cervical cancer from developing. However, the provision of cervical screening services becomes useless if follow-up, diagnosis and treatment are not provided for all women with a positive/abnormal result of the cervical screening test.

Human resources

- *At PHC level*

A study in the field revealed significant gaps in the skills of PHC staff in performing cervical screening activities. To fulfil these duties, PHC staff must have a good understanding of the entire cervical screening process and also know how to effectively counsel women about the importance of cervical screening, monitor and manage the cases in the context of different Pap tests results, the follow-up procedures and further treatments[32].

Because of the importance of PHC staff to the effective operation of a cervical screening program, many countries with organised cervical screening programs require PHC staff to be certified as having completed an approved training program before they can participate in the cervical screening. Adopting this policy in RM would ensure PHC staff understand the operation of the screening services, women referral criteria and pathways, and their counselling, needed to maximise recruitment and ensure the smooth conduct of the follow-up.

- *At laboratory level*[33]

Conducting cervical cytological screening and cervical cytopathology services:

  - *Cervical cytology* screening is the process of examining Pap tests to find any abnormal cervical cells that may indicate, in the earlier stages, the presence of clinically relevant cervical pre-cancer or cancer. In most of Western Europe, cervical cytology screening is conducted by specially trained laboratory technicians (cyto-screeners) who sign-off Pap tests when abnormal cells are found and refer these tests with abnormal cells to cytopathologists.
  - *Cervical cytopathology* is the process of examining and classifying the abnormal cells that have been found by the cyto-screeners and proposing appropriate procedures to follow-up the women. This will be conducted by medically qualified doctors who have undertaken a cytopathology residency program.

Within Chisinau municipality, the total number of laboratory technicians would be more than sufficient to meet the requirements for the required number of screening tests under a fully operational cervical screening program with 75% coverage of the target population and using the limit of 67 Pap tests/cyto-screener/day set previously by the Order of the Ministry of Health No 68 of 10 March 2005 (282,352 Pap tests/year ÷ 67 Pap tests/cyto-screener/day x 240 working days/year = 18 full-time cyto-screeners), depending on the amount of work these people are required to do for other health services.

In the Republic of Moldova there are no defined requirements for training and certification for the laboratory specialists involved in cervical screening. Recognition of such a separate laboratory specialisation would ensure the provision of these services by trained and qualified specialist and an adequate level of safe and quality services.

For the training of cytopathologists, a mandatory cytopathology residency program was established in 1998 so people subsequently choosing this profession will have completed this residency, while those choosing at an earlier date will have undertaken an internship program. For the training of cyto-screeners, RM has no nationally approved training curriculum or program, so the specialists currently providing these services will have been trained in general laboratory techniques with subsequent on-the-job training in cytology. Cyto-screener performance is highly dependent on the specialised training, so the lack of an evidence-based training program, with high training standards, compromises the quality of cervical screening services.

An analysis by international experts (from the Royal College of Pathologists) states/recommends[34] that RM nationally would need further 9 histopathologists and 10 laboratory technicians specialised in histology. It also stated the need to purchase additional specific laboratory equipment.

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[32] Philip Davies, Diana Valuta. Capacity Assessment and Recommendations for a National Cervical Cancer Screening Program in the Republic of Moldova. Chisinau, 2014. Available at https://moldova.unfpa.org/sites/default/files/pub-pdf/Assessment%26Recommendations_Cervical%20Cancer%20Screening%20Moldova%202014_EN.pdf

[33] Philip Davies, Cesare Gentili, Diana Valuta and others. Assessment of Cervical Cytology Services in the Republic of Moldova and Recommendations for their Reorganisation to Comply with International Evidence-Based Standards. Chisinau, 2016. Available at https://moldova.unfpa.org/sites/default/files/pub-pdf/RM%20Cervical%20Cytology%20Assessment%20%20Recommendations_eng.pdf

[34] Michael Coutts, Charles van Heyningen. Moldova: Building capacity in gynaecological pathology. Report and capacity assessment following a visit from the Royal College of Pathologists, June 2016.

Rules on cervical cancer prevention and treatment (international approach)

It is important that cervical screening in the Republic of Moldova shift from predominantly opportunistic to well-organised (population-based). In order for a population-based cervical screening program to be successfully implemented, the following elements are needed:

1. A stable budget sufficient for the on-going costs of all of the services required to implement the cervical screening program.
2. A central administration with responsibility for cervical screening policy and for coordination of all elements in the cervical screening process, including recruitment, recall, monitoring and continuous improvement of service quality.
3. Access to a current database of the target population for recruitment, monitoring and continuous improvement of service quality.
4. A central screening register or linked registers to record cervical cytology, colposcopy and histology that can be used for call, recall, tracking of screen positive or abnormal results and continuous improvement of service quality.
5. Access to a cancer register for continuous improvement of service quality, and an audit program.
6. Evidence-based training standards, clinical guides and performance indicators.
7. A comprehensive policy on continuous quality improvement, covering the entire cervical screening process from initial recruitment to the supervision and management of people with different cervical test results.
8. Educational programs and information for behavioural change for the general public and for health professionals.
9. Mechanisms for identifying and recruiting vulnerable groups from the target population.

These elements are essential to the effective operation of cervical screening programs. Therefore, the suboptimal performance of any one or more of them will reduce both the effectiveness and the efficiency of a cervical screening program, even to the point where it has no measurable effect on cervical cancer incidence but still consumes substantial resources and produces a range of harms.

The World Health Organization issued a set of recommendations on the criteria for age and frequency of cervical screening [35].

- Women younger than 30 years of age should not undergo cervical screening except for women known to be HIV-infected or living in a high HIV prevalence area.
- Cervical cancer screening should be performed at least once for every woman in the target age group where most benefit can be achieved: 30-49 years. At a minimum, a national program should prioritize women who are between 30-49 years old for cervical screening.
- Priority should be given to maximizing coverage within the at-risk target age group and assuring complete follow-up of those women with abnormal cervical screening test results rather than maximizing the number of tests performed in a woman's lifetime.
- Cervical screening tests currently recommended: HPV testing, conventional Pap test and liquid based cytology, and visual inspection with acetic acid (VIA).
- The recommended screening interval (frequency) should not be less than 5 years (and not less than 10 years, if using an HPV test).
- In high HIV prevalence countries, women who screen positive/abnormal for cervical cancer should be offered HIV testing and counselling.
- Among women who test negative with VIA or cytology, the interval for re-screening should be three to five years.
- Among women who test negative with HPV testing, re-screening should be done after a minimum interval of five years.

[35] WHO guidance note: comprehensive cervical cancer prevention and control: a healthier future for girls and women. WHO 2013. Available at http://apps.who.int/iris/bitstream/handle/10665/78128/9789241505147_eng.pdf;jsessionid=E688ADE7008D2909CC02775F42174587?sequence=3;
Comprehensive cervical cancer control: a guide to essential practice – 2nd ed. WHO, 2014. Available at: http://apps.who.int/iris/bitstream/handle/10665/144785/9789241548953_eng.pdf?sequence=1

- For cervical cancer prevention to be effective, women with positive cervical screening test results must receive appropriate/effective treatment.
- Three options for providing services for cervical screening and treatment of precancerous lesions are recommended: 'screen-and-treat', 'sequential testing, followed by treatment if precancerous lesions are re-confirmed', and 'cervical screening, followed by colposcopy and biopsy with treatment based on the biopsy result in case of abnormal outcome'.
- Decisions on which cervical screening and treatment approach to use in a particular country should be based on a variety of factors, including benefits and harms, potential for women to be lost to follow-up, cost, and availability of the necessary equipment and trained human resources.
- In the screen-and-treat approach, the treatment decision is based on a screening test and treatment is provided soon or, ideally, immediately after a positive screening test (i.e. without the use of a diagnostic test).
- The screen-and-treat approach reduces loss to follow-up, and can reduce the time lag for women to receive treatment.
- If cervical cancer is suspected in women who attend screening, they should be referred to a facility specialised in the diagnosis and treatment of oncological diseases.
- Loop electrosurgical excision procedure (LEEP) is the treatment recommended for the majority of women who screen positive for pre-cancer. Cryotherapy is another recommended method of treatment if the loop electrosurgical excision procedure (LEEP) is not available.

CHAPTER II: OBJECTIVES AND METHODOLOGY OF THE RESEARCH

2.1 Survey Objectives

1. Identify the perception, beliefs and general practices of women in the target group on preventing health problems
2. Assess the knowledge, beliefs and attitudes of women in the target group on preventing cervical cancer by cervical screening and the availability of cervical screening services
3. Assess the knowledge, beliefs and attitudes of women in the target group on preventing cervical cancer by HPV vaccination
4. Estimate the prevalence of cervical screening among women in the target group in Moldova
5. Elucidate possible associations between socio-demographic factors and cervical screening behaviour
6. Identify the level of satisfaction of women in the target group with cervical screening access and quality
7. Identify the barriers to accessing screening services and the intention of women in the target group to use screening services and follow the indications/recommendations of health professionals
8. Identify the preferences for forms of information and invitation of women in the target group to access cervical screening services
9. Deepen and contextualise the aspects relevant to cervical screening from the perspective of women in the target group
10. Identify the perspective of health care providers involved in the prevention of cervical cancer, and in particular in the provision of cervical screening services
11. Identify the health experts' perspective on developing, coordinating and monitoring the implementation of policy documents on cervical cancer prevention (organisation, financing, ensuring and continuously improving the quality of cervical screening services, etc.)
12. Formulate evidence-based recommendations for decision-making in order to improve the access to and quality of cervical cancer prevention services in the Republic of Moldova
13. Formulate evidence-based recommendations for the development of a communication strategy for behavioural change of the target population in order to improve the access to cervical cancer prevention services in the Republic of Moldova.

2.2 Research Methodology

The **triangulation** of both the participants and the data collection methods (quantitative/qualitative) was the principle of the methodology used.

2.2.1 Data Collection Methods

Quantitative (survey/structured interview) and qualitative (focus groups, semi-structured interviews) data were collected.

The **structured interview with women** (which allowed for quantitative data coding) included various aspects that make it possible to outline the answers to the above objectives:

- Demographics (age, education, profession, marital status, ethnicity, religion, etc.)
- Medical history
- Cervical screening history
- Knowledge about cervical screening, cervical cancer risk, HPV vaccination; information sources
- Experience of accessing health care services for cervical screening
- Satisfaction with service access and quality/barriers to accessing cervical screening services
- Health beliefs
- Intention to do the cervical screening

The field interviewer reads the questions of the structured interview in the same order for each participant.

The understanding of the structured questionnaire was tested by a pilot study on 30 women aged 25-61 (20 questionnaires in Romanian and 10 in Russian). This group included at least 1-2 women for each of these education categories: No education; Primary school; Secondary school; High school; Vocational school; College; University studies (and the difference of up to 30 was made up of the prevailing educational segment among women in Moldova).

Distribution of pilot interviews

Education	Urban	Rural
No education	1	1
Primary school	1	1
Secondary school	1	1
High school	1	1
Vocational school	4	4
College	3	3
University studies	4	4
Total	**15**	**15**

Focus groups and semi-structured interviews with women:

The interview guide allowed exploring women's perceptions of their health, risk, their experience with accessing the health care system, barriers to cervical screening, decision-making, doctor-patient relationship. Questions of the semi-structured guide did not have a strict order, the themes in the guide were indicative to encourage women to relate their views and own experiences.

Semi-structured interview with cervical screening doctors and health policy experts:

The interview guide for cervical screening providers was structured on 12 major themes for cervical screening and early detection of cervical cancer risk. The guide was flexible, so that every health worker was able to detail his/her expertise in his/her answers.

The guide for experts mainly included questions about relevant national policy documents, organisation procedures, financing, ensuring the quality of cervical screening services, etc.; realities, aspirations and opportunities.

All semi-structured interviews were recorded and fully transcribed.

2.2.2 Research Sample

2.2.2.1 Structured Interviews

The target population of the Assessment of Knowledge, Attitude and Practice on Cervical Cancer Prevention in the Republic of Moldova – KAP Survey – was represented by female adult population aged 25-61 from the Republic of Moldova (target group eligible for cervical screening in the Republic of Moldova, according to the National Standard Operating Procedures for Cervical Screening). According to the data of the National Bureau of Statistics (NBS) for 2016, the target population includes about 1,025,101 women, 47.95% living in the urban area and 52.05% – in the rural area. The sampling population did not include the population from the left bank of the Nistru River and Bender municipality. According to NBS data, the *sample volume of N=1,226 had an error margin of ±3%.*

Sample design

A stratified, multistage probabilistic sampling design was used in order to maximise the chance of obtaining a representative sample.

Stratification was conducted on the basis of the following criteria:

- geographic region (districts)
- are of residence (urban and rural) and
- community type (municipality, town, large-, medium- and small-sized villages).

The number of people included in the survey was established for each layer, using the share of layers in the population, which ensured the representativeness of all regions of the country. In its first stage, the selection focused on the *communities* from different districts; the second stage – the *households*; and the third stage – the *respondents*. The number of communities (including Chisinau and Balti municipalities) where questionnaires were used: 80. The number of sampling points: 200 per sample.

Stratified multistage sampling

1) Choosing the community

Stage 1: multistage stratification. Level 1 stratification in 11 groups and level 2 stratification in urban and rural areas (large-, medium- and small-sized villages).

To select a nationally representative sample, the whole country was divided into 11 geographic region groups, each of them comprising on average 3 districts. Thanks to this procedure, interviews had a uniform geographic coverage. Interviews were conducted in each of the 11 groups, both in urban and rural areas.

The 11 groups are based on the former counties:

Step 2: Stratification. Towns and villages were selected in each layer.

The next step was to select randomly the required number of communities where the interviews took place.

Villages: There are three layers for the rural area – large-, medium- and small-sized rural communities. The number of communities was established taking into account that the number of interviews was limited: for a bigger village – 13 interviews, for a medium village – 10 interviews and 8 interviews – for a small village.

Towns: urban communities are divided into district centres and other urban communities. The country has 34 district centres and 21 other towns (other than district centres). District centres were selected randomly from each group. To ensure that smaller towns can also be part of the sample, a random selection of certain towns in the northern, centre and southern area was made. In this way, the survey made sure that such urban communities are also part of the sample (otherwise, in the case of samples below 3,000 respondents, these communities would practically not be included in the sample because in most cases they are significantly smaller than district centres).

Distribution of interviews per towns (district centres and other cities than district centres) and villages (small-, medium- and large-sized)

Group	Area	Sample quotas	Rural	Urban District centre	Urban Other towns
Gr. 1, Briceni, Edinet, Ocnita and Donduseni	Urban	**17**	-	17	-
	Rural	**52**	52	-	-
Gr. 2, Soroca, Drochia and Floresti	Urban	**39**	-	27	12
	Rural	**57**	57	-	-
Gr.12, Balti municipality	Urban	**61**	-	61	-
Gr.3, Falesti, Glodeni, Rascani, Sangerei and Balti municipality, rural	Urban	**20**	-	20	-
	Rural	**76**	76	-	-
Gr.5, Chisinau municipality	Urban	**308**	-	308	-
	Rural	**26**	26	-	-
Gr.4, Orhei, Rezina, Soldanesti, Telenesti and Dubasari, rural	Urban	**24**	-	24	-
	Rural	**79**	79	-	-
Gr.6, Anenii Noi, Criuleni, Ialoveni and Straseni	Urban	**32**	-	24	8
	Rural	**91**	91	-	-
Gr.7, Ungheni, Calarasi and Nisporeni	Urban	**27**	-	27	-
	Rural	**56**	56	-	-
Gr.8, Basarabeasca, Hancesti, Leova and Cimislia	Urban	**21**	-	21	-
	Rural	**62**	62	-	-
Gr.9, Causeni, Stefan Voda	Urban	**13**	-	9	4
	Rural	**39**	39	-	-
Gr.11, Taraclia, Cahul and Cantemir	Urban	**32**	-	32	-
	Rural	**48**	48	-	-
Gr.10, ATU Gagauzia	Urban	**13**	-	-	13
	Rural	**33**	33	-	-
Total	Urban	**607**		570	37
	Rural	**619**	619		
Total		**1,226**	**619**	**607**	

2) Choosing the household

For the capital city, a list of streets was used to select randomly the **streets**, and the starting points for each street. If the starting point was not a liveable house or no one lived at that address, the interviewer went further on the same side of the street until he/she found a liveable house. Using the random number table, depending on the number of apartments in this house, the **starting apartment** was selected. After that, the interviewer knocked on the third door, skipping 2 apartments.

Return: the interviewer returned two more times to apartments that were unavailable for the first time, with an interval of a minimum 4 hours, or returned another day.

For other towns: using Google Maps, the town was divided into 4 proportional quadrants. Randomly, one of the quadrants in which the interviews were conducted was selected.

Further, the **street** and the **exact house** were selected randomly (the starting point for each interviewer was selected separately). Then he/she followed the +3 rule, skipped 2 apartments and knocked on the third door to make the next interview.

Villages:
Below is described the methodology for selecting the households in rural areas:

1. Division of villages into quadrants (for a small village of up to 300 inhabitants – no quadrants, for villages up to about 1,000 inhabitants – 2 quadrants, for villages of up to about 1,500 inhabitants – 3 quadrants and for villages larger than 1,500 inhabitants – 4 quadrants).
2. **Random** selection of the **quadrant** for each village that entered the sample.
3. Choosing the starting point – the **starting point** and the interviewer were selected; if the starting point was not available, he/she went to the next house.
4. Follow of the +3 house rule.

3) Choosing the respondent

If someone in the household opened the door, the interviewer invited for interview the person who met the criteria, and in cases where there were several persons in the household who met the criteria, the interviewer selected the eligible person **who celebrated last his/her birthday**. If this person was away for a long time (e.g., working abroad), the interviewer chose the person who had the birthday before the former. Eligible for participation in the survey were considered only the persons residing at the address/household selected; visiting persons were not considered eligible.

If the eligible person was not at home, the interviewer returned later (the maximum number of visits being 3, after the third unsuccessful attempt to contact the respondent, the interviewer did not return to the same household). Each contact was recorded in the interviewers' road-maps (where the result of each contact was also recorded).

Data collection

If he/she contacted the eligible person, following the introduction of the purpose and objectives of the survey and the information covered by the questionnaire, the interviewer sought their informed consent. Field interviewers used a set of standard instructions in communicating with the respondents.

A team of 30 interviewers was involved in data collection. All interviewers who collected data for this research were women. All of them were trained prior to the field work. The training explained the interviewers the purpose of the project, the questions and pre-coded answers. They were also trained in the procedures for marking the answers and how following the questionnaire instructions.

Quality control and elimination of potential risks

The accuracy of survey data collection was checked via the following methods:

1. Checking the quality and accuracy of the survey, *field checking* of 30% of routes and visiting the domicile of the subjects to check comprehensively the accuracy of route choice and person selection. The checking was done by selecting randomly the routes from the list of communities included in the sample (the check chose randomly the routes per each interviewer to verify the work done by each of them);

2. *Calling by phone* 50% of the persons surveyed, randomly selected (except the respondents re-called face to face). Thanks to this method, 611 respondents were re-called and confirmed their participation in the survey. According to the internal procedures, 50% of the questionnaires filled in by each interviewer were verified by phone. If suspect trends/cases were identified at an interviewer, 100% of the questionnaires filled in by him/her were verified by phone;

3. *Reviewing all questionnaires* and verifying by phone those 'suspect'.

2.2.2.2 Focus Groups and Semi-Structured Interviews with Women

As many as 8 group discussions and 7 in-depth interviews, attended by 51 women aged 25-61, were conducted. The table below includes the demographic characteristics of the women who participated in the qualitative survey:

Distribution of participants in group discussions

Type	Community	Education	Age			Total	Grand Total
			25-35	36-50	50+		
Participated in the screening	Chisinau	Secondary or lower[36]	2	2	-	4	10
		Vocational or higher[37]	2	2	2	6	
	Urban without Chisinau	Secondary or lower	1	2	2	5	10
		Vocational or higher	2	2	1	5	
	Rural	Secondary or lower	1	3	2	6	6
Did not participate in the screening	Chisinau	Secondary or lower	2	1	1	4	10
		Vocational or higher	2	3	1	6	
	Urban without Chisinau	Secondary or lower	2	2	3	7	10
		Vocational or higher	1	2	-	3	
	Rural	Secondary or lower	2	1	2	5	5

2.2.2.3 Semi-Structured Interviews with Health Workers

In-depth interviews with 40 doctors and nurses (women and men) involved in various stages of the cervical cancer prevention program: family doctors, family doctor nurses, gynaecologists, oncologists, cytologists, histopathologists, were conducted. Doctors invited to participate in the survey (family doctors and specialist doctors) came from both big and small towns, as well as from villages (family doctors and nurses).

Distribution of in-depth interviews with health workers

Specialist	Area			Total
	Chisinau	Other towns	Rural	
Family doctors	5	5	5	15
Nurses	2	1	2	5
Gynaecologists / gynaecologists colposcopists	5	5	-	10
Oncologists	2	3	-	5
Cytologists	2	1	-	3
Histopathologists	1	1	-	2

2.2.2.3 Semi-Structured Interviews with Health Policy Experts

As many as 15 individual interviews with health policy experts (women and men) involved particularly in coordinating the implementation of the National Strategy for Non-communicable Disease Prevention and Control for 2012-2020, National Cancer Control Program for 2016-2025, Action Plan Building the Capacities to Implement Cervical Screening for 2016-2018 were also conducted. Experts from the Ministry of Health, Labour and Social Protection, National Agency for Public Health, Mother and Child Institute/Cervical Screening Coordination Unit, Oncology Institute and other relevant institutions involved in performing cervical screening participated in these interviews. Each participant signed the informed consent form before providing information, thus agreeing to participate in the survey.

[36] By 'secondary or lower' education it is assumed that the respondent has no education or completed an educational institution, such as primary, lower secondary, upper secondary or upper secondary (lyceum).

[37] By 'vocational or higher' education it is assumed that the respondent completed an educational institution, such as vocational school, college, university or he/she has post-university studies.

2.3 Analysis Methods for Data

For structured interviews: numerical/quantitative analysis; besides the frequency and percent analysis, the data allow to identify significant differences between groups via the chi-squared test, comparisons between areas via the t test, and possible predictors for screening intention and behaviour. SPSS software was used for the analysis.

For semi-structured interviews: thematic analysis of the inductive-deductive content, with the identification of major themes and sub-themes (e.g. awareness and knowledge about cervical screening, cervical screening perception). The themes were interpreted in a national context.

Calculation of the integrated indicator: 'Women' satisfaction with accessibility and quality of cervical screening services' was calculated taking into account the respondents' answers to two questions. The number of women who indicated they were satisfied (they gave 5 or 4 points on a scale from 1 to 5, where 5 is very satisfied and 4 – satisfied) both with the accessibility and the quality of the cervical screening services was calculated.

The results were synthetically summarised, and conclusions and a set of recommendations based on the results were drawn up.

2.4 Ethical Agreement and Data Confidentiality

Before participating in the survey, each respondent gave his/her informed consent. Each participant was informed verbally and in writing, via the consent form/informed consent, about the research objectives and the conditions for participation in the survey. Each respondent was informed that participation in the survey was voluntary, that he/she could withdraw at any time, that his/her answers would be confidential and anonymous, and that he/she would not be exposed to any physical, psychological or social risk. If the respondent agreed to participate, he/she signed the consent form/informed consent. If the respondent did not agree participate in the study, the interviewer left the household and selected a new respondent according to the procedure described above.

Respondents' answers were treated as strictly confidential and anonymous, and their name was not recorded. Contact details were used only to make sure that data collection was accurate.

CHAPTER III: RESULTS OF THE SURVEY AMONG THE FEMALE POPULATION

3.1 Results of the Survey for the Female Population

3.1.1 Socio-Demographic Data of the Female Sample

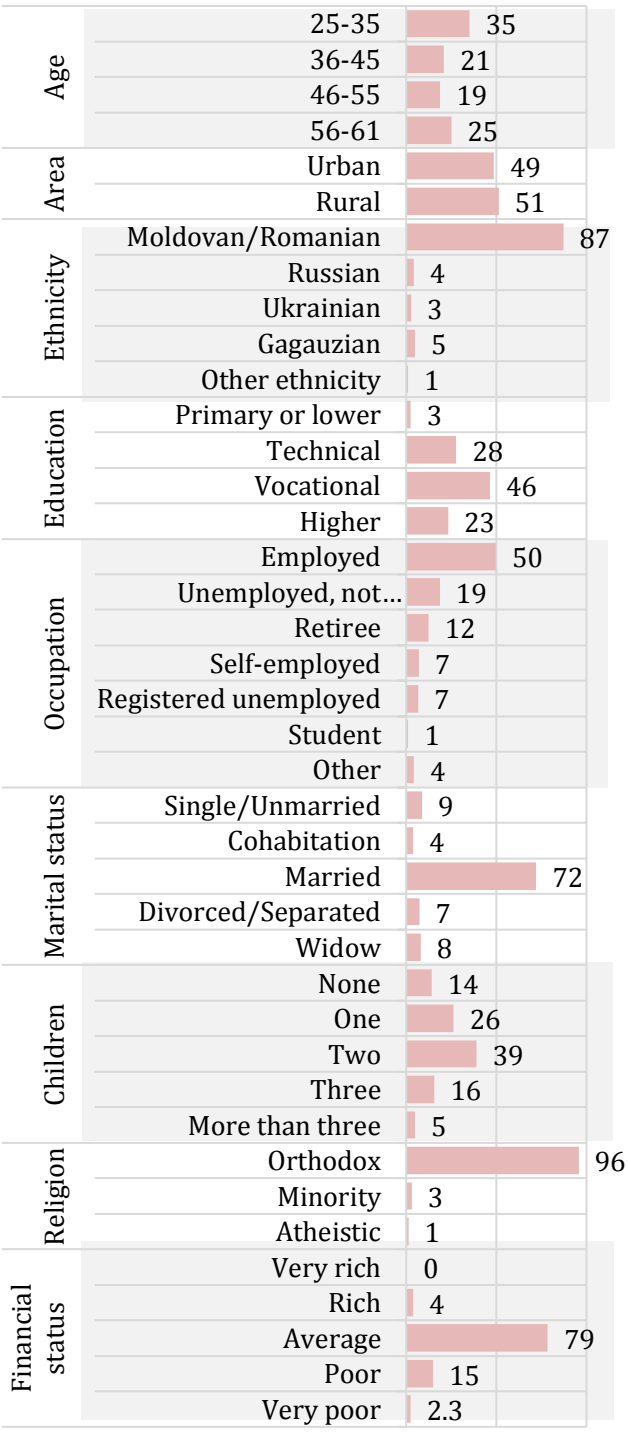


Figure 3.1.1: Socio-demographic characteristics of the sample, N=1,226, %

As many as 1,226 women participated in the survey, and their socio-demographic characteristics are presented in Figure 3.1.1.

The target group of the survey was women aged 25-61 and the average age of the sample was 43 years.

The majority of women (87%) who participated in the survey identified themselves as Moldovan/Romanian, 5% said they were Gagauz, and 4% declared themselves as Russians.

Most women (46%) have vocational[38] or secondary [39](28%) education, and 23% had higher education.

Of the total sample, 57% said they were employed, 26% were unemployed and 12% were retiring.

Almost three quarters of women interviewed said they were married, and 86% said they had at least one child.

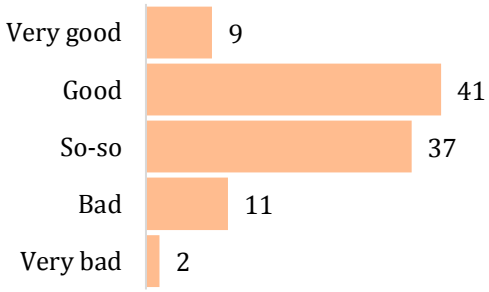
At the same time, 79% of women described their household as having an average level of prosperity/income, and 17% described it as poor or very poor.

[38] By vocational education it is assumed that the respondent has graduated from a vocational school or a college.
[39] By secondary education it is assumed that the respondent completed an educational institution, such as lower secondary, upper secondary or upper secondary (lyceum).

3.2 Women's Opinion on Their Health Status

Among women aged 25-61, most considered their health to be good and very good (50%), or neither good nor bad (37%). At the same time, 13% of women said they perceived their health as bad or very bad.

Figure 3.2.1: Opinion on health status, N=1,226, %



As much as 31% of the women who participated in the survey said they were diagnosed with a chronic disease, and 3% said they had a physical or mental disability. Most of the women diagnosed with a chronic disease mentioned to suffer from high blood pressure (24%), diabetes (14%), and pancreatitis (6%).

Figure 3.2.2: Self-reported medical diagnostic, N=1,226, %

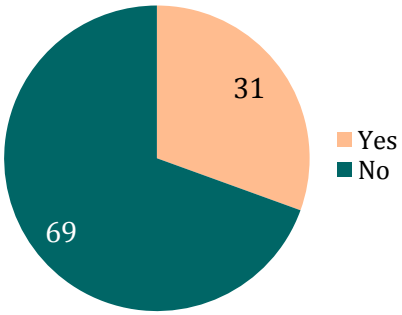
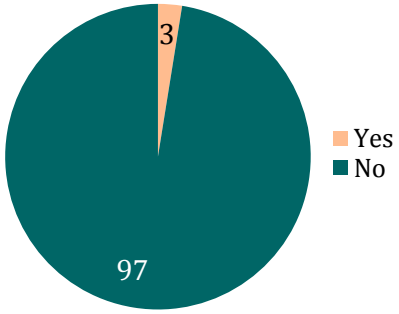


Figure 3.2.3: Self-reported disability, N=1,226, %



3.3 Access to Health Care

Of the total sample of women aged 25-61, 69% said they were covered by the compulsory health insurance system, and 87% – that they were registered on a family doctor's list. As much as 95% of the insured women said they were registered on a family doctor's list, in relation to 70% of the uninsured women.

Figure 3.3.1: Share of insured and uninsured persons, N=1,226, %

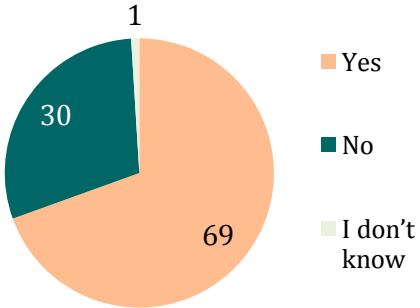
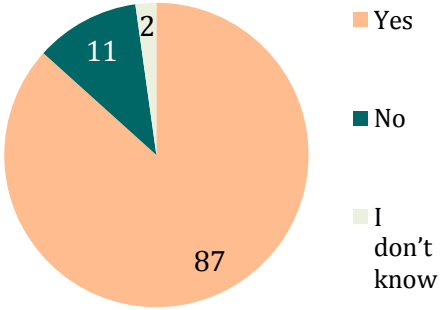
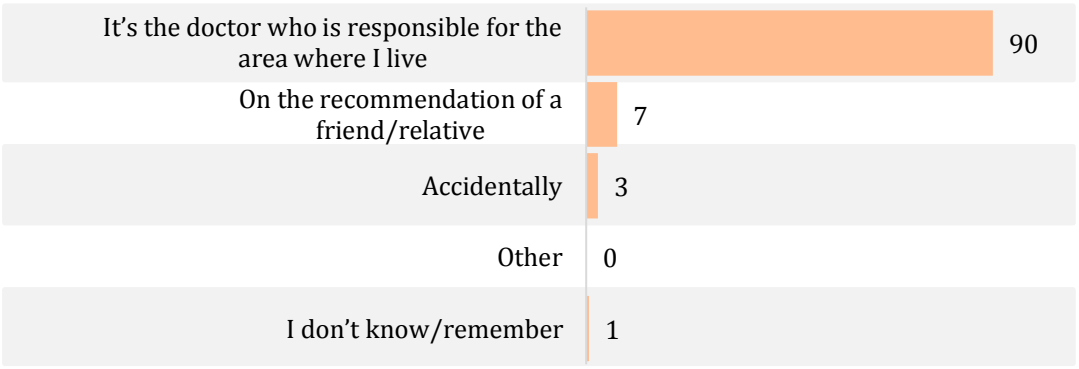


Figure 3.3.2: Share of persons registered on a family doctor's list, N=1,226, %



In most of the cases, women went to the family doctor who served the sector where they lived. However, 7% declared that they went to a doctor recommended by an acquaintance, and 3% said they chose the doctor at random.

Figure 2.3.3: The way of choosing the family doctor by the persons registered on a family doctor's list, N=1,063, %



Of those reported by respondents, 81% of the family doctors they go to are women. At the same time, 27% of women preferred the family doctor to be a woman, and 69% said they did not care about the gender of the general practitioner who consulted them.

Figure 3.3.4: Family doctor's gender, N=1,063, %

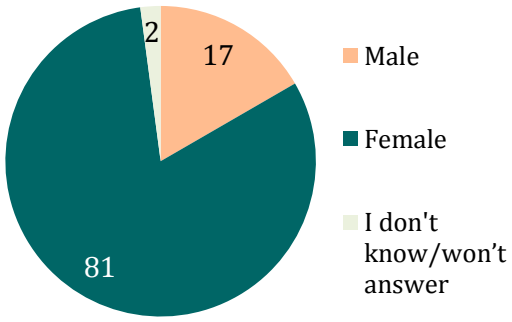
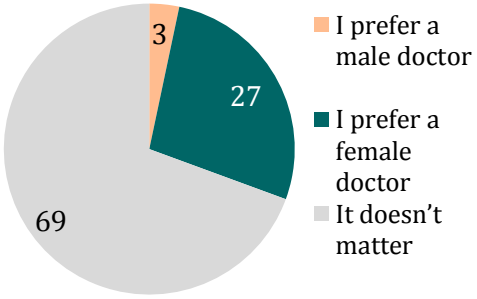
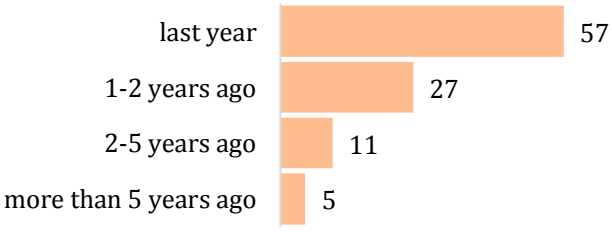


Figure 3.3.5: Preference for the family doctor's gender, N=1,226, %



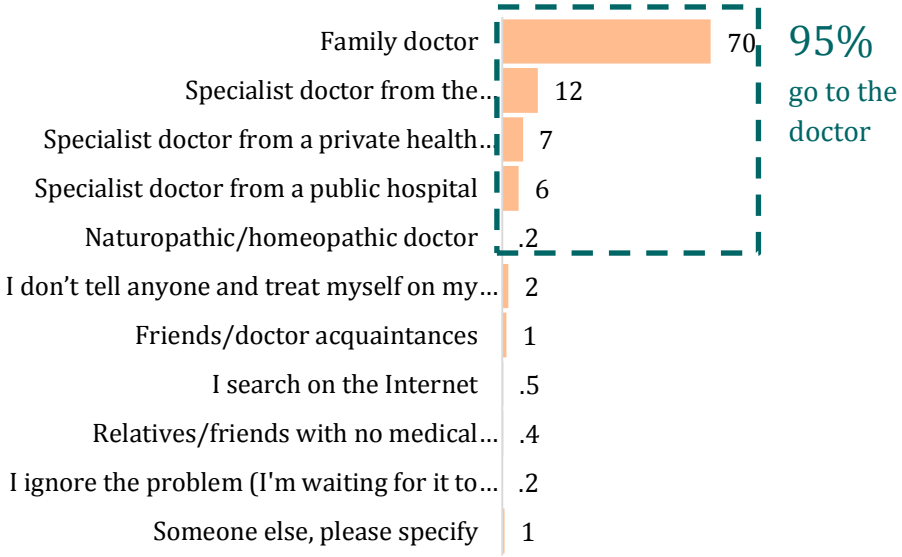
Most women requested a medical examination in the last year (57%), or 1-2 years ago (27%). However, 16% said they had a medical examination earlier than 2 years ago.

Figure 3.3.5: Last medical examination, N=1,226, %



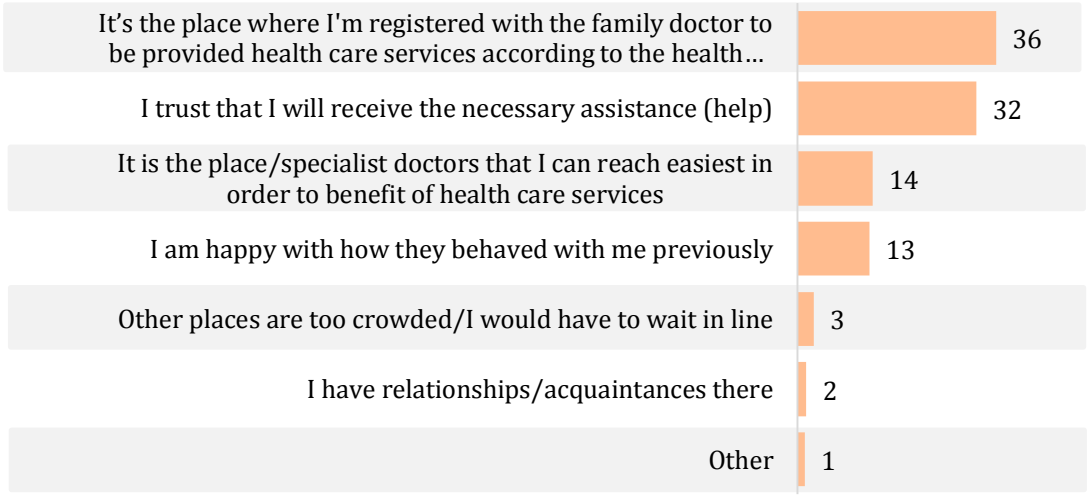
In case of health conditions, 95% of women interviewed go to a doctor. In most cases (70%), women go to the family doctor. Additionally, 12% said they go directly to a specialist doctor in district or municipal health care centres, 7% go to specialist doctors in private facilities, and 6% go to specialist doctors in public hospitals.

Figure 3.3.6: Visits paid to doctors in case of health conditions, N=1,226, %



The decision of 36% of women on the facility/medical worker to whom they can go for a medical consultation is determined by the opportunity to go to the facility where they are registered with the family doctor to receive services covered by the compulsory health insurance. At the same time, 32% said that they chose the doctor because of the confidence that they will receive the help they need. For 14%, the main criterion in choosing the place where to go to a doctor is the proximity to the place of living, and for 13% – the satisfaction with the medical service.

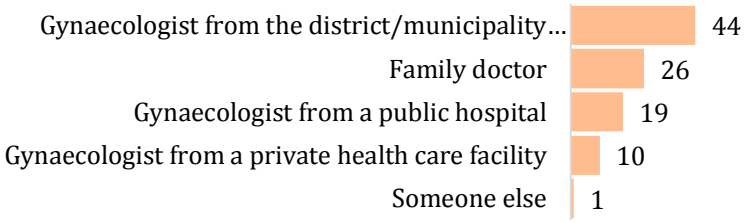
Figure 3.3.7: Main reasons for going to a certain service/specialist in case of a health problem, N=1,226, %



Three quarters of women aged 25-61 contact a gynaecologist for a gynaecological examination or consultation. Moreover, a quarter goes to the family doctor for such a consultation.

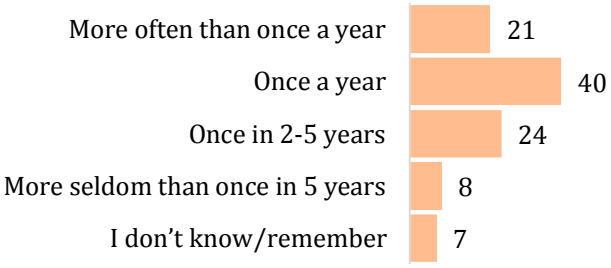
Most women (44%) go to the gynaecologist in the district/municipal health centres for a gynaecological examination. As much as 19% of respondents contact the gynaecologist in a public hospital, and 10% – the gynaecologist in private facilities.

Figure 3.3.8: Where did women go for a gynaecological examination, N=1,226, %



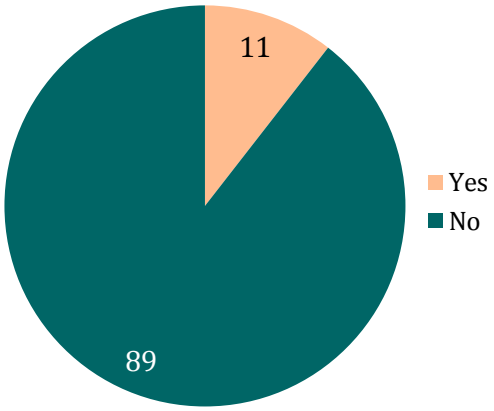
A proportion of 61% of women aged 25-61 said they undergo gynaecological examinations once a year or more often. At the same time, 24% said they consult the gynaecologist once every 2-5 years, and 8% do gynaecological examinations less frequently than every 5 years.

Figure 3.3.9: Frequency of gynaecological examinations, N=1,226, %



Of the total sample, 11% said they had their uterus removed. The likelihood of having had such an intervention increases with age. For instance, 22% of the women aged 56-61 said they had a surgery removing their uterus.

Figure 3.3.10: Proportion of women who had their uterus removed, N=1,226, %



Opinions on the experiences of accessing gynaecological services

The women had different experiences with the gynaecological examination. Mostly, in urban areas, women are more likely to go to the gynaecologist than in rural areas, where women visit this specialist more often if they are guided/referred by the family doctor. Moreover, women in rural areas who did not participate in cervical screening generally said they rarely underwent gynaecological examinations and that they did gynaecological tests only when pregnant. The awareness of the need for preventive gynaecological checks is low in this group. Thus, there are women who choose not to go to the gynaecologist unless they are encouraged by the doctor. These respondents said that they are afraid and feel intimidated when they visit the gynaecologist and that for these reasons they avoid seeing this specialist as much as possible.

Urban women visit the gynaecologist more often. Half of the urban women who participated in the qualitative survey visit the gynaecologist at least once a year for preventive examination. Many women said they use to go

to the gynaecologists that were recommended to them earlier and to whom they have been going for a long time. Thus, urban women said that the quality of gynaecological services is very important for them and they prefer to go to doctors they trust, even if sometimes this means going to private facilities.

According to some women, the need for guidance/referral from the family doctor is a difficulty related to gynaecological examinations. Some women were not satisfied with the appointments they need to make for both family doctor and gynaecologist consultations.

Summary: Access to health care

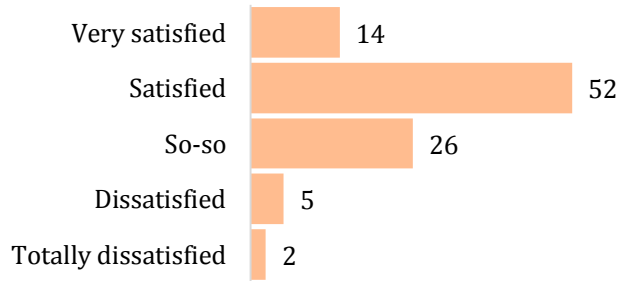
Around 69% of respondents said they are covered by the compulsory health insurance system, and 87% – that they are registered on a family doctor's list. Most people on a family doctor's list (90%) are registered with the doctor who serves the sector where the former are domiciled. The last medical examination of 43% of interviewed women happened more than a year ago. At the same time, 39% of women said they undergo a gynaecological examination less often than once a year. In case of health problems, 95% of respondents visit the doctor, most of them – the family doctor (70%). If a gynaecological examination is needed, 26% of women continue to go to the family doctor, and 63% – to the gynaecologist in a public facility. As much as 11% of women said that they had their uterus removed.

The qualitative research found that rural women are less likely to visit the gynaecologist, both because they go to him/her only if referred by the family doctor and because they feel intimidated. In contrast, urban women are aware of the importance of visiting a gynaecologist; they are dissatisfied with the fact that they need initially to make an appointment with the family doctor who would further refer them to a gynaecologist.

3.4 Satisfaction with Health Care

Most of the women registered on a family doctor's list are satisfied and very satisfied (66%) with his/her services. However, one quarter of women have an average level of satisfaction with health, while 7% are dissatisfied with them.

Figure 3.4.1: Satisfaction with family doctor's services among the women who are on his/her list, N=1,063, %



Opinions on barriers to interacting with the health care system

Regardless of the area of residence, women stated that a major problem is the long waiting time till the appointment for a medical consultation. Although they have an insurance policy, a number of persons criticised the fact that they do not go to and do not benefit from the services provided under the compulsory health insurance system, because they need investigations or consultations faster than they are usually provided. One third of women indicated that it happened that the waiting period for an investigation was more than a few weeks. Hence, they had to go to private clinics because their health status did not allow them to wait.

At a city health care centre she used to go, a woman said she could be consulted at 2 p.m. although she had an appointment at 9 a.m. She explained that, as she noticed, many people were consulted without an appointment

and without following the queue. People in rural areas said they can go without appointment to a doctor to access faster their service. Women in Chisinau choose to go to private clinics where they can schedule an earlier consultation.

According to the respondents from some districts, the shortage of health professionals is the reason why appointments take so long. As regards the gynaecologists, the respondents mentioned that in some towns, where their number is small, they have to work both in hospitals and polyclinics. This is why the appointments to these specialists are longer and consultations are carried out in a hurry. Another problem the respondents reported was the fact that doctors spend a lot of time on bureaucracy issues rather on patients.

It'd be desirable that doctors had more free time for their patients. They always have to fill in a lot of documents, records, etc... we practically don't have enough time to talk or say something.

Respondents believe that hurried consultations influence the quality of and the trust in the medical diagnosis.

I had some more questions to ask, but the doctor told me 'harry up, the next patient has to come in'. In contrast, the doctor from the private clinic calmly explained me every detail. If I'd ask him 10 times a question, he'd explain 10 times the answer.

The women mentioned the brutal attitude of some health professionals, where patients are treated with an inhuman and, sometimes, degrading attitude. Due to the negative experiences they had in interacting with the public health care system and though being covered by the compulsory health insurance system, a number of women gave up on public health care services.

I prefer, however, to pay a little more, but to receive an attitude that is worth the money I give.

Opinions on the satisfaction with the heath care

During some discussions, it became obvious that the patients didn't trust doctors' skills. Much of the distrust is caused by experiences in which treatments were not effective or by situations where different specialists had different opinions on diagnosis and treatment. The respondents told about similar experiences with both family doctors and gynaecologists.

If you go to a doctor, he tells you one thing, if you go to another one, he tells you another thing. You simply don't know who to trust. If I have a serious health problem, I never go just to one doctor.

During some discussions, the respondents made clear that they don't trust the treatment prescribed by doctors due to their suspicion that doctors would have some *'arrangements'* with the pharmaceutical companies or with some pharmacies to prescribe more expensive drugs.

In some rural areas, women said they don't access the health care in districts or small towns because they don't like the doctors' attitude towards rural women. They claim that the doctors don't take them seriously, humiliate them and are arrogant. This is why women prefer to go in bigger towns, where doctors have a better attitude and can explain everything to the women in a simple and understandable language.

Unlike ours, the doctors from Chisinau are better and more attentive. Wherever I went I was accepted and not rejected, they didn't speak brutally, they explained calmly everything to me.

There are opinions that the poor attitude of health workers is fueled, on the one hand, by the fact that few consumers of health care claim their right to quality services and, on the other hand, by the lack of a good control of how health care should be provided.

We, the service consumers, are all very quiet. Few are going to ask the register for complaints, suggestions, recommendations, services. Everyone is silent because this way it's simpler, faster, and cheaper.

At the same time, some women mentioned that they had positive experiences with the family doctors. Most of the times, these women said that these doctors were recommended to them.

Opinions on satisfaction with gynaecological services

Most of the women are satisfied with the interactions they had with the gynaecologists. However, some women mentioned that they were not provided with sufficient information during the gynaecological examination, such as the diagnosis or treatment.

He gives us the recipe and we need to go, buy and do the procedure by ourselves.

Some women highlighted that there are gynaecological investigations that are conducted without a good communication and counselling, the doctor asking very few questions or providing few explanations.

There is no real conversation. You just sit on the gynaecological couch, the gynaecologist does what he/she has to do, and then he/she tells you to dress up. Hence – a minimum of words.

Unlike women in Chisinau, women in rural areas or small towns mentioned the lack of equipment/consumables and the need for them to be purchased by the patient.

It's supposed everything to be free of charge. However, we need to pay the vaginal speculum, the gloves, etc. I don't get it.

Women outside the capital city also mentioned that the offices where examinations take place require repair, or are endowed with old equipment and furniture. It was mentioned that the office for examination and gynaecological consultations does not have a private examination area. This makes women feel uncomfortable.

Rural women expressed strong reluctance to have the gynaecological examination carried out by a male specialist. Some women admitted that they avoid the sector male doctor and choose to go to female specialists.

We'd like to have a female gynaecologist. However, our doctor is a man and, to be honest, we don't want to go to him, since we are ashamed and feel uncomfortable.

Opinions on the out-of-pocket payments for health care

In almost all the group discussions, the out-of-pocket payment issue was present. On the one hand, note that out-of-pocket payments are treated by some respondents as a '*tradition*' – an implied practice, which they follow without being asked. On the other hand, some respondents claimed that they were directly or indirectly asked for out-of-pocket payments. Some respondents said that without these payments, some doctors show an indifferent or negative attitude.

If you give them money, they immediately have a different behaviour towards you.

Some women believe that out-of-pocket payments are required or offered in cases where the consultation is carried out without an appointment or by a doctor other than the sector doctor.

I needed urgently to see a doctor and I went to another sector. There I was asked if I was from that sector and I said no. I was asked for out-of-pocket money. I had no choice but to pay instead of going there for a month or so.

In some places, the payment is mandatory according to a so-called 'Internal Regulation of the Doctor'. At the end of the examination, the doctor writes with a pencil the amount of money the patient needs to pay. If you give him/her MDL 100, he/she can warn you: 'Wait a minute! According to this Regulation, you have to pay...' and there he/she wrote MDL 300 with a pencil.

Summary: Satisfaction with health care

Most women registered with a family doctor (66%) are satisfied with his/her services.

In the qualitative survey, the most common barrier to interacting with public health services was the long waiting period. The dissatisfactions with health care related to the following: failure to observe the

appointment schedules, short and hurried consultations, brutal attitude of some workers, and shortage of staff to cope with the flow of patients.

Other reasons for dissatisfaction with health care were: mistrust in treatment caused either by treatments that did not work, or by doctors' 'interests' to prescribe certain preparations. The contradictions between the diagnoses made by different doctors and the suspicions of 'arrangements' between the doctors and pharmaceutical companies for prescribing more expensive preparations were also mentioned. Rural women said they feel humiliated in the facilities from small towns and prefer to go to medical centres in bigger towns or Chisinau.

The dissatisfactions with the gynaecological services related to the following: lack of sufficient communication (treatment explanation) between the doctor and the patient, lack of equipment/supplies, offices that don't have a private examination area, and the fact that some specialists are men – which makes some women feel uncomfortable.

The out-of-pocket payments are treated by respondents as a 'tradition' that some people follow without the doctor asking for them. Besides, some people claim that doctors have an indifferent or negative attitude if they are not given out-of-pocket payments. Some women claim that out-of-pocket payments are offered when the consultation is carried out without an appointment or by a doctor other than the sector doctor.

3.5 Knowledge of Cervical Cancer Prevention

Of the women who participated in the survey, 47% said they had heard of the Pap test. When asked about the name, besides the Pap test, the women also named the 'cytology test', 'cancer test', 'cancer smear', and 'cervical screening test'.

Figure 3.5.1: Share of women who heard and who did not hear about the Pap test, N=1,226, %

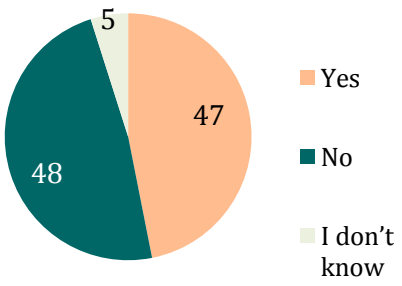


Table 3.5.1: Socio-demographic characteristics associated with knowledge of the Pap test, N=1,226, %

Know about the test	Age			
	25-35	36-45	46-55	56-61
Yes	56	59	49	33
No	44	41	51	67
X^2=48.9, df=3, p<.001				

Know about the test	Area	
	Urban	Rural
Yes	55	44
No	45	56
X^2=13.9, df=1, p<.000		

Know about the test	Marital status				
	Unmarried	Cohabitation	Married	Divorced	Widow
Yes	37	49	55	41	24
No	63	51	45	59	76
X^2=43, df=4, p<.000					

	Ethnicity

Know about the test	Moldovan/Romanian	Russian	Ukrainian	Gagauzian	Other ethnicity
Yes	51	50	34	28	46
No	49	50	66	72	54
X^2=14.6, df=4, p<.005					

Know about the test	Education			
	Primary	Secondary	Vocational	Higher
Yes	19	43	46	67
No	81	58	54	33
X^2=53.1, df=3, p<.000				

Know about the test	Occupation		
	Unemployed	Employed	Retired
Yes	48	54	30
No	52	46	70
X^2=28.1, df=2, p<.000			

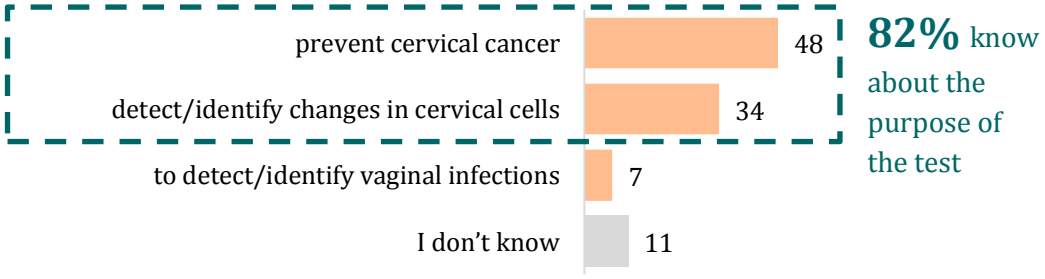
Know about the test	Welfare		
	Rich	Average	Poor
Yes	48	54	26
No	52	46	74
X^2=54.7, df=2, p<.000			

The analysis of contingency tables (Table 2.5.1) indicates that young and middle-aged, married women, women with higher education, employed and with at least an average financial status report, in higher shares, that they heard of the Pap test. In contrast, women aged 56+, rural women, Ukrainian, Gagauz or other minorities, retired women, as well as those in low-income households report more frequently that they did not hear about the Pap test.

Answers of those who heard about the Pap test – 47% (N=575)

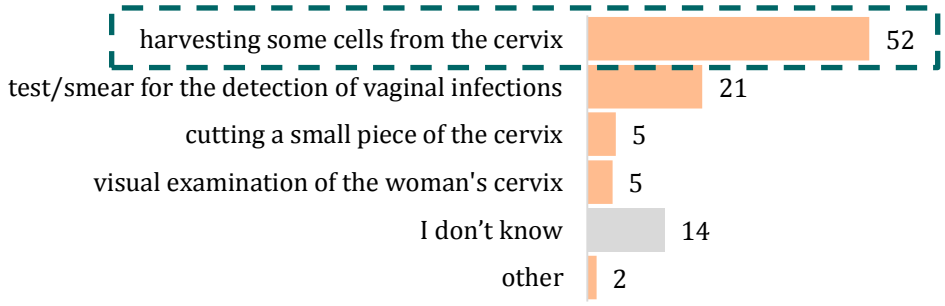
As much as 82% of the women who heard about the cytology test knew exactly its purpose. However, 18% did not know the real purpose of the test, 11% said they did not why they do it, and 7% indicated that the test detected vaginal infections.

Figure 3.5.2: Share of women who knew exactly the purpose of the Pap test, N=575, %



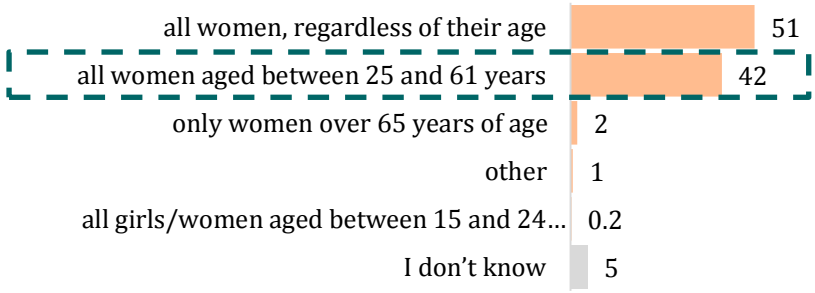
Fewer than half of the women correctly indicated the sampling method for the cytology test – i.e. collecting cervical cells. At the same time, 21% of women believe that the test involves a general analysis for the detection of vaginal infections, 5% – that the test involves cutting a small part of the cervix and 5% – that it involves only the visual inspection of the cervix.

Figure 2.5.3: Share of women who correctly indicated the sampling method for the Pap test, N=575, %



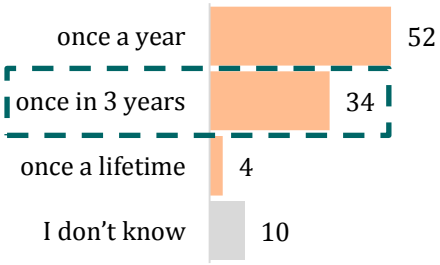
Of the women who heard about the Pap test, most (51%) believe that all women, regardless of age, should be screened. At the same time, 42% know that the test is indicated for women aged 25-61.

Figure 2.5.4: Share of women who correctly identified the target group of cervical screening, N=575, %



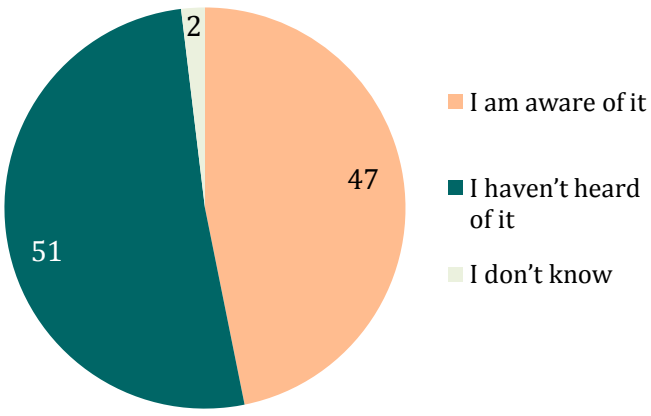
Data show that most women (56%) mistakenly identify the frequency with which the Pap test should be done, or declare they do not know at all (10%). Thus, one third of women who know about the test know that it should be done every three years.

Figure 2.5.5: Share of women who know the frequency of the Pap test, N=575, %



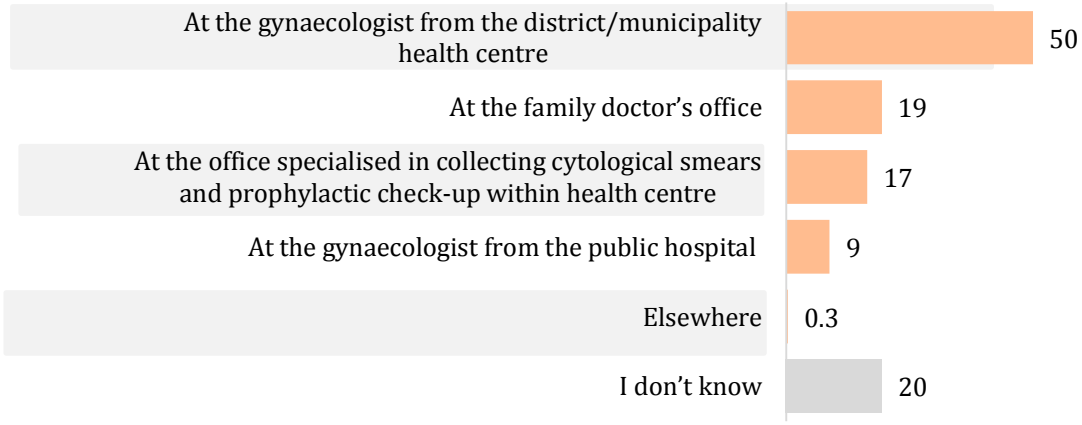
Of the women who know about the Pap test, 47% know that it's free of charge.

Figure 3.5.6: Share of women who know that the Pap test is free of charge, N=575, %



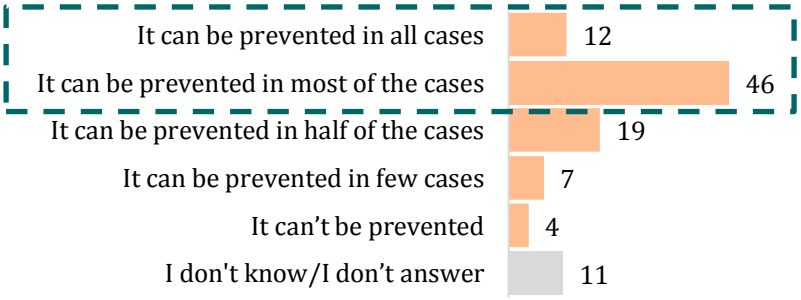
Most of the women who know about the test believe that they need to visit the gynaecologist's office in the district health centre in order to request a cervical screening. At the same time, only 19% of women know that they can go to the family doctor to do the test.

Figure 3.5.7: Share of women who know where to go for a Pap test, N=575, %



As much as 58% of the women who knew about the Pap test said that cervical cancer can be prevented in all or in most of the cases. On the other hand, 11% of women believe that cervical cancer can be prevented in few cases or not at all. Another 11% do not know whether cervical cancer can be prevented or not.

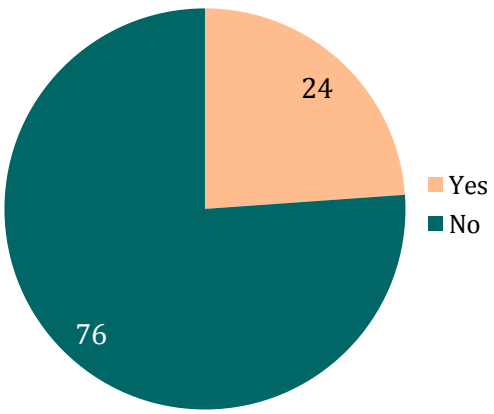
Figure 3.5.8: Share of women who know about the Pap test effectiveness, N=575, %



Total sample

The survey asked all the women whether they heard or not about the free-of-charge cervical screening. Of the whole survey sample (N=1,226), 24% said they had heard about this medical service.

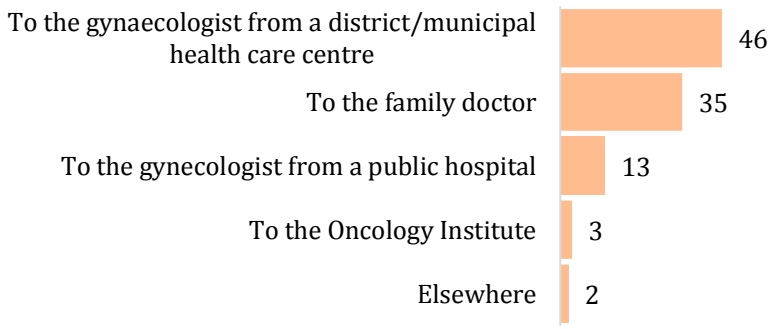
Figure 3.5.9: Percentage of women who know about the cervical screening service, N=1,226, %



Answers of those who knew about the cervical screening service – 24% (N=293)

Of all interviewed women who knew about the existence of the cervical screening service, 46% said that this examination can be done at the gynaecologist in district or municipal health care centres. At the same time, 35% think that it is possible to go to the family doctor to do a free-of-charge cervical screening.

Figure 3.5.10: Knowledge of the medical services where it is possible to do the free-of-charge cervical screening, N=293, %



Most of the women found out about the cervical screening service from the family doctor (43%). In addition, 36% of women who know about the cervical screening learned about it from the gynaecologist, and 18% – through the media. Note that about a quarter of women heard about the free-of-charge screening service from family members or friends.

Figure 3.5.11: Source of information about the free-of-charge cervical screening service, N=293, %

Opinions on cervical cancer incidence, risk and causes

According to many women, the cervical cancer is a disease that develops asymptomatically and is often found at an advanced stage.

Cancer is such a disease that one cannot feel it until its last stages.

More than half of women worry about the cervical cancer. Mostly, women are worried because they believe that the number of people diagnosed with cervical cancer increases.

I worry because many people have cancer. Both the TV and doctors say that many women are now diagnosed with cancer.

Moreover, there were people who said that every single woman is at risk of developing cervical cancer. Because of the fear, a number of women would prefer to be screened more frequently.

Some women worry about cancer because of lack of trust in the health care system and the effectiveness of the prescribed treatments. In rural areas, the fear of cancer is amplified by the fact that women perceive that only people with a higher standard of living can afford adequate treatment and have chances to treat the cancer. It was notices that some women avoid thinking about cancer, claiming that the thoughts about a certain disease can actually cause it.

If you start thinking about a certain disease, then you really can get it. We need to think more positively, because all diseases are caused by the negative thoughts.

It is important to note that women also have erroneous beliefs about cancer causes and risks. For instance, one of the frequently mentioned causes of cervical cancer was the poor nutrition. A number of respondents indicated that the food products are not healthy, contain additives, are genetically modified, and 'polluted'.

I think that food is another cause of developing cancer. Everything is polluted and our body cannot fight anymore. There are also many genetically-modified products, which also increase the risk of having cancer.

Women also have the idea that cancer occurs in people with a weaker immune system or people with chronic diseases. In this regard, some women said that personal hygiene and stress avoidance are important factors in preventing cancer. Some women said that any body has cancer cells that develop once the body is weakened by other diseases or infections. Other women believe that the early start of the sexual life or the high number of sex partners could cause cervical cancer. There are women who believe that they are not exposed at the risk of developing cervical cancer once nobody in their relatives had this disease. Some believe that breast disorders can cause changes in the cervix, and thus leading to the cancer to develop in this area. Other women heard that the abortions or poorly done C-sections may cause cervical cancer. At the same time, some women said they are afraid that cervical cancer can be caused by hormonal imbalances.

Opinions on the possibility of treating cervical cancer

Most women believe that cervical cancer can be treated only if detected at an early stage. However, about one third of interviewed women think that this disease cannot be treated. Their opinion built on what they heard about cancer incidence and on the lack of trust in the health care system's ability to treat this disease.

If God decided you should have cancer – you'll have it. No one is sure that the test will prevent it.

Opinions on cervical screening as a form of cervical cancer prevention

Most respondents believe that woman and especially adolescent health education needs to be strengthened in order to improve cervical cancer prevention. The women also noted that if information campaigns on cervical screening or HPV vaccination were to be organised, the materials used in this campaign should be developed using national statistics and Moldovan women's stories. Respondents affirm that health professionals should further encourage the preventive medical checks.

Both screened and unscreened women have some misperceptions and wrong beliefs about the preventive medical checks. Often, unscreened women do not know what's the test purpose, supposing that it aims at detecting bacterial and viral infections. On the other hand, those who heard about the test often believe that cervical screening detects only cancer cells. Very often, women mentioned that the purpose of the test is to *'detect cancer'*. None of the participants in the group discussions mentioned that the Pap test may detect pre-cancerous changes.

Also, the women who did not have the cervical screening believe it is only indicated if a woman has cancer symptoms. According to others, this test is done only at the Oncology Institute. In addition, the perception that the test is not free of charge is widespread, and some women avoid the preventive medical checks for which they need to pay.

You need to do the test only if you feel that something is going wrong.

There are women who believe that the Pap test is a curative procedure, i.e. *'cleaning'* the uterine walls to prevent cervical cancer. Even among the women who had the Pap test, they do not all understand how the sample is taken. Hence, some of them believe that part of the tissue is cut. Others think that a blood sample is being analysed, and the test detects whether the body has or not cancer cells.

There are misperceptions about the age at which women should be screened. A part of the women believe that the girls who started their sexual life should be screened. At the same time, in rural areas, women aged 55+ believe that gynaecological tests are indicated only to younger or sexually-active women. On the other hand, some women aged 50+ and believe that the Pap test is more indicated to women during the menopause.

Many women do not know what the recommended frequency of the Pap test is. Most women said that the test should be done more frequently than every three years.

The more often you do the test, the better.

There are women who are screened every year – a test they do in private facilities. When asked about the reaction the doctor had when he/she heard that they want to do the Pap test every year, several women said that the doctor had no reaction to this decision and referred them to an examination.

Summary: Knowledge of cervical cancer prevention

Of the interviewed women, 47% said they had heard of the Pap test. Of those who heard about the test, 82% said they know its purpose, 42% correctly indicated that the target group of cervical screening are women aged 25-61 women, 34% know that the test should be done once every three years, and 47% know that the test is free of charge.

Of the total sample, 24% of respondents know about the cervical screening service. As much as 43% found out about the service from the family doctor, and 36% – from the gynaecologist. Of the people who know about the cervical screening service, 46% know that the test can be done at the gynaecologist in district or municipal health care centres.

The qualitative research highlighted that many women believe that cervical cancer is a disease that develops asymptomatically and is often found at an advanced stage. Most women were worried about this disease because they heard that incidence is increasing. Because of the fear, a number of women said they would prefer to be screened more frequently.

The fear of cancer of certain women is related to the lack of trust in the health care system. Other opinions claim that only higher-income women can afford adequate treatments. Some women prefer not to think about cancer believing that these thoughts can actually cause this disease.

Participants in group discussions mentioned the following causes of cervical cancer development: poor nutrition, weak immune system, an early sexual life or a large number of sexual partners, genetic predisposition of each woman, cancer cells in each body, abortion, hormonal imbalances or breast disorders.

Most of the women believe that cervical cancer can be treated only if detected at an early stage. However, one third of the participants in the discussions consider that this disease cannot be cured.

Opinion on cervical screening

During the group discussions, the following cervical cancer prevention measures were mentioned: teenage education via cervical screening information campaigns, promotion of HPV vaccination, and encouraging the preventive screening by health professionals.

According to some women, the test can detect pre-cancerous changes, and the screening test is necessary for women who have symptoms or risks of developing this disease. Most of the women believe that the test is aimed at 'detecting the cancer' or bacterial and viral infections. Even among the women who had the test, they do not all understand how the sample is taken. The group discussions highlighted that people do not know the frequency of and the age at which the test needs to be done. Besides, there is the perception that the test is not free of charge.

3.6 Cervical Screening Among the Female Population Aged 25-61

As much as 35% of the women aged 25-61 in Moldova, part of the survey, said they had the Pap test at some point in their life. To make ensure that the respondents understood what the Pap test was, the women were read a definition of test's procedure and informed about its purpose. After the definition was read, 36% of women said that they had the test.

Figure 3.6.1: Share of women declaring they had the Pap test, N=1,226, %

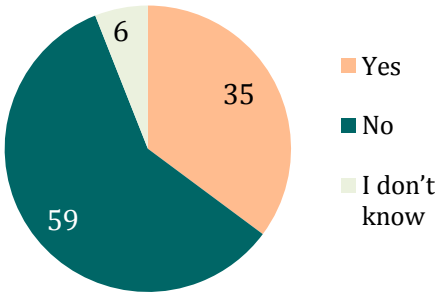
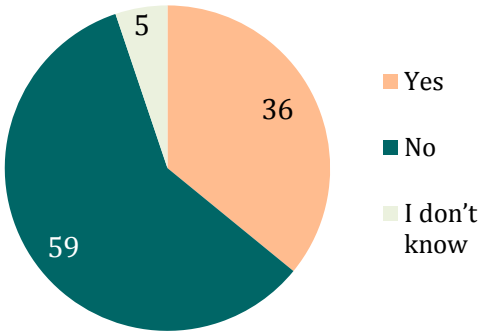


Figure 3.6.2: Share of women declaring they had the Pap test, after hearing its description, N=1,226, %



The X^2 indices for the contingency tables demonstrate that they are associations between being part of certain socio-demographic groups and conducting the Pap test in the past. Thus, middle-aged women, women from urban areas, women who are in a marital or cohabitation relationship, those with higher education, who are employed and have a good or very good financial status, are more likely to declare that they had the Pap test at some point in their life.

Table 3.6.1: Socio-demographic characteristics associated with cervical screening experience, N=1,226, %

Pap testing	Age			
	25-35	36-45	46-55	56-61
Yes	38	49	44	24
No	62	51	56	76
X^2=40.1, df=3, p<.000				

Pap testing	Area	
	Urban	Rural
Yes	43	33
No	57	67
X^2=10.7, df=1, p<.001		

Pap testing	Marital status				
	Unmarried	Cohabitation	Married	Divorced	Widow
Yes	22	40	42	38	15
No	78	60	58	62	85
X^2=36.6, df=4, p<.000					

Pap testing	Ethnicity				
	Moldovan/Romanian	Russian	Ukrainian	Gagauzian	Other ethnicity
Yes	40	42	18	17	31
No	60	58	82	83	69
X^2=17.02, df=4, p<.002					

Pap testing	Education			
	Primary	Secondary	Vocational	Higher
Yes	7	30	37	52
No	93	70	63	48
X^2=46.3, df=3, p<.000				

Pap testing	Occupation		
	Unemployed	Employed	Retired
Yes	33	45	17
No	67	55	83
X^2=42.1, df=2, p<.000			

Pap testing	Financial status

	Rich	Average	Poor
Yes	43	41	20
No	57	59	80
X^2=31.04, df=2, p<.000			

Contingency tables demonstrate that there are statistically significant associations between chronic diseases, the presence of the insurance policy under the compulsory health insurance system, the annual medical and gynaecological examinations and the probability of having done the Pap test. Thus, women who do not have a chronic disease or a disability, insured women, as well as those who did medical and gynaecological examinations in the last year declare, in significantly higher proportions, that they had the cytology test.

Table 3.6.2: Association between the respondents' characteristics on health, insured status, medical examination frequency and the cervical screening experience

Pap testing	Chronic disease, %	
	Yes	No
Yes	31	59
No	69	41
X^2=8.6, df=1, p<.003		

Pap testing	Physical/mental disability, %	
	Yes	No
Yes	28	38
No	72	62
X^2=1.3, df=1, p<.248		

Pap testing	Insurance policy, %	
	Yes	No
Yes	40	34
No	60	66
X^2=4.02, df=1, p<.045		

Pap testing	Last medical examination, %			
	Last year	1-2 years ago	2-5 years ago	More than 5 years ago
Yes	43	35	27	20
No	57	65	73	80
X^2=20.3, df=3, p<.000				

Pap testing	Gynaecological examinations, %			
	More often than once a year	Once a year	Once in 2-5 years	Less than once in 5 years
Yes	46	46	30	25
No	54	54	70	75
X^2=60.2, df=4, p<.000				

Survey data show that 7 out of 1,226 persons said they did not benefit from the cervical screening service when they asked for it. Two of the women said that the test was not carried out due to the lack of equipment/consumables needed, while other two – because the community where they live has no doctor or nurse qualified to take the test sample.

Of the total survey sample, 27% of women stated that the Pap test was recommended to them by the family doctor. This percent amounts to 67% among the women who had the test.

Figure 3.6.3: Family doctor's recommendation to do the test, **general sample**, N=1,226, %

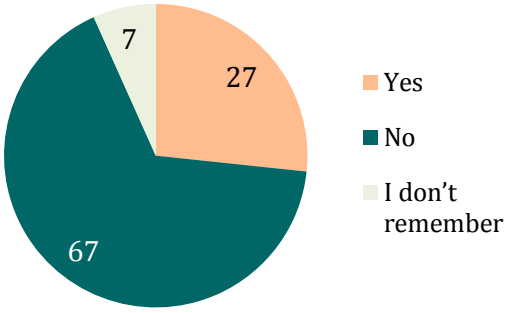
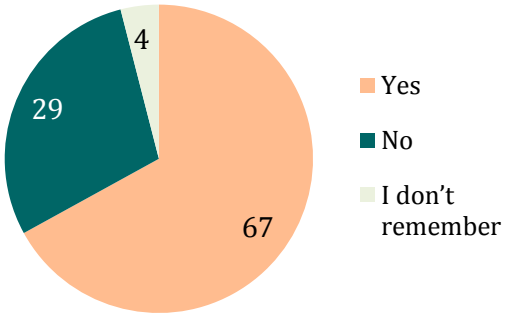


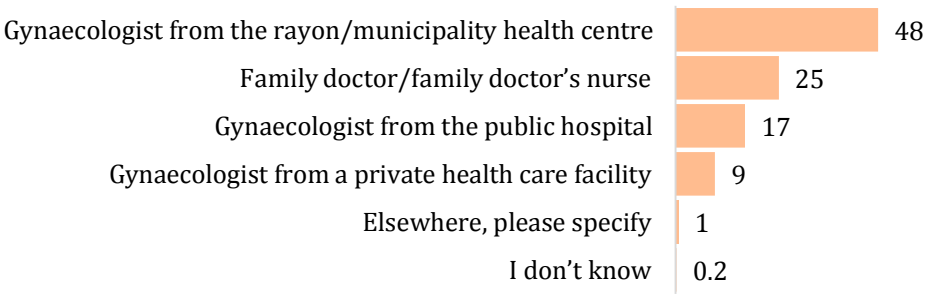
Figure 3.6.4: Family doctor's recommendation to have the test, **women who had the test**, N=440, %



Answers of those who said they had the Pap test – 27% (N=440)

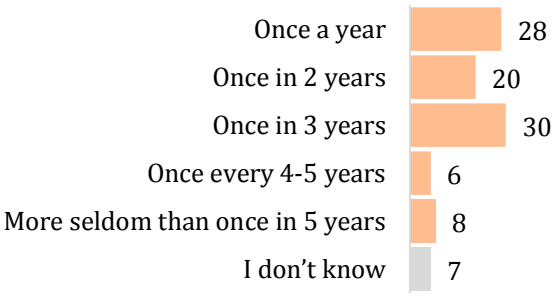
The data show that only 25% of the women who had the Pap test went to the family doctor or his/her nurse. On the other hand, most women went to the gynaecologists from public facilities (65%), and 9% – to the gynaecologists from private facilities.

Figure 3.6.5: Where did women go for the Pap test, N=440, %



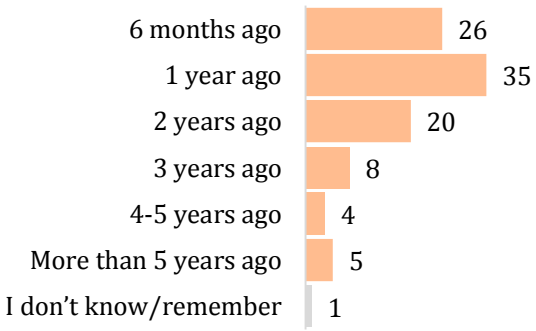
Note that women have the Pap test with a different frequency. Thus, 30% of the women who had the Pap test said that they have it once in three years. At the same time, 48% do the test once in two years or more, this being more often than the recommended frequency.

Figure 3.6.6: Frequency of the Pap test, N=440, %



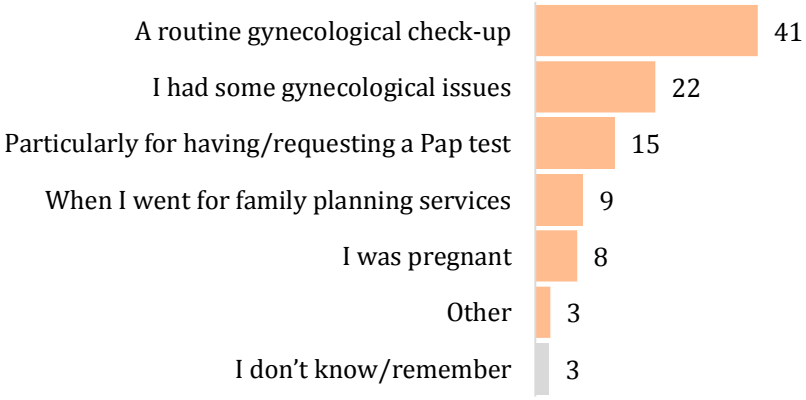
According to the women who had the cytology test, 9% had it more than 4-5 years ago, this being more rarely than the recommended frequency.

Figure 3.6.7: When the Pap test was done the last time, N=440, %



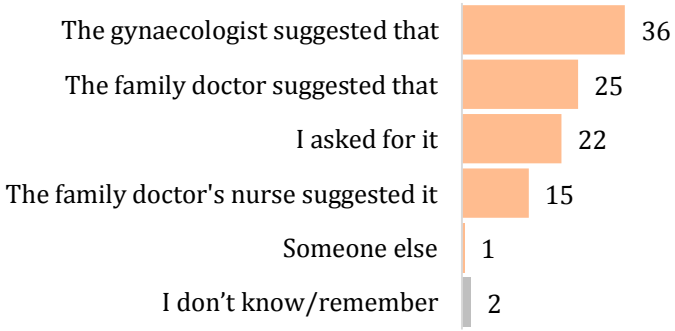
The survey shows that women often had the Pap test when they visited the doctor for another reason. Thus, according to women, in 41% of cases when the cytology smear was taken, they actually went to a routine gynaecological examination. In addition, 22% said they had the test when they visited the doctor because of some gynaecological problems. Also, 9% said they had the test when they contacted the family planning services, and 8% – when pregnant. Of all women, only 15% went to the doctor to do exclusively the cervical screening test.

Figure 3.6.7: Reason for seeing the doctor when the Pap test was done, N=440, %



Most of the time, the initiative to do the Pap test comes from health professionals. According to women, the cervical screening test is most often suggested by the primary health care workers (40%). Also, in about one third of cases (36%), the test is done following the advice of the gynaecologist. Sometimes, it is done at women's initiative (22%).

Figure 3.6.8: Initiative to do the last Pap test, N=440, %



Most women (70%) who had the Pap test did not pay for it. However, one quarter of the women said they paid for the test. Data show that women most often paid for the cervical screening test in private facilities (67% of the women who had the test in a private facility paid for it). Some women indicated during the qualitative research that though the Pap test is free of charge, sometimes it may involve some expenses such as transport, buying supplies, out-of-pocket payments, or appointment to a family doctor other than the sector doctor.

Figure 3.6.9: Way of doing the test, N=440, %

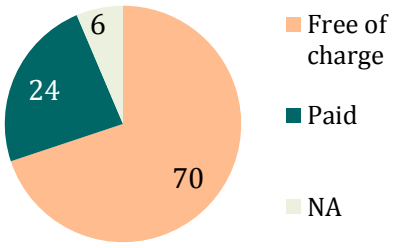
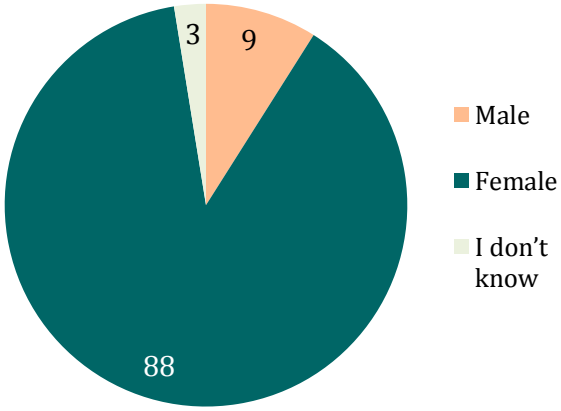


Table 2.6.9: Way of doing the test depending on the service a woman sought, N=440, %

Medical service	Free of charge	Paid	I don't remember
Total, N=440	70	24	6
Family doctor/nurse, N=108	71	25	4
Gynaecologist from the health care centre, N=213	79	16	5
Gynaecologist from the public hospital, N=73	65	21	14
Gynaecologist from a private health care facility, N=42	29	67	5
Someone else, N=3	66	34	0

Of the women who had the Pap test, 88% said that the medical worker who took the smear was a woman.

Figure 3.6.10: Gender of the person who took the Pap smear, N=440, %



Opinions on the decision to have the Pap test

Most women who participated in the survey and who had the test said that the decision to have the test was their own. Most of them found out about the cervical screening test from the family doctor or the gynaecologist. Some of the respondents said that they did not make this decision on their own because they follow the doctor's suggestions as mandatory. Other said the family doctors required them do the test, offering them little explanation about the test or information about how to prepare for it.

If the doctor said, it means that I have to do it. I'll go and I'll have the test.

The awareness of the risk of developing cervical cancer motivated some of the respondents to have the cytology test.

Some rural women did not discuss their decision to have a Pap test with family members because of the shame. Although urban women said that they discussed with their partners about the Pap test, these discussions had no impact whatsoever on their decision simply because their partners did not know about this test.

Some discussions pointed out that a woman's *'obligation'* to be healthy motivated the women to have preventive medical checks and the cervical screening test. Thus, some women said that when they decided to have the cervical screening test, they thought that they were fulfilling the obligation to be healthy for their children.

Some respondents declared that they know women who avoid the Pap test because they believe they are not at risk of developing cervical cancer. According to the respondents, many of these women belong to socially disadvantaged groups. In fact, the risk of developing cancer or the genetic predisposition to this disease were among the criteria the women took into account when they thought about the need to be screened.

I don't think this test is necessary. I'm not genetically predisposed since nobody in my family suffered and died of cancer.

Among the women who never had the test, there were respondents who said they would never even have the Pap test taken because they believed that health workers prescribe treatments even when it is not really necessary.

Until I feel bad, I wouldn't have any test, because when you have a test, the doctors see you only as a person who needs treatment regardless of the disease.

After having the Pap test, some women in Chisinau had the impression that this procedure was superficial. They believe that health workers are not interested in women's health and organise the cervical screening only because the Ministry of Health, Labour and Social Protection requires it, or that invitations to cervical screening are motivated by the performance indicators for those services.

They have a plan and they have to call people to do the tests for some statistics, perhaps for the Ministry of Health, and some do it just for a check.

Note that the decision to have the cytological test done in private clinics is motivated by the belief that their sampling equipment and laboratories analysing the samples are more efficient than in the public health care facilities.

Summary: Cervical screening among the female population aged 25-61

As much as 36% of women declare that they had the Pap test. Nationwide, 27% of women said that the family doctor was the one who recommended them the test.

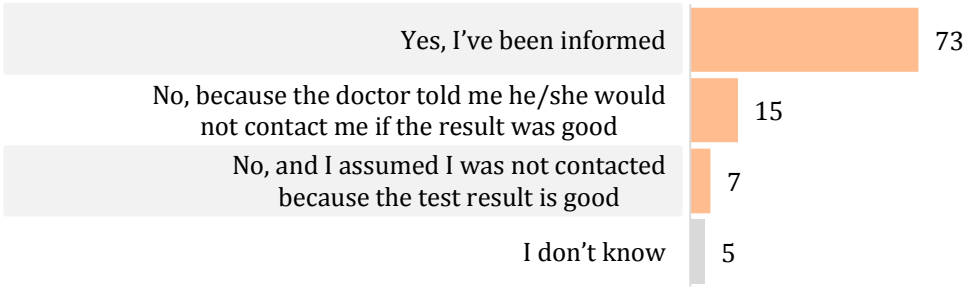
Of those who had the test, 30% said they have it once in three years, 48% – more often than recommended, and 9% – more than 4-5 years ago. In most cases, the respondents had the test when they were seeing the doctor for a routine gynaecological examination (41%), and health professionals where whose who recommended the women to have the test. As much as 70% of women had a free-of-charge test.

As part of the qualitative research, the respondents mentioned that they themselves decided to have the test or that the doctor indicated it. Rural women rather avoided talking with family members about the need to have Pap test. On the other hand, urban women often consulted with the family members, however these discussions had no impact since the latter were unaware of the cytology test. The fear of cancer and awareness of the importance of early detection of cervical cancer were the key reasons for having the test. The genetic predisposition was also mentioned as a criterion women take into account when considering the need for cervical screening.

3.7 Communicating the Results of the Pap Test and Follow-up/Supervision of Women with Abnormal Results

As much as 73% of the women who had the cytology test said they were communicated the results. At the same time, health professionals tend not to inform the women about test results if they are normal. Thus, 15% of women said they were not communicated the test results, but they were informed of not being contacted if the result is normal, and 7% – were not contacted and assumed that the test results were normal.

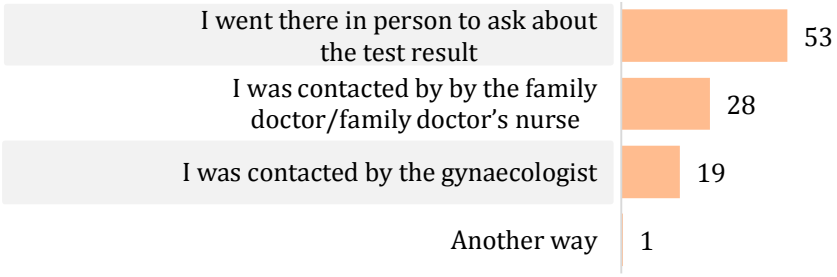
Figure 3.7.1: Informing the women about the results of the last Pap test, N=440, %



Answers of the women who were communicated the Pap test result – 73% of the women who had the test (N=322)

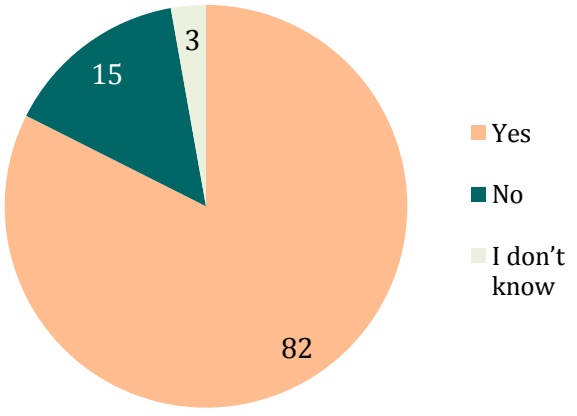
Of the women who were communicated the Pap test result, little more than half visited the doctor to ask about the result. In the other cases, the women were informed by the health professionals about the result – 28% said the family doctor or his/her nurse contacted them, and 19% said the gynaecologist contacted them.

Figure 3.7.2: The way of being communicated the results of the last Pap test women had, N=322, %



As much as 82% of the women who got the result of the cytology test discussed about it with the doctor, while 15% said they did not discuss the result with any medical worker.

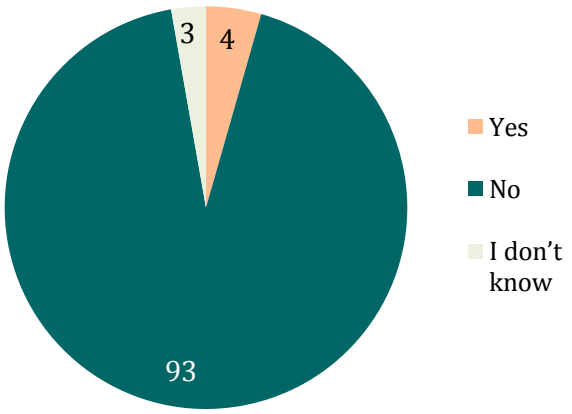
Figure 3.7.3: Share of women who discussed the Pap test result with the doctor, N=322, %



Answers of those who said they had the Pap test – 27% (N=440)

As much as 4% of the respondents who had the Pap test received abnormal results.

Figure 3.7.4: Share of women with an abnormal Pap test, N=440, %



Answers of those who said they had an abnormal Pap test result – 4% of the women who had the test, (N=19)

If the result is positive, women are referred to repeat the Pap test. As many as 15 out of 19 positive screened women said they repeated the cytology test.

Table 3.7.1: Share of positive screened women who repeated the Pap test, N=19, %

	No of respondents
Yes	15
No	5
I don't know	0
N	19

According to the women who repeated the cervical screening test, most of them (5 out of 15 women) repeated the investigation to a gynaecologist from a district or municipal health care centre. At the same time, 4 women said they went to a gynaecologist from a private facility, while 3 went to the Oncology Institute.

Table 3.7.2: Where did women go to repeat the test, N=15, %

	No of respondents
At a gynaecologist from a district/municipal health care centre	5
At a gynaecologist from a private health care facility	4
At the Oncology Institute	3
At the same family doctor	1
At a gynaecologist from a public hospital	1
At the office specialised in collecting cytological smears and prophylactic check-up within health care centre	0
At the Republican Centre for Medical Diagnostics	0
N	15

Of the 19 positive screened women, almost all of them were referred to colposcopy, only one of them said she was not referred to such a procedure.

Table 3.7.3: Share of women referred to colposcopy, N=19, %

	No of respondents
Yes	17
No	1
I don't know	1
N	19

According to the women, they were referred to colposcopy either at the Oncology Institute (8 women) or at a gynaecologist from a public hospital (4 women), or at a gynaecologist from a district/municipal health care centre (3 women). Only one out of 18 women was referred to colposcopy at a gynaecologist from a private facility.

Table 3.7.4: Medical service that performed the colposcopy, N=18, %

	No of respondents
Oncology Institute	8
Gynaecologist from a public hospital	4
Gynaecologist from a district/municipal health care centre	3
Gynaecologist from a private health care facility	1
I don't know/remember	1
N	18

Of the women who were referred to colposcopy, 17 said they did the procedure. At the same time, one woman argued that she failed to do the colposcopy due to the fact that she left the country.

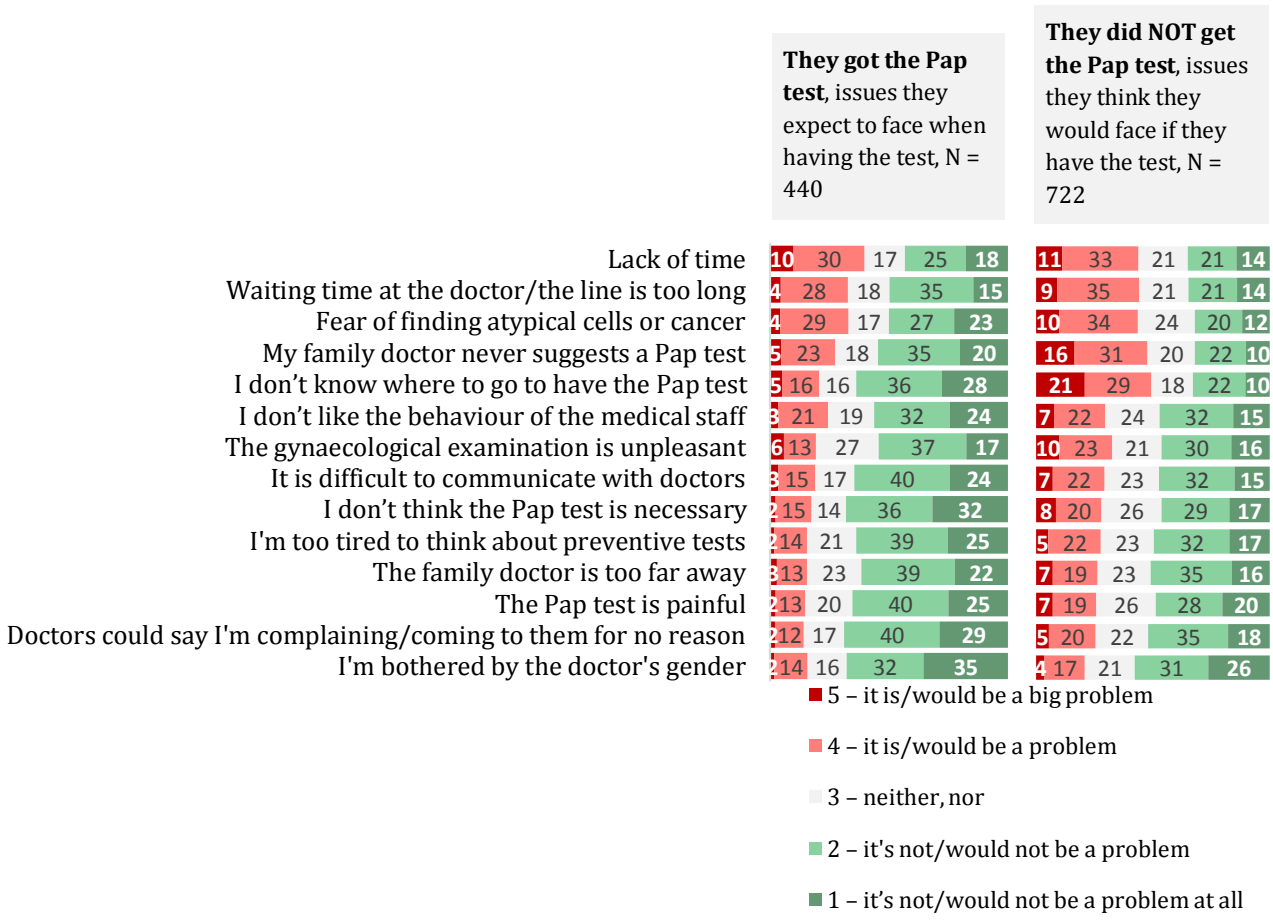
Summary: Communicating the Pap test results

As much as 73% of women who had the test said they were communicated the result of the last test. Of those who were told the test results, half (53%) said they went to the doctor to ask about the result. Of those who had the test, 4% said they had abnormal results. Three out of four women with abnormal results said they repeated the test and almost all (of those 4%) of them were referred to colposcopy.

3.8 Barriers to Doing the Pap Test

The fact that they do not know where to go to do the test or the fact that the family doctor failed to recommend it was an important barrier for a larger number of women who did not do the Pap test. The women who did the test most often mentioned the lack of time (40% – a problem or a big problem).

Figure 3.8.1: Perceived barriers to doing the Pap test, %



The average difference for the indicator 'barriers' was analysed in order to find out whether women who did not do the Pap test perceive a stronger influence of barriers to doing this test. This indicator was calculated on the basis of the average for items that captured women's perceptions of different barriers and has a value between 1 and 5, where 1 means no barriers and 5 means major problems. The analysis demonstrates that there are significant differences in barrier perception reported by the women who did and who did not do the test. Women who did not do the test perceive more barriers that would prevent them from doing the test (Table 2.11.1).

Table 3.8.1: Average difference for the perceived barriers in doing the test by the women who did and who did not do the Pap test

	Score	Cervical screening experience (average, SD) N=440	No cervical screening experience (average, SD) N=722	*t*	*p*
Barriers	1-5	2.4 (.70)	2.8 (.72)	-9.5	.000

Opinions on the barriers to participating in cervical screening

In most cases, women who know about and did the Pap test do not see significant barriers that could prevent them from doing it. Respondents indicated that the lack of time could postpone the cervical test. Hence, they could do it outside the working hours or on Saturdays.

The key barriers for the women in rural areas, who never had a Pap test, are the lack of time and the fact that this test may entail some expenses.

The belief that the Pap test entails some expenses is widespread among the women who did not do the cervical screening test. Some women don't believe that the cervical test is free of charge because even if it is, out-of-pocket payments need to be made. The distance to the sampling point and the need to visit the district centre, which entails expenses, was another barrier women mentioned.

They suggested that they would be more comfortable with doing this test during the winter. For instance, a 50-year-old respondent said: '*I've got a ton of work to do at home. I have to harvest the grape, other crops, etc... There is much work to be done. I'd be able to do the test only during the winter.'*

On the other hand, some women living in the rural area, who did the Pap test, find the gynaecological checks and the cytology test, respectively, as being embarrassing, which is why it's not easy for them to go for an examination and feel uncomfortable during this procedure. The discomfort of some women in rural areas is amplified if the specialist taking the sample is a man. Though some women said that the Pap test is an embarrassing procedure, this is not a barrier that could prevent them from doing the test.

A difficulty with cervical screening within the public system is the long waiting period for the results. Several women said they worry while waiting for the test result. In this context, some women are unhappy when health professionals fail to inform them about the negative result.

Some women do not trust the quality of the results of the investigations made at public facilities due to obsolete equipment.

As regards the women who emigrate, a barrier to accessing cervical screening is the fact that they are not in the country for longer periods of time. They said that they do the Pap test only if they see the doctor while being in the country.

For some women who did not do the test, the fear of finding out whether or not they have cancer determines them to avoid doing this test.

It's better not to know instead of staying and waiting to find out if it's positive or negative.

My mother died of cancer and the fear is so big that I sometimes think that I shouldn't even know the truth.

Summary: Barriers that may prevent women to do the Pap test

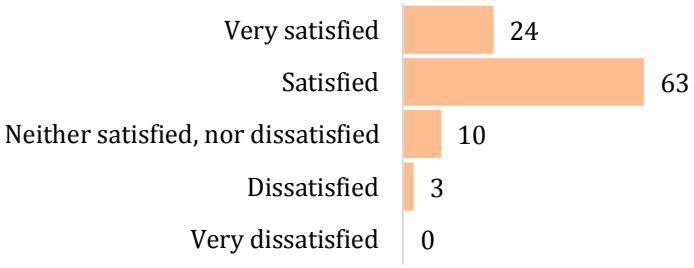
The most common barriers to doing the Pap test were as follows: the lack of knowledge of where the test can be done, the family doctor fails to recommend this test and the lack of time. The analysis of average differences showed that women who did not have the Pap test perceive more barriers.

The qualitative research identified barriers such as the lack of time, some expenses (a barrier mentioned by women living in rural areas and often by those who did not do the test), the distance to the sampling point, discomfort and shame, especially of the women in rural areas, especially if the test is taken by a man. The lack of trust in the quality of the results of the investigations made at public facilities, leaving the country for a longer period and the fear of finding out the results were also mentioned.

3.9 Satisfaction with the Health Care of the Women who Had the Pap Test

In most cases (87%), the women who had the Pap test were satisfied and very satisfied with the health care, and only 3% said the opposite.

Figure 3.9.1: Satisfaction with the heath care of the women who had the Pap test, N=440, %



The satisfaction with the heath care accessibility of the women who had the Pap test was assessed via 7 items (Figure 3.9.2). The average score was also calculated for every aspect of satisfaction with the health care accessibility. This index has also a score of 1 to 5, where 1 means that the woman was very dissatisfied, and 5 – very satisfied. The data show that women are most satisfied with the fact that the test was done by a female worker, the average score for this aspect being 4.3. Women are also more likely to be satisfied with their family's attitude to the decision to do the cervical screening test (average score – 4.2). On the other hand, the lowest score had the satisfaction with the distance to medical services (average score – 3.7), the cost of travel to medical services (average score – 3.8), and the fact that the health worker who did the test was a man (average score – 3.8).

The percentage of women who are satisfied and very satisfied with each aspect is between 83% (satisfaction with family's support for the Pap test) and 69% (distance between home and medical service). As much as 81% of women are satisfied and very satisfied with the ease in accessing the services, 76% with the waiting time for an appointment, and 73% with the cost of travel to the medical service.

In order to compare whether there is a difference between the satisfaction with service accessibility between urban and rural areas, the average score for all items of the satisfaction with the accessibility was calculated and a Student-t test was conducted. According to the results, the differences between the satisfaction of urban and rural women with screening service accessibility are not significant (average difference=.23, p> .279).

Figure 3.9.2: Satisfaction with the heath care accessibility of the women who had the Pap test, N=440, %

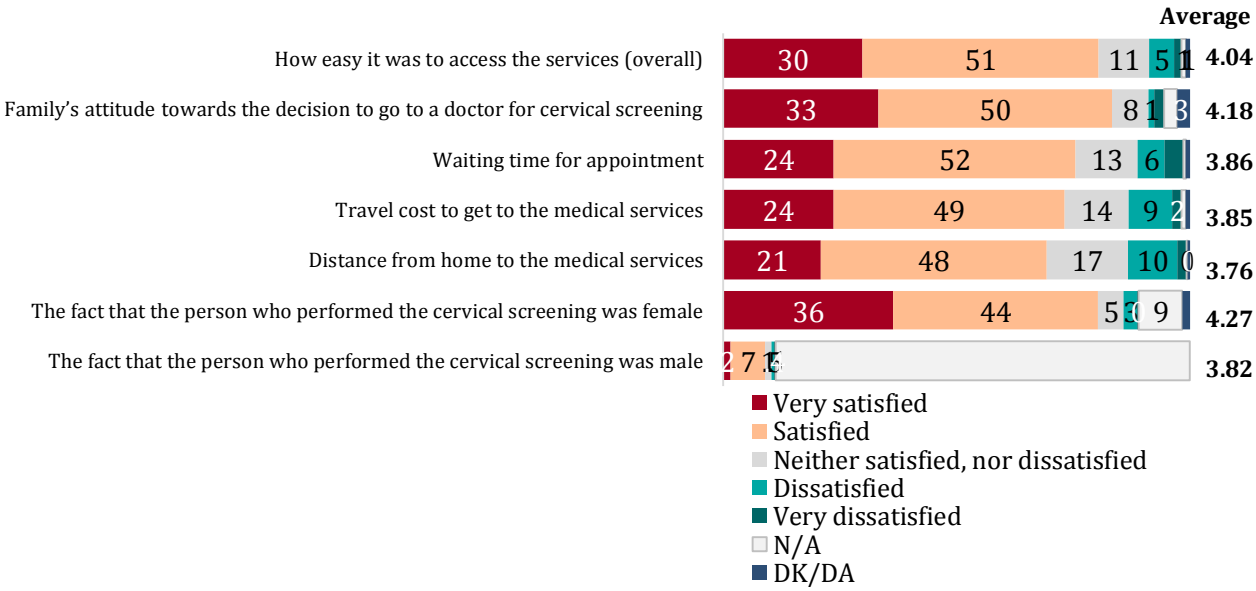


Table 3.9.2: Associations between the satisfaction with cervical screening service **accessibility** (per general) and socio-demographic characteristics

Accessibility	Age			
	25-35	36-45	46-55	56-61
Dissatisfied	4	6	12	9
Neutral	9	14	12	11
Satisfied	87	81	77	80
X^2=7.8, df=6, p<.250				

Accessibility	Area	
	Urban	Rural
Dissatisfied	6	8
Neutral	10	13
Satisfied	84	80
X^2=1.5, df=2, p<.470		

Accessibility	Marital status				
	Unmarried	Cohabitation	Married	Divorced	Widow
Dissatisfied	4	6	7	10	0
Neutral	17	6	12	0	23
Satisfied	78	88	81	90	77
X^2=8.3, df=8, p<.412					

Accessibility	Ethnicity	
	Romanian/Moldovan	Other[40]
Dissatisfied	6	15
Neutral	12	5
Satisfied	82	80
X^2=5.6, df=2, p<.060		

Accessibility	Education		
	Secondary or primary[41]	Vocational	Higher
Dissatisfied	3	11	4
Neutral	12	12	9
Satisfied	85	77	87
X^2=9.2, df=4, p<.055			

Accessibility	Occupation		
	Unemployed	Employed	Retired
Dissatisfied	4	8	13
Neutral	8	13	13
Satisfied	88	80	74
X^2=5.1, df=4, p<.279			

Accessibility	Financial status		
	Rich	Average	Poor
Dissatisfied	9	6	11
Neutral	18	11	14
Satisfied	73	83	76
X^2=2.9, df=4, p<.579			

[40] Due to the small number of respondents, the minorities were included in one group 'Other'

[41] Due to the small number of respondents, the persons with primary and secondary were included in one group.

Figure 3.9.3: Satisfaction with the heath care quality of the women who had the Pap test, N=440, %

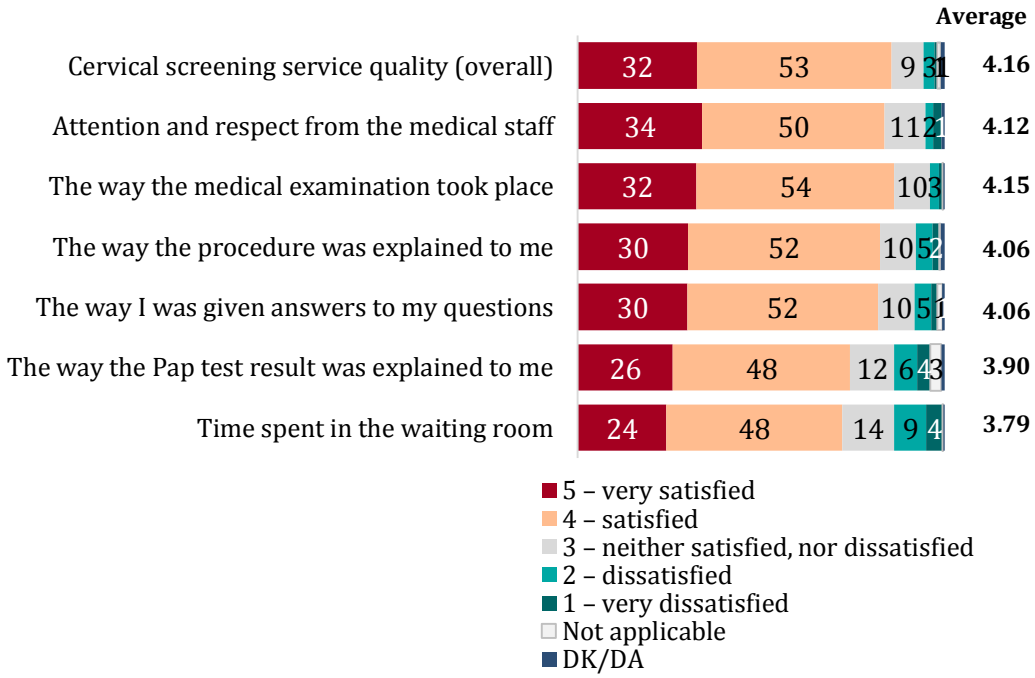


Table 3.9.2: Associations between the satisfaction with cervical screening service **quality** (per general) and socio-demographic characteristics

Satisfaction	Age			
	25-35	36-45	46-55	56-61
Dissatisfied	3	4	3	6
Neutral	10	8	9	10
Satisfied	84	87	88	82
X^2=6.8, df=6, p<.648				

Satisfaction	Area	
	Urban	Rural
Dissatisfied	4	4
Neutral	8	10
Satisfied	87	84
X^2=2.2, df=2, p<.533		

Satisfaction	Marital status				
	Unmarried	Cohabitation	Married	Divorced	Widow
Dissatisfied	0	6	4	3	14
Neutral	9	18	8	16	0
Satisfied	91	77	88	81	86
X^2=10.3, df=8, p<.245					

Satisfaction	Ethnicity	
	Romanian/Moldovan	Other[42]
Dissatisfied	3	10
Neutral	9	13
Satisfied	88	77
X^2=6.1, df=2, p<.046		

Satisfaction	Education		
	Secondary or primary[43]	Vocational	Higher
Dissatisfied	3	6	1

[42] Due to the small number of respondents, the minorities were included in one group 'Other'

[43] Due to the small number of respondents, the persons with primary and secondary were included in one group.

Neutral	10	10	8
Satisfied	87	85	92
X^2=6.9, df=4, p<.137			

Satisfaction	Occupation		
	Unemployed	Employed	Retired
Dissatisfied	3	4	13
Neutral	9	8	13
Satisfied	89	88	74
X^2=6.5, df=4, p<.144			

Satisfaction	Financial status		
	Rich	Average	Poor
Dissatisfied	5	4	3
Neutral	14	8	14
Satisfied	82	88	84
X^2=1.8, df=4, p<.768			

The satisfaction with the heath care quality of the women who had the Pap test was assessed via 7 items (Figure 2.8.3). The analysis of the average scores for the quality aspects assessed shows that women rated as highest the quality of the medical service (average score – 4.16), the way the examination was done (average score – 4.15), and the attention and respect from behalf of health professionals (average score – 4.12).

The share of women who had the Pap test and who were very satisfied and satisfied with the medical service quality varies between 86% and 72%. This share is the highest for the way the examination was done (86%), medical service quality (85%) and the attention/respect from behalf of health professionals (84%).

At the same time, the following had a lower satisfaction degree and a lower average score: the way the results of the test were explained (average score – 3.9, the share of women satisfied and very satisfied – 74%) and the time spent in the waiting room (average score – 3.8, the share of women satisfied and very satisfied – 72%).

As in the case of the satisfaction with screening service accessibility, the average differences between the satisfaction of urban and rural women with screening service quality was analysed. According to the test, the satisfaction with the quality of cervical screening services is approximately the same (average difference=-.01, p>.851).

In order to see what's **the aggregate index of satisfaction with the quality and accessibility** of cervical screening **services**, the percentage of women satisfied with both aspects (who gave 5 or 4 points on a scale of 1 to 5) was calculated. As much as 73% of the women are satisfied with the accessibility and quality of screening services.

Summary: Satisfaction with health care and its accessibility

As much as 87% of the women who had the test said they were satisfied with the medical services, 81% were satisfied with the ease in accessing screening services in general, and 85% were satisfied with the quality of the cervical screening service.

3.10 Attitude to the Pap Test

Most of the women believe that the Pap test is an important and wise decision. Thus, 69% of respondents believed that the decision to do the test was important, and only 7% said that such an examination would be rather unimportant. At the same time, 70% of women said that the decision to do the test was wise and only 6% thought the examination would be useless.

Figure 3.10.1: Opinion on the importance of seeing the doctor in order to do the Pap test in the next three months, N=1,226, %

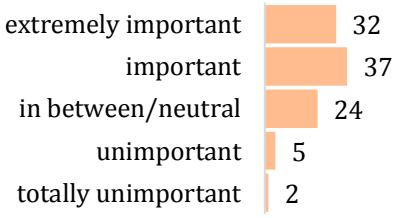
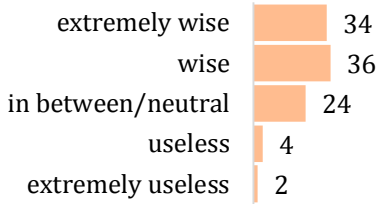


Figure 3.10.1: Opinion on how wise is the decision to do the Pap test, N=1,226, %



To see the differences between the attitudes the women who did and who didn't do the test had towards the cervical screening, the average for the two items that measured women's attitudes towards the cytology test was calculated. The score for these items varies from 1 to 5, where 1 means that women see the decision to have the test in the next 3 months as totally unimportant and extremely useless, and 5 – as extremely important and wise. A Student-t test was further done to determine the significant differences between the groups. The analysis revealed that women who had the Pap test at some point in their life show more positive attitudes to the test than those who never had it.

Table 3.10.1: Average difference between women who had and who hadn't have the Pap test for the score on the attitude to the cervical screening

	Score	Cervical screening experience (average, SD) N=440	No cervical screening experience (average, SD) N=722	*t*	*p*
Attitude	1-5	4.3 (.74)	3.7 (.93)	9.1	.000

Table 2.9.2: Association between the socio-demographic characteristics and the opinion on the importance of seeing the doctor in order to do the Pap test in the next 3 months

Attitude	Age			
	25-35	36-45	46-55	56-61
Unimportant	71	65	71	56
Neutral	23	29	24	33
Important	6	7	5	11
X^2=22.7, df=6, p<.001				

Attitude	Area	
	Urban	Rural
Unimportant	67	64
Neutral	27	27
Important	6	8
X^2=2.6, df=2, p<.267		

Attitude	Marital status				
	Unmarried	Cohabitation	Married	Divorced	Widow
Unimportant	57	69	70	63	41
Neutral	36	22	24	27	44
Important	7	9	6	10	15
X^2=41.8, df=8, p<.000					

Attitude	Ethnicity				
	Moldovan/Romanian	Russian	Ukrainian	Gagauzian	Other ethnicity
Unimportant	68	61	75	32	39
Neutral	27	28	16	35	46
Important	5	12	9	33	15
X^2=84.8, df=8, p<.000					

Attitude	Education			
	Primary	Secondary	Vocational	Higher
Unimportant	39	59	66	76
Neutral	52	32	28	18
Important	10	9	6	6
X^2=31.9, df=6, p<.000				

Attitude	Occupation		
	Unemployed	Employed	Retired
Unimportant	65	69	55
Neutral	28	25	32
Important	8	6	13
X^2=17.1, df=4, p<.002			

Attitude	Financial status		
	Rich	Average	Poor
Unimportant	70	69	51
Neutral	23	25	36
Important	8	6	13
X^2=27.3, df=4, p<.000			

Attitudes to preventive medical checks

Some women believe that the preventive medical checks are useless and that one's body could be harmed after such checks.

I see the doctor only if something serious happens, like injuries or something like this. And even then I'm going I feel like being forced.

Sometimes, women are even proud of not seeing the doctor.

I have no problem, and I'm not going to any doctor. I've never been hospitalised. I feel good.

Also, women don't trust the efficacy of the screening tests, including the Pap test. Some women said they heard many cases when cervical cancer was diagnosed in advanced stages although women were screened. For the most part, this belief is not a barrier that would determine the women not to do the test. However, because of this opinion, some women are not sure that the screening would certainly prevent the cervical cancer.

Perception of the obligation to be screened

According to a number of respondents, the cervical screening should be mandatory. They argue that women should not be able to choose whether to participate or not in cervical screening since some of them are not aware of the risk of developing cancer.

They should be obliged to do the test to avoid situations where they'd regret, when diagnosed with cancer, their failure to be screened.

However, other respondents believe that the screening should be optional because each individual is responsible for his/her own health.

If one doesn't want to be screened, no one can convince him/her. I think that only the doctor could explain him/her the symptoms, the causes of this disease and offer all the guidance needed.

Summary: Attitude to the Pap test

As much as 69% of all respondents believe it is important to see a doctor in order to do the Pap test within the next 3 months (for those who never did the test).

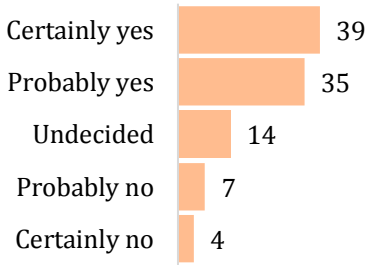
The qualitative research highlighted that preventive medical checks are seen as unnecessary. Some women prefer going to a doctor only if something serious happens. The women mentioned the inefficiency of the screening tests, arguing that they knew cases when screened women were diagnosed with cervical cancer in advanced stages.

A number of women believe that the cervical screening should be mandatory.

3.11 Intention to Do the Pap Test

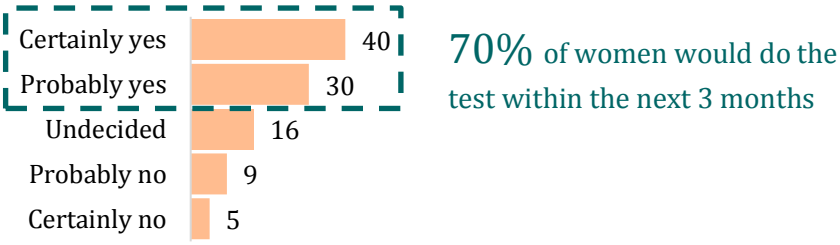
If they'd be invited to participate in the cervical screening, 74% of women said they would rather do the cytology test. However, 14% of the respondents felt undecided about whether or not to do the test, and 11% said they'd rather not do it.

Figure 3.11.1: Women's certainty of doing the Pap test if they would be invited to do it, N=1,226, %



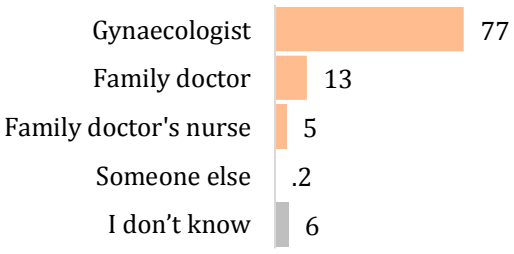
When asked whether or not they'd intend to do the cytology test within the next 3 months, 70% of women said they'd probably do it. In addition, 16% of the women felt undecided and 14% said they'd rather not do it.

Figure 3.11.2: Intention to do the test within the next 3 months, N=1,226, %



Most women (77%) believe that the gynaecologist should take the Pap smear. In contrast, only 13% believe that the family doctor should take the cytology smear during the cervical screening, and only 5% believe that it would be appropriate for family doctor's nurses to take the cytology smear. According to several respondents, the oncologists or even the surgeons should take the Pap smear.

Figure 3.11.3: Opinion on the health worker who should take the Pap smear, N=1,226, %



Opinions on the health workers that should take the Pap smear

All women in the qualitative survey believe that the gynaecologist or the midwives should take the Pap smear. The women believe that family doctors or their nurses lack specialised gynaecological training, which is why they don't trust the services the latter provide in the gynaecological area. Opinions were voiced that family doctors are general physicians and do not have the required experience to perform a cytology test. On this matter, some women highlighted that the Pap test is a rather *'delicate'* procedure that, if performed incorrectly, does not achieve its purpose because the abnormal cell wouldn't be identifiable.

The role of beliefs in the screening behaviour

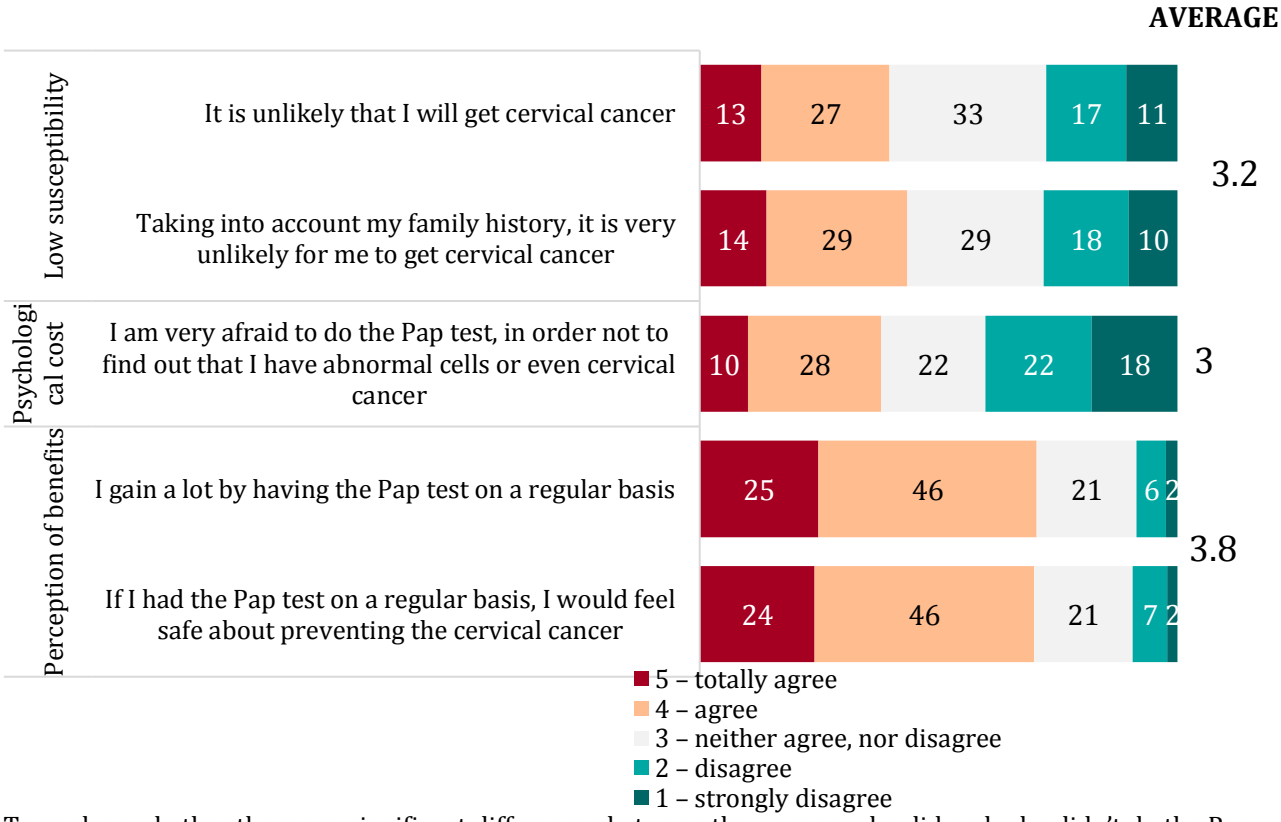
The cognitive variables related to the perception of cervical cancer's own susceptibility, the perceived psychological cost to the Pap test, and the perception of the screening benefits were also analysed.

With regards to ***susceptibility*** to cervical cancer, the average of 3.2 out of 5 (where 5 represents total agreement) show that women tend to perceive there is an average predisposition to the possibility of getting cancer.

The average for the ***psychological cost*** variable also demonstrates that most of the women neither agree nor disagree with the fact that they are afraid to do the test because they may find out they have cervical cancer.

At the same time, the average for the ***perception of benefits*** is 3.8 out of 5, indicating that women tend to agree more that they benefit if they regularly do the cytology test.

Figure 3.11.4: Indices of perceived susceptibility to cancer, psychological cost of the Pap test and perception of benefits of the Pap test, N=1,226, %



To analyse whether there are significant differences between the women who did and who didn't do the Pap test, the average of 'susceptibility', 'psychological cost', and 'perception of benefits' indicators was calculated. The score for these indicators varies from 1 to 5.

The test comparing the averages shows that women who have and who haven't been screened have different degrees of intensity of the psychological cost and of the perception of screening benefits.

In this regard, the women who got screened perceive lesser the psychological cost (fear that the test might turn out positive) of doing the cervical screening than the women who didn't get screened.

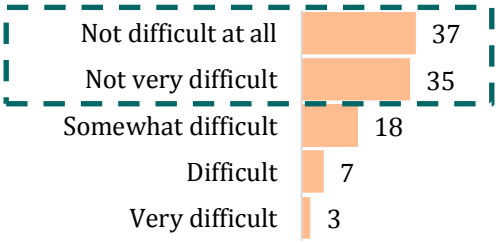
Also, the women who got screened in the past perceive significantly more screening benefits than the women who didn't have the test.

Table 3.11.1: Difference between the intensity of the indicators between the women who did and who didn't do the cytology test

	Score	Cervical screening experience (average, SD) N=440	No cervical screening experience (average, SD) N=722	*t*	*p*
Susceptibility	1-5	3.2 (1.08)	3.1 (1.01)	.6	.527
Psychological cost	1-5	2.6 (1.2)	3.0 (1.2)	-5.7	.000
Benefits	1-5	4.1 (.71)	3.7 (.86)	7.7	.000

A proportion of 37% of women said that it wouldn't be difficult at all for them to show up and have the cervical screening test within the next three months, and 35% said it wouldn't be very difficult to come up for the test.

Figure 3.11.5: (Sense of self-efficacy) Opinion on the difficulty of showing up and having the test within the next 3 months, N=1,226, %



72% of women say it wouldn't be difficult for them to show up and have the test

In order to analyse whether the women who had and who hadn't have the Pap test show different degrees of ***self-efficacy*** towards the possibility of having the cervical screening test, the averages obtained for this variable were compared. The results of the test indicate that, unlike the women who hadn't have the cervical screening, those who had it are more likely to say that it's not difficult for them to have the test.

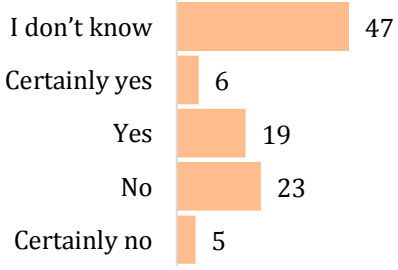
Table 3.11.2: Difference in the intensity of self-efficacy in women who had and who hadn't have the Pap test

	Score	Cervical screening experience (average, SD) N=440	No cervical screening experience (average, SD) N=722	*t*	*p*
Self-efficacy	1-5	1.8 (.85)	2.2 (1.11)	-6.3	.000

In order to see how much do the ***social norms*** influence the women, the respondents were asked three questions to learn to what extent the opinion and practices of people important to them could influence their behaviour.

Hence, when asked whether the women important to them do have or not the test, 47% said they didn't know about it. A proportion of 25% said that the women important to them do have the test, and 28% said they knew that the former don't have the test.

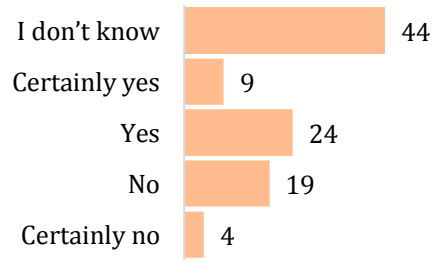
Figure 3.11.6: (Social norms) Opinion on whether the women important to the respondents do have or not the Pap test, N=1,226, %



The next question related to the social norms aimed at finding out if the people important to the respondents believe that the latter should have the Pap test. As much as 44% of the respondents could not answer to this

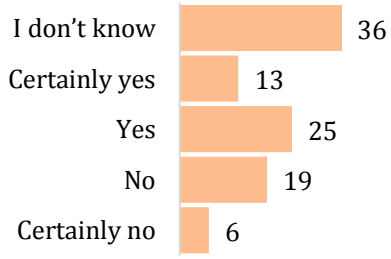
question. However, one-third of the respondents said that people who are important to them believe that the respondents should have the test, while 23% said that people who are important to them don't believe that they should do the Pap test.

Figure 3.11.7: (Social norms) Whether the people important to the respondents believe that the latter should have or not the Pap test, N=1,226, %



The last question related to the influence social norms have aimed at finding out what was the opinion of respondents' partners on the cytology test. Thus, 38% of women said that their partners believe they should do the test, 36% didn't know what their partner's opinion was, and a quarter said their partners would rather think they should not do test.

Figure 3.11.8: (Social norms) Whether respondents' partners believe that the latter should have or not the Pap test, N=1,226, %



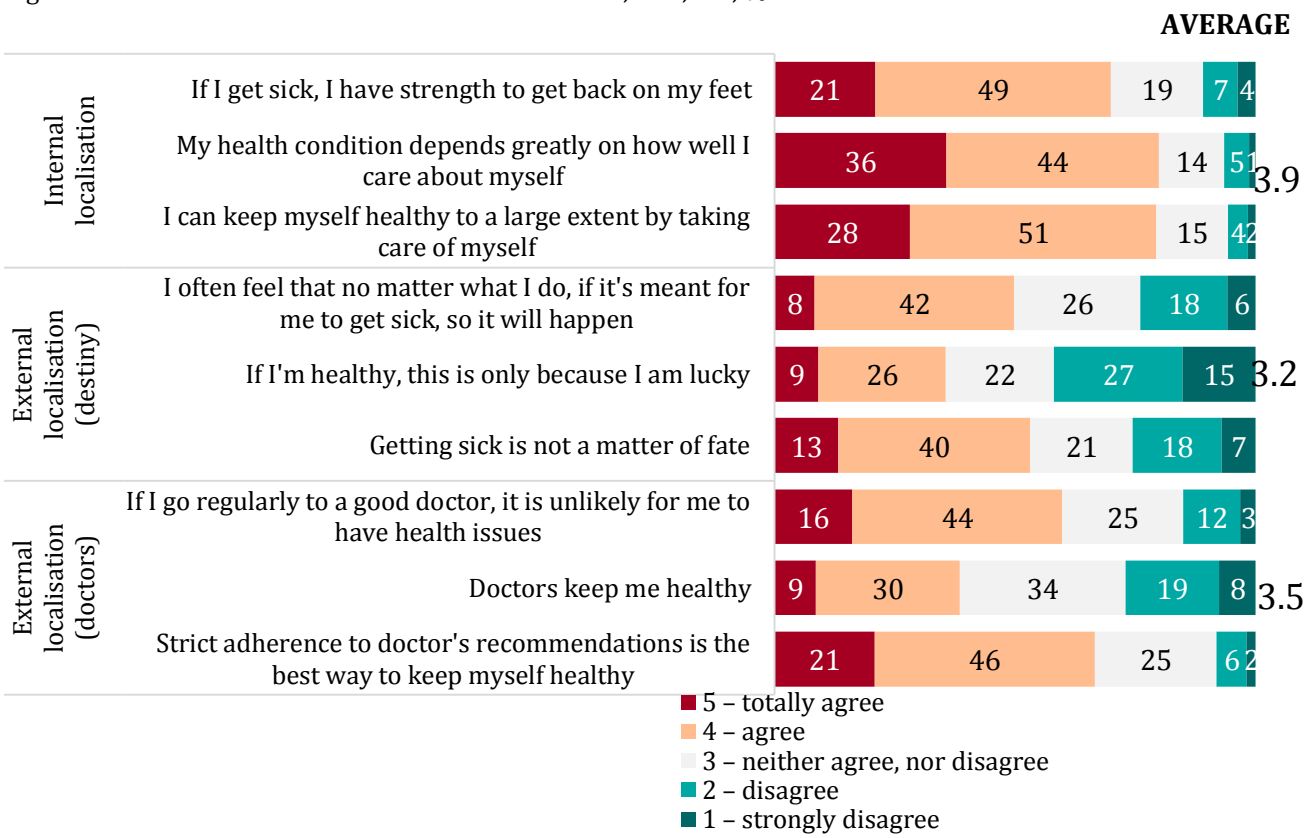
In order to see how intensively do social norms influence the decision to do the Pap test, the average for the three items was calculated. The maximum score for social norms' intensity is 5. The Student-*t* test revealed that women who had the Pap test at some point in their life perceive the social norms as having a high intensity, compared with those who never had the test.

Table 3.11.3: Difference between the perception of social norms by women who had and who hadn't have the Pap test

	Score	Cervical screening experience (average, SD) N=440	No cervical screening experience (average, SD) N=722	*t*	*p*
Social norms	1-5	3.5 (.78)	2.9 (.76)	14.5	.000

Three scales, each consisting of three items, were used to assess the impact the ***localisation of the control on health*** has on the intention to participate in the cervical screening. Data analysis indicates that the strongest health localisation of Moldovan women aged 25-61 is the internal control localisation. The average for this variable is 3.9 out of 5. Also, the external control localisation due to doctors' influence is higher, with an average of 3.5 out of 5.

Figure 3.11.9: Indicators for health control localisation, N=1,226, %



To analyse whether there are differences between the intensity of different localisations of health control, the average values for each localisation were calculated, and then a test comparing the averages was conducted. The results of the analysis show that in relation to women who didn't participate in the cervical screening, those who participated showed both more internal control and more control related to doctors' influence (Table 2.10.4).

Table 3.11.4: Student-t test results for the average differences on control localisation between the women who had and who hadn't have the Pap test

	Score	Cervical screening experience (average, SD) N=440	No cervical screening experience (average, SD) N=722	*t*	*p*
Internal control	1-5	4.0 (.62)	3.8 (.72)	2.9	.003
External control (destiny)	1-5	3.1 (.71)	3.1 (.68)	.5	.603
External control (doctors)	1-5	3.6 (.74)	3.4 (.74)	2.8	.005

Summary: Intention to do the Pap test

If the respondents were invited to do the test, 74% of the women said they'd rather do it. As much as 70% of the respondents said they'd probably do the test within the next 3 months. Most believe that the gynaecologist should take the Pap smear.

3.12 Needs of Pap Test Information and the Preferred Method of Invitation to Do the Test

The survey asked the women were asked about how they would prefer the family doctor to inform them about the Pap test. Thus, 51% of women said they would prefer to be informed by phone, and 34% would like to be verbally invited during their visits to the family doctor. Other methods of invitation were less common, for instance, only 5% of women said they would like to be invited by post.

Figure 3.12.1: Preferred method to be invited to do the Pap test, N=1,226, %

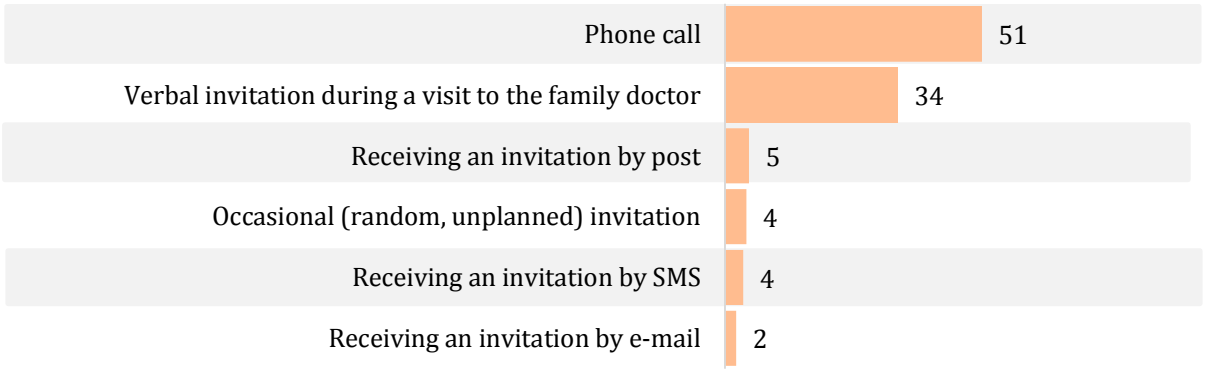


Table 3.12.1: Association between the socio-demographic criteria and the preferred method to be invited to do the Pap test, N=1,226, %

Invitation	Age			
	25-35	36-45	46-55	56-61
Letter	4	4	3	8
Phone call	52	51	56	44
Other	44	45	41	48
X^2=14.7, df=6, p<.023				

Invitation	Area	
	Urban	Rural
Letter	7	3
Phone call	53	49
Other	40	48
X^2=12.4, df=2, p<.002		

Invitation	Marital status				
	Unmarried	Cohabitation	Married	Divorced	Widow
Letter	6	0	4	8	8
Phone call	55	60	51	57	39
Other	39	40	45	35	53
X^2=15.4, df=8, p<.051					

Invitation	Ethnicity	
	Romanian/Moldovan	Other[44]
Letter	5	5
Phone call	52	44
Other	43	51
X^2=3.8, df=2, p<.150		

Invitation	Education		
	Secondary or lower[45]	Vocational	Higher
Letter	5	5	4
Phone call	49	50	54
Other	46	45	42
X^2=3.04, df=4, p<.551			

Invitation	Occupation		
	Unemployed	Employed	Retired
Letter	5	5	6
Phone call	53	53	38
Other	42	43	56
X^2=11.4, df=4, p<.023			

[44] Due to the small number of respondents, the minorities were included in one group 'Other'

[45] Due to the small number of respondents, the persons with primary and secondary were included in one group.

Invitation	Financial status		
	Rich	Average	Poor
Letter	4	4	9
Phone call	38	53	46
Other	59	43	45
X^2=13.3, df=4, p<.010			

Opinions on the invitation to do the Pap test

Most interviewed women said that they were often called by the family doctor or his/her nurse to do the Pap test. Note that in most cases, when invited to do the cytology test, the women were not informed about the preparations necessary before the test or were not asked during which period of the menstrual cycle they were. Also, during some of the focus groups, women said that invitations to do the preventive tests were done very fast and often they didn't know what tests they had.

The rural women who had the cytology test were often told about cervical screening when they were invited to a general prophylaxis, or when they visited the doctor/nurse, having a problem issue. At the same time, women were announced that they had to buy equipment/supplies to do the cytology test.

I was told to take a vaginal speculum, gloves, wipes, the gynaecological set, and then go to the examining room.

It was noticed that there is no effective track of women who did the cytology test outside the public health system and the communication of this information to family doctors. Thus, a woman from Chisinau who usually does the Pap test at private clinics was invited several times by public health workers to have the test.

For the most part, women were not refused the cytology test. However, some women said that it happened that family doctors informed them about the date they last had the test, and told them they had to wait to repeat the test because *'it's not good to do it too often'*.

Opinions on how women should be invited to do the Pap test

For the most part, women living in cities prefer to be invited both via phone and letter. They said that the call by phone call was personalised and helped establish a connection with the health worker. Also, in the case of a phone call, women would have the opportunity to ask questions about the procedure and the preparation needed for the test. Opinions suggested that the phone calls should be made after the working hours.

Women with higher education mentioned the invitations in writing or letters (on hard copy or electronic) because they are easier to memorise and allow a later referral. Women with a lower education emphasised that the message in the letter should be formulated in simple words, so that information is understandable.

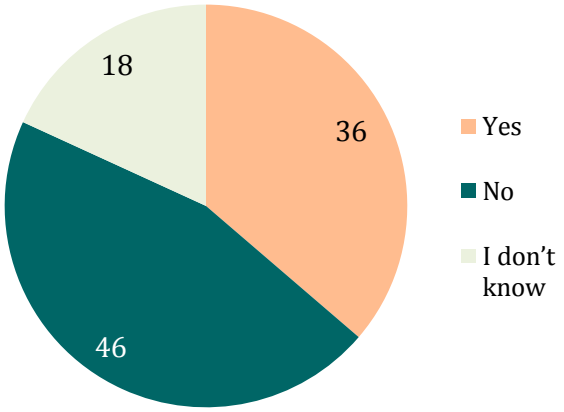
Some women said that the invitation to cervical screening should target not only women, but their partners too, because this way, more women could ultimately be motivated to do the cytology test.

Some respondents said they would like, when invited to cervical screening, to get more information about the procedure. Opinions were voiced that more detailed information on the importance of the cytological test, the sampling procedure and its effectiveness would be welcomed.

Information about the Pap test

Of the women aged 25-61, only 36% said they would like to know more about the Pap test, 46% said they wouldn't like to know more about it, and 18% abstained to answer.

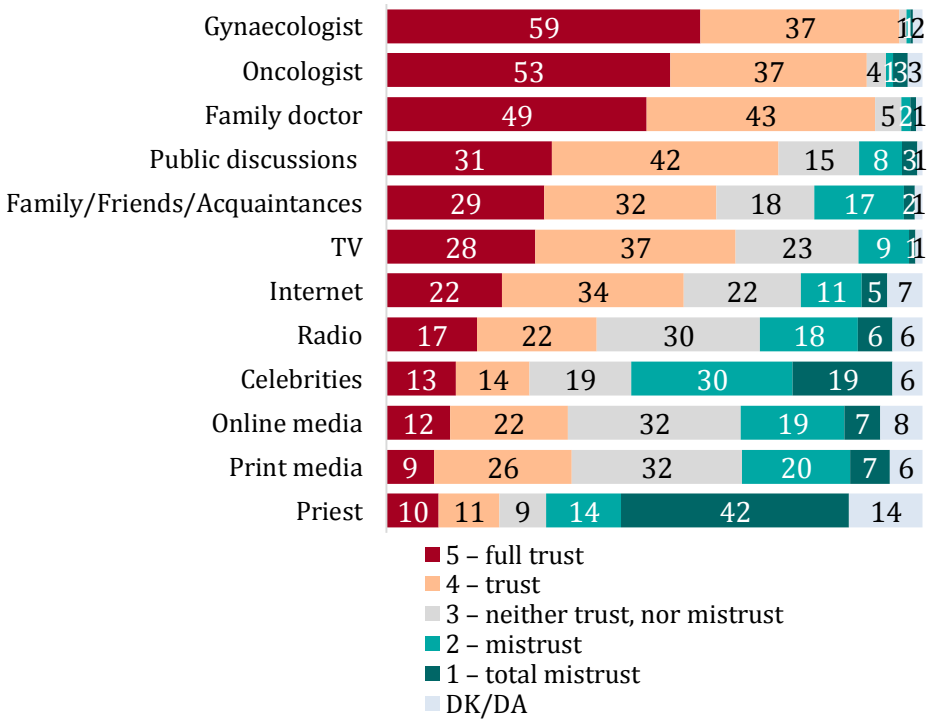
Figure 3.12.2: Share of women who would like to know more about the Pap test, N=1,226, %



Information sources about the Pap test

Women were told several potential information sources from which they could receive knowledge about the Pap test, and they had to mention how much they'd trust the information coming from these sources. The results show that women trust the health professionals the most. Of them, it seems women trust the most the gynaecologists (96%), family doctors (92% trust or fully trust them) and oncologists (90% trust these specialists). As regards other information sources, women seem to have the greatest trust in public discussions about the Pap test (73% had a certain trust in these sources). Also, 65% seem to trust information coming from the TV. There is some pronounced distrust in the possibility to be informed about the cytology test by celebrities (49% seem to distrust) and by priests (56% would not trust them).

Figure 3.12.3: Information sources about the Pap test which women would trust, N=445, %



Information sources about the reproductive health

Women who have never done the cytological test didn't know what the cervical screening test means, didn't know where they can have it or which specialists take the sample. Most of the interviewed women, who never had a cytology test, admitted to not having ever hear about this test before the survey.

Women mentioned that they generally search for information about reproductive health on the Internet, but most of the time, if they have or think they may have a reproductive health problem, they prefer to see a health worker. These women search for information via search engines rather that visiting a specific website. At the same time, the lack of trust in the information posted on the Internet, especially on social media, was pervasive.

Most women living in rural areas don't have time to search information on reproductive health. They explained that they choose to go directly to the nurse in their community since the latter use a simple, non-medical language.

Some respondents learned about the Pap test at the workplace, being advised to do the test by their coworkers diagnosed with cervical cancer. Other learned about the cervical screening from TV or radio programs that discussed about cervical cancer issue and prevention.

Opinions on requested information about cervical cancer

A number of women were interested in the cytology smear analysis and the reason why it takes a long period of time. At the same time, some women wanted to know the arguments behind the recommendation to do the test every three years. Others were interested in cervical cancer causes, symptoms and methods of prevention.

To find out about the efficacy and effectiveness of cervical screening, some women showed interest in the statistics on cervical cancer prevalence before the implementation of cervical screening program. Also, some women said they would like to know the number of false negative cases and the factors that can influence the test's accuracy.

There were comments that it would be useful for health care facilities to disseminate brochures with information about cervical cancer prevention.

Women of different ages said they'd like to participate in group discussions with health workers, sessions at which they could learn more about health and ask questions. Several women in Chisinau said they'd feel comfortable to talk to health workers at their workplace.

Maybe not all of us can afford to buy a magazine or a newspaper, or to see a doctor. Hence, a doctor should come and organise a meeting at our workplace where we could learn different information.

There was a widespread reluctance to trust the information about cervical cancer prevention coming from celebrities or public figures who are not doctors. All the women who participated in the survey said they would trust such information only if the person who tells them suffered from cancer or is a doctor.

Knowledge about Pap test names

According to the data, the most widely recognised name of the Papanicolaou test was 'cytology test' – 40% of the women said that they knew better this name. A proportion of 20% of the women heard the name 'Papanicolaou test', while only 10% knew about 'cervical screening'. At the same time, 43% of the women admitted to knowing none of the names showed to them.

The analysis proves that most women would prefer cervical screening to be called as 'cytology test' – 42% were for this name. Only 17% were for the name 'Papanicolaou test'.

Figure 3.12.4: The most known test names, N=1,226, %

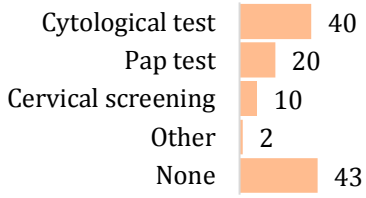
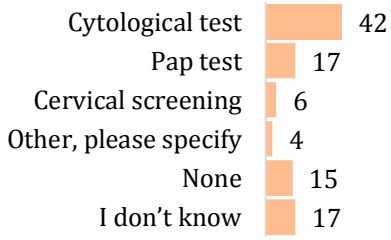


Figure 3.12.5: Opinion on the name to be used for the cytology test, N=1,226, %



Opinion on the name to be used for the cervical screening

Most women in the survey admitted to knowing none of the names proposed. It seems that '*cytology*' was the most common name of cervical screening. This is why the name '*cytology test*' was the most often chosen from the names proposed. Many women explained that the name '*cytology*' sounded simpler and was easier to remember. In addition, most women said that the health professionals they spoke to called the test '*cytology*' and, as this was the first name they heard, it was easier for them to use it. At the same time, some women highlighted that the name of the test should make its purpose clear, and therefore they preferred this test to be named 'the cancer test'.

Summary: The need to inform about the Pap test

One in two women who participated in the survey preferred to be invited by phone to do the Pap test, and another 34% would prefer a verbal invitation during the visit to the family doctor.

During the focus groups, some women mentioned they were invited to do 'some tests', without being explained the nature of the latter. When invited to do the test, some women were also asked to buy equipment/consumables. A woman who had the test at a private clinic noted that there was no communication mechanism between facilities since the family doctor invited her to do the test though she already did it. Respondents said they would prefer phone calls, personal calls and written letters as an invitation method to do the test. Opinions were voices that invitations could also target the partners who might motivate women to do the cytology test.

As much as 36% of the participants in the survey said they'd like to know more about the Pap test. A number of women in the qualitative survey were interested in the cytology smear analysis. Women who have never done the cytological test didn't know information neither about the facilities where they could be screened, nor about the persons who take the smear, nor about the cervical screening itself.

The survey shows that the gynaecologists, oncologists and family doctors are the most trusted sources of information (over 80% of women trust these specialists). Sources such as the Internet, radio, celebrities or online media enjoy a much lower trust.

Most (43%) of the respondents didn't know any name for cervical screening, while 40% knew the name 'cytological test'. According to many respondents, the latter is also the name that should be used when referring to the cytology test.

3.13 Predictors of the Intention to Do the Pap Test and Predictors of the Previous Screening Experience

In order to identify the predictors of the intention to do the Pap test within the next three months, the data were analysed in a sequential linear regression. The independent variables were grouped into four blocks on the basis of the theoretical model (Table 2.13.1 contains the variables included in the analysis). Blocks of variables were analyses one by one.

Table 3.13.1: The variables included in the sequential regression analysis to identify the predictors of the intention to do the Pap test

Block	Variables
Block 1: Demographic variables	Age Area of residence Marital status Presence of children Ethnicity Education Religion Socio-economic status Occupation
Block 2: Variables related to health and medical history	Perception of the health status Medical diagnostic Presence of disability Frequency of visits paid to the doctor Frequency of visits paid to the gynaecologist
Block 3: Variables related to the accessibility of and satisfaction with medical service	Insured status Registration on the family doctor's list Way of choosing the family doctor Satisfaction with the medical service
Block 4: Cognitive variables	Susceptibility Perception of psychological cost Perception of benefits Sense of self-efficacy Social norms Attitude towards the importance of having the test Internal control localisation External control/destiny localisation Doctor-related external control localisation

Table 2.13.2 includes the results of the regression analysis. Data indicate that models 2 and 3 do not produce significant changes. However, after the introduction of cognitive variables, model 4 predicts up to 30% of the variation. As a result, the variables included in model 4, which are significant predictors, will be reviewed.

Table 3.13.2: The results of prediction models of the intention to do the Pap test

Model	R-squared	Adjusted R-squared	Statistics of change	
			F Change	Sig. of F Change
1	.108	.065	2,509	.000
2	.123	.071	1,605	.157
3	.133	.072	1,134	.341
4	.359	.294	11,894	.000

Table 3.13.3 presents the components of the regression equation for model 4, with only the variables for which *p* value is significant. The analysis of the coefficients shows that the attitude towards the cervical screening is the most important predictor of the intention to have this test. Once the perception that having the test is a wise decision and important for women does increase, the desire of the latter to do the test increases too.

Also, knowing that the Pap test may have personal benefits is a variable with a higher prediction power. Note that the internal control localisation on health, as well as knowing the purpose of the test, might positively influence the intention to do the test.

Table 3.13.3: The components of the regression equation for model 4

	Non-standardised coefficients		Standardised coefficients	t	Sig.
	B	Error std.	Beta		
Belonging to minority ethnicities	-1,113	.440	-.098	-2,530	.012
Belonging to minority religions	-.488	.240	-.078	-2,029	.043
Primary of lower education	-1,644	.565	-.141	-2,912	.004
Low susceptibility	-.119	.041	-.123	-2,881	.004
Perception of benefits	.336	.064	.238	5,273	.000
Low self-efficacy	-.225	.050	-.187	-4,537	.000
Attitude towards the test	.345	.062	.253	5,567	.000
Internal control	.147	.077	.088	1,917	.056
Knowledge about the purpose of the test	.236	.114	.089	2,065	.040

In contrast, the feeling of low self-efficacy, which assumes that a woman perceives that the test would be difficult to be done in the next months, predicts low intentions to do it. Similarly, the perception that a woman has little chance to get cancer is negatively correlated with the intention to do the test.

What is more, belonging to ethnic minorities (Bulgarian and Roma minorities), to minority religions (Baptism, Jehovah's Witnesses, Islam) and the low level education are also predictive of small chances that the Pap smear will be taken.

The hierarchical logistic regression was used to assess the predictors of the previous screening experience. Potential predictors were included in the sequential regression model. The first block included demographic variables, the second – variables related to health status assessment, the third – variables related to the access to medical services, and the fourth – cognitive variables. The table below shows the variables that had a significant impact on the dependent variable.

Table 3.13.4: Predictors of the previous screening experience and the R^2 Nagelkerke value for the four models

	Model 1	Model 2	Model 3	Model 4
Age	1.02 [1.00-1.05]	1.03 [1.01-1.06]	1.03 [1.01-1.06]	1.02 [1.00-1.05]
Health status		1.3 [1.00-1.71]	1.3 [1.01-1.71]	
Visits paid to the gynaecologist		.76 [.60-.95]	.76 [.60-.97]	
Registration with the family doctor			.4 [.2-.8]	
Social norms				2.18 [1.64-2.9]
Knowledge about the purpose of the test				2.37 [1.44-3.9]
Constant	.36	.98	.26	.08
R2 Nagelkerke	.08	.10	.12	.26

The Nagelkerke R2 coefficient indicates that model 4 has the most explanatory power and predicts up to 26% of the variation. The knowledge about the purpose of the test and the social norms have the highest chance ratio coefficients. Thus, women who know what the Pap test is meant for are 2.4 times more likely to do the test.

Note also that when the impact of the opinion influential people have about the Pat test goes one degree up – the likelihood that a woman will do the test increases 2.2 times. At the same time, when the age goes one year up, the likelihood that a woman will do the cytology test increases 1.02 times.

Summary: Predictors of the intention to do the Pap test

The results of the regression analysis indicate that cognitive variables are significant predictors of the intention to do the cervical test. The women who know what the Pap test is meant for are 2.4 times more likely to do the test. At the same time, the impact of the opinion influential people have about the Pap test increases by 2.2 times the likelihood that a woman will do the test.

3.14 Knowledge About and Attitudes Towards the HPV Vaccine

A proportion of 40% of the women aged 25-61 heard about the HPV vaccine. Most of them (52%) learned about it from the TV or radio. One third of them were told about it by the family doctor, while one in five women heard about the vaccine form friends or acquaintances.

Figure 3.14.1: Share of women who know about the HPV vaccine, N=1,226, %

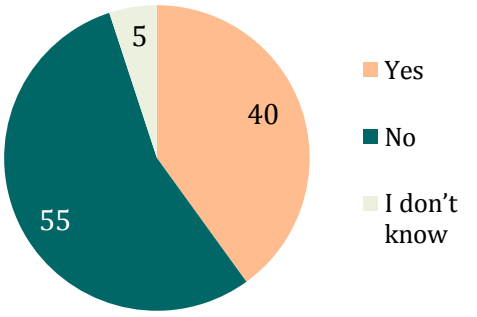
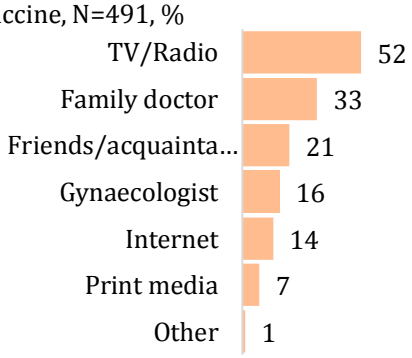


Figure 3.14.2: Sources of information about the HPV vaccine, N=491, %



The analysis of contingency tables indicates an association between the belonging to certain socio-demographic groups and the likelihood of having heard about the HPV vaccine. Thus, urban women, married women, those with higher education and a higher socio-economic status are more likely to know about this vaccine. In contrast, women aged 56+, from the rural area, Gagauzian, with elementary or secondary education, retired and living in poor households are more likely to say they didn't hear about the HPV vaccine.

Table 3.14.1: Association between socio-demographic characteristics and knowledge about the HPV vaccine, N=1,226

Knowledge about the vaccine	Age			
	25-35	36-45	46-55	56-61
Yes	47	47	44	30
No	53	53	56	70
X^2=25.3, df=3, p<.000				

Knowledge about the vaccine	Area	
	Urban	Rural
Yes	46	39
No	54	61
X^2=6.6, df=1, p<.010		

Knowledge about the vaccine	Marital status				
	Unmarried	Cohabitation	Married	Divorced	Widow
Yes	32	36	46	39	20
No	68	64	54	61	80
X^2=29.8, df=4, p<.000					

Knowledge about the vaccine	Ethnicity				
	Moldovan/Romanian	Russian	Ukrainian	Gagauzian	Other ethnicity
Yes	43	46	41	13	38
No	57	54	59	87	62
X^2=18.4, df=4, p<.001					

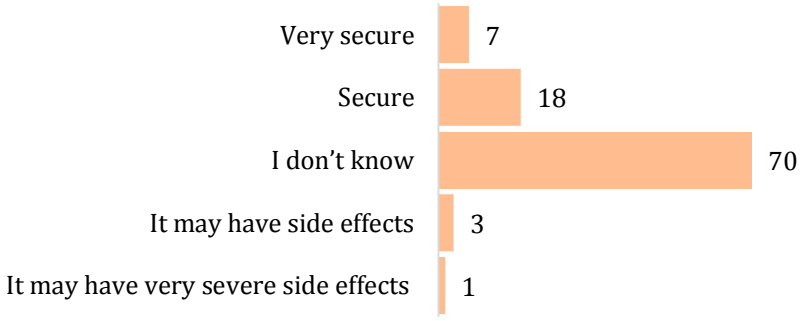
Knowledge about the vaccine	Education			
	Primary	Secondary	Vocational	Higher
Yes	24	33	39	63
No	76	67	61	37
X^2=67.03, df=3, p<.000				

Knowledge about the vaccine	Occupation		
	Unemployed	Employed	Retired
Yes	42	47	23
No	58	53	77
X^2=28.8, df=2, p<.000			

Knowledge about the vaccine	Financial status		
	Rich	Average	Poor
Yes	51	47	18
No	49	53	82
X^2=55.9, df=2, p<.000			

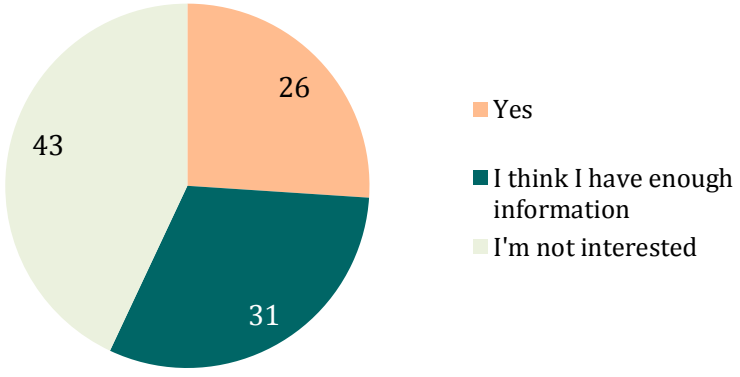
When asked about the HPV vaccine safety, 70% of the respondents said they were not aware of it. However, one fourth of women believe the vaccine is a safe method to prevent cervical cancer.

Figure 3.14.3: Opinion on HPV vaccine safety, N=1,226, %



Of the total sample of women aged 25-61, 26% said they would like to know more about the HPV vaccine, 31% believed the knowledge they already had was enough, and 43% admitted they were not interested in this vaccine.

Figure 3.14.4: Interest in learning more about the HPV vaccine, N=1,226, %



Of the women who had 10-year-old daughters, 45% said they would vaccinate their daughters with the HPV vaccine, one third would not vaccinate them, and 23% already vaccinated their daughters against HPV.

Figure 3.14.5: Share of women with 10-year-old daughters who would like to vaccinate them, N=123, %

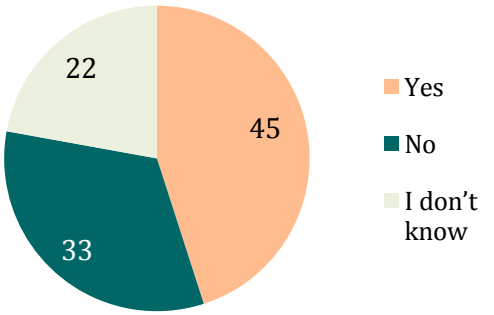
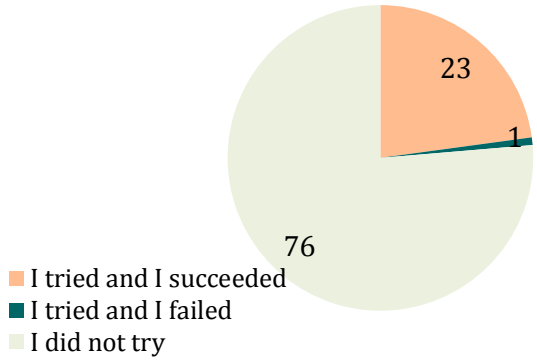
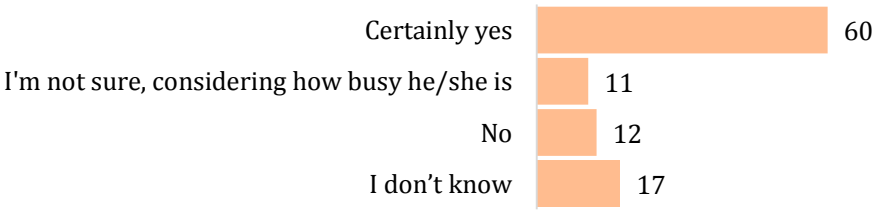


Figure 3.14.6: Share of women with daughters about the age of 10 who already vaccinated them, N=123, %



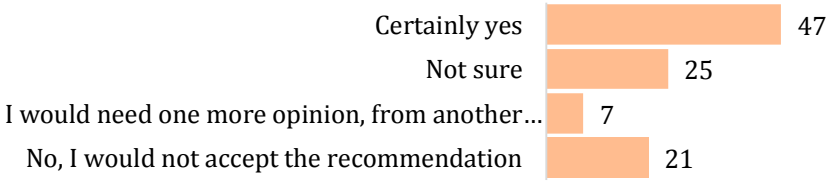
As much as 60% of the women with daughters about the age of 10 declared that family doctors were open to providing information about the HPV vaccine.

Figure 3.14.7: Opinion on the availability of family doctors to discuss about the HPV vaccine, N=123, %



In the end, women with 10-year-old daughters were asked if they would follow the doctor's advice to vaccinate their daughters against HPV. A proportion of 47% of respondents declared their intention to vaccinate their daughters, 32% were not sure if they'd follow the doctor's advice and 21% said they would not vaccinate their daughters.

Figure 3.14.8: Intention to follow the doctor's advice to vaccinate the daughters with the HPV vaccine, N=123, %



The perception of the knowledge about and the attitude towards the HPV vaccine

The women who never did a cytology test were not aware of the HPV vaccine and that HPV can cause cervical cancer.

Women who were aware of the HPV vaccine knew that this is indicated for teenage girls but could not explain why the vaccine should be done at an early age. Some women believed that the vaccine can be made until the age of 25.

Some of women were not aware what the HPV vaccine was meant for and believed that this is a form of treatment that needs to be made when the body is infected.

A number of women heard about the HPV vaccine via the media: news and radio shows. Three women said they learned about the HPV vaccine on the social media, finding out that this vaccine can cause infertility – information that worried them.

Both in urban and rural areas, there were women who were reluctant to vaccine safety because of the adverse effects they couldn't name. Moreover, there were women in Chisinau who said that the vaccination campaigns taking place in Moldova were some sort of '*experiments*', and that they had no trust in vaccine's quality or effects.

It was mostly women from the rural area who said they trusted the efficacy of the HPV vaccine and they'd vaccinate their daughters or granddaughters. In addition, some women that they'd vaccinate their daughters in private clinics only because the vaccines in private health facilities are of a higher quality and the risk of adverse effects is lower.

A small number of respondents believed the vaccine is not effective and it might cause cancer.

If God decided one should have cancer – he/she'll have it regardless of what he/she does to prevent it.

Summary:

A proportion of 40% of women heard about the HPV vaccine. Of these, about half learned about it via the TV and radio, while a third – from the family doctor. One third of respondents trusted the HPV vaccine, and 70% were unaware of its safety.

Of the women who had 10-year-old daughters, 45% would vaccinate their daughters with the HPV vaccine, and 23% already did it. As much as 60% of women were certain that family doctors are available to discuss about the HPV vaccine and 47would follow the doctor's advice on HPV vaccination.

Interviewed women had vague knowledge about HPV vaccination. It was noted that respondents who did the Pap test also knew about the HPV vaccine, but many of them couldn't explain the importance of vaccination at an early age. A number of women were reluctant to vaccine's safety, highlighting the adverse effects that may arise and the distrust in its quality.

CHAPTER IV: SPECIALISTS' AND HEALTH CARE WORKERS' OPINION ON CERVICAL CANCER PREVENTION IN THE REPUBLIC OF MOLDOVA

4.1 Cervical Cancer Incidence and Priority in the Republic of Moldova

According to the interviewed specialists, cervical cancer is a major, international and national issue, highlighting that Moldova is among the countries with a higher incidence of this type of cancer. Based on its incidence and prevalence, the respondents said that cervical cancer ranks on the top of oncological diseases, being the second cause of women's deaths, after breast cancer:

> *'As many as 180-210 women die annually of cervical cancer. Most of these women are able to work, have children, grandchildren, families. We face a real problem – the fact that 200 women die in their prime of life is too much for a small country as ours'.*

Concerning how bad this problem is in the Republic of Moldova, the specialists mentioned that the number of identified cases of cancer in stage III and IV is bigger than the number of cases of cancer in its primary stages. Given the fact that the population is declining, they believe that cervical cancer indicators are increasing.

The interviewed doctors had different opinions on cervical cancer incidence. Most of them said that this type of cancer is a problem for the Republic of Moldova due to the increase in the number of diagnosed cases. Other highlighted that the number of people diagnosed with cervical cancer is decreasing due to the efforts targeting the risk groups, i.e. socially vulnerable women.

The specialists and health professionals listed the following causes of the high incidence of cervical cancer in the Republic of Moldova:

- the population does not quite practice going to the doctor for prevention purposes. It was mentioned that women in the Republic of Moldova are not aware of the importance of periodic health checks and fail to seek information on cervical cancer causes.
  'Our population is not yet aware of the importance to see a doctor. We have to invite them, to beg or even to force them to do the tests.' (family doctor, urban area).

Both specialists and doctors believe that women are responsible for preventing the cervical cancer by constantly seeking health information and having regular medical checks.

- diagnosis of cervical cancer in its late stages because women go to the doctor too late:
  'Mortality in our country is high because women seek health care too late. Usually, most cancers are diagnosed in stage III or IV.'
- ineffective screening. It was mentioned that the tests are not informative enough and the way they are interpreted does not always allow for the identification of pre-cancer conditions;
- presence of other types of pathologies causing the cervical cancer to develop;
- not enough efforts were made to inform the population about the possibility to do the Pap test and the lack of information about cervical cancer in health care facilities and the media;

Respondents believe that the factors that prevent women from seeing the doctor are as follows:

- socio-economic status of some women;
- migration;
- shame to do gynaecological checks;
- lack of time;
- lack of information that cervical cancer is asymptomatic;

'There are women who are not taking their health seriously. They think they'll stay forever young, and as I said they go abroad, they have a stressful life and no time to do heath checks. When they come back and do these checks – with regret it's too late.' (family doctor)

- system's unfriendly attitude: '*it's difficult to go to the clinic; one needs to get an appointment, to wait in the queue'.*

Summary:

According to the specialists and health professionals, cervical cancer is a priority issue for the Republic of Moldova, due to the large number of deaths and cases diagnosed. The low health culture, late diagnosis, not enough efforts to inform women, and inefficient screening to detect pre-cancer conditions explain cervical cancer prevalence.

4.2 Services Addressing Cervical Cancer in the Republic of Moldova

Some specialists believe that the current spectrum of services to reduce cervical cancer incidence and the treatment prescribed if pre-cancer conditions are detected are ample, sufficient and in line with field international recommendations. The health workers also believe that the Republic of Moldova has appropriate services to fight cervical cancer.

A number of doctors interviewed had only positive takes on cervical screening. According to them, cervical screening identified a larger number of cases of cancer in its early stages than in the absence of cervical screening services.

The specialists mentioned what was good about the carrying out of the Pap test/cervical screening:

- smear taking is free;
- good accessibility of screening services as the primary health care level, which is much closer to the population, is involved: '*we have a primary health care covering all administrative territories, we have health workers';*
- the Government acknowledged the problem and the decision was made to screen women from 25 to 61 years old every three years;

'... our country puts a huge emphasis on cervical screening and this is good... even international specialists are surprised that despite the fact that we are a poor country with a very modest financing, our domestic policies cover the whole population according to international standards, i.e. not all countries can afford doing this.'

- both women and the Government benefit if cervical cancer is early detected, as fewer resources are needed for treatment, and women can be quickly involved in society and workforce;

'What does a woman have to gain? First of all – her life, her family, children, relatives..."

At the same time, the following drawbacks of the implementation of services addressing the cervical cancer were mentioned:

- Insufficient tools to monitor the cervical screening program.
- Lack of a mechanism to make women and health workers assume accountability to involve about 75% of women in cervical screening in order to make this service useful and cost-effective.
- In terms of smear taking and smear reading, the focus is rather on the quantity than on the quality of the provided service: *'we are talking about the real access and the access to quality screening services... If one has to admit that 30-40% out of 100 samples are of a low quality or cannot be read, then what's the point of these services?*'
- The cytology test used at present following the Romanowsky-Giemsa technique is not informative enough and that errors are possible, which is why additional examinations are needed, such as the colposcopy examination, which is not available in all district-level health care centres. A specialist mentioned the huge discrepancy between cytological and histopathological diagnosis – about 50-60% compared to Great Britain, where the cases of mistakes represent 2-3%.
- Insufficient trainings of the specialists involved in the cytology smear taking. It was mentioned that the procedure was carried out during an inappropriate phase of women's menstrual cycle, which generates wrong results of the cytology tests: *'do you realise how many duplicates of screenings were made? All this money is wasted, money that could be used wisely... I want to say that the optimisation and organisation of screening would save resources and help make it possible for the country to scale up this screening system'.*
- Performing the test based on the *Romanowsky* technique although the protocols and standards mention the Pap test: *'we are currently making efforts to use only the Pap test, according to international requirements. This method is more expensive and yet, in many districts and even in Chisinau, health professionals are working with the Romanowsky technique, which was proven globally to be less qualitative. However we are already trying to switch to the Pap test, organising trainings of the staff to this end.'*
- Insufficient funds to pay for cytology tests if more women started to show up for the screening.

- Long investigation time: '*it takes between two to three months. Besides the fact that this isn't fair towards women, the result's accuracy also becomes suspicious'.*
- Insufficient equipment and adequate training of laboratory doctors.
- Underdevelopment of the colposcopy service at national level: *'women don't have enough access to the colposcopy service'.* The shortage of colposcopy offices and their lack of capacity in the regions to provide a quality result are the reasons why patients are referred to the Oncology Institute where they can benefit from this service: *'not all women can afford this luxury.'*

Most respondents believe that cervical screening should be a priority in addressing cervical cancer, regardless of the number of cases identifies, starting from the fact that prevention costs are lower than treatment costs. In addition, some doctors said that 70-80% of cervical cancer cases can be prevented thanks to this procedure:

'Without much financial investment, this simple procedure makes it possible to identify, if well-done, all or most of the pre-cancer lesions, so as to avoid getting cancer.'

According to the specialist, although at international level cervical screening is regarded as one of the most successful procedures to prevent cervical cancer, this service is not that well organised in Moldova to be regarded as successful. They mentioned that the program is extended to the country level as far as the number of providers and services offered is concerned; however, the target group coverage percentage remains low, less than 50% of women benefiting from these services.

In relation to the HPV vaccination campaign, cervical screening is perceived as a priority and effective measure in cervical cancer prevention:

'Without any doubts, the vaccination should be promoted, it is effective and it should be further extended. However, the screening remains both effective and a priority.'

Respondents had different opinions on HPV vaccination. According to them, the HPV vaccination launched in 2017 is a success of the national health care system because it can prevent cervical cancer: *'it's a Government decision – it's always easier to invest in prevention measures'.* Most doctors see only the benefits of this prevention measure, noting that they didn't notice any side effects. The specialists were not so sure about the effectiveness of the vaccination, noting that the results will be visible after a number of years:

'I think that vaccination is a good thing and a positive benefit, but we need to vaccinate a larger sample and to analyse the surveys to see whether it has benefits or not.' (histopathologist, urban area)

'It has no effectiveness here, in our country... I'm not sure if I'd allow my daughter to be vaccinated if she was 11-12 years old. I'm not sure because there are many HPV roots, and the vaccines cover only two. It's not excluded that the cancer might grow from the other high-risk roots.' (cytologist, urban area)

According to an oncologist, parents' refusal to vaccinate their children is caused by the vision of certain family doctors who convince the former that the vaccine is not effective.

The specialists had different opinions regarding the capacity of the health care system to cope with an extended cervical screening and HPV vaccination program. Those who believed that the system was prepared pointed out to the possibility to do the cytology test in the public health care facilities, to the financial resources from the state budget covering the needs for these services and to the support of the international organisations in strengthening the national capacities to prevent cervical cancer. The respondents who weren't sure about the health care system's capacity pointed out to the following challenges: health staff shortage, uncertainty about the quality of the services provided, and inappropriate implementation of the cervical screening program:

'First, we already have a 30% or so staff shortage in the PHC system. Second, if we talk about the health care, we need to talk to qualified and well-trained nurses. Do you understand? There is no need to provide a service only because of the formality, and then complaining about low-quality results. Health workers have to do a very qualitative work, that's what I'm talking about.'

While many respondents didn't know how the cervical screening could be extended, others came with the following solutions:

- sending doctors and equipment from the capital city to the regions that lack such service: '*Unfortunately, our health care centre doesn't have this service, but many women would like to do the test... I noticed that they're more receptive when they hear that certain specialists came with a special equipment from a centre in Chisinau. I firmly believe that women won't say no to such an opportunity.'*
- constantly informing women in the regions and making the population aware by developing a culture of health;
- providing health care centres with all necessary tools to take the cytology smear;

- enhancing collaboration between specialists from the facilities involved in the screening.

Summary:

The specialists and health workers fully support the implementation of the cervical screening as a service addressing the cervical cancer problem. However, the former had reserved opinions on HPV vaccination due to the lack of knowledge about vaccine origin and effects. The respondents believe that the implementation of the cervical screening could be made more effective by strengthening institutional, human, financial and operational capacities.

4.3 The Regulatory Framework on Cervical Screening in Moldova

Emphasis was placed on the fact that at present the policy papers and the provisions on cervical screening are enough. The most important ones, in this respect, are the National Cancer Control Program and the Action Plan on Capacity Building for the Implementation of the Cervical Screening in the Republic of Moldova.

At the same time, the effectiveness of the monitoring and evaluation of national policies on cervical screening was questioned:

'Speaking about screening, there should probably be a real screening program in place because we have a problem that doesn't have to do with cancer only, but also with the many other things: the monitoring is not good, and there's almost no evaluation.'

The specialists also said that the cervical cancer problem is also tackled in other policy papers and legal acts, such as the National Health Policy, the Healthcare Law, the National Program on Sexual and Reproductive Health and Rights, etc. It was also mentioned that the provisions on the HPV vaccine are stipulated in the National Immunisation Program and in the National Cancer Control Program.

The regulatory framework is believed to be sufficient because it provides for: *'activities at all stages of service provision; primary health care with measures of prevention, promotion and screening, early detection; outpatient care with other measures that can be taken by specialists and at hospital care level.'*

Concurrently, the National Standard of Operational Procedures for Cervical Screening was described as a complex document meant for all specialists involved in cervical screening: family doctors, cytologists, histopathologists, gynaecologists/colposcopists. The specialists believe that the standards are clear and give good guidance, but that they need to be adjusted to the realities of the Moldovan health system:

'Like any other document that is developed for the first time, it might not have included the components that we need now. When more knowledge and experience will have been gained, it'll be adjusted, amended, but the doctors were very keen to have it anyway. This tool was helpful in organising the primary health care level, the colposcopy. The laboratories tried to use it.'

Asked about policy papers on cervical screening, some specialists mentioned the National Clinical Protocol on Cervical Cancer and the Standard Clinical Protocol on Cervical Cancer, which was developed for family doctors and explains how the cervical screening is organised. It was also mentioned that Institutional Clinical Protocols were developed and that they provide for the roles, responsibilities and duties of the staff.

All interviewed specialists believe that the national rules on cervical screening and HPV vaccination are in line with the international rules and recommendations. What is more, emphasis was placed on the fact that the legal framework was drafted on the basis of international standards and recommendations form the World Health Organization and the European Union:

'every three years a survey is conducted, the guides and international recommendations and what we have in place are reviewed, and in 3-5 years new policies are going to be developed. Once an international standard has been approved one must observe it, without anyone, or even the ministry trying to bypass it.

It was noted that attempts were made to adapt the regulatory framework to the national realities:

'In Moldova, cancer mortality is higher and we, therefore, decided to have women screened for cancer every third year, not very fifth year as recommended internationally. There are countries where women are screened for cervical cancer thrice in a lifetime, but vaccination is 100% in those countries. We looked at it thinking about the

funds and about the good of the women when we decided that the Pap test should be done every third year. We decreased the costs and keep struggling with the disease.'

On specialists' accounts, the harmonisation of policies and national legislation with international standards/provisions was possible thanks to the support and involvement of UNFPA – the United Nations sexual and reproductive health agency, the World Health Organization, international experts and to partnerships with other countries.

Some specialists said that the 2016-2025 National Cancer Control Program will be assessed. Its implementing action plan covers five years: 2016-2020. Reportedly, the documents that are in force at present are not enough for an extended screening program because of the implementation issues:

'In general, most of the documents developed in Moldova are very good and this has also been noted by internationals specialists, but, unfortunately, they don't always work. It all looks very well-written on paper, however, when it comes to implementation there are staff shortages, reluctance among the population and many other things – not being able to cover the services financially if, for instance, the price of a Pap test increased after tariff catalogue amendments.'

In assessing the regulatory framework, another specialist mentioned the following challenges in its implementation:

- No calculations/estimations regarding technical endowment needs that have to be met in order to be in line with legal/regulatory provisions.
- The provided cervical screening services aren't of the appropriate quality because of staff shortages and poorly skilled staff that provides them.
- There are no mechanisms to encourage women to do the Pap test.

The health workers were found to have different levels of knowledge about the legal/regulatory framework on cervical screening. It was mainly the specialised doctors who remarked there were several policy papers addressing cervical cancer while most of the interviewed primary health care staff were not aware that they existed.

The health workers turned out to have little knowledge about whether or not there is any National Standard of Operating Procedures for Cervical Screening.

Overall, one could see that the nurses and some doctors were not familiar with the policy papers and the legal and regulatory frameworks addressing cervical cancer. Some mentioned leaflets for women, the registers were they record the names of women who did the Pap test, while the nurses mainly presumed there are some policy papers at the managerial level of the health facility.

Summary:

The specialised doctors proved they had quite good knowledge of the regulatory framework having mentioned that it has been adjusted to international rules and recommendations but that it is to be assessed and adjusted to national realities. The specialised health workers proved to be more knowledgeable about the regulatory framework compared to the primary health care level staff who were not familiar with the acts in this area.

4.4 Organisation of Cervical Screening Services and the Specialists Involved in Providing Cervical Screening Services

The health workers answered hesitantly to question regarding the health facilities involved in the cervical screening. The most frequently named human and institutional resources were the following: family doctors, family doctor nurses, midwives, gynaecologists, laboratory technicians, oncologists; the Ministry of Health, the National Health Insurance Company, the Oncology Institute, the Family Doctors Centre, the National Public Health Agency, the Republican Medical Diagnosis Centre, the Mother and Child Institute, the cytological and histopathological laboratories. Other institutions, that have the role of raising awareness about cervical cancer were named too: Youth-Friendly Health Centres, educational institutions, the media. Some people mentioned the need to involve the Mayor's Offices too.

'State authorities definitely need to get involved too, not just perfunctorily. The mass-media should participate more. Awareness raising in the rural area is an acute problem, but 70% of our citizens live in the rural area, while the awareness campaigns are conducted for the most part in Health Centres located in towns. This is quite serious a matter that needs to be worked on.' (gynaecologist)

An oncologist's opinion was that placement centres and women's penitentiaries should be covered by the cervical screening too. Most respondents said they believed that enough institutions are involved in the organisation of the cervical screening:

'There are enough institutions. All we need to do is have a well-thought-out plan adjusted to our country's context.' (gynaecologist)

The health workers stated that the following institutions are involved in organising the HPV vaccination campaigns: the Ministry of Health, Labour and Social Protection, the National Public Health Agency, the Family Doctors Centre, school nurses, vaccination offices. They added that to promote the HPV vaccination campaigns, awareness-raising events should be organised and the educational institutions should have a more active role:

'It would be good to hold some talks in schools, organisations where women work, answer to vaccination-related questions and raise awareness about how we can prevent cancer.' (nurse, Chisinau).

Some respondents from the health system reported that the current organisation structure of the screening services isn't quite efficient because, on the one hand the family doctors do not manage to fulfil their role, i.e. – prevention-related tasks, and on the other hand – the process is quite bureaucratic:

'The Ministry of Health assigned family doctors very demanding obligations. These tasks used to belong to different specialists: all gynaecological issues were referred to gynaecologists, paediatricians dealt with issues in their area of expertise... It wasn't bad because there are actually so many things to do to promote a healthy lifestyle. Family medicine doesn't really have time for it. There's so much paperwork to do. There are figures we don't even have time to talk about. Sometimes, patients come to see the family doctor for mere communication, but there's no feedback from us because we're constantly working on some reports, doing paperwork, putting figures together.' (nurse, urban area)

On this subject, a family doctor said that the nurses mainly do the paperwork and that they do not manage the necessary support because there is not enough time for that: *'they should better cut the paperwork we have to do to make it possible for us to do what's best for the people. No-one needs all these statistics'.* It is thus believed that the electronic patient records will make family doctors' work easier and will help communication with patients.

Some specialists believe that staff form the National Public Health Agency and the civil society should get involved more actively in promoting the prevention of cervical cancer:

'speaking about institutions adjacent to the health system such as the educational institutions, companies and organisations where women work, the media too... it would be good for them to be responsible of informing women too because this is what we still struggle with.'

Opinion on the conditions in primary health care facilities

Most of the health workers reported that the conditions for taking the Pap smear are optimal in the health facilities where they work.

'I think they are optimal. There's a midwife and the gynaecologist in the room where the Pap smear is taken. They have all they need do take the smear the right way. Even before the Pap smear is taken, the women can see that everything is sterile, all items are opened in front of them.' (nurse, urban area).

It was also mentioned though that not all primary health care facilities are fitted out with the necessary cervical screening equipment, or if they are – the equipment is not in line with the standards. Most frequently, they said that the brushes used to collect the smear are either not very good quality or even with their shelf life expired. Reportedly, in some health facilities women are forced to purchase the tools themselves from the pharmacy. The fact that no standards were set for smear collection equipment at national level was highlighted.

'The primary health care facilities didn't know for certain what kind of cervical brushes they needed to purchase; they were all free to choose according to their interests, accessibility, price, which didn't allow for a quality cytological smear to be taken. The decisions they made were not due to insufficient resources, but to the lack of clear mechanisms to coordinate what type of brushes needed to be purchased... lack of standardisation.'

In addition, two oncologists said that more equipment is needed to treat pre-cancer conditions and to perform radiotherapy.

Opinion on the staffing with human resources involved in the screening at primary health care level and specialised outpatient care level

Several respondents emphasised that one of the PHC issues is that there is not enough staff able to take the Pap smear, but also that the health workers leave because of the small pay:

...the rural areas area affected the most by staff shortages – we don't have doctors, midwives, nurses to take the Pap smear. Slide examination is also at issue because there aren't enough cytologists in Moldova.'

The shortage of specialised health workers in laboratories was mentioned. This could lead to poorer quality of work in laboratories:

'There are few cytologists in the country. Cytologists look at very many slides, but their eyes get tired. In general, you wouldn't be allowed to use the microscope for longer than 6 hours a day because the likelihood to make mistakes would be greater. If a pathology is suspected, two cytologists should look at the slide. We don't really have this possibility because there are few cytologists.'

In specialists' view, another challenge for the implementation of the cervical screening program is the insufficient training of some health workers involved in the provision of screening services. In this regard, examples were provided of nurses not knowing how to use the medical tools and of health workers not going to training courses because they didn't have the money to:

'...officially, 2% of the budget of every health facility must be used for doctors training. The colposcopy course is very expensive – MDL 8000.'

The respondents maintained that due to financial support from international organisations, trainings were organised for cytologists and the methods of training of medical laboratory staff were changed. They mentioned that cytology courses were organised for cytologists working in laboratories in Moldova, and that UK specialists participated as trainers. The courses were believed to be very efficient. They mentioned there is an internationally certified specialist and that another specialist will get international certification in 2019.

Availability of Cytology, Histopathology Laboratories and Colposcopy Centres

Health system specialists believe that the number of laboratories is the right one considering the number of women in the country, but that they key challenges are the shortage of staff, poor technical endowment and insufficiently trained staff:

'There is no workstation in the whole country that would keep the doctor away from breathing the very toxic formalin in. All tissues must be kept in formalin. Some of our doctors put the tissues in ethanol, for instance. If you do that, that's it! Histopathology laboratories need histoprocessors, cover glass systems, automated slide stainers, baths, microtomes that cut the tissue at 2-3 microns, not 10. The tissue cut at 10 microns is 3 times thicker. To be able to tell if there's cancer or not, we need to be able to see the nucleus. The thickness of the tissues influences our ability to see what's there.'

On the subject of colposcopy offices, a specialist made mention of the initiative to make this service available regionally. This process will also imply that the staff will be monitored, trained and assessed by the Reference Colposcopy Service of the Mother and Child Centre. The plan is to train and certify, in parallel, gynaecologists performing colposcopy, in line with the standards in place.

Emphasis was placed on the fact the histopathology laboratories in the Republican Clinical Hospital and the Oncology Institute are the best endowed, unlike those in other health facilities where the technical equipment is outdated. By specialists' accounts, in such conditions the smear examination steps are not adhered to, which affects the quality of the provided laboratory services. Opinions were conveyed that there should be fewer laboratories and that those that will remain will have to be fitted out appropriately.

'...5 cytology laboratories and 2 histopahtology laboratories for the whole country would be more than enough, provided that they are absolutely in line with international requirements in terms of staff preparedness, equipment and quality maintenance.'

One specialist mentioned that cytology laboratory assessments were conducted, following which capacity building activities were planned for them both by fitting them out with required equipment and by training the relevant staff. Following a 2016 assessment, 28 cytology laboratories were identified, i.e. – more than enough to meet the national needs, it was state.

'In cytology, there's a principle that says that a better capacity and quality of this services depend a lot on the number of slides seen a year. According to international recommendations, a laboratory can be regarded as one providing quality services if it processes 25-35 thousand cytology slides a year'.

On the report of a specialist, there are laboratories in Moldova that process 300-800 Pap slides a year, *'which makes the quality of their work questionable'*.

Overall, health workers who provide cervical screening services do not know very well what is going on with the cytology, histopathology laboratories and colposcopy offices. The respondents specified that it took from one to six months to receive the Pap test results. In such circumstances, some of them had doubts about the quality and trueness of the results received from laboratories. A nurse went on to add there were cases when the samples ended up lost:

'...I think it is not enough because we receive the results after 3-6 months. They probably can't manage to do it sooner and since they deal with a huge flow information – I wonder whether they do a good job reading the slides. Hopefully they do everything right, but they just don't manage to look at the slides sooner.' (family doctor, urban area).

Some doctors believe that there are enough laboratories, cytologists and histoplathologists particularly since the slides can also be sent for examination purposes to other countries. One gynaecologist said the time they had to wait to get the results back shortened when they started to send the slides to a different institution:

'...we've had no problems since the Diagnosis Centre started to look at the slides. It used to take a lot of time back when we were sending them to the Oncology Institute. This is a problem because I'd tell the patients that the result's going to be ready in a month, plus or minus a few days. The women would come after around a month and find there's no result ready yet and they'd say "I am not going to come for the test again because the result was not on time." We stopped having this problem when we started sending the slides to the Diagnosis Centre.'

Although specialists suggested making colposcopy services available regionally, some family doctors believe that district-level health centres need colposcopes. One family doctor believed that it is necessary to hire a colposcopist in the Health Centre: *'we'd actually like to have a colposcopist because I can't think of where I could refer women to colposcopy to, I don't know whether the daycare unit provides colposcopy services.'*

Impact of the PHC reform on the cervical screening program

The respondents said that the reform means that every family doctor will have a private office and besides their key duties, they'll also be in charge of managing financial resources: *'they'll have to develop some basic knowledge about economy and budget.'* Concerns were also voiced because family doctors will thus have more tasks and responsibilities: *'they do not have enough time to call patients and inform the population now, so when they'll start solo practice they'll just be overwhelmed by other organisational duties'.*

Summary:

The respondents know the institutions and human resources involved in the cervical screening and believe that they are enough, but that organisations outside the health system should be more active in awareness-raising. Staff shortages, inappropriate endowment and poor training of health workers are the key challenges that health facilities and laboratories involved in the cervical screening struggle with.

4.5 Operation of Cervical Screening Services

The health workers maintain that cervical screening is a routine procedure and that the data on the number of women and the year when the Pap test was performed are recorded in registers.

As communicated with regards to the conduct of the cervical screening procedure – the health workers have to fill in paper-based forms Nos 025 and 027. However, in some health facilities, alongside the implementation information system as primary health care level, patient data are also available in electronic format. Emphasis was also placed on the fact health facilities keep patients' medical records either in electronic or paper format. These medical records allow for monitoring women and they also contain all the information about their health status. Additionally, the primary health care information system was developed to be used as a way of collecting information about patients' health condition, but according to some specialists, this system does not work to its fullest capacity.

In deciding who should do the Pap test, most respondents said that they take patients' age as a basis, but also other features such as risks and symptoms:

'Still, we screen women according to the age criterion – 25-61-year-olds. We do not invite to prevention controls girls from the risk category of 15-16-year-olds, and when symptoms show already, no test needs to be done and that is already a different area.'

Regarding the way in which the patients are informed about their Pap test result, the health workers mentioned detailed several practices:

- the women are informed about the results during consultations that they themselves asked for;
- the women are informed by phone;
- the women are invited to see the family doctor to be told what the results are;
- the result of the cytology test is communicated to the women at home.

Reportedly, it takes a lot of time for the results to come, which is why the results are communicate only to women whose cytology showed abnormal cells. As claimed by respondents, when a woman tests positive, another Pap smear is taken and the woman is referred to the gynaecologist who, on the basis of the tests results either treats the precancerous lesions or refers her to the oncologist.

The health workers reported that the patients are monitored at these stages by the family doctor and that at the end of the treatment they are invited to repeat the tests. More respondents mentioned that the family doctor, the gynaecologist and the oncologist are involved in monitoring, depending on women's health condition and the stage they are at.

Some specialists believe that the monitoring of women is not organised well enough and that the communication with patients is not good enough to ensure that they are contacted in due time.

'...there's no communication, no patient traceability. They can come, do the test without knowing later what the result was because they leave somewhere without having been informed.'

A specialist said that the whole cervical screening is not well-coordinated because there are no clear mechanisms of cooperation between the parties involved, which leads to losing women or not having them come to be screened.

'...at present, there aren't clear referral mechanisms in place about where these women need to go, about the health facilities that provide colposcopy services. Women are only recommended colposcopy, without making it absolutely clear where they need to go. There's no monitoring – you can't know whether or not the women referred to colposcopy actually got it and what was the final diagnosis. You can't know what the fate of the women ultimately was – were they treated or not? There are no official statistics now on how many women were referred to colposcopy, how many actually got it, what was the diagnosis, the conducted procedures – this matter was not sorted out yet.'

In this regard, it was mentioned that when there are some uncertainties about an established diagnosis, the doctors can't get in touch with one another to discuss the differences in terms of results because the contact data of the doctor that the patient went to are not provided on the patient's medical record.

Among other issues, the following were mentioned: no reports on the number of women who were referred to the second stage – to the gynaecologist or on the number of patients who were referred to the oncologist, and on the number of cancer cases detected via cervical screening. It was also mentioned that there are no other monitoring mechanisms but for the personal responsibility of family doctors who, according to the rules, must provide cervical screening services to all women in the target group

Patient information is recorded and reported in statistic format quarterly and annually, it was mentioned. An oncologist said that reports are submitted quarterly and that all the information is kept at the National Bureau of Statistics, at the Ministry of Health, Labour and Social Protection and at the Oncology Institute.

The specialists believe that creating a national electronic register for cervical screening would facilitate the work of family doctors and would serve as a reporting system. It was also stated that creating an information system that would contain every patient's data at every healthcare level would facilitate communication of health workers involved in the cervical screening and would contribute to providing a quality and well-organised service:

'...there should be a software that would allow us to introduce patients' ID and check, on a computer, what preliminary tests did a particular patient do, what were the results, what doctor did them, to know what stage the patient is at.'

It was mentioned, in this context, that there are institutions that have in-house information systems, but that they area 'too primitive' compared to the systems other countries use:

'...something needs to be changed about the system. There has to be some traceability. We need to be able to see patients' route from beginning to end. It is not good for the screening to lose patients out of sight! There should also be cancer registers in place.'

The health workers believe that women are poorly informed and do not comprehend the importance of the test. Some health workers admitted to using 'medical blackmail' telling their patients they won't give them some certificates unless they do the Pap test:

'we threaten some women into doing the test by telling them that we won't give them the sick leave certificate if they don't.' (family doctor, urban area).

Summary:

The specialists said that the cervical screening information is recorded in registers and that it is reported quarterly and annually in statistic format. According to the respondents, the key drawbacks of the cervical screening are the fact that patient traceability isn't possible, there is no clear mechanisms for specialists involved in cervical screening to cooperate with one another and there is no data on the number of women at each stage of the whole procedure. The specialists believe that setting up an information system would solve the aforementioned challenges.

4.7 Cervical Screening Quality Assurance

The interviewed specialists said that Pap test quality assurance is based on fundamental documents in this area: the Healthcare Law, the National Cancer Control Program in which the early detection of cervical cancer is tackled as a matter of priority.

Several specialists believe that documents in the field, such as, the National Clinical Protocol on Cervical Cancer, the Standardised Protocol on Cervical Cancer for Family Doctors, the Operational Standard on Operational Procedures for Cervical Screening, the quality manuals for laboratory services and the acts issued by the National Health Insurance Company jointly with the Ministry of Health, Labour and Social Protection have the role to guide specialists involved in cervical screening to provide quality health care services.

It was also mentioned that for laboratory services, quality assurance manuals were developed. They provide for the procedures that need to be observed.

'...this manual also describes internal assessment performed daily in all laboratory segments, depending on the complexity of the analysis and on the likelihood of committing errors. This assessment can also be carried out in the middle of the working day, at the end and at the beginning of working day as well.'

The respondents said that the National Health Insurance Company, which contracts health facilities and funds cervical screening services check annually the trueness of the information reported by the health facilities on the provided services. There is also a system in place to assess the cancer cases, via which an analysis is conducted of the circumstances in which cancer was diagnosed: *'the woman came too late, wrong diagnosis, patient not included in the risk group.'* It has also been mentioned that the quality of cervical screening is ensured by the Republican Centre for the External Quality Control of Laboratory Tests.

Some health facilities that have their own laboratories, mentioned that they send the samples abroad for quality assurance purposes:

'this year, when we assessed the cytology slides with unclear description, we sent them nameless to colleagues in Kiev, Ukraine and to Minsk as well to check their approach against ours.'

Speaking of assuring the quality of cervical screening, the specialists mentioned the performance indicators used previously to assess the work of primary health care staff and to remunerate them. Several respondents said they were in favour of using further on performance indicators because they believed that the indicators can be regarded as financial incentives for the health staff and also, they help thus identify cases of cancer in its early stages.

'...to achieve this performance indicator, they have to collect the cervical smear anyway. Therefore, they'd be justified to collect the smear from all women to be able to find the stage-I and stage-II cervical cancers, which is a

performance indicator... it's just that it used to be more motivating when the number of women screened was a performance indicator. I think we need to go back to the previous indicator.'

It was mentioned that quality assurance is the responsibility of every health worker: *'we all have the obligation to observe both the sanitary and the smear taking requirements'.* It is thus important to continuously inform and educate health workers in line with the regulatory framework in force. A specialist mentioned in this regard that, of late, there have been many trainings for providers of cervical screening services: *'for staff that take the smear, for cytologists and colposcopists.'*

It has also been mentioned that quality assurance is based on quarterly and annual reports from medical staff involved in different stages of cervical screening. However, judging by the large number of individual medical records, there is a belief that using an information system would facilitate the interaction between the health workers involved in cervical cancer screening and that it would make monitoring easier. In addition, some respondents mentioned the need to involve a person or an independent organization that would oversee and evaluate the quality of provided cytological services.

In terms of ensuring the quality of the HPV vaccination services, the following institutions were mentioned: the National Public Health Agency and the primary health care facilities that are responsible of implementing the HPV vaccination campaign in line with the legal provisions in this area.

Summary:

The specialists think that the quality of the cervical screening is ensured if the regulatory framework is observed, via the cancer cases assessment system and via the checks conducted by the National Health Insurance Company. Quality assurance is considered to be the responsibility of each health worker. Reintroducing performance indicators was suggested as an incentive.

4.8 Cervical Screening Funding

As regards cervical screening, smear taking and processing – these are provided for free to all women regardless of whether they are insured or not according to the compulsory health insurance system, it was stated. When it comes to colposcopy and treatment of precancerous lesions, the women that are not insured according to the compulsory health insurance system have to pay from their own pocket for these services, while the insured women are provided these services for free. When cervical cancer is found and confirmed histologically, all women – regardless of whether or not they are insured under the compulsory health insurance system – have access to specialised free-of-charge treatment at the Oncology Institute, the expenses being covered from the state budget.

At the PHC level, in the second half of each year, the structure of the patients on family doctors' lists is presented, including the number of women to be screened for cervical cancer. The funds to be appropriated to the health facility are planned according to that data. The specialists said that additional funds are not appropriated for cervical screening services and that they have to be covered form the whole budget of the primary health care facility:

'...of the total amount meant for primary health care, following the capitation principle, expenses are covered for smear taking, laboratory tests... that is – all the services required for cervical screening.'

This way of funding of primary health care, a specialist said, does not guarantee the priority of cervical screening against other oncology pathologies or diseases. It was also mentioned that some urban primary health care facilities hired a cytologist to optimise thus expenses because cytology laboratories charge a fee for every cytology smear sent to them to look at:

'...these mechanisms were not invented just now and there's no bad intention behind them. This is just about coping with the realities of Moldova. At present, we just have to work our way through.'

Emphasis was also placed on how important the input of international organisations is in strengthening national cervical cancer prevention capacity via the non-reimbursable assistance provided. One of the specialists mentioned that the health workers are trained and that, partially, laboratory capacity is being strengthened by fitting them out with equipment thanks to the implementation of an official 3-year development project supported financially by the United Nations Sexual and Reproductive Health Agency (UNFPA) and by the Swiss Agency for Development and Cooperation and thanks to the other development partners as well, such as the Romanian Agency for International Cooperation and Development (RoAid). The

sharing of good practices and international experience meant to strengthen cervical screening services in Moldova is supported by the International Cervical Cancer Prevention Association. The Reference Colposcopy Centre from the Mother and Child Institute was fitted out with the necessary equipment thanks to the support provided by the Embassy of Japan in Chisinau:

'...we received extraordinary support indeed. We wouldn't have managed to achieve any result without it.'

In some settlements, the specialists use their own resources to send invitation letters to women from the target group that need to be screened.

Some doctors believe that the resources for cervical screening and HPV vaccination are cost-effective. The key arguments were the possibility of early detection of the disease and the usefulness of the HPV vaccination for the target population. The specialists believe that investing in immunisation (HPV vaccination) and primary prevention (cervical screening) are more cost-effective than the treatment costs.

'the health system incurs a cost of MDL 100 per one case that includes smear taking and its processing at laboratory level.' It was also mentioned, in this context, that in implementing the Pap test, the cost of laboratory examination amounts to MDL 125 for every case. The cost of a colposcopy procedure costs MDL 43, while the cost for the consultation provided by the doctor who performed the colposcopy procedure amounts to MDL 90. Some specialists think that these are costs covered by the compulsory health insurance system. Thus a comparison was made between the cost of MDL 1,000 of investments in prevention and the cost of at least MDL 40,000 for treating one case of cervical cancer.

Other doctors said that investments in HPV vaccination are not relevant because of the high refusal rate.

Some respondents said that the planning of funds for the HPV vaccination campaign needs be more cost-effective:

'This sort of information is known... i.e. how many 11-year-olds will be there next year, two years from now and so on. This sort of things need to be planned ahead of time. We should look for cheaper options of procurement already, because such possibility exists.'

Summary:

The specialists said that cervical cancer services are funded from the state budget and emphasised the financial support from foreign partners in strengthening the capacity of the health care system. The prevention and immunisation methods are regarded as an efficient use of resources. The respondents believe that all the stages of the cervical screening need to be free regardless of whether or not one is insured under the compulsory health insurance system.

4.9 The Opinions of Specialists and Health Workers on the Accessibility of Cervical Screening Services

The health workers reported there are several ways in which women may come to get the Pap test: upon invitation via invitation letters, upon referral to do the test, after being persuaded to do so by the health workers and out of own initiative:

'Some come because of the invitation letters, others are imposed to or come out of their own will. About 5-10 women out of 200 come out of their own will. About 20 women are imposed to, while another 20 come because of the invitation letters. It is all achievable via communication.' (nurse, urban area).

The specialists said there are no barriers for women to access cervical screening services. They mentioned that although there are things to criticised in the health system: *'the person providing the service is not good at communicating and persuading; certain privacy requirements are not observed'*, these would become unimportant if women were acknowledged the importance of cervical screening: *'the would just fade away'.*

One of the specialists said that cervical screening is accessible, but not attractive and convenient enough for women:

'...this is elementary, it is about ensuring comfortable conditions for women by taking into account a range of peculiarities – e.g. women with disabilities, the gynaecological couch needs to be adapted to their needs. The service needs to be attractive from the point of patient-friendliness. The women need to know precisely when they have to go to see the doctor, at what time, without having to wait long hours in queues. I saw that in some health

facilities the nurse would identify the patient and then would register her in the screening program, with the Pap smear having to be taken by the gynaecologist with whom the patient was supposed to get an appointment. This makes smear taking more complicated.'

The support provided by some development partners regarding healthcare equipment adapted to people with disabilities was mentioned, giving emphasis to how important it is to ensure the access of women with disabilities to prevention checks. One of the specialists also mentioned that maximum efforts are invested into making women's access to cervical screening easier: *'women don't need to get an appointment or to wait. They can go have the test taken without appointment because the midwife takes the smear... there are special smear collection offices in districts...'*

The following were mentioned to argue that cervical screening services are accessible:

- the gynaecological examination for cytology smear taking purposes is on the list of services covered from the compulsory health insurance fund;
- the screening takes places in primary health care facilities, which are the closest to the population;
- there are several health facilities providing this service: gynaecology offices at local, district, municipal and republican levels.

Several respondents spoke about the fact that health workers make efforts to inform, persuade and invite screening age women to take the cytology test but not so many women show up nevertheless, with very few coming out of their own initiative.

A challenge mentioned by a doctor is that the patients do not follow the recommendations to take the Pap test:

'...they can walk out of my office but never reach the other one... or they can say "I'll come tomorrow because I am not ready today."'

According to specialists, the prevention checks required at the workplace are the levers that determine women, especially those in the education system, to take the cervical screening test. Recruiting in the cervical screening unemployed women or women who are abroad is more difficult to do.

Having analysed the barriers that keep screening age women away from being screened, the respondents meant the following:

- migration – connection/communication with the patients is lost. Most women abroad are of reproductive age and it is not known whether they have the possibility to perform the cytological test abroad. Also, these women do not participate in the annual oncology control.
- lack or shortage of health workers in some rural settlements. Some women that have a low income do not afford travelling long distances to a health centre. An oncologist believes that most women with cervical cancer in the rural area seek health care services only during the cold season of the year when they don't have to work the land.
- the need to pay for/purchase by themselves some consumables/tools for the cervical screening test, such as the gynaecological kit or the cytology brush. It was also mentioned that women who do not have health insurance under the compulsory health insurance system need to pay for further services and for treatment of precancerous lesions after they were diagnosed with them, which means they cannot enjoy equal conditions in accessing services at any stage of the cervical screening.
- insufficient time the health workers dedicate each woman and the inefficient way in which services are organised in the health care system:

'... women do think sometimes that they should come for preventive medical check-ups, but when they remember the queues, I think they no longer want to come...'

It was mentioned that the health system isn't quite patient-friendly in general: *'in Moldova you could die before your turn comes to see a doctor'* – which is caused by two aspects:

- one can access health care services under the compulsory health insurance system only by going to the family doctor on whose list one is registered;
- the long time it takes to get an appointment with a doctor via referral by the family doctor and the inefficient on-line appointment system:

'I should be able to get an online appointment with the family doctor when it is convenient for me, instead of having to be there at 7 o'clock in the morning, waiting under the door until it opens at 8 o'clock and then waiting for another 2-3 hours in the queue,'

Most health professionals believe that the recruitment of women to cervical screening needs to continue to be the task of family doctors. On the one hand, the respondents said that the primary health care level does not have mechanisms to convince or impose women to take the Pap test and on the other hand, some have emphasised that when family doctors insist on it – women do the tests they have to. According to a family doctor, they are sometimes penalised for not having insisted on screening age women to do the Pap test, particularly when someone is diagnosed with cervical cancer. To avoid such situations, family doctors ask women to sign a document whereby they confirm they refused the cytology test.

It has been pointed out that health workers are not responsible for the decisions patients make because every person is responsible for their own health:

'...we even sometimes have to go as far as blackmailing them. I don't even know how else to ask them and to explain them that the test is safe because they refuse anyway and do not come. If they don't want the Pap test, then let them be responsible for that.'

Opinions were shared that the cervical screening procedure should be mandatory by giving this responsibility over to women themselves and the health workers. Women should thus acknowledge how important the cytology test is and to get screened because the government pays for this service via the mandatory health insurance system and the health system should ensure universal access to quality and attractive health services:

'Considering the level of education in Moldova – yes, mandatory, because people don't get it in any other way.'

Several specialists mentioned other countries' experiences where parents who refused vaccinating their children have to pay penalties or where women must confirm in writing that they refuse the cytology test. These could be used as the methods to make the population participate in prevention checks:

'Abroad, women are invited via e-mail. They have to confirm that they disagree. They themselves sign under their disagreement, which makes them accountable for their decisions. In principle, one's health is one's personal responsibility.'

One of the specialists highlighted that the law in Moldova says that regardless of a patient's health status, the doctor must ask for patient's informed consent before performing any medical procedures, which is why there is no certainty as regards the mandatory nature of the cervical screening.

Asked about the groups exposed to a high risk of getting cervical cancer, the respondents named the following categories of women:
- women who started their sexual life early: *'who had several sexual partners, who had several abortions, who used contraceptives or who had pathologic births';*
- women with diabetes, chronic diseases, aggravated heredity or gynaecological pathologies;
- women who did not go to the gynaecologist in the last two to three years;
- socially vulnerable women;
- women leading an unhealthy lifestyle: consuming alcoholic beverages, using drugs or smoking.

It was mentioned that HPV vaccination is a solution for adolescents coming from socially vulnerable families or that have family issues and for adolescents whose lifestyle is not known to their parents and doctors.

Health workers commented on the possibility to improve access to screening services mentioning the awareness campaigns and the planning of some days dedicated to informing the population on cervical screening; organisation of some regular trips of the health workers to villages where the access to cervical screening services is limited. Statements were also made that to ensure access to cervical screening, the collection of the smear for the cytology tests should continue to be a task of the primary health care level, while if electronic medical records were developed, the task of inviting women to be screened could be assigned to a third party.

Summary:

In general, the respondents believe that access to cervical screening is ensured to women in the target group, but that there are difficulties in recruiting women because of the following barriers: few women show up, migration, shortage of health workers in some regions and inefficient way in which health services were set up. Some specialists believe that making the cervical screening mandatory and making health services more attractive would contribute to more women doing the Pap test.

4.10 Respondents' Opinion on Methods of Informing and Educating Women about Cervical Screening

Most health workers believe that it is their responsibility to inform the population about cervical screening and mentioned what information practices there are in health facilities: handing out leaflet, posting information on information boards, videos, informational lessons, and interpersonal communication. Also, women are invited to do the cytology test by phone, invitation letters and face-to-face communication.

Some doctors said that the cervical screening services are not promoted well and that the doctors themselves are overwhelmed and do not manage to dedicate enough time to talking to patients.

Having a list of activities of communication and awareness-raising regarding cervical cancer prevention scheduled for the whole year ahead was mentioned as something that would be welcome since at present such activities are conducted seldom: *'there's no strategy about informing the population about cervical screening throughout the entire year'.*

The health workers and the specialists believe that it is necessary to use all sources available to inform women about cervical screening. The proposed the following ways of disseminating information:

- organising a national awareness campaign via mass-media, by also creating some shows for TV, radio and social media;
- involving institutions in charge of public health in information dissemination;
- sticking posters, giving leaflets, brochures and showing thematic videos dedicate to cervical cancer prevention in health facilities: 'we need some leaflets with information, we don't have any actually' (gynaecologist, urban area);
- informing 15-16 years old adolescent girls in educational institutions and in youth-friendly health centres about the availability of cervical screening and the target group (of eligible age) about the cytology test by also involving doctors in information dissemination: *'it would be very good if girls and women were be told even before they turn 25 that such a test can be performed. Highlighting this matter at school would be good.' (family doctors, urban area);*
- organising public lessons: *'In the village where I was born, I was invited by a youth NGO to give a lesson on cervical cancer prevention. Many women attended it. They asked questions, they showed interest and they actually liked it. Afterwards, they had the test done.' (family doctor, urban);*
- communicating directly to women of screening age and persuading them *'by talking to them, by explaining what can happen to them, by providing examples' (nurse, rural area); 'by talking to them as much as possible' (gynaecologist, urban area);*
- organising days dedicated to communication and awareness raising about cervical screening, supported financially by the National Health Insurance Company (using the prevention fund resources);
- involving opinion leaders and foreign experts in promoting cervical cancer screening at national level;
- sharing the stories of women that were diagnosed with precancerous lesions, who were administered the necessary treatment, to encourage this way other women to be screened for cervical cancer to prevent, thus, cervical cancer;
- tailoring invitations and informative brochures about the advantages of the cervical screening meant particularly for women who need to be screened in the year concerned;
- developing some patient communication guide for the health workers to make sure that the doctors send the same message regardless of the environment and of the region;
- placing information on cervical screening on public health institutions' websites, including healthcare institutions: '*I would to go to the website of Ministry of Health or of another subordinate institution in charge of this area and to find there information about this type of screening and where I should go to get screened.';*
- sticking posters on cervical cancer prevention in public transport;
- informing women at their workplace about the advantages of getting screened and encouraging them to go to their family doctor for regular prevention tests.

Some believe that it is the health workers who have the greatest responsibility to inform the population about preventing cervical cancer because only they can provide truthful information in this context. Several doctors believe that in communicating and educating the population, it is very important to establish a mutual trust relationship between the doctor and the patient:

'If patients trust their doctor, the doctor will be able to convince them and they'll do everything as the doctor recommended.'

It was mentioned that the awareness and education campaign about cervical cancer should be designed in the form of a policy document by the Ministry of Health, Labour and Social Protection and that its implementation should be monitored by this same ministry too:

'...we need to be convincing enough, to provide relevant and well-thought-through information. The awareness campaign needs to be trustworthy and believable to make it possible to win women's trust and then they'll gladly participate in this program. We shouldn't push too much. Great work needs to be done for a health system to become credible in the eyes of the beneficiaries.'

According to one of the respondents, the awareness campaign needs to be focused on all ages and social layers so as to cover a large share of the population and make it aware of and interested in sharing the information on cervical cancer prevention:

'It should probably be publicized via television. There are many people, particularly the elder ones, who easily believe what they hear. If they heard something on the TV, it means to them that it must be right. There should probably be newspapers and medical magazines providing this sort of information. Family doctors should be involved in some educational activities. Some classes should be organised at school for girls perhaps.'

It was also added that promoting the notion that going to the doctor for prevention purposes is not something to be ashamed about, but to be actually proud of would be good.

On this matter, some people mentioned that innovative awareness-raising methods are required – reaching out via mobile phones or e-mail because the traditional way, such as the brochures or video spots are no longer efficient.

Summary:

Most of the health workers believe that one of their responsibilities is making women aware of the cervical screening, but they also said this service is not performed well because of lack of time. The respondents believe that a national awareness-raising and education campaign for women would need to be conducted throughout the whole year, involving more institutions and different ways of communication.

4.11 Health Workers' Opinion on HPV Vaccination

The health workers said their opinion about HPV vaccination was good and that they believed this vaccine has only good effects for adolescents' health. None of the respondents saw any adverse events of the HPV vaccine, but they underlined that the results will become visible in time, because this prevention campaign started to be implemented just recently. Some health workers said that their daughters were also vaccinated against HPV.

With regards to how the vaccination process is organised, one respondent said that each health centre is given a particular amount of HPV vaccine doses. They are meant for the immunisation of girls in the target group of 10-year-olds. In the event of many refusals or contraindications, girls around the age of 10 are selected. In one particular health facility, the HPV vaccine doses it was given turned out not to be enough because parents who initially refused to vaccinated their daughters, found out more about it and changed their opinion in the meantime. In this setting, the health facility concerned borrowed several HPV vaccines from other primary health care facilities.

Still, most of the health workers said that parents are afraid of adverse events and consequences, which is why they refuse to vaccinate their daughters: *'they are afraid their daughters might end up sterile in the future. This is their greatest fear.'*

Several respondents underlined that although the HPV vaccination experience has been gained just recently at national level, the initiative is welcome and, having analysed the statistics in European countries that have a richer experience in this area, the opinion is that HPV vaccination campaigns are efficient in preventing this diseases. Also, a family doctor said that this prevention method is more efficient than the cervical screening.

The specialists believe that the HPV vaccine is of a very good quality and, with the support of international organisations, it is transported in the right conditions.

On the one hand, the population does not comprehend how important is the HPV vaccine in preventing cervical cancer and, on the other hand, the assumption is that because of lack of time for communication, parents are likely not be informed by the health workers about the possibility to vaccine their adolescent daughters.

The specialists believe that some parents were misinformed about the HPV vaccine, including via the *'aggressive'* campaign against this vaccine promoted by some mass-media, by some parents and on social networks:

'...there were a lot of wrong speculations and no-one was there to actually explain what the advantages are. Now we try to change this way of thinking, but it is a difficult task. Mothers refuse to vaccinate their daughters.'

A specialist said that the anti-vaccination campaigns are very wide-spread both nationally and internationally and are the cause of massive disinformation of the population as they spread messages that are not backed by evidence. According to another specialist, the fact that a particular age group was selected for the HPV vaccination has caused reluctance and suspicions among the population: *'Why a very small group of girls particularly?! It means this is an experiment and that the vaccine is not good.'*

In this respect, many respondents underlined that the population is not quite informed and provided as an example the measles outbreak which, according to them, happened because the population was misinformed and refused to vaccinate their children. In a specialist's opinion, the health workers should be well-informed and prepared better for the vaccination campaign, to be able to convince parents about the need to get the HPV vaccine.

'...when people who suggest getting this vaccine do not know enough about it, they do not look confident when they speak about it to other people. Moldovans are very sensitive to health workers' hesitance. They think that if health workers do not believe what they say, it means they are not confident that getting the vaccine is actually good.'

The health workers said they inform parents about HPV vaccination in the following ways:

- the representative of the health facility informs parents at meetings conducted in educational institutions;
- when invited to the health centres for vaccination purposes, each parent is separately talked to.

The specialists believe that awareness-raising about HPV vaccination should be focused on:

- Educating and informing young women about the importance of preventing cervical cancer, by involving the nurse from the educational institution in this awareness-raising activity.
- Informing and communicating with parents about the prevention of cervical cancer: *'parents with children aged 10-12 years should be made aware'.*
- Launching a communication campaign focused on the advantages of getting an HPV vaccine.

Statements were made that the 2016-2020 National Immunisation Program was developed on the basis of consultations with international bodies and that is was a *'success of the country'.* The extension of the HPV vaccination program will depend on Moldova's financial capacity. At present Moldova has the support of the Global Alliance for Vaccines and Immunisation for introducing HPV vaccines: *'the vaccines will be provided for free for the first two years, but for the next two years we'll have to co-finance it ourselves at a more advantageous price'.*

The specialists believe that the primary health care level should continue to be in charge of planning, organising and providing immunisation services to the population, but that more institutions should be involved in promoting vaccination, such as: the National Public Health Agency, the National Health Insurance Company, the Ministry of Health, Labour and Social Protection, the Church, educational institutions, the local public administration, youth-friendly health centres. In this context, about 3,500 family doctors were trained about the importance of HPV vaccines, about the key messages for the population, about the availability of HPV vaccines at national level and about the vaccination of girls and adolescent girls, etc.

It was also highlighted that to prevent cervical cancer, the awareness campaigns focused on the importance of HPV vaccination and on the importance of cervical screening should be carried out in parallel because these services complement one another and, in this context, those who were vaccinated in adolescence will need to start to be screened once they turn 25.

'The vaccination of adolescent girls, if explained correctly by also making the link with their mothers' health, could also be an important step towards a greater demand to be screened among the population.'

Summary:

Most of the respondents are in favour of HPV vaccination because they think it helps prevent cervical cancer, after having analysed the statistics from European countries that have greater experience in this area. In specialists' opinion, some parents are reluctant and refuse to vaccinate their daughters because they are

misinformed by the anti-vaccination campaigns and because not enough efforts were made by the health facilities to disseminate correct information.

CHAPTER V: ANALYSIS OF THE RESULTS IN THE CONTEXT OF THE REPUBLIC OF MOLDOVA AND IN THE EUROPEAN CONTEXT

The survey allowed us to draw several essential findings on the perceptions about own health and on the level of accountability for one's own health typical of the Moldovan population. Every third woman in this survey (31%) confirmed suffering from a chronic illness, while 11% said they perceived their health as poor, with another 11% admitting to having undergone a uterus removal surgery. Considering the age of women in this survey (25-61 years), i.e. they are women of working age, these results mean the health condition of women in Moldova is something to be worried about.

With regards to how bad the cervical cancer problem is in Moldova, the specialists in this survey mentioned that the number of identified cases of cancer in stage III and IV is bigger than the number of cases of cancer in its primary stages, which was also confirmed by the official statistics provided in the first chapter of this paper. In this context, opinions were voiced that the existing statistics do not reflect the actual situation of this diseases countrywide anyway, as another problem is the monitoring of cervical cancer morbidity and mortality.

The high incidence of cervical cancer in Moldova is determined by the following:

- The population does notquite practice doing to the doctor for prevention purposes or they go too late, which leads to diagnosing cervical cancer in its late stages.
- The tests are not informative enough and the way they are interpreted does not always allow for the identification of pre-cancer conditions.
- Not enough efforts were made to inform the population that the Pap test is free of charge.
- The population is not informed enough about cervical cancer and how it can be prevented.
- The vulnerable socioeconomic condition of some women makes it difficult for them to access health care services, including prevention checks.
- The migration of women leads to the disruption of monitoring and of the screening continuity.
- The current cervical screening program is not efficient. There are many system gaps in how it is set up. The health system does not have a 'friendly attitude'.

In many documents approved and promoted internationally, the World Health Organization restates the obligation of governments to grant citizens' right to health by making services available and accessible for all, without any discrimination, that are acceptable to the population and in line with the highest quality standards. Thus, the right to health, at any level and in any form, consists of the following unalienable elements:

- *Availability* – any state must have a sufficient number of health facilities, goods, services and programs in its health system.
- *Accessibility* – the health goods and services that the state has must be accessible to every person in four ways: geographically, economically, fairly and by broad information.
- *Acceptability* – all health goods and services must comply with the principles of medical ethics and cultural criteria, taking into account the peculiarities of all categories of people (the cultural specificity of some ethnic groups, women, children, rural people, etc.).
- *Quality* – health goods and services must be scientifically and medically acceptable and of high quality.

Thus, our intention is to analyse the results collected via the survey conducted through the lens of those four components that are equally important for ensuring that the rights of all the members of the community are observed.

5.1 Availability of Screening Services

The research brought out deferring opinions regarding the capacity of the health system to cope with an extended cervical screening and HPV vaccination program. The positive ones were based on the fact that: (i) there are new possibilities for having the Pap test done in several health facilities across the country; (ii) there are funds from the state budget and donations of international organizations that are expected to cover the needs for these services; and (iii) there are fewer women in the country, which will allow the system to answer the needs of the population.

The specialists mentioned what was good about the carrying out of the Pap test/cervical screening at present, namely: (a) the government acknowledged the problem and the decision was made to screen women from 25 to 61 years old every three years, (b) smear taking is free, (c) there is good accessibility as the primary health care level, which is much closer to the population, is involved.

Still, the specialists in the survey also mentioned that although at international level cervical screening is regarded as one of the most successful procedures to prevent cervical cancer, this service is not that well organised in Moldova to be regarded as successful, with the target group coverage percentage remaining low, as less than 50% of women were screened.

Although many important documents in this area were developed and approved, (the National Cancer Control Program, the National Cervical Cancer Screening Program, Institutional Clinical Protocols, the National Standard Operating Procedures), they are not widely known by all specialists involved in the screening and, concurrently, the monitoring and evaluation of the cervical screening indicators is not efficient.

5.2 Accessibility of Screening Services

During discussions with specialists of the health system, they mentioned that the current range of screening services in Moldova id broad, sufficient and in line with the international standards in this area. To support the claim that cervical screening is accessible, the following reasons were provided:

- the gynaecological examination for cytology smear taking purposes is on the list of services covered from the compulsory health insurance fund;

- the screening takes places in primary health care facilities, which are closer to the population;

- there are several health facilities providing this service: gynaecology offices at local, district, municipal and republican levels.

There were also contradictory opinions which showed a lack of trust in the current potential of the healthcare system to ensure the access of the population to an efficient cervical screening. Several challenges and barriers were mentioned, such as: (i) shortage of health workers, (ii) uncertain quality of the services provided, and (iii) inappropriate conduct of the cervical screening program, impossibility to trace patients, lack of tools to monitor the cervical screening program, (iv) lack of clear calculations/estimations of the actual needs (consumables and equipment) to implement the approved programs, (v) lack of mechanisms to make women assume accountability and motivate them as well as the health workers for a more thorough involvement in the screening.

Geographic access

Access to primary health care specialists

The exodus of the health workers and their shortage was highlighted – at all the stages of this survey – as a problem preventing the appropriate conduct of the screening. In some areas, especially in the rural ones, there is a shortage of family doctors and nurses. Thus, every fifth woman in this survey (21%) said that a barrier to getting the test was that the family doctor's office was too far away, in a different settlement.

In fact, there actually are health facilities that do not perform the cervical screening because there is no specialist that could take the Pap smear, as it was reported. One fourth of the women in this survey said that a Pap smear was not collected from them because the primary health facility they went to did not have the required equipment to do it. Other 25% said that in their case the Pap smear was not taken because there is no doctor or nurse qualified to take the Pap smear in the settlement where they live.

Also, there were many comments that some of the staff form primary health care facilities involved in the screening procedure were not trained enough to do it. Concrete cases were mentioned, when the nurses didn't know how to use the equipment which led to poor quality smears. Although training courses are provided for health workers, some primary health care staff avoid taking the courses because of lack of time and money.

The survey found that a group of 7 women were not provided the cervical screening service when they asked for it. Half of them were denied the service by the family doctor or his/her nurse for various reasons such as lack of necessary equipment and/or lack of a qualified specialist to take the smear.

Many women in this survey said family doctors or their assistants do not have do not have specialised gynaecological training, which is why they don't trust the services the latter provide in the gynaecological area. Opinions were voiced that family doctors are 'general physicians' and do not have the required experience to perform a gynaecological test. On this matter, some women highlighted that the Pap test is a rather 'delicate' procedure that, if performed incorrectly, does not achieve its purpose because the abnormal cell wouldn't be identifiable.

Only 19% of the women in this survey knew that they could go to the family doctor for this test. Most of them believed that to get screened they needed to go to a gynaecologist. Some women believed that this is something that can only be performed at the Oncology Institute.

If they need a gynaecological examination or consultation, three quarters of the women confirmed they preferred to see the gynaecologist and only a quarter (16%) said they preferred to see the family doctor. All women in this survey believe that only the gynaecologist or the midwives should take the Pap smear.

It is also important to mention that access to primary health care can be ensured only if there are strict target group monitoring mechanisms in place. At present, the monitoring of women subject to screening is performed by health workers by filling in the paper-based forms 025 and 027, but some health facilities introduced in their practice the electronic version of such records too. Patient information is recorded and reported in statistic format quarterly and annually. Still, the primary health care information system – which is supposed to be the means for collecting information about patients' health – does not work to its fullest capacity. However, having a database, an information system that would contain information on every patient and at every stage, would make communication between specialists involved at different stages of cervical cancer screening easier and would contribute to better quality and better organised services. For instance, the quantitative study found that 6% of the women referred to colposcopy admitted to not turning up for colposcopy because they didn't have the time to or had to go abroad. At the same time, of the 4% of the women in this survey who had a positive Pap test, 5% said they were not referred further to the next stage of tests. Many women get 'lost' in the screening process and the family doctors don't know what stage they are at. Besides the quantitative indicator for family doctors, who need to cover the number of women from the target group subject to screening, there are no other monitoring mechanisms. For example, reports would be required on the number of women who were referred to the second stage – to the gynaecologist or on the number of patients who were referred to the oncologist, and on the number of cancer cases detected via cervical screening. Such a system would ensure a much more intensive communication between family doctors and the patients on their list.

Access to gynaecological consultations

The survey showed that women living in the urban area enjoy broader access to gynaecological services. About half of them affirmed they see the gynaecologist, including in private clinics, out of their own initiative at least once a year. Respondents from the rural area though, said they see a gynaecologist rarer, and usually – at the recommendation of the family doctor.

Both in the urban area and beyond the capital city, there are women who choose not to see a gynaecologist unless there is something that bothers them. Many women from the rural area who participated in the cervical screening said that they only saw the gynaecologist during their pregnancy and didn't see it for any tests whatsoever beyond that. The awareness of the need for preventive gynaecological examinations is low in this group.

One of the difficulties related to gynaecological examinations is that in order to get an appointment with the gynaecologist the women need first to be referred there by the family doctor. This process takes time because the women need to get an appointment first with the family doctor and later, with the gynaecologist. The small number of gynaecologists in some districts makes it necessary for them to work in several places and therefore getting an appointment takes time and consultations are sometimes too short and given hastily, which makes patients displeased.

One third of women indicated that it happened that the waiting period for an investigation was more than a few weeks. Hence, they had to go to private clinics because their health status did not allow them to wait.

Also, the queues are sometimes very long, with people having to wait 'for hours in a row'. About 43% of the women remarked that one of the barriers to doing the test was the lack of time, while 41% said it was the long waiting period in the queue. In some cases, the women need to travel to bigger towns for a consultation, which takes time and money.

Some of the women from Chisinau gave up going to public health facilities even though they are insured. For the most part, women who go to private health facilities do so because they can get the consultation they need faster and they are sure to be consulted at the scheduled time. They also said that doctors in private clinics have a more respectful attitude towards their patients.

During the discussions, suggestions were made to provide women more access to specialized gynaecology services and screening, respectively, by: taking doctors and the equipment periodically from the capital city to the regions that lack both of them, organising services in a way as to allow for the collection of the smears after working hours – in the evenings or on Saturdays, for instance. Some respondents mentioned that there is a lot of work to do in the rural area, particularly when it is warm outside. Therefore, it might be more convenient for them to be consulted during winter.

Women have limited access to colposcopy services, which are also underdeveloped at national level. The shortage of colposcopy offices and their lack of capacity in the regions to provide a quality and final result are the reasons why patients are referred to the Oncology Institute in Chisinau.

The survey also highlighted there were conflicting opinions regarding the way the colposcopy service should be organised. Although specialists suggest it should be a regionally available service, some family doctors believe that all district-level health centres need colposcopes.

It is also considered that regionalising this service will also mean that the staff will be monitored, trained and assessed by the Republican Colposcopy Service of the Mother and Child Centre. Colposcopy training and certification of doctors against the standards were also mentioned.

Access to advanced laboratory services

Following a 2016 assessment, 28 cytology laboratories were identified, i.e. – more than enough to answer the national needs. Furthermore, there have been opinions that the number of cytology laboratories should be reduced, while operational capacity should be enhanced to ensure the quality of the conducted tests.

On the other hand, some health system specialists believe that the number of laboratories is the right one considering the number of women in the country, but that they key challenges are the shortage of staff, poor technical endowment and insufficiently trained staff.

Overall, health workers do not know very well what is going on with the cytology, histopathology laboratories and colposcopy offices. However, most of them came to the conclusion that there aren't enough laboratories because they have to wait for too long to receive the test results. The respondents specified that it took from one to six months to receive the test results. In such circumstances, some of them had doubts about the quality and trueness of the results received from laboratories. They went on to add there were cases when the samples ended up lost.

Economic access

Less than half of the women that participated in the survey (47%) knew that doing the Pap test is free of charge as there is a widespread perception that one can only do the test against payment. Considering that almost one third (31%) of the participants in the survey were uninsured and that 13% of them were not registered with any family doctor, the likelihood that a big number of women do not go to the doctor and are not covered with screening services stands out. Thus, most of the women who said that the test is performed against payment are from among those women that do not have health insurance. Many women from among the uninsured, that were not screened for cervical cancer, said they avoided preventive checks because 'all checks have to be paid for'.

The survey showed that as much as 70% of the participants in the survey who did the Pap test did not pay for it. Still, one fourth of the women said they paid for the test, 67% of which had it done in a private clinic.

A barrier in granting financial access to health care services was the fact that many health facilities often ask women to purchase the consumables and tools for examination themselves (vaginal speculum, gloves, wipes, etc.).

Some women admitted that for the smear to be taken they'd have to see the gynaecologist from a district level facility, which means financial expenses, and they'd have to plan more time for the whole examination, which means not being present at work and bearing the consequences of that afterwards. Thus, 11% of the women in this survey said they were unhappy with the costs they would have to incur for travelling to see the doctor.

Note, also, that the funding of the screening is uneven. For both insured and uninsured women, the first stage is free – i.e. the primary screening which includes smear taking and processing. For the second stage, if the test result is positive, the women are referred to the specialised doctor, for which uninsured women have to pay. At the next stage, when the histology confirms cervical cancer, all women – regardless of their status – receive specialised free treatment at the Oncology Institute. These expenses are covered from the state budget regardless of whether the women have insurance or not.

Still, only three quarters of the women in this survey that tested positive admitted to repeating the test. Most of the times, uninsured women do not have the money to pay for the service and, thus, they give further tests up. It is obvious that it is necessary to provide free services at every stage of the screening.

Some women, who are financially insecure, are afraid of preventive checks because they are sure that they would not afford to pay for the expensive treatment and that only people having a higher standard of living can afford an appropriate treatment. Obviously, these women do not know that the government pays for the cancer treatment stage.

Some respondents shared the experiences that when they sought the Pap test, they were asked, directly or indirectly, to make some 'under-the-table' payments. Without them, the doctors showed an indifferent or negative attitude towards them.

Primary health care staff also showed concern about the insufficient funds to pay for cytology tests if more women started to show up for the screening. Primary health care facilities are not given additional funds for the cervical screening. This procedure is included in the budget meant to cover all the services in the compulsory health insurance package. This way of funding does not give priority to cervical screening against other oncology pathologies or diseases.

Access to information (adequate provision of information to people)

Knowledge and attitudes to screening

For many women an important barrier to doing the Pap test was not knowing where to go to do it. In this regard, 40% of the women said that the lack of information about where to do the test was a big problem.

There is a low level of knowledge among women about cervical cancer screening. Less than half of the participants (47%) heard at point in time in their life about the Pap test, but not all of them were able to figure out what the procedure was about, saying that it was for identifying vaginal infections (21%), for removing a tiny bit of the cervix (5%), for the visual examination of the cervix (5%) or even for sample of blood to be collected. Most women (66%) either gave a wrong answer or do not know how frequently the test needs to be performed, while 18% do not know what is the real purpose of the cytology test. There is also confusion about saying what age women should be to be subject to screening. Data analysis also showed that women who know what the Pap test is meant for are 2.4 times more likely to do the test.

Only one woman in four in this survey has heard about the cervical screening service, and most of them were told about it by the family doctor (43%), while 36% of them – by the gynaecologist. Still, the share of women who learned about it from non-medical sources such as relatives and friends is big (26%), while that of women who found out about it from the media is small (18%). Unfortunately, there were women who admitted to not having ever hear about the cytology test before the survey and to not even knowing what it was about.

There is some degree of confusion among women about the name of the test. Only 20% of the women heard the name 'Papanicolaou test', while only 10% knew about 'cervical screening'. The most widely recognised name of the Pap test was 'cytology test' (41%). At the same time, 43% of the women admitted to knowing none of the names showed to them. Most women advocated a simple and unique title that is easy for people to remember and they suggested calling it a 'cytology' test or even a name that would make the purpose of the test clear – 'the cancer test'.

Not having appropriate information, makes many women develop the wrong idea that the test needs to be done only when there is the risk for a woman to get cancer or when they show some sort of cancer symptoms. Thus, there are women who think that if they do not show any cancer symptoms, it means they do not need a health check. Because of these beliefs, many women do not do the test at all as they believe they are healthy. The fact that one fourth of the respondents stated that they felt undecided about whether or not to do the test or that they'd rather not do it at all is alarming. About 6% of the women believe that health checks are useless in general.

Thus, it is obvious that for one to decide to do the test, it is first of all necessary to understand the risks that could lead to cancer and that each and every woman is concerned.

The survey proved that women neither understand the details of the screening stages, nor how important it is to observe them. For example, 6% of women referred to colposcopy did not actually show up for this procedure, giving priority to other activities and arguing that they wither didn't have time to or had to go abroad to work.

The research confirmed the findings of other researches mentioned in the first chapter of this paper, that the opportunistic type of screening predominates in Moldova. Women do the Pap test when they go to see the doctor for a different reason, such as routine gynaecological checks (41%), having some gynaecological issues (22%), family planning services (9%), pregnancy (8%). Only 15% of the women who did the test went to see the doctor for this particular reason. Concurrently, the doctors believe that only around 20% of the women go to the doctor out of their own initiative and, for the most part, they already show some symptoms.

In health workers' opinion, preventive checks at the workplace are the most efficient levers at present whereby women are attracted into the screening program. This was also confirmed by the results of the quantitative survey , which showed that about 16% of the women included in the survey saw a doctor more than 2 years ago, 24% saw the gynaecologist once in 2-5 years, and 8% saw the gynaecologist less frequently than once in five years. Only 36% of the women aged 25-61 that participated in this survey said they did a Pap test at some point in their life. The fact that 14% of the respondents stated that they felt undecided about whether or not to do the test and that 11% said they'd rather not do it is alarming.

On the whole, the participants in the survey admitted to having little knowledge about cervical cancer, which is typical of the whole population of the country. The following measures were developed to improve prevention of cervical cancer:

- Improving the culture of health among women and among adolescents in particular;
- Taking more incentive measures and making the health staff be more insistent in persuading women to show up for preventive checks;
- Making available broader information about the availability of the test and its efficacy, about the procedure and smear collection, the purpose and importance of the test.
- Concurrently, another set of measures meant to achieve a broader population coverage were proposed, among which:
- Group discussions with health workers, sessions, public lessons at which women could learn more and ask questions, talk to health workers at their workplace.
- Organising a national awareness campaign via mass-media, by also creating some shows for TV, radio and social media.
- Involving, as many non-medical institutions responsible for the health of the population as possible in information sharing and involving opinion leaders and foreign specialists in promoting cervical cancer screening.
- Developing and disseminating as many informative materials as possible (posters, leaflets, brochures and videos).
- Informing adolescents (15-16 year-old girls) in educational institutions and youth-friendly centres.
- Organising days dedicated to cervical screening and having them widely covered by the media.
- Publicizing the stories of patients who've been through cervical cancer treatment.

Knowledge and attitudes to the HPV vaccine

The women who participated in the survey have very little knowledge about the HPV and about the purpose and need of vaccination. About 70% of the respondents said they were not aware of the HPV vaccine effects. All the women who never did a Pap test were also not aware that cervical cancer can be caused by the HPV and only a few of them – who did the test in the past – knew about it. Some of the women believed that the vaccine is a form of treatment that needs to be made only when the body is infected.

There is broad and non-homogeneous range of ways informing women about the HPV vaccine. About half of the respondents that heard about the vaccine (52%) learned about it from the TV or radio. One third of them were told about it by the family doctor, while one woman in five heard about the vaccine form friends or acquaintances. Women above 56 years of age, from the rural area, including women of Gagauz ethnicity, with elementary or secondary education, retired and living in poor households are more likely to say they never heard about the HPV vaccine.

One can also see women aren't quite interested in changing their attitude towards getting an HPV vaccine. Only about a quarter (26%) said they would like to know more about the HPV vaccine, while 43% admitted they were not interested in this vaccine, and another 31% of respondents believed the knowledge they already had was enough. More than half of the women who had daughters and participated in the survey (55%) said they were undecided or would not want to vaccinate their daughters against HPV. Also, 23% of these women added that they have already vaccinated their daughters against HPV.

The survey found, though, that the health workers involved in the research had contradictory views. While some health workers supported HPV vaccination and believed that it should be mandatory, other were rather reserved about the HPV vaccine, arguing that they were not certain about the effectiveness of the vaccine and its origin. Also, 23% of the women in the survey said their doctors was too busy or not willing to give them information on the HPV vaccine.

Undoubtedly, the inconsistent messages that the health workers send confuse the population and lead to distrust and even fear of vaccination. It is necessary to send one single message to the population, a message that should also be promoted by all health workers.

It seems women trust the most messages coming from gynaecologists (96%), family doctors (92%) and oncologists (90%). As regards information sources other than health workers, women seem to have the greatest trust in public discussions about the Pap test (73%). Also, 65% seem to trust information coming from the TV. There is some distrust in information coming from celebrities (49%) and from priests (56%).

The health workers believe they need more support from social partners to share knowledge among the population. Any organisation that interacts with women should contribute to raising awareness: the Mayor's Office, the employers, the media, the civil society, the government, etc. They should play a much bigger role. The specialists believe that to inform women, there should be more awareness campaigns funded by the National Health Insurance Company and more activities promoting and educating women, conducted by the specialist of the National Public Health Agency at local level.

5.3 Acceptability of Screening Services

The survey confirmed that in Moldova, there is little awareness about how important it is to do periodic health checks and the population didn't quite develop a preventive checks culture. Traditionally, the population prefers to see a doctor after symptoms have already appeared or when they are already sick, and it may turn out to be too late to avoid complications. About 16% of women had their last medical check more than two years ago, while 8% of the women who participated in the survey see a gynaecologist rarer than once in five years. Not knowing what is the real meaning and purpose of preventive checks leads to the population developing wrong opinions that, for instance, after preventive medical checks, which include invasive procedures, one's body is harmed, which causes unfounded concerns about the likelihood to get some cancerous changes. About 22% of the women do not believe or do not now that cervical cancer can be prevented. The survey also found that some of the interviewees took cancer as a fatalistic event that occurs only if a person is predestined to get it and the Pap test will not help prevent it.

About 4% of the respondents admitted that when they get sick, they prefer self-treatment and to get information from sources such as the internet, friends, relatives that don't have medical education, etc. rather than from health workers.

The reluctance to cervical screening is often argued by the fact that it would produce more emotional discomfort. The survey highlighted that there is a lot of fear, intimidation among Moldovan women and they also have to overcome an emotional barrier to be able to see a gynaecologist, which makes them do whatever it takes to avoid seeing this doctor and to avoid the cytology text, respectively. Some women avoid thinking about cancer as they believe that thinking about a disease can make one actually get it.

This sort of belief prevails among 50+ women living in the rural area, who think that gynaecological checks are no longer proper for women of that age and, what is more, they are convinced that gynaecological checks at an advanced age are embarrassing.

What is more, belonging to ethnic minorities (Bulgarian and Roma minorities), to minority religions (Baptism, Jehovah's Witnesses, Islam) and the low level education are also predictive of small chances that the Pap smear will be taken.

Practically, one woman out of four said that they prefer a female family doctor, and 19% of the respondents admitted that a male gynaecologist would be a barrier to doing the Pap test. Some women admitted that they avoid the family doctor if he is a man that they choose to rather see female specialists. There is a particularly strong reluctance among women living in the rural area, as one of them admitted they find gynaecological checks embarrassing. In towns, however, most of the interviewed women said it didn't matter to them what the gender of the gynaecologist is as long as they know that he/she is a good specialist.

We found that there is a low level of acceptability of the test among women's partners. Many women admitted that their partners didn't know about the test and did not show any interest in the procedure, not being even aware about what the test is. More than one third of women (36%) said they did not know what their partner's opinion was, and a quarter said their partners would rather think they should not do test. Also, there were many women (44%) who were not able to confirm whether or not important women in their lives did the Pap test, which is indicative of the fact that in Moldova cervical cancer screening is not perceived yet as a necessity and normality in women's life.

The results analysis proved there is a direct link between the influence of the social environment and the test acceptance rate. When the impact of the opinion influential people have about the Pat test goes one degree up – the likelihood that a woman will do the test increases 2.2 times.

It is worth-mentioning that some women suggested to invite to screening not only women, but their partners too, because this way, more women could ultimately be influenced to do the test. Considering that the local population is rather patriarchal, such a suggestion should be introduced in the action plan implementing the cervical cancer screening.

The research also found that women often had erroneous beliefs about cancer causes and risks. The key cervical cancer causes they mentioned were the following:

- poor nutrition,
- genetically modified products,
- carcinogenic cells transmitted through meet,
- no personal hygiene,
- frequent stress and weak immune system,
- hormonal imbalances, abortions or poorly done C-sections.

Only a few of the interviewed women mentioned the HPV infection as a potential cause of cervical cancer.

What is more, the lack of correct and comprehensive information leads to fear and the tendency to deny certain risks. Some women said they preferred not to learn too much about health issues because that way they managed to avoid negative emotions that they could start feeling once they learned about the risk to get a disease. A few women do not get screened for fear that the test might turn out positive, and this fear makes them avoid the test.

Women in Moldova are not quite aware of the risks of getting cervical cancer. With regards to susceptibility to cervical cancer, the average of 3.2 out of 5 (where 5 represents total agreement with the fact that a woman is susceptible) show that women tend to perceive there is an average predisposition to the possibility of getting cancer. Many women believe that they are not exposed to the risk of getting cervical cancer because nobody among their relatives got it. The correlation analysis reveals that the perception that a woman has little chance to get cancer is negatively correlated with the intention to do the test. This makes some women be much more relaxed and carefree about the screening and regular health checks.

The insufficient knowledge and the lack of trust in the healthcare system give women the wrong opinion that screening activities that health workers try so hard to perform are of no use for their own health, but for health workers' financial interest who are concerned about the performance indicators imposed on them by the Ministry of Health. These opinions show that the level of accountability for one's own health is low for some people who still fail to understand the advantage of the screening.

5.4 Quality of Services

Some health system specialists are convinced that if the legal framework and all procedures are observed, then the quality of the cervical cancer screening is ensured. For laboratory services, quality assurance manuals were developed. They provide for the procedures that need to be observed. The National Health Insurance Company, which contracts and funds the cervical cancer screening, checks yearly the trueness of the information reported by health facilities. There is also a system in place to assess the cancer cases, via which an analysis is conducted of the circumstances in which cancer was diagnosed. Judging by the large number of individual medical records, there is a belief that using an information system would facilitate the interaction between the health workers involved in cervical cancer screening and that it would make monitoring easier. In addition, some respondents mentioned the initiative of involving a person or an independent organization that would oversee and evaluate the quality of cytological services.

Among other things mentioned was that there are too few tools at present to monitor the implementation of policies and operational standards.

Patient satisfaction and trust

Some respondents said that they have had unpleasant discussions with doctors from town- or district-level health facilities, and that the doctors behave arrogantly and that they humiliate people from the rural area or that have a lower education level. A group of women was outlined (7%), who reported they were either unsatisfied or totally unsatisfied with the health care services they were provided. Many women have said they preferred to go straining to specialists in big health centres (e.g. in the capital city), where the attitude is better and explanations are given in a simpler language that they can understand.

In many cases, women turned out to be unhappy with the length of the family doctor consultation and with the superficial examination at the gynaecologist, with the poor communication with health workers, the insufficient information provided and the little explanation given on tests, the diseases and applied treatments. The feeling is that patients are often treated in a 'depersonalised' fashion, consultations are short, doctors dedicate too little time to analyse tests, women are only informed that 'some tests' are required, they might never be given the results or when they are informed about them, the only thing women are told is that 'everything is fine' in general. Many women said that they've seen the gynaecologist many times, without knowing what tests were made exactly and what was their purpose because the gynaecologist didn't quite explain and they felt uneasy about asking questions. As many as 28% of the women said that the bad experiences they have had in terms of their communication with health workers make them avoid seeing a doctor again, while 26% believe that communication with the doctors was difficult.

Obviously, health workers need to be trained about effective communication with women in terms of the screening process and about women's right to be informed.

There have also been cases when the doctors imposed some conditions on the women and forced them, thus, to take the Pap test. For instance, the family doctor would refuse providing them the services the women concerned came seeking for (e.g. they could have needed a certificate) unless they took the Pap test. However, this conditionality is not founded on a detailed justification, but only on 'because you must'. What is more, in the discussion with the interviewer many women showed surprise when they were asked about how they prepared for the test because they were actually never given any information about it and never even thought about it. This tells us about the poor quality of the screening services provided in certain areas of the country.

During discussion, it became obvious that the patients didn't trust doctors' skills. Among the women who never had the test, there were respondents who said they'd never even have the Pap test taken because they believed that health workers use any possible occasion there is to prescribe treatments even when it is not really necessary. Much of the distrust is caused by experiences in which treatments were not effective or by situations where different specialists had different opinions on diagnosis and treatment.

The greatest disappointments were expressed when it was found that doctors who work both in public and in private health facilities give different conclusions and treatments depending on where of the two places the consultation takes place. Suspicions were voiced that doctors allegedly have 'financial interests' to prescribe certain medicines that aren't always for the best of the patient. There are also concerns about the pharmaceutical industry having abusive interests and about the efficacy of prescribed treatments. Some women reported they trust the information the doctors give them only after they've heard the opinions of several doctors.

Because of some personal experiences they've been through or having learnt about some sad cases in the society about cervical cancer, some women developed a strong opinion that this disease cannot be treated and, thus, they do not trust the capacity of the local healthcare system in addressing early identification and treatment.

The opinion that there isn't a good enough control over the quality and provision of health care services in the public health system was stated often.

Therefore, some women who didn't know much about the HPV vaccine reported that they worried about its potential adverse effects because, in their opinion, all vaccines had adverse effects. These women were neither

able to tell what adverse effects the HPV vaccine might have, nor did they ever talk to health workers about their concerns. There were also women who said that they'd vaccinate their daughters in private clinics only because, in their opinion, the vaccines in private health facilities are of a higher quality and the risk of adverse effects is lower.

It was mostly women from the rural area who said they trusted the efficacy of the vaccine and who confirmed they'd vaccinate their daughters or granddaughters.

Technical endowment of medical offices and laboratories

Most specialists said that primary healthcare laboratories and health facilities are not fitted out appropriately to conduct the screening, and that the purchased tools are either not very good quality or not in line with the standards. Most frequently, they said that the brushes used to collect the smear are either not very good quality or even with their shelf life expired. The fact that no standards were set for smear collection equipment at national level was highlighted.

Because of shortage of equipment and tools needed for the Pap test, family doctors refer their patients to the gynaecologists. Another finding is that in some health facilities, women have to buy themselves the tools required for the examination, but some of them might not have the money to, so they could give up seeing the doctor.

The women also mentioned that sometimes the places meant for examinations were in need of renovation or that the equipment and furniture were worn out. They often mentioned that some gynaecological offices do not have a private examination area and that the felt uncomfortable because they felt exposed.

It was found that there is not enough equipment in the cytology and histopathology laboratories, which has a severe negative impact on the quality of conducted tests.

Often, women said that they did not trust the quality of the results of public health system tests because they believed that the equipment in public health facilities is outdated. This is the reason why many women said they would rather take the test in private clinics. Therefore, the perception that they are not going to be provided quality services can be a significant barrier that will make women hesitant about taking test in public health facilities.

The health system specialists that participated in the survey mentioned that the Republican Hospital and the Oncology Institute are the only ones that have the best equipped histopathology centres, while in other health facilities the equipment is outdated.

Test quality

Some doctors stated that the cytology test used at present is not informative enough and that errors are possible, which is why additional examinations are needed, such as the colposcopy examination, which is not available in all district-level healthcare centres. Also, note that the specialists taking the smears are not informed enough and because of this they do not take the smear during the right phase, which leads to wrong results. What is more, note that at present, in terms of smear taking and smear reading, the focus is rather on the quantity than on the quality of the provided service.

When the smear examination steps are not adhered to, it is the quality of health care services that is affected.

As regards the efficiency of the screening, certain specialists believe that the most widely used diagnosis method – *the Romanowski-Giemsa staining* – is not efficient, because it does not allow detecting all pre-cancer conditions. In this context, it was found that the discrepancy between cytological and histopathological diagnosis is very big in the Republic of Moldova – about 50-60% compared to Great Britain, where the cases of mistakes represent 2-3%.

Note that although all protocols and standards mention the Pap test, this method – which, in fact, implies that a particular type of staining applies – is only being implemented.

However, although there are many laboratories, when some of them process a small number of tests a year, the quality of the work becomes questionable. Frequently expressed opinions were that there should be fewer laboratories, and that those that would remain would require to be fitted out appropriately.

CONCLUSIONS

Conclusions on the Behaviour and Attitude of the Female Population

1. Both health specialists and women who participated in this survey believe that the problem of cervical cancer **is regarded as serious and of major importance** in the Republic of Moldova as the cancer is often found when it already reached advanced stages (III and IV) and the mortality rate among working age women is high.

2. The **population is poorly informed** about cervical cancer, HPV vaccination and cervical cancer screening. **People's access to information** on cervical cancer risks, HPV vaccine, purpose and frequency of the Pap-test and the fact that the procedure is free of charge, whether or not the person is insured, is **reduced**. Women expect the health system to be more active in sharing with the population knowledge in this area, tailored to age specifics, native ethnic and cultural context and comprehension peculiarities typical of different social groups.

3. The survey proved there is a direct link between acknowledging the need of undergoing cervical screening and the place where one lives (rural/urban), one's level of education, age, as well as with the local culture and peculiarities of certain ethnicities and religions. The **campaigns on cervical cancer screening** and HPV vaccination should contain **structured activities focused on particular target groups and ethnic and cultural peculiarities** that are to be conducted regularly according to a pre-established plan. It was found that women's partners could actually play a very important role in persuading them to be screened for cervical cancer.

4. There is low mass awareness raising about cervical screening, and the **partners participate passively** in informing the population and promoting support for screening. (NHIC, mass-media, civil society etc.).

5. The national health system **does not have yet a mechanism to ensure permanent show-up of all women for cervical screening.** Women are not quite motivated to get screened for cervical cancer, the survey found. Although health workers do make efforts to persuade and invite women to take the Pap-test, not too many actually come, while the share of those that come out of their own initiative continues to be small. This is largely due to people not feeling accountable for their own health, to having no health literacy, to little contact with health workers, to the health workers' carelessness, to lack of time, migration, shame, not enough money and poor organisation of the system.

6. The **population does not trust the efficiency of the healthcare system and of the prescribed treatments**, it was found. This makes women believe the private sector services are of a better quality and more reliable. There is some mistrust in doctors' skills to establish the right diagnosis and prescribe treatments. **The contradictory messages about HPV vaccination** affect the dissemination of appropriate information and the trust in the health care system. The survey found that the health workers communicate different opinions – from being totally in support of vaccination and believing that they must be made – to very reserved opinions and refusal to vaccinate their own child. Some family doctors even go as far as to not recommend this vaccine to the population, believing that it is not effective or that it would even lead to infertility as an adverse effect.

Conclusions on the Organisation, Access and Quality of Screening Services

7. The regulatory framework for cervical cancer screening is believed to be sufficient and in line with international standards and recommendations of the World Health Organization and of the European Union. However, although there are enough guidelines at present with regards to the cervical cancer process – the National Cancer Control Program and the National Cervical Cancer Screening Program particularly, there are **few tools to monitor policy implementation in this area, and the said programs are also not monitored and evaluated efficiently.** Apart from the quantitative indicator for family doctors, there are no other monitoring mechanisms in place. For example, reports would be required on the number of women who were referred to the second stage – to the gynaecologist or on the number of patients who were referred to the oncologist, and on the number of cancer cases detected via cervical screening.

8. The survey found that the **communication between the key parties in setting up the cervical cancer screening process in the country is poor**. Communication between specialists is poor too and there is no way to trace patients. No clear mechanisms of cooperation between the parties involved were established. For example, some family doctors admitted they did not know where to refer women for colposcopy. Women are often not followed-up and they end up *'lost'* from the sight of health workers even though they passed the first stage test. The primary health care information system – which is supposed to be the means for collecting information about patients' health – does not work to its fullest capacity. However, having a database that would contain information on every patient and at every stage, would make communication between specialists involved at different stages of cervical cancer screening easier and would contribute to better quality and better organised services. This would make it possible to track patients at every stage provided for in the national standard on operational procedures.

9. There is **not enough access to screening services** for some groups of women, particularly in the rural regions. The findings show that there are not enough specialists required for the screening process (family doctors and gynaecologists) and that there are some gaps in how the system is organised. These lead to serious issues when it comes to the relationship with patients that end up unhappy with the quick and superficial consultations, insufficient communication and long waiting time. Many women said that they keep postponing taking the test because of lack of time and not wanting to wait in long queues in front of the doctor's door. Suggestions were made for the screening to be conducted at times that work for women, e.g. after working hours, in the evening, on Saturdays, by organising mobile teams to go to villages during the cold time of the year when there is no agricultural work to do.

10. The findings show that there are **issues with** the health workers **observing patients' rights to being informed and to privacy**. Some rural respondents admitted that they are afraid and feel intimidated when they visit the gynaecologist and that for these reasons they avoid seeing this specialist as much as possible. It was often mentioned that some gynaecologists give very little explanations and that the gynaecological office does not have a private examination area and the women feel uncomfortable because they feel exposed. Some respondents said that they found out a smear was taken from them for the test only when they were informed about the test results without having understood or being informed that a smear was going to be collected while at the gynaecologist at all.

11. At present, when it comes to screening services, the focus is on quantity of the tests, not on quality. **Quality is not ensured throughout the entire screening process** at national level, which makes women distrust the effectiveness of the medical services provided. Not all primary health care facilities are fitted out properly (there are no gynaecological couches and required tools) and the skills of the staff in collecting correctly the smear are lacking. Thus, the tests end up being not informative enough. The way they are interpreted does not always allow for the identification of pre-cancer conditions. The **screening procedure is not standardised**, particularly when it comes to how to use brushes, which has a significant impact on the quality of the smear and on the results of the test, respectively. There is neither enough advanced equipment in laboratories, nor properly trained staff to interpret the results. The doctors believe more equipment is needed to treat pre-cancer conditions and to perform radiotherapy.

12. **The way the screening procedure is being funded has some flaws that affect women's access to screening services.** The current manner of funding health care does not guarantee the priority of cervical screening in relation to other oncologist diseases or pathologies. Some health facilities reduce the number of cytology tests intentionally because the tariffs have gone up. Therefore, such tests continue to be paid for by the patients. Also, because of shortage of funds, some primary health care facilities force women to purchase the required tools themselves (blushes, vaginal speculum, etc.). The lack of insurance prevents uninsured women that tested positive from pursuing further medical care. Women that do not have the money, give medical investigations up. It is obvious that it is necessary to provide free services at every stage of the screening. Besides, there are women who do not afford the expenses for travelling to the health facilities that provide screening services.

13. **There is little access to screening services as there are notenough colposcopy offices** all across the country. Therefore, women would have to travel long distances for this service. Also, some colposcopy offices **do not meet all technical requirements.** Due to lack of funds, these offices are not fitted out adequately with the necessary equipment, nor do they have staff trained in colposcopy. The expensive colposcopy course and the low pay for such specialists are the key causes that lead to shortage of staff in this field.

RECOMMENDATIONS

Recommendations Meant to Change the Behaviour of the Target Population

1. Develop **effective mechanisms to motivate and make women feel accountable** for undergoing screening regularly, according to specialists' recommendations based on practices successfully implemented in other countries. Women's preferences and needs, depending on where they live, must be taken into account when developing such mechanisms, as well as the nature of their work, seasonal work and migration, the ethnic and cultural context and the socio-economic condition of different target groups. Promoting the role of the women's partners in motivating them to get screened is important.

2. Develop **large-scale programs and awareness campaigns focusing on specific target groups** with structured activities that would be carried out regularly according to a plan, adjusted to the understanding capacity of different social groups, age specifics, local ethno-cultural context and peculiarities of religion. The awareness campaigns should be underpinned by a cross-sectoral approach, engaging more partners, including those beyond the health system (LPAs, educational institutions and other public institutions, entrepreneurs and employers, etc.).

3. Initiate some **trainings on communication meant to change behaviours** that pose risks for health and on **patients' rights**. These trainings need to focused on family doctors and gynaecologists involved in cervical cancer screening. At these trainings, the doctors could be taught techniques of communication and correct approach to patients, while also observing the fundamental human rights, such as the right to information, confidentiality and privacy.

4. Promote **standardised messages on cervical cancer screening as well as the importance and effectiveness of HPV vaccination among health workers** to level out communication with the population and increase confidence.

Recommendations Meant to Improve the Organisation, Access to and the Quality of Cervical Cancer Prevention Services in Moldova

5. **Develop a procedure to monitor patients' journey** all through the screening process starting with the primary screening and all the way through to administration of treatment, making it possible for all institutions participating in controlling cervical cancer in the country to work with one another. **Creating an information system** with a comprehensive database where information from each stage of women's contact with the medical system could be introduced, which would facilitate significantly women's monitoring, but also visibility and effectiveness of the actions conducted under the screening program, respectively.

6. It is necessary to review the monitoring and evaluation indicators of the National Cancer Control Program and of the National Cervical Cancer Screening Program (which are largely outcome indicators only) and to **add progress indicators** to evaluate the involvement of all actors participating in the cervical screening procedure, the continuity and efficiency of the activities performed in relation to the control of cervical cancer from the moment it was detected until treatment. For example, reports would be required on the number of women who were referred to the second stage – to the gynaecologist or on the number of patients who were referred to the oncologist, and on the number of cancer cases detected via cervical screening.

7. Organise **some programs to increase women's access to screening services** in areas where there is shortage of qualified health workers skilled in correct smear sampling. It is necessary to set up the mechanism and the algorithm for screening activities to be performed by specialists from the hospitals (gynaecologists), which need to be monitored via outcome indicators. It is also necessary to set up a mechanism to finance such activities. These activities would include, for example, organising mobile teams

to go to villages, especially during the cold season of the year, when there is no agricultural work to do, providing services after working hours, in the evening, on Saturdays, etc.

8. It is necessary to initiate an **assessment of the current capacity** of primary health care facilities in conducting the cervical screening, starting with required equipment and to the skills of the health workers. If the PHC facility lacks the appropriate capacity for this procedure, a clear **institutional algorithm** regarding the set-up of the screening process for the population concerned will have to be developed. This should mandatorily be included among the screening program monitoring indicators, individual professional performance indicators achieved by the health facilities providing primary health care services under the compulsory health insurance package, as well as among the health facility accreditation criteria.

9. Promote the **standardisation of the screening procedure** in all health facilities is necessary, particularly when it comes to how to use brushes, which has a significant impact on the quality of the smear and on the results of the test, thus.

10. Considering that the capacity of cytology laboratories differs from one laboratory to another, it is necessary to **develop an action plan** for the most optimal period of time possible, **to strengthen the laboratories and fit them out with the required equipment and to provide trainings for the staff.** This intention will require input from several partners appointed in charge of implementing the screening program (MHLSP, NHIC, LPAs, etc.)

11. Assess the **capacity of existing colposcopy offices** and of **offices performing pre-cancer treatment procedures** and developing a plan of measures to strengthen their capacity both in terms of equipment and in terms of trained human resources staff. **Develop an algorithm to ensure** women's **access** to colposcopy services, as much as possible, in regions where it is not enough.

12. **Review the financing of the screening procedure** at all implementation stages, starting with a review of priorities of primary health care, which is where cervical cancer screening should actually take place. Set up a mechanism of state funding to cover the second stage of cervical screening that, at present, is not free for uninsured women.

ANNEXES

Annex 3.2.1: Opinion on health status

% by line		No	Very good	Good	Neither good nor bad	Bad	Very bad
Total		**1226**	**9**	**41**	**37**	**11**	**2**
Age	25-35	**431**	17	56	23	3	1
	36-45	**257**	8	47	38	6	1
	46-55	**232**	5	29	50	15	1
	56-61	**306**	2	23	45	25	5
Area	Urban	**597**	10	41	38	10	1
	Rural	**629**	8	41	36	12	3
Region	North	**320**	10	44	34	11	1
	Centre	**364**	8	40	37	12	3
	Chisinau	**277**	11	41	40	8	0
	South	**265**	8	38	36	15	3
Marital status	Unmarried	**107**	22	39	33	5	2
	Cohabitation	**46**	11	48	29	12	0
	Married	**884**	8	45	36	9	1
	Divorced	**89**	8	34	41	11	6
	Widow	**99**	4	12	43	36	4
Nationality	Moldovan/Romanian	**1069**	9	41	36	11	2
	Russian	**51**	6	45	35	15	0
	Ukrainian	**32**	19	27	41	13	0
	Gagauzian	**60**	5	40	42	13	0
Education	Primary or lower	**31**	7	19	36	26	13
	Secondary	**336**	8	35	41	14	2
	Vocational	**562**	9	37	39	13	2
	Higher	**281**	12	56	27	4	0
Occupation	Unemployed	**375**	12	41	32	12	3
	Employed	**692**	9	46	37	7	0
	Retired	**152**	2	15	46	29	8
Financial status	Rich	**52**	27	42	26	6	0
	Average	**963**	9	44	36	9	1
	Poor	**211**	6	25	41	23	5

Annex 3.2.2: Medical diagnosis

% by line		No	Yes	No
Total		**1,226**	**31**	**69**
Age	25-35	**431**	12	88
	36-45	**257**	21	79
	46-55	**232**	37	63
	56-61	**306**	60	40
Area	Urban	**597**	31	69
	Rural	**629**	31	69
Region	North	**320**	30	70
	Centre	**364**	31	69
	Chisinau	**277**	31	69
	South	**265**	30	70
Marital status	Unmarried	**107**	25	75
	Cohabitation	**46**	27	73
	Married	**884**	26	74
	Divorced	**89**	41	59
	Widow	**99**	67	33
Nationality	Moldovan/Romanian	**1,069**	30	70
	Russian	**51**	36	64
	Ukrainian	**32**	37	63
	Gagauzian	**60**	27	73
Education	Primary or lower	**31**	51	49
	Secondary	**336**	29	71
	Vocational	**562**	34	66
	Higher	**281**	23	77
Occupation	Unemployed	**375**	21	79
	Employed	**692**	27	73
	Retired	**152**	73	27
Financial status	Rich	**52**	28	72
	Average	**963**	28	72
	Poor	**211**	42	58

Annex 3.2.3: Disability diagnosis

% by line		No	Yes	No
Total		**1,226**	**3**	**97**
Age	25-35	**431**	0	100
	36-45	**257**	3	97
	46-55	**232**	4	96
	56-61	**306**	4	96
Area	Urban	**597**	2	98
	Rural	**629**	3	97
Region	North	**320**	3	97
	Centre	**364**	3	97
	Chisinau	**277**	1	99
	South	**265**	3	97
Marital status	Unmarried	**107**	7	93
	Cohabitation	**46**	0	100
	Married	**884**	2	98
	Divorced	**89**	2	98
	Widow	**99**	5	95
Nationality	Moldovan/Romanian	**1,069**	3	97
	Russian	**51**	2	98
	Ukrainian	**32**	3	97
	Gagauzian	**60**	0	100
Education	Primary or lower	**31**	13	87
	Secondary	**336**	3	97
	Vocational	**562**	2	98
	Higher	**281**	1	99
Occupation	Unemployed	**375**	3	97
	Employed	**692**	1	99
	Retired	**152**	8	92
Financial status	Rich	**52**	0	100
	Average	**963**	2	98
	Poor	**211**	7	93

Annex 3.3.1: Share of insured and uninsured persons

% by line		No	Yes	No
Total		**1,214**	**70**	**30**
Age	25-35	**427**	68	32
	36-45	**257**	63	37
	46-55	**228**	69	31
	56-61	**302**	81	19
Area	Urban	**591**	73	27
	Rural	**623**	68	32
Region	North	**315**	69	31
	Centre	**364**	75	25
	Chisinau	**275**	75	25
	South	**260**	60	40
Marital status	Unmarried	**105**	75	25
	Cohabitation	**46**	50	50
	Married	**878**	70	30
	Divorced	**88**	67	33
	Widow	**96**	77	23
Nationality	Moldovan/Romanian	**1,059**	71	29
	Russian	**51**	79	21
	Ukrainian	**31**	73	27
	Gagauzian	**59**	58	42
Education	Primary or lower	**29**	76	24
	Secondary	**333**	62	38
	Vocational	**558**	71	29
	Higher	**278**	79	21
Occupation	Unemployed	**372**	56	44
	Employed	**685**	75	25
	Retired	**151**	84	16
Financial status	Rich	**49**	60	40
	Average	**957**	72	28
	Poor	**208**	63	37

Annex 3.3.2: Share of persons registered on the family doctor's list

% by line		No	Yes	No	I don't know
Total		**1,226**	**87**	**11**	**2**
Age	25-35	**431**	86	11	3
	36-45	**257**	85	14	1
	46-55	**232**	87	11	1
	56-61	**306**	88	9	3
Area	Urban	**597**	87	12	1
	Rural	**629**	86	11	3
Region	North	**320**	87	11	2
	Centre	**364**	92	5	4
	Chisinau	**277**	90	9	1
	South	**265**	76	23	2
Marital status	Unmarried	**107**	87	11	2
	Cohabitation	**46**	72	19	9
	Married	**884**	88	11	2
	Divorced	**89**	85	9	6
	Widow	**99**	85	13	2
Nationality	Moldovan/Romanian	**1,069**	89	9	2
	Russian	**51**	90	10	0
	Ukrainian	**32**	91	6	3
	Gagauzian	**60**	53	47	0
Education	Primary or lower	**31**	80	13	7
	Secondary	**336**	85	11	4
	Vocational	**562**	89	10	1
	Higher	**281**	85	13	2
Occupation	Unemployed	**375**	87	11	2
	Employed	**692**	86	12	2
	Retired	**152**	90	8	2
Financial status	Rich	**52**	78	20	2
	Average	**963**	88	11	2
	Poor	**211**	84	12	5

Annex 3.3.3: The way of choosing the family doctor by the persons registered on the family doctor's list

% by line		No	On the recommendation of a friend/relative	Accidentally	It's the doctor who is responsible for the area where I live	I don't know/remember
Total		**1,226**	**7**	**3**	**90**	**1**
Age	25-35	**431**	10	3	86	1
	36-45	**257**	7	1	92	0
	46-55	**232**	3	3	93	1
	56-61	**306**	5	4	91	1
Area	Urban	**597**	9	3	87	0
	Rural	**629**	4	2	93	1
Region	North	**320**	10	1	88	1
	Centre	**364**	5	3	91	2
	Chisinau	**277**	10	2	88	0
	South	**265**	3	4	93	0
Marital status	Unmarried	**107**	10	3	85	2
	Cohabitation	**46**	12	0	88	0
	Married	**884**	6	3	90	1
	Divorced	**89**	10	1	89	0
	Widow	**99**	2	0	98	0
Nationality	Moldovan/Romanian	**1,069**	7	3	89	1
	Russian	**51**	8	2	90	0
	Ukrainian	**32**	3	7	90	0
	Gagauzian	**60**	0	0	100	0
Education	Primary or lower	**31**	0	8	92	0
	Secondary	**336**	5	1	94	0
	Vocational	**562**	6	3	89	1
	Higher	**281**	11	3	86	0
Occupation	Unemployed	**375**	6	3	89	1
	Employed	**692**	8	2	88	1
	Retired	**152**	1	2	96	0
Financial status	Rich	**52**	10	5	83	2
	Average	**963**	7	3	89	0
	Poor	**211**	3	2	93	2

Annex 3.3.4: Family doctor's gender

% by line		No	Male	Female	I don't know/I don't answer
Total		**1,063**	**17**	**81**	**2**
Age	25-35	**371**	14	84	2
	36-45	**219**	18	79	3
	46-55	**202**	18	77	5
	56-61	**270**	18	82	0
Area	Urban	**519**	10	89	1
	Rural	**544**	23	74	3
Region	North	**279**	16	80	4
	Centre	**333**	23	75	2
	Chisinau	**249**	7	92	1
	South	**201**	19	79	2
Marital status	Unmarried	**94**	12	83	4
	Cohabitation	**33**	9	88	3
	Married	**776**	17	80	2
	Divorced	**76**	16	84	0
	Widow	**84**	18	82	0
Nationality	Moldovan/Romanian	**947**	18	80	2
	Russian	**46**	5	92	2
	Ukrainian	**30**	12	85	4
	Gagauzian	**32**	9	88	3
Education	Primary or lower	**25**	16	75	8
	Secondary	**285**	20	80	0
	Vocational	**498**	17	80	2
	Higher	**239**	12	86	2
Occupation	Unemployed	**325**	18	80	2
	Employed	**597**	16	81	3
	Retired	**137**	17	83	0
Financial status	Rich	**41**	15	85	0
	Average	**846**	17	81	2
	Poor	**176**	17	81	2

Annex 3.3.5: Preference for the family doctor's gender

% by line		No	I prefer a male doctor	I prefer a female doctor	It doesn't matter
Total		**1,226**	**3**	**27**	**69**
Age	25-35	**431**	2	29	69
	36-45	**257**	6	25	68
	46-55	**232**	3	26	70
	56-61	**306**	2	27	71
Area	Urban	**597**	3	26	71
	Rural	**629**	4	28	68
Region	North	**320**	2	22	77
	Centre	**364**	5	22	73
	Chisinau	**277**	3	26	71
	South	**265**	4	43	53
Marital status	Unmarried	**107**	3	35	62
	Cohabitation	**46**	3	26	71
	Married	**884**	3	26	71
	Divorced	**89**	3	28	68
	Widow	**99**	3	31	66
Nationality	Moldovan/Romanian	**1,069**	3	26	71
	Russian	**51**	5	17	78
	Ukrainian	**32**	5	16	80
	Gagauzian	**60**	3	58	38
Education	Primary or lower	**31**	0	45	55
	Secondary	**336**	4	26	70
	Vocational	**562**	4	28	68
	Higher	**281**	2	26	72
Occupation	Unemployed	**375**	3	28	70
	Employed	**692**	4	28	68
	Retired	**152**	1	22	76
Financial status	Rich	**52**	2	38	60
	Average	**963**	3	26	70
	Poor	**211**	4	29	67

Annex 3.3.6: Latest medical examination

% by line		No	last year	1-2 years ago	2-5 years ago	more than 5 years ago
Total		**1,226**	**57**	**27**	**11**	**5**
Age	25-35	**431**	60	28	9	4
	36-45	**257**	54	29	13	5
	46-55	**232**	58	26	12	5
	56-61	**306**	57	25	11	8
Area	Urban	**597**	61	26	9	3
	Rural	**629**	54	28	12	7
Region	North	**320**	51	29	13	7
	Centre	**364**	65	22	8	6
	Chisinau	**277**	66	21	10	3
	South	**265**	46	37	13	4
Marital status	Unmarried	**107**	57	33	5	4
	Cohabitation	**46**	56	20	17	7
	Married	**884**	58	27	11	4
	Divorced	**89**	47	27	12	14
	Widow	**99**	60	19	12	9
Nationality	Moldovan/Romanian	**1,069**	59	25	11	6
	Russian	**51**	66	26	8	0
	Ukrainian	**32**	37	43	14	6
	Gagauzian	**60**	37	48	13	2
Education	Primary or lower	**31**	45	36	13	6
	Secondary	**336**	51	27	11	11
	Vocational	**562**	58	27	12	3
	Higher	**281**	66	25	7	3
Occupation	Unemployed	**375**	54	28	12	5
	Employed	**692**	59	27	10	4
	Retired	**152**	59	23	11	7
Financial status	Rich	**52**	50	38	8	5
	Average	**963**	61	26	10	4
	Poor	**211**	45	29	15	11

Annex 3.3.7.1: Visits paid to doctors in case of health conditions

% by line		No	Family doctor	Specialist doctor from the health centre	Specialist doctor from a private health care facility	Specialist doctor from a public hospital	I don't visit any doctor and treat myself on my own
Total		**1,226**	**70**	**12**	**7**	**6**	**2**
Age	25-35	**431**	68	11	9	5	2
	36-45	**257**	66	12	9	10	1
	46-55	**232**	67	14	6	6	3
	56-61	**306**	77	11	3	3	3
Area	Urban	**597**	70	12	9	5	1
	Rural	**629**	70	12	6	6	3
Region	North	**320**	73	10	7	5	2
	Centre	**364**	75	7	7	4	4
	Chisinau	**277**	68	15	10	3	1
	South	**265**	61	17	5	11	2
Marital status	Unmarried	**107**	72	11	8	5	0
	Cohabitation	**46**	61	12	13	8	2
	Married	**884**	69	13	7	6	2
	Divorced	**89**	68	9	3	8	6
	Widow	**99**	76	10	3	3	6
Nationality	Moldovan/Romanian	**1,069**	70	12	7	5	2
	Russian	**51**	73	8	13	1	0
	Ukrainian	**32**	82	9	3	0	3
	Gagauzian	**60**	53	17	3	20	3
Education	Primary or lower	**31**	51	23	7	16	3
	Secondary	**336**	71	13	4	6	4
	Vocational	**562**	72	11	6	5	2
	Higher	**281**	66	13	12	6	1
Occupation	Unemployed	**375**	71	9	8	6	2
	Employed	**692**	66	15	8	6	2
	Retired	**152**	83	7	1	3	2
Financial status	Rich	**52**	61	12	8	11	2
	Average	**963**	71	11	8	5	1
	Poor	**211**	66	15	4	6	7

Annex 3.3.7.2: Visits paid to doctors in case of health conditions

% by line		No	Doctor friends /acquaintances	I search on the Internet	Relatives/friends with no medical qualification	I ignore the problem	Naturopathic doctor	Someone else
Total		**1,226**	**1**	**0**	**0**	**0**	**0**	**1**
Age	25-35	**431**	1	1	1	0	0	1
	36-45	**257**	2	0	0	0	0	0
	46-55	**232**	2	0	0	0	0	1
	56-61	**306**	1	0	0	0	0	1
Area	Urban	**597**	1	0	0	0	0	1
	Rural	**629**	1	0	1	0	0	1
Region	North	**320**	1	1	0	0	1	1
	Centre	**364**	1	0	1	0	0	1
	Chisinau	**277**	1	1	0	0	0	1
	South	**265**	2	0	1	0	0	0
Marital status	Unmarried	**107**	0	2	0	1	0	1
	Cohabitation	**46**	0	2	0	0	2	0
	Married	**884**	1	0	1	0	0	1
	Divorced	**89**	4	0	0	0	0	1
	Widow	**99**	1	0	0	0	0	1
Nationality	Moldovan/Romanian	**1,069**	2	1	0	0	0	1
	Russian	**51**	4	0	2	0	0	0
	Ukrainian	**32**	0	0	0	0	3	0
	Gagauzian	**60**	0	0	2	0	0	2
Education	Primary or lower	**31**	0	0	0	0	0	0
	Secondary	**336**	0	0	0	0	0	1
	Vocational	**562**	2	0	1	0	0	1
	Higher	**281**	2	1	0	0	0	0
Occupation	Unemployed	**375**	1	1	0	0	0	1
	Employed	**692**	2	0	1	0	0	1
	Retired	**152**	3	0	0	0	0	1
Financial status	Rich	**52**	4	0	0	0	0	2
	Average	**963**	2	1	0	0	0	1
	Poor	**211**	0	0	1	0	0	2

Annex 3.3.8.1: Main reasons for going to a certain service/specialist in case of a health problem

% by line		No	It's the place where I'm registered with the family doctor to be provided health care services	I trust that I'll receive the necessary help	It's the place that I can reach easiest in order to benefit of health care services	I'm happy with how they behaved with me previously
Total		**1,226**	**36**	**32**	**14**	**13**
Age	25-35	**431**	36	32	14	13
	36-45	**257**	28	36	19	11
	46-55	**232**	38	33	12	12
	56-61	**306**	39	29	10	15
Area	Urban	**597**	38	29	14	12
	Rural	**629**	33	35	13	14
Region	North	**320**	31	37	11	16
	Centre	**364**	42	34	8	11
	Chisinau	**277**	42	25	20	8
	South	**265**	26	31	18	18
Marital status	Unmarried	**107**	39	28	15	13
	Cohabitation	**46**	37	26	25	2
	Married	**884**	34	34	13	13
	Divorced	**89**	38	28	13	9
	Widow	**99**	39	23	10	17
Nationality	Moldovan/Romanian	**1,069**	37	32	14	12
	Russian	**51**	51	19	10	17
	Ukrainian	**32**	35	40	6	9
	Gagauzian	**60**	3	33	20	35
Education	Primary or lower	**31**	13	26	26	29
	Secondary	**336**	41	32	11	10
	Vocational	**562**	38	29	14	12
	Higher	**281**	29	37	14	15
Occupation	Unemployed	**375**	39	35	11	9
	Employed	**692**	32	32	16	14
	Retired	**152**	44	25	10	15
Financial status	Rich	**52**	27	25	24	19
	Average	**963**	35	33	13	13
	Poor	**211**	38	28	14	11

Annex 3.3.8.2: Main reasons for going to a certain service/specialist in case of a health problem

% by line		No	Other places are too crowded	I have relations/acquaintances there	Other
Total		**1,226**	**3**	**2**	**1**
Age	25-35	**431**	3	1	1
	36-45	**257**	4	3	0
	46-55	**232**	3	1	1
	56-61	**306**	3	1	2
Area	Urban	**597**	3	2	1
	Rural	**629**	3	1	1
Region	North	**320**	3	2	0
	Centre	**364**	3	0	2
	Chisinau	**277**	3	2	1
	South	**265**	3	2	2
Marital status	Unmarried	**107**	2	3	1
	Cohabitation	**46**	4	3	2
	Married	**884**	3	1	1
	Divorced	**89**	7	1	3
	Widow	**99**	2	2	6
Nationality	Moldovan/Romanian	**1,069**	3	2	1
	Russian	**51**	2	1	0
	Ukrainian	**32**	6	0	3
	Gagauzian	**60**	7	0	2
Education	Primary or lower	**31**	3	0	3
	Secondary	**336**	2	1	2
	Vocational	**562**	3	2	1
	Higher	**281**	3	1	1
Occupation	Unemployed	**375**	3	2	1
	Employed	**692**	3	2	1
	Retired	**152**	3	0	3
Financial status	Rich	**52**	2	2	2
	Average	**963**	2	2	1
	Poor	**211**	5	1	2

Annex 3.3.9: Where did women go for a gynaecological examination

% by line		No	To the family doctor	To the gynaecologist from the health centre	To the gynaecologist from a public hospital	To the gynaecologist from a private health care facility	To some one else
Total		**1,226**	**26**	**44**	**19**	**10**	**1**
Age	25-35	**431**	19	46	19	16	0
	36-45	**257**	24	45	19	11	0
	46-55	**232**	27	39	27	5	1
	56-61	**306**	37	45	11	5	2
Area	Urban	**597**	21	41	23	14	1
	Rural	**629**	31	47	14	6	1
Region	North	**320**	28	49	16	7	1
	Centre	**364**	24	40	23	10	3
	Chisinau	**277**	21	39	20	20	0
	South	**265**	31	50	14	5	0
Marital status	Unmarried	**107**	23	33	26	17	1
	Cohabitation	**46**	13	37	25	25	0
	Married	**884**	25	46	18	10	1
	Divorced	**89**	29	44	17	8	2
	Widow	**99**	40	39	12	5	3
Nationality	Moldovan/Romanian	**1,069**	25	45	19	10	1
	Russian	**51**	29	41	14	16	0
	Ukrainian	**32**	44	43	3	6	4
	Gagauzian	**60**	23	40	27	10	0
Education	Primary or lower	**31**	55	26	10	10	0
	Secondary	**336**	27	53	13	5	2
	Vocational	**562**	29	41	21	8	1
	Higher	**281**	15	43	22	20	0
Occupation	Unemployed	**375**	24	41	22	11	2
	Employed	**692**	23	47	19	12	0
	Retired	**152**	44	42	9	3	3
Financial status	Rich	**52**	12	53	16	17	2
	Average	**963**	25	43	21	11	0
	Poor	**211**	36	46	10	5	4

Annex 3.3.10: Frequency of gynaecologist examinations

% by line		No	More often than once a year	Once a year	Once in 2-5 years	More seldom than once in 5 years	I don't know/remember
Total		**1,226**	**21**	**40**	**24**	**8**	**7**
Age	25-35	**431**	29	44	19	3	4
	36-45	**257**	20	41	29	7	3
	46-55	**232**	19	36	26	11	7
	56-61	**306**	12	34	25	15	14
Area	Urban	**597**	26	42	21	7	4
	Rural	**629**	16	38	27	10	10
Region	North	**320**	18	41	28	10	3
	Centre	**364**	21	44	23	8	4
	Chisinau	**277**	31	39	22	8	1
	South	**265**	13	33	23	8	23
Marital status	Unmarried	**107**	25	40	22	1	11
	Cohabitation	**46**	35	27	25	11	2
	Married	**884**	21	42	24	8	5
	Divorced	**89**	20	31	26	13	10
	Widow	**99**	12	30	27	11	20
Nationality	Moldovan/Romanian	**1,069**	22	40	25	9	5
	Russian	**51**	21	52	14	6	8
	Ukrainian	**32**	15	33	38	6	8
	Gagauzian	**60**	7	30	12	10	42
Education	Primary or lower	**31**	19	13	26	7	35
	Secondary	**336**	13	38	27	13	9
	Vocational	**562**	23	40	24	8	6
	Higher	**281**	28	44	19	4	4
Occupation	Unemployed	**375**	20	42	21	10	7
	Employed	**692**	23	40	25	7	4
	Retired	**152**	15	31	24	12	19
Financial status	Rich	**52**	25	40	29	2	4
	Average	**963**	24	42	23	7	5
	Poor	**211**	8	29	29	17	17

Annex 3.3.11: Share of women who had a hysterectomy

% by line		No	Yes	No
Total		**1,226**	**11**	**89**
Age	25-35	**431**	3	97
	36-45	**257**	8	92
	46-55	**232**	12	88
	56-61	**306**	22	78
Area	Urban	**597**	10	90
	Rural	**629**	11	89
Region	North	**320**	9	91
	Centre	**364**	16	84
	Chisinau	**277**	8	93
	South	**265**	8	92
Marital status	Unmarried	**107**	6	94
	Cohabitation	**46**	11	89
	Married	**884**	9	91
	Divorced	**89**	18	82
	Widow	**99**	26	74
Nationality	Moldovan/Romanian	**1,069**	11	89
	Russian	**51**	8	92
	Ukrainian	**32**	12	88
	Gagauzian	**60**	2	98
Education	Primary or lower	**31**	20	80
	Secondary	**336**	9	91
	Vocational	**562**	14	86
	Higher	**281**	4	96
Occupation	Unemployed	**375**	5	95
	Employed	**692**	10	90
	Retired	**152**	29	71
Financial status	Rich	**52**	8	92
	Average	**963**	11	89
	Poor	**211**	11	89

Annex 3.4.1: Satisfaction with family doctor's services among the women who are on his/her list

% by line		No	Gynaecologist from the health centre	Family doctor	Gynaecologist from a public hospital	Gynaecologist from a private health care facility	Someone else
Total		**1,226**	**44**	**26**	**19**	**10**	**1**
Age	25-35	**431**	46	19	19	16	0
	36-45	**257**	45	24	19	11	0
	46-55	**232**	39	27	27	5	1
	56-61	**306**	45	37	11	5	2
Area	Urban	**597**	41	21	23	14	1
	Rural	**629**	47	31	14	6	1
Region	North	**320**	49	28	16	7	1
	Centre	**364**	40	24	23	10	3
	Chisinau	**277**	39	21	20	20	0
	South	**265**	50	31	14	5	0
Marital status	Unmarried	**107**	33	23	26	17	1
	Cohabitation	**46**	37	13	25	25	0
	Married	**884**	46	25	18	10	1
	Divorced	**89**	44	29	17	8	2
	Widow	**99**	39	40	12	5	3
Nationality	Moldovan/Romanian	**1,069**	45	25	19	10	1
	Russian	**51**	41	29	14	16	0
	Ukrainian	**32**	43	44	3	6	4
	Gagauzian	**60**	40	23	27	10	0
Education	Primary or lower	**31**	26	55	10	10	0
	Secondary	**336**	53	27	13	5	2
	Vocational	**562**	41	29	21	8	1
	Higher	**281**	43	15	22	20	0
Occupation	Unemployed	**375**	41	24	22	11	2
	Employed	**692**	47	23	19	12	0
	Retired	**152**	42	44	9	3	3
Financial status	Rich	**52**	53	12	16	17	2
	Average	**963**	43	25	21	11	0
	Poor	**211**	46	36	10	5	4

Annex 3.5.1: Share of women who heard and who did not hear about the Pap test

% by line		No	Yes	No	I don't know
Total		**1,226**	**47**	**48**	**5**
Age	25-35	**431**	53	42	5
	36-45	**257**	55	39	6
	46-55	**232**	46	48	5
	56-61	**306**	31	65	4
Area	Urban	**597**	52	43	5
	Rural	**629**	42	53	5
Region	North	**320**	44	51	5
	Centre	**364**	42	51	7
	Chisinau	**277**	58	36	6
	South	**265**	45	54	1
Marital status	Unmarried	**107**	36	60	5
	Cohabitation	**46**	45	48	7
	Married	**884**	52	43	5
	Divorced	**89**	37	54	9
	Widow	**99**	23	75	2
Nationality	Moldovan/Romanian	**1,069**	48	46	5
	Russian	**51**	48	48	4
	Ukrainian	**32**	34	66	0
	Gagauzian	**60**	28	72	0
Education	Primary or lower	**31**	19	81	0
	Secondary	**336**	40	55	5
	Vocational	**562**	44	51	4
	Higher	**281**	63	31	6
Occupation	Unemployed	**375**	46	50	4
	Employed	**692**	51	43	5
	Retired	**152**	29	67	4
Financial status	Rich	**52**	47	51	2
	Average	**963**	52	43	5
	Poor	**211**	24	70	5

Annex 3.5.2: Share of women who knew exactly the purpose of the Pap test (* - N<30, must be carefully analysed)

% by line		No	Prevent cervical cancer	Detect changes in cervical cells	Detect vaginal infections	I don't know
Total		**575**	**48**	**34**	**7**	**11**
Age	25-35	**229**	51	30	10	10
	36-45	**143**	42	45	4	9
	46-55	**107**	53	31	7	10
	56-61	**96**	46	30	6	18
Area	Urban	**312**	42	39	8	11
	Rural	**263**	56	28	6	10
Region	North	**142**	51	28	11	11
	Centre	**152**	57	28	7	8
	Chisinau	**160**	39	41	4	15
	South	**120**	47	38	6	9
Marital status	Unmarried	**38**	40	36	15	8
	Cohabitation	**21***	62	28	5	5
	Married	**460**	48	35	6	10
	Divorced	**33**	60	18	10	12
	Widow	**23***	40	26	0	35
Nationality	Moldovan/Romanian	**516**	49	33	7	11
	Russian	**25***	40	40	8	12
	Ukrainian	**11***	37	27	18	18
	Gagauzian	**17***	41	53	6	0
Education	Primary or lower	**6***	33	33	0	33
	Secondary	**136**	48	30	8	14
	Vocational	**249**	47	34	8	11
	Higher	**177**	51	36	6	7
Occupation	Unemployed	**173**	48	30	9	13
	Employed	**355**	50	36	6	8
	Retired	**44**	44	29	5	23
Financial status	Rich	**25***	76	12	8	4
	Average	**499**	48	35	7	9
	Poor	**51**	8	27	35	29

Annex 3.5.3: Share of women who correctly indicated the sampling method for the Pap test (* - N<30, must be carefully analysed)

% by line		No	Collecting cervical cells	Detecting vaginal infections	Removing a tiny bit of the cervix	Visual examination of the woman's cervix	Other	I don't know
Total		**575**	**52**	**21**	**5**	**5**	**2**	**14**
Age	25-35	**229**	46	28	6	6	2	13
	36-45	**143**	61	17	5	4	3	10
	46-55	**107**	59	16	6	5	2	13
	56-61	**96**	47	20	3	4	0	26
Area	Urban	**312**	54	21	4	5	1	15
	Rural	**263**	51	22	7	4	3	14
Region	North	**142**	47	21	5	8	2	17
	Centre	**152**	48	26	6	2	3	15
	Chisinau	**160**	59	14	4	4	1	17
	South	**120**	56	25	7	4	1	7
Marital status	Unmarried	**38**	56	26	5	7	3	3
	Cohabitation	**21***	67	19	5	10	0	0
	Married	**460**	53	21	5	4	2	15
	Divorced	**33**	39	33	7	6	0	15
	Widow	**23***	48	9	0	0	0	43
Nationality	Moldovan/Romanian	**516**	53	21	6	4	2	14
	Russian	**25***	61	20	4	0	0	16
	Ukrainian	**11***	46	9	0	9	0	36
	Gagauzian	**17***	35	53	0	12	0	0
Education	Primary or lower	**6***	16	34	0	17	0	32
	Secondary	**136**	40	31	6	5	0	18
	Vocational	**249**	55	20	4	5	2	14
	Higher	**177**	60	16	7	4	2	10
Occupation	Unemployed	**173**	42	24	5	5	1	22
	Employed	**355**	59	20	6	5	2	9
	Retired	**44**	43	23	2	2	0	29
Financial status	Rich	**25***	64	20	0	4	4	8
	Average	**499**	54	21	5	5	2	14
	Poor	**51**	35	28	8	4	0	25

Annex 3.5.4: Share of women who correctly identified the target group of cervical screening(* - N<30, must be carefully analysed)

% by line		No	All women, regardless of their age	All women aged between 25 and 61 years	Only women over 65 years of age	All girls/women aged between 15 and 24 years	I don't know	Other
Total		**575**	**51**	**42**	**2**	**0**	**5**	**1**
Age	25-35	**229**	49	44	3	0	3	1
	36-45	**143**	47	47	1	0	4	0
	46-55	**107**	59	35	0	0	4	2
	56-61	**96**	51	36	3	0	10	0
Area	Urban	**312**	50	41	2	0	6	1
	Rural	**263**	52	43	2	0	4	0
Region	North	**142**	51	38	2	1	8	1
	Centre	**152**	58	35	1	0	5	1
	Chisinau	**160**	53	41	2	0	2	1
	South	**120**	39	55	2	0	3	1
Marital status	Unmarried	**38**	59	33	0	0	8	0
	Cohabitation	**21***	38	58	5	0	0	0
	Married	**460**	49	43	2	0	5	1
	Divorced	**33**	64	33	0	0	3	0
	Widow	**23***	65	22	9	0	4	0
Nationality	Moldovan/Romanian	**516**	51	41	2	0	5	1
	Russian	**25***	55	45	0	0	0	0
	Ukrainian	**11***	64	36	0	0	0	0
	Gagauzian	**17***	24	71	6	0	0	0
Education	Primary or lower	**6***	33	33	33	0	0	0
	Secondary	**136**	62	34	1	0	3	0
	Vocational	**249**	46	46	2	0	4	1
	Higher	**177**	50	43	2	1	5	1
Occupation	Unemployed	**173**	62	32	2	0	3	1
	Employed	**355**	44	48	2	0	5	1
	Retired	**44**	62	30	2	0	7	0
Financial status	Rich	**25***	32	60	0	4	4	0
	Average	**499**	50	42	2	0	5	1
	Poor	**51**	71	28	2	0	0	0

Annex 3.5.5: Share of women who know the frequency of the Pap test (* - N<30, must be carefully analysed)

% by line		No	Once a year	Once in 3 years	Once a lifetime	I don't know
Total		**575**	**52**	**34**	**4**	**10**
Age	25-35	**229**	50	36	4	10
	36-45	**143**	50	41	1	8
	46-55	**107**	57	27	4	12
	56-61	**96**	55	28	5	11
Area	Urban	**312**	55	34	3	8
	Rural	**263**	48	35	5	12
Region	North	**142**	58	28	3	11
	Centre	**152**	51	33	1	15
	Chisinau	**160**	57	34	3	6
	South	**120**	40	43	8	8
Marital status	Unmarried	**38**	59	31	8	3
	Cohabitation	**21***	47	38	5	10
	Married	**460**	50	36	3	11
	Divorced	**33**	55	33	0	12
	Widow	**23***	74	13	4	9
Nationality	Moldovan/Romanian	**516**	53	35	3	9
	Russian	**25***	43	37	8	12
	Ukrainian	**11***	65	9	0	27
	Gagauzian	**17***	18	47	17	18
Education	Primary or lower	**6***	49	33	0	17
	Secondary	**136**	57	30	3	10
	Vocational	**249**	50	34	5	11
	Higher	**177**	50	40	2	7
Occupation	Unemployed	**173**	53	32	4	10
	Employed	**355**	50	38	3	9
	Retired	**44**	63	16	5	16
Financial status	Rich	**25***	36	52	12	0
	Average	**499**	52	35	3	9
	Poor	**51**	59	20	2	20

Annex 3.5.6: Share of women who know that the Pap test is free of charge (* - N<30, must be carefully analysed)

% by line		No	I'm aware of it	I haven't heard of it	I don't know/I don't answer
Total		**575**	**47**	**51**	**2**
Age	25-35	**229**	43	55	2
	36-45	**143**	54	44	2
	46-55	**107**	53	46	1
	56-61	**96**	40	58	2
Area	Urban	**312**	46	52	2
	Rural	**263**	48	50	2
Region	North	**142**	44	51	4
	Centre	**152**	45	51	3
	Chisinau	**160**	49	51	0
	South	**120**	48	52	0
Marital status	Unmarried	**38**	45	45	11
	Cohabitation	**21***	62	38	0
	Married	**460**	46	52	2
	Divorced	**33**	57	43	0
	Widow	**23***	35	65	0
Nationality	Moldovan/Romanian	**516**	48	50	2
	Russian	**25***	49	51	0
	Ukrainian	**11***	35	65	0
	Gagauzian	**17***	29	71	0
Education	Primary or lower	**6***	33	51	16
	Secondary	**136**	45	55	1
	Vocational	**249**	48	50	2
	Higher	**177**	50	49	2
Occupation	Unemployed	**173**	41	56	2
	Employed	**355**	51	47	2
	Retired	**44**	36	62	2
Financial status	Rich	**25***	68	28	4
	Average	**499**	46	52	2
	Poor	**51**	41	55	4

Annex 3.5.7: Share of women who know where to go for a Pap test
(* - N<30, must be carefully analysed)

% by line		No	To the gynaecologist from the health centre	To the family doctor	To the office specialised in collecting cytological smears and prophylactic check-up within health centres	To the gynaecologist from the public hospital	Elsewhere	I don't know
Total		**575**	**50**	**19**	**17**	**9**	**0**	**20**
Age	25-35	**229**	55	15	17	7	0	21
	36-45	**143**	56	25	10	8	0	15
	46-55	**107**	39	22	23	15	1	20
	56-61	**96**	43	19	18	6	1	23
Area	Urban	**312**	53	18	16	9	0	18
	Rural	**263**	47	21	17	8	0	22
Region	North	**142**	45	20	18	8	0	17
	Centre	**152**	36	18	17	9	1	30
	Chisinau	**160**	60	18	12	9	1	17
	South	**120**	61	22	20	8	0	14
Marital status	Unmarried	**38**	50	14	13	18	0	21
	Cohabitation	**21***	57	19	19	5	0	14
	Married	**460**	51	19	16	8	0	19
	Divorced	**33**	46	30	25	9	0	12
	Widow	**23***	39	13	9	4	0	43
Nationality	Moldovan/Romanian	**516**	49	19	16	8	0	20
	Russian	**25***	56	8	29	12	0	16
	Ukrainian	**11***	36	37	17	9	0	9
	Gagauzian	**17***	88	17	18	18	0	6
Education	Primary or lower	**6***	33	34	16	33	0	16
	Secondary	**136**	48	23	12	7	0	23
	Vocational	**249**	49	20	23	10	0	17
	Higher	**177**	53	15	12	8	1	21
Occupation	Unemployed	**173**	51	21	17	8	0	20
	Employed	**355**	51	18	16	10	0	19
	Retired	**44**	41	25	16	9	2	23
Financial status	Rich	**25***	64	12	24	12	0	4
	Average	**499**	50	19	17	9	0	20
	Poor	**51**	51	28	8	4	0	23

Annex 3.5.8: Share of women who know about the Pap test effectiveness (* - N<30, must be carefully analysed)

% by line		No	It can be prevented in all cases	It can be prevented in most of the cases	It can be prevented in half of the cases	It can be prevented in few cases	It can't be prevented	I don't know
Total		**575**	**12**	**46**	**19**	**7**	**4**	**11**
Age	25-35	**229**	13	41	22	9	4	12
	36-45	**143**	13	51	17	6	6	7
	46-55	**107**	10	48	19	6	3	14
	56-61	**96**	13	47	16	7	4	14
Area	Urban	**312**	11	49	17	9	5	10
	Rural	**263**	14	43	22	6	3	13
Region	North	**142**	15	46	17	11	2	9
	Centre	**152**	18	43	13	4	4	17
	Chisinau	**160**	7	50	16	9	6	12
	South	**120**	8	43	33	6	5	5
Marital status	Unmarried	**38**	10	38	28	10	0	13
	Cohabitation	**21***	5	72	5	5	0	14
	Married	**460**	14	45	18	7	4	11
	Divorced	**33**	0	48	25	9	9	9
	Widow	**23***	0	53	21	4	4	18
Nationality	Moldovan/Romanian	**516**	13	47	17	7	4	12
	Russian	**25***	4	52	20	8	4	12
	Ukrainian	**11***	9	46	19	17	9	0
	Gagauzian	**17***	6	12	65	6	12	0
Education	Primary or lower	**6***	17	16	33	0	17	16
	Secondary	**136**	10	41	22	8	4	15
	Vocational	**249**	13	46	20	7	4	11
	Higher	**177**	12	51	16	8	5	8
Occupation	Unemployed	**173**	10	42	19	7	5	17
	Employed	**355**	14	47	19	8	4	8
	Retired	**44**	7	52	20	5	2	14
Financial status	Rich	**25***	20	44	16	4	8	8
	Average	**499**	13	47	19	7	3	11
	Poor	**51**	2	35	24	8	12	20

Annex 3.5.9: Share of women who know about the cervical screening service

% by line		No	Yes	No
Total		**1,226**	**24**	**76**
Age	25-35	**431**	24	76
	36-45	**257**	33	67
	46-55	**232**	27	73
	56-61	**306**	13	87
Area	Urban	**597**	28	72
	Rural	**629**	20	80
Region	North	**320**	26	74
	Centre	**364**	20	80
	Chisinau	**277**	33	67
	South	**265**	18	82
Marital status	Unmarried	**107**	18	82
	Cohabitation	**46**	28	72
	Married	**884**	26	74
	Divorced	**89**	24	76
	Widow	**99**	8	92
Nationality	Moldovan/Romanian	**1,069**	25	75
	Russian	**51**	29	71
	Ukrainian	**32**	21	79
	Gagauzian	**60**	3	97
Education	Primary or lower	**31**	3	97
	Secondary	**336**	18	82
	Vocational	**562**	23	77
	Higher	**281**	37	63
Occupation	Unemployed	**375**	21	79
	Employed	**692**	28	72
	Retired	**152**	11	89
Financial status	Rich	**52**	38	62
	Average	**963**	26	74
	Poor	**211**	9	91

Annex 3.5.10: Knowledge of the medical services where it is possible to do the free-of-charge cervical screening
(* - N<30, must be carefully analysed)

% by line		No	Family doctor	Gynaecologist from a health centre	Gynaecologist from a public hospital	Oncology Institute	Elsewher
Total		**293**	**35**	**46**	**13**	**3**	**2**
Age	25-35	**105**	33	52	8	3	4
	36-45	**85**	37	46	14	2	1
	46-55	**62**	32	44	16	5	3
	56-61	**40**	40	38	17	5	0
Area	Urban	**168**	33	45	15	4	3
	Rural	**125**	37	49	10	2	2
Region	North	**82**	29	52	13	4	2
	Centre	**71**	41	40	12	1	6
	Chisinau	**92**	35	48	10	5	1
	South	**48**	36	42	19	2	0
Marital status	Unmarried	**19***	49	41	0	5	5
	Cohabitation	**13***	30	62	0	0	8
	Married	**231**	35	46	15	3	2
	Divorced	**21***	23	42	16	14	5
	Widow	**8***	37	63	0	0	0
Nationality	Moldovan/Romanian	**266**	37	46	12	3	2
	Russian	**15***	20	46	27	6	0
	Ukrainian	**7***	28	43	0	15	14
	Gagauzian	**2***	0	49	51	0	0
Education	Primary or lower	**1***	100	0	0	0	0
	Secondary	**59**	39	43	14	5	0
	Vocational	**129**	30	49	14	4	3
	Higher	**104**	38	46	11	2	3
Occupation	Unemployed	**79**	38	44	15	2	0
	Employed	**197**	33	47	13	4	4
	Retired	**17***	47	53	0	0	0
Financial status	Rich	**20***	40	50	0	5	5
	Average	**254**	33	46	14	4	2
	Poor	**19***	53	42	5	0	0

Annex 3.5.11.1: Source of information about the free-of-charge cervical screening service (* - N<30, must be carefully analysed)

% by line		No	I haven't heard of this test until today	I heard of it from the family doctor/ nurse	I heard of it from the gynaecologist	I heard of it from the radio, TV, newspaper, magazine	I heard of it from a friend
Total		**293**	**2**	**43**	**36**	**18**	**16**
Age	25-35	**105**	2	36	35	19	13
	36-45	**85**	1	48	37	12	21
	46-55	**62**	2	44	39	21	13
	56-61	**40**	7	50	35	23	15
Area	Urban	**168**	2	44	35	17	13
	Rural	**125**	2	42	38	19	19
Region	North	**82**	5	35	36	17	19
	Centre	**71**	1	43	36	14	13
	Chisinau	**92**	1	47	28	25	14
	South	**48**	2	49	53	11	15
Marital status	Unmarried	**19***	5	31	33	20	10
	Cohabitation	**13***	0	46	24	0	23
	Married	**231**	2	43	37	18	16
	Divorced	**21***	9	42	37	24	21
	Widow	**8***	0	75	37	12	0
Nationality	Moldovan/Romanian	**266**	2	42	36	19	16
	Russian	**15***	0	73	27	7	0
	Ukrainian	**7***	15	14	57	0	14
	Gagauzian	**2***	0	49	51	0	100
Education	Primary or lower	**1***	0	100	100	0	0
	Secondary	**59**	2	36	37	17	19
	Vocational	**129**	3	46	40	13	17
	Higher	**104**	2	43	31	24	12
Occupation	Unemployed	**79**	2	44	33	18	14
	Employed	**197**	1	41	38	18	17
	Retired	**17**	12	58	36	18	0
Financial status	Rich	**20***	5	45	40	15	15
	Average	**254**	2	42	37	19	16
	Poor	**19***	0	58	27	11	10

Annex 3.5.11.2: Source of information about the free-of-charge cervical screening service (* - N<30, must be carefully analysed)

% by line		No	I heard of it from a family member	I heard of it from the oncologist	I don't remember	I heard of it from other sources
Total		**293**	**10**	**2**	**2**	**3**
Age	25-35	**105**	12	2	2	5
	36-45	**85**	11	3	2	1
	46-55	**62**	6	2	3	3
	56-61	**40**	10	0	2	0
Area	Urban	**168**	10	2	2	4
	Rural	**125**	11	2	2	2
Region	North	**82**	9	4	5	2
	Centre	**71**	6	2	1	6
	Chisinau	**92**	13	2	1	2
	South	**48**	15	0	2	0
Marital status	Unmarried	**19***	21	10	0	10
	Cohabitation	**13***	8	8	7	8
	Married	**231**	10	1	3	2
	Divorced	**21***	9	2	0	5
	Widow	**8***	0	0	0	0
Nationality	Moldovan/Romanian	**266**	11	2	2	3
	Russian	**15***	0	0	7	7
	Ukrainian	**7***	0	0	14	0
	Gagauzian	**2***	51	0	0	0
Education	Primary or lower	**1***	0	0	0	0
	Secondary	**59**	7	2	3	2
	Vocational	**129**	12	2	2	2
	Higher	**104**	10	2	3	5
Occupation	Unemployed	**79**	10	4	3	1
	Employed	**197**	11	2	2	4
	Retired	**17***	0	0	0	0
Financial status	Rich	**20***	20	0	0	5
	Average	**254**	10	3	2	3
	Poor	**19***	0	0	5	0

Annex 3.6.1: Share of women declaring they had the Pap test

% by line		No	Yes	No	I don't know
Total		**1,226**	**35**	**59**	**6**
Age	25-35	**431**	35	59	5
	36-45	**257**	46	49	5
	46-55	**232**	37	56	7
	56-61	**306**	24	69	7
Area	Urban	**597**	42	53	5
	Rural	**629**	29	64	7
Region	North	**320**	28	65	6
	Centre	**364**	35	58	8
	Chisinau	**277**	50	44	6
	South	**265**	29	68	3
Marital status	Unmarried	**107**	24	75	2
	Cohabitation	**46**	35	54	11
	Married	**884**	38	56	6
	Divorced	**89**	35	54	11
	Widow	**99**	20	78	2
Nationality	Moldovan/Romanian	**1,069**	36	57	6
	Russian	**51**	40	58	2
	Ukrainian	**32**	25	72	3
	Gagauzian	**60**	20	75	5
Education	Primary or lower	**31**	13	84	3
	Secondary	**336**	28	65	7
	Vocational	**562**	34	61	5
	Higher	**281**	49	44	7
Occupation	Unemployed	**375**	31	63	6
	Employed	**692**	40	54	6
	Retired	**152**	22	72	6
Financial status	Rich	**52**	40	58	2
	Average	**963**	39	56	5
	Poor	**211**	18	72	10

Annex 3.6.2: Share of women declaring they had the Pap test, after hearing its description

% by line		No	Yes	No	I don't know
Total		**1,226**	**36**	**59**	**5**
Age	25-35	**431**	37	59	4
	36-45	**257**	47	49	4
	46-55	**232**	41	53	6
	56-61	**306**	22	71	7
Area	Urban	**597**	41	55	4
	Rural	**629**	31	63	6
Region	North	**320**	34	61	5
	Centre	**364**	36	57	7
	Chisinau	**277**	46	52	2
	South	**265**	27	67	6
Marital status	Unmarried	**107**	22	74	4
	Cohabitation	**46**	37	56	7
	Married	**884**	40	55	5
	Divorced	**89**	35	57	8
	Widow	**99**	14	78	8
Nationality	Moldovan/Romanian	**1,069**	37	57	5
	Russian	**51**	40	56	4
	Ukrainian	**32**	15	72	12
	Gagauzian	**60**	17	80	3
Education	Primary or lower	**31**	6	90	3
	Secondary	**336**	28	65	7
	Vocational	**562**	34	60	6
	Higher	**281**	51	47	2
Occupation	Unemployed	**375**	31	63	6
	Employed	**692**	43	53	4
	Retired	**152**	16	77	7
Financial status	Rich	**52**	42	56	2
	Average	**963**	40	56	4
	Poor	**211**	18	71	11

Annex 3.6.3: Family doctor's recommendation to have the test, **general sample**

% by line		No	Yes	No	I don't remember
Total		**1,226**	**27**	**67**	**7**
Age	25-35	**431**	29	66	5
	36-45	**257**	34	60	6
	46-55	**232**	28	62	10
	56-61	**306**	16	77	7
Area	Urban	**597**	31	63	6
	Rural	**629**	23	70	7
Region	North	**320**	25	66	9
	Centre	**364**	25	66	9
	Chisinau	**277**	36	61	3
	South	**265**	21	74	5
Marital status	Unmarried	**107**	14	81	6
	Cohabitation	**46**	30	63	7
	Married	**884**	30	63	6
	Divorced	**89**	21	71	8
	Widow	**99**	10	81	9
Nationality	Moldovan/Romanian	**1,069**	27	66	7
	Russian	**51**	27	69	4
	Ukrainian	**32**	12	78	9
	Gagauzian	**60**	15	82	3
Education	Primary or lower	**31**	3	81	16
	Secondary	**336**	20	72	8
	Vocational	**562**	25	68	7
	Higher	**281**	40	56	4
Occupation	Unemployed	**375**	24	68	8
	Employed	**692**	31	63	6
	Retired	**152**	13	80	7
Financial status	Rich	**52**	30	64	6
	Average	**963**	30	64	6
	Poor	**211**	11	79	10

Annex 3.6.4: Family doctor's recommendation to have the test, **women who had the test** (* - N<30, must be carefully analysed)

% by line		No	Yes	No	I don't remember
Total		**440**	**67**	**29**	**4**
Age	25-35	**158**	68	29	4
	36-45	**120**	68	29	3
	46-55	**95**	66	30	4
	56-61	**67**	67	27	6
Area	Urban	**244**	67	29	4
	Rural	**196**	68	28	4
Region	North	**109**	68	25	7
	Centre	**132**	67	29	4
	Chisinau	**128**	67	30	2
	South	**72**	66	32	1
Marital status	Unmarried	**23***	64	36	0
	Cohabitation	**17***	70	23	6
	Married	**355**	69	27	4
	Divorced	**31**	57	40	3
	Widow	**14***	57	36	7
Nationality	Moldovan/Romanian	**400**	67	29	4
	Russian	**21***	62	38	0
	Ukrainian	**5***	79	21	0
	Gagauzian	**10***	80	20	0
Education	Primary or lower	**2***	51	0	49
	Secondary	**93**	66	29	5
	Vocational	**193**	67	29	4
	Higher	**144**	70	29	1
Occupation	Unemployed	**117**	68	27	4
	Employed	**295**	66	30	3
	Retired	**24***	71	21	8
Financial status	Rich	**22***	68	28	5
	Average	**381**	68	28	4
	Poor	**37**	60	35	5

Annex 3.6.5: Where did women go for the Pap test (* - N<30, must be carefully analysed)

% by line		No	To the family doctor	To the gynaecologist from the health centre	To the gynaecologist from the public hospital	To the gynaecologist from a private health care facility	To someone else	I don't know
Total		**440**	**25**	**48**	**17**	**9**	**1**	**0**
Age	25-35	**158**	23	50	15	12	0	0
	36-45	**120**	28	45	15	12	0	0
	46-55	**95**	26	48	22	3	0	1
	56-61	**67**	22	51	15	7	4	0
Area	Urban	**244**	22	49	18	11	1	0
	Rural	**196**	28	48	15	8	1	0
Region	North	**109**	18	54	15	13	0	0
	Centre	**132**	29	46	13	11	1	1
	Chisinau	**128**	28	40	21	9	2	0
	South	**72**	20	59	19	1	0	0
Marital status	Unmarried	**23***	30	44	13	13	0	0
	Cohabitation	**17***	17	47	24	12	0	0
	Married	**355**	25	47	18	9	1	0
	Divorced	**31**	23	57	8	12	0	0
	Widow	**14***	29	64	0	7	0	0
Nationality	Moldovan/Romanian	**400**	26	48	16	9	1	0
	Russian	**21***	19	43	20	19	0	0
	Ukrainian	**5***	20	80	0	0	0	0
	Gagauzian	**10***	0	31	69	0	0	0
Education	Primary or lower	**2***	0	49	51	0	0	0
	Secondary	**93**	30	48	15	6	0	0
	Vocational	**193**	25	51	16	9	1	0
	Higher	**144**	23	46	17	12	1	1
Occupation	Unemployed	**117**	20	56	17	7	0	1
	Employed	**295**	27	46	15	11	0	0
	Retired	**24***	21	45	25	0	8	0
Financial status	Rich	**22***	45	28	9	14	5	0
	Average	**381**	23	48	18	10	1	0
	Poor	**37**	24	65	11	0	0	0

Annex 3.6.6: Frequency of the Pap test (* - N<30, must be carefully analysed)

% by line		No	Once a year	Once in 2 years	Once in 3 years	Once in 4-5 years	More seldom than once in 5 years	I don't know
Total		**440**	**28**	**20**	**30**	**6**	**8**	**7**
Age	25-35	**158**	35	17	27	5	7	9
	36-45	**120**	25	28	31	6	6	3
	46-55	**95**	27	16	32	8	12	5
	56-61	**67**	22	21	31	9	9	7
Area	Urban	**244**	29	18	32	7	8	6
	Rural	**196**	27	24	27	6	8	7
Region	North	**109**	25	18	24	11	13	10
	Centre	**132**	35	27	22	3	5	8
	Chisinau	**128**	31	20	33	6	8	2
	South	**72**	18	13	48	6	8	7
Marital status	Unmarried	**23***	28	30	34	8	0	0
	Cohabitation	**17***	29	18	24	18	6	6
	Married	**355**	29	20	30	5	8	7
	Divorced	**31**	22	10	38	11	13	6
	Widow	**14***	28	36	14	7	7	7
Nationality	Moldovan/Romanian	**400**	28	22	30	7	7	6
	Russian	**21***	38	15	19	0	14	14
	Ukrainian	**5***	20	0	61	0	0	19
	Gagauzian	**10***	0	0	60	20	20	0
Education	Primary or lower	**2***	51	49	0	0	0	0
	Secondary	**93**	24	26	26	6	14	3
	Vocational	**193**	27	18	33	7	8	7
	Higher	**144**	33	20	29	5	5	8
Occupation	Unemployed	**117**	32	18	33	7	3	6
	Employed	**295**	28	21	29	7	9	6
	Retired	**24***	21	21	21	4	21	13
Financial status	Rich	**22***	27	13	41	18	0	0
	Average	**381**	29	21	28	6	9	7
	Poor	**37**	19	16	46	0	8	11

Annex 3.6.7: When the latest Pap test was done (* - N<30, must be carefully analysed)

% by line		No	6 months ago	1 year ago	2 years ago	3 years ago	4-5 years ago	More than 5 years ago	I don't know
Total		**440**	**26**	**35**	**20**	**8**	**4**	**5**	**1**
Age	25-35	**158**	30	34	20	8	3	4	1
	36-45	**120**	27	42	17	10	2	2	1
	46-55	**95**	24	31	19	12	3	10	1
	56-61	**67**	21	30	30	1	9	7	1
Area	Urban	**244**	26	34	19	10	4	5	1
	Rural	**196**	27	36	22	6	3	5	1
Region	North	**109**	25	29	22	13	4	6	1
	Centre	**132**	32	37	18	7	2	2	2
	Chisinau	**128**	29	36	16	6	4	8	1
	South	**72**	13	38	30	7	6	6	1
Marital status	Unmarried	**23***	26	57	8	4	4	0	0
	Cohabitation	**17***	35	24	12	11	12	6	0
	Married	**355**	26	35	21	8	3	5	1
	Divorced	**31**	22	26	19	17	0	13	3
	Widow	**14***	28	29	29	0	7	0	7
Nationality	Moldovan/Romanian	**400**	27	35	20	8	4	5	1
	Russian	**21***	39	28	10	9	5	5	5
	Ukrainian	**5***	0	81	19	0	0	0	0
	Gagauzian	**10***	0	10	60	20	10	0	0
Education	Primary or lower	**2***	51	0	49	0	0	0	0
	Secondary	**93**	26	34	16	8	7	9	1
	Vocational	**193**	26	36	20	10	3	4	1
	Higher	**144**	28	33	23	7	3	4	1
Occupation	Unemployed	**117**	22	37	23	13	3	3	0
	Employed	**295**	29	35	17	7	4	6	1
	Retired	**24***	17	25	42	4	4	9	0
Financial status	Rich	**22***	23	36	32	4	5	0	0
	Average	**381**	27	34	20	9	4	5	1
	Poor	**37**	22	48	14	8	0	8	0

Annex 3.6.7: Reason for seeing the doctor when the Pap test was done (* - N<30, must be carefully analysed)

% by line		No	I was pregnant	I had some gynaecological issues	A routine gynaecological check-up	When I went for family planning services	Particularly for requesting a Pap test	Other	I don't know
Total		**440**	**8**	**22**	**41**	**9**	**15**	**3**	**3**
Age	25-35	**158**	17	23	35	9	13	3	1
	36-45	**120**	5	22	45	7	16	2	3
	46-55	**95**	1	18	46	6	20	4	4
	56-61	**67**	0	27	43	16	9	0	4
Area	Urban	**244**	8	24	37	11	15	3	3
	Rural	**196**	7	20	47	7	15	3	2
Region	North	**109**	9	18	48	4	19	3	0
	Centre	**132**	8	25	34	12	14	4	4
	Chisinau	**128**	8	20	41	10	15	2	4
	South	**72**	6	28	45	8	10	1	1
Marital status	Unmarried	**23***	4	22	47	6	17	0	4
	Cohabitation	**17***	6	41	35	0	12	0	6
	Married	**355**	9	21	43	8	14	3	2
	Divorced	**31**	3	28	32	14	19	0	3
	Widow	**14***	0	21	22	21	29	0	7
Nationality	Moldovan/Romanian	**400**	8	21	42	9	14	3	2
	Russian	**21***	5	14	29	10	38	0	5
	Ukrainian	**5***	0	40	39	0	21	0	0
	Gagauzian	**10***	0	41	50	10	0	0	0
Education	Primary or lower	**2***	0	51	49	0	0	0	0
	Secondary	**93**	12	24	41	9	10	1	3
	Vocational	**193**	4	28	42	6	16	4	1
	Higher	**144**	9	12	42	13	18	3	3
Occupation	Unemployed	**117**	15	16	39	9	15	3	3
	Employed	**295**	5	24	42	8	15	3	2
	Retired	**24***	0	29	37	17	13	0	4
Financial status	Rich	**22***	5	27	45	9	9	4	0
	Average	**381**	8	21	41	9	16	3	3
	Poor	**37**	8	30	43	11	5	0	3

Annex 3.6.8: Initiative to do the latest Pap test (* - N<30, must be carefully analysed)

% by line		No	I asked for it	The family doctor's nurse suggested it	The family doctor suggested it	The gynaecologist suggested it	I don't know/remember	Someone else
Total		**440**	**22**	**15**	**25**	**36**	**2**	**1**
Age	25-35	**158**	24	13	26	38	0	0
	36-45	**120**	18	14	27	39	2	0
	46-55	**95**	25	20	23	25	4	2
	56-61	**67**	19	12	24	39	5	2
Area	Urban	**244**	23	11	26	37	1	1
	Rural	**196**	20	19	24	34	4	1
Region	North	**109**	25	16	27	29	2	0
	Centre	**132**	16	19	23	37	3	2
	Chisinau	**128**	26	12	24	37	1	0
	South	**72**	18	8	29	40	3	1
Marital status	Unmarried	**23***	17	16	22	45	0	0
	Cohabitation	**17***	24	6	47	18	6	0
	Married	**355**	22	15	25	36	2	1
	Divorced	**31**	28	13	20	35	3	0
	Widow	**14***	7	7	35	42	7	0
Nationality	Moldovan/Romanian	**400**	21	15	25	36	2	1
	Russian	**21***	28	19	19	28	0	5
	Ukrainian	**5***	59	20	21	0	0	0
	Gagauzian	**10***	10	10	60	20	0	0
Education	Primary or lower	**2***	0	51	0	49	0	0
	Secondary	**93**	18	11	25	43	3	0
	Vocational	**193**	20	16	30	33	1	1
	Higher	**144**	28	15	22	33	1	1
Occupation	Unemployed	**117**	26	9	21	40	3	0
	Employed	**295**	20	18	27	33	2	1
	Retired	**24***	29	0	29	38	0	4
Financial status	Rich	**22***	18	13	36	32	0	0
	Average	**381**	23	15	25	35	2	1
	Poor	**37**	8	14	27	49	3	0

Annex 3.6.9: Way of having the test (* - N<30, must be carefully analysed)

% by line		No	I didn't pay	I paid	I don't remember
Total		**440**	**70**	**24**	**6**
Age	25-35	**158**	63	31	6
	36-45	**120**	72	22	6
	46-55	**95**	71	19	10
	56-61	**67**	81	15	5
Area	Urban	**244**	69	24	7
	Rural	**196**	71	23	6
Region	North	**109**	77	17	6
	Centre	**132**	70	24	6
	Chisinau	**128**	70	27	3
	South	**72**	60	27	13
Marital status	Unmarried	**23***	61	26	13
	Cohabitation	**17***	71	23	6
	Married	**355**	71	24	6
	Divorced	**31**	70	21	10
	Widow	**14***	64	29	7
Nationality	Moldovan/Romanian	**400**	69	24	7
	Russian	**21***	67	33	0
	Ukrainian	**5***	59	41	0
	Gagauzian	**10***	90	0	10
Education	Primary or lower	**2***	100	0	0
	Secondary	**93**	74	18	7
	Vocational	**193**	72	22	6
	Higher	**144**	65	30	5
Occupation	Unemployed	**117**	65	28	7
	Employed	**295**	71	23	6
	Retired	**24***	87	8	4
Financial status	Rich	**22***	73	23	5
	Average	**381**	69	25	6
	Poor	**37**	76	14	11

Annex 3.6.10: Gender of the person who took the Pap smear (* - N<30, must be carefully analysed)

% by line		No	Male	Female	I don't know/I don't answer
Total		**440**	**9**	**88**	**3**
Age	25-35	**158**	7	92	1
	36-45	**120**	8	88	4
	46-55	**95**	12	85	3
	56-61	**67**	12	87	2
Area	Urban	**244**	8	91	1
	Rural	**196**	10	85	4
Region	North	**109**	9	87	4
	Centre	**132**	12	87	2
	Chisinau	**128**	7	92	1
	South	**72**	7	87	6
Marital status	Unmarried	**23***	19	81	0
	Cohabitation	**17***	6	88	6
	Married	**355**	8	90	3
	Divorced	**31**	10	90	0
	Widow	**14***	29	64	7
Nationality	Moldovan/Romanian	**400**	10	88	3
	Russian	**21***	5	95	0
	Ukrainian	**5***	0	100	0
	Gagauzian	**10***	0	100	0
Education	Primary or lower	**2***	49	51	0
	Secondary	**93**	5	92	3
	Vocational	**193**	10	87	2
	Higher	**144**	10	88	3
Occupation	Unemployed	**117**	3	94	3
	Employed	**295**	11	86	3
	Retired	**24***	8	92	0
Financial status	Rich	**22***	4	96	0
	Average	**381**	9	88	3
	Poor	**37**	11	89	0

Annex 3.7.1: Informing the women about the results of the latest Pap test, (* - N<30, must be carefully analysed)

% by line		No	Yes	No, because the doctor told me he/she would not contact me if the result was good	No, and I assumed I was not contacted because the result was good	I don't know/remember
Total		**440**	**73**	**15**	**7**	**5**
Age	25-35	**158**	77	13	6	4
	36-45	**120**	71	17	8	4
	46-55	**95**	72	15	6	6
	56-61	**67**	70	18	6	6
Area	Urban	**244**	77	14	4	4
	Rural	**196**	68	17	10	5
Region	North	**109**	74	11	10	5
	Centre	**132**	74	13	6	7
	Chisinau	**128**	79	14	4	3
	South	**72**	61	28	7	4
Marital status	Unmarried	**23***	74	9	17	0
	Cohabitation	**17***	71	12	6	12
	Married	**355**	74	16	6	4
	Divorced	**31**	68	19	7	7
	Widow	**14***	64	14	7	14
Nationality	Moldovan/Romanian	**400**	75	14	6	5
	Russian	**21***	61	29	5	5
	Ukrainian	**5***	59	0	41	0
	Gagauzian	**10***	20	60	10	10
Education	Primary or lower	**2***	51	0	0	49
	Secondary	**93**	68	18	7	7
	Vocational	**193**	71	17	7	4
	Higher	**144**	78	12	6	3
Occupation	Unemployed	**117**	73	17	6	3
	Employed	**295**	73	14	8	5
	Retired	**24***	71	21	0	8
Financial status	Rich	**22***	77	9	9	5
	Average	**381**	75	15	6	4
	Poor	**37**	57	24	11	8

Annex 3.7.2: The way of being communicated the results of the latest Pap test women had, (* - N<30, must be carefully analysed)

% by line		No	I was contacted by the family doctor	I was contacted by the gynaecologist	I went there in person to ask about the test result	Another way
Total		**322**	**28**	**19**	**53**	**1**
Age	25-35	**122**	27	23	49	1
	36-45	**85**	25	12	64	0
	46-55	**68**	37	16	47	0
	56-61	**47**	24	23	51	2
Area	Urban	**188**	22	16	61	1
	Rural	**134**	36	22	42	0
Region	North	**81**	32	26	43	0
	Centre	**97**	35	19	45	1
	Chisinau	**101**	21	11	68	1
	South	**44**	23	24	53	0
Marital status	Unmarried	**17***	34	17	49	0
	Cohabitation	**12***	17	9	75	0
	Married	**263**	29	19	51	1
	Divorced	**21***	30	19	51	0
	Widow	**9***	12	10	78	0
Nationality	Moldovan/Romanian	**302**	29	18	52	1
	Russian	**13***	8	30	63	0
	Ukrainian	**3***	32	0	68	0
	Gagauzian	**2***	0	50	50	0
Education	Primary or lower	**1***	0	100	0	0
	Secondary	**64**	32	16	53	0
	Vocational	**138**	32	17	51	1
	Higher	**113**	23	19	57	1
Occupation	Unemployed	**86**	30	15	53	1
	Employed	**217**	28	19	52	0
	Retired	**17***	12	24	65	0
Financial status	Rich	**17***	36	24	40	0
	Average	**285**	27	18	54	1
	Poor	**21***	33	24	42	0

Annex 3.7.3: Share of women who discussed the Pap test result with the doctor, (* - N<30, must be carefully analysed)

% by line		No	Yes	No	I don't know
Total		**322**	**82**	**15**	**3**
Age	25-35	**122**	77	20	2
	36-45	**85**	85	12	4
	46-55	**68**	88	12	0
	56-61	**47**	83	10	6
Area	Urban	**188**	82	17	2
	Rural	**134**	83	12	5
Region	North	**81**	81	16	4
	Centre	**97**	85	9	5
	Chisinau	**101**	79	21	0
	South	**44**	86	12	2
Marital status	Unmarried	**17***	71	29	0
	Cohabitation	**12***	84	16	0
	Married	**263**	84	12	3
	Divorced	**21***	63	37	0
	Widow	**9***	100	0	0
Nationality	Moldovan/Romanian	**302**	83	14	3
	Russian	**13**	54	46	0
	Ukrainian	**3***	68	32	0
	Gagauzian	**2***	100	0	0
Education	Primary or lower	**1***	100	0	0
	Secondary	**64**	83	14	3
	Vocational	**138**	83	14	2
	Higher	**113**	83	17	1
Occupation	Unemployed	**86**	78	18	4
	Employed	**217**	83	14	2
	Retired	**17***	88	6	6
Financial status	Rich	**17***	88	12	0
	Average	**285**	82	15	3
	Poor	**21***	86	14	0

Annex 3.7.4: Share of women with an abnormal Pap test result, (* - N<30, must be carefully analysed)

% by line		No	Yes	No	I don't know/remember
Total		**440**	**4**	**93**	**3**
Age	25-35	**158**	2	96	3
	36-45	**120**	5	92	3
	46-55	**95**	11	86	3
	56-61	**67**	2	97	2
Area	Urban	**244**	5	94	1
	Rural	**196**	4	92	5
Region	North	**109**	5	92	3
	Centre	**132**	2	96	2
	Chisinau	**128**	6	93	1
	South	**72**	4	89	7
Marital status	Unmarried	**23***	2	94	4
	Cohabitation	**17***	12	88	0
	Married	**355**	4	93	3
	Divorced	**31***	6	90	3
	Widow	**14***	7	85	7
Nationality	Moldovan/Romanian	**400**	5	93	3
	Russian	**21***	0	100	0
	Ukrainian	**5***	0	100	0
	Gagauzian	**10***	0	100	0
Education	Primary or lower	**2***	0	100	0
	Secondary	**93**	5	90	5
	Vocational	**193**	4	93	3
	Higher	**144**	5	94	1
Occupation	Unemployed	**117**	0	97	3
	Employed	**295**	6	91	3
	Retired	**24***	9	91	0
Financial status	Rich	**22***	0	95	5
	Average	**381**	5	93	2
	Poor	**37**	6	89	5

Annex 3.8.1.1: Perceived barriers to doing the Pap test

AVERAGE		No	My family doctor never suggests a Pap test	Lack of time	I don't know where to go to have the Pap test	Waiting time at the doctor/the line is too long	Fear of finding atypical cells or cancer	The gynaecological examination is unpleasant	I don't like the behaviour of the medical staff
Total		**1,226**	**3.01**	**3.00**	**2.95**	**2.95**	**2.93**	**2.72**	**2.65**
Age	25-35	**431**	2.99	2.92	2.86	2.95	2.89	2.68	2.58
	36-45	**257**	2.83	3.12	2.78	2.86	2.93	2.73	2.64
	46-55	**232**	3.10	3.00	2.94	2.98	2.90	2.68	2.64
	56-61	**306**	3.12	3.04	3.22	2.98	3.03	2.78	2.76
Area	Urban	**597**	2.81	2.97	2.77	2.94	2.94	2.63	2.59
	Rural	**629**	3.21	3.04	3.12	2.95	2.93	2.81	2.70
Region	North	**320**	2.98	2.98	2.98	2.92	2.94	2.64	2.79
	Centre	**364**	3.20	2.97	3.23	3.02	2.90	2.61	2.66
	Chisinau	**277**	2.60	2.95	2.57	2.92	2.90	2.59	2.42
	South	**265**	3.22	3.12	2.91	2.90	3.01	3.10	2.70
Marital status	Unmarried	**107**	3.10	2.99	3.13	2.97	3.16	2.88	2.66
	Cohabitation	**46**	3.03	2.73	2.79	2.86	2.80	2.59	2.53
	Married	**884**	2.95	2.98	2.86	2.88	2.85	2.67	2.61
	Divorced	**89**	3.12	3.26	3.19	3.37	3.30	3.09	2.73
	Widow	**99**	3.38	3.13	3.41	3.18	3.16	2.71	2.96
Nationality	Moldovan/Romanian	**1,069**	3.01	2.99	2.98	2.95	2.93	2.68	2.65
	Russian	**51**	2.70	2.63	2.36	2.79	2.81	2.47	2.34
	Ukrainian	**32**	3.18	3.20	3.31	3.14	3.20	2.76	2.97
	Gagauzian	**60**	3.22	3.44	2.75	2.89	3.08	3.32	2.67
Education	Primary or lower	**31**	3.29	3.26	3.01	2.59	3.00	3.10	2.79
	Secondary	**336**	3.26	3.12	3.14	3.14	3.11	2.87	2.74
	Vocational	**562**	2.95	2.93	2.96	2.89	2.87	2.70	2.60
	Higher	**281**	2.78	2.94	2.66	2.84	2.81	2.48	2.56
Occupation	Unemployed	**375**	3.15	3.05	3.05	2.99	3.01	2.78	2.72
	Employed	**692**	2.89	3.00	2.79	2.93	2.86	2.67	2.60
	Retired	**152**	3.18	2.89	3.39	2.94	3.08	2.75	2.67
Financial status	Rich	**52**	2.86	2.99	2.91	2.81	3.02	2.82	2.74
	Average	**963**	2.93	2.96	2.87	2.86	2.89	2.63	2.60
	Poor	**211**	3.45	3.20	3.33	3.37	3.13	3.12	2.82

Annex 3.8.1.2: Perceived barriers to doing the Pap test

AVERAGE		No	It is difficult to communicate with the doctors	The family doctor is too far away	I don't think the Pap test is necessary	I'm too tired to think about preventive tests	The Pap test is painful	Doctors could say I'm complaining/coming to them for no reason	I'm bothered by the doctor's gender
Total		**1,226**	**2.60**	**2.55**	**2.54**	**2.53**	**2.51**	**2.46**	**2.31**
Age	25-35	**431**	2.50	2.43	2.34	2.39	2.45	2.37	2.27
	36-45	**257**	2.53	2.47	2.58	2.46	2.59	2.48	2.38
	46-55	**232**	2.67	2.56	2.55	2.62	2.52	2.48	2.33
	56-61	**306**	2.76	2.80	2.77	2.73	2.53	2.58	2.30
Area	Urban	**597**	2.43	2.34	2.46	2.47	2.48	2.35	2.23
	Rural	**629**	2.77	2.76	2.61	2.59	2.54	2.58	2.38
Region	North	**320**	2.66	2.61	2.53	2.68	2.57	2.56	2.26
	Centre	**364**	2.78	2.61	2.41	2.49	2.50	2.51	2.28
	Chisinau	**277**	2.23	2.21	2.35	2.36	2.40	2.20	2.11
	South	**265**	2.69	2.77	2.92	2.59	2.59	2.57	2.62
Marital status	Unmarried	**107**	2.71	2.45	2.74	2.64	2.64	2.39	2.29
	Cohabitation	**46**	2.25	2.12	2.38	2.36	2.54	2.30	2.38
	Married	**884**	2.59	2.54	2.45	2.46	2.45	2.42	2.29
	Divorced	**89**	2.53	2.76	2.81	2.82	2.96	2.76	2.18
	Widow	**99**	2.85	2.84	2.87	2.90	2.54	2.74	2.62
Nationality	Moldovan/Romanian	**1,069**	2.61	2.54	2.50	2.54	2.51	2.47	2.27
	Russian	**51**	2.02	2.42	2.35	2.34	2.17	2.19	2.12
	Ukrainian	**32**	2.55	2.76	2.33	2.68	2.67	2.43	2.49
	Gagauzian	**60**	2.95	2.80	3.38	2.43	2.75	2.62	2.96
Education	Primary or lower	**31**	2.85	3.16	3.32	2.62	2.59	2.62	2.53
	Secondary	**336**	2.63	2.63	2.68	2.65	2.62	2.58	2.37
	Vocational	**562**	2.60	2.56	2.48	2.52	2.48	2.43	2.29
	Higher	**281**	2.49	2.34	2.32	2.37	2.40	2.32	2.28
Occupation	Unemployed	**375**	2.69	2.62	2.55	2.48	2.55	2.52	2.25
	Employed	**692**	2.54	2.46	2.47	2.50	2.50	2.39	2.33
	Retired	**152**	2.67	2.79	2.77	2.74	2.42	2.64	2.35
Financial status	Rich	**52**	2.77	2.43	2.81	2.69	2.89	2.58	2.31
	Average	**963**	2.55	2.47	2.45	2.48	2.43	2.38	2.28
	Poor	**211**	2.78	2.97	2.85	2.71	2.82	2.83	2.43

Annex 3.9.1: Satisfaction with the health care services that collected the Pap smear, (* - N<30, must be carefully analysed)

% by line		No	Very satisfied	Satisfied	Neither satisfied, nor dissatisfied	Dissatisfied	Very dissatisfied
Total		**440**	**24**	**63**	**10**	**3**	**0**
Age	25-35	**158**	25	60	12	3	0
	36-45	**120**	18	70	8	3	1
	46-55	**95**	26	63	10	2	0
	56-61	**67**	27	60	9	4	0
Area	Urban	**244**	22	63	11	3	0
	Rural	**196**	25	63	9	2	1
Region	North	**109**	26	63	10	1	0
	Centre	**132**	27	63	8	2	1
	Chisinau	**128**	22	62	11	5	0
	South	**72**	17	66	13	4	0
Marital status	Unmarried	**23***	21	62	17	0	0
	Cohabitation	**17***	30	65	6	0	0
	Married	**355**	24	64	9	3	0
	Divorced	**31**	23	55	19	3	0
	Widow	**14***	7	72	14	7	0
Nationality	Moldovan/Romanian	**400**	23	64	9	3	0
	Russian	**21***	29	62	9	0	0
	Ukrainian	**5***	20	40	21	19	0
	Gagauzian	**10***	20	40	40	0	0
Education	Primary or lower	**2***	0	51	49	0	0
	Secondary	**93**	21	68	12	0	0
	Vocational	**193**	26	59	10	4	1
	Higher	**144**	24	65	8	3	0
Occupation	Unemployed	**117**	27	64	7	2	0
	Employed	**295**	23	63	10	3	0
	Retired	**24***	21	58	17	4	0
Financial status	Rich	**22***	37	50	14	0	0
	Average	**381**	24	64	10	3	0
	Poor	**37**	14	70	11	3	3

Annex 3.9.2.1: Satisfaction with the heath care accessibility of the women who had the Pap test, (* - N<30, must be carefully analysed)

AVERAGE		No	Ease in accessing the screening services	Distance from home to the place where cervical screening service is provided	Travelling costs to the place where cervical screening service is provided	Waiting time until the appointment for a Pap test
Total		**440**	**4.04**	**3.76**	**3.85**	**3.86**
Age	25-35	**158**	4.18	3.77	3.88	3.91
	36-45	**120**	4.01	3.81	3.84	3.73
	46-55	**95**	3.90	3.76	3.81	3.82
	56-61	**67**	3.96	3.64	3.83	4.06
Area	Urban	**244**	4.08	3.87	3.99	3.93
	Rural	**196**	3.98	3.63	3.67	3.78
Region	North	**109**	4.03	3.76	3.82	3.92
	Centre	**132**	4.06	3.62	3.63	3.88
	Chisinau	**128**	4.05	3.86	4.05	3.92
	South	**72**	3.99	3.84	3.93	3.64
Marital status	Unmarried	**23***	4.13	3.74	4.00	3.83
	Cohabitation	**17***	4.20	3.89	3.95	3.78
	Married	**355**	4.02	3.76	3.84	3.88
	Divorced	**31**	4.21	3.75	3.97	3.66
	Widow	**14***	3.77	3.54	3.49	4.07
Nationality	Moldovan/Romanian	**400**	4.05	3.74	3.85	3.86
	Russian	**21***	4.38	3.95	4.09	4.15
	Ukrainian	**5***	3.03	3.23	3.42	4.02
	Gagauzian	**10***	3.69	4.20	3.60	3.33
Education	Primary or lower	**2***	4.01	4.51	4.01	4.51
	Secondary	**93**	4.08	3.69	3.72	3.78
	Vocational	**193**	3.97	3.72	3.85	3.75
	Higher	**144**	4.12	3.84	3.92	4.04
Occupation	Unemployed	**117**	4.14	3.72	3.91	3.80
	Employed	**295**	4.02	3.79	3.83	3.89
	Retired	**24***	3.79	3.54	3.62	3.95
Financial status	Rich	**22***	3.91	3.74	3.83	4.28
	Average	**381**	4.06	3.78	3.86	3.88
	Poor	**37**	3.92	3.62	3.72	3.49

Annex 3.9.2.2: Satisfaction with the heath care accessibility of the women who had the Pap test, (* - N<30, must be carefully analysed; ** - all respondents in this category answered to this question with 'I don't know')

AVERAGE		No	The person who performed the cervical screening was male	The person who performed the cervical screening was female	Family's attitude towards the decision to go to a doctor for cervical screening
Total		**440**	**3.82**	**4.27**	**4.18**
Age	25-35	**158**	3.55	4.34	4.26
	36-45	**120**	4.06	4.18	4.03
	46-55	**95**	3.69	4.29	4.19
	56-61	**67**	4.00	4.26	4.20
Area	Urban	**244**	3.73	4.27	4.16
	Rural	**196**	3.89	4.27	4.19
Region	North	**109**	3.72	4.29	4.15
	Centre	**132**	3.65	4.38	4.30
	Chisinau	**128**	4.20	4.24	4.14
	South	**72**	3.88	4.12	4.07
Marital status	Unmarried	**23**	4.00	4.36	4.23
	Cohabitation	**17**	2.54	4.44	3.95
	Married	**355**	3.77	4.30	4.20
	Divorced	**31**	4.67	4.04	4.09
	Widow	**14**	4.00	3.44	3.94
Nationality	Moldovan/Romanian	**400**	3.86	4.30	4.16
	Russian	**21**	2.00	4.22	4.43
	Ukrainian**	**5**	.	3.43	3.78
	Gagauzian**	**10**	.	3.81	4.43
Education	Primary or lower	**2**	4.00	5.00	5.00
	Secondary	**93**	4.00	4.24	4.14
	Vocational	**193**	3.66	4.25	4.14
	Higher	**144**	3.95	4.34	4.25
Occupation	Unemployed	**117**	4.00	4.34	4.18
	Employed	**295**	3.77	4.28	4.19
	Retired	**24**	4.00	3.96	3.96
Financial status	Rich	**22**	1.00	4.50	4.09
	Average	**381**	3.84	4.26	4.19
	Poor	**37**	4.25	4.24	4.07

Annex 3.9.3: Satisfaction with the heath care quality of the women who had the Pap test

AVERAGE		No	Time spent in the waiting room	The way the medical examination took place	The way the procedure was explained to me	The way I was given answers to my questions	Attention and respect from the medical staff	The way the Pap test result was explained to me	Cervical screening service quality
Total		**440**	**3.79**	**4.15**	**4.06**	**4.06**	**4.12**	**3.90**	**4.16**
Age	25-35	**158**	3.75	4.18	4.11	4.09	4.08	3.89	4.23
	36-45	**120**	3.86	4.06	3.93	3.96	4.07	3.93	4.13
	46-55	**95**	3.70	4.19	4.12	4.11	4.18	3.94	4.17
	56-61	**67**	3.90	4.18	4.08	4.10	4.21	3.84	4.03
Area	Urban	**244**	3.80	4.18	4.03	4.05	4.10	3.93	4.14
	Rural	**196**	3.78	4.11	4.09	4.08	4.15	3.87	4.18
Region	North	**109**	3.81	4.13	4.02	4.12	4.17	3.92	4.20
	Centre	**132**	3.90	4.18	4.09	4.07	4.15	3.95	4.21
	Chisinau	**128**	3.79	4.16	4.01	3.98	4.05	3.85	4.14
	South	**72**	3.57	4.13	4.16	4.10	4.10	3.86	4.05
Marital status	Unmarried	**23**	3.65	4.00	3.91	4.04	3.95	3.95	4.18
	Cohabitation	**17**	3.66	4.01	3.94	3.95	3.77	3.60	3.95
	Married	**355**	3.80	4.18	4.06	4.07	4.14	3.92	4.19
	Divorced	**31**	3.85	4.12	4.24	4.24	4.24	3.90	4.11
	Widow	**14**	3.78	3.84	3.91	3.68	3.99	3.68	3.78
Nationality	Moldovan/ Romanian	**400**	3.79	4.15	4.06	4.04	4.11	3.91	4.17
	Russian	**21**	4.24	4.20	4.14	4.38	4.34	4.00	4.38
	Ukrainian	**5**	3.21	3.41	3.63	4.19	4.41	3.82	3.62
	Gagauzian	**10**	3.00	4.40	3.89	4.09	3.79	3.48	3.41
Education	Primary or lower	**2**	3.51	4.51	4.00	4.01	4.49	3.00	4.51
	Secondary	**93**	3.75	4.23	4.11	4.10	4.13	3.90	4.10
	Vocational	**193**	3.67	4.07	3.99	4.03	4.06	3.78	4.16
	Higher	**144**	3.95	4.21	4.14	4.14	4.20	4.07	4.22
Occupation	Unemployed	**117**	3.82	4.19	4.07	4.04	4.11	3.98	4.21
	Employed	**295**	3.79	4.13	4.07	4.08	4.13	3.90	4.19
	Retired	**24**	3.75	4.17	3.88	4.12	4.17	3.67	3.65
Financial status	Rich	**22**	4.02	4.37	4.37	4.33	4.37	4.05	4.19
	Average	**381**	3.80	4.14	4.04	4.03	4.11	3.90	4.17
	Poor	**37**	3.54	4.13	4.11	4.21	4.08	3.81	4.05

Annex 3.10.1: Opinion on the importance of seeing the doctor in order to do the Pap test in the next three months

% by line		No	Extremely important	Important	Neither important, nor unimportant	Unimportant	Totally unimportant
Total		**1226**	**2**	**5**	**24**	**37**	**32**
Age	25-35	**431**	2	3	20	37	38
	36-45	**257**	2	4	25	41	28
	46-55	**232**	1	4	22	37	36
	56-61	**306**	1	8	30	36	24
Area	Urban	**597**	1	4	26	40	30
	Rural	**629**	3	6	22	35	34
Region	North	**320**	0	3	23	38	36
	Centre	**364**	1	5	16	38	41
	Chisinau	**277**	1	3	28	40	28
	South	**265**	6	8	32	34	21
Marital status	Unmarried	**107**	3	4	27	42	24
	Cohabitation	**46**	0	5	27	26	41
	Married	**884**	1	4	21	38	36
	Divorced	**89**	2	6	31	35	26
	Widow	**99**	2	12	41	33	12
Nationality	Moldovan/Romanian	**1069**	1	4	23	38	34
	Russian	**51**	0	6	28	39	27
	Ukrainian	**32**	3	3	17	40	36
	Gagauzian	**60**	13	12	35	28	12
Education	Primary or lower	**31**	3	7	39	29	22
	Secondary	**336**	2	6	28	37	27
	Vocational	**562**	1	5	24	36	34
	Higher	**281**	2	2	18	40	38
Occupation	Unemployed	**375**	2	6	22	42	28
	Employed	**692**	1	3	24	35	37
	Retired	**152**	3	9	30	34	24
Financial status	Rich	**52**	0	7	21	31	42
	Average	**963**	1	4	22	40	34
	Poor	**211**	4	8	35	29	23

Annex 3.10.1: Opinion on how wise is the decision to do the Pap test

% by line		No	Extremely wise	Wise	Neither wise, nor unwise	Unwise	Extremely unwise
Total		**1,226**	**2**	**4**	**24**	**36**	**34**
Age	25-35	**431**	2	3	21	35	38
	36-45	**257**	2	4	25	38	32
	46-55	**232**	1	2	24	33	40
	56-61	**306**	2	8	28	37	26
Area	Urban	**597**	1	4	22	40	33
	Rural	**629**	3	4	26	32	35
Region	North	**320**	1	3	23	34	38
	Centre	**364**	1	3	19	36	42
	Chisinau	**277**	1	5	23	42	30
	South	**265**	6	6	36	31	22
Marital status	Unmarried	**107**	3	5	34	32	26
	Cohabitation	**46**	2	2	24	32	39
	Married	**884**	1	3	22	37	36
	Divorced	**89**	3	8	22	31	35
	Widow	**99**	3	10	37	31	18
Nationality	Moldovan/Romanian	**1,069**	1	3	23	37	36
	Russian	**51**	4	8	22	37	29
	Ukrainian	**32**	3	6	14	37	40
	Gagauzian	**60**	12	13	42	20	13
Education	Primary or lower	**31**	3	10	45	23	19
	Secondary	**336**	3	5	29	36	28
	Vocational	**562**	1	4	26	34	36
	Higher	**281**	2	4	14	39	41
Occupation	Unemployed	**375**	2	4	27	38	28
	Employed	**692**	1	3	23	34	39
	Retired	**152**	3	10	24	39	24
Financial status	Rich	**52**	2	6	16	28	48
	Average	**963**	1	3	23	37	35
	Poor	**211**	3	7	31	32	26

Annex 3.11.1: Women's certainty of doing the Pap test if they would be invited to do it

% by line		No	Certainly yes	Probably yes	Undecided	Probably no	Certainly no
Total		**1,226**	**39**	**35**	**14**	**7**	**4**
Age	25-35	**431**	47	33	12	5	3
	36-45	**257**	38	38	14	9	1
	46-55	**232**	40	38	15	4	3
	56-61	**306**	28	31	18	12	11
Area	Urban	**597**	39	35	16	7	3
	Rural	**629**	39	34	13	8	5
Region	North	**320**	35	39	15	9	3
	Centre	**364**	47	34	9	5	5
	Chisinau	**277**	45	34	14	5	2
	South	**265**	27	31	22	12	8
Marital status	Unmarried	**107**	28	48	13	8	4
	Cohabitation	**46**	35	37	18	10	1
	Married	**884**	44	34	14	6	3
	Divorced	**89**	28	32	19	11	10
	Widow	**99**	23	27	19	15	15
Nationality	Moldovan/Romanian	**1,069**	41	35	13	7	4
	Russian	**51**	44	31	12	12	2
	Ukrainian	**32**	25	46	8	12	9
	Gagauzian	**60**	5	20	47	18	10
Education	Primary or lower	**31**	10	29	23	19	19
	Secondary	**336**	34	37	15	9	5
	Vocational	**562**	38	35	16	8	4
	Higher	**281**	52	31	11	4	2
Occupation	Unemployed	**375**	40	34	14	8	4
	Employed	**692**	42	36	14	6	3
	Retired	**152**	26	29	19	13	13
Financial status	Rich	**52**	36	38	15	6	5
	Average	**963**	42	35	14	6	4
	Poor	**211**	26	33	18	15	8

Annex 3.11.2: Intention to do the test within the next 3 months

% by line		No	Certainly yes	Probably yes	Undecided	Probably no	Certainly no
Total		**1,226**	**40**	**30**	**16**	**9**	**5**
Age	25-35	**431**	49	27	14	8	2
	36-45	**257**	39	35	16	9	1
	46-55	**232**	38	33	17	7	5
	56-61	**306**	28	28	18	13	12
Area	Urban	**597**	40	30	17	10	4
	Rural	**629**	39	31	16	8	6
Region	North	**320**	39	33	15	11	3
	Centre	**364**	48	28	13	6	5
	Chisinau	**277**	43	30	15	10	3
	South	**265**	26	30	23	11	9
Marital status	Unmarried	**107**	25	42	22	8	3
	Cohabitation	**46**	48	22	20	11	0
	Married	**884**	44	30	14	8	4
	Divorced	**89**	26	26	22	17	9
	Widow	**99**	23	23	21	17	16
Nationality	Moldovan/Romanian	**1,069**	42	31	15	8	5
	Russian	**51**	42	19	15	20	4
	Ukrainian	**32**	34	37	17	9	3
	Gagauzian	**60**	2	27	37	26	8
Education	Primary or lower	**31**	16	23	26	19	16
	Secondary	**336**	36	32	17	10	6
	Vocational	**562**	38	30	17	9	5
	Higher	**281**	50	28	12	8	3
Occupation	Unemployed	**375**	41	29	16	8	5
	Employed	**692**	41	31	16	8	3
	Retired	**152**	30	27	14	18	11
Financial status	Rich	**52**	38	31	23	5	4
	Average	**963**	42	31	15	8	4
	Poor	**211**	29	27	21	14	9

Annex 3.11.3: Opinion on the health worker who should take the Pap smear

% by line		No	Gynaecologist	Family doctor	Family doctor's nurse	I don't know
Total		**1,226**	**77**	**13**	**5**	**6**
Age	25-35	**431**	83	8	5	3
	36-45	**257**	77	14	6	4
	46-55	**232**	76	14	5	5
	56-61	**306**	67	18	4	11
Area	Urban	**597**	83	9	4	4
	Rural	**629**	71	16	6	7
Region	North	**320**	82	9	5	4
	Centre	**364**	78	10	3	9
	Chisinau	**277**	89	8	1	1
	South	**265**	56	26	10	8
Marital status	Unmarried	**107**	78	13	6	4
	Cohabitation	**46**	84	2	4	10
	Married	**884**	78	13	4	5
	Divorced	**89**	73	14	7	7
	Widow	**99**	63	15	10	12
Nationality	Moldovan/Romanian	**1,069**	78	12	4	6
	Russian	**51**	87	11	0	2
	Ukrainian	**32**	70	25	3	1
	Gagauzian	**60**	55	18	15	12
Education	Primary or lower	**31**	45	32	13	10
	Secondary	**336**	71	15	6	8
	Vocational	**562**	77	13	4	6
	Higher	**281**	86	9	3	2
Occupation	Unemployed	**375**	76	13	4	7
	Employed	**692**	80	11	5	4
	Retired	**152**	66	21	5	8
Financial status	Rich	**52**	80	6	11	3
	Average	**963**	80	12	4	4
	Poor	**211**	61	18	9	12

Annex 3.11.4: Indices of the perceived susceptibility to cancer, Pap test psychological cost and perception of the Pap test benefits

AVERAGE		No	I gain a lot by having the Pap test on a regular basis	If I had the Pap test on a regular basis, I'd feel safe about preventing the cervical cancer	Taking into account my family history, it's very unlikely for me to get cervical cancer	It's unlikely that I'll get cervical cancer	I'm very afraid to do the Pap test, in order not to find out that I have abnormal cells or even cervical cancer
Total		**1,226**	**3.84**	**3.82**	**3.19**	**3.14**	**2.90**
Age	25-35	**431**	3.99	3.96	3.22	3.14	2.79
	36-45	**257**	3.85	3.84	3.15	3.06	3.00
	46-55	**232**	3.94	3.87	3.13	3.05	2.77
	56-61	**306**	3.56	3.58	3.24	3.28	3.06
Area	Urban	**597**	3.83	3.76	3.18	3.21	2.86
	Rural	**629**	3.85	3.89	3.20	3.08	2.94
Region	North	**320**	3.81	3.82	3.23	3.20	2.89
	Centre	**364**	4.01	3.96	3.25	3.13	2.86
	Chisinau	**277**	3.83	3.75	3.10	3.18	2.85
	South	**265**	3.65	3.71	3.18	3.06	3.03
Marital status	Unmarried	**107**	3.63	3.66	3.08	3.01	3.03
	Cohabitation	**46**	3.94	3.68	3.21	3.29	2.60
	Married	**884**	3.93	3.91	3.19	3.14	2.85
	Divorced	**89**	3.64	3.66	3.32	3.26	3.24
	Widow	**99**	3.42	3.48	3.18	3.20	3.01
Nationality	Moldovan/Romanian	**1,069**	3.90	3.87	3.22	3.16	2.90
	Russian	**51**	3.62	3.67	3.22	3.07	2.70
	Ukrainian	**32**	3.77	3.68	3.34	3.57	2.89
	Gagauzian	**60**	3.22	3.28	2.75	2.72	3.05
Education	Primary or lower	**31**	3.46	3.39	3.68	2.99	3.23
	Secondary	**336**	3.73	3.72	3.29	3.18	2.91
	Vocational	**562**	3.84	3.84	3.11	3.13	2.96
	Higher	**281**	4.04	3.96	3.16	3.12	2.70
Occupation	Unemployed	**375**	3.77	3.80	3.18	3.03	2.86
	Employed	**692**	3.95	3.89	3.16	3.16	2.88
	Retired	**152**	3.54	3.59	3.32	3.33	3.05
Financial status	Rich	**52**	4.06	3.73	3.46	3.57	3.15
	Average	**963**	3.91	3.88	3.18	3.14	2.86
	Poor	**211**	3.47	3.61	3.18	3.05	3.03

Annex 3.11.5: (Sense of self-efficacy) Opinion on the difficulty of showing up and having the test within the next 3 months

% by line		No	Not difficult at all	Not very difficult	Somewhat difficult	Difficult	Very difficult
Total		**1,226**	**37**	**35**	**18**	**7**	**3**
Age	25-35	**431**	44	31	17	6	3
	36-45	**257**	35	36	19	8	2
	46-55	**232**	37	36	17	9	1
	56-61	**306**	27	40	20	7	6
Area	Urban	**597**	38	35	16	8	2
	Rural	**629**	36	35	20	6	4
Region	North	**320**	31	37	23	8	1
	Centre	**364**	42	33	18	5	3
	Chisinau	**277**	40	37	13	8	3
	South	**265**	33	34	18	9	6
Marital status	Unmarried	**107**	36	28	23	6	6
	Cohabitation	**46**	41	33	22	3	0
	Married	**884**	39	35	17	7	2
	Divorced	**89**	28	43	15	10	3
	Widow	**99**	22	37	19	11	11
Nationality	Moldovan/Romanian	**1,069**	38	34	19	7	3
	Russian	**51**	40	41	13	6	0
	Ukrainian	**32**	24	45	28	0	3
	Gagauzian	**60**	18	42	10	20	10
Education	Primary or lower	**31**	29	35	19	0	16
	Secondary	**336**	35	36	20	6	3
	Vocational	**562**	35	36	18	9	2
	Higher	**281**	44	30	17	7	2
Occupation	Unemployed	**375**	39	32	20	6	2
	Employed	**692**	37	37	18	8	1
	Retired	**152**	32	34	16	7	11
Financial status	Rich	**52**	48	17	23	6	6
	Average	**963**	39	35	17	7	2
	Poor	**211**	22	40	21	10	8

Annex 3.11.6: (Social norms) Opinion on whether the women important to the respondents do have the Pap test or not

% by line		No	Certainly yes	Yes	I don't know	No	Certainly no
Total		**1,226**	**6**	**19**	**47**	**23**	**5**
Age	25-35	**431**	7	20	45	23	5
	36-45	**257**	5	23	42	25	4
	46-55	**232**	7	20	45	23	6
	56-61	**306**	5	12	56	21	6
Area	Urban	**597**	6	22	53	15	4
	Rural	**629**	6	16	41	30	7
Region	North	**320**	6	18	48	24	4
	Centre	**364**	8	14	50	24	4
	Chisinau	**277**	6	29	50	13	3
	South	**265**	5	16	39	31	10
Marital status	Unmarried	**107**	5	16	44	25	9
	Cohabitation	**46**	4	17	64	10	4
	Married	**884**	7	20	44	24	4
	Divorced	**89**	4	16	52	19	9
	Widow	**99**	1	11	61	19	7
Nationality	Moldovan/Romanian	**1,069**	7	19	47	22	5
	Russian	**51**	2	15	57	22	4
	Ukrainian	**32**	0	22	50	22	6
	Gagauzian	**60**	0	10	35	42	13
Education	Primary or lower	**31**	0	16	16	48	19
	Secondary	**336**	5	14	49	26	6
	Vocational	**562**	6	17	49	21	6
	Higher	**281**	8	28	43	20	1
Occupation	Unemployed	**375**	5	17	47	26	5
	Employed	**692**	7	22	45	22	4
	Retired	**152**	5	9	56	20	10
Financial status	Rich	**52**	11	27	38	15	9
	Average	**963**	7	20	46	23	4
	Poor	**211**	2	11	53	26	8

Annex 3.11.7: (Social norms) Opinion on whether the people important to the respondents believe that the latter should have or not the Pap test

% by line		No	Certainly yes	Yes	I don't know	No	Certainly no
Total		**1,226**	**9**	**24**	**44**	**19**	**4**
Age	25-35	**431**	10	25	43	18	3
	36-45	**257**	8	30	41	19	2
	46-55	**232**	10	24	47	13	5
	56-61	**306**	7	16	45	24	7
Area	Urban	**597**	9	27	46	15	3
	Rural	**629**	8	21	42	23	6
Region	North	**320**	9	24	46	18	3
	Centre	**364**	11	18	48	20	4
	Chisinau	**277**	9	35	39	14	2
	South	**265**	6	21	41	23	10
Marital status	Unmarried	**107**	10	17	47	19	7
	Cohabitation	**46**	2	32	59	4	2
	Married	**884**	10	25	44	18	3
	Divorced	**89**	4	24	34	28	9
	Widow	**99**	1	14	48	28	8
Nationality	Moldovan/Romanian	**1,069**	10	25	44	19	3
	Russian	**51**	4	19	51	20	6
	Ukrainian	**32**	3	28	50	13	6
	Gagauzian	**60**	2	10	49	25	15
Education	Primary or lower	**31**	0	16	19	51	13
	Secondary	**336**	6	21	47	22	5
	Vocational	**562**	10	23	46	17	5
	Higher	**281**	12	30	40	14	2
Occupation	Unemployed	**375**	7	21	46	22	5
	Employed	**692**	11	27	43	16	3
	Retired	**152**	5	16	45	24	11
Financial status	Rich	**52**	15	28	30	11	16
	Average	**963**	10	26	44	17	3
	Poor	**211**	2	15	48	29	7

Annex 3.11.8: (Social norms) Opinion on whether respondents' partners believe that the latter should have or not the Pap test

% by line		No	Certainly yes	Yes	I don't know	No	Certainly no
Total		**1,226**	**13**	**25**	**36**	**19**	**6**
Age	25-35	**431**	16	27	37	16	4
	36-45	**257**	13	30	34	18	5
	46-55	**232**	13	26	39	17	6
	56-61	**306**	10	17	35	27	11
Area	Urban	**597**	13	29	35	18	5
	Rural	**629**	13	22	37	21	8
Region	North	**320**	11	23	42	20	4
	Centre	**364**	16	22	35	20	7
	Chisinau	**277**	16	34	33	14	4
	South	**265**	8	23	33	24	12
Marital status	Unmarried	**107**	9	17	48	19	7
	Cohabitation	**46**	20	18	37	20	7
	Married	**884**	15	28	34	18	4
	Divorced	**89**	6	23	36	21	15
	Widow	**99**	1	10	38	35	16
Nationality	Moldovan/Romanian	**1,069**	14	26	35	19	5
	Russian	**51**	16	24	39	14	8
	Ukrainian	**32**	6	28	43	16	8
	Gagauzian	**60**	2	10	39	28	22
Education	Primary or lower	**31**	6	16	10	55	13
	Secondary	**336**	11	21	39	21	8
	Vocational	**562**	13	25	37	18	7
	Higher	**281**	16	32	33	16	3
Occupation	Unemployed	**375**	11	24	37	21	6
	Employed	**692**	15	28	35	16	5
	Retired	**152**	9	13	37	29	13
Financial status	Rich	**52**	17	24	32	9	17
	Average	**963**	15	27	35	19	4
	Poor	**211**	6	15	41	24	15

Annex 3.11.9.1: Indicators for health control localisation

AVERAGE		No	My health condition depends greatly on how well I care about myself	I can keep myself healthy to a large extent by taking care of myself	Strict adherence to doctor's recommendations is the best way to keep myself healthy	If I get sick, I have strength to get back on my feet	If I go regularly to a good doctor, it's unlikely for me to have health issues
Total		**1,226**	**4.08**	**4.00**	**3.77**	**3.76**	**3.58**
Age	25-35	**431**	4.14	4.08	3.87	3.89	3.56
	36-45	**257**	4.00	3.88	3.69	3.74	3.59
	46-55	**232**	4.20	4.05	3.78	3.74	3.68
	56-61	**306**	3.96	3.95	3.71	3.62	3.52
Area	Urban	**597**	4.07	4.00	3.72	3.74	3.54
	Rural	**629**	4.08	4.00	3.82	3.78	3.62
Region	North	**320**	4.03	3.98	3.81	3.85	3.62
	Centre	**364**	4.26	4.15	3.85	3.84	3.73
	Chisinau	**277**	4.17	4.10	3.79	3.78	3.48
	South	**265**	3.79	3.73	3.60	3.54	3.41
Marital status	Unmarried	**107**	3.91	3.67	3.53	3.75	3.39
	Cohabitation	**46**	4.29	4.18	3.73	3.96	3.60
	Married	**884**	4.12	4.06	3.85	3.80	3.66
	Divorced	**89**	4.00	3.98	3.61	3.73	3.36
	Widow	**99**	3.88	3.83	3.49	3.40	3.27
Nationality	Moldovan/Romanian	**1,069**	4.14	4.05	3.81	3.82	3.60
	Russian	**51**	3.87	3.79	3.69	3.71	3.54
	Ukrainian	**32**	3.98	4.01	3.70	3.75	3.63
	Gagauzian	**60**	3.25	3.39	3.40	2.87	3.25
Education	Primary or lower	**31**	3.52	3.49	3.51	3.46	3.42
	Secondary	**336**	4.09	4.04	3.68	3.74	3.52
	Vocational	**562**	4.10	4.00	3.83	3.74	3.63
	Higher	**281**	4.09	4.03	3.81	3.86	3.56
Occupation	Unemployed	**375**	4.08	4.04	3.73	3.81	3.52
	Employed	**692**	4.10	4.01	3.82	3.79	3.64
	Retired	**152**	3.93	3.89	3.71	3.51	3.47
Financial status	Rich	**52**	4.07	4.02	3.87	3.90	3.55
	Average	**963**	4.10	4.03	3.80	3.83	3.62
	Poor	**211**	3.97	3.86	3.63	3.42	3.40

Annex 3.11.9.2: Indicators for health control localisation

AVERAGE		No	Getting sick isn't a matter of fate	I often feel that no matter what I do, if it's meant for me to get sick, so it will happen	Doctors keep me healthy	If I'm healthy, this is only because I'm lucky
Total		**1,226**	**3.34**	**3.28**	**3.12**	**2.88**
Age	25-35	**431**	3.40	3.16	3.10	2.71
	36-45	**257**	3.37	3.30	3.17	2.88
	46-55	**232**	3.46	3.23	3.08	2.98
	56-61	**306**	3.14	3.49	3.15	3.03
Area	Urban	**597**	3.36	3.20	3.03	2.82
	Rural	**629**	3.32	3.36	3.21	2.93
Region	North	**320**	3.37	3.30	3.24	2.76
	Centre	**364**	3.45	3.46	3.07	2.93
	Chisinau	**277**	3.35	3.13	2.94	2.89
	South	**265**	3.13	3.18	3.26	2.93
Marital status	Unmarried	**107**	3.39	3.29	3.08	2.73
	Cohabitation	**46**	3.47	3.04	3.08	2.74
	Married	**884**	3.37	3.24	3.17	2.83
	Divorced	**89**	3.06	3.44	2.90	3.15
	Widow	**99**	3.23	3.65	2.97	3.31
Nationality	Moldovan/Romanian	**1,069**	3.37	3.30	3.12	2.87
	Russian	**51**	3.15	3.43	3.18	2.94
	Ukrainian	**32**	3.55	3.33	3.10	2.94
	Gagauzian	**60**	2.90	2.89	3.00	3.02
Education	Primary or lower	**31**	3.27	3.42	3.00	2.96
	Secondary	**336**	3.16	3.39	3.10	3.07
	Vocational	**562**	3.35	3.31	3.14	2.88
	Higher	**281**	3.52	3.10	3.13	2.65
Occupation	Unemployed	**375**	3.26	3.23	3.04	2.81
	Employed	**692**	3.46	3.24	3.19	2.85
	Retired	**152**	2.92	3.62	3.04	3.17
Financial status	Rich	**52**	3.63	3.17	3.36	2.96
	Average	**963**	3.38	3.25	3.15	2.84
	Poor	**211**	3.06	3.48	2.95	3.03

Annex 3.12.1: Preferred method to be invited to do the Pap test

% by line		No	Phone call	Verbal invitation during a visit to the family doctor	Receiving an invitation by post	Occasional invitation	Receiving an invitation by SMS	Receiving an invitation by e-mail
Total		**1,226**	**51**	**34**	**5**	**4**	**4**	**2**
Age	25-35	**431**	53	31	4	4	6	3
	36-45	**257**	51	34	4	4	3	4
	46-55	**232**	56	31	3	6	3	0
	56-61	**306**	44	42	8	4	0	1
Area	Urban	**597**	53	29	7	3	5	3
	Rural	**629**	49	39	3	6	2	2
Region	North	**320**	54	36	2	2	4	2
	Centre	**364**	57	31	4	4	2	2
	Chisinau	**277**	55	25	9	2	5	3
	South	**265**	34	45	5	9	4	3
Marital status	Unmarried	**107**	55	23	6	4	7	5
	Cohabitation	**46**	60	34	0	2	0	4
	Married	**884**	50	36	4	4	4	2
	Divorced	**89**	57	21	8	7	4	3
	Widow	**99**	39	43	8	7	1	2
Nationality	Moldovan/Romanian	**1,069**	52	33	5	4	3	2
	Russian	**51**	48	41	2	0	9	0
	Ukrainian	**32**	65	31	0	1	0	3
	Gagauzian	**60**	31	40	10	13	5	0
Education	Primary or lower	**31**	52	35	0	10	0	3
	Secondary	**336**	49	37	6	6	2	2
	Vocational	**562**	49	36	5	4	4	1
	Higher	**281**	55	28	4	3	6	5
Occupation	Unemployed	**375**	53	32	5	6	2	2
	Employed	**692**	52	32	4	4	5	3
	Retired	**152**	38	52	6	3	1	1
Financial status	Rich	**52**	38	39	4	8	8	4
	Average	**963**	53	33	4	4	4	2
	Poor	**211**	46	37	9	6	1	1

Annex 3.12.2: Share of women who would like to know more about the Pap test

% by line		No	Yes	No	I don't know
Total		**1,226**	**36**	**46**	**18**
Age	25-35	**431**	44	37	18
	36-45	**257**	35	50	15
	46-55	**232**	37	45	18
	56-61	**306**	25	54	21
Area	Urban	**597**	35	50	15
	Rural	**629**	38	42	21
Region	North	**320**	40	41	19
	Centre	**364**	41	35	25
	Chisinau	**277**	34	50	15
	South	**265**	28	61	11
Marital status	Unmarried	**107**	38	39	22
	Cohabitation	**46**	39	36	25
	Married	**884**	39	44	17
	Divorced	**89**	31	49	20
	Widow	**99**	18	65	17
Nationality	Moldovan/Romanian	**1,069**	37	44	19
	Russian	**51**	30	59	12
	Ukrainian	**32**	49	37	14
	Gagauzian	**60**	18	73	8
Education	Primary or lower	**31**	13	61	26
	Secondary	**336**	39	42	19
	Vocational	**562**	36	46	18
	Higher	**281**	36	49	15
Occupation	Unemployed	**375**	40	38	22
	Employed	**692**	37	47	15
	Retired	**152**	24	56	21
Financial status	Rich	**52**	25	55	20
	Average	**963**	39	44	17
	Poor	**211**	27	48	25

Annex 3.12.3.1: Information sources about the Pap test which women would trust (* - N<30, must be carefully analysed)

AVERAGE		No	Gynaecologist	Oncologist	Family doctor	Public discussions /events	TV	Internet
Total		**445**	**4.58**	**4.44**	**4.39**	**3.93**	**3.85**	**3.76**
Age	25-35	**190**	4.63	4.44	4.38	3.97	3.75	3.80
	36-45	**90**	4.57	4.39	4.33	3.94	3.92	3.81
	46-55	**87**	4.54	4.58	4.40	3.98	4.02	3.70
	56-61	**77**	4.53	4.35	4.46	3.75	3.83	3.65
Area	Urban	**208**	4.54	4.38	4.31	3.98	3.69	3.73
	Rural	**237**	4.62	4.49	4.46	3.88	3.99	3.78
Region	North	**127**	4.58	4.56	4.38	3.87	3.67	3.67
	Centre	**149**	4.69	4.62	4.50	4.09	4.01	3.82
	Chisinau	**95**	4.52	4.40	4.25	4.03	3.70	3.74
	South	**74**	4.45	3.93	4.38	3.57	4.04	3.81
Marital status	Unmarried	**41**	4.61	4.20	4.10	3.68	3.86	3.68
	Cohabitation	**18**	4.78	4.61	4.39	4.17	4.00	3.83
	Married	**341**	4.57	4.44	4.41	3.93	3.80	3.78
	Divorced	**28***	4.61	4.64	4.57	4.21	4.11	3.61
	Widow	**18***	4.45	4.45	4.40	3.84	4.17	3.73
Nationality	Moldovan/Romanian	**396**	4.59	4.44	4.39	3.98	3.82	3.72
	Russian	**15***	4.52	4.45	4.39	3.61	4.00	3.55
	Ukrainian	**16***	4.43	4.55	4.38	3.74	3.92	3.94
	Gagauzian	**11***	4.73	4.37	4.46	3.17	4.46	4.81
Education	Primary or lower	**4***	4.00	4.49	3.24	3.75	3.50	2.99
	Secondary	**131**	4.53	4.36	4.42	3.92	3.88	3.77
	Vocational	**202**	4.63	4.48	4.41	3.94	3.93	3.74
	Higher	**102**	4.56	4.43	4.37	3.96	3.69	3.79
Occupation	Unemployed	**151**	4.53	4.52	4.39	3.89	3.73	3.73
	Employed	**257**	4.62	4.42	4.39	4.01	3.91	3.79
	Retired	**36***	4.53	4.30	4.39	3.59	3.92	3.63
Financial status	Rich	**13***	4.69	4.22	4.38	3.92	3.70	4.23
	Average	**374**	4.57	4.45	4.38	3.88	3.80	3.68
	Poor	**58**	4.65	4.44	4.48	4.26	4.19	4.16

Annex 3.12.3.2: Information sources about the Pap test which women would trust (* - N<30, must be carefully analysed)

AVERAGE		No	Family/ Friends/ Acquaintances	Radio	Online media	Print media	Celebrities	Priest
Total		**445**	**3.74**	**3.42**	**3.37**	**3.27**	**2.89**	**2.73**
Age	25-35	**190**	3.69	3.36	3.38	3.23	2.85	2.68
	36-45	**90**	3.94	3.24	3.21	3.11	2.99	2.84
	46-55	**87**	3.70	3.63	3.51	3.38	2.98	2.80
	56-61	**77**	3.68	3.53	3.37	3.42	2.79	2.66
Area	Urban	**208**	3.59	3.21	3.32	3.20	2.75	2.52
	Rural	**237**	3.88	3.60	3.41	3.33	3.02	2.91
Region	North	**127**	3.76	3.42	3.31	3.36	3.01	2.96
	Centre	**149**	3.99	3.79	3.60	3.46	3.12	3.30
	Chisinau	**95**	3.48	3.29	3.33	3.28	2.69	2.24
	South	**74**	3.56	2.82	3.05	2.71	2.51	1.82
Marital status	Unmarried	**41**	3.88	3.22	3.44	3.12	2.77	2.43
	Cohabitation	**18***	4.18	3.62	3.78	4.01	2.67	3.35
	Married	**341**	3.71	3.43	3.33	3.23	2.91	2.72
	Divorced	**28***	3.75	3.11	3.25	3.40	2.90	2.87
	Widow	**18***	3.52	3.95	3.68	3.34	3.00	2.71
Nationality	Moldovan/Romanian	**396**	3.75	3.43	3.40	3.30	2.91	2.80
	Russian	**15***	3.34	3.29	3.01	2.96	2.85	2.53
	Ukrainian	**16***	3.24	3.93	3.49	3.25	3.00	2.81
	Gagauzian	**11***	4.64	2.65	2.82	2.73	2.83	1.09
Education	Primary or lower	**4***	3.71	3.74	3.48	3.98	3.00	2.73
	Secondary	**131**	3.65	3.51	3.43	3.35	2.90	2.78
	Vocational	**202**	3.92	3.31	3.30	3.23	2.94	2.81
	Higher	**102**	3.50	3.51	3.40	3.24	2.82	2.53
Occupation	Unemployed	**151**	3.63	3.31	3.18	3.12	2.72	2.55
	Employed	**257**	3.83	3.48	3.48	3.34	3.06	2.89
	Retired	**36**	3.60	3.51	3.38	3.42	2.48	2.39
Financial status	Rich	**13***	3.62	3.31	3.46	3.39	3.07	3.23
	Average	**374**	3.72	3.35	3.30	3.20	2.82	2.62
	Poor	**58**	3.94	3.88	3.77	3.70	3.30	3.32

Annex 3.12.4: The most known test names

% by line		No	Pap test	Cytology test	Cervical screening	Other	None
Total		**1,226**	**20**	**40**	**10**	**2**	**43**
Age	25-35	**431**	26	38	12	2	38
	36-45	**257**	24	48	13	2	34
	46-55	**232**	16	42	8	2	44
	56-61	**306**	10	33	5	1	58
Area	Urban	**597**	21	47	14	1	34
	Rural	**629**	19	33	6	2	52
Region	North	**320**	17	39	9	2	42
	Centre	**364**	17	30	9	2	55
	Chisinau	**277**	20	56	15	1	27
	South	**265**	26	36	7	1	45
Marital status	Unmarried	**107**	24	26	11	3	50
	Cohabitation	**46**	13	43	11	0	42
	Married	**884**	22	43	9	2	39
	Divorced	**89**	11	35	15	1	48
	Widow	**99**	6	26	7	1	66
Nationality	Moldovan/Romanian	**1,069**	20	41	10	2	42
	Russian	**51**	15	44	9	2	41
	Ukrainian	**32**	3	27	15	0	57
	Gagauzian	**60**	20	20	0	0	62
Education	Primary or lower	**31**	10	29	3	0	65
	Secondary	**336**	14	37	6	1	51
	Vocational	**562**	17	37	8	2	47
	Higher	**281**	33	49	18	2	24
Occupation	Unemployed	**375**	20	36	7	1	49
	Employed	**692**	23	44	13	2	35
	Retired	**152**	5	29	2	0	67
Financial status	Rich	**52**	25	31	21	2	32
	Average	**963**	23	43	11	2	39
	Poor	**211**	5	29	4	1	64

Annex 3.12.5: Opinion on the name to be used for the cytology test

% by line		No	Pap test	Cytology test	Cervical screening	Other	None	I don't know/I don't answer
Total		**1,226**	**17**	**42**	**6**	**4**	**15**	**17**
Age	25-35	**431**	21	39	8	4	12	16
	36-45	**257**	17	48	9	2	13	10
	46-55	**232**	15	48	3	4	12	18
	56-61	**306**	10	38	4	4	23	22
Area	Urban	**597**	16	47	8	3	13	13
	Rural	**629**	17	37	4	4	17	20
Region	North	**320**	16	43	6	4	16	16
	Centre	**364**	18	30	6	4	17	25
	Chisinau	**277**	14	55	10	5	8	8
	South	**265**	18	44	2	3	18	15
Marital status	Unmarried	**107**	26	31	6	1	19	19
	Cohabitation	**46**	11	46	8	2	16	16
	Married	**884**	17	44	6	4	13	15
	Divorced	**89**	11	47	7	5	15	16
	Widow	**99**	6	29	5	4	27	29
Nationality	Moldovan/Romanian	**1,069**	17	42	6	4	15	16
	Russian	**51**	10	48	11	6	14	11
	Ukrainian	**32**	6	40	9	6	12	26
	Gagauzian	**60**	17	37	0	0	20	27
Education	Primary or lower	**31**	16	42	3	3	10	26
	Secondary	**336**	11	44	5	3	12	24
	Vocational	**562**	15	41	6	4	18	16
	Higher	**281**	26	40	8	5	13	8
Occupation	Unemployed	**375**	15	40	6	5	14	21
	Employed	**692**	19	46	7	3	13	13
	Retired	**152**	7	32	4	6	28	23
Financial status	Rich	**52**	25	38	13	2	14	8
	Average	**963**	18	43	6	4	16	13
	Poor	**211**	8	41	3	2	11	34

Figure 3.14.1: Share of women who know about the HPV vaccine

% by line		No	Yes	No	I don't know
Total		**1,226**	**40**	**55**	**5**
Age	25-35	**431**	44	50	5
	36-45	**257**	45	50	5
	46-55	**232**	42	54	5
	56-61	**306**	28	67	5
Area	Urban	**597**	44	51	5
	Rural	**629**	36	58	5
Region	North	**320**	41	54	5
	Centre	**364**	33	61	5
	Chisinau	**277**	52	46	3
	South	**265**	36	56	8
Marital status	Unmarried	**107**	28	62	9
	Cohabitation	**46**	34	61	4
	Married	**884**	45	51	4
	Divorced	**89**	36	56	8
	Widow	**99**	19	75	6
Nationality	Moldovan/Romanian	**1,069**	42	54	4
	Russian	**51**	44	52	4
	Ukrainian	**32**	40	57	3
	Gagauzian	**60**	10	70	20
Education	Primary or lower	**31**	23	71	7
	Secondary	**336**	31	65	4
	Vocational	**562**	36	58	6
	Higher	**281**	60	35	5
Occupation	Unemployed	**375**	40	55	5
	Employed	**692**	44	50	6
	Retired	**152**	22	74	4
Financial status	Rich	**52**	49	47	4
	Average	**963**	45	51	5
	Poor	**211**	17	76	8

Annex 3.14.2: Information sources about the HPV vaccine (* - N<30, must be carefully analysed)

% by line		No	TV/Radio	Family doctor	Friends/ Acquaintances	Gynaecologist	Internet	Print media	Other
Total		**491**	**52**	**33**	**21**	**16**	**14**	**7**	**1**
Age	25-35	**192**	46	35	23	18	17	6	1
	36-45	**116**	48	41	15	17	11	7	2
	46-55	**96**	54	29	21	19	13	7	2
	56-61	**86**	68	22	24	9	9	12	0
Area	Urban	**261**	54	25	23	15	16	10	1
	Rural	**229**	50	42	18	17	11	4	2
Region	North	**131**	47	35	17	22	7	8	2
	Centre	**120**	47	41	25	12	15	2	2
	Chisinau	**143**	61	21	19	12	19	14	0
	South	**96**	52	37	22	20	13	3	1
Marital status	Unmarried	**31**	54	20	33	3	29	6	3
	Cohabitation	**16**	13	44	6	31	18	13	0
	Married	**394**	51	34	20	17	12	7	1
	Divorced	**32**	69	38	22	19	19	9	0
	Widow	**19***	74	16	27	5	10	16	0
Nationality	Moldovan/Romanian	**444**	52	33	20	16	12	7	1
	Russian	**23***	56	18	17	22	26	13	0
	Ukrainian	**13***	47	54	15	8	15	8	0
	Gagauzian	**6***	34	67	50	16	34	0	0
Education	Primary or lower	**7***	43	71	14	0	0	0	0
	Secondary	**105**	57	32	19	10	11	3	0
	Vocational	**205**	49	34	25	18	11	5	1
	Higher	**168**	53	32	15	19	19	14	2
Occupation	Unemployed	**150**	55	29	22	13	12	7	1
	Employed	**306**	48	37	20	19	15	8	2
	Retired	**33**	79	12	18	6	6	6	0
Financial status	Rich	**26***	35	38	19	38	15	0	0
	Average	**430**	52	33	22	16	14	8	1
	Poor	**35**	65	32	11	3	11	9	0

Annex 3.14.3: Opinion on HPV vaccine safety

% by line		No	Very secure	Secure	I don't know	It may have side effects	It may have very severe side effects
Total		**1,226**	**7**	**18**	**70**	**3**	**1**
Age	25-35	**431**	7	18	70	3	2
	36-45	**257**	8	22	62	6	1
	46-55	**232**	7	19	70	3	1
	56-61	**306**	5	15	76	2	2
Area	Urban	**597**	6	17	71	4	2
	Rural	**629**	8	20	69	2	1
Region	North	**320**	8	18	70	2	1
	Centre	**364**	6	16	76	1	1
	Chisinau	**277**	6	15	70	6	2
	South	**265**	7	25	61	4	2
Marital status	Unmarried	**107**	5	17	76	2	0
	Cohabitation	**46**	9	13	72	2	4
	Married	**884**	7	20	68	4	1
	Divorced	**89**	8	18	64	7	3
	Widow	**99**	3	7	87	1	2
Nationality	Moldovan/Romanian	**1,069**	7	19	70	3	1
	Russian	**51**	6	12	75	8	0
	Ukrainian	**32**	12	9	67	6	6
	Gagauzian	**60**	7	27	63	0	3
Education	Primary or lower	**31**	3	22	71	3	0
	Secondary	**336**	6	14	75	3	2
	Vocational	**562**	6	18	71	3	2
	Higher	**281**	10	24	61	5	1
Occupation	Unemployed	**375**	7	16	72	3	2
	Employed	**692**	8	20	67	4	1
	Retired	**152**	2	16	78	1	2
Financial status	Rich	**52**	19	23	56	0	2
	Average	**963**	7	20	68	4	2
	Poor	**211**	3	11	84	1	1

Annex 3.14.4: Interest in learning more about the HPV vaccine

% by line		No	Yes	I think I have enough information	I'm not interested
Total		**1,226**	**26**	**31**	**43**
Age	25-35	**431**	35	31	34
	36-45	**257**	27	32	41
	46-55	**232**	21	35	43
	56-61	**306**	17	26	57
Area	Urban	**597**	26	31	43
	Rural	**629**	26	31	43
Region	North	**320**	34	31	35
	Centre	**364**	29	34	37
	Chisinau	**277**	24	30	46
	South	**265**	15	28	57
Marital status	Unmarried	**107**	28	30	42
	Cohabitation	**46**	30	27	43
	Married	**884**	28	33	39
	Divorced	**89**	22	25	53
	Widow	**99**	11	19	70
Nationality	Moldovan/Romanian	**1,069**	28	32	40
	Russian	**51**	13	37	50
	Ukrainian	**32**	25	31	45
	Gagauzian	**60**	5	15	80
Education	Primary or lower	**31**	10	10	81
	Secondary	**336**	29	21	50
	Vocational	**562**	23	33	44
	Higher	**281**	30	42	28
Occupation	Unemployed	**375**	34	23	42
	Employed	**692**	23	36	41
	Retired	**152**	19	25	56
Financial status	Rich	**52**	23	43	35
	Average	**963**	28	34	38
	Poor	**211**	20	13	66

Annex 3.14.5: Share of women with 10-year-old daughters who would like to vaccinate them (* - N<30, must be carefully analysed)

% by line		No	Yes	No	I don't know
Total		**123**	**45**	**33**	**22**
Age	25-35	**54**	46	33	20
	36-45	**54**	46	30	24
	46-55	**9***	33	34	33
	56-61	**5***	40	60	0
Area	Urban	**54**	42	35	22
	Rural	**69**	47	31	22
Region	North	**32**	47	28	25
	Centre	**37**	50	22	28
	Chisinau	**28***	50	32	18
	South	**27***	31	54	15
Marital status	Unmarried	**6***	34	33	33
	Cohabitation	**2***	50	50	0
	Married	**106**	46	32	22
	Divorced	**8***	51	25	25
	Widow	**1***	0	100	0
Nationality	Moldovan/Romanian	**110**	48	28	24
	Russian	**1***	100	0	0
	Ukrainian	**5***	20	80	0
	Gagauzian	**5***	0	80	20
Education	Primary or lower	**3***	32	68	0
	Secondary	**34**	56	21	24
	Vocational	**50**	30	44	26
	Higher	**34**	56	26	18
Occupation	Unemployed	**44**	39	36	25
	Employed	**74**	50	28	22
	Retired	**3***	33	67	0
Financial status	Rich	**5***	20	20	59
	Average	**109**	44	35	20
	Poor	**9***	67	11	22

Annex 3.14.6: Share of women with daughters about the age of 10 who already vaccinated them (* - N<30, must be carefully analysed)

% by line		No	I tried and I succeeded	I tried and I failed	I didn't try
Total		**123**	**23**	**1**	**76**
Age	25-35	**54**	22	0	78
	36-45	**54**	24	2	74
	46-55	**9***	22	0	78
	56-61	**5***	20	0	80
Area	Urban	**54**	16	2	82
	Rural	**69**	28	0	72
Region	North	**32**	19	0	81
	Centre	**37**	33	0	67
	Chisinau	**28***	21	4	75
	South	**27***	15	0	85
Marital status	Unmarried	**6***	17	0	83
	Cohabitation	**2***	50	0	50
	Married	**106**	25	1	74
	Divorced	**8***	0	0	100
	Widow	**1***	0	0	100
Nationality	Moldovan/Romanian	**110**	25	1	74
	Russian	**1***	100	0	0
	Ukrainian	**5***	0	0	100
	Gagauzian	**5***	0	0	100
Education	Primary or lower	**3***	32	0	68
	Secondary	**34**	35	0	65
	Vocational	**50**	18	0	82
	Higher	**34**	18	3	80
Occupation	Unemployed	**44**	20	0	80
	Employed	**74**	24	1	74
	Retired	**3***	33	0	67
Financial status	Rich	**5***	0	0	100
	Average	**109**	23	1	76
	Poor	**9***	33	0	67

Annex 3.14.7: Opinion on the availability of family doctors to discuss about the HPV vaccine,
(* - N<30, must be carefully analysed)

% by line		No	Certainly yes	I'm not sure, considering how busy he/she is	No	I don't know
Total		**123**	**60**	**11**	**12**	**17**
Age	25-35	**54**	65	5	15	15
	36-45	**54**	52	17	13	18
	46-55	**9***	78	0	0	22
	56-61	**5***	60	20	0	20
Area	Urban	**54**	57	15	11	17
	Rural	**69**	62	7	13	18
Region	North	**32**	56	12	16	16
	Centre	**37**	72	5	3	19
	Chisinau	**28***	54	18	7	21
	South	**27***	53	8	27	12
Marital status	Unmarried	**6***	50	33	0	17
	Cohabitation	**2***	50	0	50	0
	Married	**106**	60	9	12	19
	Divorced	**8***	63	25	12	0
	Widow	**1***	100	0	0	0
Nationality	Moldovan/Romanian	**110**	61	11	11	17
	Russian	**1***	100	0	0	0
	Ukrainian	**5***	60	0	0	40
	Gagauzian	**5***	59	0	41	0
Education	Primary or lower	**3***	32	0	35	33
	Secondary	**34**	59	6	12	23
	Vocational	**50**	64	12	8	16
	Higher	**34**	59	15	14	12
Occupation	Unemployed	**44**	59	4	19	18
	Employed	**74**	61	15	8	16
	Retired	**3***	67	0	0	33
Financial status	Rich	**5***	81	19	0	0
	Average	**109**	59	11	13	17
	Poor	**9***	56	0	11	33

Figure 3.14.8: Intention to adhere to doctor's recommendation to vaccinate the daughter with the HPV vaccine, (* - N<30, must be carefully analysed)

% by line		No	Certainly yes	I'm not sure	I'd need another doctor's opinion	I wouldn't adhere to his/her recommendation
Total		**123**	**47**	**25**	**7**	**21**
Age	25-35	**54**	46	28	7	19
	36-45	**54**	50	22	7	21
	46-55	**9***	33	33	11	22
	56-61	**5***	60	0	0	40
Area	Urban	**54**	42	24	9	24
	Rural	**69**	51	25	6	18
Region	North	**32**	60	34	0	6
	Centre	**37**	53	25	8	14
	Chisinau	**28***	50	21	4	25
	South	**27***	23	16	19	43
Marital status	Unmarried	**6***	50	17	17	16
	Cohabitation	**2***	50	50	0	0
	Married	**106**	47	25	7	21
	Divorced	**8***	38	25	12	25
	Widow	**1***	100	0	0	0
Nationality	Moldovan/Romanian	**110**	50	27	6	16
	Russian	**1***	100	0	0	0
	Ukrainian	**5***	40	0	20	40
	Gagauzian	**5***	0	20	20	61
Education	Primary or lower	**3***	32	0	33	35
	Secondary	**34**	59	18	6	18
	Vocational	**50**	40	32	8	20
	Higher	**34**	47	23	6	24
Occupation	Unemployed	**44**	39	25	12	25
	Employed	**74**	53	26	5	16
	Retired	**3***	67	0	0	33
Financial status	Rich	**5***	20	60	20	0
	Average	**109**	47	23	7	22
	Poor	**9***	67	22	0	11

Annex: Questionnaire among the female population

STRUCTURED QUESTIONNAIRE FOR WOMEN

We are interested in your opinions on your health status, the experiences you had when you sought health care, and the knowledge you have in this field. I will read a number of questions, and I will ask you to give the answer that best describes your experience related to these situations. All the information you will provide is confidential.

1. Age: _____ years old

Section 1

2. In general, how would you describe your current health status? Would you say it is:
    1. Very bad
    2. Bad
    3. Neither bad, nor good
    4. Good
    5. Very good

3. Do you have a chronic illness diagnosed by a doctor? (one possible answer)
    NO YES
    If yes, which is it? (which are they?)_____

4. Do you have a physical or mental disability? (one possible answer) NO YES
If yes, which is it?_____

5. Do you have a valid compulsory medical insurance policy? (one possible answer)
    1. Yes
    2. No
    3. I don't know

6. Are you registered with a family doctor? (one possible answer)
    1. Yes
    2. No – **GO TO Q10**
    3. **I don't know – GO TO Q10**

7. How did you choose/register with a family doctor? (one possible answer)
    1. On the recommendation of a friend/relative
    2. Accidentally
    3. It's the doctor who is responsible for the area where I live
    4. Other, specify _____
    5. I don't know/remember

8. How satisfied are you with the services your family doctor provides to you? (one possible answer)
    1. Very satisfied
    2. Satisfied
    3. Neither satisfied, nor dissatisfied
    4. Dissatisfied
    5. Totally dissatisfied

9. Is your family doctor male or female? (one possible answer)

1. Male
2. Female
3. (don't read) I don't know/I don't answer

10. Do you have any preference regarding the gender of your family doctor? (one possible answer)

1. I prefer a male doctor
2. I prefer a female doctor
3. It doesn't matter

11. When did you have your latest health check-up? (one possible answer)

1. during the last year
2. 1-2 years ago
3. 2-5 years ago
4. more than 5 years ago

12. Who do you usually approach when you have a health issue? (one possible answer)

SHOW CARD Q12

1. Family doctor
2. Specialist doctor from the district/municipal health centre/family doctors centre
3. Specialist doctor from a public hospital
4. Specialist doctor from a private health care facility
5. Naturopathic/homeopathic doctor
6. Doctor friends/acquaintances
7. Relatives/friends with no medical qualification
8. I search on the Internet
9. I don't visit any doctor and treat myself on my own
10. I ignore the problem (I'm waiting for it to pass)
11. Someone else, please specify _____

13. What is the main reason why you use these services/contact these specialist doctors when you have a health issue? (one possible answer)

SHOW CARD Q13

1. I trust that I will receive the necessary assistance (help)
2. I'm happy with how they behaved with me previously
3. It's the place/specialist doctors that I can reach easiest in order to benefit of health care services
4. Other places are too crowded/I would have to wait in line
5. It's the place where I'm registered with the family doctor to be provided health care services covered by the compulsory health insurance
6. I have relationships/acquaintances there
7. Other, please specify _____

14. Who do you go to for a gynaecological examination/screening? (one possible answer)

1. Family doctor
2. Gynaecologist from the district/municipal health centre/family doctors centre
3. Gynaecologist from a public hospital
4. Gynaecologist from a private health care facility
5. Someone else, please specify _____

15. How often do you get a gynaecological check-up? (one possible answer)

1. More often than once a year
2. Once a year
3. Once in 2-5 years
4. More seldom than once in 5 years
5. I don't know/remember

16. Have you had a hysterectomy? (one possible answer)

1. Yes
2. No

Section 2

Please be careful with the following questions and answers, and choose the one you consider to be correct. Please choose one answer.

17. Have you ever heard of the Pap test, or cytology test, or cancer test/cancer smear/cervical screening test? (one possible answer)

1. Yes
2. No – **GO TO SECTION 3**
3. I don't know – **GO TO SECTION 3**

18. Which of the following statements describe the purpose of the Pap test? (one possible answer)

- ☐ detect vaginal infections
- ☐ detect changes in cervical cells
- ☐ prevent cervical cancer
- ☐ I don't know
- ☐ other, please specify _____

19. What does the Pap test mean? (free answer) (one possible answer)

OPERATOR: DON'T READ THE ANSWER OPTIONS

- ☐ (don't read) visual examination of the woman's cervix
- ☐ (don't read) removing a tiny bit of the cervix
- ☐ (don't read) collecting cervical cells
- ☐ (don't read) detecting vaginal infections
- ☐ (don't read) I don't know
- ☐ (don't read) other, please specify _____

20. Who should get a Pap test? (one possible answer)

- ☐ all girls/women aged between 15 and 24 years
- ☐ all women aged between 25 and 61 years
- ☐ only women over 65 years of age
- ☐ all women, regardless of their age
- ☐ I don't know
- ☐ other, please specify _____

21. How often should a woman have a Pap test? (one possible answer)

- ☐ once a lifetime
- ☐ once in 3 years
- ☐ once a year
- ☐ I don't know

22. Do you know that the Pap test is free of charge even if you don't have a (valid) compulsory health insurance policy? (one possible answer)

1. I'm aware of it
2. I haven't heard of it
3. (don't read) I don't know/I don't answer

23. Where is the Pap test taken for free even if you don't have a compulsory health insurance policy? (multiple answers)

1. At the family doctor's office
2. At the office of the gynaecologist from the district/municipal health centre/family doctors centre
3. At the office specialised in sampling (collecting) cytological smears and prophylactic check-up within health centres
4. At the office of the gynaecologist from the public hospital
5. Elsewhere, please specify_____
6. I don't know

24. What is the likelihood to prevent cervical cancer by taking the Pap test? (one possible answer)

- ☐ It can't be prevented
- ☐ It can be prevented in few cases
- ☐ It can be prevented in half of the cases
- ☐ It can be prevented in most of the cases
- ☐ It can be prevented in all cases
- ☐ I don't know/I don't answer
- ☐ other, please specify _____

Section 3

25. Have you ever had a Pap test/cytology test/cancer test/cancer smear/cervical screening test? (one possible answer)

1. Yes
2. No
3. I don't know/remember

SHOW CARD 25

The operator reads the following description: ***the Pap test consists in collecting a small number of cervical cells. The smear is taken with an endocervical brush sample during a gynaecological examination. It is then sent to a laboratory and examined microscopically for changes in the cervical cells. Depending on the degree of changes noticed, different stages of cervix changes are identified. Most of them can be treated and healed, thus preventing the cervical cancer to develop.***

Based on this description, which is your answer to the following questions?

26. Have you ever had a Pap test? (one possible answer)

1. Yes
2. No
3. I don't know/remember

27. Was your family doctor the one who recommended you to have a Pap test? (one possible answer)

1. Yes
2. No
3. I don't remember

If you consider you never had a Pap test, we will pass to other questions **(GO TO QUESTION 48).**

28. Where do you go for a Pap test? (one possible answer)
    1. To the family doctor/family doctor's nurse
    2. To the gynaecologist from the district/municipal health centre/family doctors centre
    3. To the gynaecologist from the public hospital
    4. To the gynaecologist from a private health care facility
    5. To someone else, please specify _____
    6. I don't know

29. How often do you have a Pap test? (one possible answer)
    1. Once a year
    2. Once in 2 years
    3. Once in 3 years
    4. Once every 4-5 years
    5. More seldom than once in 5 years
    6. I don't know

30. When did you have your latest Pap test? (one possible answer)
    1. 6 months ago
    2. 1 year ago
    3. 2 years ago
    4. 3 years ago
    5. 4-5 years ago
    6. More than 5 years ago
    7. I don't know/remember

31. When you had your latest Pap test, what was the reason why you went to the doctor? (one possible answer)
    1. I was pregnant
    2. I had some gynaecological issues
    3. A routine gynaecological check-up
    4. When I went for family planning services (to choose a contraception method)
    5. Particularly for having/requesting a Pap test
    6. Other, please specify _____
    7. I don't know/remember

32. Who had the initiative for you to get the latest Pap test? (one possible answer)
    1. I asked for it
    2. The family doctor's nurse suggested it
    3. The family doctor suggested it
    4. The gynaecologist suggested it
    5. I don't know/remember
    6. Someone else, please specify _____

33. Did you pay for your last Pap test? (one possible answer)
    1. I didn't pay
    2. I paid
    3. I don't remember

34. Have you been communicated the result of the latest Pap test? (one possible answer)
    1. Yes
    2. No, because the doctor told me he/she wouldn't contact me if the result was good
    3. No, and I assumed I wasn't contacted because the test result was good
    4. I don't know/remember

If the answer is 'No' or 'I don't know', go to question 37.

35. If 'yes' – How have you been communicated (informed about) the Pap test result? (one possible answer)

1. I was contacted by the family doctor/family doctor's nurse
2. I was contacted by the gynaecologist
3. I went there in person to ask about the test result
4. Elsewhere, please specify_____

36. Have you talked to your doctor about the Pap test result? (one possible answer)

1. Yes
2. No
3. I don't know/remember

37. How satisfied were you with the medical services when you had the Pap test? (one possible answer)

1. Very satisfied
2. Satisfied
3. Neither satisfied, nor dissatisfied
4. Dissatisfied
5. Very dissatisfied

38. Have you ever had an abnormal (bad) result of the Pap test? (one possible answer)

1. Yes
2. No
3. I don't know/remember

If the answer is 'No' or 'I don't know', go to question 45.

39. If 'yes', did you repeat the Pap test? (one possible answer)

1. Yes
2. No – **GO TO Q41**
3. I don't know/remember – **GO TO Q41**

40. Where did you repeat the Pap test? (one possible answer)

1. At the same family doctor
2. At a gynaecologist from a district/municipal health centre/family doctors centre
3. At the office specialised in sampling (collecting) cytological smears and prophylactic check-up within health centres
4. At a gynaecologist from a public hospital
5. At a gynaecologist from a private health care facility
6. At the Republican Centre for Medical Diagnostics
7. At the Oncology Institute
8. Elsewhere, please specify_____

41. If the Pap test was result abnormal, were you referred to get a colposcopy (imaging examination to identify a potential cervical pathology)? (one possible answer)

1. Yes
2. No – **GO TO Q44**
3. I don't know/remember – **GO TO Q44**

42. Where have your doctor referred you for colposcopy? (one possible answer)
    1. To a gynaecologist from a district/municipal health centre/family doctors centre
    2. To a gynaecologist in a public hospital
    3. To a gynaecologist in a private health care facility
    4. To the Oncology Institute
    5. I don't know/remember
    6. Elsewhere, please specify_____

43. Did you get the colposcopy done when your family doctor referred you to have one? (one possible answer)
    1. Yes – **GO TO Q45**
    2. No
    3. I don't know/remember

44. If you didn't have the colposcopy done, please state the reason (you may choose more than one answer)
    1. I left the country
    2. I didn't have time
    3. I didn't have a (valid) compulsory health insurance policy
    4. I was afraid that they would find atypical/abnormal cells or even cancer
    5. Long distance to the place where the medical examination (colposcopy) is performed
    6. Because of the travel costs to the place where the medical examination (colposcopy) is performed
    7. Another reason, please specify_____

45. Was the person who took your latest Pap test male or female? (one possible answer)
    1. Male
    2. Female
    3. (don't read) I don't know/I don't answer

46. Think of your latest Pap test/cervical screening and please tell us how satisfied or dissatisfied you were with following issues. Please answer on a scale from 1 to 5, where 1 means very dissatisfied and 5 means very satisfied. (one possible answer per line)

SHOW CARD Q46

FLIP AROUND THE ITEMS

	1 – very dissatisfied	2 – dissatisfied	3 – neither satisfied, nor dissatisfied	4 – satisfied	5 – very satisfied	(don't read) DK/DA	(don't read) NA
1. Ease in accessing the screening services (in general)	1	2	3	4	5	99	97
2. Distance from home to the place where cervical screening service is provided	1	2	3	4	5	99	97
3. Travelling costs to the place where cervical screening service is provided	1	2	3	4	5	99	97
4. Waiting time until the appointment for a Pap test	1	2	3	4	5	99	97
ITEM 5 – ONLY FOR THE RESPONDENTS SCREENED BY A MALE SPECIALIST Q45=1 5. The fact that the person who performed the cervical screening was male	1	2	3	4	5	99	97
ITEM 6 – ONLY FOR THE RESPONDENTS SCREENED BY A FEMALE SPECIALIST Q45=2 6. The fact that the person who performed the cervical screening was female	1	2	3	4	5	99	97
7. Family's attitude towards the decision to go to a doctor for cervical screening	1	2	3	4	5	99	97

47. Think of your latest Pap test and please tell us how satisfied you were with the following issues. Please answer on a scale from 1 to 5, where 1 means very dissatisfied and 5 means very satisfied. (one possible answer per line)

SHOW CARD Q47

FLIP AROUND THE ITEMS

	1 – very dissatisfied	2 – dissatisfied	3 – neither satisfied, nor dissatisfied	4 – satisfied	5 – very satisfied	(don't read) DK/DA	(don't read) NA
1. Time spent in the waiting room	1	2	3	4	5	99	97
2. The way the medical examination took place	1	2	3	4	5	99	97
3. The way the procedure was explained to me	1	2	3	4	5	99	97
4. The way I was given answers to my questions	1	2	3	4	5	99	97
5. Attention and respect from the medical staff	1	2	3	4	5	99	97
6. The way the Pap test result was explained to me	1	2	3	4	5	99	97
7. Cervical screening service quality (in general)	1	2	3	4	5	99	97

FOR ALL WOMEN:

48. If you were given the opportunity to have a Pap test as a method of cervical cancer prevention, would you accept the offer? (one possible answer)

Certainly No	Probably No	Undecided	Probably Yes	Certainly Yes
1	**2**	**3**	**4**	**5**

49. Who do you think should have the Pap test? (one possible answer)

1. Family doctor
2. Family doctor's nurse
3. Gynaecologist
4. Someone else, please specify _____
5. I don't know

50. Has it ever happened for you to request the Pap test and not to get it done? (one possible answer)

1. Yes
2. No – **GO TO Q52**
3. I don't know/remember – **GO TO Q52**

51. If 'yes', what was the reason why you didn't get the Pap test done? (one possible answer)

1. Lack of the needed gynaecological equipment/consumables
2. Lack of a family doctor/family doctor's nurse in the community where I live
3. The family doctor/family doctor's nurse refused to do the Pap test
4. Other reasons, please specify _____

52. Have you heard about the existence of the cervical screening service – a service that performs the Pap test **free of charge** for all women from Moldova aged between 25 and 61 years? (one possible answer)

1. Yes
2. No – GO TO Q55

53. Where should you go for a free-of-charge Pap test? (one possible answer)

1. To the family doctor
2. To a gynaecologist from a district/municipal health centre/family doctors centre
3. To the gynaecologist from a public hospital
4. To the Oncology Institute
5. Elsewhere, please specify:_____

54. Where from have you heard about the free-of-charge cervical screening service (Pap test)? (multiple answers)

1. I haven't heard of this test until today
2. From a family member
3. From a friend
4. From the family doctor/family doctor's nurse
5. From the gynaecologist
6. From the oncologist
7. From the radio, TV, newspaper, magazine
8. I don't remember
9. Other sources, please specify_____

55. Which method would you like the family doctor to use when inviting you for the cervical screening (to perform the Pap test)? (one possible answer)

1. Invitation by post
2. Phone call
3. Invitation by SMS
4. Invitation by e-mail
5. Verbal invitation during a visit to the family doctor
6. Occasional (random, unplanned) invitation

56. Would you like to learn more about the Pap test? (one possible answer)

1. Yes
2. No – **GO TO Q58**
3. I don't know – **GO TO Q58**

57. If 'yes', what are the sources of information that you believe trustworthy for you to learn about the Pap test? Choose a number according to your opinion about each of the sources, where 1 means total mistrust and 5 means total trust (one possible answer per line)

SHOW CARD Q57

FLIP AROUND THE ITEMS

	1 – total mistrust	2 – mistrust	3 – neither trust, nor mistrust	4 – trust	5 – total trust	(don't read) DK/DA
1. TV	1	2	3	4	5	
2. Radio	1	2	3	4	5	
3. Printed media (newspapers/magazines)	1	2	3	4	5	
4. Online media	1	2	3	4	5	
5. Family doctor	1	2	3	4	5	
6. Gynaecologist	1	2	3	4	5	
7. Oncologist	1	2	3	4	5	
8. Family/friends/acquaintances	1	2	3	4	5	
9. Celebrities	1	2	3	4	5	
10. Priest	1	2	3	4	5	
11. Internet	1	2	3	4	5	
12. Public discussions/events during which information is provided by the health professionals	1	2	3	4	5	

58. Which of the following names is most familiar to you? (multiple answers)

1. Pap test
2. Cytology test
3. Cervical screening
4. Other, specify _____
5. None

59. Which of the following names should be used to be understandable for the public? (one possible answer)

1. Pap test
2. Cytology test
3. Cervical screening
4. Other, specify _____
5. (don't read) None
6. (don't read) I don't know/I don't answer

60. For women who did the test: What are the problems that you are sure/expect to face when you will do the nest Pap test?

For women who didn't do the test: What are the problems you believe you will face if you decide to do the Pap test?

Please give an answer to each of the statements below, where 1 means 'It's not a problem at all' and 5 means 'It's a huge problem' (one possible answer per line)

SHOW CARD Q60

FLIP AROUND THE ITEMS

	1 – it's not/wouldn't be a problem at all	2 – it's not/wouldn't be a problem	3 – neither, nor	4 – it's/would be a problem	5 – it's/would be a huge problem
1. Lack of time	1	2	3	4	5
2. I'm too tired to think about preventive tests	1	2	3	4	5
3. The gynaecological examination is unpleasant	1	2	3	4	5
4. It is difficult to communicate with the doctors	1	2	3	4	5
5. I don't like the behaviour of the medical staff	1	2	3	4	5
6. I'm bothered by the doctor's gender	1	2	3	4	5
7. Fear of finding atypical cells or cancer	1	2	3	4	5
8. My family doctor never suggests a Pap test.	1	2	3	4	5
9. Waiting time at the doctor /the line is too long	1	2	3	4	5
10. I don't know where to go to have the Pap test	1	2	3	4	5
11. The family doctor is too far away	1	2	3	4	5
12. I don't think the Pap test is necessary	1	2	3	4	5
13. Doctors could say I'm complaining/ coming to them for no reason	1	2	3	4	5
14. The Pap test is painful	1	2	3	4	5
15. Other reasons _____					

Section 4

61. Please listen to the following statements and point out to what extent you deem them to be true/untrue for you; the answers are on a scale of 1 to 5, which means: Totally agree (5); agree (4); uncertain/neither agree, nor disagree (3); disagree (2); strongly disagree (1). (one possible answer per line)

SHOW CARD Q61

FLIP AROUND THE ITEMS

	1 – strongly disagree	2 – disagree	3 – neither agree, nor disagree	4 – agree	5 – totally agree
[1] It's unlikely that I'll get cervical cancer	1	2	3	4	5
[2] I'm very afraid to do the Pap test, in order not to find out that I have abnormal cells or even cervical cancer	1	2	3	4	5
[3] Taking into account my family history, it's very unlikely for me to get cervical cancer	1	2	3	4	5
[4] I gain a lot by having the Pap test on a regular basis	1	2	3	4	5
[5] If I had the Pap test on a regular basis, I'd feel safe about preventing the cervical cancer	1	2	3	4	5

Section 5

Please listen to the following statements and tell me what do you think about them.

62. If you had the opportunity, would you intend to take the Pap test within the next 3 months? (one possible answer)

Certainly no	Probably no	Undecided	Probably yes	Certainly yes
1	**2**	**3**	**4**	**5**

63. If you had the opportunity, how difficult would it be for you to come and have the Pap test within the next 3 months? (one possible answer)

Not difficult at all	Not very difficult	Somewhat difficult	Difficult	Very difficult
1	**2**	**3**	**4**	**5**

64. Most women that are important to me (e.g. mother, daughter, sister, friend) get their Pap test. (one possible answer)

Certainly no	No	I don't know	Yes	Certainly yes
1	**2**	**3**	**4**	**5**

65. Most people that are important to me think I should have the Pap test. (one possible answer)

Certainly no	No	I don't know	Yes	Certainly yes
1	**2**	**3**	**4**	**5**

66. My husband/partner thinks I should have the Pap test. (one possible answer)

Certainly no	No	I don't know	Yes	Certainly yes
1	**2**	**3**	**4**	**5**

67. I think that going to a doctor to get the Pap test over the next 3 months (for women that never had the test done or had it more than 3 years ago) is: (please provide an answer for every component) (one possible answer)

(1) extremely important | important | in between/neutral | not important | totally not important

(2) extremely wise | wise | in between/neutral | useless | extremely useless

Section 6

68. Have you heard about the HPV vaccine (against the human papilloma virus, the virus that can cause cervical lesions, including cervical cancer if there is no timely intervention)? (one possible answer)

1. Yes
2. No – **GO TO Q70**
3. I don't know – **GO TO Q70**

69. If 'yes', where did you get information about this vaccine? (multiple answers)

1. TV/Radio
2. Printed media (newspapers/magazines)
3. Family doctor
4. Gynaecologist
5. Friends/acquaintances
6. Internet
7. Other, specify _____

70. How secure do you think the HPV vaccine is in preventing cervical cancer? (one possible answer)

1. Very secure
2. Secure
3. I don't know
4. It may have side effects (if so, what are they)?_____
5. It may have very severe side effects (if so, what are they)?_____

71. Would you like to get more information about the HPV vaccine? (one possible answer)

1. Yes (if YES, what are the trustworthy sources you want to get information from:_____
2. I think I have enough information
3. I'm not interested

72. Do you have a daughter/daughters around the age of 10? (one possible answer)

Yes
No – **GO TO SECTION 7**

73. If you have a daughter/daughters around the age of 10, would you like her/them to be vaccinated against HPV? (one possible answer)

1. Yes
2. No
3. I don't know

74. In the last 12 months, did you try to vaccinate your daughter/daughters with the HPV vaccine and fail? (one possible answer)

1. I tried and I succeeded
2. I tried and I failed (if Yes, why couldn't you vaccinate them):_____

75. Do you think the family doctor is open to talk to you about the HPV vaccination of your daughter/daughters and to answer all your questions and concerns about this vaccine? (one possible answer)

1. Certainly yes
2. I'm not sure, considering how busy he/she is
3. No
4. I don't know

76. If your family doctor recommended the HPV vaccine for your daughter/daughters, would you adhere to his/her recommendation? (one possible answer)

1. Certainly yes
2. I'm not sure
3. I'd need another doctor's opinion
4. I wouldn't adhere to his/her recommendation

Section 7

77. I will read some statements and please tell me if you agree or disagree with each statement. Please answer on a scale from 1 to 5, where 5 means totally agree and 1 means strongly disagree. (one possible answer per line)

SHOW CARD Q77

FLIP AROUND THE ITEMS

	1 – strongly disagree	2 – disagree	3 – neither agree, nor disagree	4 – agree	5 – totally agree
1. If I get sick, I have strength to get back on my feet.	1	2	3	4	5
2. I often feel that no matter what I do, if it's meant for me to get sick, so it will happen.	1	2	3	4	5
3. If I go regularly to a good doctor, it's unlikely for me to have health issues.	1	2	3	4	5
4. My health condition depends greatly on how well I care about myself.	1	2	3	4	5
5. If I'm healthy, this is only because I'm lucky.	1	2	3	4	5
6. Doctors keep me healthy.	1	2	3	4	5
7. I can keep myself healthy to a large extent by taking care of myself.	1	2	3	4	5
8. Getting sick isn't a matter of fate.	1	2	3	4	5
9. Strict adherence to doctor's recommendations is the best way to keep myself healthy.	1	2	3	4	5

Section 8

DEMOGRAPHICS:

78. Marital status: (one possible answer)

1. Unmarried
2. Cohabitation
3. Married
4. Divorced/Separated
5. Widow

79. How many children do you have? (one possible answer)

1. None
2. One
3. Two
4. Three
5. More than three How many?.....

80. What is your nationality? (one possible answer)

1. Moldovan/Romanian
2. Russian
3. Ukrainian
4. Gagauzian
5. Bulgarian
6. Roma
7. Other, which.....?

81. What language do you usually speak in the family? (one possible answer)

DON'T READ THE ANSWERS

Romanian/Moldovan	1
Russian	2
Ukrainian	3
Bulgarian	4
Gagauzian	5
Romani	6
Other, specify _____	7
Several languages, almost equally, specify _____	8
(don't read) I don't know	98
(don't read) I refuse to answer	99

82. What is your religious affiliation: (one possible answer)

1. Orthodox
2. Roman Catholic
3. Greek Catholic
4. Protestant, which one.....?
5. Neo-Protestant, which one.....?
6. Other, please specify _____
7. Atheist/none

83. What is your education level: (one possible answer)

1. No education
2. Primary
3. Secondary
4. Upper secondary
5. Vocational
6. College
7. High (Bachelor, Master)
8. Postgraduate (PhD)

99. (don't read) I don't know/I don't answer

84. How would you describe the financial situation of your family? (one possible answer)

1. Very rich
2. Rich
3. Average
4. Poor

5. Very poor

85. Which of the following statements fit best for your household? (one possible answer)
SHOW CARD 85

Money are not enough for even for food	1
Money are enough only for food, but not enough to pay the bills	2
We can buy food and pay the bills, but we can't buy clothes	3
We can buy clothes, but we can't afford important household goods	4
We can buy household goods (fridge/washing machine), but we can't buy a car	5
We can buy a car, a summer house, we can travel abroad	6
(don't read) I don't know	8
(don't read) I refuse to answer	9

86. What is your occupation? (one possible answer)

Student	1
Pupil	2
Employee	4
Self-employee (e.g. agriculture, etc.)	5
Pensioner	6
Unemployed (inactive persons, I'm not actively searching for a job)	7
Unemployed (registered with the employment agency, I'm searching for a job)	8
Other, specify _____	9
(don't read) I don't know/I don't answer	99

87. Region

North	1
Centre	2
Chisinau	3
South	4

THANK YOU FOR YOUR PARTICIPATION