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Implementing an organised cervical screening programme in the Republic of Moldova—Stakeholder identification and engagement

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ABSTRACT

Introduction: Successfully implementing cervical screening programmes requires them to be adapted to the local context and have broad stakeholder support. This can be achieved by actively engaging local stakeholders in planning as well as implementing the programmes. The Moldovan government started implementing an organised cervical screening programme in 2010 with the first step being stakeholder identification and engagement.
Materials and methods: This process started by contacting easily identified stakeholders with each asked to recommend others and the process continued until no new ones were identified. Stakeholders were then involved in a series of individual and group meetings over a 2-year period to build confidence and encourage progressively greater engagement.
Results: In total, 87 individuals from 46 organisations were identified. Over the 2-year process, the individual and group meetings facilitated a change in stakeholder attitudes from disinterest, to acceptance and finally to active cooperation in designing the screening programme and preparing an implementation plan that were both well adapted to the Moldovan context.
Discussion: Developing the broad support needed to implement cervical screening programmes required ongoing interaction with stakeholders over an extended period. This interaction allowed stakeholder concerns to be identified and addressed, progress to be demonstrated, and stakeholders to be educated about organised screening programmes so they had the knowledge to progressively take greater responsibility and ownership.

1. Introduction

Compared to Western Europe, cervical cancer rates are much higher in Eastern Europe and Central Asia (EECA) where ≈40,000 women develop and ≈20,000 women die from this disease every year [1,2]. Cervical screening could reduce these rates substantially and while available in most EECA countries, it is provided opportunistically with low population coverage, limited health service coordination and no quality assurance, so its impact is minimal [3]. For cervical screening to be effective, it must be delivered through organised programmes with the mechanisms to achieve high and equitable population coverage (≥75%), monitor screening and follow-up attendance, and ensure all the component health services are well-coordinated and high quality [4,5]. Under these conditions, organised cervical screening programmes (CSPs) can reduce both incidence and mortality by ≤80% [4,5].

The collapse of the Soviet Union at the end of 1991 led to political and economic upheaval across the region so governments and their health policies changed frequently and health budgets were cut drastically with the organisational elements of health systems badly affected [6–8]. These factors had many repercussions including a greatly reduced ability to plan or execute health sector development actions. This is particularly relevant for organised CSPs because their implementation requires both time

Abbreviations: EECA, Eastern Europe and Central Asia; CSP, cervical screening programme; RM, Republic of Moldova; SA, situation analysis; CA, capacity assessment.

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and high-level coordination which is only possible with sustained political support and competent direction at the level of the health sector.

A further issue with implementing cancer screening programmes is that health systems are complex adaptive networks with many components that each have many stakeholders [9,10]. The implementation of new health programmes was examined by Atun and colleagues who identified a number of factors that facilitated the process [11]:

- Ensuring regular interaction and communication between all stakeholders,
- Understanding stakeholder interests and aligning programme benefits with them,
- Understanding the interests of the public, aligning programme benefits with these interests and ensuring stakeholders are aware of these benefits,
- Allowing scope for reforms to be adapted to the local context (this was described as "critical" to the wider diffusion of reforms as it made them more attractive to the stakeholders, improved local ownership and reduced resistance).

This highlights the importance of doing more than just addressing the clinical aspects of a new health care programme to also account for the interests, motivations and alliances of the stakeholders who will deliver it. One way this can be achieved is by identifying and engaging all stakeholders in designing and planning the programme, not just in its implementation, as this will help to ensure the programme is well adapted to the local context, accounts for stakeholder interests and has broad stakeholder support.

In common with many EECA countries, the economic situation in the Republic of Moldova (RM) over the past 25 years has allowed only minimal health sector investment so robust data on cervical cancer are scarce. Nonetheless, the available data indicate that cervical cancer incidence and mortality rates are very high at 17.2 and 7.4 per 100,000 (ASRw) respectively [12], cervical cancer was the most common cancer among women in 2011 when it accounted for 39.3% of female cancers, the proportion of late stage (FIGO 3 & 4) diagnoses was 56.1% in 2011 and the proportion of women surviving for $\geq$5 years was only 61.5% [13]. These data are consistent with a lack of effective cervical screening and the consequent diagnosis of most cervical cancers on the basis of clinical symptoms that only appear in the late stages of this disease.

In recognition of this, the United Nations Population Fund (UNFPA) RM Country Office led advocacy actions to build political will for the implementation of the organised CSP. These included:

- Meetings with the Minister and Deputy Ministers of Health to inform them about the current situation with cervical cancer and its prevention in RM,
- Taking a delegation (Minister of Health, Deputy Speaker of the Parliament, Director of the Oncology Institute) to the Cervical Cancer Summit Meeting in the European Parliament.
- Organising events during the Cervical Cancer Prevention Weeks in January 2009 and 2010 that generated media coverage about cervical cancer prevention and thereby encourage greater political interest.

As a result, the MoH committed to the implementation of an organised CSP in March 2010 when the Director of the MoH Department of Hospital Care was appointed to liaise with the UNFPA for the organisation of subsequent actions.

The process then continued by identifying and recruiting a wide range of stakeholders who were actively involved in designing the programme and preparing its implementation plan. The objective of this paper is to describe the process by which the Moldovan stakeholders were identified, recruited and successfully motivated so that similar efforts in other countries can benefit from the lessons learned here.

2. Methods

Stakeholder identification and recruitment were undertaken from September to December 2010 by contacting the obvious ones such as the Ministry of Health (MoH), National Health Insurance Agency, medical societies, etc. But to ensure comprehensive representation, each of these stakeholders was asked to recommend others and this process was continued iteratively until no new ones were recommended.

Individual stakeholder meetings were then held from January to December 2012 to present an outline of the project together with the evidence upon which it was based, to gain a better understanding of their views and interests, and to obtain their recommendations for adaption of the project outline to the local context. These meeting were organised by the UNFPA and were chaired by the lead author.

Subsequently, all stakeholders were invited to a series of group meetings that were convened under Ministerial Orders (obliging stakeholder attendance), were held in the MoH and were chaired by either the Minister of Health or one of the Deputy Ministers who were responsible for facilitating the discussions.

The 1st stakeholder plenary meeting was held on 23 March 2012 to present the revised project outline, to address misconceptions identified during the individual stakeholder meetings, to obtain further feedback for final revision of the outline, and to agree the next steps. In addition, stakeholders with relevant experience were identified and subsequently provided with training so they could progressively take greater responsibility for leading the project.

After the 1st group meeting, a Ministerial Order was issued for all stakeholders to participate in:

- A Situation Analysis (SA) to collect data on cervical cancer rates, prevention and treatment practices as well as legislation, guidelines, etc. that could influence CSP delivery,
- A Capacity Assessment (CA) to collect quantitative data on staff, facilities and equipment for relevant health services, together with current service volumes.

Data were collected from June to September 2012 with data triangulation (stakeholder-stakeholder; stakeholder-government documents/published literature) used to identify inconsistencies and gaps in the data set. The data were collated, summarised and presented in a draft SA/CA report that was circulated to all stakeholders at the end of October 2012.

The 2nd stakeholder plenary meeting was held on 11 December 2012 to review the draft SA/CA report and resolve inconsistencies or gaps in the dataset. Further work was required to complete the datasets with the stakeholders again involved from January to September 2013. After verification of the datasets, the data were analysed to identify barriers to implementing or operating the CSP (inconsistent legislation; capacity deficits; etc.) with a revised SA/CA report prepared and sent to the stakeholders at the beginning of November 2013.

The 3rd stakeholder plenary meeting was held on 21 November 2013 when the stakeholders reviewed, revised and approved the final SA/CA report. Subsequently, they divided into working groups reflecting each of the health services that would be involved in the CSP (programme administration, screening registry, PHC services, colposcopy, cytology/pathology, QA and public health education)