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SHORT REPORT

Gynaecological examination in the context of prevention – attendance, attitudes and expectations of women

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A – Research concept and design, B – Collection and/or assembly of data, C – Data analysis and interpretation, D – Writing the article, E – Critical revision of the article, F – Final approval of the article

Abstract

Background: A gynaecological examination, often as part of a preventive gynaecological examination (PGE), has a legislatively determined content. Despite the efforts of all those involved, women do not attend gynaecological examinations sufficiently often. The aim of this short report is to highlight the current status of women's attendance at PGEs in Slovakia and to present women's expectations as well as the reasons for their attendance at gynaecological examinations.
Material and methods: This paper takes the form of a literature review.
Results: The results of the studies suggest ways to increase women's attendance at PGEs. The communication skills of physicians and nurses/midwives, creating a safe and intimate environment, as well as consistent education about the examination process, are considered key factors in increasing women's participation at a PGE.
Conclusion: Exploring the topic in a broader context may help to understand some of the changing aspects of women's motivation to participate, but more importantly to understand the importance of the attitude of health professionals in gynaecological examinations.
Keywords: preventive gynaecological examination, women's expectations, women's attitudes, prevention, legislative norm

Introduction

Despite the fact that every woman is entitled to a free preventive gynaecological examination (PGE) covered by health insurance and the availability of gynaecological outpatient clinics in our area is sufficient, the number of attendees at PGEs has shown a long-term downward trend. The aim of a PGE is a comprehensive gynaecological screening aimed at the search and early diagnosis of organic and functional disorders of the female genital organs (Act No 577/2004). The examination includes

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a thorough medical history and professional advice on contraception, hormone replacement therapy, prevention of sexually transmitted diseases and advice on the increased risk of gynaecological malignancies associated with a positive family history and the presence of other risk factors in a woman. As follows from the foregoing, a gynaecological examination is always an integral part of a PGE, but a woman may also undergo a gynaecological examination for reasons other than preventive ones (Figure 1).

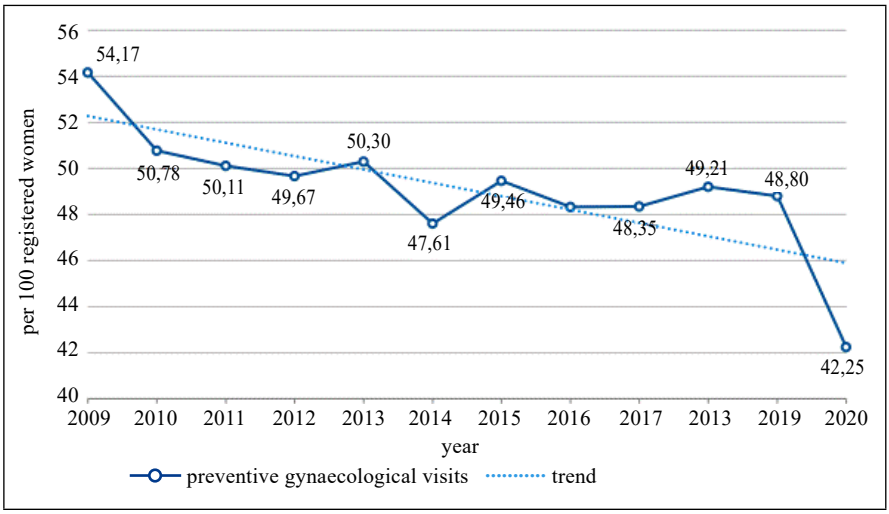


Figure 1. Attendance at PGEs for the period 2009–2020 (NCHI, 2021a)

The prevailing trend abroad is to conduct surveys about women's feelings, experiences and expectations regarding gynaecological examinations. The words intimacy, communication skills, safe environment and support, etc., are emphasized. It has been shown that these expectations play a crucial role as they influence women's motivation and attendance at gynaecological clinics.

Attendance of women at PGE

We relied on statistical data obtained from the National Centre of Health Information (NCHI) in Slovakia, which summarizes data provided by gynaecological outpatient clinics. In 2020, as many as 773,837 PGEs were reported, representing 42.2% of these visits per 100 registered women. Compared to 2019, the number of PGEs had dropped, resulting in a 13.4% year-on-year decrease (based on the total number of possible PGEs in

the given years). This is the lowest annual number of recorded PGEs for the reporting period 2009–2020, probably also due to measures related to the COVID-19 pandemic. In the long term, compared to 2009, there was a 23% decrease in PGEs recorded in 2020. Attendance at PGEs, despite a slight increase in 2013, 2015 as well as 2018, shows a long-term downward trend (Figure 1).

The lowest diagnostic and therapeutic attendance of women for screening and subsequent treatment of a pre-existing condition or disease within the study period (2009–2020) was recorded in 2020. Compared to 2019, a year-on-year decrease of 9.9% was observed (all calculations based on the total number of possible visits), which may also be related to the pandemic measures of COVID-19. In 2020, PGEs accounted for 26.1% of outpatient visits [1].

In Slovakia, preventive medical examinations are fully covered by health insurance companies. At present, there are 3 health insurance companies in Slovakia, one state and two private insurance companies, which currently offer benefits in connection with the PGE, as listed on their websites.

Comparison of PGE conditions in Slovakia and abroad

Table 1 gives an overview of the differences in the conditions, content and intervals of the different components of PGE in selected countries.

Table 1. Comparison of PGEs in selected countries

Country	Age of the 1st gynaecological examination	Oncocytology	Breast examination
Slovakia	From the age of 18 or 1st pregnancy	Aged 23–64, the first two cytology collections at annual intervals. If these two cytology results are negative, repeat examination at 3-year intervals	Palpation: part of every PGE Ultrasound: every 2 years Mammography: from age 40–50
The Czech Republic	From the age of 15	Aged 35–45, covered by health insurance	Palpation: from the age of 25 in women with a positive family history Mammography: from 45 every 2 years

Country	Age of the 1st gynaecological examination	Oncocytology	Breast examination
Poland	From the age of 12–15, usually after the first menstruation, but at the latest before the first sexual intercourse	Free cytology is recommended within 3 years of the beginning of sexual activity (*virgo intacta*: before the age of 25), once every 2–3 years until the age of 59	Ultrasound: aged 20–30 every 2 years, aged 30–40 once a year, over 40 every 6 months Mammography: from 50 to 69 years every 2 years, over 50 once a year
Hungary	After first sexual intercourse, or between the ages of 18–20	Aged 25–65 every 3 years with negative result	Mammography: from 45–65 every 2 years
Italy	From the age of 16–21, or within a year of the first sexual intercourse	From 25 to 64 years of age every 3 years	Mammography: from ages of 45 to 49 every 12–18 months, from 50 to 74 every 2 years

Different countries have set different age ranges of the target population for organized cervical cancer screening programmes (Table 1). On the basis of the analyses of screening issues initiated by the Europe Against Cancer Programme (EACP), groups of experts from 17 European Union member states have developed the European Guidelines for Quality Assurance in Cervical Cancer Programmes [2]. As follows from these guidelines, the screening should start around the age of 20–30 and stop at the age of 60–65 if the last three cytology results are negative.

Attitudes, expectations and reasons for gynaecological examinations in women

PGE and regular screening are also strongly recommended by the WHO [3], which, in one of its publications, draws attention to the fact that there are currently approximately one million women with cervical cancer worldwide who are unaware of their disease because they do not visit a gynaecologist. In order to increase the number of preventive visits to gynaecological clinics with the aim of preventing and identifying any problems, and ensuring early detection of more serious health conditions, including gynaecological cancers at an early stage, many studies have addressed the question of women's attitudes, expectations and reasons for attending or not attending a PGE.

Since the 1970s, many researchers have analyzed the experience of women through gynaecological examinations. During the examination, women are in an extremely vulnerable situation. A gynaecological examination can trigger many negative feelings such as fear of illness, pain,

embarrassment and awkwardness. Many women have negative experiences of gynaecological examinations. Women receive inadequate information about how the examination is to be performed, about the anatomy and physiology of their genitals. The examination procedure can be perceived as very uncomfortable and even humiliating. In addition to the physical discomfort, psychological factors also play an important role, as the gynaecological examination involves the exposure of intimate parts of the body in a vulnerable situation with a loss of control. Women experience many feelings such as embarrassment about undressing, concerns about cleanliness, doubts about vaginal odour, fears that the gynaecologist might find out something about sexual practices, fear of revealing a pathological condition, and fear of pain. Cold instruments, a lack of awareness of the procedure and a lack of care on the part of the gynaecologist are also perceived as important factors. Most of these aspects may be of greater significance when the gynaecologist is male [4].

The embarrassment of exposure can be alleviated by a simple measure such as a wrap skirt, which greatly reduces the discomfort and sense of vulnerability associated with nudity [5].

A Swedish study evaluated more than 520 questionnaires sent to randomly selected Swedish women of childbearing age [6]. The women had positive attitudes towards gynaecological examinations in general, but negative experiences with specific parts of the procedure. The experience of the first examination was more negative than the experience of the last examination. The first gynaecological examination has been shown to be a statistically strong factor for subsequent attitudes towards gynaecological examinations [6,7]. A woman's first gynaecological examination should therefore be used as an opportunity to condition positive emotions as a basis for future positive experiences. The effects of different relaxation methods (aromatherapy, music therapy, etc.) on reducing anxiety about the gynaecological examination are also currently being investigated with positive responses [7]. The temperature of the environment, the choice of wall colours and lighting of the room as well as the overall design of the outpatient clinic have also been shown to have an impact on women's attitudes in this field [8].

The emotional contact between the woman patient and the examining gynaecologist seems to have a great influence on comfort/discomfort during the examination. A Danish study points out that discomfort during gynaecological examinations tends to be associated with a number of factors that are rarely known to gynaecologists, such as a history of sexual abuse, mental health problems and a woman's sex life [9]. Gynaecologists should focus on emotional contact and make full use of their communication skills prior to the examination.

Women often report a feeling of a lack of information about the examination process. They would welcome a verbal description of the different stages of the examination before and during the examination itself – a warning about possible soreness, coldness and touch. A negative experience of a gynaecological examination correlates with a woman patient's lack of knowledge [10]. Reasons such as lack of time, workload, discomfort due to shyness, fear of illness/bad results have been reported across studies examining this issue. Research involving 106 respondents has also shown that shame, fear of the gynaecologist (of not receiving a positive result), as well as a lack of awareness of the possible risks of not attending preventive check-ups, are frequent barriers to attending PGE [11]. In 2011, a British survey with 1515 woman patients reported the shame of telling the doctor about their problems (47%), but also inconvenient appointment options (35%), as the main reasons for not attending a PGE [12].

Workload and the feeling that visiting a gynaecologist is futile unless a woman has problems are also leading reasons for neglecting a PGE [13]. Similarly, a study on a sample of 1000 Slovak women showed that the most common barrier for those women who do not visit a gynaecologist is the belief that they do not need to go for a PGE unless they have health problems. The study also showed a lack of awareness among women. To increase awareness, the author recommends leaflets from the doctor or pharmacy as the most appropriate source of information, which has proved to be the first spontaneously named source and, after a conversation with the doctor, also the most trustworthy. The internet, mainly used by younger age groups, is also a suitable communication channel, being considered by respondents as the most important, intimate and detailed source of information about the course of gynaecological examinations. Journals and women's magazines also appear to be a suitable platform for the most simple communication campaigns [14].

Another study showed that women perceive the importance of a PGE and that important factors that motivate them to undergo a PGE are trust, discretion, sensitivity, communication and the gynaecologist's expertise [15]. Another piece of research pointed out that awareness of PGE is sufficient, but less than half of women (44.09%) actually perform a breast self-examination [16]. It has also been revealed that only 15.2% of university female students regularly perform a breast self-examination [17], and around 37% of women do not consider breast self-examination to be important, which is worrying in the context of the risk of breast cancer [18].

Awareness, education and lifestyle are not the only parameters that influence women's participation at PGEs. It is also determined by women's

own attitudes towards the importance of PGEs, as well as the fear of a serious disease [19]. Therefore, it is necessary to inform women in a broader context about the risks associated with the occurrence of these diseases, but also about ways in which they can be prevented. The most effective tools in this field are direct contact with women, for example, in the form of an SMS or an invitation to a PGE [20].

It can be concluded that across studies the following have been found to be the principal reasons why women do not undergo gynaecological examinations: discomfort and shyness, fear of illness/bad results, a lack of the perception of its importance, a lack of time and workload. In the course of the examination, women particularly expect clear communication, a sensitive approach, a thorough explanation of the results of the examination and protection of intimacy by health professionals, which appear to be more of a priority for women than the expertise and experience of the gynaecologist.

Conclusion

The contribution of this paper can be linked to the fact that we have identified an area in which women's motivation for PGE attendance can be improved: a personal approach, sensitive communication and the professionalism of health professionals (gynaecologists, midwives, nurses). The prevention platform has an important position in this issue. The communication skills of doctors and nurses/midwives, the creation of a safe and intimate environment and consistent education about the examination process are considered key factors in increasing women's participation at PGEs.

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