

# Female Genital Cancer in Kosovo

## a situational analysis of breast and cervical cancer 2008

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## Executive summary

This paper details the preliminary findings of the first phase of a study of cervical and breast cancer in Kosovo. Although it touches upon potential directions the public health sector might take, it is primarily a **Situational Analysis**, looking at the various services available to the women in Kosovo and any obstructions to the diagnosis and management of these important diseases.

The analysis involved site visits, structured interviews and data collection. Throughout the study, the team was received with courtesy and helpfulness. There was a universal recognition that the current situation is far from satisfactory and an equally universal desire to improve. We thank all those dedicated professionals who took time out to meet us and talk through the issues as they see them. We found that:-

1. A study of female genital cancer in any population and health system requires accurate data. **Robust epidemiological , clinical and survival information is unavailable in Kosovo at the present time.** Although there is a reporting process for cancer registration this is rarely utilised currently. Operative data are only available by direct scrutiny of protocols and there is no system for documenting postoperative outcome or survival long term.
2. **Many cervical and breast cancer cases in Kosovo remain undiagnosed and untreated.** There is hidden burden of disease amongst women who live and die with their disease, lacking even basic medical or social intervention or support. We estimate that at least 50% of female genital cancers – probably well in excess of two hundred new cases every year – are going undiagnosed. **Without intervention, this figure is going to increase significantly year on year as the relatively young population matures.**
3. When a woman actually presents with symptoms, **there is widespread evidence of inadequate investigation and work-up, haphazard management decision making and inappropriate treatment and follow-up.** Some women elect at an early stage to take their management – especially if radiotherapy is indicated – out of Kosovo altogether. Thus even the current volume of cases, if managed according to contemporary guidelines, represents a real challenge to secondary care.
4. Although there appears to be the overall capacity to manage the disease that is currently being detected, albeit suboptimally, **there will be a significant capacity crisis when detection rates increase**, even in the absence of a real increase in case numbers year on year.
5. **Those cancers that are detected are almost exclusively in symptomatic women, presenting too late for a reasonable success of clinical cure.** There are no public sector systems in place to encourage women to become “breast aware” or to promote opportunistic clinical examination of the breast in primary or secondary care and no organised breast screening programme. No coordinated cervical screening service exists and opportunistic smears from asymptomatic women are rarely undertaken in primary care.
6. Efforts to raise awareness of breast disease run the risk of further escalating the pressures on current capacity. Even with the relatively high mortality rate of breast cancer, **“catch up” of cases currently undiagnosed would increase the number of patients requiring immediate management by well over 200%.** Given that cervical

disease includes intervention for premalignant disease, a similar crisis would be precipitated by an awareness campaign in this field unless capacity is addressed first.

7. **The patient pathway, from presentation to definitive treatment, is confused, inefficient and ineffectual.** Self referral to secondary or tertiary clinics continues, despite legislative attempts to encourage consultation and referral from primary care; **diagnostic support is frequently unavailable or difficult to access at the place of presentation**, requiring the use of private facilities, often in Pristina not in the locality.

8. Across all services and at all levels **there are real problems regarding technical support.** Radiological, colposcopic and laboratory equipment, where present, is poorly serviced and difficult to repair. Consumables and parts are frequently unavailable.

9. When the equipment is functional, staff are generally either untrained or inadequately trained to utilise the equipment appropriately. **The need for training was a universal theme throughout the visit**, from primary care through to the campus in Pristina.

10. **Patients, specimens and results are often lost to the process** and there is absolutely no audit as to the quality of diagnostic support. Even after a firm diagnosis of malignancy has been made, a patient may default from care but will be assumed simply to have moved into the private sector for definitive care.

11. Although operative decisions may be made by local consilia, these are generally limited to members of the surgical team with no consistent input from radiology or pathology. **Clinical decisions with regard to treatment in secondary care do not conform to any recognised set of guidelines**, either local or international and vary considerably across the health care facilities we visited.

12. Partly because of the pressure of work at a secondary level, **the UCCK units managing breast and cervical cancer are unable to deliver a comprehensive tertiary clinical service to Kosovar women.** UCCK is also unable to provide important oversight of clinical pathways, training and continued professional development for staff working in breast and cervical disease across Kosovo.

13. **At present there are no facilities for radiotherapy within Kosovo. Chemotherapy is limited and poorly orchestrated. No palliative care facilities exist** and long term planning for the management of patients with advanced disease is not seen as a core service in any of the institutions we visited, including UCCK.

14. **The Institute of Public Health, Centre for Development of Family Medicine and the Telemedicine Centre of Kosova are underutilised resources** that might play a more pivotal role in advancing quality in the detection, investigation and treatment of female genital malignancy.

In summary, female genital cancer in Kosovo represents a major challenge and an unmet need. Although some services are in place, these need considerable additional support. Before any consideration is given to the introduction of routine screening programmes, progress needs to be made in the following key areas: community awareness; process mapping and data collection; professional education and training; equipment maintenance and consumable supply; diagnostic support and the development of clear and universal treatment protocols or clinical pathways.

Most critically, the system needs urgent capacity building across all aspects of care from diagnosis to definitive treatment and palliative care. Ideally, this capacity should be in place before there are any attempts to materially increase community awareness or introduce systematic screening services.

## Introduction

There is a growing recognition that the burden cancer places on low resource countries is a challenge that must be met with some urgency. The background to this Situational Analysis is best summarised by a direct quote from its Terms of Reference:

*“Breast and cervical cancers are among the leading cause of cancer death in women, with fatality rates higher in low-resource countries and, in regions without early detection programs, mortality is also increasing.*

*In Kosovo, breast and cervical cancer rates have been on the increase constantly, according to reports from different regional hospitals, although there is no official data to confirm this trend.*

*There are no primary cancer prevention programs in Kosovo through education on risk factors, behaviour change strategies or vaccination. No systematic early detection through screening programs for breast and cervical cancer are in place.*

*There is insufficient functioning mammography equipment available and no central laboratory is in place that has the capacity to properly analyze a large number of Pap-smears and breast cytology tests. The quality control of existing cytology and colposcopy tests is very poor and there is no systematic referral system for the positive cases.*

*The Institute for Public Health in Kosovo recently started to organize the cancer registry, but the referral system is unclear and medical services for treatment of pre-cancer and cancer patients are very poor.”*

It was concluded that, prior to starting development of new services and activities addressing breast and cervical cancer or modifying the existing ones, a needs assessment was required to determine what services are available, how they are functioning and what factors limit women’s access and utilization of them. Given the magnitude of the challenge, it was determined by the UNFPA at the initial briefing session on the 27<sup>th</sup> November to restrict the remit of the first report to a Situational Analysis, on which further work on a Needs Assessment and Options Review might be built later.

A team was assembled, comprising two external consultants and representatives of the Ministry of Health, the National Institute of Public Health, the Centre for the Development of Family Medicine and the Departments of Thoracic Surgery and Gynaecology at the University Medical Centre of Kosovo, supported by a project manager from the UNFPA. We are very grateful to the team members for the time and enthusiasm they dedicated to a very intensive programme and also to all the health care professionals that took time to talk to us – at very short notice – and who all expressed the same desire to improve the future for women with genital cancer in Kosovo.

Cancer prevention, diagnosis and treatment requires a complex, coordinated multi-agency approach, based on sound reporting, best clinical practice and consistent application of standard protocols. Cancer care in Kosovo lacks a sound epidemiological database; it operates as a function of secondary and tertiary care with practically no involvement by primary care or community based services; this care is unevenly distributed geographically and involves the private sector in a haphazard and unregulated fashion. Treatment is generally in response to self-referral from a population that is poorly informed with regard to genital cancer and, where women are finally diagnosed with a genital cancer, there is no coordinated system to examine quality of care and operative outcomes and no standardised system of aftercare or palliation.

The patient journey for Kosovar women with possible breast or cervix cancer is unpredictable and inequitable. It is complicated by historical, cultural, political and financial factors as well as by entrenched attitudes amongst both the general public and Kosovar health care workers. Options for change must take all these factors into account. There is a great deal of work to be done.

## 1 Methodology

The situational analysis was based on a series of site visits and questionnaire-based, semi-structured interviews in Pristina and the major regional centres. At each visit, the team investigated the detection, investigation and treatment of breast and cervical disease as well as assessing capacity, training, quality control mechanisms (audit), equipment, referral systems, documentation and reporting systems and identifying local needs and barriers. The clinical facilities were inspected, data was gathered wherever possible and the process of clinical care was mapped. We have also documented regional initiatives and regional and local best practice wherever possible. In each of the regional centres the visits included visits to, or discussions with, the Directorates of Surgery, Gynaecology, Radiology and the clinics (including the Women's Wellness Centre in Gjilan Regional Hospital). In several centres we were also able to meet the Hospital Director.

### 1.1 The team consisted of the following members:

**Dr Njazi Shala** – Officer for MCHRH, Ministry of Health

**Dr Majlinda Gjocaj** – Officer for Quality Control, CDFM

**Prof Merita Berisha** – Head of Maternal & Child Health Observatory, Institute of Public Health

**Dr Saudin Maliqi** – Thoracic Surgeon, University Medical Centre of Kosovo

**Dr Jakub Ismajli** – Gynaecologist, University Medical Centre of Kosovo

**Dr Zarife Miftari** – Project Manager, UNFPA

**Dr Simon Knowles** – Pathologist, Somerset, UK

**Dr Mary Packer** – Reproductive Health Consultant, UK

### 1.2 The visits and interviews were as follows:

#### **University Clinical Centre of Kosovo**

Thoracic Surgery

Gynaecology and Obstetrics Clinic

Cytology laboratory in GOC

Department of Radiology

Institute of Pathology

Institute of Oncology

Department of Telemedicine

#### **Regional Hospitals**

**Prizren Regional Hospital**

**Gjakova Regional Hospital**

**Gjilan Regional Hospital**

**South Mitrovica Hospital**

**Peja Regional Hospital**

**Ferizaj Hospital**

### 1.3 Other visits included:

**National Institute of Public Health**

**Gjakova Institute of Occupational Health**

**Kaçanik Main Family Medicine Centre**

**A private acute secondary and tertiary facility in Pristina**

### 1.4 Interviews were held with

**Prof Naser Ramadani**, Director of the National Institute of Public Health of Kosovo

**Dr Selami Sylemani**, President of the Kosovan Society for the Medical Application of Ultrasound

**Dr Curr Gjocaj**, Director of the Department of Health Services in the Ministry of Health

**Dr Elvis Ahmedi**, former Director of Thoracic Surgery, UCCK

**Prof. Ass. Dr. Lumnije Luci**, Pathologist, Institute of Pathology, UCCK

## 2 Background to the Current Situation

By most definitions, Kosovo can be described as a “fragile State”. Ten years after the war of 1999, and a nearly a year since the birth of the Republic, the health care system in Kosovo remains in a state of uncomfortable transition. Following the war, UN Security Council Resolution 1244 established UNMIK as an interim administration overseeing the civil administration. The Department of Health (now the Ministry of Health) made a conscious decision to radically reform the whole of the health care system around a general European model rather than restoring the system that it had inherited from the former republic of Yugoslavia. This was always going to be a challenging ambition and the successes and shortcomings of the policy as at 2006 are discussed by Dragudi Buwa and Hannu Vuori (see appendix). It could be argued that little has changed for the better since that paper and perhaps the situation is less optimistic than previously as the rate of reform has slowed and as international aid begins to falter.

The major factors relating to the current state of the health care system can be summarised thus:

### 2.1 The Original Soviet Socialist Health Care System

Soviet health care has traditionally been characterised by a monolithic, centralised, hierarchical and intensely bureaucratised system, driven by a target-orientated management using vertical programmes with a strong focus on treatment rather than prevention and on hospital-based and (medical) specialist-based services rather than on primary care. Such primary care as existed in the municipal health houses was under-equipped and under-funded and jobs in this arena were regarded as relatively low status. The health care system in Kosovo remains characterised by an almost complete disconnect between primary and secondary care. Nurses and midwives – pivotal to womens health elsewhere across the globe – are still underutilised, undervalued and unsupported because of a deeply embedded cultural preference for specialist medical care.

### 2.2 The “Temporary Measures” 1988-1998

Following on the political events of 1988 to 1990 there was a systematic removal of Albanian Kosovars from all areas of public service including health. The Albanian response was to form a parallel programme of health care, including education for medical students. For entirely understandable reasons, this parallel system was under resourced and unable to keep abreast with modern developments in health care. In addition to the damage caused to the Albanian medical profession in Kosovo by the “Temporary Measures”, the loss of experienced managers to the health service following the war meant that there was a shortage of the skilled managers needed to move local reform forward, compounded by a tendency to revert to the traditional socialist mind-set that all decisions come from the centre, despite a conscious and very well publicised policy to decentralise health service operations to district and local level.

### 2.3 The 1999 War

Many of the health care facilities that had been badly maintained or systematically stripped of capital investment prior to the war suffered direct physical damage during 1999. The damage the conflict caused to infrastructure was compounded by the harm caused by the sudden virtual disappearance of staff from all positions in health, including medical and managerial posts, with spiteful “putting beyond repair” activities on equipment and furnishings as they departed. With most remaining Serbs now based in enclaves, another “parallel system” is being established – with explicit encouragement from Serbia – to the detriment of the evolving health programmes envisaged by the Kosovo Ministry of Health.

## 2.4 Post-war international aid and budgetary constraints

At the end of the 1999 conflict, over 400 international donors and agencies descended upon Kosovo. Coordination of a wide range of disparate programmes designed to assist in the reconstruction of the health care system has, predictably, been only partially successful. Some aid programmes have worked well but others have been less effective. This is often due to lack of continuity: equipment without consumables, maintenance contracts or trained personnel; individuals who are trained but do not have access to patients or facilities to use or to maintain these skills; and a tendency to fund a specific component of care without attention to the whole “patient journey” or the context in which health care currently operates in Kosovo. As international aid contracts, future developments will need to be self-funding. This will prove a real challenge for the Ministry of Health, given the current budget.

Given this background, it is not surprising that the current situation for Kosovar women with possible breast and cervical cancer is far from ideal.

## 3 Findings from the Situational Analysis

The report will follow the “patient journey” then look at key support services including public health and need for CPD and service contracts etc. A major conclusion from the Situational Analysis is that quantitative information is poor or completely unavailable. For this reason, much of the following discussion is descriptive rather than supported by specific data.

### 3.1 Personal and community attitudes to female genital cancers

Women in Kosovo, like women worldwide, fear developing cancer, particularly if the breast or other genital organs are affected. Not only is there an emotive fear about potential disfigurement and shortened lifespan, but there is the added anxiety of an unclear route to obtaining appropriate treatment which is likely to be costly, as well as the embarrassment of medical consultations about symptoms in intimate parts of the body.

In a study undertaken by Dr Arberesha Nela-Turjaka (see appendix) as part of a Masters programme, 303 women attending primary care facilities in and around Pristina were questioned about their knowledge of risk factors and early detection of breast cancer. The average age of the cohort was 38 years and a third had completed higher education at University level, a very high proportion compared to the general population. With regard to place of residence, just a third lived in a rural location contrasting with the population wide proportion of 60% from rural dwellings. Key findings included the response that, whereas only 2.4% of urban women did not know that breast cancer was a serious illness, almost a fifth of women from the village were unaware of this fact. There was a significant difference in awareness of the seriousness of breast cancer between employed and unemployed women, the latter group being less likely to know.

Despite the high level of educational attainment of the group, there was still a considerable lack of understanding about risk factors and methods of early detection of breast cancer. However, it was clearly shown that the more educated the woman was the more likely she was to have talked to someone about the disease: ranging from 30% of women with no education to 82.9% of women with higher education. When asked who they had talked with, only a quarter of the women mentioned a health care worker, with the Family Medicine doctor being the most commonly cited. The majority of those who had ever talked with anyone about breast cancer, had talked with a female friend.

Fear was a major barrier to women going for any kind of breast examination, with around half the sample stating that they would be frightened or hesitant to go. Reasons given included: fear of breast cancer being diagnosed; better not to know; high cost of investigative procedures. Although slightly over half of the women questioned knew about breast self-examination, less than a half ever



examined their own breasts and the proportion of the group correctly understanding the procedure and its timing was very small.

The conclusion of Dr Nela-Turjaka's study was that there is a paucity of clear information as regards risk factors and early detection of breast cancer in the general population, but particularly in rural areas. She recommends involving Family Medicine doctors in more pro-actively disseminating relevant information about breast awareness and screening techniques.

No similar study exists of attitudes and knowledge about cervical cancer among Kosovan women. A general comment can be made that many women in Kosovo do not know about the existence of a test for detecting precancerous cervical disease. However, in general, women will consult a gynaecologist if they experience irregular bleeding or other pelvic or vaginal symptoms. Of the relatively small number of women who do request, or are offered, a smear test when consulting a gynaecologist many become very alarmed by a result that is not totally normal, for instance, a Papanicolaou Grade II result with a 'hygiene' level of Class 3. They are also subjected to polypharmacy with antibiotics, antifungals and antiseptic agents commonly prescribed. A Grade III result may be seen as almost amounting to a 'cancer', even though this is merely equitable to the possibility of low grade precancerous change. Overuse of cytology amongst the 'worried well' is a major problem in the unregulated setting in which cervical cytology exists in Kosovo. In this group, it is not unusual to have two to four smears in a year. With the absence of adequate colposcopy services, women will, if they can afford to, go to Skopje to consult gynaecologists in private clinics where they consider that the approach is more 'women centred' and the possibility of outpatient treatment more appealing.

### 3.2 Primary care

Primary care facilities in Kosovo comprise a total of 448 units. These span 32 Main Family Health Centres, 14 of which have maternity units, 152 Family Health Centres and 263 Ambulancas/punkts. Sixty seven of these primary health care facilities are in the parallel health system. They are spread relatively evenly across the country and should allow the majority of Kosovars easy and local access to advice, support, basic treatment and, where necessary, triage and referral to secondary care or further investigation. A recent World Bank report, yet to be finalised and published, asserts that these units are sufficiently well staffed to be fit for current purpose but current purpose is far from optimal and the Kosovo Health Strategy foresees a much broader remit for primary care than is currently in evidence. This is of particular relevance to breast and cervix cancer. We have encountered no evidence to suggest that primary care is effective in screening for these cancers, either systematically or opportunistically and no evidence that any patient is offered either a clinical breast examination or cervical smear as part of a routine consultation.

There are three issues here, all endemic within the current environment in Kosovo. Firstly, the effective abuse of primary care facilities for minor ailments leading to time pressures upon the clinic staff and often resulting in unnecessary and inappropriate treatments. Secondly, the continued practice of self-referral to secondary or tertiary care not only sidelines primary care facilities but also continues to prevent empowerment of family medicine doctors in their crucial role as gatekeepers to secondary care. And thirdly, although newer training may equip family medicine doctors to take cervical smears and perform clinical breast examination (CBE), in practice, these examinations are rarely performed, requested or suggested. This is in part a general cultural issue but also reflects a deep prejudice by the gynaecological specialists against smears being performed by other specialist medical staff (let alone trained nurses or midwives such as are used elsewhere).

With regard to screening capacity, there will be little point in developing effective awareness raising campaigns with regard to cervical and breast disease unless it can be met by widespread competence and confidence at primary care level in CBE and smear taking. It is possible that opportunistic CBE will be a more effective modality for the detection of established and breast

disease than a formulaic method of breast self-examination and it will prevent excessive referral for the treatment of innocent lesions.

In terms of the equipment required within the primary care facilities, CBE requires warm hands and a quiet examination room. Cervical smears require clean specula, glass slides, a pencil, spray-on fixative and cervical spatulae that are fit for purpose – Ayres or Aylesbury type and not the tongue depressors in universal use across Kosovo. The outlay for such consumables is negligible.

### 3.3 Secondary care

As can be seen by the details of the site visits in the appendix, secondary care facilities are variable across Kosovo. Although there are examples of good practice, no single unit is satisfactory in every regard. General and systemic issues have been listed in a variety of reports, most recently that from the World Bank. These issues include:

- poor infrastructure, especially with regard to cleaning and maintenance;
- ongoing self-referral despite minor financial disincentive in the copayment system;
- equipment haphazardly acquired, without maintenance contracts or consumable budgets;
- training and competence shortfalls at all levels;
- poor record keeping and consequent lack of continuity of care;
- poor or absent diagnostic support within the public sector;
- an absence of standard working practices such as clinical protocols or pathways;
- lack of audit and failure to register cancer cases to the Institute of Public Health;
- blurred or absent lines of communication to and from primary and tertiary care

Perhaps the single most important problem identified was the lack of a defined patient pathway for cases of suspect breast or cervix cancer that would accommodate all aspects of investigation, diagnosis and treatment. Although several of the regional centres used a *consilium* for the purposes of clinical decision making, these did not, in many cases, appear to function as genuine multidisciplinary team meetings and none had regular input from the diagnostic services nor did most of the teams work to defined clinical protocols or treatment pathways. The absence of a defined pathway allows patients to be lost to any form of follow-up and there seems little appetite for any local service to take ownership of a patient from the point of referral through to a satisfactory and documented outcome.

Problems identified in the support services such as pathology and radiology are discussed later.

With regard to the surgical procedures documented during the site visits (and detailed in the appendix), the following general observations can be made:

#### **Breast disease**

Surgical treatment of breast disease in secondary care is limited to two procedures. *Lumpectomy* (with variable width of clearance up to and including segmentectomy) is generally the procedure of choice for palpable lumps which are thought to be benign or where a tissue diagnosis is required. Core biopsy is not undertaken anywhere routinely, including at the UCCK. *Modified radical mastectomy* is the modality used where cancer has been confirmed (radiologically or cytologically) or is clinically probable. No surgeon we spoke to liked the idea of a two stage process depending on tissue diagnosis. Sentinel node biopsy is not an option at the moment. Axillary clearance rather than axillary sampling is the general rule.

#### **Cervical disease**

A fairly widespread approach to high grade abnormality based on a single cervical smear with no supportive colposcopic or biopsy evidence) seems to be to proceed to a “prophylactic” *simple hysterectomy* or an over-generous cone biopsy. In a young patient this is inappropriate. In a patient who turns out to have an early invasive carcinoma this prevents the treatment of choice which

would be a Wertheim's procedure. Even in Pristina, treatment for proven cancer appears to be by simple hysterectomy only. Clinical staging is inadequate and does not include examination under anaesthetic and cystoscopy. Where units undertake (cold knife) cone biopsy this is inevitably performed in theatre with no outpatient LLETZ treatments. In the absence of accepted standard guidelines for the investigation, diagnosis and treatment of cervical dysplasia or carcinoma (early or late stage) it would appear that Kosovar women are either undertreated or overtreated.

### 3.4 Tertiary care, aftercare, follow-up and palliation

The University Clinical Centre of Kosovo provides the secondary care for around 800,000 individuals and yet is also expected to meet the tertiary demands of the whole of Kosovo. There are clear tensions between these two obligations and the current net result is that the centre fails to meet either demand. This is compounded by the endemic problem of self-referral. As both the tertiary referral centre and also the main academic unit within Kosovo there should be an obligation on the UCCK to act as a beacon site for cancer care, to train and support continuing professional for health care professionals working in the regional centres and to facilitate appropriate referral from these centres to Pristina for definitive treatment. In practical terms, local circumstances prevent such a leadership role for the UCCK and its clinicians. They also mitigate against the provision of a high quality service, since diagnostic support is not a great deal better within Pristina than it is elsewhere in Kosovo. Capacity is a particular issue in the Pristina units as, for example, theatre time for breast surgery is already insufficient for current needs. Were there to be a significant increase in demand, driven by an awareness campaign, there would be little chance of responding.

With regard to surgical approaches, some of the comments from the section on secondary care apply at UCCK also. However there are better access to FNA and imaging for preoperative confirmation of **breast carcinoma** and a more analytical approach is taken to the surgery required. However no wire guided processes are undertaken, no core biopsy facilities are available, no frozen section facilities are utilised and no sentinel node biopsies are performed. Cervical dysplasia may be treated by cone biopsy however simple hysterectomy remains the most common intervention for **cervical carcinoma** and no tumours appear to be treated by Wertheim's (radical) hysterectomy.

There is one particular problem with regard to the patient pathway for Kosovan women with cancer of breast or cervix that is common for all cancer cases: palliative care does not exist within Kosovo. And documented follow-up and aftercare is also at best rudimentary. This flows in part from the absence of documentation and the lack of a formal pathway for patients. The current philosophy within Kosovo is that follow-up is the responsibility of the institution in which definitive treatment took place. However it would seem inappropriate for a tertiary hospital in, for example Tirana or Skopje to have long term responsibility for the care of a woman returned to her own municipality. When a patient is discharged from secondary or tertiary care, details as to her ongoing care – for example how many years of tamoxifen medication – should be delegated either to the local hospital or, more powerfully, to a specific primary care organisation or family medicine doctor.

### 3.5 Supporting services

There are significant problems in the delivery of effective clinical care, as discussed above, purely on the grounds of capacity, training and continuing professional development of clinical staff- gynaecologists, surgeon and family medicine physicians. However these problems are compounded to a great degree by failures in diagnostic services.

### 3.6 Radiology - ultrasound and mammography

The role of imaging in the diagnosis and management of cervical disease is limited to the investigation of advanced disease. This discussion relates largely to breast disease.

**Breast Ultrasound** is available extensively across the country both in the public hospitals and in private clinics, most notably that in Prizren. It is difficult to assess the clinical utility of these services as no usable records are kept in the public sector whatever. It would also seem that, within the public sector at least, ultrasound is not used to guide the accurate placement of either FNA or core biopsy.

Whilst the development of *diagnostic* ultrasound of the breast may need to be postponed until issues relating to patient presentation can be addressed, the introduction of the *clinical* use of ultrasound for guided sampling or for determining appropriate treatment should not be delayed. There is a significant difference between a diagnostic ultrasound performed by a fully qualified radiologist and a clinical ultrasound undertaken by a breast surgeon either to guide his FNA needle or in order to decide precisely which surgical intervention is appropriate (tumour size; presence of enlarged axillary lymph nodes etc). The Ministry of Health may need to be able to differentiate between diagnostic and clinical ultrasound for the purposes of licencing.

**Mammography** is even more variable across Kosovo. There is little in the way of screening mammography so the modality is generally used for the investigation of a clinical presentation (mass or discharge). Although mammography equipment is available across all regional hospitals, some of the equipment had yet to be commissioned, some was sitting unused because of engineering, training or consumable issues and all radiologists we spoke to expressed a desire for formal training. Again, given the lack of follow-up or audit, it would be difficult to state with confidence that any safe and accurate public sector mammography is available. We would not regard stereotactic biopsy or even wire localisation as immediate requirements for the service. **CT and MR** services are, perhaps, a relative luxury in the current climate but will become pivotal to good clinical practice in the longer term.

### 3.7 Colposcopy

Most of the colposcopes are situated in secondary or tertiary facilities. Most of them are underused. The Women's Wellness Centres in Prizren and Pristina have colposcopes and provide a limited service of colposcopy at present. The standard of the existing colposcopes is reasonable, although there is a need to replace a couple of units as a priority. One colposcope should be condemned immediately as it is effectively unusable. Despite this assessment, it is reported to be used regularly questioning the accuracy of the findings. A new colposcope and equipment to carry out LLETZ procedures was donated to the Gynaecology and Obstetrics clinic in Pristina last year and has been used a total of sixteen times since, with four LLETZ procedures performed on the basis of smear results alone.

There are two key limitations to increasing the capacity of colposcopy in Kosovo. Firstly, there is a need for trained colposcopists. There are only two gynaecologists regularly practising colposcopy (ie more than 50 cases per year) in the public sector: one was self taught and is now training a colleague; the other was trained as part of a project implemented by Doctors of the World, USA to establish Women's Wellness Centres in Kosovo, of which there are now three. The 2008 data from the WWC in Gjilan are shown in **Tables 1** and **2**. A number of other Gynaecologists have received some training, both theoretical and practical from the same source. A two day theoretical course was held in December 2006 but practical training for most of the attendants has not commenced. There is a great desire from these individuals and the institutions they work in for this training to be forthcoming. One hospital has budgeted for two gynaecologists to be trained in colposcopy in 2009.

The second limitation is the supply of consumables and appropriate instrumentation. Items such as acetic acid, Luegol's iodine, correct cervical sampling spatulae, endocervical sampling brushes, single frosted end slides, smear fixative and specimen containers are in short supply or non-existent in all the units visited. Punch biopsy forceps, where seen, were notably old and unlikely to provide good

samples for histological examination. Other instruments, including endocervical retractors, were not available.

Out patient treatment of cervical dysplasia is limited to ablative procedures in the WWCs (cold coagulation), cryotherapy in private clinics or LLETZ in private clinics or at UCCK.

It is recommended that two gynaecologists from each of the Regional hospitals and up to six from the tertiary unit in Pristina are selected to complete Colposcopy training to a standard comparable to that recommended by the European Federation for Colposcopy. A Colposcopy Society within Kosovo could be formed under the auspices of the Kosovo Obstetrics and Gynaecology Association and links explored with the EFC with a view to membership in the future.

Within each department providing colposcopy services, nursing staff should be identified and trained to provide support for the women undergoing colposcopy and for the gynaecologists performing the examination.

In addition to training, the setting of the colposcopy service requires attention and investment. Most of the outpatient clinics are too busy to provide a dedicated colposcopy service, for example, a couple of sessions a week. Alternative locations may be needed where colposcopy can be carried out without time pressure on the trainees/trainer or compromise to the woman's privacy by frequent interruptions from other patients or staff.

Every unit providing Colposcopy services requires a full quota of the accessory equipment (including treatment units) and regular supplies of consumables. Data collection and audit should be established from the beginning of the service and good cytology and histology back up is essential.

<b>Gjilanë WWC: Pap test results for 2008</b>		
<b>Modified Papanicolaou grading</b>	<b>Interpretation of grading</b>	
I	Normal	14
II	Benign inflammation	80
II↑	Borderline changes	2
III	Low grade squamous cell abnormalities	16
	Result not returned for review	77
		<b>189</b>

**Table 1**

<b>Gjilan WWC: Targeted cervical biopsy results for 2008</b>	
Normal	5
HPV Condyloma planum (flat warts)	1
CIN1	4
Squamous carcinoma	2
Adenocarcinoma	1
Cervical cancer, not specified, verbal result only	1
Result not returned for review	10
	<b>24</b>

**Table 2**

### 3.8 Pathology – cytology and tissue pathology

The only public sector cervical cytology available to Kosovan women is provided from the department of gynaecology at the University Clinical Centre of Kosovo . Two other relevant laboratories are also present on that site – the Institute of Pathology and the laboratories within the Institute of Public Health.

In the laboratories within the Department of Gynaecology, slides are processed through the week. Like all cervical smears in Kosovo, the slides are “conventional” smears as opposed to liquid based samples and are taken using a tongue depressor rather than an purpose designed device such as the Ayers spatula. The use of tongue depressors will fail to sample the most important part of the cervical surface (the transformation zone close to the squamocolumnar junction) in a significant percentage of cases.

The preparations we saw were technically suboptimal, with manual pap staining and without coverslipping. This problem could easily be remedied with training and with minimal resource implications. The slides are then reported (unscreened) on Saturday mornings by a pathologist from outside the department so there is minimal opportunity for teaching or training. No slides are marked for abnormal so it is not possible to use them either for audit/QC or, in reality, for teaching and training. There is no feedback from the Institute of Pathology with regard to correlation of smear with biopsy result and no attempt at year end to analyse the profile of reporting.

The overall conditions within the laboratory are far from satisfactory and the equipment used is basic at best. It would take very little investment to improve the situation. But this would not address issues relating to training and continued upskilling of staff. The slides are kept for one year only. Until recently, slides were stored for five years. There should be an immediate return to this practice to allow retrospective audit of results and identify false negative cases if a patient presents with cancer having previously had a negative smear. This should be regarded as base line for good practice.

The Department of Gynaecology cytology department reports 3000 smears per annum. These come exclusively from the clinics within the gynaecology department. If the visiting pathologist is reporting all cases then he is doing an absolute minimum of 60 cases per Saturday morning assuming he attends in Pristina 50 weeks of the year. This is neither safe nor sustainable. An analysis of smears reported in 2008, yields the results in **table 3**:

<b>Cytology Lab, UCKK: Pap test results for 2008</b>		
<b>Modified Papanicolaou grading</b>	<b>Interpretation of grading</b>	<b>Number (n=3240)</b>
I	normal	0
II	benign inflammation	2136
II↑	borderline changes	884
III	low grade changes in squamous cells of increasing atypia	12
IIIa		217
IIIa↑		22
IIIb	high grade changes in squamous cells of increasing atypia	28
IIIb↑		3
IV	suggestive of malignancy	0
V	conclusive of malignancy	0
<b>unsatisfactory</b>		<b>93</b>
no result		25

**Table 3**

There are two comments to be made about these data: Firstly, the unsatisfactory rate in a screened population using conventional smear technology runs at approximately 5-15%. Where smears are being performed in symptomatic women (with bleeding or discharge) one would expect the rate of unsatisfactory smears to be at the higher end of the spectrum. This would equate to a minimum of 450 samples in the analysis above, rather than 93.

Secondly, almost no smears in this sample were regarded as entirely negative which must result in potential distress to women as well as providing a framework for both over-investigation and over-treatment. Furthermore, the concept of cervicovaginal “hygiene”, routinely reported and usually categorised as “class 3” – ie poor, is of dubious clinical or scientific worth, except to retail pharmacists and is explicitly demeaning to the women who have been screened.

Judging from a scrutiny of smear reports from this unit and from a variety of private facilities, there seems to be a highly variable use of reporting terminology, primarily based on an outdated version of the original Papanicolaou classification with inconsistent comparison to the Bethesda System. The consistent use of a single modern terminological system should be introduced at the first available opportunity and should be a mandatory requirement for laboratory licencing.

### **Institute of Pathology**

The Institute of Pathology provides the histopathology for the University Hospital complex. It is staffed by five pathologists who report all types of biopsy and supervise the training of 4-5 junior doctors at any one time. The workload according to Prof Lumnija Gashi-Luci has fallen steadily since the war as shown in **Table 4**:

Institute of Pathology: Approximate workload		
	2000	2007
Tissue specimens	10,000	8000
Non-cervical Cytology	3000	1500

**Table 4**

This she puts down to the influence of private pathology laboratories. So either the current surgical activity remains unchanged year on year or else the private facilities are doing even more work and this is concealing a genuine growth in resection surgery. As part of ongoing licencing of private facilities, the MoH should require details of all major procedures undertaken. An additional strategy would be to use a “patient passport” as a method of gathering process and outcome data.

The histopathology laboratory is poorly equipped but does include a multiheader microscope for teaching purposes. Tissue processing and staining are all automated but one of the embedding stations is broken. The cut-up facilities are very poor and should be regarded as a significant health and safety issue for the staff who work there on regular basis. There is no venting of toxic fumes out of this area, despite the fact that there is an adjacent external wall.

Immunocytochemistry is not undertaken within the Institute laboratory at present, largely due to the issue of reagent purchase and maintenance. Without immunocytochemistry it is impossible to study oestrogen and progesterone receptor status in order to determine appropriate and cost effective chemotherapy for breast cancer. It is also pivotal to tumour diagnosis in many other organ systems and will be regarded as a baseline diagnostic service as Kosovar pathology moves to meet European standards of care.

No cervical cytology is performed at the Institute of Pathology and there is no mechanism to feed back the biopsy results for positive cytology from either the public laboratory in gynaecology or the laboratories in the private sector. Without such regular feedback there is no possibility of delivering an accurate cytology service. It might make good sense in terms of quality control and economies of technical scale to have both public services under one roof. Other strategies will be required to quality assure the private services.

### **Institute of Public Health (IPH)**

The IPH functions as an independent organisation directly accountable to the Ministry of Health. It is responsible for many aspects of public health including epidemiology and environmental health (see appendix X). The Social Medicine unit includes the Observatory of Mother and Child Health and is responsible for health education and promotion as well as planning and health policy development. Most importantly, the IPH is responsible for maintenance of the cancer register and is, or should be, in receipt of all significant data flowing from the regional hospitals and from primary care facilities through the Health Information System which was established several years ago and designed to collect epidemiological information as well as details on financial and operational management. This function of the IPH will be pivotal to any process designed to increase capacity and improve outcomes in the diagnosis and treatment of female genital cancer in Kosovo. The HIS has been virtually non-functional since its introduction and efforts to address this failure need to be a priority for the IPH and Ministry of Health.

Within the IPH building are laboratories serving the microbiological and ecological needs of the Institute. These laboratories are well laid out, feature **ergonomic benching** and are equipped to a very high standard, a stark comparison with the laboratories within the Institute of Pathology or the Department of Gynaecology. The single major problem within the IPH laboratories is the servicing and maintenance of equipment. This is a universal problem within the breast and cervical cancer services. If cervical screening is considered to be a public health initiative then there might be an argument for housing such services within IPH – both administratively and physically. This would provide the Institute with the additional benefit of instant feedback as to the progress of any screening campaign.

### **3.9 Information technology**

This section does not refer to electronic technology exclusively. Information technology may be as simple as a hand-written referral letter. A consistent theme from our visits related to the absence of clinical record keeping except in the form of the universal “protocol” books. This prohibits continuity of care between primary, secondary and tertiary care. It prevents appropriate follow-up of patients; makes every admission or attendance a new episode of care and it excludes any possibilities of audit of, for example, postoperative complications.

It would be easy to claim that many of the communication and data handling problems currently encountered in the Kosovan system will be resolved by the introduction of a universal system of computerised medical records. The logical conclusion from this argument is that nothing need be done pending the development of such a system. And yet good clinical practice has existed within medical systems since long before the introduction of the computer. The Women’s Wellness Centre in Pristina, which maintains ongoing paper records of all its clients is proof of the value of conventional record keeping that runs in parallel with “high tech” solutions. The financial savings to the community from such schemes would far outweigh the cost of implementation and maintenance.

If the current medical infrastructure is too vulnerable to support patient notes in primary, secondary and tertiary care, then one short term solution may be to generate notes which are held by the patient herself. This might be incorporated into the concept of a “patient passport” to be used in



collaboration with a navigator or advocate to help guide a patient through the referral process and to document final outcome (see below).

### **3.10 Public Health – education, screening and data collection**

Breast and cervical cancers are, first and foremost, public health issues. The Institute for Public Health (IPH) must play a pivotal role at every step of the process. The IPH is responsible for health education and as such will act as the natural focus for campaigns to drive up community awareness which, in turn, will lead to pressure on clinical capacity. This can only be monitored and managed appropriately if the second function of the IPH – data collection and interpretation – is treated more seriously by clinicians, health care institutions and by the Ministry of Health. Mandatory reporting of data should become an essential part of licencing and re-licencing. When capacity has been built and the burden of established malignant disease has been reduced then further progress in the area of female genital cancer will require formal and coordinated screening programmes. Screening is, rightly, the responsibility of the IPH. It makes sense to put the institute in the driving seat with regard to current initiatives in this field, backed by a system of rewards and sanctions from the MOH. We appreciate that the IPH is overstretched already. Any move to take on a coordinating role in cancer would need to be backed by a significant increase in human resources.

### **3.11 Licensing, audit and the role of the Ministry of Health**

It is clear that the Ministry plays a pivotal role in licencing and supervising health care facilities in all sectors. During the course of the visit there were several comments about problems relating to the licencing process. It would appear that the process could be accelerated and the requirements for licencing made more transparent. However, a more important issue for the purposes of the current assessment is the importance of linking the licencing process to audit and performance – both of individual clinicians and of health care facilities. Many national health care systems like continuing licence to practice with mandatory reporting of workload, casemix and outcome. There is a pivotal role here for the MOH, perhaps with help or collaboration from external agencies such as the Royal Colleges or accreditation organisations from overseas. Close cooperation with the IPH has already been considered above.

However there are other areas in which the MOH might choose to be yet more active. Every site visit included negative comments regarding consumable availability, equipment servicing and maintenance. This is not surprising, given the history of the last few years. We note that the MOH has already initiated a programme of providing engineers for all the larger health care facilities but there is clearly work to be done in this area. One suggestion, from Dr Curr Gjocaj, was that each of the regional hospitals take responsibility for a particular segment of equipment maintenance and care across all public institutions in Kososvo. There is a great deal to commend this approach.

### **3.12 Training and continuous professional development**

In our visits and interviews we encountered a call for improved training at every level of care. Smears are not taken in primary care because training in a 'live' setting rather than on pelvic models is unavailable; primary tissue diagnosis follows lumpectomy rather than preceding surgery because staff are untrained in fine needle aspiration or core biopsy (and the laboratory support is unavailable locally); modified radical mastectomy remains the operation of choice for breast cancer because there is no consistent education and training in more conservative surgery; colposcopy is either not performed or, in a number of settings, performed with dubious outcome and the reason given here is – again – lack of training; where colposcopy is performed by competent providers the observation is frequently made that the findings are discordant with the cytology result, usually normal in the presence of a mildly abnormal smear; and "Prophylactic" hysterectomy is undertaken instead of cone biopsy or LLETZ for cervical dysplasia or less. At a diagnostic level, training in ultrasound, mammography, cytology and histopathology requires significant investment.

The need for training is well recognised both by professionals and by the Ministry of Health. Resources invested in training have occasionally proved to be a wasted opportunity. Sending a professional out of the country – whether to an adjacent Balkan state or further afield – is not as cost effective as bringing trainers into Kosovo where they can transfer skills and knowledge to several individuals in the same visit, with a better understanding of what is “fit for purpose” in the context of the local clinical and economic environment. This sort of training is particularly effective if a long term relationship is established with the trainers and with their institution.

### 3.13 The role of the private sector – positive and negative

Although the focus of this assessment is firmly on the public sector, it is impossible to ignore the positive and negative roles of private health care providers. Given that many primary and secondary care units do not have access to public sector diagnostic support, it is inevitable that they turn to the private sector. And there is no doubt that the private sector in Kosovo provides some aspects of care that are highly desirable and – as is the case in many countries – it is likely that innovative or front line care will be initially promoted by private units before being adopted in the public sector. So patients presenting in a public clinic and anticipating treatment through the public sector are still dependent upon private provision of cytology (universal), mammography and ultrasound (variable) and biopsy histology (almost universal). Furthermore, many women elect to take themselves into the private sector either from the onset of symptoms or after primary diagnosis.

Unfortunately, in the context of the current environment, this leads to several problems. Firstly, there is an unwelcome financial burden which may lead some women to default from care altogether. Secondly, movement in and out of the private and public sectors leads to further problems with continuity of documentation. Thirdly, the public clinics make an unwarranted assumption that, if a patient fails to return for definitive treatment of a proven cancer, this is because they have elected to be treated privately. No attempt is made to find out what has happened to that individual. It seems highly likely that there are women dying untreated after a firm diagnosis of cancer because of this problem.

## 4 The Way Ahead

Female genital cancer in Kosovo represents a major challenge and an unmet need. This was clearly recognised by everyone we interviewed. Although some services are in place, these require considerable additional support and there is an overall need to integrate the various components of the patient journey. Specifically, progress needs to be made in the following key areas:

- process mapping and data collection
- professional education and training
- equipment maintenance and consumable supply
- diagnostic support
- capacity building across all aspects of care
- community awareness

***There is a clear need to gather more precise data and strengthen reporting processes as a first and essential step to service improvement. But there is also much that can be done to streamline the current processes and develop a framework for building the capacity that will be needed to meet demand before attention is turned to awareness building and screening programmes. The next step should be a needs assessment followed an options appraisal that will inform future policy in this important area of health care.***

# 5 Appendices

Abbreviations

Information Sources

Site Visit data

## 5.1 Abbreviations

CBE	Clinical breast examination
CDFM	Centre for the Development of Family Medicine
CPD	Continuing Professional Development
CT	Computerised tomography
EFC	European Federation for Colposcopy
FNA	Fine needle aspiration
GOC	Gynaecology and Obstetric Clinic
IPH	Institute of Public Health
LA	Local anaesthetic
LLETZ	Large loop excision of the transformation zone
MCHRH	Maternal and Child Health and Reproductive Health
MR	Magnetic resonance
N/A	Not available
NORWAC	Norwegian Aid Committee
UCCK	University Clinical Centre of Kosovo
UNFPA	United Nations Population Fund
UNMIK	United Nations Mission in Kosovo
USAID	United States Agency for International Development
WWC	Women's Wellness Centre

## 5.2 Information Sources

### General Background

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3. Health and Health Care of Kosovo: UNMIK and Ministry of Health 2004.
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6. Medium Term Expenditure Framework 2009-2011. Ministry of Economy and Finance. Pristina 2008.
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### General Cancer

9. Details on WHO National Cancer Control Programmes, screening, prevention, treatment and palliative care documentation all accessed via here: <http://www.who.int/cancer/nccp/en/>
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### Breast Cancer

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14. Survival of patients with untreated breast cancer. PAS Johnstone , MS Norton and RH Riffenburgh. *J. Surgical Oncol,* 2000,**73**:273-277

### Cervical Cancer

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16. The Burden of Cervical Cancer in South-East Europe at the beginning of the 21<sup>st</sup> Century. Arbyn M, Primic-Žakelj M, Raifu A O, Grce M, Paraskevaidis E, Diakomanolis E, Kesić V, Nicula F A, Suteu O and von Karsa L. Coll. Antropol. 2007, **31** Suppl. 2: 7-10 (accessed at: <http://www.ncbi.nlm.nih.gov/pubmed/17600932> )
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18. Statistical data on cervical cancer in a screened population are based on data here: <http://info.cancerresearchuk.org/cancerstats/types/cervix/>
19. Comprehensive Cervical Cancer Control. A guide to essential practice. WHO 2006 Accessed at: [http://www.who.int/reproductive-health/publications/cervical\\_cancer\\_gcp/index.htm](http://www.who.int/reproductive-health/publications/cervical_cancer_gcp/index.htm)

## 5.3 Site Visit Data

Prizreni/Prizren Regional Hospital	p25
Gjakovë/Đakovica Regional Hospital	p27
Gjilani/Gnjilane Regional Hospital	p29
Pejë/Peć Regional Hospital	p31
Ferizaji/Uroševac Hospital	p33
Vushtrri/Vučitrn Hospital	p35
Mitrovicë/Mitrovica (South) Hospital	p37
Prishtinë/Priština: University Clinical Centre of Kosovo	p39

## ◆ Prizreni/Prizren Regional Hospital

Serving a population of around 400,000, Prizren Regional Hospital provides secondary level care in a partially rebuilt facility to the west of the city centre. Patients from multiple ethnicity backgrounds come mainly from four municipalities: Prizren, Suhareka, Dragash and Mamusha; and from over the Albanian border. The Gynaecology and Surgical units are contained in the same main hospital building. Gynaecology outpatient facilities are in a small but dedicated suite on the ground floor. The main outpatient clinic is in an adjacent block, as is the Radiology department. The Luxembourg Agency for Development Cooperation and the Canadian International Development Agency were the principal funders of the rebuilding and renovation work .

Area served:



### Beds:

Total	578
Surgical	38
Gynaecology	27

### Patient throughput in 2008

Surgical	Outpatient	11681
	Inpatient	2909
Gynaecology	Outpatient	7530
	Inpatient	1742

### Medical staff:

	Specialist	Sub speciality trained	In training
General surgeons	13*	0	0
Thoracic surgeons	0	-	0
Radiologists	6	0	0
Gynaecologists	19	0	0
Pathologists	0	-	0

\*  
\*of which 5 do breast surgery

## BREAST

Type	Situation	2008 Numbers**
Breast awareness promotion	No structured programme	-
Clinical breast examination	According to patient presentation	Not recorded
Breast ultrasound	Not available in the hospital. Most women attend one particular Prizren private clinic (see GyneKos data)	
Mammography	Alfa RT model from GE. Installed 2006. Often broken. No appropriate developer unit; rarely enough reagents. Operated by 1 radiologist	Not available at time of visit
CT/MRI	CT available. 2-15 performed/day. Mostly skull. Cost 20 Euros	
Biopsy procedure	Lumpectomy only	22 <sup>v</sup>
Surgical treatment	Radical mastectomy and axillary clearance	3 <sup>v</sup>
Pathology services (cytology and histology)	Not available: patients take specimens to private lab in Prizren.	-
Radiotherapy	Not available	-
Chemotherapy	Not available	-
Palliative care	No organised service at primary or secondary care level	-



## CERVIX

Type	Situation	2008 Numbers**
Cervical screening promotion	No coordinated programme, opportunistic screening only	-
Pap test procedure	Available in Women's Wellness Centre	566
Pap test interpretation	Only in private pathology labs	-
Colposcopy	Karl Kaps with 3 levels of magnification. Appears to be in good working order.	0
Colposcopy targeted punch biopsy	Appropriate equipment available	27
Histology	Only available in private facilities	-
Colposcopic treatment	Not available	0
Cone biopsy	In gynaecology theatre	5
Surgical treatment of cervical cancer	Limited to simple hysterectomy	3
Radiotherapy	Not available	-
Palliative care	No organised service at primary of secondary care level	-

### Number of cases in 2008:

Condition	Numbers	Age range
Breast cancer	No access to data	
High grade CIN	No data available	-
Cervical cancer	No data available	-

### Comments and future plans:

- There is a Women's Wellness Centre in the Main Family Medicine Centre where basic Colposcopy examination was introduced in 2003: not visited due to time constraints.
- There is great interest in developing colposcopy services in the hospital .
- Municipal capital expenditure plan for 2009 includes purchase of mammography equipment.
- Further training in mammography for radiologists and technicians requested
- Most breast ultrasound in Prizren is performed by Dr Selim Sylemani, a Gynaecologist who has sub- specialised in ultrasound. He has a private practice and is also President and Founder of the Kosovan Society for Ultrasound Application in Medicine.

**Interviewed:** Dr Mehmedali Skeraj, Quality Assurance Officer from Hospital Directorate; Dr Adem Kafexholli, Director of Gynaecology; Dr Agron Hoxha, Gynaecologist; Dr Rafet Sinami, Gynaecologist, Dr Hatim Baxhaku, Director of Surgery; Dr Syleman Krasniqi, Radiologist. Gynaecology data provided by Dr Teuta Dallxhiu, Gynaecologist.

Date of visit: 27 November 2008; \*\*All 2008 data reported to date of visit; <sup>v</sup> Verified by team

## ◆ Gjakovë/Đakovica Regional Hospital

Two kilometres from the city centre, the regional hospital in Gjakova has one of the highest bed to population ratios in Kosovo at 247/100,000 if calculated in regard to Gjakova municipality alone. However, patients come from other geographically close municipalities as well as from the remote parts of northern Albania resulting in ~300,000 population served by the hospital. Rebuilding began in 2000 resulting in one renovated hospital block housing almost all of the clinical departments, including gynaecology and surgery. A new adjacent building houses outpatient facilities. The Norwegian Aid Committee (NORWAC) played a major role in the changes. In addition to the primary care (public and private) facilities using the hospital services, the Occupational Medicine tertiary centre on the outskirts of Gjakova provides CT, ultrasound and Colposcopy services, though mammography was not functional at the time of survey.

Area served:



### Beds:

Total	450
Surgical	40
Gynaecology	50 <sup>inc obstetrics</sup>

### Patient throughput in 2008

Surgical	Outpatient	8243
	Inpatient	1805
Gynaecology	Outpatient	4925
	Inpatient	1302

### Medical staff:

	Specialist	Sub specialty trained	In training
General surgeons	5	0	0
Thoracic surgeons	0	-	0
Radiologists	1	0	0
Gynaecologists	14	0	0
Pathologists	0	-	0

### BREAST

Type	Situation	2008 Numbers*
Breast awareness promotion	No structured programme	-
Clinical breast examination	According to patient presentation	Not recorded
Breast ultrasound	Not available. Patients referred to Peja, Prizren or Pristina .	
Mammography	Not available in hospital although one unit has been installed in Occupational Medicine facility (see separate summary)	0
CT/MRI	Not available. CT scanner in Primary Care facility	
Biopsy procedure	Lumpectomy only	7 (22-85 yrs) <sup>v</sup>
Surgical treatment	Radical mastectomy and axillary clearance	2 (50 and 61 years) <sup>v</sup>
Pathology services (cytology and histology)	Not available. Gjakova has an agreement with one private pathologist in Pristina and all specimens are transported and results returned weekly	-
Radiotherapy	Not available	-
Chemotherapy	Not available	-
Palliative care	No organised service at primary or secondary care level	-

## CERVIX

Type	Situation	2008 Numbers*
Cervical screening promotion	No coordinated programme, opportunistic screening only	-
Pap test procedure	Available	~50 in 3 mth period
Pap test interpretation	Only via private hospital arrangement with one Gynaecologist. Cost 10 Euros	N/A
Colposcopy	One Olympus colposcope in good working order. Situated in Gynaecology outpatients but directed punch biopsies not possible.	~6 in 3 mth period
Colposcopy targeted punch biopsy	Not available. Non-directed biopsies taken in intervention room of Gynaecology ward.	0
Histology	Via private hospital agreement 20Euros charge. One week wait for results	N/A
Colposcopic treatment	Not available	1
Cone biopsy	In gynaecology theatre	3
Surgical treatment of cervical cancer	Limited to simple hysterectomy	4 (aged 41 to 53yrs)
Radiotherapy	Not available	-
Palliative care	No organised service at primary of secondary care level	-

### Number of cases in 2008\*:

Condition	Numbers	Age range
Breast cancer	~18	
High grade CIN	N/A	
Cervical cancer	N/A	

### Comments and future plans:

- Due to the short notice of the visit it was not possible to talk with the Director of Surgery.
- Although there is only one room for gynaecology outpatients (with two examination chairs side by side) the room size is large enough to allow infrastructure change to improve privacy and versatility of the space if wished
- As there is the potential of a public mammography service in the Occupational Medicine Centre, and currently only one radiologist at the hospital there is no firm plan to purchase mammography equipment

**Interviewed:** Dr Ahmet Aslani, Hospital Director; Dr Xhamil Hamze, Gynaecologist ; Dr Ali Tolaj, Surgeon; Ardjana Xheravina, nurse working in outpatient department.

Date of visit: 1 December 2008; \*2008 data to date of visit; ~ Estimations provided; <sup>v</sup> Verified by team

## ◆ Gjilani/Gnjilane Regional Hospital

The hospital is sited close to the centre of Gjilan and serves a population of 350,000 from the Gjilan region and up to 100,000 Albanians living in Serbia in three municipalities close to the Kosovan border. One main hospital block contains the general surgery and radiology departments. The gynaecology department shares premises with paediatric and outpatient services in one of the satellite buildings in the large hospital estate. Gynaecology outpatient services, including Colposcopy, are situated in the Women's Wellness Centre in the same building. The WWC was established by Doctors of the World, USA in 2003 with funding from USAID. The American Military medical staff have provided professional and technical support for the hospital since 1999.

Area served:



### Beds:

Total	450
Surgical	36
Gynaecology	38

### Medical staff:

	Specialist	Sub specialty trained	In training
General surgeons	7	0	1
Thoracic surgeons	0	-	0
Radiologists	2	0	0
Gynaecologists	12	0	0
Pathologists	0	-	0

### Patient throughput in 2008

Surgical	Outpatient	5071
	Inpatient	2399
Gynaecology	Outpatient	8036
	Inpatient	1257

## BREAST

Type	Situation	2008 Numbers*
Breast awareness promotion	No structured programme	-
Clinical breast examination	According to patient presentation	Not recorded
Breast ultrasound	1 machine: Kontron Sigma 330 with resolution problems. No maintenance available.	Maximum 12/week. Exact number unknown
Mammography	New Hologic Affinity unit, funded by Ministry of Health, installed mid 2008, still unused due to delay in receiving technical training from supplier. No dedicated developing unit supplied.	0
CT/MRI	Not available but expected soon	
Biopsy procedure	Lumpectomy only	2
Surgical treatment	Radical mastectomy and axillary clearance	0
Pathology services (cytology and histology)	Not available. Patients take specimens to private laboratories in Gjilan (1) or Pristina or to the Institute of Pathology in Pristina	-
Radiotherapy	Not available	-
Chemotherapy	Not available	-
Palliative care	No organised service at primary or secondary care level	-

## CERVIX

Type	Situation	2008 Numbers*
Cervical screening promotion	No coordinated programme, opportunistic screening only	-
Pap test procedure	Available in Women's Wellness Centre	296 <sup>i</sup> /190 <sup>ii</sup>
Pap test interpretation	Only in private pathology labs	189 (see Table 1)
Colposcopy	Available in Women's Wellness Centre	64 <sup>i</sup> /67 <sup>ii</sup>
Colposcopy targeted punch biopsy	Appropriate equipment available	37 <sup>i</sup> /24 <sup>ii</sup>
Histology	Available in private pathology labs or in Institute of Pathology, Pristina	(See Table 2)
Colposcopic treatment	Cold coagulation unit in WWC for >1yr but training still required	0
Cone biopsy	In gynaecology theatre	0
Surgical treatment of cervical cancer	Limited to simple hysterectomy	0
Radiotherapy	Not available	-
Palliative care	No organised service at primary of secondary care level	-

<sup>i</sup> from hospital directorate      <sup>ii</sup> from electronic database in WWC

### Number of cases in 2008\*:

Condition	Numbers	Age range
Breast cancer	No access to data	
High grade CIN	0	0
Cervical cancer	13 (data from hospital directorate)	30-55yrs

### Comments and future plans:

- Space has been allocated for a hospital based pathology service. A pathologist currently working in the Institute of Pathology in Pristina will relocate to Gjilan and two doctors will be selected to begin pathology specialisation. There is currently no budget allocation for equipment for the pathology laboratory. The costs are estimated at 12-13,000 Euros.
- Once technical training has been received by staff, mammography will be available. However, no definite date set and only a limited amount of film has been received.
- No definitive plans to develop treatment services except for cervical premalignancy.

**Interviewed:** Dr Xhavit Hajdari, Hospital Director; Dr Zijadin Hasani, Chief Doctor; Dr Ilaz Porashtitza, Director of Surgery; Dr Shaban Linjan, Radiologist; Dr Mevlyde Iliazi, Director of WWC and Colposcopist

Date of visit: 3 December 2008

\*All 2008 data reported to date of visit

## ◆ Pejë/Peć Regional Hospital

Reputed to be the oldest health facility in Kosovo, Peja hospital is set at the mouth of the majestic Rugova gorge to the west of Peja city centre. In recent years, the hospital has been managed by Italian KFOR and then, from 2005, supported by Italian healthcare professionals from the Venice region. There is still an active memorandum of understanding in place and potential for on-going collaboration. Doctors are encouraged to perform audit and research and can apply for support from the directorate for travel expenses if invited to make presentations at conferences in the region. The Director of the hospital has created links with specialists in Croatia and Slovenia for the purpose of establishing mentoring and training visits and exchanges.

Area served:



### Beds:

Total	438
Surgical	40
Gynaecology	36

### Patient throughput in 2008:

Surgical	Outpatient	7656
	Inpatient	1713
Gynaecology	Outpatient	9334
	Inpatient	1447

### Medical staff:

	Specialist	Sub specialty trained	In training
General surgeons	7		
Thoracic surgeons	0		
Radiologists	4		2
Gynaecologists	14	1 has Masters in Cytology	2*
Pathologists	0		

\*training in Pristina in UCCK

## BREAST

Type	Situation	2008 Numbers**
Breast awareness promotion	One-off pilot screening project in 2005 has raised awareness in community	-
Clinical breast examination	According to patient presentation	Not recorded
Breast ultrasound	Medison 128BW with 7.5Hz and 3.5Hz probes	202
Mammography	Alpha RT unit often lacking film	110
CT/MRI	Not available	
Biopsy procedure	Lumpectomy only	30
Surgical treatment	Radical mastectomy and axillary clearance	6
Pathology services (cytology and histology)	Not available in Peja either in public or private laboratories. Patients responsible for taking specimens to private labs in Pristina	-
Radiotherapy	Not available	-
Chemotherapy	Not available	-
Palliative care	No organised service at primary or secondary care level	-

## CERVIX

Type	Situation	2008 Numbers**
Cervical screening promotion	Screening project in 2007	-
Pap test procedure	No database of results returned	1400
Pap test interpretation	All specimens taken to Pristina by patients	-
Colposcopy	Very old colposcope, with (non-fiberoptic) light source, binocular vision not possible	400
Colposcopy targeted punch biopsy	Women are admitted as day cases. Colposcope in inpatient Gynaecology is broken.	0
Histology	All specimens taken by patients to Pristina private labs	-
Colposcopic treatment	Not available	0
Cone biopsy	In gynaecology theatre	34
Surgical treatment of cervical cancer	Limited to simple hysterectomy	78 (not confirmed cases – preventative measure for clinical suspicion)
Radiotherapy	Not available	-
Palliative care	No organised service at primary of secondary care level	-

### Number of

### cases in 2008\*\*:

Condition	Numbers	Age range
Breast cancer	~18	
High grade CIN	N/A	-
Cervical cancer	N/A	-

### Comments and future plans:

- It was not possible to find a surgeon or radiologist available for interview.
- Peja Hospital has a web site: [www.spitali-peje.com](http://www.spitali-peje.com). Amongst the information recorded are lists of operative cases, including general surgery and gynaecology, since October 2008.
- Close to establishing a 'one-stop' unit for women with breast and cervical problems which will be run on a multi-disciplinary basis by surgeons, gynaecologists and radiologists
- Space and equipment exist for a pathology service, but two specialists from Peja were retained in Pristina after completion of specialisation.
- Peja surgeons collaborate closely with thoracic surgeons from UCCK in Pristina
- The earlier pilot screening projects are to be rolled out to all female staff from all public institutions in Peja.
- A comprehensive CPD programme for nurses and doctors has been developed for 2009, including subspecialty training for three doctors: two for management of cervical problems and one for breast surgery

**Interviewed:** Dr Skender Dreshaj, Hospital Director; Dr Ahmed Panxhaj, Director of Gynaecology; Dr Jashar Buçani, Gynaecologist, Dr Mazllum Smajli, Gynaecologist and webmaster.

Date of visit: 4 December 2008; \*\*All 2008 data reported to date of visit; ~ Estimations provided

## ◆ Ferizaji/Uroševac Hospital

This health facility in Ferizaj has been upgraded within the past five years to a secondary facility offering limited acute services and inpatient care. There is a significant problem with available space, particularly for the obstetric and gynaecology services. Most surgical cases are routine procedures for appendicectomy or hernia repairs. Very little gynaecological surgery is undertaken in the unit at present.

Area served:



### Beds:

Total	80
Surgical	18
Gynaecology	24(obstetric)

### Patient throughput in 2008:

Surgical	Outpatient	1621
	Inpatient	832
Gynaecology	Outpatient	4230
	Inpatient	0

### Medical staff:

	Specialist	Sub specialty trained	In training
General surgeons	7		
Thoracic surgeons	0		
Radiologists	1	Currently undergoing training on breast imaging in Prishtinë	
Gynaecologists	3	0	
Pathologists	0		

## BREAST

Type	Situation	2008 Numbers*
Breast awareness promotion	No organised activities	-
Clinical breast examination	According to patient presentation	Not recorded
Breast ultrasound	Not available	-
Mammography	Not available. Mammography available privately in two clinics in Ferizaj	-
CT/MRI	Not available	
Biopsy procedure	Not available	-
Surgical treatment	Very rarely, a local thoracic surgeon who works privately will perform radical mastectomy and axillary clearance in Ferizaj hospital. Usually this surgery was done in his private facility, but this is no longer possible.	0
Pathology services (cytology and histology)	Not available. Specimens taken to Pristina private pathology labs	-
Radiotherapy	Not available	-
Chemotherapy	Not available	-
Palliative care	No organised service at primary or secondary care level	-



## CERVIX

Type	Situation	2008 Numbers*
Cervical screening promotion	No programmed activities	-
Pap test procedure	Rarely performed. If requested, local pathologist will provide necessary materials. Total cost to woman: 13 to 18 Euros	4 in previous 4 months
Pap test interpretation	Only available privately	-
Colposcopy	One unused but functioning colposcope Training requested by gynaecologists for a number of years	-
Colposcopy targeted punch biopsy	Not performed	-
Histology	Only available privately	-
Colposcopic treatment	Not available	-
Cone biopsy	Not performed	-
Surgical treatment of cervical cancer	Not performed	-
Radiotherapy	Not available	-
Palliative care	No organised service at primary of secondary care level	-

### Number of cases in 2008\*:

Condition	Numbers	Age range
Breast cancer	N/A	
High grade CIN	N/A	-
Cervical cancer	N/A	-

### Comments and future plans:

- The radiologist is undergoing training in mammography imaging. However, Ferizaj hospital does not have a mammography unit, nor is it planning to buy one during 2009
- The gynaecology outpatient clinic occupies one room only for both obstetric and gynaecology services
- The thoracic surgeon working privately has a busy practice and keeps a database for self audit purposes. He has concerns about the adequacy of training for mammography services provided privately.

**Interviewed:** Dr Syleman Metushi, Hospital Executive Director; Dr Sevdije Bajraliu, Hospital Director and Gynaecologist; Dr Xhaladin Reçica, private Thoracic Surgeon .

Date of visit: 3 December 2008; \*All 2008 data reported to date of visit; ~ Estimations provided; ~  
 ^ validated by team

## ◆ Vushtrri/Vučitrn Hospital

Vushtrri Hospital, or 'Sheikh Zayed' Hospital as it is also known, was built with funding and support from the United Arab Emirates after the war of 1999. The building is spacious and reasonably well equipped. Services are available for the residents of Vushtrri municipality and, for a time, endoscopic and laparoscopic surgery was offered as a tertiary service for all Kosovo. The hospital site also houses a Family Medicine facility, one of 13 primary care facilities in the Vushtrri municipality. As there are no surgeons or gynaecologists in the primary care facilities (in common with many others in Kosovo), women often self refer to these departments when symptoms are present; or choose to consult specialists privately.

Area served:



### Beds:

Total	78
Surgical	15
Gynaecology	11

### Patient throughput in 2008:

Surgical	Outpatient	3722
	Inpatient	961
Gynaecology	Outpatient	2348
	Inpatient	558

### Medical staff:

	Specialist	Sub specialty trained	In training
General surgeons	7		
Thoracic surgeons	0		
Radiologists	1	6/12 module on ultrasound during specialisation in 1998	
Gynaecologists	4	0	
Pathologists	0		

## BREAST

Type	Situation	2008 Numbers*
Breast awareness promotion	No organised activities	-
Clinical breast examination	According to patient presentation	Not recorded
Breast ultrasound	Logiq 200 Pro Series; 3.5Hz and 7.5Hz probes – latter too big for accurate breast imaging	~1 to 4 every week day
Mammography	Not available	-
CT/MRI	Not available	
Biopsy procedure	Lumpectomy	5 (aged 17 to 22yrs, all benign) <sup>v</sup>
Surgical treatment	Available but no cases in last year	0
Pathology services (cytology and histology)	Not available. Specimens taken to Pristina private pathology labs	-
Radiotherapy	Not available	-
Chemotherapy	Not available	-
Palliative care	No organised service at primary or secondary care level	-

## CERVIX

Type	Situation	2008 Numbers*
Cervical screening promotion	No programmed activities	-
Pap test procedure	Not prioritised. Most patients attending Gyn OPD are pregnant	N/A
Pap test interpretation	Only available privately	-
Colposcopy	Functional Carl Zeiss colposcope donated by U.A.E., rarely used	-
Colposcopy targeted punch biopsy	Not performed	-
Histology	Only available privately	-
Colposcopic treatment	Not available in Vushtrri hospital, but local treatment with LLETZ/LEEP is performed by two gynaecologists in private clinics	-
Cone biopsy	Not performed	-
Surgical treatment of cervical cancer	Not performed	-
Radiotherapy	Not available	-
Palliative care	No organised service at primary of secondary care level	-

### Number of cases in 2008\*:

Condition	Numbers	Age range
Breast cancer	N/A	
High grade CIN	N/A	-
Cervical cancer	N/A	-

### Comments and future plans:

- The purchase of a mammography unit is in the hospital capital expenditure plan for 2009
- There were five gynaecologists in the hospital until 2008 when one resigned to work in a private obstetrics and gynaecology hospital in Pristina
- Women having Pap tests carried out at one of three private Gynaecology clinics in Vushtrri are paying 20-25 Euros per test, including reporting
- The surgeons interviewed stated that they are equipped to deal surgically with any cases with breast malignancy but no cases were operated on in 2008

**Interviewed:** Dr Vedat Mulaku, Hospital Director; Dr Agim Zahiti, Chief Gynaecologist and Health Director of the hospital; Dr Arsim Latifi, General Surgeon; Dr Akrem Sefiu, General Surgeon; Dr Fasliu Jetullahu, Radiologist

Date of visit: 16 December 2008; \*All 2008 data reported to date of visit; ~ Estimations provided  
 ^ validated by team

## ◆ Mitrovicë/Mitrovica (South) Hospital

The main regional hospital block is in North Mitrovica with its services unavailable to the 90,000 or so Albanians living in Mitrovica municipality. A second Secondary care facility was developed in the building adjacent to the Main Family Medicine Centre in the centre of South Mitrovica. Despite restricted space, the unit provides acute services in general surgery, obstetrics and gynaecology and several other surgical specialties. To the southwest of the centre, in the middle of land previously used for military purposes, a new hospital is being constructed through the support of NORWAC. It will contain operating theatres, an emergency department and an obstetrics and gynaecology unit.

Area served:



### Beds:

Total	40
Surgical	6
Gynaecology	

### Medical staff:

	Specialist	Sub specialty trained	In training
General surgeons	2		
Thoracic surgeons	0		
Radiologists	2		
Gynaecologists	7	0	
Pathologists	0		

### Patient throughput in 2008:

Surgical	Outpatient	
	Inpatient	
Gynaecology	Outpatient	~13000
	Inpatient	

## BREAST

Type	Situation	2008 Numbers*
Breast awareness promotion	No organised activities	-
Clinical breast examination	According to patient presentation	Not recorded
Breast ultrasound	One old Logiq α machine and a new Acuson X300 unit recently delivered and awaiting installation	Not possible to distinguish US of breast from other exams
Mammography	Melody mammography imager funded from Luxembourg in 2000. Irregular supply of film; often purchased privately by patient	110
CT/MRI	Not available	
Biopsy procedure	Sent to thoracic surgical unit in Pristina	0
Surgical treatment	Only in thoracic surgical unit in Pristina or out of Kosovo	0
Pathology services (cytology and histology)	One private Pathology lab in Mitrovica, otherwise patients send specimens to Pristina	-
Radiotherapy	Not available	-
Chemotherapy	Not available	-
Palliative care	No organised service at primary or secondary care level	-

## CERVIX

Type	Situation	2008 Numbers*
Cervical screening promotion	Active promotion of screening by hospital director (also a Gynaecologist)	-
Pap test procedure	No database of results returned	665
Pap test interpretation	All specimens taken to Pristina by patients	-
Colposcopy	Not available. Patients with abnormal cytology sent to Pristina	
Colposcopy targeted punch biopsy	Have correct instruments and individually sterilised but no colposcope therefore nondirected biopsies taken	N/A
Histology	All specimens taken by patients to Pristina private labs	-
Colposcopic treatment	Not available	0
Cone biopsy	Not performed	-
Surgical treatment of cervical cancer	Not performed	-
Radiotherapy	Not available	-
Palliative care	No organised service at primary of secondary care level	-

### Number of cases in 2008\*:

Condition	Numbers	Age range
Breast cancer	N/A	
High grade CIN	N/A	-
Cervical cancer	N/A	-

### Comments and future plans:

- The new secondary facility should begin functioning during 2009, a colposcopy service is planned provided equipment and training can be secured
- Due to the influence of the hospital director, Dr Drita Fazliu, in raising awareness about cervical screening, women usually present directly to the gynaecology department rather than via a Family Medicine doctor. If attending for a Pap test, no participation fee is levied.
- There are no plans to begin treatment for breast cancer, rather to continue to refer to the thoracic surgery department in Pristina

**Interviewed:** Dr Ferida Idrizi, Medical Director; Dr Nustret Haradinaj, Gynaecologist; Dr Gezimi Beqiri, Gynaecologist; Mrs Halime Klisurica, Head Midwife; Dr Mohamed Babaj, Radiologist; Dr Sadiku Haziri, Radiologist

Date of visit: 16 December 2008; \*All 2008 data reported to date of visit; ~ Estimations provided

## ◆ Prishtinë/Priština: University Clinical Centre of Kosovo

UCCK occupies one of the largest hospital estates in Europe. The acute services block (for medical, surgical, emergency and intensive care services) is surrounded by separate buildings for other specialties including the gynaecology and obstetrics clinic (GOC). The complex is both a secondary care centre for Pristina and at least four surrounding municipalities, and the tertiary level care facility for all of Kosovo. Although there are 26 operating theatres, only one is available for breast surgery and is shared with another surgical specialty limiting access for breast cases that can lead to treatment delay. In the GOC, the absence of sub-specialised Gynaecology Oncologists means that women requiring surgical management of cervical cancer need to travel out of Kosovo for treatment.

Area served:



### Beds:

Total	~2500
Surgical (Thoracic)	36 (11 for breast)
Gynaecology	369(163 for gynaecol.)

### Patient throughput in 2008:

Surgical (thoracic)	Outpatient	49617
	Inpatient	5445
Gynaecology	Outpatient	115763
	Inpatient	47069

### Medical staff:

	Specialist	Sub specialty trained	In training
General surgeons	77		
Thoracic surgeons	6		4
Radiologists	17		
Gynaecologists	68	0	
Pathologists	0		

### BREAST

Type	Situation	2008 Numbers*
Breast awareness promotion	No organised activities	-
Clinical breast examination	According to patient presentation	N/A
Breast ultrasound	Not available in Thoracic Surgery Department. Performed in Radiology	N/A
Mammography	Available in Radiology department but women often go privately as quicker	~700
CT/MRI	CT available but long wait for appointment. CT and MRI available in private hospital.	
Biopsy procedure	Fine Needle Aspiration or Lumpectomy	193 (in theatre) ~400 under LA in clinic
Surgical treatment	Wide repertoire of breast cancer surgery, including recent introduction of reconstruction surgery	70 mastectomies
Pathology services (cytology and histology)	Patient choice to take to Inst of Pathology (> 1 mth wait for results) or to private laboratory	N/A
Radiotherapy	Not available	-
Chemotherapy	Administered in Gynaecology clinic. Patient pays for Chemotherapy drugs	158 in total since service began (includes ovary ca)
Palliative care	No organised service at primary or secondary care level	-

## CERVIX

Type	Situation	2008 Numbers*
Cervical screening promotion	No programmed activities	-
Pap test procedure	Women referred to GOC outpatients for screening Pap tests, or when symptomatic	
Pap test interpretation	Lab in GOC , part-time cytologist. Services restricted to women using GOC services or private clients of some GOC gynaecologists	3420 (total from public sector for 2008)
Colposcopy	Performed on an ad hoc basis in out-patients using an Olympus colposcope donated 8-9 years ago. New colposcope in 'Oncology' department with equipment for LLETZ/LEEP procedures. training in colposcopy 2008	86 (most in outpatient department)
Colposcopy targeted punch biopsy	Available though using aged and poor quality biopsy instruments	66
Histology	Patient takes to Institute of Pathology (>1 mth wait for results) or to private Pathology lab	-
Colposcopic treatment	LLETZ/LEEP	~4 since equipment installed early 2008
Cone biopsy	Available	19
Surgical treatment of cervical cancer	Simple hysterectomy only	28
Radiotherapy	Not available	-
Palliative care	No organised service at primary or secondary care level	-

### Number of cases in 2008\*:

Condition	Numbers	Age range
Breast cancer	N/A	
High grade CIN	N/A	-
Cervical cancer	N/A	-

### Comments and future plans:

- Urgent need for subspecialty training in Gyne-Oncology to support tertiary status of GOC.
- Increased capacity required for cervical screening at laboratory and clinical levels. Colposcopy training is a priority. An ultrasound scanner is required in the thoracic surgery department for surgeons to be able to carry out targeted biopsies and to plan surgery appropriately.
- A weekly multi-disciplinary meeting co-ordinated by the thoracic surgeons is open to all those involved in managing breast cancer cases from any hospital in Kosovo. It is poorly attended by regional surgeons due to distance. There is a database of breast disease cases but this information has not been made available to the Institute of Public Health.
- An Institute of Oncology is about to open with radiotherapy equipment expected early in 2009.
- A symposium on breast pathology, organised by the Kos. Soc. of Radiology will be held in Jan 09.

**Interviewed:** Dr Frederik Çuperjani, Thoracic Surgeon; Dr Saud Maliqi, Thoracic Surgeon; Prof Dr Ali Aliu, Chief Gynaecologist in Gynaecology Oncology Dept; Dr Leandrit Bejtullahu, Gynaecologist; Prof Dr Selim Kolgeci, Chief of Laboratory; Dr Shehrezade Islami, Gynaecologist assigned to Cytology laboratory.

Date of visit: 2 December 2008; \*All 2008 data reported to date of visit; ~ Estimations provided;

^ validated by team