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Review

Problems related to gynaecological and obstetric care in Poland—selected issues

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Introduction: Obstetric and gynaecological care are undoubtedly one of the most important elements in protecting a woman's health. From the period of puberty characterised by many hormonal changes, until late old age, every woman should be cared for depending on her age and state of health. However, women and girls living in rural areas have difficulties in accessing reproductive health care, especially public services that are financed by the National Health Fund (Narodowy Fundusz Zdrowia — NFZ). There is a significant gap in access to antenatal and gynaecological health care services between women living in urban and rural areas. *Objective*: The goal of this paper is to explore current state of knowledge and data from recent reports on access to reproductive health care services in rural areas of Poland with a special focus on people living with disabilities and to share recommendations and solutions to improve access to universal reproductive healthcare services. *Conclusions*: Family policy should be coordinated with health policy to ensure comprehensive, tailored and free maternal and child healthcare at primary, local and national levels. The observed insufficient access to obstetric and gynaecological care in rural areas is probably associated with increased outlays, and thus the more efficient functioning of health care facilities in large cities. Additional campaigns, introducing mobile clinics and quality improvement in fulfilling the national standards of antenatal and gynaecological care are pivotal to universal access of reproductive health services of Polish women. People living with disabilities are facing structural and information barriers in order to access reproductive health services they need and deserve. Efforts should be made in order to develop the standards of care in order to facilitate and increase access to obstetrics and gynaecological care.

Keywords

Rural health; Obstetrics and gynaecology; Universal health care

1. Introduction

According to philosophers of medicine and ethicians, a healthcare professional delivers services to patients (in the case of gynaecology — to female patients) who are in a specific state of defenceless humanity, i.e., disease [1]. That person clearly declares having particular knowledge and abilities to provide help and treatment, and also claims that any activities undertaken will be performed in the patient's interest, not his/her own. This is paramount in becoming a representative of a given profession, and this act is not just associated with becoming a member of a specific group with the same education, standard operating procedures and common ethics. People working in the healthcare sector officially join the group of members of a given profession upon graduation from university and receiving a degree, adopting the Oath of Hippocrates and, most importantly, every time they come into contact with patients in need, looking for their help in the treatment process [1].

We should also mention the Universal Declaration of Human Rights, also called the Declaration of Geneva, adopted in 1948 (amended in Sydney in 1968, in Italy in 1983, and in 2017), which clearly refers to the Oath of Hippocrates, and reminds us about the obligation to respect medical teachers, other doctors, and patients. Particular attention should be paid to the respect for human life from its beginning, similarly to the Oath of Hippocrates. Recalling the medical oath taken by graduates of medicine in Poland, their faithful discharge of duties, preventing any suffering and diseases regardless of ethnicity, religion, nationality, social status and political ideology, and respect for doctors, should be emphasised [2, 3].

We should emphasise the special character of gynaecology (the science of woman: gyne – woman, logia – study) which apart from the knowledge requires a particular empathy and

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respect for the woman's intimacy, which is even more complex in gynaecological care for disabled women [1, 4, 5].

Although in the era of a pandemic, the fight against SARS-CoV-2 (COVID-19) coronavirus infections is a priority, one of the main tasks of medicine is gynaecological care for patients at all stages of life.

It should be highlighted that the SARS-CoV-2 pandemic has had an enormous global impact on both healthcare systems and economies. Evidence suggests that due to limited access to healthcare and obstetric services during the pandemic, the number of stillbirths and premature births may have significantly risen. Increased domestic violence (as the main reason of the growth in maternal mortality rate), the great risk of losing jobs, time consuming home child care due to closed nurseries, kindergartens and schools, and the resulting financial restrictions, all may have far-reaching consequences for the physical and emotional health of pregnant women [6–9].

Certain worrying signals have also appeared, such as the suspension of elective gynaecology, postponement of prenatal screening tests, and reduced surgical oncology capacity. Prolonged suspension of these basic obstetric and gynaecological services will probably increase incidence rates in the long run. In addition, limited direct prenatal appointments may result in more complications during pregnancy in at-risk groups, such as domestic violence victims, poor populations with limited access to advanced technologies, and people with mental disorders [10, 11].

Summing up, it should be emphasised that the SARS-CoV-2 epidemic constitutes a great challenge for healthcare managers, epidemiologists, and doctors of various specialties, such as gynaecologists and obstetricians. The clinical course of COVID-19 encompasses mainly symptoms from the respiratory system, i.e., coughing, dyspnoea and fever. In some patients acute respiratory distress syndrome (ARDS) may also occur, which can lead to death. Pregnant women suffering from this disease are a group requiring special clinical activities.

The World Health Organisation pays a lot of attention to reproductive health, particularly within infertility, family planning, contraception, maternal and newborn health, preventing unsafe abortions, as well as HIV/AIDS among women. They also recommend international procedures and standards in health promotion, prophylaxis, and treating women of reproductive age [12].

As a subsidiary body of the UN General Assembly, the United Nations Population Fund (UNFPA) perceives parenting as a most significant challenge, and considers maternal health a profitable investment that guarantees a high health condition in future generations. To achieve this, international partnership and cooperation between governments, organisations and institutions are of key importance [13–16].

Further, the Beijing Conference set out the responsibilities for primary healthcare professionals in establishing levels of healthcare in women of reproductive age [17]. In 1994 at the International Conference on Population and Development (ICPD), the governments obliged themselves to provide universal access to reproductive health care "as soon as possible and no later than 2015" as a key for the implementation of human rights, sustainable development, gender equality and women's empowerment [13].

Article 68 of the Constitution of the Republic of Poland of 2 April 1997, clearly states that [17]: "Everyone has the right to health protection. Citizens, regardless of their financial situation, are guaranteed the equal and public access to health care services financed from public funds. Public authorities are required to provide specific health care for children, pregnant women, people with disabilities and the elderly".

The aim of this paper is to explore the current situation of access to obstetric and gynaecological care for women living in rural areas of Poland with a special focus on people living with disabilities and to make the policy recommendations to improve access to healthcare among Polish women.

2. Aiming to improve maternity and gynaecological care in rural areas

The situation in Polish society, namely for women, should be evaluated through the prism of changes over the last 15 years, and by referring to situations in other countries, including the European Union States [14]. The remarkable reduction in maternal and newborn deaths, as well as the decline in teen birth rates, both deserve particular attention. On the other hand, an alarming trend of an increasing number of cancers, deaths and sexually transmitted diseases is noticeable [18–23].

Article 68 of the Constitution of the Republic of Poland guarantees every citizen the right of equal access to healthcare services financed from public funds. Section 3 of this Article states that public authorities shall ensure special healthcare to children and pregnant women [17]. For this reason, family policy should be coordinated with health policy to ensure comprehensive, tailored and free maternal and child healthcare [24] at primary, local and national levels.

The observed insufficient access to obstetric and gynaecological care in rural areas is probably associated with increased outlays, and thus the more efficient functioning of health care facilities in large cities with which the National Health Fund has concluded contracts for the provision of health services including outpatient obstetric and gynaecological care. This, in turn, may lead to the risk of limited antenatal care, which may result in limited availability of preventive examinations specified in the standards of perinatal care and in the early detection of breast and reproductive organ cancers [17].

It should be strongly emphasised that properly implemented preventive care not only reduces the risk of cancer [25–29], but also the risk of lifestyle diseases such as type 2 diabetes, obesity, osteoporosis and atherosclerosis. Maternal and child healthcare services in Poland are provided by: midwifes, physicians, primary care nurses or school hygienists.

In 2018, rural areas accounted for 93% of the country's area, which builds up to around 40% of the total population of Poland [30]. Compared to 2010, the number of inhabitants of the village increased by about 243,000, i.e., by 1.6% with 360,000 inhabitants in the city, i.e., by about 1.5% [30].

Noteworthy is the slow improvement in access to outpatient healthcare services (outpatient clinics, medical practices providing services under public funds). When compared to 2010 there was an increase of 2.5%, and thus to advice by 4.7%. However when comparing the data between rural and urban areas, there is a significant gap in the number of consultations given: 279.8 million were provided in cities, 40.5% of which were specialised ones in comparison to 48.3 million consultations in rural areas, of which 6.3% in specialist care [30]. Moreover, the data show the insufficient access to services per capita in the rural vs urban areas (3.2 vs 12.1 respectively). 2010 vs 2018, the number of outpatient clinics increased in both rural and urban areas (by 14.7%, and 37.5% respectively) [30]. Despite the slow improvement, efforts should be made to systematically increase the expenditures on contracting outpatient gynaecological and obstetric services in rural areas.

In accordance with the Decree of the Ministry of Health of 21 March 2019 regarding the publication of the Regulation of the Minister of Health on guaranteed services in the field of universal healthcare guaranteed by a midwife in primary healthcare facilities, the services include: (1) an outpatient visit; (2) a visit to the recipient's home, in medically justified cases; (3) a patronage visit (a health care professional visits to assess the babies health, up to six weeks post partum); (4) preventive visit [31].

In 2017, patronages constituted 10.340, including 5176 visits up to the fourth days of life. In addition, when analysing patronage visits and screening tests performed up to the sixth month, the ninth month and the twelfth month of life, they constituted, 69.49%, 15.04% and 15.47%, respectively. There is a significant decrease in the contracted visits with the passage of time [30].

Visible differences are also observed in the number of gynaecological and obstetric clinics having a contract with the National Health Fund, and individual voivodships: for Lubuskie Voivodship amounted to 49, for Opolskie — 58, for Podlasie — 59. The largest number of clinics included Mazowieckie and Śląskie voivodships: 288 and 384 respectively.

Analysing access to gynaecological clinics in 2016–2017, the residents of Lubelskie and Podlaskie voivodships were in a bad situation, where the benefits in gynaecological clinics contracted by the National Health Fund in 2016 and 2017 were respectively: 5075 and 4454 women, while in urban areas it was — 27.743 and 23.942 potential patients, respectively. In addition, the working hours of most of the rural outpatient clinics ranged between 10–13 hours a week. For this reason, some outpatient clinics in rural areas had limited access of female residents to preventive examinations including cervical cancer prevention, while access to the preventive breast cancer program implemented in outpatient clinics and mammobuses (mobile clinics were free mammography examinations are performed) was correct.

In accordance with the Regulation of the Ministry of Health of 16 August 2018 regarding the organisational standard of antenatal care, it defines "individual elements of the organisation of care aimed at ensuring good health of mother and child, limited to necessary medical interventions". In addition, a pregnant woman has the right to "benefit from midwife primary health care between the 21st and 26th weeks of pregnancy for educational sessions and antenatal care provided for pregnant women". Moreover "the primary health care midwife confirms that a woman is covered during pregnancy and after delivery by entering the antenatal care plan and pregnancy record card (pl. "Karta Ciąży") of her data or subject data performing medical activity in the field of primary healthcare, including: contact and fax number or e-mail address;" "[midwife] may order additional health services of a preventive or diagnostic nature if the state of health of the pregnant woman or the results of earlier tests indicate the possibility of complications or pathologies of pregnancy, delivery or postpartum" [32].

An indispensable part of women's healthcare is mental health protection, particularly in the perinatal period. This element of free obstetric care is intended to ensure mental comfort, with first and foremost early diagnosis and treatment of perinatal depression [33].

According to the data of the Supreme Audit Office (Najwyższa Izba Kontroli — NIK) in 19 outpatient clinics, among the 70.4% of the audited clinics no patient received comprehensive health services in accordance with perinatal care standards, in the five clinics recommended services were provided only partially, and three other healthcare entities did not report medical records of services performed, explaining the omission and excess in studies of the relationship to the needs arising from the course of pregnancy. Furthermore, proper intimate conditions were not observed in any of the audited entities [34]. For example, up to the 10th week of pregnancy, 38.8% of pregnant women were not ordered for rubella antibody tests. The same for HBs antigen test performed between 33 and 37 weeks of pregnancy (34.5% not tested), as well as in of the or culture tests for B-hemolytic streptococci (49.9% not tested). Moreover, in antenatal care standards women should be tested twice for HIV—in 10weeks and between 33–37 weeks. However, tests up to the 10th week of pregnancy have not been performed or documented in 17% of women and in 43% of women at 33–37 weeks of pregnancy [35]. Diabetes is a very important issue as a group of metabolic diseases characterised by chronic hyperglycaemia leading to disturbances in the metabolism of proteins, fats and water and electrolyte balance. During pregnancy, elevated glucose levels in the pregnant woman cause a number of complications in the mother and foetus. Introducing lifestyle changes through education is both preventive and therapeutic [36]. Therefore, early pregnancy planning is

a very important issue, especially among women with pregestational diabetes [37]. It should be noted that the failure to perform the recommended services constitutes a violation of one of the basic rights of the patient in accordance with article 6, 6 and 8. The Ombudsman for Patient Rights clearly states that "for health services that meet the requirements of current medical knowledge the patient has the right to health services provided with due diligence by entities providing health services under conditions that meet professional and sanitary requirements specified in separate regulations. When providing health services, persons practicing in the medical profession profession are guided by the principles of professional ethics defined by competent self-governments of medical professions" [38].

On the other hand, despite the observed decline in the female fertility rate, and thus the decrease in the birth rate, the number of qualified midwives increases, from 22,200 in 2010 to 22,900 thousand in 2018 and midwives with a master's degree (30.6% in the Świętokrzyskie voivodship, 44.2% in Lublin) [30]. In 2016, almost 37,000 midwives had the right to practice.

Lack or insufficient gynaecological care also has a negative impact on sexual and reproductive health, especially among women with disabilities [39–43].

3. Gynaecological care of persons living with disabilities

It should be strongly emphasised that women living with disability have the same right to receive gynaecological care during all stages of life. However, the stereotypes about people with disabilities have minimised prophylaxis within gynaecological health [44, 45].

When providing gynaecological care, special attention should be paid to women with intellectual disabilities, who associate the gynaecological examination with painful experiences and an act of violence, resulting in increased negative emotions [46].

Steele *et al.* [47] in their studies proved that women with disabilities attended less gynaecological consultations and therefore have less breast and cervical cancer screening opportunities when compared to women without disabilities. In addition, the authors point to the stereotype according to which, the alleged lack of sexual activity of a woman with disability explains her lack of interest in reproductive health. In other studies, which assess factors that impede access to gynaecological care for women with disabilities, as many as 42% of women with physical disabilities declared dissatisfaction with the quality of gynaecological visits [48–50].

An important element is also the need for addressing the architectural barriers hindering access to healthcare facilities of women and girls to specialists and the creation of appropriate facilities for visually impaired patients, which would allow to maintain intimacy when reaching the gynaecologist's office [49].

Another problem impacting the avoidance of gynaecological examinations by disabled women is mainly connected with negative experiences such as pain, fall, as well as inappropriate adaptation of surgeries, chairs and medical equipment [50].

Art. 5. of the Polish Constructional Law clearly indicates that "A building object with related construction devices should, taking into account the expected period of use, be designed and built in a manner specified in regulations, ensuring: the necessary conditions for the use of public buildings and multi-family housing by people with disabilities, in particular those using the wheelchairs" [51].

Detailed solutions necessary for recognising a given building as suitably adapted for the people with disabilities are discussed in the Regulation of the Minister of Infrastructure of 12 April 2002 on the technical conditions to be met by buildings and their locations (Dz. Of Laws of 2002 No. 75, item 690, as amended d.). This ordinance quite thoroughly discusses the conditions that a newly constructed building must meet, but also applies to situations in which a building is being rebuilt, expanded and the way it is used. It is worth noting that pursuant to Article 29 (18) of the Regulation, construction of a ramp for people with disabilities is exempted from the need to obtain a building permit.

Another important factor is to address information barriers, and ensure proper understanding of prevention and health education taking into account the special requirements of patients with disabilities. Information barriers result from both a lower rate for enrolment of services of girls and women with disabilities with regards to the general population. Numerous sociological observations indicate that Polish society is very traditional, also in relation to many negative stereotypes that have long been absent in European Union countries. One of them is the alleged disability of a disabled person. The illusive consequence of this stereotype is marginalization of prophylaxis in the field of gynaecological health, often found among pedagogues as well as among paediatricians and neurologists [4].

4. Recommendation

Based on the current state of knowledge the following recommendations have been formulated:

(1) Efforts should be made to systematically carry out inspections of medical entities, the aim of which will be to detect irregularities in the implementation of health services at an early stage in accordance with accepted standards of perinatal care. That pertains to properly maintaining medical records in health care facilities as well as conducting large-scale campaigns to promote screening diagnostic tests in order to detect at an early clinical stage malignant changes of the cervical and breast cancer.

(2) There is a significant gap in access to antenatal and gynaecological health care services between women living in urban and rural areas. Additional campaigns, introducing mobile clinics and quality improvement in fulfilling the na-

tional standards of antenatal and gynaecological care are pivotal to universal access of reproductive health services of Polish women.

Author contributions

KP-R, GJ-B and MD analyzed the data; WK, MP-K and PM performed the review and editing. KP-R, GJ-B, WK, MG-K, PM, M-D wrote the paper. All authors read and approved the manuscript.

Ethics approval and consent to participate

Not applicable.

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Conflict of interest

The authors declare no conflict of interest.

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