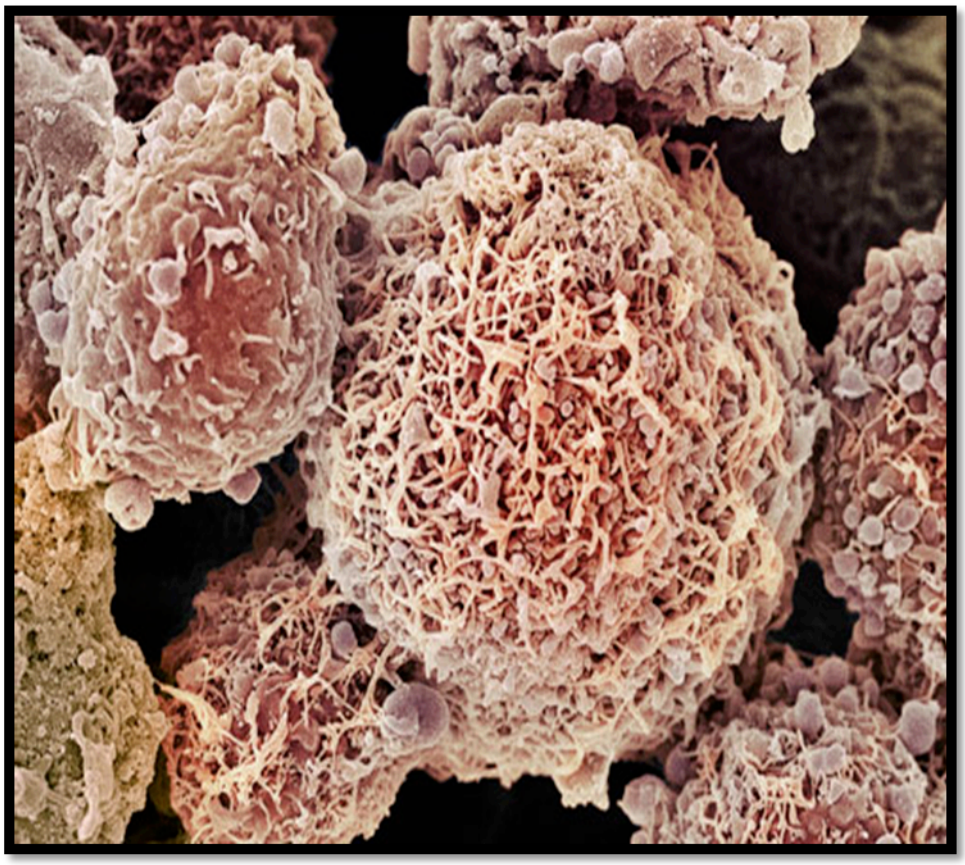
CANCER SCREENING IN THE EUROPEAN UNION

- A POLICY ANALYSIS -



A RESEARCH BY

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S T A N D A R D F R O N T P A G E
F O R
E X A M I N A T I O N P A P E R S

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Abstract

The purpose of the thesis is to analyze policies concerning cancer screening in the European Union. The thesis will focus on cervical cancer as the type of cancer. The main focus will be to see how cancer screening is represented in policy documents and if there are other areas that need to be taken into account, like assumptions and effects caused by the problem representation. The thesis might have impact on further studies performed on problem representations of cancer within the European Union.

The problem I am trying to solve in the thesis is how the representation of cancer screening comes to a stand within the European Union and which limitations can be found during this process. Instead of focusing on a single Member State, my focus goes out to all the Member States as a whole. The problem of cervical cancer only affects women, after being infected with the Human Papilloma Virus due to sexual contacts. Therefore, screening should be provided as a tool that should be incorporated in all the Member States to perform screening on both HPV and cervical cancer. Without offering screening more victims of cervical cancer will die.

For the analysis I use statistical data and policy documents about cancer screening within the European Union to discuss the problem represented. The extent of my work is limited to several policy documents that are familiar with the topic of cancer screening as well as aimed at cervical cancer.

The implications of the thesis are not to change the world, but can only give a clear overview of the representation of cancer screening within the institutions of the European Union. The results expected at the end of thesis can be considered to be potentially generalizable as I have not discussed a Member State on a thorough level, therefore having applied the data on a general level.

In the end, the thesis will discuss the results found throughout the process and give a view on future researches to be performed on the topic.

Dedication

I would like to dedicate my thesis to my family, who have always supported me throughout the years, and encouraged me to pursue my dreams. Without your believe in me, I would not have made it this far.

I love you all.

Abbreviations

EAC	Europe against Cancer
EBCN	European Breast Cancer Network
EC	European Commission
ECCSN	European Cervical Cancer Screening Network
ECN	European Cancer Network
EU	European Union
EUNICE	European Network for Information on Cancer
HPV	Human Papilloma Virus
IARC	International Agency for Research on Cancer
WHO	World Health Organization
WHO-Europe	World Health Organization – Regional Office for Europe
WPR approach	'What's the problem represented to be' approach

1. Introduction to the thesis

First, a general introduction to the thesis will be offered and afterwards the problem area and research question will be presented. Next there will be a definition of central terms and the chapter will be rounded off with a glance at literature that is already written on the subject.

1.1. General introduction to the thesis

In 2005, 500.000 new cases of cervical cancer were reported, according to projections of the World Health Organization, and 90% of the cases were detected in developing countries. In this same year, almost 260.000 women died of cervical cancer, with 95% of the victims coming as well from the developing countries. Up to 1 million women were estimated to be suffering from cervical cancer, without any chance of being diagnosed, access to treatment and a possibility to be cured, leading to an unusual high number of death due to cervical cancer[1]. These statistics are interesting because the burden of cervical cancer is much lower in the developed countries, but still remains an important issue on the agendas of health organizations in those regions.

With the introduction of Council Recommendation 2/12/03 on cancer screening, the Council of the European Union, backed with the support of the European Commission and European Parliament, an important step is taken to reduce further deaths and offer more screening possibilities within the Member States of the European Union. In relation to the developing world, well-planned and organized screening programs with high coverage in the developing world have shown reduced numbers of cases and deaths[2]. But this takes not away that there is a dissimilar difference between the Member States in the European Union and this deserves attention.

Thus, even though there has been more attention towards the prevention of cervical cancer, there is need for better screening and vaccination programs in the future to decrease the number of women with cervical cancer. This thesis is inspired by the fact that even though there is a recommendation in place, there is still distinct differences between Member States.

[1] World Health Organization. *'Comprehensive Cervical Cancer Control – A guide to essential practice'*. Page 16. <http://ehqlibdoc.who.int/publications/2006/9241547006_eng.pdf> [8 March 2010]
[2] Ibid.

1.2. Introduction of the problem area and research question

There are many aspects of cervical cancer, including the screening and vaccination of women as being discussed in this thesis. We can detect more aspects varying from more medical aspects to the impact of cervical cancer within a certain age group and so on. According to the World Health Organization, cancer control programs are essential to prevent cervical cancer and play an important role in reducing cancer related morbidity and mortality[3].

What is important to note is that even though reports show that more countries are implementing screening programs, new problems are being detected. The role of the Human Papilloma Virus (HPV) has been receiving attention since its presence in the body of women has been connected to the development of cervical cancer in a later stage. Together, they make the current question of cervical cancer very interesting and more research is being performed to investigate the problems. To avoid that the thesis becomes a place of too much information about cancer screening on cervical cancer, I have chosen to focus on the work of the European Union as a whole, identifying how the problem is represented within legislation. These choices will be elaborated on in the next chapter on methodology. The following research question will be used in the thesis to guide the case study of the problem area:

How can we understand the policies concerning cervical cancer taken by the European Union when applying Carol Bacchi's analysis?

1.3. Defining the research area

This part of the introduction to the project will deal with the choices that have been made and help outlining the limitations of the project. Two distinctions mentioned below helped me to define the research area.

The first distinction to make is that this project will focus on policies directed towards cancer screening programs instead of focusing on cervical cancer as a disease. Although cervical

[3] Ibid. Page 15.

cancer is here the inspiration of discussion, writing about the cancer itself would become to complicated and would take the focus away from the policies direct towards screening programs. In other words: this thesis is on policies and problem representations – cancer is to be seen as the problem through which we can study EU policies.

The second distinction that is necessary to comment on is the choice to focus on the Council Recommendation 2/12/03 from the European Council as the starting point of writing my thesis. The Council Recommendation represents the work delivered in the past on cancer issues and also represents of what will happen in the future. By using it as point of departure, it will help defining the structure of the rest of the thesis

1.4. Definition of central terms

A short definition of the central terms of this project will now be offered. This part on definition is relevant as terms in the project are of a nature, which can be interpreted in various ways. A definition of three terms will be given: 'cervical cancer', 'Human Papilloma Virus', 'screening' and 'vaccination'.

'Cervical cancer' might seem a peculiar term to define, but it is needed to acquire some basic knowledge of what the cervix actually is and what is affected when cancer affects the area. The cervix is located on the lower end of the uterus and is located on top of the vagina. The cervix allows menstrual blood to flow out of the women's body into the vagina. As well it serves to let sperm reach the uterus during intercourse[4]. The cervix will transform during the process of puberty and pregnancy of the woman, allowing the transformation of the cervix, which could lead to cervical cancer when infected with the Human Papilloma Virus[5].

'Human Papilloma Virus' is a term that will be used throughout the thesis. HPV is the virus that causes the infection of the cervix, leading it to develop into cervical cancer. The virus is spread through sexual intercourse, but not all types of the virus will trigger cervical cancer, but might also cause genital warts[6].

[4] MedlinePlus Medical Encyclopedia. *'Cervix'*. <http://www.nlm.nih.gov/medlineplus/ency/article/002317.htm> [27 June 2010]
[5] World Health Organization. *'Comprehensive Cervical Cancer Control – A guide to essential practice'*. Op.cit. Page 33.
[6] MedlinePlus Medical Encyclopedia. *'HPV vaccine'*. <http://www.nlm.nih.gov/medlineplus/ency/article/007436.htm> [27 June 2010]

'Screening' is a method of testing destined to detect abnormalities. Cervical cancer screening "aims to detect precancerous changes, which, if not treated, may lead to cancer"[7]. This term will be used throughout the thesis and in a later stage when I will focus on different kind of screenings that are being performed by the Member States.

'Vaccination' is like screening a method used to protect women from obtaining the HPV infection. Since the introduction of vaccination is quite recent, there are no definite results of what the vaccination will mean for the elimination of both HPV infection and cervical cancer in the future. Together with screening, vaccination is the future of preventive medicine.

1.5. Literature on the subject

Rounding off the introduction to the thesis, I will shortly introduce some information on the choices made regarding the literature. There is a lot of information on cervical cancer, cancer screening and vaccination to be found. Most of the time it is combined into policy documents or official documents published by for example the World Health Organization, the departments of public health of the European Union and academic journals. Most of the literature found is quite recent and is being updated constantly due to new innovations in the area of screening and vaccination. Much of the data used comes therefore from reports and documents that have been published in the recent years. The information on the theory used in the thesis is also fairly new, since the book by Carol Bacchi was published in 2009. This makes reading the thesis relevant to present time, as the information used is not outdated at the moment of writing.

2. Methodology

Following part will present the methodology of this thesis. Introductory, the philosophy of science will be presented. Following this, I will outline the research design, followed by an

[7] World Health Organization. *'Comprehensive Cervical Cancer Control – A guide to essential practice'*. Op.cit. Page 81.

introduction to the case of study, the representation of cervical cancer within the European Union. Concluding this chapter, the combining of the methods will be explained.

2.1. Philosophy of science – Social Constructivism

The following part will describe this thesis's philosophy of science: social constructivism. The philosophy of science will have an influence on which areas will be in focus how the case study is organized, the purpose of the thesis and which theory I have chosen to work with and which will show throughout the thesis.

The philosophy of science will leave traces in the whole thesis because it constitutes an understanding of the research are and therefore influences the theory, the method, the research object and how they do not search for a definitive truth. The thesis will work with social constructivism as the philosophy of science in answering the research question. Using a perspectivistic paradigm, the research object, cervical cancer in the European Union, is seen as being dependent on the context related to time and place. Therefore you cannot talk about an objective truth and only show perspectivistic views. I will aim and show how the problem of cervical cancer is represented in the policies of the European Union. In relation to this perspectivistic paradigm, the thesis will have a social constructivist epistemology. According to social constructivism, the world is constructed by our perceptions of phenomena. These perceptions are not necessarily shared by all members of the same context, therefore it is not possible to talk about an objectively truth.

The thesis, as presented below, will use a social constructivism from the modern sociology, and the theorists in this approach are of the opinion that humans act in correlation with social relations and structures in the society[8]. The policies concerning cervical cancer will be understood as constructed of social relations made by politicians and as an inconsistent term and therefore dependent of its time and context. A thorough description of the context; the current situation in the European Union, is therefore essential.

[8] Rasborg, Klaus. "Socialkonstruktivismer I klassisk og moderne sociologi" in *Videnkabsteori I samfundsvidenskaberne,* edited by Lars Fuglsang, Poul Bitsch Olsen, 2007, Roskilde: Roskilde Universitetsforlag Rasborg, 2004. Page 349ff.

In creating a thesis concerning cancer screening in the European Union as a social construction, I have chosen to use a single theory on analyzing policies by Carol Bacchi. Her work on analyzing policies is heavily influenced by the work of Michel Foucault, but I have decided not to incorporate his work in my thesis and only refer to him on occasion because the theory by Bacchi is directly applicable and more from the present time. Bacchi's theory therefore can be categorized as anti-realistic. This is to be understood as that knowledge and reality are not perceived as something objective; knowledge and reality are value-laden because it is a result of interpretation. The theory is created from a certain understanding of how representations are seen in policies. These understandings are derived from perceptions of the human being and the structures of societies, and therefore it is an already interpreted area that is in focus. Furthermore, the theory is in line with social constructivism in the way that knowledge is seen as historical and cultural specific, meaning that the theory can be seen as a theory that can be fitted in relation to the subject of research and the context.

The philosophy of science in this thesis is to be seen to Max Weber's theory on value-laden research. Awareness of this tendency will help the researcher to identify which areas in the research question that are influenced by prejudices and thereby give the researcher the chance to be critical. According to Weber, the situations that are being studied will always be related unconsciously to the researcher's personal cultural values[9]. In my case, this means I have chosen my topic because it has my personal interest and wanted to do more research on what action the European Union has undertaken to prevent cervical cancer. Also, my perception of the topic is, that as a young female from a Western country with free access to hospitals, I have more chances of not fall victim to cervical cancer due to screening programs and vaccinations presented.

2.2. Research Design

The following part will contain a description of the research design for the thesis. This research design is not only to be seen as a work plan, but also as a logical structure of inquiry to ensure that the conclusions drawn enables me to answer the research question as unambiguously as possible.

[9] Weber, Max. *Den Protestantiske etik og kapitalismens ånd.* København: Nansensgade Antikvariat. 1920/2005. Page 25f.

The research will take an abductive approach in the understanding of the research question as concluding the best explanation. All ways of concluding can be said to work well with a social constructivist approach, and in this project abduction will be used. Abduction can be used to see connections in the world and to question the connections that are taken for granted. In abduction, conclusions are made between the rules, the theory, and the single case[10]. That is to be understood in the order, that I will choose the theory to be used, decide on the method, apply the empirical data obtained and then go back to the theory again. The theory will then be used as a help to structure the work processes of the project and decide in which order the analysis will be done.

The research focuses on a case study and attempts to study a phenomenon in a certain context. This will be a single case study where contextual information is collected about the representation of cervical cancer within the European Union as a whole, so that there will be a context within which to understand the research object[11]. Using a single case study, the theory plays a central role in the sense that the analysis will be guided by theory. Using de Vaus's view of case study designs, I will approach the case study as an embedded unit of analysis, meaning that there is a collection of information from a wide range of sources, which leads to the experiences and perspectives of the case. At the same time it also includes some holistic aspects, since the focus of the thesis is rather on the European Union as a whole, than on the Member States. Also, looking at the case in a retrospective way of design, allows me to collect information from an extended period of time, and take a look into the history of the topic, in this case, former documents of the institutions of the European Union[12].

2.3. Introduction to the case

As I started the research of data available in the area of study, several problems came to my attention. The following will contribute to the transparency of the research process by focusing on my choice to work with the European Union as a case.

[10] Fulgsang, Lars, Olsen, Poul Bitsch. "Introduktion" in *Videnskabsteori I samfundsvidenskaberne,* edited by Lars Fuglsang, Poul Bitsch Olsen, 2007. Roskilde: Roskilde Universitetsforlag Rasborg, 2004. Page 30.
[11] De Vaus, David A. *Research Design in Social Research.* London: Sage Publications. Page 231.
[12] Ibid. Page 220ff.

The reason for choosing the European Union as a focus in this thesis is to keep it related to my field of studies and by combining it with a topic that has my personal interest. The scope of the thesis would not allow me to go into depth with a single Member State as a case study, because it might have given a biased view on the answer of the research question and also forgets that each Member State has, even with the Council Recommendation in place, a different approach to the topic. With taking the European Union as my center of focus I will become less biased as I treat all Member States as an equal within the research and only pointing out what can and should be improved according to the Council Recommendation.

The intention of this thesis is to research the policies concerning cervical cancer taken by the European Union and what impact this has on the Member States when applying Carol Bacchi's analysis. This will be done by taking a look at the different actors that are involved in this process and see what kind of actions are taken throughout the last decades. The actors chosen as research objects can be defined as followed:

- The European Union, represented by the Commission, the Council, and the Parliament; and
- The national governments of the Member States.

Besides these main actors, it is important to look into some actors that besides the European Union work closely with the topic of the thesis, like the World Health Organization (WHO-Europe) and the pharmaceutical industry that has provided vaccines against cervical cancer. The actors will be discussed in the following chapter and will help clarify the choices of theory and analysis.

2.4. Combining methods

In this thesis, I will make use of a combination of written documents and statistics. I have chosen this because I believe that this combination has its advantages in relation to the research question. Triangulation means that there will be different types of information about the same phenomenon, policies on cervical cancer, which will cover the area the best way[13].

[13] Bryman, Allan. *Social Research Methods*. New York: Oxford University Press. 2008. Page 379.

The description of the case above uses both statistical data and policy documents to show in which extent the policies represent the consequences cervical cancer. This approach is chosen, because to get a deeper understanding of the context, triangulation will give this. Also, triangulation will increase the internal and external validity. Internal validity allows us to draw conclusions from our results, where the external validity is referring to the results of the study and if they can be generalized in other studies[14]. Using different types of data will also compensate for possible weaknesses in the data, because it will give different views on the same subject. Using triangulation demands awareness, that different types of data may not elucidate exactly the same reality. Furthermore different kinds of data will have different biases and can be seen as watching the subject through different glasses.

3. Data

In the following chapter I will present empirical data existing of policy documents that is relevant to the subject of the thesis. After the presentation of the data I will continue to present the theoretical framework and combine the two chapters to analyze the data on the basis of the theoretical framework.

3.1. Causes of cervical cancer

The Human Papilloma Virus (HPV) is the main cause of cervical cancer in women. HPV is considered part of the DNA virus that infects skin or mucosal cells, and consists out of more than a 100 subtypes, where only 13 of them are known to cause actual cervical cancer. These types are the so-called 'high-risk' genotypes, which are found in women that develop the cancer. Causing about 70% of all cervical cancers are genotypes 16 and 18, while genotypes 6 and 11 of the HPV infection causes genital warts, a condition to be related to cervical

[14] De Vaus, David A. *Research Design in Social Research.* Op.cit. Page 27f.

cancer. In total, over 13 genotypes are found to cause cancer, where genotypes 16 and 18 stand on top of the list to actually cause the disease[15].

HPV not only can cause cervical cancer, besides that, it is also responsible for cancer on the vagina, vulva or anus in women and the penis, scrotum, or anus in men. HPV, therefore, is "estimated to cause 100% of cases of cervical cancer, 90% of anal cancer, 40% of cancers of the external genitalia, at least 12% of oropharyngeal cancers and at least 3% of oral cancers"[16].

Women are getting infected with HPV by having unsafe sexual contacts, and the infection shows up after the first sexual contact. It is known to be transmissible on a high rate, and most individuals (both men and women) will be infected by it at one point in their life. Besides contracting HPV, there are other related factors to cervical cancer like early age of first delivery, smoking and long-term use of hormonal contraceptives[17].

While an HPV infection might resolve over time spontaneously, it has the risk of developing into cervical cancer over a time period of 20 to 30 years. During this transition time and continuous infection of the cervix, the cancer can develop. By screening of the women, early detection of the changes in the cervix can be considered as a strategy that is effective for prevention of cervical cancer[18]

3.2. Burden of cervical cancer in the European Union

After cardiovascular disease, the second cause of death within the Member States of the European Union is cancer, signing for one out of four deaths. Although, cancer is more common to be found in older people, cancer of the uterine cervix (which leads to cervical cancer) is mostly found by younger women between the age of 35 and 30, but cases of

[15] World Health Organization. *Human Papillomavirus and HPV vaccines: Technical information for policy-makers and health professionals.* Geneva, Switzerland: WHO Press. 2007. Page 2ff. <http://whqlibdoc.who.int/hq/2007/WHO_IVB_07_05_eng.pdf> [8 March, 2010]
[16] Ibid. Page 5.
[17] Ibid. Page 2.
[18] World Health Organization Regional Office for Europe. "Can we prevent cervical cancer?" *Entre Nous: The European Magazine for Sexual and Reproductive Health,* Number 64-2007. <http://www.euro.who.int/__data/assets/pdf_file/0007/69766/en64.pdf> [8 March, 2010]

women younger have been reported as well[19]. According to the International Agency for Research on Cancer (IARC), in 2006, about 36.500 cases and 15.000 deaths due to cervical cancer were reported in the European Union. The majority of the cases accounted were by the new Member States that joined in both 2004 and 2007[20].

When observing the mortality rates of cervical cancer within the European Union, the new Member States peak with their high mortality numbers, where the rates of the Member States before expansion remain on the low side. Where Romania and Lithuania rake as the two newest Member States with the highest mortality rates (13.7 and 10.0 per 100.000 women a year respectively), Finland has the lowest rate of mortality (1.1 per 100.000 women a year) as of 2004[21].

3.3. History of EU policy on HPV and cervical cancer

The European Council took its first steps towards creating a program of action against cancer with adapting a resolution of July 7th, 1986. The resolution resulted in the creation of the 'Europe against Cancer' (EAC) programs established in 1985, which included organized systematic population-based screening for specific sites of cancer where such interventions had been judged to be effective. The EAC programs have led to the current known networks as the European Breast Cancer Network (EBCN) and the European Cervical Cancer Screening Network (ECCSN). The EAC program existed of three key elements, namely the partnership approach, the European Code against Cancer and the long-term vision of lowering the cancer-specific mortality of the European population by 15% for the year 2000[22].

It was in 1999 during a conference attended by all the Member States that the European Commission reached consensus to create a recommendation for cancer screening. An

[19] European Commission. *European guidelines for quality assurance in cervical cancer screening, second edition.* Luxembourg: Office for Official Publications of the European Communities. 2008. Page 3.
[20] European Commission. *Cancer screening in the European Union: Report on the implementation of the Council Recommendation on cancer screening. First Report.* 2008. Page xii. <http://ec.europa.eu/health/ph-determinants/genetics/documents/cancer_screening.pdf> [3 May, 2010]
[21] European Commission. *European guidelines for quality assurance in cervical cancer screening, second edition.* Op.cit. Page 3.
[22] Commission of the European Communities. "Proposal for Council Recommendation on cancer screening". Page 2ff. <http://ec.europa.eu/health/ph_determinants/genetics/documents/com_2003_0230_en.pdf> [8 March 2010]

agreement was reached, but did not get validated by the attending parties, which lead to a continuation of opportunistic screening in several Member States[23]. The report published as result of the conference describes that a European set of guidelines for cervical cancer was developed in 1993, where targets for quality assurance of organized screening programs. In the report, the Advisory Committee on Cancer Prevention recommended the Member States the following:

- "Pap smears should be the method used in cervical cancer screening;
- When screening is offered it should start at the latest by the age of 30 and definitely not before age 20;
- Screening intervals should be between three and five years, and
- Cervical cancer screening programs should be organized in accordance with the European guidelines"[24].

To the European Commission and the European Parliament, the Advisory Committee on Cancer Prevention advised that:

- "A common terminology for histology (structure of tissues) and cytology (structure of cells) should be implemented;
- Recommendations for training and quality control could be proposed and tested in the network centers;
- Validation studies of liquid based and automated screening methods with special attention to cost-effectiveness should be undertaken, and
- Studies should be undertaken of recent trends in incidence of cervical cancer in Europe in order to optimize the lower and upper age limits for screening"[25].

[23] Arbyn, Marc, et al. "European Consensus On Cancer Screening Should Be Applied Urgently By Health Ministers." *BMJ: British Medical Journal,* Volume 323, Number 7309 (Aug. 18, 2001), page 396. <http://jstor.org/stable/25467676> [12 May 2010]
[24] Advisory Committee on Cancer Prevention. "Recommendation on Cancer Screening in the European Union". Page 4. <http://ec.europa.eu/health/ph_determinants/genetics/cancerscreening_en.pdf> [8 March, 2010].
[25] Ibid. Page 4f.

The Advisory Committee concluded in its report that only healthy people should be offered cancer screening if this would lead to a decrease of mortality or incidence rates of the disease and the that the cost-effectiveness of the screening would be acceptable[26].

It was not until 2003 that the European Commission came with the proposal for a Council Recommendation on Cancer Screening, following up the agreement reached in Vienna in 1999. The Recommendation, based on Article 152 of the EC Treaty, recommends the implementation of best practice principles in cancer screening in all Member States, preferably executed through following European guidelines[27]. The main points of the proposal were in line with the report of the Advisory Committee, and set to be used in the final recommendation of the Council. The proposal included the following points:

- "Sufficient evidence has been accumulated on cost effectiveness and negative effects to recommend screening at a population level;
- Periodic pap smear testing should start before the age of 30 but not earlier than the of 20;
- New technologies can be introduced only after their effectiveness and cost effectiveness have been established in randomized controlled trials on public health relevant outcomes, like liquid based cervical cytology, human papilloma virus detection and automatic screening devices, and
- The European Commission recommends that screening be offered in organized programs, with quality assurance at all levels and good information about benefits and risks"[28].

With the unanimous signing of the Council Recommendation of 2 December 2003 on Cancer Screening, the Health Ministers of the European Union acknowledged the burden of cancer within the borders of the European Union and that screening to reduce the burden of breast, cervical and colorectal cancer is effective. Implementing national cancer screening programs with a population-based approach and quality assurance at all levels forms together with

[26] Ibid. Page 11.
[27] Commission of the European Communities. "Proposal for Council Recommendation on cancer screening". Op. cit. Page 7.
[28] Arbyn, Marc, et al. "European Commission's Proposal For A Council Recommendation on Cancer Screening". *BMJ: British Medical Journal,* Volume 327, Number 7409 (Aug. 2, 2003), page 289f. <http://jstor.org/stable/25444164> [12 May 2010].

principles of best practice the foundation of the Council Recommendation. The Recommendation also enjoys support by the European Parliament, with resolutions adopted in 2003, 2006 and 2008 and a mentioning in the EU Health Strategy. Under the Health Strategy, the European Cancer Network (ECN) and the European Network for Information on Caner (EUNICE) were established to deal with monitoring, evaluation and quality assurance of cancer screening.

The Council Recommendation advised the Member States to implement a list of items to ensure that cancer screening would be harmonized throughout the European Union. The list consists of six sections being:

- Implementation of cancer screening programs;
- Registration and management of screening data;
- Monitoring;
- Training;
- Compliance, and
- Introduction of novel screening tests[29].

As a follow-up to the Council Recommendation, the European Commission issued their first report on the implementation of the Recommendation in 2007. The report discussed both quantitative as qualitative information on cancer screening implementation in the Member States as well as an extensive discussion about the Recommendation. The main findings of the report relate to the introduction of organized screening in the Member States and concluded that in 2007, 25 of the 27 Member States were having or were establishing cervical cancer screening programs, therefore agreeing that the Council Recommendation has had a positive influence on the implementation of programs[30].

[29] Commission of the European Communities. "Report from the Commission to the Council, the European Parliament, the European Economic and Social Committee and the Committee of the Regions – Implementation of the Council Recommendation of 2 December 2003 on Cancer Screening (2003/878/EC)". Page 2ff. <http://ec.europa.eu/health/ph_determinants/genetics/documents/com_2008_882_en.pdf> [8 March 2010].

[30] European Commission. *Cancer screening in the European Union: Report on the implementation of the Council Recommendation on cancer screening. First Report.* 2008. Op. Cit. Page 28f.

Four years after the adoption of the Council Recommendation considerable differences between the Member States were detected, despite great support for implementing the cancer screening programs. At that point, most countries were in the process of rolling out population-based screening programs nationwide or were in the phase of planning regional and / or limited screening programs (eight countries). Still, after four years there were several countries offering non-population-based screening (twelve countries) or even no programs at all were planned (two countries). Improvement in actual number of screened people was also encouraged in the Report, saying that about 125 million examinations a year were available and to be utilized by all EU citizens, offering 27 million screenings available for cervical cancer only[31].

The biggest concern of the Report remains the replacement of non-population-based (opportunistic) screening programs with population-based screenings throughout the European Union. In 2007, about 32 million cervical cancer screenings were performed, with 24 million out of this number performed by non-population-based programs. Non-population-based screening concentrates on a selected group of women which results in ineffectiveness of limited amounts of women getting screening as well as it encourages poor cost-related issues. Population-based screening, on the other hand, offers equal opportunities to women to get tested with it being more effective and efficient in the end[32].

During the pan-European conference held in Brdo, Slovenia in February 2008, both representatives of national health authorities and experts in cancer prevention agreed that "regular, systematic monitoring, evaluation and EU-wide status reporting would promote the exchange of information on successful developments between Member States and would identify weak points requiring improvement"[33]. Furthermore, in the future, more effort should be taken on the European level to implement the Council Recommendation and collaboration and cooperation between Member States is of crucial importance to reach this on a Community level. Future success of battling cancer in the European Union therefore lies within the "development and implementation of an objective and reliable EU-wide accreditation / certification scheme for cancer screening, diagnosis and management"[34].

[31] Ibid. Page 29f.
[32] Ibid.
[33] Ibid. Page 32.
[34] Ibid.

3.4. Cervical cancer and screening

Cervical cancer is almost always being detected in a woman by cytology screening. Screening is being used as a public health intervention for those at risk as for certain target groups of the population. The main task of screening is to identify, but not to diagnose cervical cancer. There is certain criteria's that must be met before performing the screening as outlined by the WHO. The following points defines if screening programs are effective when following elements are present:

- "High coverage (80%) of the population at risk of the disease;
- Appropriate follow-up and management for those who are positive on screening. Efforts to increase coverage will be wasted if those who test positive are not followed up correctly;
- Effective links between program components;
- High quality of coverage, screening tests, diagnosis, treatment, and follow-up;
- Adequate resources[35]".

Screening programs also come in different forms, which depend on the preferred method of the country. Screenings can be divided in organized and opportunistic screening. Organized screening has as goal to reach as many women in the target groups and offer them the opportunity to get screened within the resources available. This type of screening is planned on a national or regional level, while opportunistic screening is performed on an individual, organization-based program. The downside of opportunistic screening is that women that are at lower risk of cervical cancer will be called in for screening, while those in the target group might be left out of screening at all. Organized screening can therefore be considered more cost-effective than opportunistic screening, because it uses its resources in a more effective way and more women are benefitting from the screening[36].

[35] World Health Organization. *Comprehensive Cervical Cancer Control: A guide to essential practice.* Geneva, Switzerland: WHO Press. 2006. Page 83. <http://whqlibdoc.who.int/publications/2006/9241547006_eng.pdf> [8 March, 2010]
[36] Ibid. Page 84.

Screening for cervical cancer does exist in all Member States of the European Union, but the policies of screening differ from country to country. Organized screening exists in the following countries (based on information from 2008): Denmark, Finland, Slovenia, Sweden, the Netherlands, the United Kingdom, Ireland, Poland and large parts of Italy[37].

3.5. Cervical cancer and HPV vaccination

Treatment of cervical cancer could therefore become a thing of the past and a source of primary prevention, if applied correctly. The HPV vaccine is part of a public health need and one of the elements that makes part of cervical cancer control strategy. The World Health Organization (WHO) has acknowledged certain implementation and research challenges concerning the introduction of the vaccination. New vaccination programs need to be set up, since the vaccine is targeted for young pre-adolescent girls instead of infants. Both delivery costs and cultural sensitive issues can cause challenges to introduce the vaccine. It has to be kept in mind that the vaccine is not a guarantee at the moment that screening can be eliminated, since it can take up to 10 to 30 years to evaluate the outcomes of the effect of vaccinating young girls. The WHO does give the freedom to countries to decide upon them selves of when to introduce the vaccines based on the burden of cervical cancer and the prioritization of introducing the vaccine by policymakers. All in all, vaccination of young adolescents together with screening and treatment can therefore be considered to become a strategy of eliminating cervical cancer[38].

With the authorization of Gardasil on September 20th, 2006[39] and Cervarix on September 20th, 2007[40], the European Union has taken the next step towards preventing HPV infection, which could lead to cervical cancer. Although both vaccines protect against genotypes 16 and 18, Gardasil also protects against genotypes 6 and 11 that causes genital warts.

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[37] European Center for Disease Prevention and Control. *Guidance for the introduction of HPV vaccines in EU countries.* Page 21. <http://www.ecdc.europa.eu/en/publications/Publications/0801_GUI_Introduction_of_HPV_vaccines_in_EU.pdf> [8 March, 2010]

[38] World Health Organization Regional Office for Europe. "Can we prevent cervical cancer?" *Entre Nous: The European Magazine for Sexual and Reproductive Health,* Number 64-2007. Op.cit. Page 5ff.

[39] European Medicines Agency. EPARs for authorized medicinal products for human use – Gardasil. <http://www.ema.europa.eu/humandocs/Humans/EPAR/gardasil/gardasil/htm> [13 June 2010]

[40] European Medicines Agency. EPARs for authorized medicinal products for human use – Cervarix. <http://ema.europa.eu/humandocs/Humans/EPAR/cervarix/cervarix.htm> [13 June 2010]

The vaccines offer protection to girls that are not yet infected with HPV, and therefore needs to be administered to girls before they become sexually active, for example, girls between the age of 11 and 15 years. For women that are above the age of 25 years, regular screening programs needs to be continued, and those that will be vaccinated from this point on should not be withheld from screening in the future. Modifications and re-definition of the screening programs in the future (10 to 20 years) will be needed after studies of results become public[41].

It should be taken into account, that vaccinating against HPV does not mean that cervical cancer will be eliminated and it can only be reduced. Screening women should still be available for those that have not been vaccinated. Policymakers need to rethink their screening policies for those that have been vaccinated in the future and make a clear difference between the groups[42]. Although the vaccines have been welcomed with open arms, there are still questions remaining about costs, availability, effectiveness of the HPV vaccine and when there should be vaccinated exactly, which I will discuss in the next sub-chapter.

3.6. Barriers to and prospects for further progress

With both the introduction of the screening recommendation of the European Commission and the vaccines over the last years, there are also some unresolved issues that need to be worked on in the years to come.

The WHO has identified, despite progress, problems within the European region concerning screening, such as a lack of organized screening instead or opportunistic screening and the difficulties the countries encounter when trying to switch to organized screening, difficulties reaching out to the population that is at most risk of contracting cervical cancer and limitations in financial resources to name just a few. It therefore has set up a list with specific country needs for cervical cancer prevention that includes political will and commitment of the country to obtain and continue a sustainable cervical cancer prevention program and more

[41] World Health Organization Regional Office for Europe. "Can we prevent cervical cancer?" *Entre Nous: The European Magazine for Sexual and Reproductive Health,* Number 64-2007. Op.cit. Page 11.
[42] World Health Organization. *Human Papillomavirus and HPV vaccines: Technical information for policy-makers and health professionals*. Geneva, Switzerland: WHO Press. 2007. Page 28.

important, a framework regarding a screening policy, screening method, diagnostic, follow-up and treatment methods, vaccination and delivery services[43].

In the future, the WHO likes to see that the countries establish a comprehensive cervical cancer prevention and control strategy focused on primary and secondary prevention. Those countries that are currently offering opportunistic screening, the task for them will be to initiate organized screening and deal with the barriers that are withholding them of offering organized screening and for the other Member States expanding and / or improving the existing programs will be a priority. Moreover, improving the fields of data collection and evaluation together with the accessibility of treatment are high on the list[44].

Besides the issues and advices as described above, the WHO has also identified issues relating to the many questions that the introduction of the vaccinations have brought. By addressing these issues, the WHO takes a lead into expanding the research of the vaccinations provided within the EU. Therefore, it can take up years before clear answers can be provided.

The issues mentioned by the WHO are:

- "Age of vaccination;
- Duration of the vaccination effect;
- Vaccination of young males, and
- Vaccines based on multiple HPV types"[45].

The first issue is one where it is not exactly clear what the best way of practice is. It is only clear that vaccinations have to be provided to those girls that are not yet sexually active, but the age to start with the vaccination is yet unclear and every Member State has to decide this based on the burden of cervical cancer within its own borders. Both the duration of the effect of the vaccination effect as well as a vaccine based on multiple HPV types is something that only can be figured out in the future by doing more extensive research and weigh in the pro and cons concerning cost-effectiveness. As last, vaccinating younger boys is an interesting

[43] World Health Organization Regional Office for Europe. "Strengthening cervical cancer prevention in Europe - Report." Page 26f. <http://www.euro.who.int/en/what-we-do/health-topics/diseases-and-conditions/cancer/publications/pre-2009/strengthening-cervical-cancer-prevention-in-europe> [8 March 2010]
[44] Ibid. Page 27.
[45] World Health Organization Regional Office for Europe. "Can we prevent cervical cancer?" *Entre Nous: The European Magazine for Sexual and Reproductive Health,* Number 64-2007. Op.cit. Page 17.

issue based on the future burden of cervical cancer combined with cost-effectiveness as well[46].

Besides these points, questions like the costs of the vaccination and if vaccination will replace screening in the future remain undisclosed at this moment. For now, screening will be continued even though vaccination rounds have started and women that do not qualify for vaccination at this moment should be screened according to the national guidelines in their country[47].

4. Theoretical framework

In the following chapter I will provide an outline of the theory that will be used during the analysis chapter of the thesis. I have chosen to work with Carol Bacchi and her work on how to analyze a policy from her book *Analyzing policy: What's the problem represented to be?*. Her theory on this works with a specific set of questions that can be used to approach a policy problem and can be applied to multiple areas of interest. First, I will discuss her general approach towards analyzing policy and after that how her theory can be used in the health approach.

4.1. Approach to policy analysis

To understand what Bacchi means throughout her book, a good understanding of what a policy is needs to be discussed. Bacchi sums it up as how we can understand the role of the government and that it can be perceived as a part of a cultural dimension, making it therefore a cultural product[48]. If it is being approached as a cultural product, it will give us an understanding of how governing works and how this turns out for those that are implicated by these policies.

[46] Ibid.
[47] Ibid. Page 29.
[48] Bacchi, Carol. *Analysing Policy: What's the problem represented to be?.* Pearson Australia, Frenchs Forest NSW, Australia. 2009. Page ix.

With taking the previous said into consideration, it is important to present the main focus of the theory before continuing on. Bacchi created a set listed with six questions that can be applied to different problem representations, depending on the research being performed. The six questions are as followed:

1. "What is the 'problem' represented to be in a specific policy?;
2. What presuppositions or assumptions underlie this representation of the 'problem'? ;
3. How has this representation of the 'problem' come about? ;
4. What is left unproblematic in this problem representation? Where are the silences? Can the 'problem' be thought about differently? ;
5. What effects are produced by the representation of the 'problem'? and
6. How / where has this representation of the 'problem' been produced, disseminated and defended? How could it be questioned, disrupted and replaced?"[49].

To have a better understanding, it is necessary to look into some of the main terms that are used throughout the theory. Bacchi mentions the role of the 'problem' in relation to the policy. According to her "problems are endogenous – created within – rather than exogenous – existing outside – the policy making process. Policies give shape to 'problems'; they do not *address* them"[50]. And although we can give different notions to the word problem, in Bacchi's view the word 'problem' refers to a change made in the policy proposal that is being discussed[51].

Another central term in her understanding of the theory is the notion of problem representation. Problematizations imply what needs to be fixed and helps understanding what can be implied in policies or rules, as well as determining what is being in- or excluded in policies. Therefore, problematizations are in the center of the governing process and cannot be worked around[52]. To sum up the two important points that Bacchi makes are that "we are

[49] Ibid. Page xii.
[50] Ibid. Page x.
[51] Ibid. Page xi.
[52] Ibid. Page xii.

governed through problematizations and we need to study problematizations rather than 'problems'[53].

How can we get a better understanding of the WPR approach as Bacchi has outlined in her book? The approach allows us to take a better look at 'problems' discovered within public policies and apply them to situations in daily life. The WPR approach is therefore an important tool within policy analysis and its intentions is to develop policies by gaining the attention to the assumptions and presuppositions that were part of the developing process. This might imply that after applying the approach, we as researchers, understand the policies better than those that actually have developed it, marking it as an innovative in the way of researching policies[54].

While this approach can be called innovative, it constitutes of what Bacchi calls 'cross-border' moves, implying that it not only focuses on a specific area, but also can be expanded into other areas of interest. The three moves that Bacchi cite are as followed:

- "Challenging national / international boundaries;
- Challenging policy 'specialism's' and
- Extending the purview of analysis beyond the state to include full array of professionals and agencies involved in governing"[55].

The moves will come of good use when applying the policy to the data provided in the previous chapter and what outcome it will produce in the following chapter of the analysis. But before going further into that, I will describe the approach on a more thorough level.

4.2. The 'What's the problem represented to be?' approach to policy analysis

As discussed above, policies play an important role within the government and how it deals with 'problems', trying to work with issues that were generated outside the process of making

[53] Ibid. Page xiii.
[54] Ibid. Page xviiif.
[55] Ibid. Page xx.

policies. The WPR approach implies that governments create policy 'problems', and considers that policies thus shape 'problems'. As mentioned before, the WPR approach consists of six interrelated questions and is suitable to apply to different problem representations[56]. To get a more clear understanding of the six questions, I will shortly elaborate on all the questions and point out the most important information, providing a solid framework for the analysis after this chapter.

Question 1: What is the 'problem' represented to be in a specific policy?

The first out of six questions serves as the most explanatory question of all. It assumes that all policies exits of an implicit problem representation that needs to be recognized and elaborated on before continuing to the next questions in the analysis. The question focuses on the problem representation that will be discussed when applying the five remaining questions. It main task therefore is to identify the problem representation within specific policies or policy proposals[57].

Question 2: What presuppositions or assumptions underlie this representation of the 'problem'?

After having established the problem representation with Question 1, the following question starts with the investigation of the background of the 'problem'. It researches the presuppositions or assumptions that can be found within the problem representation. But what does a presupposition actually mean? It "refers to background 'knowledge' that is taken for granted" and "the task is to identify the assumptions and / or presuppositions that lodge within problem representations"[58]. Not only does it identify those available within the problem representation, it can give more extended information about how it is that some things happen and what is necessary for that certain action to actually happen.

According to Bacchi, discourses are part of policies and includes the assumptions and presuppositions as mentioned, as well as values and signs. Binaries, key concepts and categories play an important role while analyzing and should be used while doing so.

[56] Ibid. Page 1f.
[57] Ibid. Page 2ff.
[58] Ibid. Page 5.

Binaries imply hierarchy and assume that there is relationship between the topics proposed. The role for us as researchers is that when we are using binaries is "to watch where they appear in policies and how they function to shape the understanding of the issue"[59].

Key concepts, on the other hand, are well represented in policies. Bacchi describes concepts as "abstract labels that are relatively open-ended"[60] but that it can not be taken for granted as it differs in visions from person to person and in context of language.

As final part of the discourse, categories are being discussed. Not only are they considered to play a central role within the practice of governing, but as with binaries and key concepts, the function that is given to meanings of problem representations cannot be taken for granted as mentioned before. Categories are said to be created through measurement where they highlight the role of research techniques like surveys and censuses[61].

Question 3: How has this representation of the 'problem' come about?

Of all the questions that Bacchi presents in her book, question number three comes the closest to policy analysis. This question can be understood to consist of two objectives. The first objective is concerning the specific developments and decisions that has contributed to the making of the identified problem formulation, while the second objective focuses on that multiple problem representations might have existed in the same time frame and that policies therefore might have developed in a different way[62].

Bacchi here describes the term 'genealogy' and how this also applies in this approach. She means that we start with what we know in present time and work our way back to the past to get the answer. Therefore, answers can turn out not to be as expected, making that genealogy has, as she calls it, a destabilizing effect on problem representations. The process and how it came into place is here the main focus when using genealogy. We can conclude that question three of the WPR approach "is to highlight the conditions that allow a particular problem representation to take shape and to assume dominance"[63].

[59] Ibid. Page 7.
[60] Ibid. Page 8.
[61] Ibid. Page 9.
[62] Ibid. Page 10.
[63] Ibid. Page 11.

Question 4: What is left unproblematic in this problem representation? Where are the silences? Can the 'problem' be thought about differently?

Where the previous three questions focused on how the problem representation came into place, this question focus on the more critical issues. Central in this question is the research to what fails to be problematized. This means that there are constrictions about the way in which specific policies are representing the 'problem', and in order to deal with this, discussion is needed to take the issues and perspectives into account that are not being mentioned in the problem representation. Silences are being considered to give tensions and contradictions in problem representations, which show during the analysis of the 'problem'[64].

Question 5: What effects are produced by this representation of the problem?

As we have seen before, the WPR approach also provides critical questions to be answered, presuming that problem representation can cause tension between groups of different social backgrounds or between members of a certain social group. Effects therefore play a crucial role within the WPR approach. Bacchi has identified "three, interconnected and overlapping kinds of effects that need to be 'weighed up':

1. Discursive effects: effects which follow from the limits imposed on what can be thought and said;
2. Subjectification effects: the ways in which subject and subjectivities are constituted in discourse; and
3. Livid effects: the impact on life and death"[65].

We can now say that the main goal of question five "is to identify the effects of specific problem representations so that they can be critically assessed"[66]. To understand what Bacchi means with the abovementioned effects, I will describe them all briefly.

By discursive effects, Bacchi wants to point out that certain thoughts about situations can pose difficulties when analysis needs to be performed and bring certain social groups into

[64] Ibid. Page 12f.
[65] Ibid. Page 15.
[66] Ibid.

difficulties by applying certain ideas. This can be considered as a form of silencing which needs to be taken into account while applying the WPR approach[67].

Subjectification effects on the other hand, assumes that we become subjects of a certain kind because the social relationships and our place within those relationships are determined by policies. The influence of the discourse is therefore notably present and will decide the position that will be taken. Subjectification has the tendency to point out that there are clear group oppositions present within policies As an example, Bacchi uses Foucault's 'dividing practices' to make her standpoint clear. As with discursive effects, the silences detected need to be acknowledged within the problem representation[68].

The last effect, or lived effects as mentioned by Bacchi, has its focus on the material impact of problem representations. How are people directly affected by the 'problems' is the main question to be posed here. The main task of livid effects is to "highlight the way in which policies create representations of problems that have effects *in the real* by materially affecting our lives"[69].

The WPR approach, as described in this chapter, assumes that the problem representations have impact on groups in an uneven way and that this affects the analysis performed. Question number five of the WPR approach has the overall task to detect effects that are affecting different groups and come up with either solutions or what long-range impacts towards social groups can be detected. Bacchi therefore provides sub-questions that can be considered as an integral part of the question, being:

- "What is likely to change with this representation of the 'problem'?
- What is likely to stay the same?
- Who is likely to benefit from this representation of the 'problem'?
- Who is likely to be harmed by this representation of the 'problem'? and

[67] Ibid. Page 16.
[68] Ibid. Page 16f.
[69] Ibid. Page 18.

- How does the attribution of responsibility for the 'problem' affect those so targeted and the perceptions of the rest of the community about who is to 'blame'?"[70].

In the next chapter of analysis, I will incorporate all of the sub-questions above after discussing question five itself, except for the last one to make the analysis more concrete in answering the question.

Question 6: How/where is this representation of the 'problem' produced, disseminated and defended? How could it be questioned, disrupted and replaced?

The final question of the WPR approach stands in relation to question number three and has as main goal to use the means "through which some problem representations become dominant, and to the possibility of challenging problem representations that are judged to be harmful"[71]. It becomes a complex intertwining of multiple questions that can be answered by using discourses, which can help to re-formulate the original problem representation.

As we have seen above, a list of questions can be applied to a wide range of problem representations. These problem representations are the core of the approach, which Bacchi tries to describe in her book. Defining the problem representations can make analyzing policies easier and more structured through the use of the questions above. It is possible to leave out questions and still be able to get a clear answer, but ideally, all should be used. In relation to the subject of the thesis, I will add another dimension that Bacchi has described in her book concerning health issues.

4.3. The WPR approach and health, wellbeing and the social determinants of health

As established before, the WPR approach focuses on how we are governed on a daily basis, how we are ruled and how order is being maintained. In this sub-chapter, I will go a bit deeper into the topic of health as a problem representation, which will be used throughout the analysis in combination with the six questions mentioned above. Instead of existing as separates and different, policy areas can be interconnected at a basic level. This also applies

[70] Ibid.
[71] Ibid. Page 19.

to the topic of health. The way we perceive and conceptualize 'health' has influence on specifics found in policies recommended and adopted, and can therefore be labeled as a slippery concept instead of a stable fixed idea that is common knowledge. To understand the concept of 'health', background information is needed[72].

Bacchi starts with a theoretical approach to health policy, where she distinguishes two competing paradigms, being "a *biomedical* paradigm that focuses on technology-based medical care and biomedical public health interventions such as immunization and health screening; and a *social* paradigm that understands health as a *social* phenomenon, a product of complex environmental and social factors"[73].

The absence of a disease present is the spill of the biomedical paradigm, and focuses on the *physical* disease. Public health policy is part of this paradigm as it can both focus on the individual as bigger groups of population. Whereas the social paradigm in this case emphasizes the factors related to social wellbeing and the absence of a disease. This divides the two paradigms in a clear way, but Bacchi mentions Foucault's observation "that modern industrialized states attend to the health of population to maintain order and economic security" and that "this concern with population produces a *functional* understanding of health – that is, health becomes what is required to make governing possible and successful"[74].

Although both paradigms differ in their definition, they also have opposite meanings when it comes to preventive approaches to health. The biomedical paradigm, as described earlier, has its focus on both the curative as the preventive level. Immunization, screening programs and preventive surgery falls under the umbrella of the biomedical paradigm. Whereas the social paradigm focuses on something beyond the wellbeing of people in the biomedical focus, and stretches out to things like social and economic wellbeing of the person related to their health. These are the significant differences between the two paradigms[75].

Bacchi takes it further by discussing health policy and different approaches that are available. She uses Osborne's notion of defining health as an indeterminate goal, meaning that health is dependent on time, place and cultural norms and that it is inevitably will fail, because we all

[72] Ibid. Page 127f.
[73] Ibid. Page 127.
[74] Ibid. Page 128f.
[75] Ibid. Page 130.

are dying in the end. The WPR approach therefore gives the opportunity to approach the issue of health from an angle where identifying and addressing certain 'problems' have priority and to come to an answer[76].

In addition to the six WPR approach question aforementioned, in the analysis I will take the following set of questions into consideration and incorporate them with question one of the WPR approach. Due to the complex definition of what health entails, these questions "consider whether an indentified program, piece of legislation or report:

- Represents the 'problem' of 'ill-health' to be either *biomedical* or a *social* 'problem';
- Represents the 'problem' of 'ill health' to be either *curative* or a *preventive* 'problem';
- Represents 'prevention' to be a *biomedical* or *social* 'problem'; and
- Represents 'prevention' to be an *individual* or *social/environmental* 'problem"[77].

What can we assume and expect by using this theory by Carol Bacchi and what does she sees as final product of using the questions as discussed above? Bacchi notes that "the objective is to make visible the multiple and overlapping forms of rule enshrined in selected programs, projects or legislation (Q2, Q3), to identify silences and ambiguities where they exist (Q4), to assess the implications that flow from specific ways of representing the 'problem' (Q5) and to identify forms of resistance (Q6), always keeping in mind the need to subject one's own problem representations to critical scrutiny"[78].

4.4. Summing up the WPR approach

To end the chapter before moving on to the analysis, I will shortly sum up again the most important points of Bacchi's findings in her book that will be used throughout the rest of the thesis. The WPR approach helps us understand of how we are governed and how this takes place on a day-to-day basis, given these two being connected. We need to understand that the key element of policies are problematizations, because they imply that there is a problem that

[76] Ibid. Page 138.
[77] Ibid. Page 140.
[78] Ibid.

needs to be taken care of. These problematizations are decisive for the output and / or solutions of the policy. Therefore we can say that policies make up 'problems', and within those we will find problematizations. Basically, this means we are governed through those problematizations and that our focus need to be on them instead of the 'problems' we encounter. By applying the WPR approach, answers to the question of the representation of the 'problem' can be traced making it suitable to apply the approach to a wide arrange of topics[79]. In the next chapter I will make an analysis using Bacchi's WPR approach combined with the data provided in chapter three.

5. Analysis

In the following chapter I will apply the previously outlined theoretical framework of analyzing policies to the relevant data as provided in chapter three. The analysis will be divided according to the structure presented in the chapter about the theoretical framework. I have chosen to not answer all the questions as provided in the theoretical framework, but only to take questions one, three, five (with some of the sub-questions provided) and six into consideration, as well as the set of questions presented in the theoretical framework on health policy specifically. This decision was taken because there was not enough data available to analyze questions two and four to make a coherent analysis out of it. After the analysis, in the end I will provide a short summary to round off the chapter.

5.1. Analysis on Question 1: What is the 'problem' represented to be in a specific policy?

In this thesis, cervical cancer is the problem to be represented in the policy. The European Union is trying to encourage its Member States to adopt a better screening program against cervical cancer, but is only able to do this through a Council Recommendation, which has no binding power on the Member States, but can only be considered as a preparation for possible future legislation. With a recommendation being soft law, it is not binding to the Member States and can be considered as a weakness to eliminate the problem. The 'problem' in this

[79] Ibid. Page 262f.

thesis can be described as a not efficient working program for screening and vaccination concerning cervical cancer, leaving girls and women throughout the European Union to acquire the disease without having proper medical care to detect, prevent and follow-up on.

After determining the problem as cervical cancer, the policies that are selected due to the problem representation include also the policy measures, in this case screening and vaccination programs. Where screening is more considered as an individual measure, vaccination is more a collective measure in the way it is presented. In her chapter about health, wellbeing and the social determinants of health, Bacchi acknowledges that the field of health is complex and therefore difficult to discover what the representation of the 'problem' actually encompasses. Cervical cancer is considered to be part of biomedical paradigm, since it is based on health interventions like screening and vaccination. By offering these two options, the state intervenes on how to prevent its citizens from getting cervical cancer or when it is being detected, palliative care that is aligned to the disease can be offered through health networks in the country of residence.

The biomedical paradigm can be considered to have two approaches to health. Since it offers screening and vaccination, it falls in the curative dimension, because it does try to cure the disease. But on the other hand, it also shows signs of the preventive dimension. The practice of immunization and screening are preventive programs, trying to prevent HPV infection in young girls and tries to prevent the HPV of developing in cervical cancer. The biomedical paradigm therefore secures the best of the two health approaches.

Prevention can as well be considered to be a biomedical problem. It still represents the health intervention as described above, but in the end, it is always better to prevent then let it come to the actual unfolding of the disease. Prevention is also aimed to focus on a collective group of people. Since cervical cancer only occurs in women, protecting them against HPV is essential. Preventive screening must therefore be available and in correspondence with guidelines from higher authorities like the World Health Organization or Directorate General of the Health department within the European Union. Vaccination is therefore also part of being a preventive medicine, because the vaccines will already work before the infection is obtained. And although current vaccinations are only offered to a small group of girls within the age of puberty, it does not mean that in the future the range of vaccinations will be expanded to women of older age, or that another type of vaccination will be designed.

Prevention within the representation can be considered both an individual as well as a social/environmental 'problem'. It can be seen as an individual act since getting screened or vaccinated will protect only that person that undergoes the procedure. It can be seen as a social 'problem' since it is not compulsory to get vaccinated or screened. HPV infection and cervical cancer are first and foremost a result of a transmittable sexual disease. In this case, it can be as well considered as a case of both, because it does include certain elements that can be found in both the individual or social elements of prevention.

There are elements connected to the problem representation of cervical cancer which makes it is hard to distinguish their actual place within the health field. This only means that the representation of the 'problem' can be seen in a broad perspective.

5.2. Analysis on Question 3: How has this representation of the 'problem' come about?

The signing of the Council Recommendation in 2003 announced a new era of cancer prevention that encouraged Member States to take action to ensure that cancer screening would be taken into consideration within their national policies. As described in the data, the Council Recommendation has had predecessors since the late 1980s that were already concerning with the growing numbers of citizens with cancer. Those earlier texts were often only dedicated to breast cancer, as that was one of the earliest cancers were detection with screening was used for. The programs that arose from this, like Europe against Cancer, was only a beginning of gaining more attention for cancer. It can be questioned what the exact role of these erected programs were at that time and on what they really focused and if this was for the benefit of the citizens of Member States. It was not until the late 1990s that new reports were issued about the importance of screening programs throughout the European Union. Coming almost a decade later, it can be questioned why there has not been a mid-term update of programs or a new program that was applicable to multiple concerns of cancer within the borders of the European Union.

Interestingly enough, it was already in 1993 that a guideline concerning cervical cancer screening was introduced. Its main points, like the introduction of the pap smear, target ages for women to be screened and screening intervals were discussed and are still used as

recommendations in certain Member States. Then, how come, as the data provided, that during the meeting that took place in 1999, a new agreement could be reached but no validation by the Member States? This decision of not validating the agreement meant a continuation of opportunistic screening in those countries where organized screening still was not organized. It can be said that the guidelines therefore had no significant impact, but that it was at least a step in the right direction, leading to what later would be the Council Recommendation as signed in 2003. The Advisory Committee laid the foundation that was hard needed in the European Union to take further action and to improve cancer screening.

With the signing of the Council Recommendation, a legit successor was signed, combining the best of the guidelines concerning cervical screening from 1993 and the agreement stemming from 1999. The Council Recommendation has implied that it is necessary to know what is the best way to prevent cervical cancer and in which way it is this can be reached. The process of getting to the Recommendation may have been a long way, but it has also secured the best interest of the position of the women to obtain screening.

It is a possibility that in the future another piece of legislation in the form of another recommendation or other binding law will be introduced to secure the future of the screening programs within the European Union.

5.3. Analysis on Question 5: What effects are produced by this representation of the 'problem'?

The effects that have been produced by the representation can be considered positive. The Council Recommendation has the interest to reach as many people as possible, encouraging Member States to offer screening through organized programs. In the case of cervical cancer screening, this applies for women from the age of 25 (depending on the Member State, screening starts as early as 23 years old) up to 60 years with a continued interval of three to five years.

As described in the theory, the livid effects, implies the impact on life and death and in this situation remains the most important effect out of the three mentioned. Screening can make a difference between life and death of women who have cervical cancer. Without offering the

screening it is almost certain that cervical cancer will not be detected until it is too late to receive preventive medical attention, resulting in unnecessary deaths of women. Screening programs therefore need to be encouraged throughout the European Union to prevent unnecessary deaths.

Although not mentioned in the Council Recommendation, vaccination can also be considered as a livid effect, preventing in first case infection by the HPV and second, lowering the numbers of deaths in the long run by giving protection to a bigger group of women starting at a younger age. Just like screening programs, vaccination programs should be introduced as a measurement of preventing cervical cancer to those women in the group that are eligible and follow up with screening for cervical cancer.

As described in the theory, the question has been made up from several sub-questions, which are considered as an integral part and are important to be answered as well. What is likely to change with this representation of the 'problem' is that more attention will be given by Member States by introducing new cancer screening programs to detect cervical cancer. It calls for drastic changes for some Member States, but at the same time it secures that every person should get equal access to screening in their country. More attention will be given by introduction of this Recommendation to training, how the monitoring is supposed to be performed, registration and management of data, which only can help improve further legislation in the future. Also, with the introduction of the Council Recommendation, opportunistic screening is discouraged and is preferably to be replaced by population-based screening, which will offer all women the option to get screened. We can assume that only positive outcomes and results can be expected from introducing the Recommendation throughout the European Union, which might lead to a binding legislative article in the future, like a directive for example.

The answer to the second sub-question, which asks what will remain the same with the representation of the 'problem', is here quite clear. If the Recommendation is followed by the Member States, this will mean that the previous and/or current affairs concerning cancer screening will be eliminated and be replaced by the up-to-date points made significant within the Recommendation. Either way, cancer screening and prevention therefore will be improved and it is highly doubtful that practices regarding unsafe screening will remain the same for much longer.

This connects to the following sub-question, where the benefiters of the representation of the 'problem' are to be announced. First and foremost, the biggest groups who benefitted or are benefitting from the Council Recommendation are girls and women throughout the European Union. The introduction of the Council Recommendation has meant that all women have been entitled since that moment to get screened for cervical cancer (or any other cancer) within their national jurisdiction. Nevertheless, also Member States themselves are benefitting from the cancer screening programs. Being able to provide screenings means that the national governments take interest and investment in the wellbeing of their citizens.

It is therefore to be seen that screening programs are not a single act to be performed by an individual, but relies on teamwork from different levels to ensure that screening can be performed as outlined in the Council Recommendation.

5.4. Analysis on Question 6: How/where has this representation of the 'problem' been produced, disseminated and defended? How could it be questioned, disrupted and replaced?

This question questions the power of the discourse related to the representation of the 'problem'. The discourse of the problem of cervical cancer can be described as a troublesome disease, affecting women who are in the bloom of their life, sometimes finding out that they are struck by it when it is already too late. But with the introduction of the Council Recommendation and the attention that it has generated by the press, it might be expected that the discourse has changed over time. Screening programs are offered and invitations are sent to women to attend screenings on a regular basis. The discourse concerning vaccination is currently in debate and has changed since the introduction. Since the vaccinations are quite new, questions have been raised about the safety and the costs of vaccinating young girls. The discourse between screening and vaccination also differentiates in the experiences of people. Screening has been a trusted method of searching for cervical cancer, with the use of the pap smear, where vaccination has to be applied in shots over three different times and where results will not be known until extensive research and analysis has been performed.

The discourse of both the screening programs and vaccination can take a turn if there would be more information available for the public provided by official agencies, like hospitals,

ministries of Health in Member States, as well as women's magazines and articles in daily newspapers. It is important that the right information about these programs is being distributed through the right channels in order to reach as many women as possible with the correct information.

The representation of the 'problem' could be questioned, disrupted and replaced if after careful considerations of both screening and vaccination programs, or either one of them as a separate, not seem to be appropriate to continue. The discourse could change due to information published, negative commentary about the programs or due to clinical trials from medical institutions that provide more accurate information. These scenarios are only to be guessed at during this moment since there is not enough data available to give an accurate answer.

Replacement of the 'problem' is in this case one of the better options, as replacement can indicate that the 'problem' has been looked at in a different way and a different outcome has been observed. In the case of cervical cancer screening and vaccination programs this has a highly possible chance of happening in the future, since more information will become available and also medical advances are being made. A good example could be the replacement of the Council Recommendation by another piece of legislation, like a direction, which encourages Member States to reach a determined goal but leave it up to them on how to reach it or by another updated version of the Recommendation, which takes into account the progress that has been made since the introduction of the 2003 version of the Council Recommendation.

Although the abovementioned points are possibilities, it is possible that resistance against the problem representation will occur. This as well is connected to the discourse of cervical cancer within the borders of the European Union. Resistance can be expected with introducing a vaccination program for HPV. The vaccinations will be required to be given to girls of young age before they become sexual active. The vaccination might indicate that when the girls have been vaccinated, they will be encouraged to have sexual encounters earlier and practice unsafe sex since they are 'protected'. It has to be made clear that HPV vaccination does not protect against sexual transmitted diseases like chlamydia, and neither does it protect them against pregnancies. In general, it could be assumed that discourses play a great role on how the public perceives the programs of screening and vaccination.

Government officials, both on regional, national and supranational, should take note on what the reactions are from the public and proceed from there to either adapt or construct a new problematization. In this case, it should be the European Council in cooperation with the European Commission that could change the way that the discourse of cervical cancer is perceived and create and replace it by a new, better representation of the 'problem'.

5.5. Summing up the analysis chapter

In this chapter, we have seen that the problem within the representation is cervical cancer and that from here both policy measures as well as solutions are being created. Policies are selected due to the connection they have with the problem representation and from there on, decisions are being made to proceed. In case of cervical cancer, the policy measures are what drive the policies. With the help of the WPR approach, certain angles of the problem can be discussed and possibly serve to propose changes. The main focus remains throughout the analysis stays the representation of the problem and the focus on it through all questions. We have seen that all questions provide an answer, which forms part of a more united whole.

6. Conclusion

This conclusion will first and foremost answer the research question; *How can we understand the policies concerning cervical cancer taken by the European Union when applying Bacchi's analysis?* Furthermore, a perspective on the thesis in the form of a suggestion on how this thesis can contribute to the academic discussion on the area of focus will be offered.

The purpose of this research of cancer screening in the European Union has been to identify how the problem of cervical cancer is represented and how we can understand the policies taken by the European Union by applying Bacchi's questions on analyzing policies, which have been discussed in the chapter of the theoretical framework. Hence, the research question consists of one part, but due to the nature of Bacchi's construction on how to analyze policies, the answer to the research question will consist of different elements that are included in the analysis.

6.1. Answering the research question

Through the analysis several issues concerning the problem of cervical cancer have been identified. The main problem detected is that the Council Recommendation signed in 2003 has no binding force on the Member States, creating gaps between the countries in implementing cancer screening programs targeted towards women. If the Member States would implement the Council Recommendation as advised, a lot of lives of women could be saved on a yearly basis. The Recommendation calls for the implementation of new cancer screening programs, registration and management of data, monitoring, training and compliance. If these five points were to be followed, Member States would enjoy a higher level of women attending screenings without the risk op opportunistic screening as explained before.

In relation to the abovementioned, the change from opportunistic screening towards population based screening will continue to be an important point in the future of screening practices in the European Union. If opportunistic screening is to be continued in the countries offering it, the amount of women dying of cervical cancer will not reduce, and might even lead to an increase of deaths in the future. Population-based screening, on the other hand, will offer equal opportunities for all women from a by Member State determined age to get screened and receive medical care if cervical cancer would be detected.

In reaction to the screening, new methods have been introduced to prevent HPV infection, which leads to cervical cancer. With the introduction of both Gardasil and Cervarix, the European Union has taken a step forward in preventing HPV infection in younger girls, which as well will reduce the numbers of cervical cancer victims in the future. Although the vaccinations are still in the experimental phase, reactions and results towards vaccinating young girls have been positive so far. Concerns relating vaccination programs will have to be kept in mind for the future once the duration of protection is known.

In relation to the future of cancer screening, it is from importance that changes are made within the Member States to make cancer screening and vaccination available to all women will be improved. This should happen in accordance with other players like the WHO-Europe and the national governments that are responsible for taking action in their own national interest of preventing cancer related sickness.

Policies will change over time when new innovations are expected to make its debut concerning cervical cancer and its prevention. It is from importance that the policies will be updated and replaced if new information concerning cancer screening and vaccination becomes available. In current time, Member States should continue to introduce cancer screening on a national level and reach out as much as possible to the population that are the most vulnerable to contract cervical cancer.

It can be concluded that the European Union, according to Bacchi's analysis, has understood the challenge of preventing cervical cancer by taking measurements that can be applied to all Member States and which will contribute to a reduction of cervical cancer. It is in the best interest of everyone to eliminate cervical cancer and to contribute to a more sustainable way of cancer screening within the borders of the European Union.

6.2. Contribution to the research area

The product produced by accomplishing this research contributes to the area of study with a suggestion on how to analyze policies concerning cancer screening. The results achieved are not to be seen as a final truth but can be seen as a contribution to further research in several different ways.

The theoretical framework, formulated by Bacchi's WPR approach, applied on data containing policy documents and statistics can be used on a wide range of topics. Thereby the results of the research conducted can be understood as a guideline for similar research on for example individual countries or on different topics. Furthermore, the results can be used as an inspiration to research other areas of cervical cancer or cancer screening in general. This is to be understood in the way, that the results suggests which areas to look into when it comes to discussing cancer screening. Future research can be of a more qualitative character, in the shape of interviews, and of a quantitative character, in the shape of questionnaires.

7. General critical view of the project

Conducting the research brings up thoughts on what could have been done different and what be perceived as weaknesses in this project. This part will shortly reflect on the validity, the choice of the method and the choice of theories.

The validity can be divided into two sub-points: external and internal validity. The external validity, the generalizability, will not be of great focus, because this research builds on a case study. By executing a case study the purpose of the research is not to make generalizations, but in a higher degree to create and exhaustive understanding of the case. The internal validity can be said to be relative high in the relation to which extend the research question is answered. The research question requests that the project defines the understanding of policies concerning cervical cancer taken by the European Union when applying Bacchi's analysis. The research provides a clear suggestion, of how these understandings can be reached by discussing policies concerning cervical cancer.

It is also relevant to take a look at the choice of the theory. The theory formulated by Bacchi provides a specific approach to apply to policy analysis. Her WPR approach can be considered a great help to detect what the problem is represented to be. It could have been interesting to use other theories with different approaches and thereby different suggestions, giving the thesis another angle from which the topic is looked at.

Using a case study as a method provides an in-depth understanding of cervical cancer in the European Union. If several case studies had been carried out, a comparative method could have been used to look into which problem representation could have been detected. This could have shown a difference in policies depending which countries or organizations would have been chosen to compare. That would be another suggestion for another research that could be performed in the future.

In closing, it seems relevant to mention, that this project does not produce any definite answers to the current situation of cervical cancer in the European Union, but it can be seen as material to a further discussion and debate in the future.

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