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Women's Cancer Prevention and Disabilities: Do Institutions Provide Better Access?

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Many physical and mental barriers reduce disabled women's access to female cancer prevention[a]. Nevertheless, institutions for disabled people may implement specific preventive care programs to reduce these barriers. We question whether institutions provide better access to women's cancer prevention by comparing the access to breast and cervical cancer screening for French disabled women living in institutions to those living at home. Since disabled women living in institutions have more complex limitations, we use a matching method to correct specific characteristics of residents that may impact preventive care use by selecting comparable persons living at home. We also study disparities in access to preventive care depending on institution types (medicalized or not).

After taking into account the differences in individual characteristics, disabled women living in institutions had a significantly higher probability of being screened than disabled women living at home. Our results therefore confirm that institutions act as facilitators by helping disabled women gain access to female cancer screening.

People with disabilities face many obstacles in accessing healthcare (Denormandie and Cornu-Pauchet, 2018), particularly preventive care. Cancer is the leading cause of death for women in France; improved female cancer screening is therefore a major public health concern. This study highlights the role played by institutions in which disabled women live in improving access to female cancer screening by comparing them to women living at home.

In France, breast cancer remains the leading cause of death from cancer for women, with around 12,000 deaths a year (INCA, 2019). Breast cancer is a disease of ageing that often occurs after the age of 50 and whose risk factors include a family history of breast cancer, mammographic density, whether or not a woman has had children, obesity, etc.. (French National Authority for Health, HAS, 2012). Cervical cancer causes around 1,100 deaths per year. The median age at the onset of cervical cancer is 51 and there are very few cases of the disease below age 30 and after 65 (French National Authority for Health, HAS, 2013). Risk factors are early sexual activity, multiple sexual partners, immunodeficiency virus infections, etc. Access to preventive care and screening procedures for these cancers are important levers to avoid a premature deterioration in the health status of the patient and the occurrence of life-threatening complications (Sun et al., 2017). Hence, there are breast and cervical cancer screening recommendations in France. Carrying out a

[a] According to the French National Health Authority (*Haute Autorité de Santé*, HAS), prevention consists of avoiding the emergence, the development, or the worsening of diseases or disabilities. Traditionally, it is considered that there are three types of prevention: primary prevention, which is carried out before the disease develops (e.g. vaccinations and preventive action on risk factors), secondary prevention, which is carried out during the early stage of disease development (screening), and tertiary prevention, which aims to limit or delay complications and prevent the risk of relapse (https://www.has-sante.fr/jcms/c_410171/fr/depistage-et-prevention). In this article, the term refers to secondary prevention.

mammography for breast cancer detection is recommended every two years for women aged between 50 and 75, while a smear test should be carried out every three years for women aged between 25 and 65 to detect the onset of cervical cancer[1].

In France, around 1,400,000 women aged between 25 and 75 have difficulties in performing activities of daily living (Activities of Daily Living (ADL) or Instrumental Activities of Daily Living (IADL)); 4% of these women live in institution (Facilities for young disabled persons[2] or Nursing Home for elderly persons[3]). Many studies, based on various definitions of disability or which have targeted specific populations of disabled women, have demonstrated that disabled women are less likely to be screened for cancer than women who are not disabled (Armour et al., 2009; Penneau et al., 2015a). Many obstacles reduce disabled women's access to breast and cervical cancer screening, such as physical access difficulties, reduced communication skills, and difficulties in interacting with healthcare professionals, and so on. (Angus et al., 2012).

However, these physical and mental access barriers to female cancer screening could be reduced amongst disabled and dependent women residing in institutions. One of the missions of the institutions for disabled and elderly dependent people –medicalized or non-medicalized institutions– is to promote residents' access to preventive care and healthcare (Couëpel et al., 2011). Indeed, institutions can improve access to cancer screening by organising specific screening programmes, and by providing support adapted to residents' needs. For example, establishments may decide to improve access to care by facilitating transport to the private practice that provides screening, by carrying out a cancer prevention campaign (information, explanations, etc.) or by providing the support of a member of staff during the cancer screening.

Few studies have analysed cancer prevention amongst women living in institutions. Most of the international and French quantitative studies on this subject have focused on the prevalence of screening in institutions, as well as on the predictors of screening. Mack et al. (2018) showed that the diagnosis of cognitive impairment, fragility, and dementia considerably reduces the likelihood of benefitting from breast cancer screening amongst women residing in long-term institutions in the United States (Mack et al., 2018). Bussière et al. (2015) showed that disabled women with severe motor or cognitive limitations residing in institutions are less likely to be screened for cervical cancer. Certain studies have shown the positive effect of establishments in female cancer screening compared to disabled women residing at home. An American study showed that mentally disabled women residing in institutions are more likely to get smear tests than those living at home (Parish et al., 2013). Trétarre et al. (2017) showed that breast cancer screening is more prevalent amongst mentally disabled women residing in institutions than in the general population. This study, which did not examine differences in characteristics between mentally disabled women residing at home and those residing in institutions, seems to show that French institutions have a positive effect on access to preventive care. A study on the Provence-Alpes-Côte d'Azur region also shows that regular gynaecological monitoring is provided for women in 90% of the long-term

SOURCE

The 2008–2009 survey on disability and health (*Handicap-Santé* or HS), on which this study is based, comprised a "Household" ("*Ménages*") section and an "*Institution*" section, in which disabled women who were old enough to have a smear test or a mammography were identified.

Disabled women residing in an institution, three types of institution were identified:

- Non-medicalized residential facilities (assisted living facilities, "*foyers de vie*", Residential facilities, "*foyers d'hébergement*"): Residential facilities are establishments for disabled adults who are autonomous enough to carry out a daily professional activity (often in a protected environment, educational activities, etc.). The assisted living facilities are for individuals who have no professional activity.
- Medicalized residential facilities (MAS or FAM) are establishments for disabled adults who are often very dependent and have difficulty in performing personal activities of daily living (washing, dressing, etc.), and who require continuous medical surveillance and care. Apart from the fact that they are funded through different channels, the profiles of the people in Specialised care homes (MAS) and Medical-Care homes (FAM) are somewhat different. The Specialised care homes (MAS) are largely for mentally disabled people (40%) or people with multiple disabilities (30%), whereas the Medical-Care homes (FAM) are largely for mentally disabled people (46%) or people with severe mental health disabilities (29%) [Mordier, 2013].
- Nursing homes for elderly persons (Nursing homes for dependent elderly persons (EHPAD) and the long-term care facilities (USLD)) are establishments for dependent elderly adults who have difficulty in performing activities of daily living, and who require continuous medical surveillance and care. People in long-term care facilities (USLD) are often more dependent and their health status is poorer than persons living in an EHPAD (Delattre and Paul, 2016).

Living at home or in institutions, disabled women were identified through the fact that they had reported difficulty in performing at least one personal activity of daily living (washing, dressing, personal hygiene, etc.) or at least one instrumental activity of daily living (shopping, cleaning, etc.).

Two populations living at home and in institutions were then identified: the women eligible for cervical cancer screening, aged between 25 and 65, and the women eligible for breast cancer screening, aged between 50 and 75. 2,089 women living at home aged between 25 and 65 responded to the question about cervical cancer screening and 985 women residing in institutions responded (490 in non-medicalized residential facilities, 495 in medicalized residential facilities). In this part of the analysis, women living in nursing homes for elderly persons aged 60 or over were excluded, because very few of them were age-eligible for this type of screening. 2,078 women living at home aged between 50 and 75 responded to the question about breast cancer screening and 589 women residing in institutions responded (187 in non-medicalized residential facilities, 189 in medicalized residential facilities, and 213 in nursing homes for dependent elderly persons).

[1] Since May 2018, it is recommended that women aged over 30 have a HPV test every five years: https://www.santepubliquefrance.fr/les-actualites/2020/depistage-du-cancer-du-col-de-l-uterus-le-test-hpv-recommande-chez-les-femmes-de-plus-de-30-ans#:~:text=Un%20nouveau%20programme%20national%20pour,entre%2025%20et%2065%20ans

[2] Which include: « *Foyers de vie* », « *foyers d'hébergements* », « *Foyer d'accueil médicalisé* (FAM) » and « *Maison d'accueil spécialisée*, MAS)

[3] Which include: « *Établissements d'hébergement pour personnes âgées dépendantes* (EHPAD)» or « *Unité de soins de longue durées* (USLD) ».

Context

This study is part of research work carried out by the Institute for Research and Information in Health Economics (*Institut de Recherche et Documentation en Économie de la Santé*, IRDES) on the issue of the access that disabled people living at home and in institutions have to standard healthcare and preventive care. It completes the results presented in issues 197[1], 207[2], and 208[3] of *Questions d'Économie de la Santé* ("Issues in Health Economics") and the IRDES reports 560 and 561[4]. The Institute for Research and Information in Health Economics (*Institut de recherche et documentation en économie de la santé*, IRDES) received funding from the National Fund for Solidarity and Autonomy (*Caisse Nationale de Solidarité pour l'Autonomie*, CNSA) for the project, as part of a call for projects by the Public Health Research Institute (*Institut de Recherche en Santé Publique*, IRESP).

[1] https://www.irdes.fr/recherche/2014/questions-d-economie-de-la-sante.html#n197
[2] https://www.irdes.fr/recherche/2015/questions-d-economie-de-la-sante.html#n207
[3] https://www.irdes.fr/recherche/2015/questions-d-economie-de-la-sante.html#n208
[4] https://www.irdes.fr/recherche/2015/rapports-560-561-l-acces-aux-soins-courants-et-preventifs-des-personnes-en-situation-de-handicap-en-france.htm

care facilities for disabled adults in which living accommodation is provided, substantiating the theory that these establishments facilitate access to care (Couëpel et al., 2011).

This study investigates the supposed positive effect of institutions on the use of female cancer prevention services. To achieve this, access to preventive care for disabled women residing in institutions was compared to that of disabled women residing at home. Amongst women aged between 25 and 75, we identified disabled women residing at home and in institutions in data from the 2008 survey on disability and health (*Handicap-Santé*, HS) through respondents who reported difficulty in performing at least one activity of daily living (see insets "Source"on p.2 and "Method" on p.4). After assessing the overall impact of institutions on female cancer screening, the effects observed were distinguished according to the types of institutions (non-medicalized residential facilities, medicalized residential facilities, nursing homes for elderly persons) [see inset "Source" on p.2].

Women living in institutions have profiles and characteristics (level of dependence, social ties, etc.) that differ from those of disabled women residing at home. These characteristics may also affect the likelihood of benefitting from female cancer prevention procedures. Hence, in raw data terms, access to preventive care for disabled women residing at home is greater than that of women residing in institutions, but this difference is linked to their different individual characteristics, with more unfavourable situations for women residing in institutions.

One out of every two women residing in institutions reported that they had been screened

Around 44% of women residing in institutions reported that they had been screened for cervical cancer and 54% had been screened for breast cancer (Table 1). These rates of use were lower than the rates of use reported by disabled women[4] residing at home, which for the smear test and mammography were 64% and 69% respectively. These differences in use may be explained by the very different profile of disabled women residing in institutions in comparison with that of disabled women residing at home and who reported difficulty in performing at least one activity of daily living (Tables 2 and 3). Hence, women living in institutions were more often dependent, had multiple disabilities, and were also much less socially integrated. Indeed, they were much less likely to be in a relationship (2% of women in institutions stated that they were in a relationship compared with 58% of women living at home), were also less likely to be graduates, and had rarely had a professional career. All these characteristics are determinants associated with a lesser use of female cancer screening by disabled women (Penneau et al., 2015b).

In order to remove this selection bias from the study, a matching method was used, which made it possible to select a population comparable to that of women living in institutions amongst

[4] Definition of disabled women living at home in insets "Source" on p.2 and "Method" on p.4.

T1

Rates of female cancer screening use by disabled women according to their place of residence

	Women without a disability (%)	Disabled women living at home (%)	Disabled women living in an institution (%)			
			Overall	Non-medicalized facilities	Medicalized facilities	Nursing homes for elderly
Smear test (carried out within three years)	82	64	44	61	26	-
Mammography (carried out within two years)	80	69	54	78	67	46

Reading: Amongst the women living at home who did not report any difficulty in performing activities of daily living, 82% reported that they had had a smear test within the preceding three years. Amongst the women who reported that they had difficulty in performing activities of daily living, 64% reported that they had had a smear test within the preceding three years, whereas 44% of the women who lived in an institution had had a smear test.

Scope: For the smear test, women aged between 25 and 65, and for the mammography, women aged between 50 and 75.

Source: The "Household" and "Institution" sections of the 2008–2009 survey on disability and health (*Handicap-Santé*, HS).

Download the data

T2

Differences in characteristics between disabled women eligible for cervical cancer screening residing in an institution and at home

Reading: The women who reported difficulty in performing activities of daily living, who were living at home and who were eligible for cervical cancer screening, were on average seven years older than the women who suffered from daily activity restrictions and who lived in an institution (the average age of the women living at home was 50 compared with 43 for those living in an institution). After applying the matching method, significant differences between these disabled women residing at home and in an institution were no longer identified, as the average age of the two populations was 43. Although there were still significant differences in some of the indicators, they were nevertheless largely attenuated by the matching method.

Scope: Women eligible for cervical cancer screening aged between 25 and 65.

Source: The "Household" and "Institution" sections of the 2008–2009 survey on disability and health (*Handicap-Santé*, HS).

Download the data

	Disabled women eligible for a smear test...				
	... living in an institution	... living at home			
		Before matching		After matching	
		Average	Difference p-value t-test	Average	Difference p-value t-test
Age	43.24	49.99	-6.75 ***	43.48	-0.24
In a relationship	2.4 %	57.7 %	-55.3 ***	3.3 %	-0.9
Activities of daily living (ADL)					
Being independent	58.9 %	91.6 %	-32.7 ***	58.4 %	+0.5
Needing help with an activity	9.7 %	3.4 %	+6.3 ***	7.2 %	+2.5 *
Needing help with 2 to 4 activities	9.6 %	3.1 %	+6.5 ***	13.9 %	-4.3 ***
Needing help with more than 5 activities	21.7 %	1.9 %	+19.8 ***	20.4 %	+1.3
Accumulation of functional limitations (motor, cognitive, visual, auditory)	2.45	1.59	+0.86 ***	2.34	+0.1 *
Completed higher education studies	5.0 %	61.6 %	-56.6 ***	13.0 %	-8.0 ***
Employment situation					
Currently employed	22.9 %	24.0 %	+1.1 **	26.3 %	-3.4
Previous work experience	16.3 %	60.5 %	-44.2 ***	13.2 %	+3.1 *
Never having worked due to a disability	49.3 %	9.2 %	+40.1 ***	54.6 %	-5.3 ***
Never having worked due to another reason	11.1 %	6.4 %	+4.7 ***	5.9 %	+5.2 *

disabled women residing at home (see insets "Source" and "Method").

This method made it possible to reduce to a maximum the differences in individual characteristics and therefore make a comparison of the screening rates between two more comparable populations in terms of age, marital status, level of dependence, type of disability, and past professional life (Tables 2 and 3).

Institutions facilitate access to preventive care

After taking into account the differences in individual characteristics between disabled women living in institutions and at home, we determined that institutions facilitate access to preventive care. Hence, disabled women residing in institutions were significantly more likely (+15 points) to report that they had been screened for cervical cancer and more likely (+5 points) to report that they had been screened for breast cancer compared with disabled women residing at home (Table 4).

High breast cancer screening rates

In non-medicalized and medicalized residential facilities, in which disabled women lived, the declared breast cancer screening rates were around 70%. Compared with disabled women with comparable characteristics living at home, these rates were 20 points (non-medicalized facilities) to 35 points (medicalized facilities) higher, indicating that these establishments facilitate access to breast cancer screening (Table 5). However, for elderly women residing in Nursing homes for dependent elderly persons who had difficulty

METHOD

The aim of the study was to compare the use of female cancer screening by women living in a "standard" household with that of women residing in institutions. Significant differences in profiles (dependency levels, type of disabilities, marital status, etc.) between disabled women living at home and women residing in institutions may have an effect on the likelihood of being screened. To reduce this selection bias, we used a matching method with an exact matching on age groups (for ten-year periods) and a kernel propensity score matching on other matching variables. The matching variables we selected were variables that affected both the fact that women were living in an institution and being screened. Several matching variables were thus considered: age, the couple's situation, dependency level, the accumulation of functional limitations (motor, cognitive/intellectual, visual, and auditory), further education, and the current or past professional life. All the average comparisons before and after matching were weighted and analysis of the survey included a weighting variable.

Robustness analysis was carried out by modifying the matching model specification (the nearest neighbour method, caliper matching, etc.), which had very little effect on the results. We also tested the results by modifying or adding matching variables. This had a more significant effect on the results, without, however, changing their interpretation. We also reproduced the analyses using a linear regression model instead of a matching method, which produced similar results. Lastly, we had information on a person's date of entry in institutions with some missing data. In order to ensure that screening performed in an individual's home was not incorrectly attributed to an institution, we verified that the effects observed were similar when women residing in an institution for less than two years were excluded from the analysis for breast cancer screening and less than three years for cervical cancer screening. The results were also very similar to those obtained with the chosen configuration.

T3

Differences in characteristics between disabled women eligible for breast cancer screening residing in an institution and at home

	Disabled women eligible for breast cancer screening...				
	... living in an institution	... living at home			
		Before matching		After matching	
		Average	Difference p-value t-test	Average	Difference p-value t-test
Age	60.7	62.3	-1.6 ***	60.8	-0.1
In a relationship	4.8 %	57.6 %	-52.8 ***	6.2 %	-1.4
Activities of daily living (ADL)					
Being independent	56.2 %	89.9 %	-33.7 ***	58.7 %	-2.5
Needing help with an activity	11.6 %	4.2 %	+7.4 ***	10.7 %	+0.9
Needing help with 2 to 4 activities	9.7 %	3.5 %	+6.2 ***	13.1 %	-3.4 *
Needing help with more than 5 activities	22.5 %	2.4 %	+20.1 ***	17.4 %	+5.1 ***
Accumulation of functional limitations (motor, cognitive, visual, auditory)	2.33	1.57	-0.8 ***	2.22	-0.1
Completed higher education studies	20.7 %	59.9 %	39.2 % ***	23.2 %	2.5 %
Employment situation					
Currently employed	11.4 %	10.5 %	-0.9 %	13.7 %	2.3 %
Previous work experience	45.3 %	75.4 %	30.1 % ***	36.4 %	-8.9 % ***
Never having worked due to a disability	31.2 %	3.9 %	-27.3 % ***	40.4 %	9.2 % ***
Never having worked due to another reason	10.8 %	10.1 %	-0.7 %	9.5 %	-1.3 %

Reading: Women who reported difficulty in performing activities of daily living, who were living at home and who were eligible for breast cancer screening, were on average a year and a half older than the women who suffered from daily activity restrictions and who lived in an institution (the average age of the women living at home was 62.3 compared with 60.7 for those living in an institution). After applying the matching method, significant differences between these disabled women residing at home and in an institution were no longer identified. Although there were still significant differences in some of the indicators, they were nevertheless largely attenuated by the matching method.

Scope: Women eligible for breast cancer screening aged between 50 and 75.

Source: The "Household" and "Institution" sections of the 2008–2009 survey on disability and health (*Handicap-Santé*, HS).

Download the data

in performing activities of daily living, the declared breast cancer screening rate (less than 50%) was lower than in the institutions for disabled women. Furthermore, we did not identify a difference in the use of cancer screening services compared with comparable elderly women residing at home. Hence, there appear to be effective cancer prevention policies in institutions for disabled people aged under 60 –whether they are medicalized or non-medicalized institutions–, which do not exist in institutions for dependent elderly people. This result may potentially be explained by the relatively small proportion of women aged under 75 residing in Nursing homes for dependent elderly persons (EHPAD), who were eligible for breast cancer screening (around 6% in our sample).

T4

Comparison of the rates of female cancer screening use between women residing at home and in an institution, with comparable characteristics (after matching)

	Rate of use in an institution	Rate of use at home (after matching)	Difference (after matching) [in points]	Confidence intervals at 95% (in points)	
Smear test (cervical cancer screening)	45%	30%	+15.0	14.5	15.7
Mammography (breast cancer screening)	53%	48%	+5.0	4.0	6.0

Reading: The rate of cervical cancer screening reported by women who suffered from daily activity restrictions and who lived in an institution was 45%, compared with 30% for women with comparable characteristics who lived at home (after applying the matching method, see "Source" and "Method" insets).

Scope: For the smear test, women aged between 25 and 65, and for the mammography, women aged between 50 and 75.

Source: The "Household" and "Institution" sections of the 2008–2009 survey on disability and health (*Handicap-Santé*, HS).

Download the data

Institutions facilitate access to cervical cancer screening

Unlike breast cancer screening, the cervical cancer screening rates were much lower in certain institutions. Indeed, a significant difference was observed in the screening rates between medicalized residential facilities (26%) and non-medicalized residential facilities (61%). However, for these two types of institution, the screening use rates were almost two times higher than the screening rates reported by comparable disabled women residing at home, thereby indicating that institutions also facilitate access to cervical cancer screening. The low rates of cervical cancer screening use in medicalized residential facilities, and amongst disabled women with comparable characteristics living at home, may be explained by the difficulty in carrying out smear tests for women in these populations. Indeed, the people

T5

Comparison of the rates of female cancer screening use between women residing at home and in an institution after matching, according to the type of medical-social facility

	Rate of use in an institution	Rate of use at home (after matching)	Difference (after matching) [in points]	Confidence intervals at 95% (in points)	
Cervical cancer screening (smear test)					
Non-medicalized residential facilities	61.2%	35.5%	+ 25.6	24.9	26.4
Medicalized residential facilities	26.9%	16.8%	+ 10.1	9.5	10.8
Breast cancer screening (mammography)					
Non-medicalized residential facilities	77.8%	57.8%	+ 20.0	18.8	21.1
Medicalized residential facilities	67.7%	33.1%	+ 34.6	33.4	35.8
Nursing homes for elderly persons	44.9%	45.0%	- 0.1	-1.0	0.9

Reading: The rate of cervical cancer screening reported by women who suffered from daily activity restrictions and who lived in non-medicalized residential facilities was 61%, compared with 35% for women with comparable characteristics who lived at home (after applying the matching method, see "Source" and "Method" insets).

Scope: For the smear test, women aged between 25 and 65, and for the mammography, women aged between 50 and 75.

Source: The "Household" and "Institution" sections of the 2008–2009 survey on disability and health (*Handicap-Santé*, HS).

Download the data

who are admitted to medicalized facilities are largely people with intellectual disabilities, severe mental health disabilities, or people with multiple disabilities, for whom the performance of an intimate and invasive procedure, such as a smear test, could potentially be traumatic (Swaine et al., 2013). Furthermore, sexual activity is a primary cervical cancer risk factor (Liu et al., 2015). The sexual activity of people in medicalized facilities is a subject that has been little studied (Giami and de Colomby, 2008). Hence, the principal surveys on disability do not make it possible to identify sexual behaviour, and, at the same time, surveys of sexual behaviour do not make it possible to identify whether the respondent is disabled. There are indicators, such as for example whether someone is in a relationship or has children, but ultimately they provide little information about sexual behaviour. The question of the benefits compared with the problems and mental disorders that could result from this type of invasive procedure amongst women in medicalized residential facilities remains to be investigated. Further epidemiological and qualitative research on the sexual behaviour of disabled people in institutions would be worth pursuing, thereby making it possible to contribute to the development of national recommendations on the benefits of performing smear tests, depending on the profiles of people in these facilities.

Limitations and further analysis

One of the main limitations of this study was the declarative aspect of the survey on screening. Indeed, the reporting of screening within two to three years may be prone to extensive respondent recall bias. It is not unusual for the coverage reported during general population surveys to be overstated, which may undoubtedly be explained by a social desirability or recall bias. Indeed, during the period 2003–2005, the National Health Insurance Fund (*Caisse Nationale de l'Assurance Maladie*, CNAM) reported a rate of use of 58.7% for women aged 25 to 65, while 81% of the women aged 25 to 65 interviewed in the Baromètre Cancer survey had reported that they had been screened for cervical cancer in the preceding three years (Duport, 2008). Furthermore, the disabled people interviewed in the survey could use a proxy who could respond to the questions on their behalf when they were not able to do so. Hence, the use of a proxy could potentially introduce a social desirability bias in the survey, especially if the proxy is a health professional in the institution, who may be inclined to put forward an idealised view of the institution's preventive care programme. However, the disparities in the results in the medicalized residential facilities between the low cervical cancer screening rate and the high breast cancer screening rate seem to suggest that, if such a bias exists, it is probably limited. The second limitation of this study is the age of the data (2008–2009), which were, however, drawn from the last survey results available in France, pending data from the Autonomie survey conducted by the French Centre of Research, Studies, and Statistics (*Direction de la Recherche, des Études, de l'Évaluation et des Statistiques*, DREES). However, this study made it possible to provide an overview of the situation and show that the overall impact of institutions on the prevention of female cancers is positive. The national administrative data that made it possible to identify the long-term care facilities, and which could be cross-referenced with data from the French Health Insurance system (*Assurance Maladie*), is currently expanding (Résid'Ehpad, data from the *Etablissements Sociaux ou Médico-Sociaux* (ESMS) survey). This data will make it possible to track the use of screening in these facilities. Furthermore, the Autonomie survey, which will be launched in the field in 2021, and which will be cross-referenced with several years of data from the National Health Data System (*Système National des Données de Santé*, SNDS), will also be available to study this issue. ♦

FOR FURTHER INFORMATION

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