REPORT OF TRAINING OF TRAINERS COURSE ON VISUAL INSPECTION WITH ACETIC ACID (VIA) AND CRYOTHERAPY

Venue: **Centre Régional Francophone de Formation et de Prévention des Cancers Gynécologiques, Hôpital Donka, Conakry, Guinea.**

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World Health Organization
REGIONAL OFFICE FOR Africa

BILL & MELINDA GATES foundation

Contents

List of Acronyms

AFRO	WHO Regional Office for Africa
AIDS	Acquired immunodeficiency syndrome
BMGF	Bill and Melinda Gates Foundation
C4P	The WHO Cervical Cancer Prevention and Control Costing Tool
C4GEP	Comprehensive Cervical Cancer Control: Guide for Essential Practice
HIV	Human immunodeficiency virus
HSS	Health Systems Strengthening Cluster
HQ	WHO Headquarters
HPV	Human papillomavirus
IEC	Information Education and Communication
IST	Inter country support team
LEEP	Loop electrosurgical excision procedure
MO	Medical Officer
MoH	Ministry of Health
NCCCP	National Coordination Committee for Cervical Cancer Prevention
NCDs	Non communicable diseases
PHC	Primary health care
STI	Sexually transmitted infections
VIA	Visual inspection with acetic acid
WCO	WHO Country Office
WHO	World Health Organization
WR	WHO Representative

Executive Summary

Cervical cancer is largely a preventable disease, but in Africa it is one of the leading causes of cancer death in women. There are 97,000 new cases and 56,000 women die from cervical cancer each year in the region[1]. It is the leading cause of cancer deaths in Eastern and Central Africa. The majority of these deaths can be prevented through universal access to comprehensive cervical cancer prevention and control programs, which have the potential to reach all girls through human papillomavirus (HPV) vaccination and all women with screening and treatment for pre-cancer.

Though screening women within the age 30 to 49 years using visual inspection with acetic acid (VIA) and immediate treatment of those eligible with cryotherapy is a cost effective strategy for cervical cancer prevention, coverage of eligible women in the region is very low and most screening services are opportunistic. With financial support from the Bill and Melinda Gates Foundation, AFRO is supporting 10 high burden countries for cervical cancer, to strengthen their respective cervical cancer prevention and control programme. As part of this project, it has developed specific toolkits in order to reverse the growing burden of cervical cancer in the Region. Cervical Cancer Screen and treat training manual using VIA/Cryotherapy is one of these toolkits. It is therefore important to build the capacity and orient a pool of master trainers on AFRO's approach to cervical cancer prevention and control as regards VIA and cryotherapy to facilitate the scale up of VIA screen and treat services.

The participants for the TOT consisted of 31 experts;3 from each of the following countries, Ghana, Kenya, Madagascar, Malawi, Nigeria, Senegal, Sierra Leone, Zambia and Zimbabwe. Guinea, as the host country for the training, had 4 participants. They were selected based on their respective areas of specialization in cervical cancer screening using VIA and cryotherapy. In addition, they have committed to their readiness and their availability to cascade the trainings at national level and provide short to medium term technical support to other countries in the Region as needed. The facilitators were from the WHO Regional office for Africa as well as independent regional experts in cervical cancer and VIA/cryotherapy. The WHO Guinea country office provided adequate secretarial back-up for the workshop.

The 5-day ToT was held at the Regional Training Centre for Gynecological Cancers Prevention based in Donka Hospital in Conakry Guinea. The training of these experts was intensive and methodology used included role plays, presentations and orientation of these experts on the WHO recommended guidance on cervical cancer prevention and control as well as practical VIA/cryotherapy sessions where 145 women were screened, 14 of these women were identified as suspicious for cancer and one VIA positive client benefited from immediate treatment with cryotherapy.

[1]GLOBOCAN 2012 (IARC) *Section of Cancer Surveillance (5/9/2014)*

Introduction

Cervical cancer is largely a preventable disease, but in Africa it is one of the leading causes of cancer deaths in women. There are 97,000 new cases and 56,000 women die from cervical cancer each year in the region. It is the leading cause of cancer deaths in Eastern and Central Africa. Most women who die from cervical cancer, particularly in developing countries, are in the prime of their lives. They may be raising children, caring for their families and contributing to the social and economic lives of their towns and villages. A woman's death is a personal tragedy and a sad and unnecessary loss to her family and her community, with enormous repercussions for the welfare of both. These deaths are unnecessary because there is compelling evidence that cervical cancer is one of the most preventable and treatable forms of cancer if it is detected early and managed effectively. The majority of these deaths can be prevented through universal access to comprehensive cervical cancer prevention and control programs, which have the potential to reach all girls through human papillomavirus (HPV) vaccination and all women with cervical screening and treatment for pre-cancer.

Cervical cancer screening is the systematic application of a test to identify cervical abnormalities in an asymptomatic population. Women targeted for screening may actually feel perfectly healthy and see no reason to visit health facilities. Screening services may be provided either as organized or opportunistic services or a combination of both. It is generally accepted that organized screening is more cost-effective than opportunistic screening, making better use of available resources and ensuring that the greatest number of women will benefit. Most screening programs in Africa are opportunistic with an average coverage rate of 10% of eligible women2.

The challenges of Cervical cancer prevention and control in Africa are mainly due to lack of awareness of the early signs and symptoms of cervical cancer by the community; lack of universal access to cost effective primary and secondary prevention services; lack of awareness of these services when available; weak National capacity including at peripheral level; high cost of immunization against HPV and inaccessibility of therapeutic resources; and insufficiency or lack of information and skill as well as scarce local, effective and sustainable research.

AFRO supported the conduct of a pilot on the introduction of Visual Inspection with Acetic acid (VIA) and cryotherapy in 6 countries: Malawi, Madagascar, Uganda, Tanzania, Zambia and Nigeria. At the end of the project important recommendations on the cost effectiveness of VIA/Cryotherapy were made to support national scale up of this method of screening[3]. WHO recommends that at a minimum, a national programme should prioritize women who are between 30–49 years old for screening based on the natural history of cervical cancer. WHO also recommends that women younger than 30 years of age should not undergo screening except for women known to be HIV-infected or living in a high HIV prevalence area. The screening interval should not be less than 5 years (and not less than 10 years, if using an HPV test) and priority should be given to maximizing

[2] ***WHO NCD Country Capacity Survey 2015***

[3] WHO. Prevention of cervical cancer through screening using visual inspection with acetic acid (VIA) and treatment with cryotherapy. A demonstration project in six African countries: Malawi, Madagascar, Nigeria, Uganda, the United Republic of Tanzania, and Zambia. World Health Organization 2012.

coverage within the at-risk target age group and assuring complete follow-up of those women with abnormal screening test results rather than maximizing the number of tests performed in a woman's lifetime. This implies that it is better to screen a high proportion of women in the 30 to 49 year age bracket at least once in their life time than screen a smaller proportion of women multiple times in their life time. In high HIV prevalence countries, women who screen positive for cervical cancer should be offered HIV testing and counseling.

In addition to contributing to the development and updating of the Comprehensive Cervical Cancer Control, Guide for Essential Practice (C4GEP), with the financial support of the Bill and Melinda Gates Foundation, AFRO is supporting 10 high burden countries for cervical cancer to strengthen their respective cervical cancer prevention and control programme. As part of this project, it has developed specific toolkits in order to reverse the growing burden of cervical cancer in the Region. These toolkits are aimed at generating support among key government officials, and agencies for cervical cancer prevention, ensure informed and active participation among girls, their families and community collaborators and enable health staff to effectively raise awareness about cervical cancer prevention within their communities. Specifically, these toolkits include: (i) Cervical Cancer Prevention and Control Strategic Planning toolkit; (ii) Cervical Cancer Prevention and Control IEC tool kit; (iii) Cervical Cancer Prevention and Control Advocacy toolkit and; (iv)Cervical Cancer Screen and treat training manual using VIA/Cryotherapy.

It is therefore important to build the capacity and orient a pool of master trainers on AFRO's approach to cervical cancer prevention and control. To ensure that all countries in the region are able to develop implement and scale up cervical cancer screening programmes using VIA and cryotherapy, AFRO in collaboration with the BMGF organized this training workshop targeting experts from the AFRO-10 countries.

The experts have been selected based on their respective areas of specialization in cervical cancer screening with VIA and treatment of precancer with cryotherapy as well as other aspects of cervical cancer prevention and control. In addition, the experts have committed to their readiness and their availability to cascade the trainings at national level and provide term technical support to countries in the Region as needed.

General Objective

- To contribute to the reduction of cervical cancer burden in Africa though capacity building to implement comprehensive cervical cancer prevention and control programmes.

Specific Objectives

- Orient the experts on the review and implementation of cervical cancer screening and immediate treatment of precancerous lesions that are aligned with the AFRO cervical Cancer Prevention and Control VIA and Cryotherapy toolkit.

- Orient the experts on the design of cervical cancer "screen and treat programme" that are aligned with the AFRO Cervical Cancer Prevention and Control VIA and Cryotherapy toolkit
- Review and agree on a plan to cascade the training at national level.

Outcomes

Expected outcomes of the training workshop are:

- Experts are informed; updated and able to cascade the training on the AFRO Cervical Cancer Prevention and Control VIA and Cryotherapy toolkit
- Experts discuss and come up with a plan on how to champion the roll out of the toolkits in the AFRO region
- A body of experts trained to act as change agents in Cervical Cancer Prevention and Control in other countries across Africa

Training Methods

A blend of training methods was used to achieve the course objectives. These included;

- Illustrated lectures and group discussions
- Individual and group exercises
- Role plays
- Simulated demonstrations and clinical practice with real clients
- Guided practice skills with feedback from trainers and participants

Workshop Opening

The workshop was opened by the Honorable Minister of Health for Guinea, represented by Dr. Robert Camara, Director for Disease Prevention in the MoH.

The WHO Representative in Guinea; Dr Abou Beckr Gaye in his welcome speech, thanked the Ministry of Health of Guinea for kindly hosting this workshop and for mobilizing necessary resources for its success. He stressed the importance of cervical cancer in the African region as a public health problem that can be prevented if detected and treated early. He noted that cervical Cancer is a looming health and development crisis in the region. It is a leading cause of death and disability in middle and low income countries where the incidence and mortality is raising. The high burden of cervical cancer in the region is due to lack of awareness of the community; the lack of universal access to cost effective primary and secondary prevention services; weak national capacities; high cost of vaccination against HPV and the inaccessibility of therapeutic resources. Failure or lack of information and skills by providers, as well as local research also contribute to the high burden of cervical cancer in the region. He further stressed that cervical cancer should be addressed through a comprehensive approach as recommended by the WHO and pointed to several

strategic, policy guidelines, tools and research on best practices developed by the organization to tackle this. Dr Abou Beckr Gaye noted the importance of screening eligible women and treatment of those found with pre-cancer as well as strengthening the health system to be able to deliver these services, as important considerations to ensure that cervical cancer burden is reduced in Africa. The organization of this workshop for the 10 countries most affected by cervical cancer in the region, underlines the continued commitment of WHO/AFRO to assist countries in the fight against cervical cancer. He appreciated the support of the Bill and Melinda Gates Foundation in funding the project to reduce the burden of cervical cancer in the countries with the highest burden in the region and he wished all the participants a fruitful workshop.

Representative of the Minister of Health, Dr Robert Camara, welcomed the participants to the workshop. He recalled that cervical cancer is the 4th most common cancer in women worldwide, the 2nd in the African region after breast cancer and the most common cancer in Guinea. He thanked WHO for continued support to Guinea and wished all participants and trainers success in the Training of Trainers workshop before declaring it open.

Pre test

The pre-test was administered to the participants to objectively evaluate the level of knowledge of the participants on cervical prevention and control as well as their ability to identify normal and abnormal VIA slides. Thus it included a section addressing cervical cancer prevention and control and another separate section where participants were shown slides of VIA and asked to make a diagnosis. In the table below, the mean scores for the various aspects of the pretest administered is presented.

Table 1: Mean pretest scores. n =25

Pre-test	Knowledge	VIA Image	Management	Average Total
	74%	60%	55%	64%

Overview of Cervical Cancer in Africa

Prof JM. Dangou gave an overview of cervical cancer in Africa. This presentation focused on the global and regional burden of cervical cancer. It was noted that the African region bears most of the burden from cervical cancer and that 18 of the 20 countries with the highest burden of cervical cancer, are in the region. In 2012, there were 97,000 new cases of cervical cancer and 56,000 deaths. He noted that the projected new cases and deaths from cervical cancer for 2015 for the African region, has since been surpassed and that if appropriate steps are not taken, the projection for 2030 of 135,000 new cases and 83,000 deaths will shortly be reached. The high mortality from cervical cancer in the region is due to late clinical stage presentation, inadequate services, lack of cervical cancer policies, strategies and programs and Lack of recent and comprehensive data, Lack of collaboration and coordination of interventions, Insufficiency or lack of information and skills. He

described the natural history of cervical cancer from HPV infection to frank cancer and the importance of developing programs and policies that covers all aspects of the natural history and progression of the disease as recommended by the WHO. He also discussed WHO's guidance tools including Cervical cancer Strategic Planning toolkit, Cervical cancer IEC toolkit and Cervical cancer Advocacy toolkit.

Current Evidence – Based Strategies for Screening and Pre-cancer Treatment

Dr Y. Ahmedou made a presentation of the strategy for screening and treatment of pre-cancer. He highlighted the various evidence-based approaches to screening of cervical cancer including PAP smear, VIA and HPV DNA test and made a comparisons of each of these methods. He discussed several treatments modalities for treatment of pre-cancerous lesions to include, cryotherapy, LEEP and cold knife conization (CKC). In linking treatment with screening, it was highlighted that there are 2 approaches which includes screening and treatment and screening, diagnosis and treatment. He also discussed the algorithm for setting up screening programmes.

Current Policy and Programmatic Environment for CCP in AFRO

In his presentation, Dr P. Barango discussed policy and programmatic options for cervical cancer in Africa. He began with an overview of cervical cancer policies pointing out that cervical cancer should be tackled within the overarching framework of the NCD Global Action Plan 2013-2020(GAP). Cervical cancer policies should address all aspects of WHO recommended comprehensive approach. He noted several policy approaches by countries in the region in addressing cervical cancer prevention and control. In terms of comprehensive cervical cancer program, he gave examples of countries that have implemented aspects of cervical cancer prevention and control including, HPV vaccination, screening and treatment programs as well as palliative care. He noted that most countries in the region have low coverage of cervical cancer screening because most of the screening programs were mostly opportunistic.

Questions and comments following the presentations from the WHO team

The association of long term oral contraceptive (OC) use and cervical cancer was raised by most of the participants. In response, experts noted that though long term use of OC was one of the risk factors for cervical cancer, over 90% of cervical cancer is caused by HPV and thus, oral contraceptive use should not be discouraged. It is important for all women in the screening age group to be screened irrespective of their status regarding contraceptive use.

Best ways to organize population based screening was raised. In response, it was stressed that, the MoH should take leadership of cervical cancer program and develop comprehensive policies and strategies that all partners should adhere to. It was also highlighted that an integrated approach must

be used to ensure that the various components of a comprehensive cervical cancer prevention and control are well coordinated.

Considering the cost and supply chain issues with refrigerant gas for cryotherapy, the use of cold coagulation in place of cryotherapy was discussed. However, it was noted that WHO is yet to adopt this method because currently, there is insufficient evidence on its safety and efficacy. Cold coagulation is currently been used by some screening programs in Africa. Before its recommendation for use by AFRO, a pilot on the introduction of Visual Inspection with Acetic acid (VIA) and cryotherapy was carried out in 6 countries: Malawi, Madagascar, Uganda, Tanzania, Zambia and Nigeria. At the end of the project important recommendations on the cost effectiveness of VIA/Cryotherapy were made to support national scale up of this method of screening. This same rigor needs to be applied before any recommendation can be made on cold coagulation.

Use of cervicography to improve the sensitivity and quality assurance for VIA was discussed. It was noted that though this is a useful strategy to improve quality assurance, it needs to follow standard technical specifications and should not replace the hands on supervision when available.

Age group recommendation for cervical cancer screening of 30 to 49 years was raised. It was noted that though this age group has the highest burden of cervical cancer, countries were free to revise the age group for screening based on their peculiar situation such as HIV prevalence.

A question was raised on the place of Lugol's iodide (VILI) in comparison to acetic acid (VIA) for screening. In response, the expert facilitators were unanimous in reiterating the advantage of acetic acid over Lugol's iodine which includes, the cost and availability of acetic acid, the staining of undergarments from Lugol's and the slightly better sensitivity of screening with acetic acid. Lugol's iodine should be reserved for colposcopy only.

Capacity Building SWOT in the Countries

Dr. Murokora gave guidance to participants on development of SWOT analysis for CCP capacity building. He explained in details the components that should be taken into consideration in development of a SWOT analysis. Each country team was tasked to use this guidance and develop a SWOT analysis of CCP capacity building for their respective countries.

Adult Learning Principles

Dr. D. Murokora gave another presentation on adult learning principles and learning cycle. He explored the different ways that adults learn, emphasizing that the adult learning process is participatory, supportive and builds on learner's experience. Understanding how adults learn and the cycle, is important to properly engage and get the best out of training programs designed for adults. He further stressed that practice is essential for adult learning and the focus of adult learning is on mastery of the desired competencies, rather than scoring them compared to others.

Competency Based Training and Introduction to CCP Training and Course Overview

Prof Keita Namory Keita made a presentation on competency based training. He emphasized that the specificity of adult training is based on skills noting the significant difference between this and the regular learning methodology. He noted that all leaners should be able to master the desired competencies if they have sufficient practice and feedback.

On the overview of the course, professor Keita began by providing some context to the course methodology, harping on the importance of use of adult learning principles. The workshop is geared towards adult learning in mind hence it will provide participants with ample opportunity to practice skills acquired in an environment of mutual respect and cordiality. Teaching aids would include audio-visual equipment, images and photographs normal and abnormal cervix, tables and other training aid would be used throughout the training. In addition, each participant would have an opportunity to perform VIA screening on client.

He went on to provide an overview of the training and reference manuals for the course. He then summarized the expected outcome from the participants which includes being able to plan and conduct training of experts in their respective countries.

ToT Trainees Presentations (Slide Decks) and Feedback Managing Course Beginnings

Dr D. Leno introduced the participants to the presentations that each would make on the next day. He elaborated on the training Objectives & outputs, as well as on the course Methodology. Countries were randomly allocated to make presentations on the following topics.

- Why Screen for Cervical Cancer/Rationale
- Female Reproductive Anatomy
- HPV and Pathophysiology of Cervical Cancer
- Visual Inspection with Acetic Acid
- Cryotherapy
- Infection prevention
- Talking to Women about Cervical Cancer

Following the allocation of their respective topics to country teams, the facilitators provided clarifications on the mode of the presentation. The facilitations referred the participants to the VIA training manual. Using relevant chapters in the manual, each Country team was to prepare a PowerPoint presentation on their allotted topic. The objective of this is for each of the participants to demonstrate their ability to provide appropriate technical information to their target trainees as well as demonstrate appropriate facilitation skills.

Day 2

ToT Trainees Presentations (Slide Decks) and Feedback

This session was anchored by Professor Namory Keita and Dr Daniel Murokora. The checklist for effective facilitation skills was distributed and explained to participants. Representatives from each country made presentations on their allotted topic following which feedback was received from their peers as well as from the facilitators.

Guinea: why screen for cervical cancer. The presentation focused on the burden and risk factors for cervical cancer as well as the natural history of cervical cancer and opportunities for prevention and control. It also highlighted the various screening methods.

Malawi: Anatomy of the Female Pelvis. The presentation provided a description of the female reproductive anatomy highlighting the site for and spread of cervical cancer

Senegal: Human Papilloma Virus (HPV) and the pathophysiology of cervical cancer. This presentation described the HPV and its mode of infection noting that cervical cancer is caused by the sexually transmitted HPV, which is the most common viral infection of the reproductive tract. The presenter went on to say that almost all sexually active individuals will be infected with HPV at some point in their lives and some may be repeatedly infected with the peak time for infection being shortly after becoming sexual active. He further noted that the majority of HPV infections resolve spontaneously and do not cause symptoms or disease. However, persistent infection with specific types of HPV (most frequently, types 16 and 18) may lead to precancerous lesions. If untreated, these lesions may progress to cervical cancer.

Kenya: Visual Inspection with Acetic Acid (VIA). The presentation focused on the procedure, indication and contraindications for VIA. It noted that VIA is a cost effective intervention to prevent cervical cancer.

Zimbabwe: Cryotherapy. The presenter from Zimbabwe focused on cryotherapy. He described the procedure, indications and contraindications.

Sierra Leone: Infection Prevention and Control (IPC). The focus of this presentation was on the principles of infection prevention in general and as it related to VIA and cryotherapy settings.

Following the presentations, feedback was received from both the participants and the facilitators. The feedback was guided using the checklist on effective facilitation, provided for these and are summarized below.

Overall, participants listened to each team, assessed their performance and provided feedback to each team on their strengths, weaknesses and areas for improvement. This interactive session provided facilitators to clarify on several areas of contention as well as correct wrong understanding of the key CCP concepts.

Technical content: The technical contents of each of the presentations should be clear and concise on the topic. Each of the slides should not be crowded to allow for easy following by the audience. There should be supporting relevant charts, graphs, photos and diagrams that further the audience understands the topic.

Presentation style: The presentations should be delivered in such a manner that it is interactive with the audience. The importance of engaging with the audience ensures that presenter is able to deliver the key message and get the audience alert. One way to ensure this is to regularly make eye contact with the audience as well as moving around the room.

Talking to Women about Cervical Cancer and Role plays on counselling for VIA and Cryotherapy

This session was anchored by Dr. Murokora. The objective of the session was to inculcate counseling skills for VIA/cryotherapy to the participants. Dr. Murokora gave an overview of the importance of counseling, highlighting the qualities of a good counselor. He reiterated that Women need accurate information about cervical cancer prevention, testing, and treatment and that counseling allows women to make an informed decision about being screened and treated (if indicated). He highlighted the various stages of counseling to include pre and post VIA counseling as well as pre and post Cryotherapy counseling and the key information to be provided to the clients in each of these. He informed the participants of the role play to 'act out' a situation that supports a learning objective. Role plays are a nice way to demonstrate and practice a range of skills, both clinical and training skills such as to demonstrate and practice counseling and education skills, history taking skills or demonstration and coaching skills.

Following his presentation, Dr. Murokora, provided the participants with a counseling assessment guide which rates the counseling skills of participants in their capacity to provide appropriate information for clients they are likely to meet a VIA screening facility. Each country team was provided with different scenarios of patients for counseling. Each team used role plays to depict how they would handle the counseling of clients that they would encounter in the scenario provided to them. Following each of the teams role play, they were assessed in their capacity to provide appropriate information to their clients by all the facilitators and other participants.

Day 3

Decision Making Case Discussions

The session was facilitated by Professor Namory and Drs Murokora and Leno. The objective of the session was to ensure that the participants had the same level of information on the WHO's guideline on prevention and control of cervical cancer. This recognizes the diverse knowledge and experience the participants have from their respective local practice and the need to standardize this knowledge

and practices to conform to international recommendations. Various questions and clinical case studies ranging from case definition of cervical cancer and pre-cancer, to eligibility criteria for cryotherapy and referrals[4] were extensively discussed by all the participants with guidance from the facilitators. The facilitators also provided guidance on international recommended practices on aspects of cervical cancer prevention and control that needed clarification.

Summary of issues which required standardized approach clarification during the session.

Age group for screening: WHO recommends that the screening age for cervical cancer targets women 30 to 49 years. This is based on current evidence and on the natural history of HPV and cervical pre-cancer. High-risk HPV infections are very common in young women, but most of these infections are transient and are eliminated spontaneously by the woman's body. Thus screening younger women will detect many lesions that will never develop into cancer, which will lead to considerable overtreatment, and is thus not cost-effective. Although there were cases of "suspected cancer" seen in younger women, screening younger age group is not cost effective. Efforts should be made to strengthen early detection services which will pick up people with symptoms early in including young women.

Frequency of screening: Among women who test negative with VIA or cytology, the interval for re-screening should be three to five years. Among women who test negative with HPV testing, re-screening should be done after a minimum interval of five years. After a subsequent screening with negative test results, and also for older women, the screening interval can be longer than five years. Women who have been treated for cervical pre-cancer should receive post-treatment follow-up after 12 months.

Screening for women living with HIV: Recommendations for women living with HIV:

- Screening for cervical pre-cancer and cancer should be done in women and girls who have initiated sexual activity as soon as the woman or girl has tested positive for HIV, regardless of age.
- Women living with HIV whose screening results are negative (i.e. no evidence of pre cancer is found) should be rescreened within three years.
- Women living with HIV who have been treated for cervical pre-cancer should receive post treatment follow-up after 12 months.

Table 2: Eligibility and exclusion criteria for cryotherapy

Eligibility criteria (all must be met)	Exclusion criteria (if any are met)
• Positive screening test for cervical pre-cancer	• Lesion extends beyond the cryoprobe edge
• Lesion small enough to be covered by the cryoprobe	• Pregnancy
• Lesion and all edges fully visible with no	Pelvic inflammatory disease (until treated)

[4] Annex 1: Guidance For Counseling_Participant.docx

extension into the endocervix or onto the vaginal wall	
	Active menstruation
	Evidence or suspicion of invasive disease or glandular dysplasia (pre-cancer)

Practical session- Review of VIA slides

This session was anchored by Professor Namory, Dr Leno and Dr Murokora. The objective of this session was to ensure that the participants had standardized information and skills in the performance of VIA and identification/interpretation of screening results. The participants were divided into 3 groups and each group reviewed over 50 different slides consisting of both normal, VIA positive and suspicious for cancer slides. Each group was guided by one of the expert facilitator. For each of these slides, participants took turns to describe the cervix, make a diagnosis based on the description and discuss the management modality for the patient.

Day 4

Practical session- VIA Counseling and screening of clients

The objective of the practical session was to expose participants to real life screening situation and inculcate standardized clinical skills on VIA and cryotherapy. With guidance from the expert facilitators, participants were able to demonstrate pre and post VIA counseling on clients that were invited for screening, perform VIA, interpret their respective findings and make a diagnosis based on this. Each of the participants screened 5 clients on the average.

Issues and lessons learnt from the practical session.

The morning session was particularly chaotic as there was no clear guidance on the maximum number of participants in each of the 3 examination rooms. This resulted in overcrowding thereby compromising client's privacy. Coupled with this, there were delays in replenishing the equipment and consumables supply to the examination rooms. These resulted in the screening taking longer than anticipated and clients being delayed.

The challenges observed in the morning were addressed during the afternoon session. The strategy in the afternoon was modified by restricting 2-3 participants per screening room at a time. Screening became better organized and the time taken per client screened became significantly shorter.

Synopsis of participants feedback on the screening session

Following the screening, a post mortem on the exercise was performed. Participants gave their feedback on the exercise. This is summarized below.

Zambia: Procedure was chaotic before lunch. VIA sessions was quicker after lunch. No preparation was made on handling of VIA positive cases (suspicion of cancer). Most participants were able to do VIA. There were 3-4 cases of suspicion of cancer. Hence need to take screening serious.

Sierra Leone: Had good experience. Patients were many for counseling. Significant time spent on counseling.

Zimbabwe: need to make clients more comfortable. Time management needs to be taken into consideration. Clients were not given any refreshment though they had spent the whole day waiting. Time should be given for participants to share personal experience.

Guinea: Need to clarify results i.e what is –ve, what is +ve

Nigeria: The importance of better organization of the grouping was raised. Communication for the group was raised. Lack of refreshment for participants. Suggestion of age of screening should be reviewed. Slide show was very helpful.

Malawi: Good learning experience in organization of training. Need for better organization for better flow of participants and clients in future training.

Nigeria: Need to better organize cleaning of equipment to make screening faster and forestall delays.

Senegal: VIA slides-show was very useful. There were very many clients and too many people in the examination room. This needs to be better managed.

Response to the issues raised by the participants: most of the bottlenecks were due to the participants not demonstrating the key criteria for attending the workshop. The criterion for the participants was that they should have had at least 2 years of continuous VIA screening experience. However, the questions that were being asked in during the screening sessions did not correspond to the level of expected experience hence the initial long time spent with the patients.

It is neither feasible nor sustainable to provide refreshment to clients since this would create challenges for the center in future screenings.

Day 5

Practical session- VIA Counseling and screening of clients

The VIA counseling and screening sessions continued in the morning session from the previous day. With guidance from the expert facilitators, participants were able to demonstrate pre and post VIA counseling on clients that were invited for screening, perform VIA, interpret their respective findings

and make a diagnosis based on this. The lessons learnt from the previous day were implemented and this ensured better organization and client flow. Over the 2 days of the screening, a total of 145 clients were screened with 14 positive cases. One of the positive client that was eligible for cryotherapy and was treated immediately.

Country presentations on Next steps

This session was anchored by Dr Barango. During the session, each of the country teams made a 15 minutes presentation of their respective plans to scale-up cervical cancer screening. Country presentations of the next steps/action plans for each of the countries are in annex 3.

Table 3: Summary of VIA TOT cryotherapy scale up plans

Country / Activity	Feedback to stake holders	Advocacy meetings	Procure equipment/scale up screening sites	Conduct TOT	Monitor service provision at screening sites
Ghana	Oct-Nov 2016	Oct-Nov 2016	TBA	Nov-Dec 2016	Nov/Dec -ongoing
Guinea	Oct-2016	Oct-Nov 2016	Nov-2016	Jan to April 2017	May 2017 -ongoing
Kenya	Oct-Nov 2016	Oct-Nov 2016	Oct -Dec 2016	Regional trainings. Dec 2016 to Mach 2017	Jan 2017 - Ongoing
Madagascar	Oct-2016	Oct-Dec 2016		Regional trainings. Jan to Dec 2017	Jan 2017 - ongoing
Malawi	Oct-2016	Oct-Nov 2016		Dec 2016 to ongoing	On going
Nigeria	Oct-Dec 2016	Oct to Dec 2016	Oct -Dec 2016	Zonal trainings Jan 2017 to Ongoing	April 2017 to ongoing
Senegal	Dec -2016	Dec 2016 – Jan 2017	Jan – June 2017	Regional trainings Jan to August 2017	Jan 2017 to ongoing
Sierra Leone	Oct-Nov 2016	Oct to Dec 2016	March to May 2017	March to May 2017	March 2017 to ongoing
Zambia	Oct-2016	Oct to Dec 2016		Provincial trainings Nov 2016 to August 2017	Ongoing
Zimbabwe	Oct-2016	Oct to Dec 2016			Ongoing

Post Course Evaluation

The course was generally well received by all participants and they considered it well organized and focused to achieving their learning needs.

The participants were particularly pleased with the interactive nature of the sessions as well as the opportunity to screen women all in one place.

The downside of the training as reported by the participants was the limited time for the whole course (5 days) as the program would have needed 10 days to better accomplish its objective.

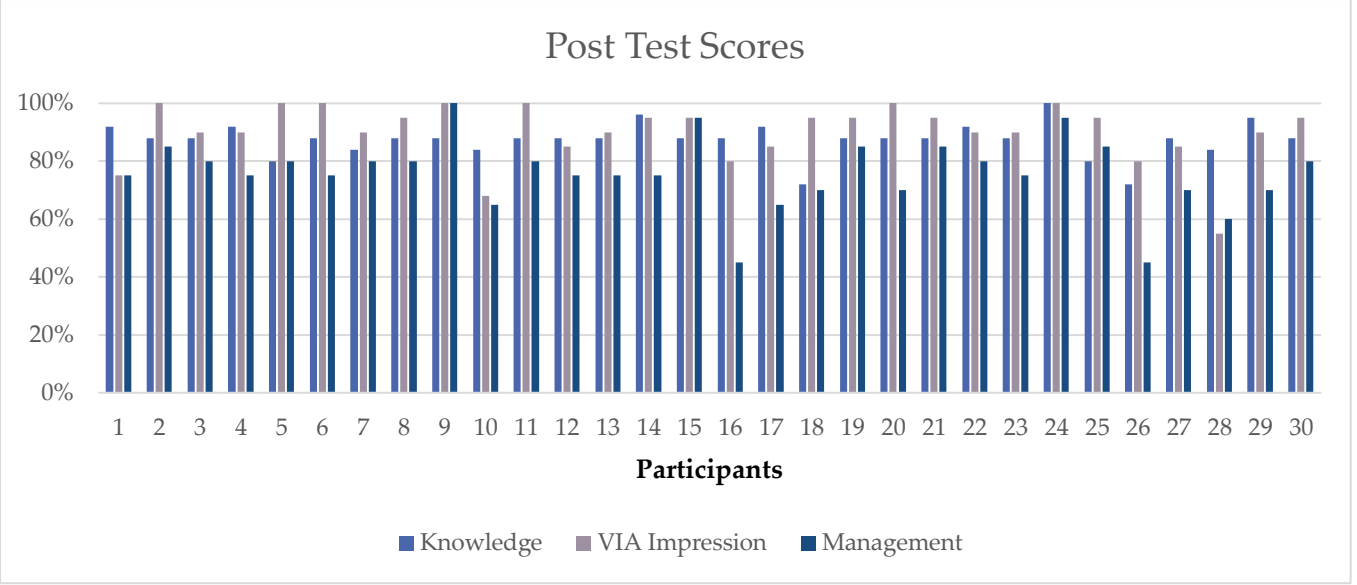
Consulting rooms for screening clients were reported to be few leading to crowding and delays in attending to clients.

Proposals for improvement in subsequent trainings mentioned included taking a smaller class of participants, allowing longer time for skills practice and ensuring that all materials are available in relevant languages.

ToT Post Test:

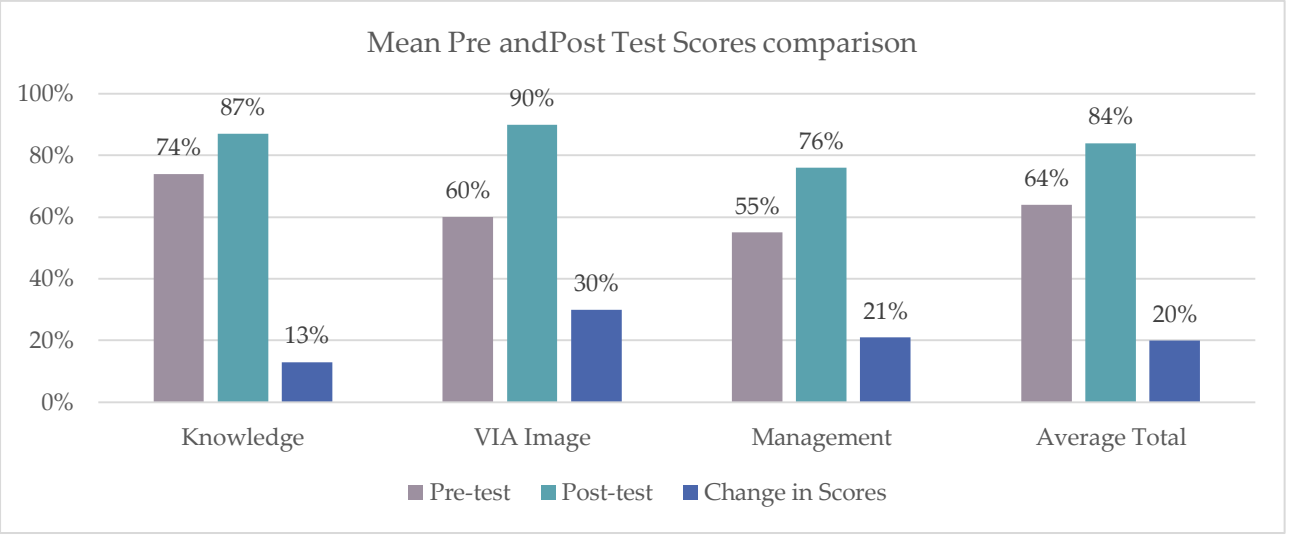
Analysis of training performance: This was an evaluated VIA-Cryotherapy ToT Course with both pre and post course assessment. The participants scores in the various facets tested are shown in the results analysis below.

Chart 1: Participants post test scores. N=30



The post test scores show that majority of trainees achieved the 70% pass mark in the knowledge. With the exception of 3 participants, all other participants achieved 60% or more in VIA impressions and management. These 3 participants need to spend more time in the clinics screening women to improve their skills The chart below summarizes the mean pre and post test scores and well as the mean percentage improvement by assessment category.

Chart 2: Comparison of Mean Pre and Post Test Performance



Closing ceremony

The closing ceremony was attended by the minister of Health of the republic of Guinea, represented by Dr Robert Camara, Director for Disease Prevention in the MoH, the WHO country representative for Guinea, Dr Abou Beckr Gaye, and the Director of The Regional Training Centre for Gynecological Cancers Prevention based in Donka Hospital in Conakry Guinea, Professor Namory Kaita.

In his closing remarks, professor Keita noted that the success of the week-long training was an attestation of the level of commitment of both the facilitators and the willingness of the participants to learn. He noted that during the screening exercise, a total of 145 clients were screened and 14 clients were detected with precancer. He thanked the organizers for their commitment and wished the participants well in their plans to scale-up screening in their respective countries.

In his closing remarks, the WR conveyed the appreciation of the WHO Regional Director; Dr Moeti Matshidiso, on the success of the meeting. She noted that cervical cancer screening was a WHO "Best Buy" intervention and gave her assurance of the willingness of AFRO to provide needed support to the participants to scale up cervical cancer screening through the cascade of this training in their respective countries.

A representative of the participants, Dr Jabulane Mahoso from Zimbabwe, thanked the WHO AFRO for their effort to support member states in their effort to reduce the burden of cervical cancer. He noted that the training workshop was indeed very successful as all the objectives for the workshop was fully achieved. He appreciated the high quality of the presentations as well as the very useful feedback provided by the facilitators. He promised on behalf of all the participants to start implementation of the training cascade plans developed as soon as they return back to their respective duty stations.

The meeting was closed by the representative of the Minister of Health. He noted the importance of screening Women for cervical cancer as this leads to detection in asymptomatic cases and halts the possible progression of pre cancer to cancer. He thanked the WCO for their energy and continuous support to the MoH. He ended by thanking all the participants for their effort and wished them a safe travel back to their respective countries.

Recommendations

Following the successful training of 31 master trainers in WHO's approach to cervical cancer prevention using Visual inspection with Acetic acid and treatment of eligible women with Cryotherapy, the following are recommendations to enhance better delivery of future VIA trainings.

1. **Selection of participants**: Although the criteria for selection of participants specifically mentioned the prerequisites of having at least 2 years' experience in delivery of VIA/cryotherapy services by potential MoH nominees, there was an indication that some participants did not meet this requirement. This resulted in delays in some sessions because extra time and effort had to be made to bring these participants up to speed with their contemporaries. In addition, during the first day of the VIA practical screening session, it was the underlying cause of over crowing in the screening rooms as VIA screening-naïve participants spent time asking questions that showed their lack of the prerequisite experience. To circumvent this, more effort should be made to ensure that the MoH nominees meet this vital criterion in future training.

2. **Facilitators' collaboration on the agenda**: The agenda on the first day had some sessions that were similar in scope and outcome. This is most likely because the expert facilitators did not have adequate time to review the agenda until close to the workshop. To ensure that there are no repeated sessions in future workshop, the facilitators should review the training agenda weeks before the date of the training and provide their input to the agenda as well as peer-review their respective presentations to ensure harmonization of the content of their respective presentations.

3. **Post training follow up for participants**: Following the successful training, it is important to continuously provide mentorship and follow up to the participants to ensure that they are providing WHO standard recommendations impacted during the training. This has already gotten off on a positive start as the cohort of participants has established a WhatsApp user group. This is a platform that will be supported to promote standard practice. On this Platform, participants will post technical issues, challenges they come across and share best practices.

Annex

ANNEX 1. TRAINING AGENDA

Training of Trainers Course in VIA/Cryotherapy

Conakry, 26-30 September 2016

Monday 26 September 2016		
Time	*Activity*	*Responsible*
8.00 – 8.15	Registration	Secretariat
8.15 – 9.00	Opening ceremony • Welcome remarks • Opening remarks • Introduction • Meeting Objectives, Expected Outputs	WR/Guinea MoH/Guinea WHO (Dr Dangou)
9.00 – 9.30	Pre-Course Assessment Setting the Scene – Overview of Cervical Cancer in Africa	Dr Leno WHO (Dr Dangou)
9.30 – 10.00	Current Evidence – Based Strategies for Screening and Pre-cancer Treatment	WHO (Dr Yacoub)
10.00 – 10.30	Current Policy and Programmatic Environment for CCP in AFRO	WHO (Dr Barango)
10.30 – 11.00	Health Break	
11.00 – 11.30	Capacity Building SWOT in the Countries	Dr Murokora
11.30 – 12.30	Adult Learning Principles Competence Based Training	Dr Murokora Dr Keita
12.30 – 13.00	Introduction to CCP Training and Course Overview (Trainers/Participants Manual) Course Design and Duration	Dr Keita
13.00 – 14.00	Lunch Break – **Security & Administrative Briefings**	
14.00 – 15.00	Clinical Standards Clinical Competencies Trainee Assessment (pre-course, midcourse, post course F/U) Course Evaluation by participants Trainee Summative Evaluation of Sessions using checklists – Peer to Peer.	Dr Leno
15.00 – 16.00	Overview of Training Manual: • Review Material • Instructions on preps for presentations • Assignment of chapters to teams [Adapt	Dr Murokora

	chapters & create slides]	
16.00 – 16.30	Health Break	
16.30 – 17.00	ToT Trainees Presentations (Slide Decks) and Feedback Managing Course Beginnings • Training Objectives & Outputs • 321b Evaluation	Dr Leno
17.00 – 17.30	Re-cap to Day 1 and plans for Day 2	
Tuesday 27 September 2016		
8.00 – 8.15	Registration	Secretariat
8.15 – 9.00	ToT Trainees Presentations (Slide Decks) and Feedback Why Screen for Cervical Cancer/Rationale	Dr Keita
9.00 – 9.30	ToT Trainees Presentations (Slide Decks) and Feedback Female Reproductive Anatomy • Cervix, SCJ etc	Dr Leno
9.30 – 10.00	ToT Trainees Presentations (Slide Decks) and Feedback • HPV and Pathophysiology of Cervical Cancer	Dr Murokora
10.00 – 10.30	ToT Trainees Presentations (Slide Decks) and Feedback • Visual Inspection with Acetic Acid	Dr Keita
10.30 – 11.00	Health Break	
11.00 – 11.30	ToT Trainees Presentations (Slide Decks) and Feedback • Cryotherapy	Dr Murokora
11.30 – 12.30	ToT Trainees Presentations (Slide Decks) and Feedback • Infection prevention	Dr Leno
12.30 – 13.00	ToT Trainees Presentations (Slide Decks) and Feedback • Feedback to ToT Trainees by Session	Facilitators
13.00 – 14.00	Lunch Break	
14.00 – 15.00	ToT Trainees Presentations (Slide Decks) and Feedback • Talking to Women about Cervical Cancer • Role plays on Counselling for VIA and Cryotherapy	Dr Murokora
15.00 – 16.00	ToT Trainees Presentations (Slide Decks) and Feedback • Talking to Women about Cervical Cancer	Dr Murokora

	• Role plays on Counselling for VIA and Cryotherapy	
16.00 – 16.30	Health Break	
16.30 – 17.00	Role Plays on VIA and Cryotherapy – continued • Feedback • Review and Adoption of IEC Materials	Dr Murokora
17.00 – 17.30	Re-cap to Day 2 and plans for Day 3	
Wednesday 28 September 2016		
8.00 – 8.15	Registration	Secretariat
8.15 – 9.00	ToT Trainees Presentations (Slide Decks) and Feedback Case Dscussions on VIA/Cryo • FAQs • Decision Making Case Discussion • Post Cryo Management Case Discussions	Dr Keita
9.00 – 9.30	ToT Trainees Presentations (Slide Decks) and Feedback Case Dscussions on VIA/Cryo (Continued) • FAQs • Decision Making Case Discussion Post Cryo Management Case Discussions	Dr Keita
9.30 – 10.00	ToT Trainees Presentations (Slide Decks) and Feedback Managing Skills Stations, Preparations and Guidelines	Dr Leno
10.00 – 10.30	Skills Stations and Demonstrations/Return Demonstrations • Pelvic Examination & VIA • Cryotherapy • Image Reviews for VIA and Treatment Decision Making	Dr Leno
10.30 – 11.00	Health Break	
11.00 – 11.30	Skills Stations and Demonstrations/Return Demonstrations • Pelvic Examination & VIA • Cryotherapy • Image Reviews for VIA and Treatment Decision Making	Dr Leno
11.30 – 12.30		
12.30 – 13.00	Skills Stations and Demonstrations/Return Demonstrations • Pelvic Examination & VIA	Dr Leno

	• Cryotherapy • Image Reviews for VIA and Treatment Decision Making	
13.00 – 14.00	Lunch Break	
14.00 – 15.00	ToT Trainees Presentations (Slide Decks) and Feedback Preparing for Clinical Skills Practice • Clinic Set up • Preparation of VIA/Cryo resources • Competence Checklists & Forms	Dr Keita
15.00 – 16.00	ToT Trainees Presentations (Slide Decks) and Feedback Preparing for Clinical Skills Practice • Clinic Set up • Preparation of VIA/Cryo resources • Competence Checklists & Forms	Dr Keita
16.00 – 16.30	Health Break	
16.30 – 17.00	ToT Trainees Presentations (Slide Decks) and Feedback Tour of the clinic and set up of clinic equipment and supplies	Dr Keita
17.00 – 17.30	Re-cap to Day 3 and plans for Day 4	
Thursday 29 September 2016		
8.00 – 8.15	Registration	Secretariat
8.15 – 9.00	Training Evaluation Approaches and materials; o Pre/Mid-course test o Checklists o Mid-course Image Assessments	Dr Murokora
9.00 – 9.30	Review of Forms Sample Client Registers; Sample referral Forms; Sample Cryotherapy forms	Dr Murokora
9.30 – 10.00	Clinical Skills Practice Paired ToT Trainees – French Speaking Paired ToT Trainees – English Speaking	Facilitators
10.00 – 10.30	Clinical Skills Practice Paired ToT Trainees – French Speaking Paired ToT Trainees – English Speaking	Facilitators
10.30 – 11.00	Health Break	
11.00 – 11.30	Clinical Skills Practice Paired ToT Trainees – French Speaking	Facilitators

	Paired ToT Trainees – English Speaking	
11.30 – 12.30	Clinical Skills Practice Paired ToT Trainees – French Speaking Paired ToT Trainees – English Speaking	Facilitators
12.30 – 13.00	Clinical Skills Practice Paired ToT Trainees – French Speaking Paired ToT Trainees – English Speaking	Facilitators
13.00 – 14.00	Lunch Break	
14.00 – 15.00	Clinical Skills Practice Paired ToT Trainees – French Speaking Paired ToT Trainees – English Speaking	Facilitators
15.00 – 16.00	Clinical Skills Practice Paired ToT Trainees – French Speaking Paired ToT Trainees – English Speaking	Facilitators
16.00 – 16.30	Health Break	
16.30 – 17.00	Introduction to Action Planning • Pre-Training Preparation Activities & checklist • Schedule of Cascade Trainings • Training Materials, Tools & Reporting	Dr Murokora Dr Keita
17.00 – 17.30	Re-cap to Day 4 and plans for Day 5	
Friday 30 September 2016		
8.00 – 8.15	Registration	Secretariat
8.15 – 9.00	Clinical Skills Practice Paired ToT Trainees – French Speaking Paired ToT Trainees – English Speaking	Facilitators
9.00 – 9.30	Clinical Skills Practice Paired ToT Trainees – French Speaking Paired ToT Trainees – English Speaking	Facilitators
9.30 – 10.00	Clinical Skills Practice Paired ToT Trainees – French Speaking Paired ToT Trainees – English Speaking	Facilitators
10.00 – 10.30	Clinical Skills Practice Paired ToT Trainees – French Speaking Paired ToT Trainees – English Speaking	Facilitators
10.30 – 11.00	Health Break	
11.00 – 11.30	Clinical Skills Practice Paired ToT Trainees – French Speaking Paired ToT Trainees – English Speaking	Facilitators
11.30 – 12.30	Clinical Skills Practice Paired ToT Trainees – French Speaking Paired ToT Trainees – English Speaking	Facilitators

12.30 – 13.00	Clinical Skills Practice Paired ToT Trainees – French Speaking Paired ToT Trainees – English Speaking	Facilitators
13.00 – 14.00	Lunch Break	
14.00 – 15.00	Presentation of Training Cascade Action plan • Country Specific Plans: French Speaking • Country Specific Plans: English Speaking	Participants WHO
15.00 – 16.00	Management of Next Phase • Timelines for Country-specific cascade trainings • Technical Support Needs – if any	Participants WHO
16.00 – 16.30	Health Break	
16.30 – 17.00	Course Evaluation ToT Post Test • Knowledge • Images • Summative – training skills ToT Participant Evaluation	Facilitators
17.00 – 17.30	Closing ceremony - Representative of Trainees - The Host - WHO Representative	Pr Keita WR/Guinea
	Meeting adjourn	

ANNEX 2. GUIDANCE FOR COUNSELING

Guidance For Counseling

Topics to address in pre-VIA counselling

Issue to discuss	Things to remember- Your Responses:
What is cervical cancer Ghana response CC is abnormal growth on mouth of womb. it is caused by HPV	There is local language on cancer and this needs to be taken into consideration. Need to be culturally sensitive words in description of cancer
What the cervix is and where it is located Zimbabwe response	

What a precancerous lesion is Guinea response Pre-cancerous Lesions are abnormal lesions at the mouth of the uterus womb which if not taken care of can lead to cancer	
Why screening with VIA is important Nigeria response It's important but it's a test that can pick abnormality at the mouth of the womb before it ccc	Becomes cancer
What happens during VIA Zambia response During VIA, you will be check and a solution will be applied to help see if there are any changes in the cervix.	
Possible results and their implications Kenya response VIA –ve where u see a pink smoot cx VIA +ve where u have aceto-white lesion and treatment by cryo Suspicious for cancer	Normal cervix Some changes that may require some localtreatment Changes might require referral to higher facilities

Topics to address in pre-cryotherapy counselling

Issue to discuss	Things to remember
What is cryotherapy Senegal	Method that allows treatment of cervical precancer. It entails using gas to freeze and kill cancer cells. It is a simple procedure
Benefits of the procedure Sierra Leone response. When you do cryo, you stop the abnormal growth of the cells at the mouth of the womb and avoid possible death	
What the client might feel during and after the procedure Malawi response The patient might not feel anything. The client may feel4 mild pain on lower abdomen. After the procedure, there might be lower abdominal pain and possible vaginal discharge for up to 6 weeks	
Post treatment care and follow-up Ghana response. Nothing should be inserted (specify) into the vagina within 4 to 6 weeks of procedure. To report back one year after the procedure.	
Onward screening Guinea response.	

Frequently Asked Questions in CCSPT

Q: Why should I have this test done?
A: Zimbabwe responsed that we can identify the treatable conditions that prevent development of cancer

Q: Are there symptoms I should know about?
A: Zambia response: Usually there are no symptoms but when symptoms, it may be post coital bleeding, abnormal discharge, pain during intercourse. Precancerous lesions have no signs

Q: Can cervical cancer be prevented?
A: Sierra Leone: yes cervical cancer can be prevented if detected early using a test that can identify the early lesions before progressing to advanced disease

Q: Do these precancerous lesions have symptoms?
A: Senegal: No precancerous lesions have no symptoms

Q: What is cervical cancer and how is it contracted?
A: Nigeria: CC is abnormal growth of mouth of the womb that is caused by organisms that not seen by eye. The agent is sexually transmitted.

Q: Does HPV infection have symptoms?
A: Malawi: HPV infection does not have symptoms when it infects the cervix. There may be symptom

Q: I am a smoker. Does that increase my risk of contracting cervical cancer in any way?
A: Kenya: yes. The risk of contracting HVP is increased with smoking.

Q: How does visual inspection with acetic acid work?
A: Guinea: positive lesions appear whitish

Q: If I test positive on VIA, does it mean I have cancer?
A: Ghana: it means that there are abnormal cell which if not taken care of can lead to cancer in future.

Q: What is the treatment if abnormal (precancerous) cells are found?
A: Zimbabwe: the treatment is called cryo. The abn cells are destroyed using cold coagulation

Q: How effective is this treatment?
A: Zambia: the treatment is very effective in majority of cases will need you to come after one year to be sure. However, treatment will depend on the extent of the leision.

Q: Does the treatment hurt?
A: Sierra Leone: No. U might feel some slight discomfort

Q: What are the side effects of the treatment?
A: Senegal: vaginal discharge, minimal abdominal pain. If side effects such as fever or severe abdominal pains persist please come back to the clinic.

Counselling clients on CCSPT - Standard Protocol Checklist

PRE-VIA COUNSELLING	
1. Greet client respectfully and establish rapport	
2. Describe the need for screening and the CCSPT procedure	
3. Check client's knowledge about the cervix and its location, clarifying as necessary	
4. Explain what cervical cancer and pre-cancerous cells are	
5. Explain the importance of testing and potential consequences of not being tested	
6. Assess client's knowledge of VIA test	
7. If necessary, describe the VIA procedure in simple terms	
8. Explain each of the possible VIA test results and its meaning	
9. Describe briefly the treatment options and follow-up process	
10. Encourage the client to ask questions before obtaining consent to proceed	
POST-VIA COUNSELLING	
11. Give the result of the test and explain what it means: • Negative (no lesions, return in 5 years for re-testing) • Positive and eligible for cryotherapy (some lesions, refer to cryotherapy; if successful return in 1 year for re-testing) • Positive ineligible for cryotherapy (extensive lesions, refer for alternative treatment; if successful return in 1 year for re-testing) • Cancer suspected (preventative treatment not appropriate, refer for alternative treatment)	
12. Provide follow-up instructions. Ensure the client is OK and has understood what to do next before allowing her to leave.	
PRE-CRYOTHERAPY COUNSELING	
13. Explain why cryotherapy is recommended	
14. Describe the procedure, step by step and what she might feel	
15. Identify benefits (including likelihood of success) and potential risks of the	
16. Explain post-treatment care and follow up	
17. Based on previous exam, ensure that client is not pregnant, or at least that she is less than 20 weeks gestation	
18. Encourage the client to ask questions and clarify outstanding concerns	
19. Ask the client for her consent for treatment	
POST PROCEDURE INFORMATION	
20. Ask client how she is feeling. If cramping, administer analgesics if required	
21. Explain that mild cramping and watery discharge (up to 6 weeks) are expected side effects and should not cause concern	
22. Advise client to avoid intercourse and if not possible to use condoms for her	
23. Advise that infection can occur. She should return immediately if discharge becomes smelly or pus-coloured, she experiences severe bleeding (for more than 2 days and heavier than usual, or with clots), prolonged fever or lower abdominal	
24. Advise client to return for follow up in one year's time.	

Case-study 1

Joanna is 35 and has four children, the oldest of whom is 18. She has frequent, heavy bleeding.

Guinea; she needs to be examined to find out the cause of the bleeding and where the origin of the bleeding.

Case-study 2

Mary is a 20 year old smoker with no children. She began having sex at 15 years of age. She says that some years ago she had painful blisters on her genitals but they cleared up and have not returned.

Senegal: she is VIA eligible to check if she has pre-cancerous lesions due to her history of early onset of sex, and smoking. This should be on an individual level as she is not qualified for population based screening.

Case-study 3

Grace is 35 and has three children. She says she has warts on her external genitalia. Her partner travels a lot and, although they have never discussed it, she assumes he has other sexual partners while he is away. He refuses to use condoms.

Sierra Leone: based on her age and history, she is eligible.

Case-study 4

Margaret, 25, was diagnosed with HIV several years ago. She and her partner always use condoms.

Nigeria: Eligible for VIA based on HIV status.

Case-study 5

Priscilla is 40 years old. Her last VIA was abnormal. She has been taking oral contraception for 10 years.

Malawi: Eligible based on time of last screening.

Case-study 6

Flora is 32 and is due to give birth next month. She has only ever had sex with her partner

Zimbabwe: not eligible for screening based on late pregnancy.

Role Plays

Case Scenario 1a:

Fatumata Jargo is a 43 yr old para 6+5. She had her first sexual intercourse at 14 years when she was married off as a 4th wife. She came to the screening clinic because she has abdominal pain and a vaginal discharge.

Please take Fatumata through a counseling process:

1. **Pre-VIA Counseling**

Case Scenario 1b:

Fatumata Jargo is a 43 yr old para 6+5. She had her first sexual intercourse at 14 years when she was married off as a 4th wife. She came to the screening clinic because she has abdominal pain and a vaginal discharge. VIA examination found an abnormality of the cervix

Please take Fatumata through a counseling process:

1. **Post VIA counseling**

Case Scenario 1c:

Fatumata Jargo is a 43 yr old para 6+5. She had her first sexual intercourse at 14 years when she was married off as a 4th wife. She came to the screening clinic because she has abdominal pain and a vaginal discharge. Fatumata was found with a VIA abnormality of the cervix and treated with cryotherapy

Please take Fatumata through a counseling process:

1. **Post Cryo Counseling**

ANNEX 3. PRE/POST COURSE KNOWLEDGE

Pre/Post Course Knowledge			
Names			Date:
District			Participant Number:
1		Cryotherapy usually requires local anaesthesia	
2		Sexual intercourse can be resumed one week post-cryotherapy	
3		Using oral contraceptives for more than five years is a risk factor for cervical cancer	

4		A history of multiple births is a risk factor for cervical cancer
5		HIV infection is not a risk factor for cervical cancer
6		VIA involves a standard speculum exam followed by visual inspection of the cervix 1 minute after washing it with a 3-5% acetic acid solution
7		The VIA test is considered ***negative (normal cervix)*** when the cervix is found to be smooth, pink, uniform and featureless **OR** if aceto-whitening is insignificant.
8		If a client develops a fever or severe abdominal pain after cryotherapy she should return to the centre as soon as possible
9		The' double-freeze' technique involves applying the coolant continuously for 3 minutes, allowing the abnormal lesion(s) to thaw for 5 minutes, and then reapplying the coolant for a further 3 minutes
10		A VIA test is considered ***positive (abnormal cervix and ineligible for cryotherapy)*** if the cervix is seen to have raised and thickened white plaques or aceto-white epithelium near the SCJ that: • cover less than 75% of cervix • do not extend onto the vaginal wall
11		Most women do not experience significant problems following cryotherapy
12		Clients with suspected cervical cancer should first be treated with cryotherapy before being referred to an appropriate health facility for follow-up
13		Cervical cancer prevention screening is recommended for all women aged 18-50
14		Cryotherapy involves applying a cryoprobe to the cervix and freezing its surface using carbon dioxide or nitrous oxide gas as the coolant
15		Cryotherapy cannot be performed on clients with cervicitis
16		No treatment is required where there are no aceto-white lesions on the client's cervix
17		If an ice ball is not present after the 'double-freeze' technique, a further single-freeze procedure should be performed
18		When the procedure is complete, the master valve on the cryotherapy unit must be left open for disinfecting
19		Cervical cancer can be suspected where a cauliflower-like growth or ulcer or fungating mass is seen on the cervix

20		Thawing of the ice ball produces a watery discharge that usually lasts for a few hours after treatment
21		After the procedure, the parts of the cryotherapy unit that came into direct contact with the client should be removed and sterilised
22		The vast majority of cases of cervical cancer are related to persistent infection with human papilloma virus (HPV)
23		Headache and mild chills are normal following cryotherapy
24		Ectropion, polyp, cervicitis, inflammation and Nabothian cysts are all considered as positive VIA results
25		Women who have had been treated following a positive screening test should receive a post-treatment follow up at 1 year