AFD
AGENCE FRANÇAISE DE DÉVELOPPEMENT

MÉDECINS DU MONDE

MANAGING AND TREATING PRECANCEROUS CERVICAL LESIONS

SERIES OF FACTSHEETS 2024

MÉDECINS DU MONDE FRANCE

CONTENTS

LIST OF ACRONYMS AND ABBREVIATIONS

Ca	Cancer
CSO	Civil society organisations
HIV	Human immunodeficiency virus
HPV	Human papilloma virus
LEEP	Loop electrosurgical excision procedure
MdM	Médecins du Monde
MEAL	Monitoring, evaluation, accountability, and learning
NHIS	National health information system
PCR	Polymerase chain reaction
PLHIV	People living with HIV
POCT	Point-of-care tests
SRHR	Sexual and reproductive health and rights
VIA	Visual inspection with acetic acid
VILI	Visual inspection with Lugol's iodine
WHO	World Health Organization

GLOSSARY

BIOPSY	Sampling of a fragment of tissue to examine under a microscope
COUNTER-REFERRAL	The act of referring a patient back to the initial provider for the provision of care to be concluded
COUNSELLING	Relationship in which one person tries to help another to understand and resolve the problems that concern them
SCREENING	Detecting a disease in an individual who is apparently in good health before any symptoms appear
EMPOWERMENT	Increasing the options for individuals to face up to the economic, social or political conditions confronting them
SMEAR TEST	Sampling and preparing a thin layer of tissue to examine under the microscope
HUMAN PAPILLOMA VIRUS (HPV)	Viral disease transmitted through direct contact with an infected person and with the potential to cause precancerous lesions
INCIDENCE	Number of new cases of a disease during a given period of time
VISUAL INSPECTION WITH ACETIC ACID (VIA)	Screening process involving inspecting the cervix following the application of acetic acid
VISUAL INSPECTION WITH LUGOL'S IODINE (VILI)	Screening process involving inspecting the cervix following the application of Lugol's iodine
PRECANCEROUSLESIONS	Form taken by tissue or an organ in which a cancer is likely to develop
VIRAL CLEARANCE (VC)	Capacity of a virus to clear spontaneously in the absence of any treatment
PREVALENCE	Number of cases of a disease in a given population at a given time
ACCOUNTABILITY	Signifies the right of any individual affected by the actions of a person or organisation to call them to account
REFERRAL	The act of directing a person to a more specialised provider following initial contact
COMMUNITY RELAY	Individual or organisation ensuring the continuity of actions undertaken by an NGO
LOOP ELECTROSURGICAL EXCISION PROCEDURE (LEEP)	Surgical removal of part of the cervix for analysis
SCREEN, TRIAGE AND TREAT	Strategy involving closely linking the stages of case management to limit the numbers lost to follow-up
THERMAL COAGULATION	Treatment of precancerous lesions of the cervix using heat
TRANSFORMATION ZONE	Area of the cervix between the ectocervix (outer part) and the endocervix (inner part) where cells can be of two types and are more susceptible to becoming cancerous

0. GENERAL INTRODUCTION

The rapid development in medical knowledge and practice in cervical cancer prevention and treatment means that the MdM SRHR technical adviser must ensure that this document and its annexes are consistently updated.

I. PREAMBLE

Cervical cancer is a form of female cancer and is the fourth most prevalent cancer among women worldwide, killing more than **340,000 people annually. Yet it is an avoidable and eradicable disease** that is preventable using effective screening tests. It is the rare consequence of a commonly occurring virus – the human papillomavirus (HPV) – which causes 99% of cervical cancer cases and which is transmitted during sex. **More than 90% of deaths occur in low- or middle-income countries where** access to screening and treatment is inadequate.

Understanding the natural history of cervical cancer

In 70% of cases, cervical cancer is caused by the viruses HPV 16 and 18, and to a lesser extent by **HPV 45, 33 and 52**. The clearance phenomenon of HPV means that the cervical cells develop slowly into cancerous cells over a period of 5 to 10 years due to the persistence of the virus in the cervix. This delay in the development is shortened to 5 years **in people living with HIV who are 6 times more at risk of developing cervical cancer.**

Screening therefore has a crucial place in cervical cancer prevention. Effective screening is possible using simple methods followed, if necessary, by a phase of effective and affordable treatments. Early screening enables pre-cancerous lesions to be identified and treated.

The strategy of the World Health Organization (WHO) is to eliminate cervical cancer and comprises vaccination, screening and treatment. It aims to **reduce the incidence rate of the disease to 4 cases per 100,000 women** by 2050.

II. WHO ARE THE FACTSHEETS FOR?

This operational guide is designed to support **sexual and reproductive health and rights (SRHR) project teams** wishing to develop and put in place projects to prevent and manage precancerous lesions of the cervix and/or improve their SRHR care package.
These factsheets are intended for use by **health professionals and community and advocacy actors.**

This guide is addressed at **everyone involved in the projects** (actors operating in the field and at head office), to ensure a common understanding of the approach taken by Médecins du Monde (MdM). It is not directed solely at medical personnel but at all those working for MdM in constructing and implementing projects.

III. WHAT IS THE PURPOSE OF THE FACTSHEETS?

1. To support teams as they put in place a new cervical cancer project that fits with the MdM cervical cancer strategy.
2. To guarantee that key activities are put in place to enable precancerous lesions of the cervix to be prevented and managed within the health facilities supported or by introducing a suitable referral pathway.
3. To guarantee the use of validated protocols, decision-making trees and algorithms, established in line with the latest international recommendations and the approach and values of MdM, and thus enhance the quality of our projects.

These factsheets are **tools designed to assist with the implementation phase and to ensure that cervical cancer prevention needs** are taken into account and suitable responses implemented. They do not provide ready-made responses given that operational methods **have to be adapted to the relevant intervention contexts and national policies and protocols, and to the resources available.**

IV. WHAT DO THE FACTSHEETS CONTAIN?

LIST OF FACTSHEETS FOR MANAGING CERVICAL CANCER SCREENING

1. Guidelines for cervical cancer screening
2. Diagnosis: Identifying existing resources
3. Establishing the screening strategy
4. Patient pathway and lost-to-follow-up procedure
5. Medical management of precancerous lesions
6. Managing referrals
7. Strengthening capacities
8. Logistics
9. Community strategies and activities, partnerships and advocacy
10. Monitoring and evaluation

LIST OF ANNEXES

1. Cervical cancer diagnosis checklist
2. Mapping stakeholders/Care costs
3. Healthcare facility evaluation sheet
4. Training plans checklist
5. Screening algorithm/Patient pathway
6. Protocols for preparing VIA and VILI solutions and for decontamination
7. Model informed consent form/Form for returning VIA results
8. Model register
9. Supervision checklist
10. Community mobilisation/key messages checklist
11. Cervical cancer advocacy factsheet

The first part of each factsheet introduces the subject dealt with and defines key concepts. This section features a box setting out **the key activities** to be put in place systematically as part of projects.

The second part sets out **the operational aspects**. The activities to implement are detailed and organised by type of work or group of activities. Users can find the relevant activities listed here along with the equipment required, specific elements for monitoring and evaluating the subject in question and the principal indicators.

In addition, some factsheets contain **annexes, 'ready-to-use' documents** (e.g. register, diagnosis checklist, etc.) and links to other resource documents.

V. HOW SHOULD THE FACTSHEETS BE USED?

Preparing

Each sheet is devoted to a theme that is intended as a stage of the implementation process. But it should be noted that, while thought must be given in advance to some areas such as the guidelines and identifying resources, the various factsheets are not necessarily intended to be implemented consecutively and some stages may happen in parallel, such as logistics and training, or may be cyclical and ongoing, such as advocacy and community mobilisation.

Actioning

All **key activities** mentioned in the text boxes in the first part of each sheet must be considered. Based on the conclusions of the diagnosis, users should refer to the intervention methods proposed in relation to the themes concerned.

Implementing

Several practical elements are set out in the sheets which will save the teams considerable time, particularly when collating **the protocols to use**. These are based on international recommendations and approved by head office. The **resources needed** for implementing the activities in terms of materials, equipment, etc. are also set out in some factsheets and, in the case of human resources, are detailed in a specific factsheet.

Monitoring/tracking

A list of specific indicators for the purposes of monitoring and tracking is provided. It is recommended that **MdM tools (Monitool) or those drawn from international directives** be used.

NOTES

1. GUIDELINES FOR CERVICAL CANCER SCREENING

I. PREAMBLE

The World Health Organization (WHO) strategy for eliminating cervical cancer comprises vaccination, screening and treatment with the aim of reducing the number of new cases of the disease between now and 2050[1]. This global strategy puts forward

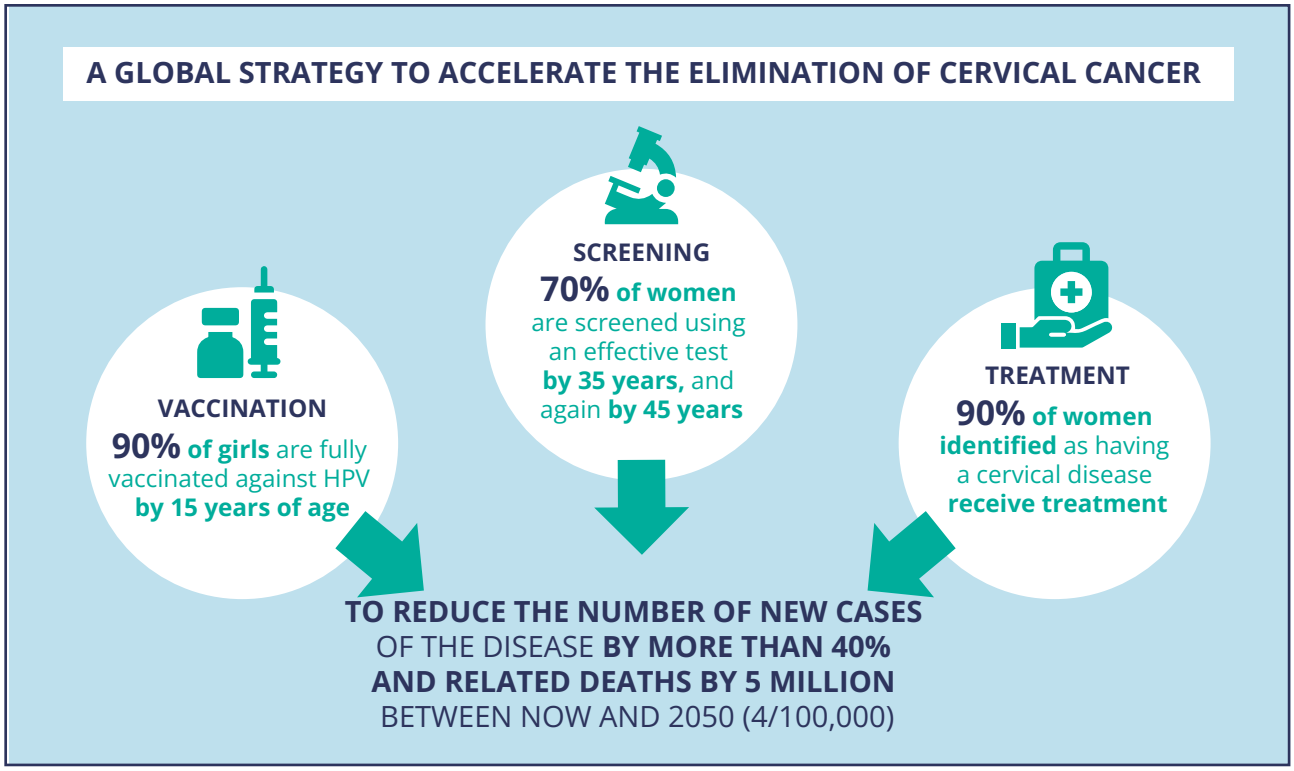
➡ **A world where cervical cancer has been eliminated as a public health problem** by achieving an incidence rate below four cases per 100,000 women.

➡ **The targets of 90-70-90 must be reached:**

- 90% of girls are fully vaccinated against the human papillomavirus by 15 years of age
- 70% of women benefit from screening carried out using a high-performance test at age 35 and again at age 45
- 90% of women who have been diagnosed with a cervical disease receive treatment (90% of women with precancerous lesions are treated and 90% of women with an invasive cancer receive care).

A mathematical model which illustrates the interim advantages that would be obtained if the 90-70-90 targets were met between now and 2030 in low-income and lower-middle-income countries, namely a 10% reduction in the median incidence rate of cervical cancer between now and 2030, with projected reductions of 42% between now and 2045 and more than 97% between now and 2120, would avoid 74 million new cases of cervical cancer.

Recommendations on screening. The WHO encourages screening using an effective test to increase the impact. While the majority of low- and middle-income countries use visual inspection with acetic acid (VIA), Médecins du Monde has developed pilot projects involving screening using the HPV test which affords several advantages, including being effective without being complex and therefore feasible in low- and middle-income countries. In addition,



1. Global strategy to accelerate the elimination of cervical cancer as a public health problem. In English: https://www.who.int/publications/i/item/9789240014107 and in French: https://www.who.int/fr/publications/i/item/9789240014107

sampling can be carried out by individuals themselves, making the test accessible to a greater number of people, particularly those living furthest from healthcare facilities.

However, the cost of this screening remains high, and so **where it is not possible to carry out the screening using an effective test, MdM recommends screening nonetheless using visual inspection with acetic acid** and treating precancerous lesions with thermal coagulation.

II. PRINCIPLES OF MÉDECINS DU MONDE

MdM works to promote **respect for the right to health and for universal access to SRH services** and does so by consolidating the care continuum from community level through to reference services as part of the lifelong provision of care to service users.

MdM adopts two complementary approaches to fulfilling its commitments in this area:
➡ **A public health approach** which takes the form of providing comprehensive, good quality care that fits with the care continuum and is accessible to all
➡ **A sexual and reproductive health promotion approach** which takes the form of advocating for respect for the right to access appropriate, good quality health services.

These are based on 3 types of complementary intervention:
➡ **Providing comprehensive care**, which is accessible and of good quality for the most vulnerable populations
➡ **Mobilising the community**
➡ **Advocating in favour of respect for the right** of these populations to access appropriate, good quality healthcare.

A cervical cancer prevention project at MdM forms part of the global SRHR approach which is centred on empowering and ensuring the autonomy of the people who are at the heart of the approach. Health is a universal human right to which everyone is entitled, and which states have an obligation to guarantee.

For MdM, this involves supporting and strengthening public health systems as guarantors of accessible care and of respect for the right to health. It is also necessary to strengthen The individual capacities of service users as rights holders must be strengthened too so that they are aware of their rights and can lay claim to them.

III. OPERATIONAL ASPECTS

a. Managing and treating precancerous cervical lesions – what should be the response?

MdM focuses on managing and treating precancerous lesions by integrating the management of cases into comprehensive SRH services. Depending on the screening method used, provision may be offered in a health centre (opportunistic screening) or directly in the community (organised screening).

Different types of tests currently exist, and these must be adapted to the context and the realities of scheduling. Tests can also be combined to improve the effectiveness of the screening. The table below summarises the advantages and disadvantages of the various tests.

➡ **HPV test**
➡ **Smear test**
➡ **Visual inspection with acetic acid (VIA)** or
➡ **Visual inspection with Lugol's iodine (VILI)**
➡ **HPV test + VIA/VILI**
➡ **HPV serotyping (DNA-based) test (16, 18, 45, 33, 51)**

TYPES OF SCREENING	ADVANTAGES	DISADVANTAGES
VIA	➡ Lower cost ➡ Easier to carry out 'screen and treat'	➡ Greater need for training ➡ Risk of overtreatment ➡ Person-dependant with the risk of false positives and false negatives
HPV	➡ Extremely sensitive ➡ Self-sampling possible ➡ HPV typology in the result ➡ Few cases lost to follow-up	➡ Overtreatment ➡ Higher cost ➡ Laboratory required
SMEAR TEST	➡ Good specificity	➡ Specific appointment ➡ Greater frequency – every 3 years ➡ Specific analysis
HPV + VIA	➡ Reduced risk of overtreatment ➡ Reduced risk of false negatives	➡ Higher cost ➡ Need for training ➡ Greater risk of incomplete screening
HPV + serotype	➡ 16, 18, 45, 31, 33 ➡ Extremely sensitive ➡ Self-sampling possible ➡ HPV typology in the result ➡ Greater sensitivity and specificity than HPV + VIA ➡ Fewer lost-to-follow-up cases	➡ Higher cost ➡ Laboratory required

b. Cervical cancer screening: definitions and concepts

Empowerment: Increasing individuals' options to face up to the economic, social or political conditions confronting them.

Self-care: Refers to the capacities of individuals, families and communities to promote health, prevent diseases, remain in good health and confront illness and disability with or without the support of a healthcare provider.

Human Papilloma Virus: Viral disease that is transmitted through direct contact with an infected person and with the potential to cause precancerous lesions.

Prevalence: Number of cases of a disease in a given population at a given time.

Incidence: Number of new cases of a disease during a given period of time.

Lost to follow-up: People who leave the care pathway before the end[2].

In the absence of global norms establishing the moment when an individual who does not comply with a referral or who does not present for treatment can be categorised as 'lost to follow-up', programmes must draw up their own standard definitions. (Cf. Sheet 4.)

Screen, triage and treat: A strategy involving closely linking the stages of case management to limit the numbers lost to follow-up.

Point-of-care tests: Decentralised analysis conducted outside the laboratory at the patient's bedside when care is being dispensed. For cervical cancer, point-of-care tests consist of PCR testing equipment to rapidly detect the presence of the HPV virus.

Effective screening: As for diagnostic tests, the effectiveness of a screening test is based on its sensitivity (the proportion of ill individuals who test positive), its specificity (the proportion of individuals who are not unwell who test negative), on positive predictive values (the

2 https://www.who.int/publications/i/item/9789241514255 page 110

proportion of individuals testing positive who have the disease) and negative predictive values (the proportion of individuals testing negative who do not have the disease).

Opportunistic screening: Screening that takes place outside an organised screening programme and that is performed when the opportunity arises for contact with potential patients in a health centre.

Organised screening: Screening that is systematically offered to a whole target population which does not present symptoms or particular risk factors. A census of the eligible population must be carried out in advance, and the screening and sampling take place as close as possible to patients, so they do not have to travel to a health centre.

Referral/counter-referral: Referral involves sending a patient from a lower to a higher level of healthcare. Counter-referral involves sending a patient from the higher to the lower level.

Visual inspection with acetic acid: This screening approach consists of a visual inspection of the cervix following application of acetic acid.

Visual inspection with Lugol's iodine: This screening approach consists of a visual inspection of the cervix following application of Lugol's iodine.

Transformation zone: The transformation zone or 'Squamocolumnar junction' is the line of the junction between the squamous epithelium and the columnar epithelium and the cervix. It is important to inspect this line during the VIA as it is where precancerous lesions of the cervix commonly arise.

Smear test: Preparation of a thin layer of tissue for examination under a microscope to analyse the cervical-vaginal cells.

Precancerous lesions: Abnormal cells that are likely to develop into cancer.

Clearance phenomenon: Capacity of a virus to clear spontaneously in the absence of treatment.

Biopsy: Sampling of a tissue fragment in order to examine it under a microscope.

LEEP (Loop electrosurgical excision procedure/ Loop diathermy): Surgical removal of a section of the cervix for analysis and/or elimination of cancerous cells.

Thermal coagulation/cryotherapy: Treatment of cancerous lesions of the cervix using the effects of heat/cold.

Scaling up: Scaling up concerns taking effective solutions that have been identified during successful interventions as worth reproducing and/or extending and doing so. Investing in scaling up is an acknowledgement that that the intervention could have a more significant impact. An essential component of the project proposal would therefore be the production of reliable data as evidence of the benefits of the intervention, and consideration from the outset of how the project might subsequently develop.

c. Approaches to cervical cancer screening

To make this section on screening approaches and principles easier to understand and use, below is a reminder of the definitions of some concepts:

1. Ethics

In the guide *For Ethics in the Field*, MdM provides a reminder of the seven ethical principles that must be systematically observed in all places and at all times. These principles are as follows:

- Respect for dignity
- Duty to treat without discrimination
- Duty to do no harm
- Free and informed consent
- Respect for confidentiality
- Duty to protect
- Duty to provide a medical certificate at the request of a victim of violence.

2. Sociocultural determinants

Sociocultural determinants correspond to all popular norms, values, knowledge and practices associated with health that govern ways of doing, saying and thinking about health, illness or healthcare.

Analysis of these determinants must be as fully integrated as possible from the diagnosis phase as such determinants can hinder access to healthcare. Failure to take these determinants into account could result in a discrepancy between the activities envisaged and the real possibility of implementing them.

3. Public health approach to SRH

Due to their prevalence, seriousness and consequences for individuals and society, SRH problems are significant public health issues. It is therefore essential for MdM to provide good quality comprehensive care that is accessible and helps reduce the impact of SRH problems. For this to happen, SRH services must not work in isolation or be conceived of vertically but must be integrated into primary healthcare services.

4. Human rights-based approach

Health is a universal human right to which each person is entitled, and which must be guaranteed by states. For MdM, this means supporting and strengthening public health systems as guarantors of accessibility to care and respect for the right to health. The individual capacities of the population must also be reinforced so that people know their rights and can lay claim to them.

5. Gender-based approach

MdM fulfils the recommendations of the 1994 Cairo Conference and the 1995 Beijing Conference by incorporating the gender perspective in its projects as a part of a commitment to social equity and justice in relation to health and sexual and reproductive health. As highlighted in the Beijing Declaration, gender inequalities are at the root of inequalities in access to health services for people and in the control they have over their own health.

In this respect, MdM is committed to incorporating the gender perspective in all its projects in response to the practical and strategic needs relating to SRHR for men, women and non-binary individuals.

As regards the practical needs, the projects and activities are designed to respond to gender- and sex-specific needs and to develop practices that do not replicate the various forms of gender discrimination and stereotyping. As regards the strategic needs, the activities help reduce gender inequalities by developing actions that empower women and help men take joint responsibility. MdM also views gender inequalities as an obstacle to respect for sexual and reproductive rights and access to healthcare and affirms the importance of a gender-based approach. Gender is a sociological analysis tool which refers to how the societal roles attributed to each gender in a society at a given period are constructed and divided. The gender-based approach is particularly relevant in SRHR projects; it takes account of this division of roles and activities between women, men and non-binary individuals in a given context and promotes gender equality.

IV. SPECIFIC GUIDELINES FOR CERVICAL CANCER

➡ **Provide care that is appropriate to everyone** including those who are distanced from healthcare and specifically **people living with HIV (PLHIV), who are 6 times more at risk of developing cancer.**

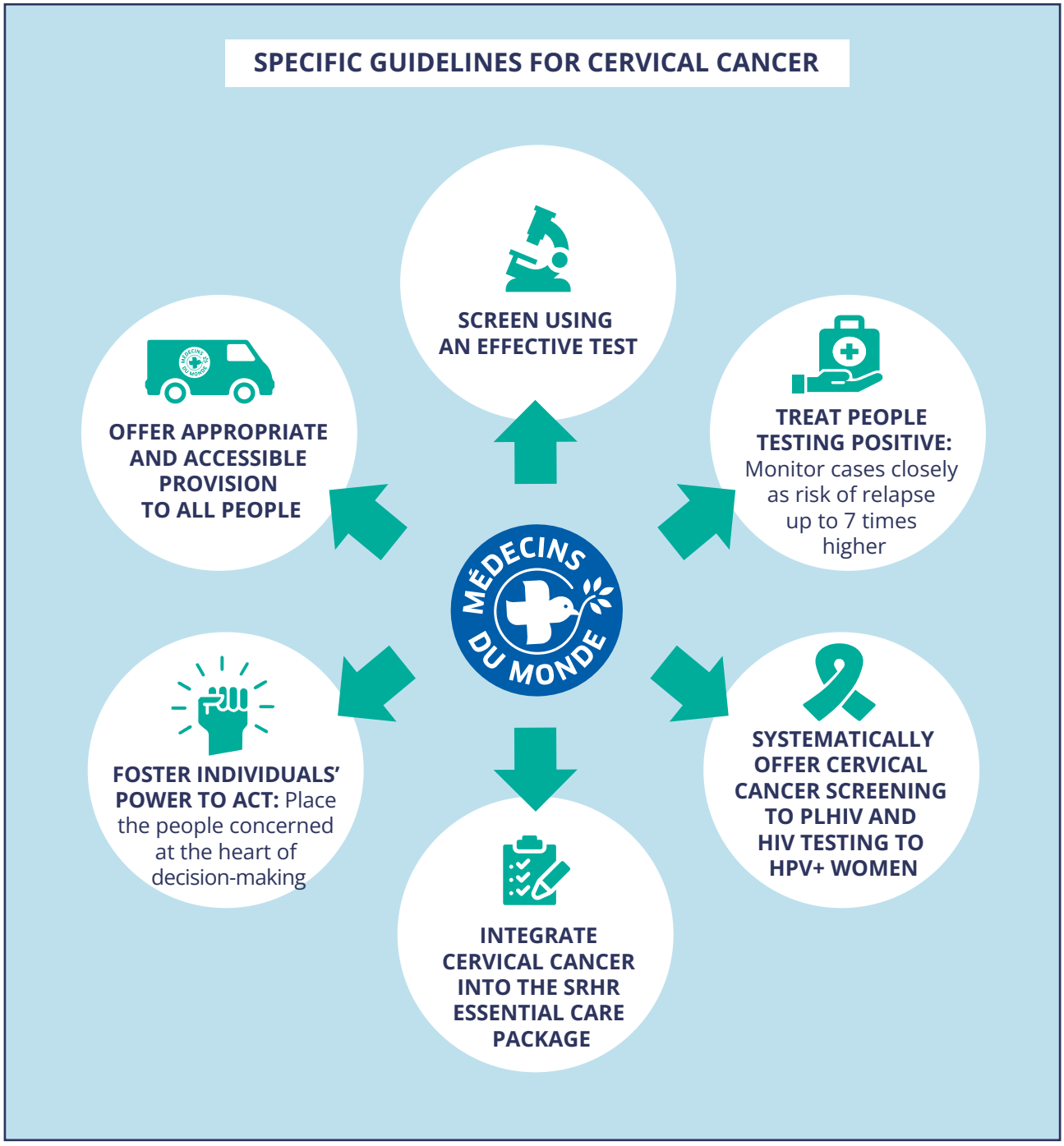
➡ **Screen using effective tests** to avoid overtreatment and missed opportunities.

➡ **Treat people who test positive.**

➡ HPV+ individuals have a higher risk of being HIV+; **it is important to (re)offer screening for HIV.**

➡ **Offer (screening/treatment) pathways that are simple and appropriate** and can be easily replicated and incorporated into healthcare provision so that they can be scaled up.

➡ **Encourage partners and men to take joint responsibility** for preventing cervical cancer.


SPECIFIC GUIDELINES FOR CERVICAL CANCER
SCREEN USING AN EFFECTIVE TEST
TREAT PEOPLE TESTING POSITIVE: Monitor cases closely as risk of relapse up to 7 times higher
SYSTEMATICALLY OFFER CERVICAL CANCER SCREENING TO PLHIV AND HIV TESTING TO HPV+ WOMEN
INTEGRATE CERVICAL CANCER INTO THE SRHR ESSENTIAL CARE PACKAGE
FOSTER INDIVIDUALS' POWER TO ACT: Place the people concerned at the heart of decision-making
OFFER APPROPRIATE AND ACCESSIBLE PROVISION TO ALL PEOPLE
MÉDECINS DU MONDE

NOTES

2.

DIAGNOSIS: IDENTIFYING EXISTING RESOURCES

I. INTRODUCTION

KEY ACTIVITIES

❑ Mapping and analysing actors, identifying potential partners and opportunities for referral
❑ Analysing the availability of services and inputs and identifying unmet needs
❑ Analysing the general context, notably as regards the sociocultural determinants linked to access to screening and treatment and the various barriers to access
❑ Analysing national administrative, legal and institutional documents/reference guides and the care pathway
❑ Analysing risks

A global vision and analysis of the intervention context is essential for identifying **the potential entry points for setting up activities to prevent and treat precancerous cervical lesions**. Diagnosis is an indispensable process prior to implementing an intervention. It can be an integral part of the fact-finding mission. In contexts where MdM is already present, it relies on the knowledge and expertise acquired on projects conducted in the area.

The different needs, barriers to access and potential levers among the various population groups must be analysed during the diagnosis phase, while taking account of certain at-risk populations. Such comprehensive information is needed to determine an intervention strategy and how it will be rolled out, and to analyse sustainability issues and potential risks.

II. OPERATIONAL ASPECTS

a. Preparatory phase

➡ Briefing of **medical coordinators, general coordinators, the programme coordinator, those responsible for SRH/cervical cancer at** head office (SRHR adviser, health adviser, advocacy adviser), particularly on the subject of the factsheets and their use.

➡ **Reviewing and analysing existing data** (from the National Health Information System (NHIS), surveys, evaluations, etc.).
➡ **Preparing collection and analysis tools** (interview sheets, focus group sheets, service evaluation sheets).

b. Analysing factors influencing the situation and the feasibility of a cervical cancer project

This involves detailing which information needs to be collected to guide the intervention in terms of preventing and managing precancerous cervical lesions. Other information customarily collected during the diagnosis phase is not mentioned in this factsheet.

For more details, see:
MdM Health Project Planning Guide

➡ **Demographic and health factors**

- Demographic data for the areas to be covered by the intervention, **disaggregated by sex and age and HIV status**
- **Data available relating to cervical cancer** (via National Health Information System (NHIS), partners and research institutes): prevalence, frequency of screening services, incidence of referral for treatment, etc.

➡ **Factors linked to the health policy and health system organisation**

- Policies, plans, national strategies and cervical cancer prevention and management protocols
- Health facilities providing cervical cancer screening and/or treatment and the quality of the services provided (evaluated by visits/observation/mystery patient and/or interviews with health professionals)
- **Existence of referral mechanisms**
- Care pathway, cost of each stage and type of care and treatment (assistance available or otherwise)
- Availability and quality of consumables and medical equipment for screening (VIA and/or HPV test and/or smear test)
- Availability **of human resources in health, delegation of tasks** and staff training in screening and treating cases (HPV test, VIA,

thermal coagulation, cryotherapy, biopsy, radiotherapy and chemotherapy and supporting palliative care)

• Availability and quality of **laboratory centres** and their mechanism for maintaining inputs if also a testing centre. These elements together enable community strategies and advocacy to be drawn up.

The care pathway to be analysed may differ depending on whether the system being analysed is public or private. The services may also be available at national level or abroad, with or without a mechanism in place for supporting treatment abroad. Note - such information is useful to have. For this phase, start by referring to the WHO country sheets for cervical cancer (Cf. Annexe 1).

➡ **Socioeconomic factors**

• Factors exacerbating women's economic and social vulnerabilities

• **Vulnerability diagnosis**: Geographical isolation, low level of education and/or income, HIV/AIDS infection, engaged in sex work, etc.

• Influence of economic resources on screening practices.

➡ **Sociocultural factors**

• Organisation of social and family networks and leadership structures

• Identification of key individuals in the community: leaders, community relays, women's groups, youth groups, etc.

• Gender and other inequalities in accessing basic services

• Representations of health and perceptions of disease

• Representations of cervical cancer, potential stigma, acceptance of existing services

• Women's preferences as regards screening method (e.g. self-sampling/sampling by a provider for the HPV test, going to a health centre or not)

• Perception of palliative care.

c. Analysing and mapping stakeholders

➡ **Healthcare actors working in cervical cancer management**

• **Key interlocutors/resource people within the Ministry of Health**

• **Public facilities** (at primary and secondary level), methods available and their quality, **referral system** (from community to healthcare services, between healthcare services) **and specifically facilities** using **point-of-care tests** (PCR tests screening for HPV, for example: GeneXpert©, Segeen©, Hologic©)

• Partners involved in **HPV vaccination** (e.g. GAVI), **pain management and palliative care**

• **Private healthcare facilities**, level of care, methods available. These facilities must be classified according to the standard of the services delivered and whether or not these comply with international recommendations for screening and treatment (notably for the smear test)

• **NGO** (national and international, e.g. Jhpiego), civil society organisations and community actors.

➡ **Advocacy including awareness raising**

• **Organisations** bringing together and/or working with people who are particularly vulnerable as regards cervical cancer (e.g. PLHIV, male and female sex workers, etc.)

• **Organisations involved in end-of-life support:** psychosocial and other forms of support

• **Youth organisations** (vaccination issues), women's organisations, media staff, expert societies (midwives, gynaecologists, etc.), legal experts, religious and traditional bodies, etc.

• Be sure to look for/identify associations or groups of **previous cancer sufferers**

• **Identify SRH coalitions or networks** working in family planning or other areas but not on cervical cancer (e.g. technical group).

This stage also enables potential partners for the project to be identified. The existing dynamics between the various actors can be analysed and each actor classified according to their influence and interest.

NB: *Certain information cannot always be collected during the initial diagnosis. It is therefore important to instigate the diagnosis as an ongoing process.*

See MdM tools: To find out more about the methodology for analysing the existing dynamics between actors, refer to the chapter on Diagnosis in the MdM Health Project Planning Guide (p.101)

d. Qualitative methods for data collection

Qualitative methods must be deployed as part of the ongoing diagnosis. Only those elements specific to cervical cancer are set out here.

The following can therefore be organised:

➡ **Observations**, notably in healthcare facilities
- Observing the dispensing of care can be a sensitive matter for both health professionals and patients.
- The focus can be on observing other SRH services for example (with attention paid to respect for confidentiality, gathering informed consent, etc.). These observations can be carried out by MdM staff working with the health facilities (supervisor) once the project is in place.

➡ Individual interviews
- With health professionals, including the health authorities
- With key figures in the community
- With actors from civil society organisations.

➡ Focus groups
- The subject of cervical cancer must be included in a guide for a broader focus group: issues linked to SRH, resource persons, recourse to services, methods chosen and women's preferences, practices implemented at community level, etc.

See MdM Guide: Data-collection: Qualitative Methods

Practical tools
Annexe 1. Cervical cancer diagnosis sheet
Annexe 2. Mapping stakeholders/Care costs

3.

DETERMINING THE SCREENING STRATEGY

I. INTRODUCTION

KEY ACTIVITIES

❑ Analysing the pre-existing care pathway and delegating the tasks in place in the context of the intervention
❑ Establishing the algorithm and care pathway for the project and dividing out the roles and responsibilities
❑ Identifying, mapping and co-ordinating with the actors delivering the treatments and the secondary healthcare facilities for extensive lesions or cases of suspected cancer
❑ Instigating and formalising a referral and counter-referral pathway
❑ Setting up a system for people who are lost to follow-up
❑ Securing a budget heading to cover one-off paid-for treatments.

Demands for treatment cannot always be met on MdM projects, particularly for extensive precancerous lesions or in cases of cancer. It is therefore essential to set up a **referral system** to enable access to care, and this requires networking with the actors who manage and treat precancerous cervical lesions. Once the care and referral pathways are established, details must be given of the places where care is dispensed and how to access these (including information on any financial assistance available and the conditions for securing it if required). Screening must not be set up where there is no access to treatment.

The care pathway must be determined by mapping the different levels of health centres. When doing so, it is crucial to assess the quality of the services provided by visiting the facilities and through regular meetings. This applies equally to private and laboratory-type facilities.

II. OPERATIONAL ASPECTS

The setting up of a cervical cancer screening strategy varies depending on several determinants: age bracket, availability of the type of screening, issues linked to the community regarding how the health system is accessed (for example, rural/urban setting, population of displaced people, etc.).

a. Identifying the target population

➡ In close consultation with the Ministry of Health, the first task in the implementation phase of a cervical cancer project involves identifying the project's target population:

- Establish the age brackets concerned. Bear in mind that **those in the 25- to 29-year-old age bracket can only be screened using a smear test or VIA. The HPV test is not recommended for people younger than 30 years of age.**
- Remember, the WHO recommends screening women at age 35 years and 45 years to have as rapid a significant impact as possible, with a screening frequency of every 10 to 15 years.
- Explore the question of populations at risk, notably **people living with HIV** (who are 6 times more likely to develop a rapidly evolving cancer); screening using the HPV test for this group is conducted from age 25 years and the frequency increases to every 3 to 5 years.

➡ MdM recommends following the reference guides in force at national level in order to adapt to each context and to advocate, where necessary, for changes to norms and directives as a way of making access to care more effective.

b Drawing up the care pathway

➡ **A care pathway must be drawn up based on the existing one** and then formalised. Questions include: What is the pathway? What costs are involved? What are the delays in securing a consultation (and obtaining the results) at each stage? What referral systems are there, which services are available and what mechanisms exist

to support care and treatment at national level or abroad?

➡ From the outset, clarify the issue of professional skills: who can do what? Can a midwife carry out a biopsy? A VIA? As well as dividing up the tasks envisaged by the healthcare system, it is useful to examine whether the providers concerned have been well trained and equipped to conduct these tasks properly.

➡ The care pathway must be put together jointly with the partner stakeholders (such as associations of previous cervical cancer sufferers).

c. Establishing the screening algorithm

➡ The WHO recommendations serve as the basis for selecting the algorithm that is most appropriate or that matches existing resources.

➡ Selection criteria depend on the sampling method, particularly in the case of screening using the HPV test – by self-sampling or sampling by a clinician.

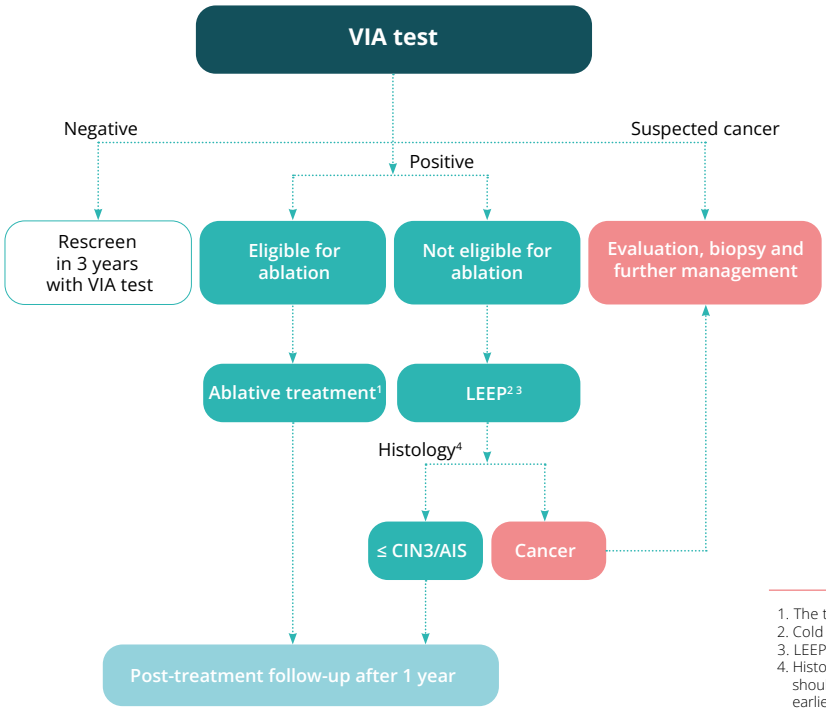
➡ Selection depends on whether the screening strategy is opportunistic or organised.

➡ Selection depends on the screening test.

See Annexe 5: MdM screening algorithm/ Patient pathway

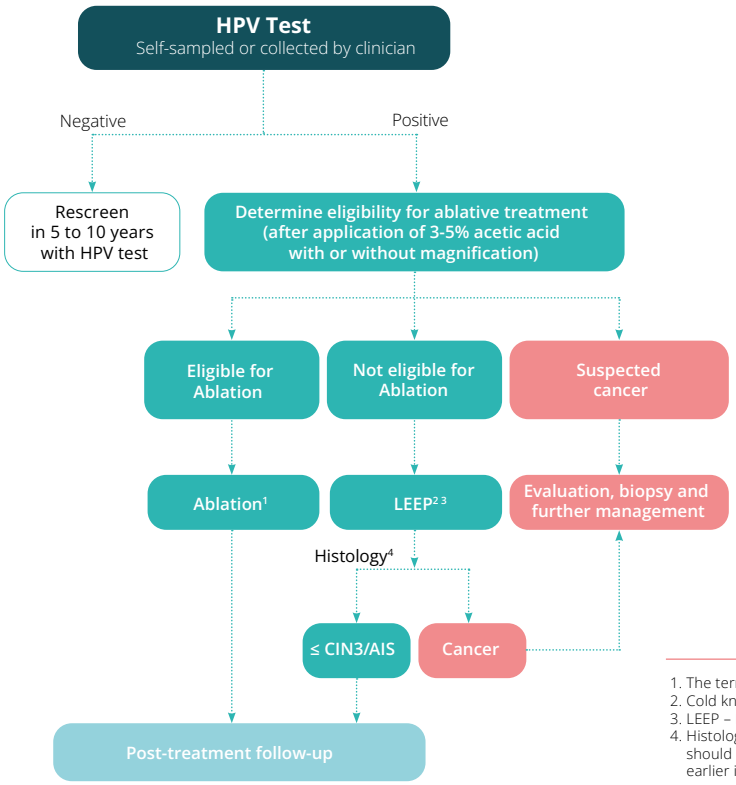
Advocacy: If a difference is observed between the national recommendations and those of the WHO, include the latter in the advocacy strategy.

DIAGRAM 1: SCREENING ALGORITHM, VIA TEST



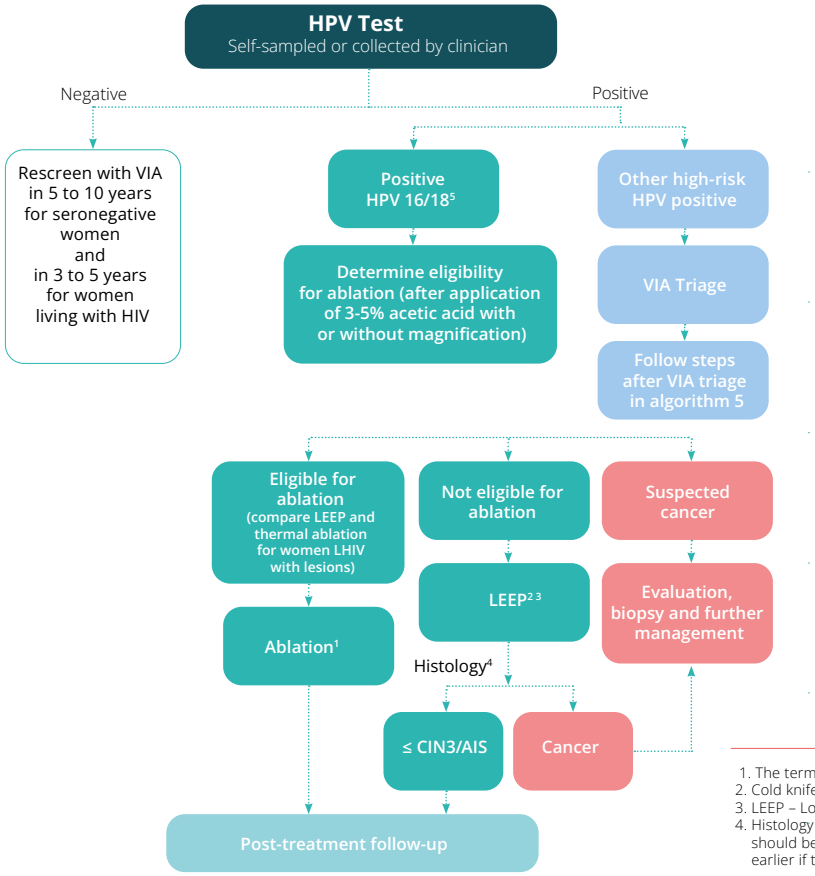
1. The term ablation includes cryotherapy and thermal ablation
2. Cold knife conisation if LEEP not available.
3. LEEP – Loop electrosurgical excision procedure.
4. Histology may not be available in certain settings; women should be advised to attend follow-up after 1 year or to report earlier if they develop any symptoms of cervical cancer.

DIAGRAM 2: SCREENING ALGORITHM, HPV TEST



1. The term ablation includes cryotherapy and thermal ablation.
2. Cold knife conisation if LEEP not available.
3. LEEP – Loop electrosurgical excision procedure.
4. Histology may not be available in certain settings; women should be advised to attend follow-up after 1 year or to report earlier if they develop any symptoms of cervical cancer

DIAGRAM 3: SCREENING ALGORITHM, HPV TEST HPV/DNA TEST



1. The term ablation includes cryotherapy and thermal ablation.
2. Cold knife conisation if LEEP not available.
3. LEEP – Loop electrosurgical excision procedure.
4. Histology may not be available in certain settings; women should be advised to attend follow-up after 1 year or to report earlier if they develop any symptoms of cervical cancer.

d. Specify a system of referral between different actors

➡ **Specify** a system of referral between the different actors involved:
Community-based intermediaries to relay information to health centres for people who are lost to follow-up; **to laboratories for** submitting samples in accordance with the strategy.

- **System for referring** any cases of extensive lesions or of proven cancer **to the referral hospital,** for additional information and therapeutic support.
- **From healthcare facilities to** laboratories to obtain screening results from HPV or VIA tests.

➡ It is important to identify sustainable referral systems.
➡ Note that in many contexts radiotherapy is rarely available and may even be unavailable.

e. Map the actors providing treatment for extensive precancerous cervical lesions or cervical cancer

➡ Identify the **different healthcare actors offering services that would be unavailable in the facilities supported** or put in place by MdM (e.g. LEEP, biopsy, smear test, radiotherapy, chemotherapy).
➡ **Evaluate the quality of the services delivered** by the actors identified to determine which facilities or organisations to direct referrals to. Use bilateral meetings, past experiences, coordination mechanisms, visits, etc. to do so.
➡ The quality of the services evaluated includes respect for confidentiality and ethical principles.
➡ Evaluate access from a geographical and security perspective.

f. Coordinate with actors providing therapeutic care and set up a referral/counter-referral pathway

➡ Meet with **the referral facilities/actors** providing the care and establish the referral procedures with the different actors selected. The procedures must specify the role and responsibility of each actor: draw up and put in place referral sheets, coordination meeting sheets, communication flow charts, counter-referral flow charts, secure data management procedures, etc.
➡ **Train the health professionals in the facilities supported,** as well as potential community partners, in the referral procedures.
➡ **Ensure coordination mechanisms are put in place**, along with visits, etc. The quality of the services evaluated includes respect for confidentiality and ethical principles.
➡ Draw up and put in place **tools for managing and monitoring referrals** to the facilities supported.
➡ When **there is a charge for the referral services, secure a budget heading to cover the one-off cost of treatments.**
➡ Include criteria relating to the quality of the **referral activities during training supervisions within the health facilities supported.**

Practical tools
Annex 5. MdM screening algorithm/ Patient pathway

NOTES

4.

PATIENT PATHWAY AND LOST-TO-FOLLOW-UP PROCEDURE

I. INTRODUCTION

KEY ACTIVITIES

❑ Working with the stakeholders concerned to determine the patient pathway within the facilities supported
❑ Determining the pathway for HPV samples between the consultation services and the laboratories equipped with a point-of-care test
❑ Setting up mechanisms for finding and contacting lost-to-follow-up cases.

Introducing the algorithm proposed by MdM for screening and treating precancerous lesions requires the involvement of different services within health centres. These include consultation services and laboratories.

Setting up the patient pathway and establishing the principle of **'screen, triage and treat' depend on how each centre and its staff are organised, links with the community-based system, the intervention model (opportunistic or organised) and the screening method chosen (VIA/HPV/HPV + VIA/HPV + serotyping).** Consideration must be given to specific points that need careful monitoring in health centres equipped with a laboratory and in those which are not, and to the question of how patients would like to be informed of the results, while ensuring that confidentiality is respected. All service providers and heads of the services concerned must be involved at this stage.

Mechanisms must also be devised and introduced in advance for tracing lost-to-follow-up cases. These must take account of the geographical, cultural or financial barriers specific to each intervention context.

The patient pathway and the search for those lost to follow-up is undertaken together with all **the stakeholders, particularly the people concerned, community workers and nursing staff.** This phase involving drawing up the patient pathway is, moreover, one of the most important elements of the community strategy.

II. OPERATIONAL ASPECTS

a. Reception of and information on the services available

➡ **Train all healthcare facility staff** in cervical cancer and the screening provision put in place. This includes **community workers,** laboratory staff and the service receiving PLHIV.
➡ **Organise information sessions in services frequented by women** (e.g. clinics for infant weighing, vaccinations and family planning).
➡ Raise healthcare facility staff awareness **of the principles of combating negative attitudes** (perception of cervical cancer as an unavoidable, incurable disease, stigmatising of the women affected, etc.).
➡ **Raise the awareness of stakeholders, local civil society organisations (CSOs), peer educators, community relays, etc.**
➡ Raise community awareness (radio spots, flyers, posters, etc.).
➡ Use clear, comprehensible language.
➡ Respect confidentiality.

b. Draw up the patient and the sampling pathways

➡ Draw up a patient pathway **with all the stakeholders** (community health providers, laboratory technician and the women themselves) in order to devise the best pathway for patients that will make it possible to 'screen, triage and treat' and limit those lost to follow-up without generating excessive workloads. At the same time, take account of the capacity of the laboratories to analyse the tests (specify the screening hours and cap the number of tests to ensure they are analysed within an acceptable timescale).

➡ **Identify the location for HPV counselling and sampling** within the health facility and in accordance with its layout (family planning service, dedicated room, etc.).

➡ **Ensure the facilities supported are provided with and medical and non-medical inputs** required for screening (swabs, acetic acid, cotton, dressing forceps, speculum, refrigerator) and for treating (thermal coagulation devices) precancerous lesions.

➡ **Ensure that the layout of the room provides for an enclosed, clean and comfortable space** and that a screen is available for self-sampling (guarantee privacy, equipment and signage for handwashing, sufficient space, etc.).

➡ Arrange **a suitable, comfortable waiting area** where patients can wait to receive their results.

➡ **Pay attention to waiting times for results** and for treatment which ideally should involve short treatment pathways (potentially a factor in lost to follow-up).

➡ **Adapt the patient pathway** as required: for example, the VIA test and thermal coagulation treatment could be carried out as part of an outreach approach, delivered as close to the patient as possible.

➡ **For samples sent to a laboratory outside the testing facility, the pathway, opening hours, methods (e.g. tricycle) and the maximum number of samples that can be sent to the laboratory daily, as well as the methods for returning the test results** to those responsible for providing counselling, must be established. It is important to make inputs available for transporting the swabs – cool box and temperature indicators.

Samples for HPV testing in a dry environment cannot be stored beyond 48 hrs

c. Lost-to-follow-up mechanisms

➡ **Using the patient pathway, identify the risks of lost to follow-up** and reduce these risks by offering alternatives. Also consider all the elements that could reduce the waiting time for results.

For example:

Long waiting times can have a significant impact on the numbers lost to follow-up. Options exist for reducing this time as much as possible such as providing phone credits for contact between the laboratory technician and the midwife to convey the results.

• Studies conducted by MdM as part of cervical cancer projects have shown that women who have been offered the option to choose the sampling method were more likely to complete the screening. The rate is even higher when the patient has chosen self-sampling.

• The research has also shown that the completion rate is 10 times higher when the patient understands the results of the screening.

➡ **Set up a system for tracing lost-to-follow-up cases** and give thought to this prior to the launch of the screening services. Involve the providers concerned and the women in discussion of this in order to understand their preferences, constraints and context.

An example of a mechanism for tracing lost-to-follow-up cases: phone calls or home visits via community workers or relay persons.

➡ **Link up with the different services to trace those lost to follow-up** as a patient may be identified through another service she uses for another health need, e.g. vaccination or weighing.

➡ **Establish a standard definition for lost to follow-up on each programme.**

Once a woman has received a positive result from the screening, the subsequent treatment sometimes has to be deferred or involves a referral. Such situations often result in women being lost to follow-up.

In the absence of global norms for fixing the point at which a woman is no longer complying with a referral or is failing to attend for deferred treatment and can be classed as 'lost to follow-up', the programmes must draw up their own standard definitions. For example, 'lost to follow-up' may be defined as 'a patient who does not attend a scheduled appointment following a referral'; or 'a patient who does not attend for a scheduled treatment after this has been deferred'.

When establishing more robust definitions, accompanying deadlines and a tracing

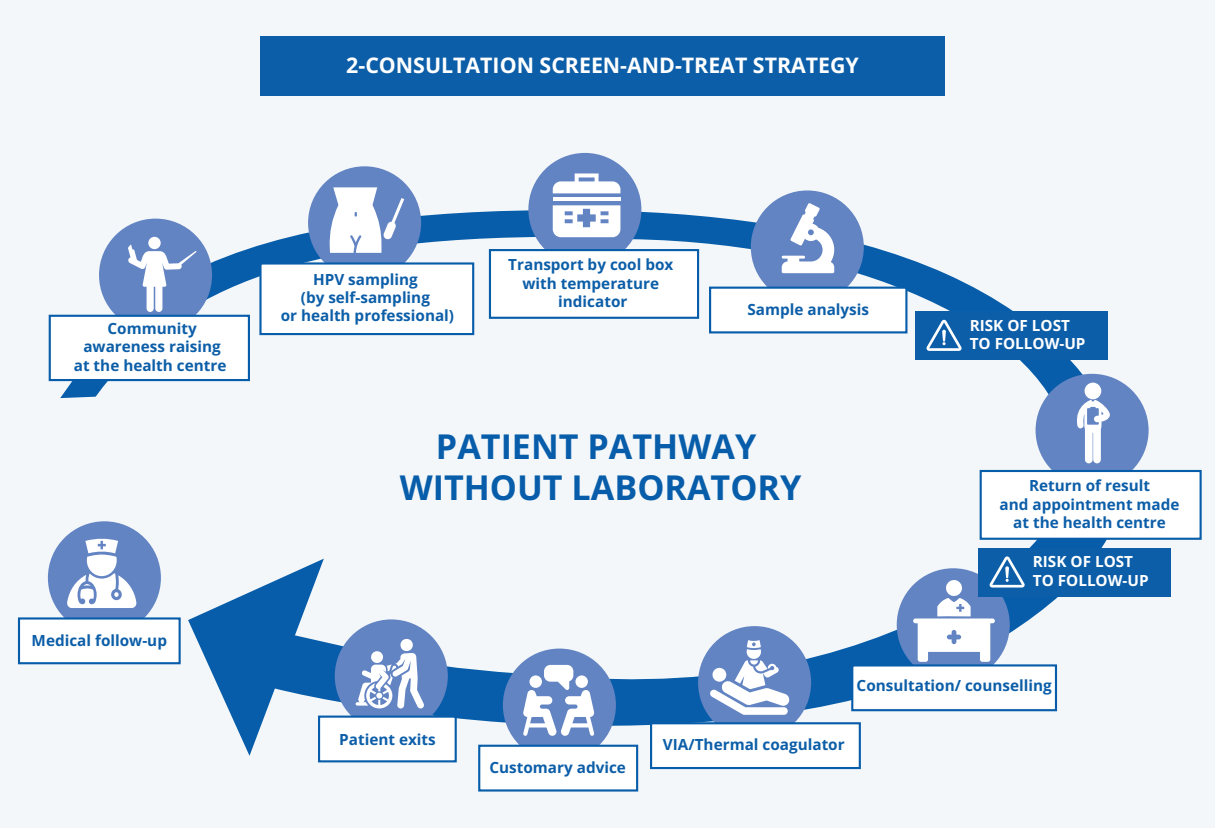
mechanism, the classification 'lost to follow-up' may be attributed to a woman who does not comply as planned with a referral or who does not attend as planned a consultation for treatment in the six months following her screening appointment.

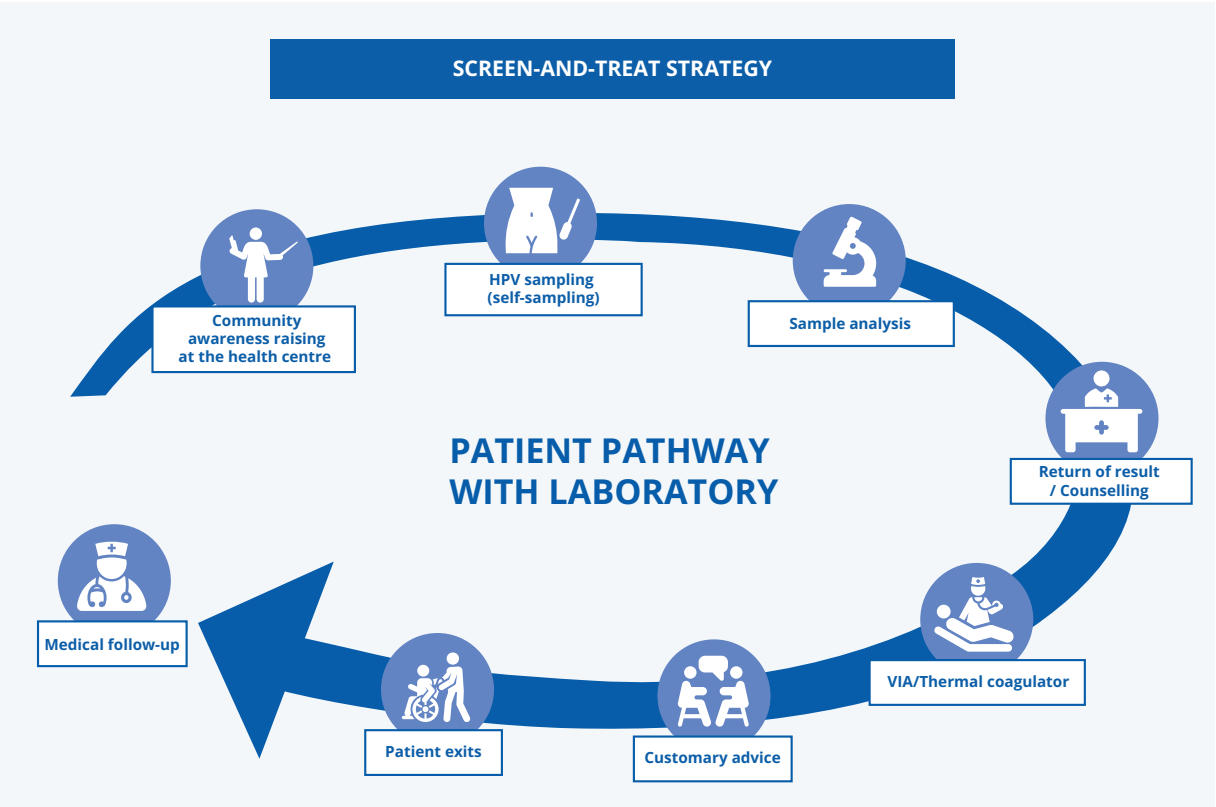
To ensure the quality of the data obtained and of the service provision offered to patients, standard definitions must be drawn up nationally and thus in association with the Ministry of Health.

Practical tools

Annexe 5. Screening algorithm/Patient pathway

EXAMPLE OF PATHWAYS PUT IN PLACE IN BURKINA FASO FOR SCREEN, TRIAGE AND TREAT IN HEALTH CENTRES WITH OR WITHOUT POINT-OF-CARE TEST:





NOTES

5.

MEDICAL MANAGEMENT OF PRECANCEROUS LESIONS

I. INTRODUCTION

KEY ACTIVITIES

❑ Ensuring the availability of necessary inputs for medical management
❑ Training the health professionals within the facilities supported in the protocols for managing precancerous lesions
❑ Guaranteeing the availability of management protocols that meet the relevant national and/or international recommendations
❑ Ensuring that the required inputs and equipment are made available and are of good quality
❑ Training all staff within the facilities supported in ethics and the principle of confidentiality
❑ Setting up a system of referral to complementary services for managing extensive lesions and cancer cases.

Once the intervention strategy, algorithm and patient pathway are established (Sheets 3 and 4), it is important to support how the management is put into practice. Initially this can be carried out by MdM but must be quickly integrated into the package of training and supervision of the healthcare system to ensure the long-term sustainability of the project.

II. OPERATIONAL ASPECTS

The screen-and-treat procedure involves a series of **stages** which guide the health professionals' practice. To ensure that the different stages for managing cases and to guarantee access to good quality care, it is necessary first of all to

➡ Assess **the availability of good quality inputs** including acetic acid and/or Lugol's iodine for VIA/VILI screening. In the case of acetic acid, if necessary it is possible to purchase and use a dilute solution (3% - 5%) of commercial white vinegar.

➡ Ensure the facilities supported are provided with **good quality inputs, medical equipment and consumables** which are needed to screen and treat precancerous lesions in accordance with the level of healthcare facility.

➡ Guarantee **the availability of clear medical protocols** describing the different consultation stages, the different options in terms of methods/procedures and the contraindications for each method. The use of national protocols is to be preferred where these exist once they have been verified as consistent with international recommendations. Where this is not the case, use the WHO protocols adapted to suit the context.

➡ **Train health professionals** to implement the **medical protocols.**

➡ **Train laboratory technicians** to implement the **analysis protocols.**

➡ **Raise health professionals' awareness of active, caring listening** and of communicating in an empathetic, precise, clear and non-judgemental way.

➡ Set up **regular training supervisions** with health professionals to ensure the care dispensed is of a good quality.

➡ Ensure **a system of referral** to secondary healthcare facilities is put in place.

a. Reception

During the consultation, it is important **to explain the cervical cancer screening process and to identify any clinical sign that would lead to cancer being suspected,** particularly in the case of irregular vaginal bleeding. A record is made of the patient's medical history, and a clinical examination plus any additional examinations are carried out during this consultation.

Symptoms appear if the cancer evolves:
• Vaginal bleeding following sexual intercourse,
• Spontaneous vaginal bleeding outside monthly periods,
• Pain during sexual intercourse,
• Vaginal discharge,
• Lower abdominal pains,
• Back pains.

These symptoms are not specific to cervical cancer and may be due to something else. They should not be ignored, however. When they are present, a medical consultation is essential.

➡ **Adopt an active, empathetic listening mode that is attentive and respectful**. Allow the patient to express herself without interruption.
➡ Conduct the consultation in a private place where she can feel secure and at ease.
➡ **Ensure free and informed consent is obtained.**
➡ Ensure a **non-stigmatising** attitude is adopted towards the patient by the health professionals.
➡ Reassure the patient as to the **confidential nature of the consultation.**
➡ Use **clear, understandable and reassuring language.**
➡ Explain how the consultation will proceed.
➡ Ensure that the patient has **fully understood the screening and the different results.**
A good understanding of the screening and the results will ensure the screening is much more comprehensive: there is a greater chance of the person continuing treatment through to the end, and this helps avoid cases being lost to follow-up.

b. HPV-test screening information and general aspects

1. Taking a sample

Screening via HPV testing uses point-of- care tests that produce a PCR result within an hour. Several brands exist so it is advisable to identify which technologies already exist to avoid machines being underused.

Advocacy: MdM recommends paying particular attention to the geographical distribution of machines to limit underuse and enable their redistribution if necessary.

Taking a vaginal sample can be done by the patient herself or by a healthcare provider.
Numerous studies show that there is no difference in the sampling between that carried out by the individual herself and that done by a care provider. Self-sampling is simple, painless, practical and inexpensive and considerably improves adherence to the screening process.
In the case of a sample taken by a healthcare professional, there is no need for a speculum to be used unless the person is presenting symptoms.

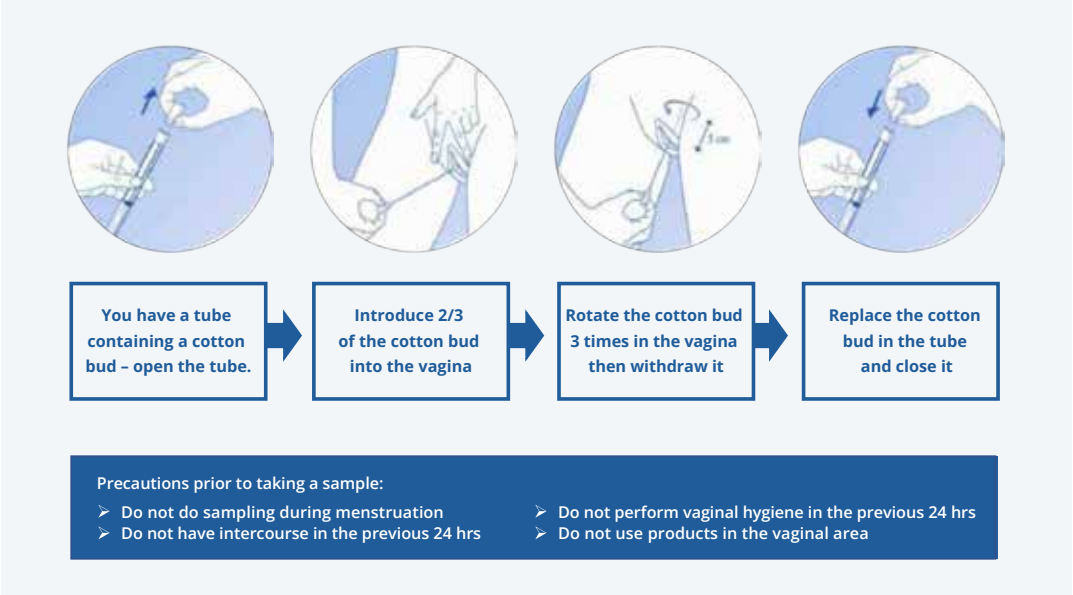
Recommendations to follow before a sample is taken to screen for cervical cancer
1. Avoid the menstrual period: it is recommended that sampling should not be carried out at the time of menstruation unless the vaginal blood flow is minimal.
2. Avoid sexual intercourse the day before: it is advisable not to have unprotected sexual intercourse in the 24 hours preceding the sampling.
3. Avoid vaginal douches: it is preferable not to flush out the vagina in the 24 hours preceding the sampling.
4. Avoid using vaginal products: it is recommended that the use of vaginal products, such as creams or gels, be avoided in the 24 hours preceding the sampling. The use of vaginal products is generally not advised.
Observing these recommendations optimises the quality of the sample taken for cervical cancer screening thus producing more accurate and reliable results.

The test can be carried out during pregnancy, but treatment cannot be dispensed before the 16th week of amenorrhea. This should be discussed with stakeholders as there is a risk of causing the patient anxiety during pregnancy.

These recommendations can be discussed and adapted in the case of female sex workers.

Advocacy: MdM advocates self-sampling and the introduction of screening using the HPV test.

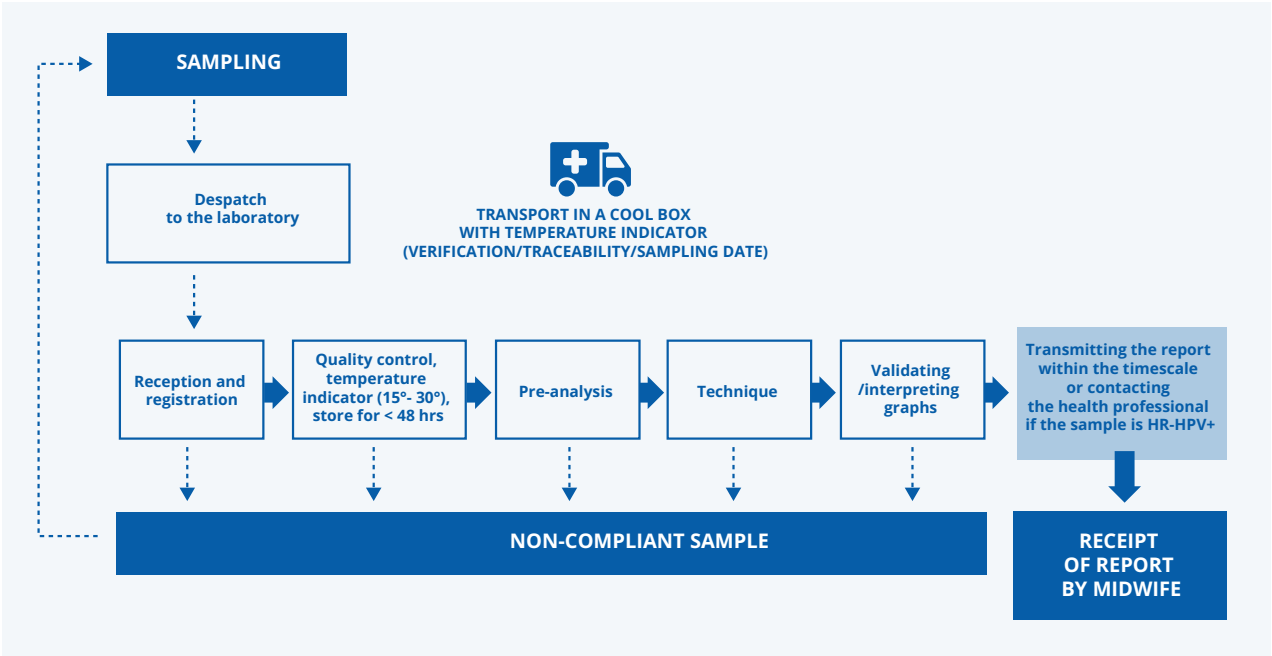
SELF-SAMPLING: INSTRUCTIONS FOR USE



A private space is offered for self-sampling if it is carried out in a health centre, and a notice is provided explaining the methods:

- Partially open the sachet containing the swab.
- Do not touch the cotton tip and do not drop the swab. If the cotton is touched or the swab is dropped, request a fresh sampling kit.
- Remove the swab from the sachet.
- Hold the swab as shown in Figure 1 between thumb and index finger placed at the end of the stick
- With your other hand, separate the labia so that the swab does not touch the external part (cf. Figure 2).
- Gently introduce the swab into the vagina for about 2/3 the length of the stick (cf. Figure 2).
- Gently rotate the swab 3 times for between 10 and 30 seconds. Make sure the swab touches the walls of the vagina so that the moisture is absorbed by the swab (cf. Figure 3).
- Withdraw the swab without touching the skin.
- Immediately place the swab in the carrying tube and close it (cf. Figure 4).

STAGES FOR TRANSPORTING A SAMPLE:



2. Stages for processing the sample

The sample must be transported to the laboratory centre according to the following procedure:

Samples must be placed in plastic sachets: one sachet per patient.

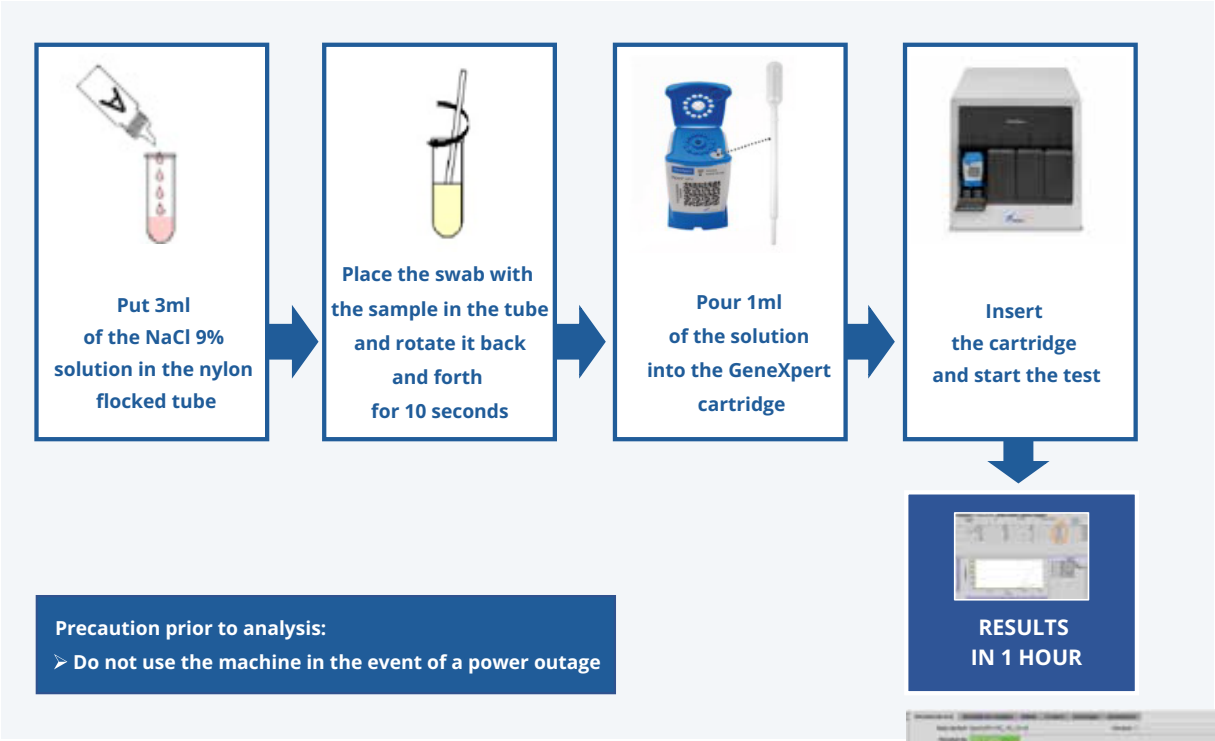
- Fold the analysis order form and put it in the sachet.
- Store the sample in the cool box to keep it a temperature of between 15° and 30° and despatch it to the laboratory with minimum delay (48 hours maximum between sampling and analysis).
- For samples placed with a courier, a transport traceability form is also included showing the time and date of the sampling and of the delivery to the laboratory.
- On receiving the samples, the laboratory technician and the courier verify the traceability, date and time of the sampling and the temperature indicated.
- Information about and the reason for any non-compliance must be provided.

3. Sample analysis

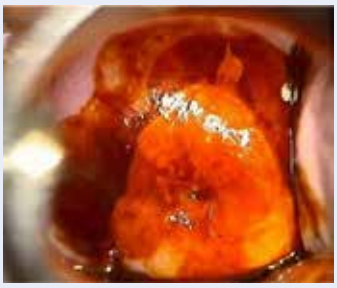
The laboratory technician carries out a pre-analysis in accordance with the following recommendations:
The results are delivered straightforwardly and rapidly (one hour): positive or negative with red and green colour coding. The results provide information on the HPV serotyping (for example, GeneXpert).

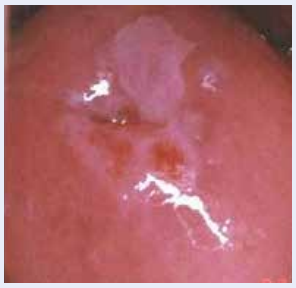
One of the screening strategies recommended by the WHO consists of directly treating people in cases of HPV 16, 18, 31, 33 and 58. No triage examination is involved, but a VIA is conducted as a complementary examination to ensure that the patient is eligible for thermal coagulation. This means that even in cases of a negative VIA the cervix is treated directly. In the case of a VIA showing extensive lesions, the patient is transferred to the referral facility.

SAMPLE ANALYSIS:



TPOSITIVE VIA TEST:





Positive VIA: An opaque, well-defined acetowhite lesion with regular edges can be distinguished on the anterior labium abutting the squamocolumnar junction which is fully visible. Note the fairly ill-defined white area on the posterior labium. The lesion is penetrating the endocervical canal.

c. Information and general aspects concerning VIA or VILI screening

The procedure for VIA and VILI screening is identical but the reaction to the product differs: acetic acid colours the precancerous lesions white and Lugol's iodine colours non-cancerous lesions blue.

The VIA and VILI results are immediately available and do not require the services of a laboratory. How the results are classified depends on the colour changes observed in the area of the cervix. Comprehensive knowledge of the anatomy, physiology and pathologies of the cervix is essential for understanding and interpreting this test.
These tests perform moderately effectively but are inexpensive and can be made more effective by prior screening using the HPV test.
The VIA Atlas[1] is an excellent practical tool.

Procedure
1. Wash your hands.
2. Inspect the external genital parts and examine the urethral orifice to detect any discharge.
3. Insert the speculum fully and gently until resistance is felt and slowly open the blades to reveal the cervix.
4. Once the cervix is fully visible, fix the speculum blades in the open position so that it remains in place and leaves the cervix visible.
5. Adjust the light source to have a good view of the cervix.
6. Inspect the cervix and check for signs of infection (cervicitis) such as a purulent, whiteish discharge (mucopus); ectopy (ectropion); evident tumours or cysts, ulcers or lesions.
7. Use a clean swab to remove any discharge, blood or mucus from the cervix.
8. Identify the cervical orifice and the junction zone that surrounds it.
9. Dip a clean swab in a dilute solution of acetic acid and apply it to the cervix.
10. After washing the cervix with acetic acid, wait at least one minute and observe the cervix to detect acetowhite changes.
11. Carefully inspect the junction. Check to see whether the cervix bleeds easily. Look for any raised and thickened white patches or an acetowhite epithelium.
12. Apply more acetic acid as required or re-swab the cervix to remove any mucus, blood or debris that develops during the inspection and that potentially obscures the view.
13. After completing the visual inspection of the cervix, use a clean, cotton swab to remove all acetic acid from the cervix and vagina.
14. Gently withdraw the speculum:
- If the VIA test is negative, soak the speculum in a 0.5% chlorine solution for 10 minutes to decontaminate.
- If the VIA test is positive and if the patient opts for the treatment, place the speculum on a high level disinfected tray or recipient for re-use during thermal coagulation.

It is helpful to have the VIA Atlas displayed in the consultation room for reading the results.

1 Atlas of visual inspection of the cervix with acetic acid for screening, triage and assessment for treatment (IARC, 2020) : https://screening.iarc.fr/atlasvia.php

Depending on the context, where there is any doubt as to the result of the VIA test, it is preferable to treat the patient.

d. Patient information on the procedure for treating with thermal coagulation

Early detection using targeted screening followed by treatment for precancerous lesions prevents the majority of cases of cervical cancer. Thermal coagulation eliminates precancerous lesions through tissue necrosis. It involves applying a high-temperature probe to the abnormal area. The cervical tissue takes around a month to heal. The indications are identical to those for cryotherapy. The indications are based on a visible lesion that covers at least 75% of the surface with the junction visible.

➡ **Inform the patient** of the speed of the procedure (2 minutes), the absence of pain and the need for anaesthetic.

➡ **Procedure:**

1. Warn the patient that the speculum is going to be inserted and tell her that she might experience some pressure.
2. Gently insert the speculum fully or until resistance is felt and slowly open the blades to view the cervix.
3. When the cervix is fully visible, fix the blades of the speculum in the open position so that it remains in place and keeps the cervix visible.
4. Adjust the light source to be able to see the entire cervix clearly.
5. Use a cotton swab to remove any discharge, blood or mucous from the cervix.
6. Identify the cervical orifice, the junction and the site and size of the lesion.
7. If necessary, apply acetic acid to render the lesion visible.
8. Hold the thermal probe in a plane perpendicular to the cervix.
9. Press the activation button for one minute.
10. Do not forget to apply pressure to the cervix.
11. At the end of the procedure, carefully inspect the cervix to ensure the presence of a white lump.

e. Patient information on post-thermal coagulation follow-up

➡ Indicate to the patient **when she must return to the health centre.**

➡ Prescribe **analgesics.**

➡ Give her advice on how to proceed:

- Self-care at home (paracetamol)
- Do not use a vaginal douche
- Do not use tampons
- **Do not have sexual intercourse** for 1 month (if this is not possible, avoid sex for at least 48 hours and gentle intercourse only)
- Sexual intercourse using condoms for 6 weeks
- Consult in the event of a high temperature, copious bleeding or severe abdominal pain.

f. Managing extensive lesions, suspected cancer or obscured junction

In the case of lesions which are ineligible for thermal coagulation or cryotherapy, the patient is referred to the next level of healthcare for appropriate treatment.

Where the junction is not visible, a smear may be carried out depending on the context, and, in the case of a suspected cancer, a biopsy may be performed.

Biopsy is the sole diagnostic examination capable of confirming whether or not cancer is present.

g. Material resources

Medicines and consumables

- Analgesics
- Compresses/cotton
- Examination gloves
- Acetic acid solution (3% - 5%) or freshly prepared solution. (To prepare the 5% acetic acid solution, add 5ml of ice-cold acetic acid to 95ml of distilled water or use commercial vinegar; check the latter's concentration in acetic acid to make sure it is indeed 5%.)
- A plastic recipient containing a 0.5% chlorine solution to decontaminate the instruments.
- A plastic bucket fitted with a plastic bag for discarding contaminated swabs and other waste.

- A timer
- Thermal coagulation device
- HPV cartridge
- Nylon flocked dry swabs.

Fittings and equipment (ideal situation):

- Room that is private, quiet and accessible and that has handwashing facilities and easy access to toilets
- Examination table
- Light source
- Sterile bivalve speculum (Cusco or Graves)
- Instrument tray or recipient
- Dressing forceps
- In the case of HPV screening: point-of-care test (of the type GeneXpert,Hologic, Seegene, Roche, ...), approved by WHO.

Administrative supplies:

- Consent form
- Medical file
- Register
- Information brochures

It is important **to regularly check the availability of inputs** and equipment required for managing cases in the facilities supported.

Practical tools

Annexe 6. Protocols for preparing VIA and VILI solutions and for decontamination

Annexe 7. Model informed consent form – Form for reporting VIA test results.

NOTES

6.

MANAGING REFERRALS

I. INTRODUCTION

KEY ACTIVITIES

- ❑ **Identifying, mapping and coordinating with the secondary healthcare facilities managing extensive lesions and treating confirmed cases of cancer.**
- ❑ **Setting up and formalising a referral pathway.**
- ❑ **Establishing procedures for maintaining the confidentiality of referrals.**
- ❑ **Securing a budget heading for managing cases where there is a charge for the services.**

The treatment for extensive lesions may be cold knife conisation or loop electrosurgical excision procedure (LEEP). A biopsy is automatically carried out to confirm the diagnosis. Treatment for cervical cancer consists of surgery, radiotherapy and chemotherapy which may be used in combination, with or without the chemotherapy. Palliative care must be put in place as soon as notice is given of the disease and may sometimes represent the only support that can be given, notably in cases of advanced cancers.

The examinations to establish the stage of a cancer can be conducted in higher level facilities or in private facilities.

It is not possible to manage extensive precancerous lesions or confirmed cases of cancer in the context of MdM projects. **It is essential therefore to set up a referral system to allow access to treatment.** This means networking with actors who deal with extensive lesions and cancer cases. These are most often referral centres or private facilities where the latter meet the minimum quality standards. When setting up referral pathways, details must be given of the locations for managing cases and the means of accessing them.

Thus, a referral system must be established by **mapping the healthcare facilities** (notably centres with radiotherapy) **and other actors** (notably for palliative care). This must involve **assessing the quality of the services** delivered (particularly in the case of private facilities) by visiting the facilities and having regular meetings.

It is also advisable to identify secondary healthcare facilities offering LEEP or cold knife conisation **for extensive lesions.**

II. OPERATIONAL ASPECTS

a. Mapping secondary healthcare facilities

➡ Identify the different healthcare actors offering treatments for extensive lesions, such as LEEP and/or cold knife conisation, or, in the case of cancer, surgery, chemotherapy, radiotherapy and palliative care.
➡ Assess **the quality of the services delivered** by the actors identified to determine which facilities and/or organisations patients should be directed to. Do this via bilateral meetings, the experience of clusters or other coordinating mechanisms, visits, etc. A quality assessment also covers respect for confidentiality and ethical principles (cf. Annexe 3: Healthcare facility evaluation sheet).
➡ In situations where no facilities provide radiotherapy, referrals to another country may be envisaged.
➡ Establish **a pain management protocol** if none exists.
➡ If the project allows, it is a good idea to set up self-support groups.

b. Coordinating with actors on medical management and setting up a referral pathway

➡ Meet with referral facilities and actors and establish **referral procedures with** the various actors selected.
➡ It is important to identify a resource person to coordinate care and the referral pathway so as not to waste time in securing treatment.
➡ **Train** the health professionals in the facilities supported and potential community partners in the referral procedures as well as in pain

management and end-of-life support.

➡ Draw up and introduce **tools for managing and tracking referrals and counter-referrals in** the facilities supported.

➡ When there is a charge for the services providedby the referral health centres, **secure a budget heading** for the treatment.

➡ Include criteria relating to the quality of the referral activities during **training supervisions** in the healthcare facilities supported.

NOTES

7.

STRENGTHENING CAPACITIES

I. INTRODUCTION

KEY ACTIVITIES

❑ Determining everyone's role and scope of activity particularly for the provision of new services (for example, if the HPV test is introduced).
❑ Training the nursing staff in the facilities supported in counselling methods and key messages for pre- and post-testing, in medical protocols and screening and treatment algorithms and in technical aspects of screening and treatment.
❑ Training operational staff in how to use the approved protocols.
❑ Conducting regular supervisions of the facilities supported to ensure the quality of the care dispensed.
❑ Raising the awareness of all staff of the MdM concept of confidentiality, of how to notify results and delivering comprehensive care for confirmed cases of cancer.

Quality is a crucial factor in setting up MdM programmes. Service providers must be supported at every level to guarantee the quality of the counselling, screening and treatment services put in place. This support can take different, complementary forms **from training to supervision, the latter also being conducted using a training approach.**

To guarantee the level of quality over the long term and in a sustainable way, the training and supervision activities **must** involve and bring together the people responsible for the quality of care at the different levels: from the departmental or centre head at the Ministry of Health at central level to the decentralised (district, regional, etc.) management teams. **This entails establishing a framework for close dialogue with the health authorities at central and decentralised level**, and a process for exchanging ideas and co-constructing frameworks, training and supervision tools with a view to integrating them into the public health system.

II. OPERATIONAL ASPECTS

a. Training

➡ Train **MdM operational staff** in the common core of operations.
➡ **Identify the type of training to be adapted in keeping with the profiles of the individuals** to be trained: community workers, civil society organisations, health workers, clinical supervisors, laboratory technicians and management teams (at different levels of the healthcare system, e.g. district health managers, regional management teams and central health directorate).
➡ **Discuss with the health authorities how to create the training and integration plan jointly.**
➡ Adapt the training plan **to how the tasks in place are delegated within the intervention context.**
➡ The different types of training to adapt in accordance with the context:

- General aspects of cervical cancer
- VIA/ VILI
- Screening, counselling, HPV testing and thermal coagulation
- Using PCR point-of-care tests (of the type GeneXpert, Hologic, Roche, Abott, etc.): this training can be carried out by the provider
- Palliative care
- Waste management
- Supervisor training (service heads and centre managers)

Some of these modules need to **be put into practice.**
➡ Where necessary and as the opportunity arises, **it may be helpful to call on other actors**, such as JHPiego or CHAI (Clinton Health Access Initiative), to organise practical workshops for the VIA tests.
➡ Working with **the Ministries of Health, consider how they are to be involved in organising and facilitating training sessions** and envisage setting up pools of trainers at national level (by organising a training-the-trainers course). This stage encompasses key issues in terms of taking ownership, consolidating the healthcare system and ensuring long-term

sustainability.

➡ Organise training sessions **as the services are gradually integrated into the facilities supported,** and from the arrival of the equipment (to avoid the risk of learning being forgotten between the time of training and the moment the equipment is delivered).

➡ Limit the number of participants to 20-25 per training session.

➡ Adapt the duration of the training and the practicalities of organising sessions to the constraints and needs of the participants (number of days, times, geographical aspects of the organisation, etc.) and **be particularly careful not to disrupt the running of the services during periods of training.**

➡ In addition to the initial training plan, draw up **the follow-up plan** (refresher sessions, active supervision, continuous strengthening of capacities) being sure to tailor it to individuals.

➡ Set up **regular meetings in the field for exchanges and sharing experiences** between the different people involved in the activities facilitated by the medical or the programme coordinator.

See MdM tool: Training kit on cervical cancer, accessible here (participant handbook) and here (trainer's handbook).

b. Monitoring human resources

➡ **Establish a clear process for organised daily monitoring** by MdM supervisors:

- Preparation: Identify tasks for the day, plan a review of the day's screenings, check tools are complete, directly observe service provision (counselling checklist used to assess the quality of the consultations),
- Activities in the field: Carry out these tasks, assess performance, collect data and provide service providers with feedback,
- On returning to the office: Conduct debriefing with the project head, share the day's experiences and formulate suggestions and recommendations.

➡ **Involve supervised and supervisory actors** (e.g. district management teams) in designing the supervision checklist (criteria and elements supervised and scoring criteria).

➡ **Train and support heads of services and centres in MdM supervision methods and approaches.**

➡ **Put in place methods for coaching between health service workers (e.g. a focal point within the service who could support colleagues if required).**

Practical tools
Annexe 9. Supervision checklist

NOTES

8. LOGISTICS

I. INTRODUCTION

KEY ACTIVITIES

❑ Setting up the processes for procuring equipment and materials, from needs analysis to reception of these.
❑ Setting up the processes for procuring medical and non-medical inputs, from needs analysis to reception of these.
❑ Analysing the needs for refurbishment and proceed with the necessary work (laboratory, consultation rooms and any other potential needs on the patient pathway).
❑ Ensuring data-collection tools are reproduced.

Logistics play a central role on projects to prevent and treat precancerous cervical lesions. Several specific technical and logistical aspects lie at the heart of a cervical cancer project, due particularly to the use of **special technical equipment** (point-of-care PCR test for HPV testing and thermal coagulation for treating precancerous lesions) which requires purchasing procedures to be monitored and refurbishment work and maintenance activities to be carried out.
Other logistical issues which are more common to all health projects must also be considered for the project to succeed: purchasing of medical and non-medical inputs, refurbishment, reproduction of tools, etc.

➡ To make these activities easier to carry out, it is important to involve the logistics team closely in the project from the design stage and **to maintain a context of close collaboration with the project team.**
➡ Different types of point-of-care testing equipment exist in many intervention countries as they are used for other forms of prevention, notably for tuberculosis, HIV, hepatitis B and COVID. It is important **that equipment be pooled before any purchase is made.**
➡ In so far as is possible, it is recommended to work with the country's **procurement system** to ensure that MdM actions are sustainable over the long term or are organisationally feasible.
Buffer stocks can be made available to avoid the project being delayed; this depends on the country's legislation. It is also possible to have a pharmacist on the team to carry out stock management and monitoring.

See Sheet 2: Diagnosis: Identifying existing resources
See Sheet 5: Medical management of precancerous lesions

II. OPERATIONAL ASPECTS

An assessment of local medical suppliers is strongly recommended: if approved, it means purchases at national level can go ahead and thus potentially reduce delivery waiting times.

a. Ordering

➡ Orders – for medical and non-medical inputs - must without fail be drawn up by the **logistics team and the medical team** working together.
Orders concern:
• Non-medical materials and inputs
• Medicines - the list must be adapted in accordance with national medicine lists.
➡ A clear purchasing plan, detailing deadlines and clarifying everyone's roles and responsibilities, must be established by the team in advance and in collaboration, and must be accompanied by a logistics timetable.
➡ Orders **must be anticipated and properly estimated to avoid any stockouts or financial losses.** Stock management sheets must be put in place, particularly for monitoring the cartridges as these have short expiry dates.
➡ For **point-of-care tests,** if it is not possible to obtain them from existing resources, it is important to discuss and identify with the Ministry of Health the most useful equipment. Several brands exist (Hologic, Seegene, GeneXpert, Roche) and this has a potential impact on the price of cartridges. This equipment can carry out between 4 and 16 tests at a time depending on the model. Preference is given to **large models for organised interventions** and **small models (4 modules) for opportunistic interventions.**

When equipment is being procured, be sure to consider all options as regards the recipient of the donated equipment. The consequences of the decision must be considered, particularly as regards who will be responsible for its maintenance and management, as well as the possibilities for redistributing it to other health centres in another geographical area (so as to improve geographical distribution).

b. Refurbishing

Attention should be paid to several specific points when evaluating the healthcare facility:

➡ Existence or otherwise of a laboratory service: **as point-of-care tests are sensitive to dust, temperature and brief power outages, it is important to ensure that the location is properly adapted**: Provide for the purchase of an air-conditioning system, a room thermometer for checking and an inverter for brief power outages and adapt the room to avoid dust. Provide for storage space for samples (refrigerator) and cartridges (cupboard).

➡ Consultation room: A room available for organising cervical cancer activities – **privacy, confidentiality and space for self-sampling.**

➡ Waste processing and management:

- General aspects: **Sorting contaminated waste**
- Specific aspects: **Assessing options for incineration** (De Montfort type of incinerator) and adapting to the context

➡ Water and sanitation: Presence of water in the laboratories and consultation rooms, handwashing and **universal precautions.**

➡ Sterilisation: Its presence or otherwise will determine the type of speculum to order.

➡ Electricity: Generator, solar panel or other mechanism in the event of a power cut; check capacity in terms of amperage.

c. Maintaining specific equipment

➡ When ordering point-of-care tests, it is important to **discuss with the supplier:**

- After-sales service provision and particularly guarantees and extended guarantees. Note that guarantees often begin from the date a purchase is confirmed and not from the date the equipment is received. Bear in mind that the guarantee is an extra charge.
- Training on how to use the machine.

Clearly laboratory protocols sometimes do not allow for adequate installation in intervention countries where indirect costs are often high. In such cases, certain protocols may be adapted in accordance with updated studies and current knowledge in consultation with the Ministry of Health.

➡ Partnerships can be developed with other facilities present in order to gain proficiency in how to use and maintain point-of-care tests and to have support with annual maintenance (such as is the case with national cancer/tuberculosis/AIDS care plans).

➡ Likewise, provision must be made for maintaining thermal coagulation equipment.

d. Managing waste

➡ Devise a mechanism for **managing cartridges**. These contain radioactive elements and so an appropriate incinerator is required. If this cannot be done on site, a partnership can be set up with a facility or institution with the required equipment for dealing with the cartridges.

➡ **Ensure a functioning incinerator is available** for disposing of other waste – needles, speculums, etc.

Practical tools
Annexe 3. Healthcare facility evaluation sheet

NOTES

9. COMMUNITY STRATEGIES AND ACTIVITIES, PARTNERSHIPS AND ADVOCACY

I. INTRODUCTION

This sheet summarises the key elements concerning advocacy and community partnerships. These elements have already been set out in the previous sheets but issues of partnership, community participation and advocacy must be considered at every stage of implementing the project.

II. IDENTIFYING PARTNERS

KEY ACTIVITIES

❑ Identifying and selecting: Mapping and diagnosing partners
❑ Determining the partnership's principles
❑ Analysing the powers of institutional partners
❑ Analysing stakeholders
❑ Producing advocacy and community mobilisation strategies
❑ Clarifying partners' roles and responsibilities
❑ Planning resources
❑ Setting out coordinating mechanisms and the framework for dialogue
❑ Drafting and signing partnership agreements.

The partnership approach is at the heart of the MdM vision. Although a partnership can be forged at different stages of a project, it is often preferable to establish it from the outset for a better understanding of the roles and objectives of each party. In the specific case of a cervical cancer project, partners can play a role in the medical component – public and potentially private non-profit health facilities – and equally in the community and advocacy components.

When drawing up partnerships, it is essential to take account of the (medical, community and advocacy) intervention strategies. These should not be put on hold, however, prior to the partnerships being established. On the contrary, this work should be carried out in parallel to ensure that partners are involved in the design and programming phases.

Partners are initially identified based on the context analysis: preexisting dynamics and initiatives must be known in order to identify the demand for potential partnerships and/or the options for complementary working.

To find out more, consult the MdM Health Project Planning Guide (Chapter 1 Diagnosis, 1.1.C The Partnership Issue)

Operational aspects

1. Identifying and selecting partners

See Sheet 5: Medical management of precancerous lesions

➡ The context analysis and diagnosis phase enable **potential partners for the new cervical cancer project to be mapped.** However, work to identify partners must include consideration of **those MdM partners who are already involved** in other projects (particularly SRH ones) and who could play a role in the new project.
➡ **The work to identify and select partners does not require specific tools,** and it is recommended that use be made of those already in place within MdM (e.g. analysis of stakeholders, analysis of dynamic actors, etc.).
➡ Bear in mind that **potential partners** include
- Civil society organisations, advocacy and awareness-raising actors (with a variety of profiles)
- Organisations that bring together and/or work with people who are particularly vulnerable to cervical cancer (e.g. PLHIV and female sex workers)
- Organisations involved in end-of-life services – psychosocial and other forms of support
- Associations of patients affected by cervical cancer
- Youth organisations (vaccination issues), women's organisations, media professional bodies, expert societies (midwives, gynaecologists, etc.), legal experts, religious and traditional bodies, etc.

➡ **Be sure to look for** and identify associations or groups **of former patients.**
➡ **Identify reproductive health coalitions or**

networks working in family planning or another area but without cervical cancer (e.g. technical group).

On cervical cancer projects, groups, associations or coalitions for PLHIV can provide an effective entry point for leading community mobilisation and advocacy actions. Similarly, associations of female sex workers may be identified for both project components given their exposure to the risks of HPV infection and the particular issues they face with accessing healthcare.

2. Partnerships and developing strategies

➡ **Partnerships are put in place during the programming phase** in parallel with the development of intervention strategies. The latter comprise:

- The implementation strategy
- The community mobilisation strategy
- The advocacy strategy

➡ These strategies must be developed in parallel and drawing them up requires **a participatory process that involves the partners.**

➡ **Document the process of drawing up the strategies**: How much time has it taken? Who was involved and/or consulted? How? This documentation facilitates the smooth implementation of the project and continuity in the event of staff turnover in the field or head office teams. When conducted in parallel with producing the strategies, this process also serves to ensure a participatory approach is maintained.

3. Apportioning roles and responsibilities

➡ **MdM recommends a targeted approach to assigning responsibility:** It is essential to clarify what the CSOs can do, their capacities (e.g. in advocacy and/or awareness raising) and make provision for the means to support them.
➡ **Consider the involvement of the logistics and administrative services in managing partnerships**: Note that they all have their place. In particular, it is important to envisage these services providing partners with support with logistical and administrative issues and the procedures to comply with.

See MdM tools:
Guide: How to conduct advocacy
Guide: Working with Communities

Practical tools
Annexe 2. Mapping stakeholders/Care costs

III. COMMUNITY MOBILISATION

KEY ACTIVITIES

❑ Drawing up the project's community strategy
❑ Identifying and mobilising key community actors in cervical cancer prevention: women's groups, PLHIV organisations, associations of male and female sex workers or other at-risk groups, community leaders, community relays, etc.
❑ Mobilising/supporting community relays or existing community-based organisations to provide information on the existence of services (including preparing capacity-building plans and partnership agreements)
❑ Involving community actors in the development and dissemination of messages on the availability of services
❑ Raising the awareness of communities, and particularly women from the target population, and informing them of sexual and reproductive rights and cervical cancer
❑ Strengthening the capacities of community actors to act
❑ Setting up an accountability framework between the project and the communities.

A **community strategy** must be established to ensure that the target population knows of and uses the new service provision. This enables work to be carried out with communities to draft and circulate messages on prevention, on the services available (screening, treatment for precancerous lesions, other services in suspected cases of cancer and mechanisms for referring and managing cases, etc.) and on the fight to combat the stigmatisation of women affected by cervical cancer.

These messages are addressed at different target groups of the public (women from the target population, groups of particularly vulnerable women, men and boys, community leaders, etc.), and **the participation of community actors representing these different groups must be assured.**

Operational aspects

1. Drawing up the community strategy

➡ Work on drawing up the community strategy must start alongside that of producing the implementation strategy or the advocacy strategy. **These areas of work are undertaken in parallel and develop together to ensure the actions taken are relevant and consistent.**

➡ The community strategy draws on different information sources:

- **A review of the literature available on cervical cancer**, the barriers or levers regarding access to screening and treatment and **existing socio-anthropological research that is appropriate for the context.**
- **Workshops for discussion involving partners and key actors** at community level.
- **Exchanges, focus groups or individual interviews with members of the community,** providing information in addition to that gathered from the literature review or workshops and enabling the points of view, needs and interests of different groups of people, including those who are most vulnerable to cervical cancer, to be collected.

2. Drafting awareness-raising messages

➡ The messages must always **be drafted in close collaboration with a range of community actors** so that they are adapted to the context and the different target groups and employ the elements of language that are appropriate to each context.

➡ Depending on the context**, social networks and media** may be considered for conveying key messages on cervical cancer.

3. Strengthening the capacities of communities to act

➡ The community strategy must feature a component on **strengthening the capacities of the community actors involved**. Capacity-building plans that are adapted to the specific needs of each actor must be drafted jointly with the partners.

➡ As a minimum, capacity-building plans include **core training on cervical cancer**, which in turn instigates a system of cascade training whereby those who have become trainers deliver training

DIAGRAM: THE COMPONENTS OF THE COMMUNITY APPROACH ON A CERVICAL CANCER

to other CSO heads or representatives.

➡ As well as focusing on partner CSOs, **the community strategies must incorporate the empowerment approach advocated by Médecins du Monde.** This means giving thought in advance as to how MdM actions as part of the community component will contribute to strengthening the individual and collective capacities to act of the people at whom the messaging is addressed.

➡ Community activities and **community support or referral mechanisms are often already in place** before a cervical cancer programme is set up. It is important to take these into account and to strengthen them rather than to substitute new, less sustainable mechanisms for them.

➡ Existing actors include **some health systems which have introduced national community health strategies.** They make provision for community health workers or community relays whom communities can turn to for health information and education. As the project aims to collaborate with workers at community level, consideration must be given to those workers already in place, and strengthening their capacities must be discussed together with the health authorities.

➡ As well as raising the awareness of communities and informing them of the existence of these services, it is also useful to consider the specific issues faced by women suffering from cervical cancer at community level: are they stigmatised? How can the project work with communities to **combat their stigmatisation? Do community and family support mechanisms exist?** What are they (e.g. associations of women with cervical cancer, support groups, etc.)?

Practical tools
Annexe 10. Community mobilisation / Key messages checklist

IV. ADVOCACY

KEY ACTIVITIES

❑ Analysing the institutional, legal and sociocultural environment and how the health systems function with regard to cervical cancer-related issues
❑ Mapping and analysing stakeholders
❑ Creating or strengthening alliances/ coalitions
❑ Setting up activities to strengthen capacities for civil society partners in accordance with identified needs
❑ Establishing the coordination mechanisms and the framework for dialogue
❑ Drafting advocacy messages concerning the different barriers to access identified and analysing the environment.

The fight against cervical cancer, unlike other areas of SRHR in which MdM works (such as preventing and responding to gender-based violence or access to abortion), is not often a subject of tension based on religious or cultural values. Aside from some people who oppose HPV vaccination based on religious arguments, **it is rare to encounter anyone opposed to cervical cancer prevention, screening and treatment.**

In contrast, a whole range of barriers may be encountered by women in accessing services: their unavailability or the poor quality of care, financial and geographical barriers, etc. **These barriers must be identified so that relevant advocacy strategies can be developed for each context.** The advocacy developed at local and/or national level via a cervical cancer programme can both target specific objectives for a given context - such as requesting that tasks relating to conducting biopsies be delegated to midwives - and can also contribute to broader advocacy at a global level, for example asking for the cost of GeneXpert cartridges to be reduced or encouraging the development of screening protocols and algorithms.

Thus, the advocacy conducted as part of the project reinforces the impact of the intervention over the longer term **by seeking to transform**

good practice into sustainable policies (e.g. scaling up the pilot project and institutionalising the screening algorithm proposed).

Cervical cancer advocacy is aimed at generating sustainable change which could involve:
• **The adoption of new policies and/or practices** leading to improvements in access to screening and treatment for cervical cancer, and to HPV vaccination.
• **The questioning, reviewing or amendment of existing policies and/or practices** that have a negative impact on access to cervical cancer prevention.
• **Respect for existing policies and legislation** on access to cervical cancer prevention which are currently not applied.
A **clear and comprehensive reading of the political and legal environment** is necessary for this to be achieved.

Operational aspects

A series of **indispensable stages** must be completed when implementing advocacy activities. For an advocacy strategy to develop successfully, it is first necessary to:

➡ Analyse **the political and legal environment.** Are there legal or judicial barriers to access to care – vaccination, screening, treatment or palliative care? If yes, at what level? For which groups among the general public? For example, some people who are particularly vulnerable to cervical cancer may be subjected to legal discrimination in trying to access care.

➡ **Analyse the health system to identify** the different barriers:
- **Financial**, such as a scale of charges for services, the absence or inadequacy of mechanisms for managing and supporting patients
- **Geographical,** such as the unavailability or limited availability of services in certain areas, the absence of referral mechanisms or the existence of overly rigid accessibility conditions
- **Administrative,** linked to the quality of the services – poor quality or inadequate service provision; in this case it is important to drill down into the causes of the poor quality which may be linked to insufficient financial, material or human resources, a lack of human resources training, non-existent or limited supervision mechanisms, etc.
- **Sociocultural –** Do other barriers, namely social, cultural or religious ones, exist that woman – or certain groups of women, for example women living with HIV – have to face in accessing services?

As the project is gradually put in place and implemented, new barriers and advocacy objectives may be identified on the basis of practical experience. For example, in Burkina Faso, issues linked to delegating tasks to midwives, or the cost of cartridges, were identified as services were being implemented. The advocacy strategy must continue to evolve to incorporate such issues and to seize opportunities for new forms of advocacy that are relevant to the context.

Drafting the advocacy strategy must involve **all the project's stakeholders – MdM project and medical teams, public partners, partner CSOs and communities.**

➡ Analysing **stakeholders and parties wielding power**
- **Stakeholders**: Identify the individuals or groups who have an interest linked to the advocacy, the allies and the opponents, and prioritise those to target
- **Parties holding power**: Understand how each stakeholder is involved in the decision-making process and establish their capacity to influence the final outcome. This helps identify which people to target and when.

1. Identifying the targets

This means **everyone who intervenes** in the decision-making process that is required to produce the desired outcome. Each of these targets holds a different degree of power:
• **Primary targets**: These are the decision-makers with direct responsibility for approving the desired change. These are the actors whom it is crucial to convince to have any chance of attaining the

advocacy objective,

• **Secondary targets**: These individuals or groups possess a certain power to influence the primary targets.

The targets identified must be people and not institutions.

2. Building alliances

Working in partnership with local organisations is **at the heart of how MdM approaches a project.** Efforts to influence decision-makers are much more effective if supported by civil society organisations.

➡ Based on the analysis of stakeholders, **identify potential partners** for implementing the advocacy strategy.

➡ Form **strong partnerships** with other groups and/or organisations, particularly national ones.

➡ Become actively involved **in existing sexual and reproductive health coalitions**.

3. Drafting advocacy messages

Advocacy messages must be **focused on action and adapted to each target**. In the case of cervical cancer, the messages developed as part of projects **must** be derived from **the organisation's global messaging,** namely respecting a public health approach founded on human rights, in this case ownership of one's own body and autonomy, and developing programmes based on reducing gender inequalities.

• Messages on cervical cancer must be **factual, clear, concise,** and non-judgemental.

• Do not use language or images likely to **stigmatise.**

• Provide **detailed references and resources.**

Note that solid, high quality expertise must be established. This expertise **relies in part on the experience and knowledge acquired on MdM projects.** The activities conducted in the field feed into the advocacy and, conversely, the advocacy reinforces the impact of the intervention.

4. Implementing the advocacy

Lobbying

➡ Enter into **direct contact** with the decision-makers targeted to **set out your intentions, inform them of the desired changes and seek to convince them.** (Do so through informal meetings with the decision-makers, by circulating position papers and advocacy reports, by sending lobbying letters and organising field visits for decision-makers.)

It is recommended **that provision be made in the budget for financially supporting certain actions at Ministry of Health level**: actions are often not undertaken due to a lack of resources rather than a lack of political will. Thus, support for this type of action helps strengthen the bond of trust between MdM and the partner health authorities.

Working with the (traditional and social) media

➡ **Inform and raise the awareness of the general public** of the issue of cervical cancer – press releases, newspaper columns, press kits, etc. – public posters, website and TV/radio spots.

Mobilising public opinion

➡ **Use the support of public opinion to influence** decision-makers indirectly, reinforce messages and reveal the importance of the cervical cancer problem – demonstrations, petitions, social media campaigns, etc.

➡ In the event the desired policy change is achieved, significant public support will facilitate the changes in practice that ought to follow.

For more information on advocacy at MdM:

See the booklet: What is advocacy at Médecins du Monde?

Practical tools

Annexe 1. Cervical cancer diagnosis checklist

Annexe 2. Mapping stakeholders/Care costs

Annexe 10. Community mobilisation/Key messages checklist

Annexe 11. MdM cervical cancer advocacy factsheet

NOTES

10.

MONITORING AND EVALUATION

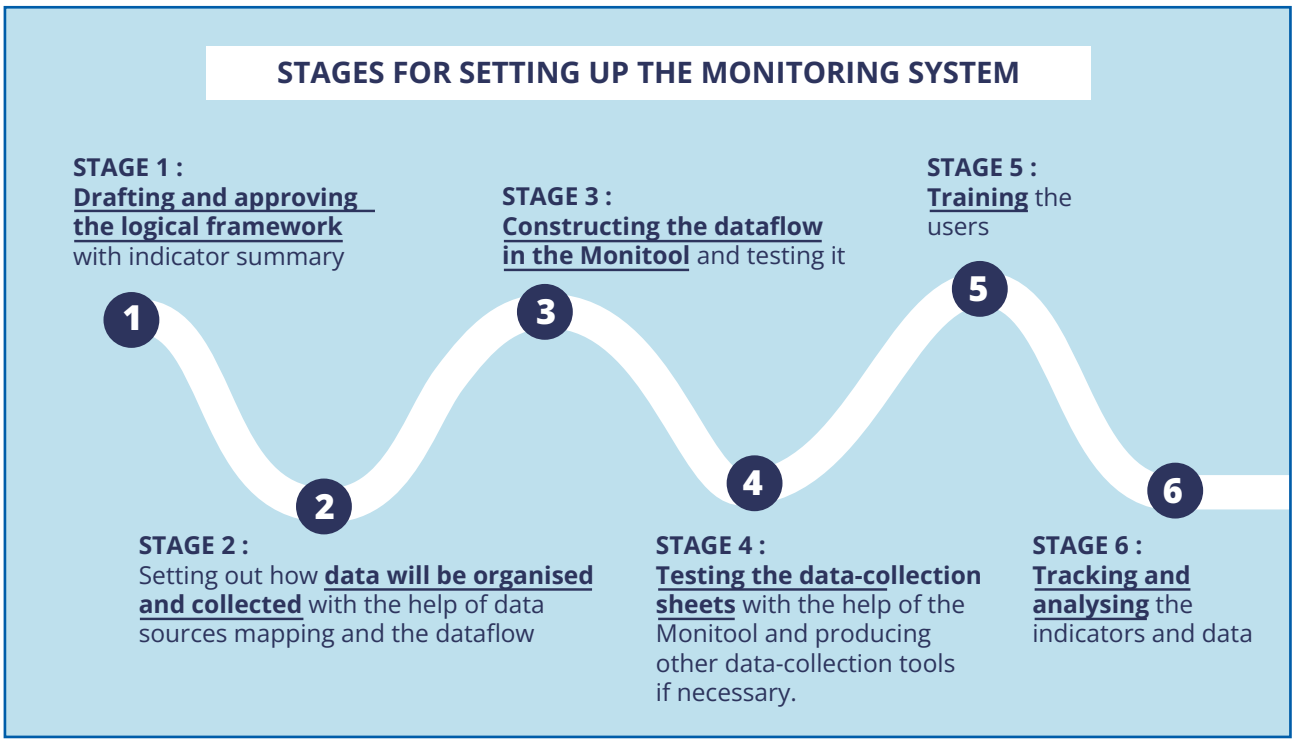
I. INTRODUCTION

KEY ACTIVITIES

❑ Drawing up the project and approving the logframe
❑ Drafting the essential monitoring tools: indicator summary, mapping of data sources, dataflow, data-collection plan
❑ Monitoring and analysing the data
❑ Training users
❑ Setting up an accountability framework with the health system.

Putting the monitoring system in place is an integral part of the project programming phase. **A good monitoring system enables the consistency and relevance of the entire project to be checked** (particularly at the stage when the logframe is drafted and approved) and ensures that the project is being implemented in line with initial planning, measures how the programme is developing quantitatively and qualitatively and feeds into discussions on the intervention strategies.

The system is established **progressively and comprises the key stages shown below**. Each stage must be monitored and observed to ensure that a satisfactory system is put in place and to guarantee the quality of the data.



II. OPERATIONAL ASPECTS

a. Identifying the indicators and the monitoring plan/manual

➡ The SRHR catalogue of indicators, including the cervical cancer indicators, is available to facilitate identification of the indicators.
➡ It is essential to **involve the health authorities** in identifying the project's indicators to ensure the system is consistent with the national system (NHIS) and to avoid duplicating data inputs. It is also another way to integrate the MdM intervention into the health centres' package of provision and, consequently, a means for state actors to take ownership of the activities. The indicators can be of several different sorts – tracking, performance or quality. Some examples of basic indicators for eliminating cervical cancer are:

- **Performance:**
  Rate of coverage of screening: Number of women screened/Number of women eligible in the area x 100
- **Quality:**
  > Positivity rate: Number of HPV+ and VIA/VILI+ women/Number of women screened x 100 (adapt depending on the algorithm)
  > Rate of treatment by thermal coagulation: Number of women treated/Number of positive women eligible x 100
  > Number lost to follow-up: Number of women who have not completed their screening or not been treated/Number of women screened x 100 (at 3 months/6 months)
- **Empowerment:**
  > Number of women who have a better knowledge of the disease and understanding of the results
  > Number of women who have used the self-sampling method
- **Advocacy:**
  > Number of changes to practice in documents relating to norms and directives
  > Number of types of actors (CSOs, policymakers, etc.) who are committed to preventing and treating cervical cancer
  > New policy, norm, regulation or practice formally adopted in support of cervical cancer prevention and treatment.

Each indicator must be summed up in an **appropriate aggregation**, including by **age bracket and HIV serology.**

To find out more, consult the MdM Health Project Planning Guide (Chapter 2. Project Programming - 2.1 Defining objectives and results) and the list of cervical cancer indicators. 2.2 Defining indicators and sources of verification. Consult the monitoring e-learning to learn how to construct each of the stages of the monitoring system: https://elearning.medecinsdumonde.net/

➡ The indicators are identified when the logframe is put in place. **They are likely to evolve as the project is set up and implemented.** It is important to maintain a dialogue with all stakeholders – project teams in the field, service providers, CSO and health system partners, head office teams and donors, for example – throughout the project to ensure it is properly understood and is relevant and to ensure the indicators are capable of tracking the project. The monitoring manual must be updated to preserve the history of exchanges and the reasons for changing the indicators, and to avoid questions being raised about decisions taken during implementation of the project.

b. Designing and reproducing data-collection tools and materials

➡ **Involve service providers** in drawing up the tools. They have essential information about certain constraints on data collection, such as whether information is readily obtainable from patients or not and equipment constraints. In addition, their involvement enables them to take ownership of the tools in advance and facilitates their collaboration in the data collection. Remember that monitoring enables data-collection sheets to be reproduced or drawn up based on what exists.

Advocacy: In many contexts, little or no recording of cervical cancer exists. It is appropriate to include the introduction of cancer and particularly cervical registers in the advocacy component.

➡ **Plan a phase to test** data-collection tools and sheets.
➡ **Printing materials:** Excessive copying of tools at one time should be avoided to prevent obsolescence and a waste of financial and the planet's resources.

c. Quality of the data collection and analysis

➡ Train **all those involved in using the MdM project monitoring tool** (data capture and/or analysis) on this subject. This does not concern just the MEAL team but also supervisors, project head, head of community liaison, head of advocacy, etc., thereby ensuring that everyone is involved in the monitoring/evaluation process and tasks can be properly shared out within the team.

➡ **Train service providers in the data-collection system**, and monitoring/evaluation more generally – issues, tools, pathway, frequency and deadlines – to guarantee they have a good understanding of the tools and adopt them. The training must be integrated into the core training for service providers to avoid a gap between the launch of activities and monitoring/evaluation training.
➡ **Set up a system for monitoring and checking the quality of the data** at several stages to ensure their standard: verification by supervisors at the collection stage, verification at the data-capture stage, etc.
➡ Data must be analysed as a team, on the initiative of the project head, to improve project steering.

It is important to make provision for a monitoring manual to be produced for the project that documents the entire system to be put in place. This greatly facilitates the coordination of the monitoring and the division of roles and responsibilities within the team and with partners.

See: Monitoring Manual

d. Accountability framework shared with the health system and other stakeholders

➡ The data collected on the project contributes to monitoring it. However, it is essential to think beyond the context of the project alone and to engage in **setting up an accountability framework**, by ensuring that information – data collected and analysis of these – is effectively fed back to service providers, service and health centre heads and the decentralised and central health authorities. This is crucial for enabling all parties to take ownership of the project and the activities put in place, for ensuring that the data is used properly (by feeding into service providers' and their supervisors' practice in the field) and for making the health system part of the drive towards sustainable interventions.
➡ When MdM is proposing an innovative algorithm in relation to that applied nationally, **the accountability framework provides a context for dialogue to enable the added value of the new algorithm to be demonstrated** along with its relevance and its efficiency where applicable and allows for discussion of the methods for replicating the innovation at national level, both during and after the project.

Several options may be considered for setting up this accountability framework including sharing reports with management teams at district, regional and central level and organising quarterly meetings on monitoring the project with all the partners.

Practical tools
Annexe 8. Model register

BIBLIOGRAPHY

BIBLIOGRAPHY

The scientific data and information come from documents published by WHO on cervical cancer

WHO resources

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14. *How to conduct advocacy.* Médecins du Monde; 2020

15. *Training Programme on Cervical Cancer Prevention – Participant Handbook.* Médecins du Monde; 2021

ANNEXES

The tools set out below can be found in digital, editable format
via the SRHR intranet link:
https://MdM1.sharepoint.com/sites/intra-dsp/SitePages/DSSR.aspx

- Annexe 1. Cervical cancer diagnosis checklist
- Annexe 2. Mapping stakeholders/Care costs
- Annexe 3. Healthcare facility evaluation sheet
- Annexe 4. Training plans checklist
- Annexe 5. Screening algorithm/Patient pathway
- Annexe 6. Protocol for preparing VIA/VILI solutions and decontamination
- Annexe 7. Model informed consent form/Form for returning VIA test results
- Annexe 8. Model register
- Annexe 9. Supervision checklist
- Annexe 10. Community mobilisation/Key messages checklist
- Annexe 11. Cervical cancer advocacy factsheet

ANNEXE 1. CERVICAL CANCER DIAGNOSIS CHECKLIST

The checklist featured here draws on the WHO country profiles which can be consulted at https://www.who.int/fr/publications/m
Enter 'cervical cancer' in the search facility. These profiles summarise all national information by country. The first stage involves obtaining this information to fill out the proposed checklist. The aim is to complete the checklist during the field implementation phase using the evaluation sheet for each health centre.

I. NATIONAL DATA

Name of country : _____

National mortality/morbidity data

Incidence of cervical cancer : _____

Deaths due to cervical cancer: _____

Incidence of HIV: _____

Predominant age bracket for deaths from cervical cancer : _____

Does a national vaccination strategy exist? ❑ Yes ❑ No

Target age: _____

Coverage rate: _____

Human resources involved: _____

Does a national screening strategy exist? ❑ Yes ❑ No

Target age: _____

Type of tests used: ❑ HPV ❑ Cervical Smear ❑ VIA ❑ VILI

Human resources involved: _____

What treatments and care are available at national level? _____

_____

_____

Does a national register exist? ❑ Yes ❑ No

Adapted to the project? ❑ Yes ❑ No

Do national treatment directives exist? ❑ Yes ❑ No

Does a specific referral pathway exist? ❑ Yes ❑ No

Are there laboratory services? ❑ Yes ❑ No

Details: _____

_____

_____

Do palliative care services exist? ❑ Yes ❑ No

Human resources involved: _____

_____

_____

Is training available? ❑ Yes ❑ No

Targets of training: _____

Types of training: _____

Areas covered: _____

II. LOCAL DATA

Type of population: ❑ Rural ❑ Urban ❑ Key/vulnerable population

Incidence:
Age bracket concerned _____ HIV rate _____ Vaccination rate _____

Existing resources identified

Human resources
Who is responsible for monitoring and supervising vaccination activities? _____
Frequency of supervisions/data analysis _____

_____

Who is responsible for monitoring and supervising screening activities? _____
Frequency of supervisions/data analysis _____

_____

Location and access for patients? _____

Possibilities for pooling human resources? _____

Material resources

PCR machine available: ❑ GeneXpert ❑ Roche ❑ Abott ❑ Hologic, Seegene

What sector is covered by each material resource? _____

_____

Are samples stored in a refrigerated facility: ❑ yes ❑ no

If GeneXpert / Hologic : Transport _____

Does the laboratory have air conditioning? ❑ yes ❑ no

Is there an inverter? ❑ yes ❑ no

Waste management: ❑ yes ❑ no

Barriers identified

Sociocultural barriers _____

_____

_____

Geographical barriers _____

_____

_____

Financial barriers _____

_____

_____

Operational barriers/Quality of the screening and treatment provision, including provision of biomedical material and the level of training of frontline health workers

_____

_____

_____

Perception of the disease/Understanding of the disease

_____

_____

_____

This final section can be completed from the literature review or by a short survey of all stakeholders with questions on understanding of the illness/of its occurrence/ of screening and the treatments available. This will enable awareness-raising messages to be adapted more effectively

ANNEXE 2. MAPPING STAKEHOLDERS/CARE COSTS

Identify the names of stakeholders in the comments column.
Establish whether the stakeholders are allied or not and their level of influence.

Use the MdM stakeholder analysis tool. Be sure to identify the costs

	PRIMARY PREVENTION: Vaccination, STI prevention, sexual health education (condom use	SECONDARY PREVENTION: Screening, treating precancerous lesions	TERTIARY PREVENTION: Treating cancers	PALLIATIVE CARE	COMMENTS
POLITICAL STAKEHOLDERS					
TECHNICAL AND ADMINISTRATIVE STAKEHOLDERS					
FINANCIAL STAKEHOLDERS					
MEDICAL STAKEHOLDERS					
COMMUNITY STAKEHOLDERS					

CARE AND TREATMENT	(AVERAGE) COST FOR THE PATIENT	COMMENTS
HPV		
VIA/VILI		
THERMAL COAGULATION / CRYO-THERAPY		
SMEAR TEST		
BIOSPSY		
LEEP		
CONISATION		
CHEST X-RAY		
SCAN/MRI		
BLOOD TEST		
SURGERY		
RADIOTHERAPY		
CHEMOTHERAPY		
OTHER EXAMINATIONS		

The costs will allow budgeting for treating cases of cancer. Assume a margin of 10 cancer cases per 10,000 patients; also bear in mind that all cases will not be at the same stage and so not all will benefit from surgery, chemotherapy or radiotherapy. In many instances, access to radiotherapy is potentially complicated. Transfers to other countries can be envisaged but surgery and chemotherapy remain acceptable treatments.

ANNEXE 3. HEALTHCARE FACILITY EVALUATION SHEET

PRIMARY HEALTHCARE CENTRE

HEALTHCARE STAFF: TYPE AND POST-UNIVERSITY TRAINING						
Healthcare workers	**Number**	**Professional training**				
		PF	**Cervical cancer screening**	**Managing cervical cancer**	**EmONC**	**MVA**
Doctor						
Midwife						
Dentist						
State registered nurse						
Specialist nurse						
Laboratory technician						
Pharmacy assistant						
Auxiliary nurse						
Orderly						
Cleaner						
Porter						
Social worker						
Others:						

CARE AND SERVICE PROVISION			
SRH Care Package	**YES**	**NO**	**Comments**
Perinatal health			
Reproductive health and family planning			
Vaccination			
Cervical cancer screening with VIA/VILI			
Cervical cancer screening with HPV testing			
Cervical cancer treatment and method			
Thermal coagulation/cryotherapy LEEP			
Biological analysis			
Pharmacy			
IEC			
NHIS data collection			

CARE PROVIDED	MATERIALS AND EQUIPMENT	QUANTITY	OPERATIONAL CONDITION	
			GOOD	FAULTY
Screening: HPV testing	PCR test (GeneXpert, Hologic, Seegene, Roche, ...)			
	HPV testing cartridges			
	Reagent buffer (isopropanol/sodium bicarbonate) 2ml/sample			
	Disposable 1ml transfer pipettes			
	Sampling swabs			
	Sterile flasks			
	Permanent markers			
Triage: VIA/VILI	Gynaecological examination table			
	Gynaecological examination light (halogen bulb)			
	Sterile single-use bivalve vaginal speculum			
	Acetic acid 5%			
	Straight dressing forceps			
	Curved dressing forceps			
	Stainless steel instrument tray 28x18x3cm			
	Kidney dish			
	Instrument trolley			
	Stainless steel cup without spout			
Smear test	Dressing forceps			
	Ayre spatula			
	Cervical sampling brush			
	Swab			
	Cytology brush (e.g. Cytobrush®)			
	Slides			
	Cover slips			
Hygiene - Infection Prevention and Control	20-litre Autoclave steriliser			
	Disinfecting buckets without cover			
	Disinfecting buckets with cover			
	Instrument cleaning brush			
	Bin			
	Bin bags			
	Aprons			
	Boots			
	Gowns			
	Protective glasses			
	Screen			

INFRASTRUCTURE AND LOGISTICS		YES/NO	Number	Comments
Building	Is there a building for MCH?			
Laboratory	Is there a laboratory?			
	If not, what is the distance from the facility to the laboratory? How are samples conveyed?			
	Is the cartridge storage area airconditioned?			
	Inverter			
Consultation	Is there a dedicated space?			
	If YES, how many rooms/booths are there?			
	If NO, where are consultations held?			
	Is privacy maintained?			
	Is there a space for self-sampling?			
Waste management	Is waste separated?			
	Is waste incinerated?			
Water and sanitation	Is there access to water in the consultation room?			
	Is there access to water in the laboratory?			
	Is there sterilisation?			
	What type of electricity supply is there?			
Procurement, management and maintenance of biomedical equipment	Is procurement national?			
	If YES, who does the maintenance?			
	Who deals with equipment guarantees?			
	Is procurement international?			
	If YES, who does the maintenance?			
	To whom does donated equipment go?			
	Can equipment be relocated if underused?			

CERVICAL SMEAR TEST		
	Yes	No
Are cervical smear tests carried out?		
If yes, where are the samples processed?		
How far away is the laboratory located?		
Who transports the samples?		
How much time is required before results are received?		
How is the patient informed of the result?		
Percentage of women attending post-test follow-up		
Data recording system		

PHARMACY			
	Medicines	**YES/NO**	**Stockouts in the previous 3 months (tick to confirm stock-kout)**
ANALGESICS	Morphine 30 mg tabs		
	Morphine 60 mg tabs		
	Morphine 10 mg/ml injection		
	Tramadol 50 mg tabs		
	Tramadol 100 mg injection		
NSAIDs	Ibuprofen 400 mg tabs		
	Diclofenac 50 mg tabs		
	Ketoprofen 100 mg injection		
	Ketoprofen 100 mg suppository		
ORAL AND INJECTABLE ANTIBACTERIALS	Amoxicillin 500 mg capsules		
	Ampicillin 1g powder for injection		
	Amoxicillin + Clavulanic acid 500mg/62.5mg tabs		
	Amoxicillin + Clavulanic acid 500mg/125 mg injection		
	Ceftriaxone 1g/10mg injection		
	Ciprofloxacin 500 mg tabs		
	Doxycycline 100 mg tabs		
	Metronidazole 500 mg tabs		
LOCAL ANTIFUNGAL AND ANTI-INFECTIVE AND ANTI-SEPTIC TREATMENTS	Nystatin 100,000 IU gynae tabs		
	Clotrimazole 100 mg pessary		
	Gyno-Pevaryl 150 mg, pessary		
	Colposeptine, vaginal tablet		
	Tergynan, vaginal tablet		
	Hexamidine Solution		
	Betadine 10%, vaginal solution, 125ml bottle		
HEMOSTATIC AGENTS	Monsel's (ferric subsulfate) solution		

PHARMACY			
ANTISEPTIC AGENTS AND DISIN FECTANTS	Sodium/Calcium Hypochlorite granules		
	Formol		
	Liquid soap (1l)		
	Powdered soap (1kg)		
PALLIATIVE TREATMENTS	Diazepam 5mg/ml injection		
	Dexamethasone 4mg/ml injection		
LOCAL ANAESTHETIC	Lidocaine 2% with adrenaline		
CONSUMABLES	Powder-free examination gloves 100 gloves		
	Non-sterile examination gloves 100 gloves		
	Sterile surgical gloves 7.5 (Box of 50)		
	Sterile surgical gloves 8 (Box of 50)		
	Non-sterile compresses (Box of 100)		
	Sterile compresses 40x40 cm (Box of 10)		
	Hydrophilic cotton 1kg		
	Needles 18 G		
	Needles 24 G		
	Syringes 5cc		
	Red betadine 125ml		
	Yellow betadine 125ml		
	Vycril 0 suture		
	Vycril 2-0 suture		

COMMUNITY HEALTH		
	YES	**NO**
Are there community health workers (CHWs) or other volunteers on site?		
Number of CHWs or other volunteers		
How are CHWs recruited?		
Role of CHWs		
Orientation and supervision of CHWs		
What type of activity report is the CHW supposed to produce?		
	YES	**NO**
Are the CHWs well-motivated?		
What is the source of their motivation?		
	YES	**NO**
Is the CHW capable of mobilising and raising awareness?		

REFERRAL HEALTH CENTRE

HEALTHCARE STAFF: TYPE AND POST-UNIVERSITY TRAINING							
Healthcare workers	**Number**	**Professional training**					
		PF	**Cervical cancer screening**	**Thermal coagulation/ cryotherapy**	**LEEP**	**EmONC**	**MVA**
Doctor (gynaecologist and surgeon)							
Midwife							
Dentist							
State registered nurse							
Specialist nurse							
Laboratory technician							
Pharmacy assistant							
Auxiliary nurse							
Orderly							
Cleaner							
Porter							
Social worker							
Others:							

HEALTHCARE AND SERVICE PROVISION			
SRH care package	**YES**	**NO**	**Comments**
Perinatal health			
Reproductive health and family planning			
Vaccination			
Cervical cancer screening with VIA/VILI			
Cervical cancer screening with HPV testing			
Managing cervical cancer			
Biological analysis			
Surgery			
LEEP			
Colposcopy			
Biopsy			

HEALTHCARE AND SERVICE PROVISION			
Cervical smear test			
Hospitalisation			
Palliative care			
Chemotherapy			
Radiotherapy			
Pharmacy			
IEC/BCC			
NHIS data collection			

HEALTHCARE PROVISION	MATERIALS AND EQUIPMENT	QUANTITY	OPERATIONAL CONDITION	
			GOOD	FAULTY
Screening: HPV testing	PCR test (GeneXpert, Hologic, Seegene, Roche, ...)			
	HPV testing cartridges			
	Reagent buffer (isopropanol/sodium bicarbonate) 2ml/sample			
	Disposable 1ml transfer pipettes			
	Sampling swabs			
	Sterile flasks			
	Permanent markers			
Triage: VIA/VILI	Gynaecological examination table			
	Gynaecological examination light (halogen bulb)			
	Sterile single-use bivalve vaginal speculum			
	Acetic acid 5%			
	Straight dressing forceps			
	Curved dressing forceps			
	Stainless steel instrument tray 28x18x3cm			
	Kidney dish			
	Instrument trolley			
	Stainless steel cup without spout			
Colposcopy	Colposcope			
	Endocervical speculum			

Treating precancerous lesions	Thermal coagulator			
	Machine for loop electrosurgical excision procedure (electrosurgical generator, electric cables, dispersive plate, LEEP electrodes, smoke extractor)			
	Cryotherapy machine			
	Insulated speculum			
	Sample bottle			
	Formol			
	Mayo 24cm needle holder			
	Mayo 18cm curved scissors			
	18cm dissection forceps with claws			
	18cm dissection forceps without claws			
	Heart-shaped forceps			
	Stainless steel instrument box 28x18x3cm			
	Stainless steel box for cotton			
	Compress dispenser 15x15cm			
Biopsy	Cervical biopsy forceps			
	Endocervical speculum			
	Endocervical curette			
Smear test	Dressing forceps			
	Ayre spatula			
	Cervical sampling brush			
	Swab			
	Cytology brush (e.g. Cytobrush®)			
	Slides			
	Cover slips			
Hygiene – Infection Prevention and Control	20-litre autoclave steriliser			
	Disinfecting buckets without cover			
	Disinfecting buckets with cover			
	Instrument cleaning brush			
	Bin			
	Bin bags			
	Aprons			
	Boots			
	Gowns			
	Protective glasses			
	Screen			

ANNEXE 4. TRAINING PLANS CHECKLIST

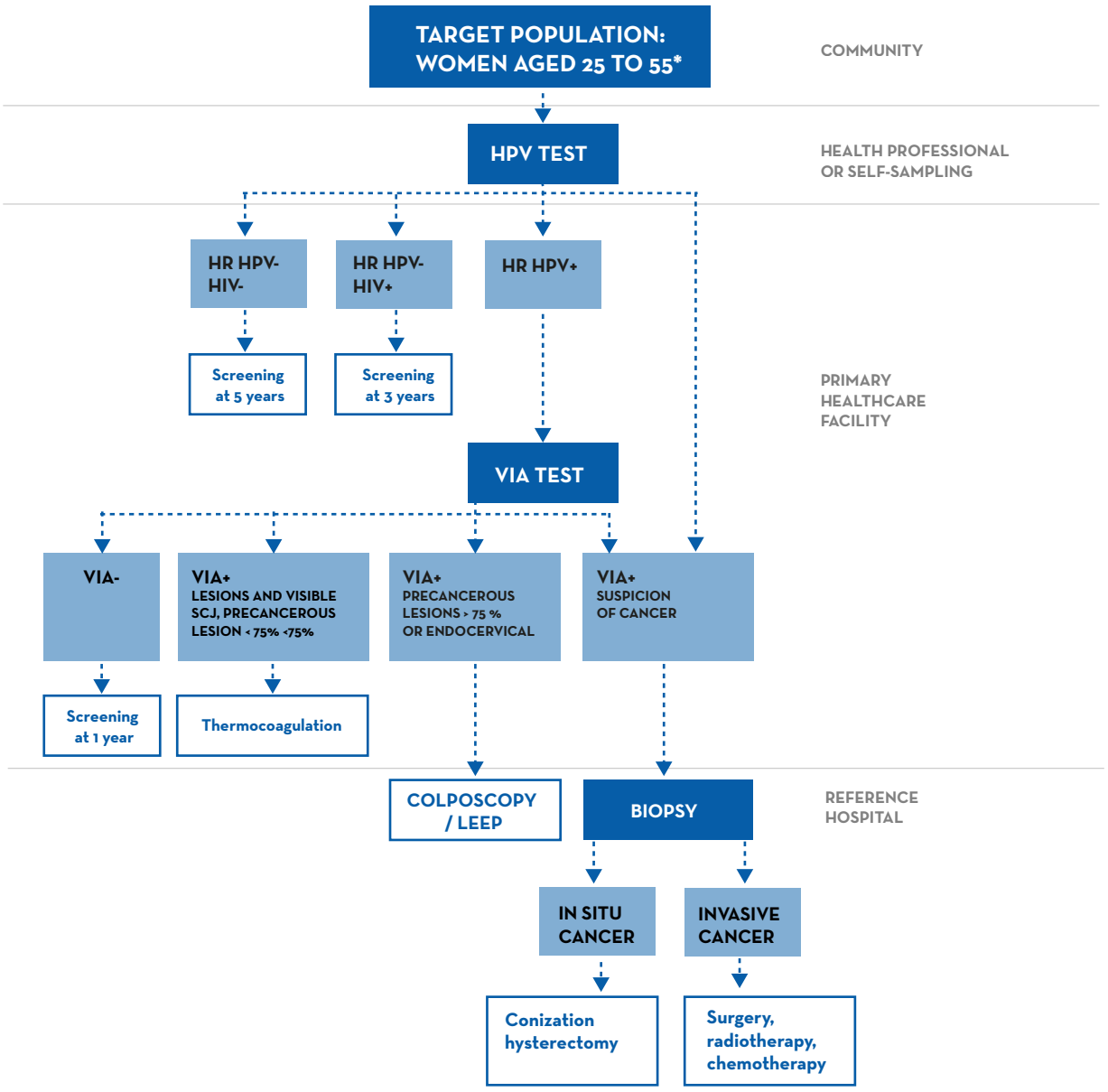
The core training is adapted to all healthcare professionals including laboratory technicians. Only the first two days are designed to suit all professional profiles.

STAGE	OBJECTIVES	POINTS TO SCRUTINISE	COMMENTS
Identify the population targeted by the training	Draw up the profile and number of people to be trained Co-create the training sessions with the target group	Ensure that all actors are trained: MdM teams, community workers, healthcare workers (midwives, nurses, doctors), clinical supervisors, laboratory technicians, technicians, management teams	
Set out the core training plan	List the training themes	VIA, screening, counselling, HPV tests, thermal coagulation, GeneXpert, treating and managing cervical cancer, palliative care, hospital waste management, supervisor training	
	Consider how each session is to be organised	Number of participants (maximum 20-25 per session), organisation of services, timetable linked to delivery of material, trainers	
Adjust the training to the intervention context to aim for sustainability	Involve local and national bodies (Ministry of Health) in the training Consider creating a national pool of trainers	Create a monitoring plan: daily monitoring, supervision, procedures Identify a focal point Implement training the trainers	

ANNEXE 5. MDM SCREENING ALGORITHM/PATIENT PATHWAY

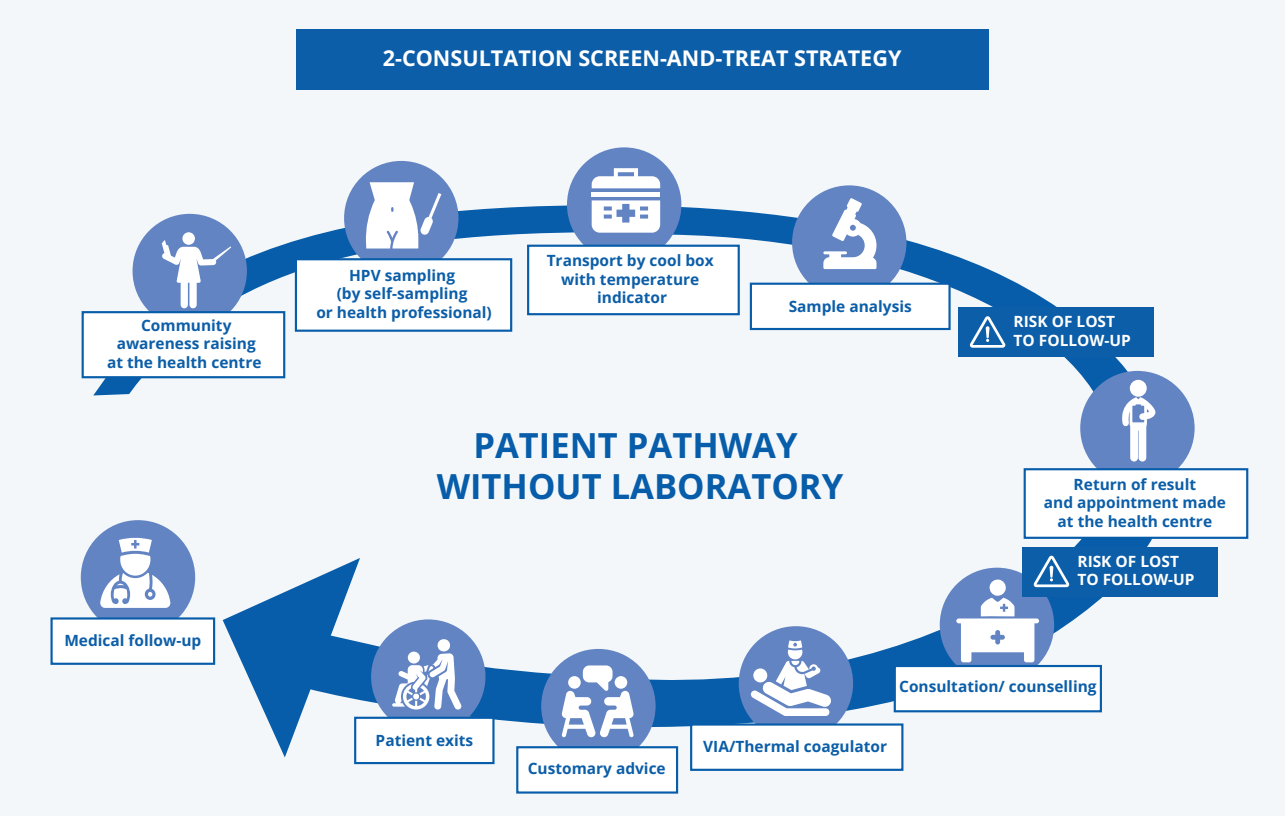
The algorithm must be devised on the basis of existing resources, target group and the capacity for it to be replicated, notably by the state (a simple pathway has a greater chance of being replicated and scaled up). This annexe sets out an algorithm proposed by MdM and a modifiable version that can be adjusted to suit your project.

NB: Think about designing a screening algorithm specifically for PLHIV.



*ALL HIV+ WOMEN AND SEXUALLY ACTIVE, AGE RANGE TO BE ADAPTED, ACCORDING TO THE MINISTRY OF HEALTH

The patient pathway must be produced together with nursing staff, laboratory technicians and the people involved at each stage. The objective is to minimise the number lost to follow-up and to avoid swamping the healthcare system. The capacity to screen and treat can be estimated based on the patient and the sample pathways, as can the overall time taken for the patient pathway. Note that reducing the time taken to complete the pathway is a major factor in limiting the number of patients lost to follow-up.



STAGE	DETAILS	WHO	WHERE	PRACTICAL METHODS	OBJECTIVES
Information	Individual or collective awareness raising	Nurse Community worker Organisation	Community outreach	Radio Discussion Mass awareness raising	Women and neighbourhood are informed to encourage them to get screened
Pre-counselling for HPV screening	Individual	Nurse Community worker Organisation	At Health Centre Outreach	Toolkit	To offer screening and above all explain the disease and how to avoid it, to personalise the message and dispel fears To secure consent
Conducting screening	Collecting vaginal sample	Patient herself	At Health Centre Outreach	Explanation of how to take a sample How to obtain the result	To identify prior precautions: no sexual intercourse in previous 24 hrs/not menstruating/no vaginal douche The nurse at the Health Centre offers a choice of sampling method – self-sampling or by a nurse

STAGE	DETAILS	WHO	WHERE	PRACTICAL METHODS	OBJECTIVES
Sampling pathway	Time taken	How many people needed to manage the sampling: transfer and analysis		Time for transporting, time for analysing	To assess the time needed for the return of the result To assess the number of samples that can be dealt with in a given period
Advising of results	Individual and confidential	Nurse Community worker Organisation Patient's choice if several options available	Health Centre Community workers Partner organisation Others By telephone by nurse Other options?	If the results are negative, explain post-test follow-up counselling If the result is positive, explain again that the fact of having an HPV does not signify the presence of cancer and offer a further appointment to complete the algorithm	To respect confidentiality To reduce the number of appointments to avoid lost to follow-up: e.g. when the community worker gives the result, they contact the Health Centre to plan the appointment or to arrange time slots without appointments for VIA and treatment
VIA	Confidential	Nurse	Health Centre Mobile field team	Pre- and post-test counselling If VIA above75%, suspected cancer or transformation zone not visible, refer to tertiary level	To identify material resources To earmark premises that respect hygiene and confidentiality requirements
Thermal coagulation	Confidential	Nurse		Pre- and post-test counselling	To identify material resources To earmark premises that respect hygiene and confidentiality requirements To explain follow-up in line with patient's status
Managing patients lost to follow-up	Identifying and relaunching	Nurses? Community workers? Text messaging service	Outreach Remotely by telephone By a trusted intermediary May need to be repeated on several occasions, notably at 3 months, 6 months and 12 months		To define what is meant by lost to follow-up To inform and raise awareness of follow-up and adapt it to the woman concerned, to plan +/- result appointment

ANNEXE 6. PROTOCOLS FOR PREPARING VIA/VILI SOLUTIONS AND DECONTAMINATION

PREPARING A 0.5% CHLORINE SOLUTION

The general formula for preparing a dilute chlorine solution based on a commercial product of whatever concentration is as follows:
Total parts water = [% of the concentrated solution/% of the dilute solution] -1.

For example, to prepare a 0.5% dilute chlorine solution using 5% concentrated household bleach = [5.0%/0.5%] -1 = 10-1 = 9 parts water; consequently, one part bleach is added to nine parts water.

If commercial powdered bleach is used, the following formula is employed to calculate the quantity of powder (in grams) needed to prepare a 0.5% chlorine solution: Grams/litre = [% dilute solution/% prepared concentrate] x 1000.

For example, to prepare a 0.5% dilute chlorine solution based on powder containing 35% calcium hypochlorite = [0.5%/35%] x 1000 = 14.2 g. So, 14.2 grams of powder are added to 1 litre of water or 142 grams to 10 litres of water. The instruments must not remain in the bleach for more than ten minutes and must be cleaned with boiling water immediately after decontamination to avoid the metal becoming discoloured and corroded.

DECONTAMINATING THE FLOOR OF THE SCREENING MEDICAL CENTRE:

The floor of the screening centre must be decontaminated daily using chemical disinfectants such as iodophors (for example 10% povidone-iodine).

5% DILUTE ACETIC ACID

Ingredients - quantities
1. 5 ml glacial acetic acid
2. 95 ml distilled water

Preparation: Carefully add 5 ml of glacial acetic acid to 95 ml of distilled water and mix well.

Storage: Unused acetic acid must be destroyed at the end of the day.

Labelling: 5% dilute acetic acid.

Note : It is important always to dilute glacial acetic acid as undiluted it can cause serious chemical burns if applied to the epithelium.

LUGOL'S IODINE SOLUTE

Ingredients - quantities
1. 10 g potassium iodide
2. 100 ml distilled water
3. 5 g iodine

Preparation
A. Dissolve 10 g of potassium iodide in 100 ml of distilled water.
B. Add approximately 5 g of iodine while shaking the mixture.
C. Filter and store in a tightly stoppered smoked glass bottle.

Storage: 1 month

Labelling: Lugol's iodine solute; Use by: (date)

MONSEL'S SOLUTION

Ingredients - quantities

1. 15 g ferric subsulfate
2. A few grains of ferric subsulfate powder
3. 10 ml of sterile water to mix
4. 12 g glycerol starch (see preparation below)

Preparation

Precautions to take: Exothermic reaction (gives off heat).

A. In a glass beaker, add a few grains of ferric subsulfate powder to 10 ml of sterile water. Shake.
B. Add the ferric subsulfate and dissolve by stirring using a glass rod. The solution must become clear.
C. Weigh the glycerol in a glass mortar. Mix well.
D. Slowly add the ferric subsulfate to the glycerol starch, stirring all the while until it is fully mixed in.
E. Store in a 25-ml smoked glass bottle.
F. Most practitioners prefer to let the solution rest long enough for some of the solution to evaporate and for it to acquire a consistency similar to mustard. This can take 2 to 3 weeks depending on the environment. Tightly stopper the bottle to store. If necessary, the solution can be thinned with sterile water.

Note: This preparation contains 15% iron.

Storage: 6 months

Labelling: Monsel's solution; Shake well; For external use only; Use by: (date)

GLYCEROL STARCH (INGREDIENT FOR MONSEL'S SOLUTION)

Ingredients - quantities
1. 30 g starch
2. 30 ml of sterile water for mixing
3. 390 g glycerine

Preparation
A. Dissolve the starch in the sterile water in a crucible.
B. Add the glycerine. Mix well.
C. Heat the crucible over the flame of a Bunsen burner, all the while mixing its contents with a spatula until a thick paste is achieved. Be careful not to overheat and cause the paste to turn yellow.

Storage: 1 year

Labelling: Glycerol starch; Store in a cool place; For external use only; Use by: (date)

Note : Do not heat because the mixture turns yellow.

CLEANING AND STERILISING OF INSTRUMENTS AND EQUIPMENT USED FOR THE EARLY DETECTION AND TREATMENT OF CERVICAL NEOPLASIA

INSTRUMENT/ EQUIPMENT	PROCEDURE	SUGGESTED METHOD
VAGINAL SPECULUM, VAGINAL WALL RETRACTORS, BIOPSY FORCEPS, CLAW FORCEPS, DRESSING FORCEPS, CHEATLE FORCEPS	Decontamination and cleaning followed by sterilisation or high-level disinfection	Decontaminate by immersing for 10 minutes in a 0.5% chlorine solution before cleaning with water and detergent; cleaned instruments can then be submerged in boiling water for 20 minutes (high-level disinfection) or sterilised in an autoclave before being reused.
GLOVES	Decontamination and cleaning followed by sterilisation	Decontaminate by immersing for 10 minutes in a 0.5% chlorine solution before cleaning with water and detergent; sterilise in an autoclave in wrapped packages.
EXAMINATION TABLE, HALOGEN LAMP, ELECTRIC LAMPS, TROLLEY, TRAYS	Intermediate- or low-level disinfection	Wipe with 60-90% ethyl or isopropyl alcohol or with a 0.5% chlorine solution.
THERMAL COAGULATION	Disinfection of handheld unit Sterilisation of probe	Detach the probe from the handheld unit and clean the latter using alcohol. Leave it for 10 minutes to decontaminate. The probe is self-sterilising so apply pressure for 30 seconds to activate sterilisation.

ANNEXE 7. MODEL INFORMED CONSENT FORM/FORM FOR RETURNING VIA RESULTS

INFORMED CONSENT

The doctor/healthcare worker has explained in detail the tests with vinegar (VIA) and iodine (VILI) which enable the early detection and prevention of cancer in the cervix of my uterus. I know that the surface of my cervix is going to be examined following the application of vinegar (5% acetic acid/dilute iodine solution) to reveal or rule out precancer/cancer. I know that these examinations are painless but may sometimes cause irritation or light bleeding which readily subsides.

I have clearly understood that, if the test is positive, I will be advised to undergo other examinations such as visual inspection of the cervix using a magnifying device called a colposcope and analysis of a sample of the tissue from my cervix (biopsy) before I am given treatment.

I have also been advised that should any anomaly be detected (infection, precancer, cancer or complications), it might be necessary to prescribe me with drug therapy or thermal coagulation (destruction of the diseased part of the cervix using a thermal probe), or to remove the diseased part in a minor or more major surgical intervention, potentially followed by radiotherapy.

By signing this document, I indicate my willingness to undergo the above tests and treatment if so advised*/I do not wish to undergo the above examinations. *

Signed :

Date :

Name :

Adress :

* Delete as applicable

FORM FOR RETURNING VIA RESULTS

1. UNIQUE NUMBER/CLINIC/FILE _____ **2. TEST DATE** _____

3. NAME: _____
4. ADRESS: _____

5. AGE (in years): _____
6. EDUCATION: _____
(1: None, 2: Primary, 3: Junior secondary, 4: Secondary, 5: University, 9: Not known)

7. DATE OF LAST PERIOD: _____
(1: Less than 12 months previously, 2: More than 12 months previously)

8. MARITAL STATUS: _____
(1: Married, 2: Widowed, 3: Separated, 8: Other, 9: Not known)

9. 9. AGE AT FIRST SEXUAL INTERCOURSE: _____
(99, if not known)

10. TOTAL NUMBER OF PREGNANCIES/MISCARRIAGES: _____

11. DO YOU SUFFER FROM ANY OF THE FOLLOWING SYMPTOMS?
(Tick box if yes; otherwise leave blank)
❏ Heavy vaginal discharge
❏ Itching in the external anogenital region
❏ Ulceration in the external anogenital region
❏ Pelvic pain
❏ Pain during intercourse
❏ Bleeding following intercourse
❏ Bleeding between periods
❏ Lower back pain

12. HPV SEROTYPE:
❏ 16 ❏ 18, 45 ❏ (31, 33, 35, 52, 58) ❏ P4 (51, 59) ❏ P5 (39, 68, 56, 66)
Note: *Profiles 16, 18, 45, P2 are at greater risk of developing cancer. Where the strategic choice is made to opt for a serotyping intervention, treatment will be envisaged in such cases even if the VIA proves negative.*

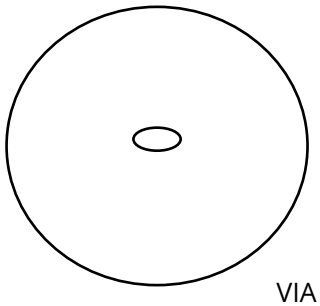
13. VISUAL INSPECTION RESULTS
(Tick box if yes; otherwise leave blank)
❏ Squamocolumnar junction is entirely visible
❏ Cervical polyp
❏ Nabothian cyst
❏ Cervicitis
❏ Leukoplasia
❏ Condyloma
❏ Tumour

14. RESULTS ONE MINUTE AFTER APPLYING 5% ACETIC ACID (VIA) _____
(1: Negative, 2: Positive, 3: Positive, invasive cancer)

15. IF THE VIA IS POSITIVE, DOES THE ACETOWHITE LESION PENETRATE THE ENDOCERVICAL CANAL? _____
(1: Yes ; 2: No)

16. IF THE VIA IS POSITIVE, HOW MANY QUADRANTS ARE AFFECTED BY THE ACETOWHITE LESION(S)? _____
(1: Two or less, 2: Three, 3: Four quadrants)

17. DIAGRAM
(Indicate the squamocolumnar junction with a dotted line and the acetowhite area(s)/iodine-negative area(s) with a solid line.



VIA

18. MEASURES TAKEN:
(1: Follow-up advised every 5 years; 2: Therapeutic treatment recommended for cervicitis and check-up appointment in six months; 3: Referral for a colposcopy; 4: Referral for immediate treatment; 5: Referral for classification and treatment of invasive cancer; 6: Other – specify)

_____

_____

_____

ANNEXE 8. MODEL REGISTER

SCREENING AND TREATMENT PROGRAM FOR PRECANCEROUS CERVICAL LESIONS IN COTE D'IVOIRE — **HPV, IVA, TERMOCOAGULATION/CRYOTHERAPY AND RAD REGISTRY**

STRUCTURE NAME _____ MONTHS: _____ Year: _____

	ADMISSION																DETECTION, TRANSFER AND TREATMENT																									
	CUSTOMER INFORMATION								NATURE OF THE CONSULTATION								SCREENING				RESULT					TREATMENTS				TRANSFER										
No.	Front door (1, 2, 3, 4, 5, 6, 7)?	HIV status (Neg/Pos/ Inc)	Date	Full name	Age	Gender Parity	Age 1st sexual interco urse	Telephone number (at least 2, including for a relative)	HPV test			IVA			Thermo coagulation postponed/cry o therapy postponed/RA D postponed	Post-treatment complications (Cryo, thermo or RAD)	HPV			IVA	HPV		IVA	Suspicion of Cancer	Initials of IVA screening provider	Thermo-coagulation	Cryotherapy	RAD	Initials of the service provider	Pelvic			Localisation	Date	Counter reference		
									Initial	1-year follo w-up	Routine	Initial	1-year follo w-up	Routine			Auto prélèvement	Made by a service provider	Date	Date	Result (Neg/Pos)	Amount cervert date	Result (Neg/Pos)	date		Date	Date	Date		Large or other lesions	Suspected cancer	Other gynaecological problems			Received (Yes/No)	RAD completed (Yes/No)	ARD date
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK
1																																					
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18																																					
19																																					
20																																					
HIV POSITIVE																																					
HIV NEGATIVE OR UNKNOWN																																					

* In Polyclinic 2=Child 3=Vaccination 4=HIV Dr Medical service 5=Community 7=Other

The digital version also features instructions on how to fill out the register and a pre-completed example from the Monitool.

ANNEXE 9. SUPERVISION CHECKLIST

This tool must be compiled with the individuals being evaluated

COUNSELING SKILLS SHEET – HPV TESTING, VIA, AND THERMOCOAGULATION				
	Healthcare facility: **Month: ...../20**			
	Date:			
	SERVICES OBSERVED//PROVIDER'S INITIALS			
	❑ Initial pre-HPV test counselling//			
	❑ Pre-VIA test counselling for patients who are HPV positive//			
	❑ Post-negative VIA test counselling//			
	❑ Counselling for thermal coagulation if the VIA test is < 75% positive//			
	❑ Counselling after thermal coagulation//			
	❑ Counselling if the VIA test is > 75% positive or suspected case of cancer for referral//			
	SCORING:			
	1: Must be improved: Stage/task omitted or not tackled			
	2 : Executed but without good command: Stage/task partially tackled but not convincing or only partly convincing for the patient			
	3 : Executed with good command: Stage/task tackled effectively and accurately, convincing for the patient			
N°	**ITEMS**	**SCORE**		
		1	**2**	**3**
	INITIAL PRE-HPV TEST COUNSELLING			
1	Welcomes the patient and settles her in a respectful, friendly manner.			
2	Questions the patient using simple terms to gather full identity details.			
3	Gathers information on the purpose of the consultation, assesses patient's basic knowledge of cervical cancer and responds to questions (checks age, asks if patient knows about cervical cancer/how it is transmitted).			
4	Gathers gynaecological and obstetric history (previous STIs, HIV serological status, number of live births and number of pregnancies).			
5	Provides general information on cervical cancer (signs, targets, eligibility criteria, potential causes and consequences for health).			
6	Provides information on the advantages of early cancer screening (cancer prevention, early treatment + total recovery).			

7	Informs the patient of the 2 sampling techniques – vaginal self-sampling (VSS) and sampling by a clinician (VCS), explains both techniques and leaves the patient to make a free and informed choice.			
8	Explains to the patient the screening process involving the laboratory and the probable waiting time for the return of the results (1hr 30min); the VIA in the event of a positive HPV test and the possibility of treatment as part of a screen-and-treat approach as well as the possibility of further contact by phone if the patient does not collect the results. **NB: Do not communicate the results over the phone.**			
9	Reassures the patient about the obligation on healthcare workers not to disclose information and to maintain professional confidentiality.			
10	Asks the patient if she has any questions.			
11	Asks the patient if she would like the screening test.			
12	If the patient accepts, the provider thanks the patient for opting for the examination and asks which sampling technique she wishes to choose.			
13	If the patient declines, the service provider encourages the patient to come back for the screening the next time.			
	Score for initial pre-HPV test counselling	**0**	**0**	**0**
	PRE-VIA TEST COUNSELLING FOR HPV-POSITIVE PATIENTS			
1	Welcomes the patient and settles her in a respectful, friendly manner.			
2	Questions the patient using simple terms to gather full identity details.			
3	Checks the result on the report then thanks the patient for coming for a VIA test.			
4	Provides a reminder of general information on cervical cancer (signs and consequences for health).			
5	Informs the patient of the advantages associated with early screening for cancer.			
6	Reassures the patient that the fact of a positive HPV test does not necessarily mean that she has cancer.			
7	Explains the technique for carrying out the VIA while reassuring the patient that it is painless and takes no time (conditions required for VIA).			
8	Explains the different possible results of the VIA and how to proceed based on each result			
9	Explains the validity of the screen-and-treat approach and potential restrictions (hygiene, abstaining from sex) in the case of treatment for precancerous lesions and the fact that the treatment for such lesions is free.			
10	Asks the patient if she has any questions.			
11	Makes sure that the patient is ready for the test, convincing her if necessary to have the VIA.			
12	Thanks the patient for her agreement and starts the test.			
	Score for pre-VIA test counselling for HPV-positive patients.	**0**	**0**	**0**
	POST-TEST COUNSELLING FOR NEGATIVE VIA TEST			
1	Explains the negative VIA test result to the patient and what this means for her health.			
2	Unless there are other problems, gives the patient an appointment for future screening in 1 year.			
3	Thanks the patient and assures she can come back for advice or treatment if needed.			
	Score for post-test counselling for negative VIA test	**0**	**0**	**0**
	COUNSELLING IF THE VIA TEST IS < 75% POSITIVE			
1	Explains the positive VIA test result to the patient and what this means for her health and reassures her of the fact that treatment is available free of charge at the facility.			

2	Explains the validity of the screen-and-treat approach.			
3	Checks that the eligibility criteria for thermal coagulation are met (no period, visible lesion, postpartum > 2 months).			
4	Explains the stages of thermal coagulation.			
5	Details the advantages and effectiveness of thermal coagulation (total recovery).			
6	Explains the potential complications (bleeding, pain, vaginal discharge, etc.) if post-treatment recommendations are not followed.			
7	Encourages the patient to ask questions and to discuss her state of health.			
8	Gives the patient time to decide.			
9	Congratulates the patient if she decides to have the treatment on the spot and proceeds with readying her.			
10	Encourages the patient to come back as soon as possible for the treatment when she cannot have the treatment on the spot, emphasises the need to get treated and the potential consequences for her health and for her family.			
	Score for counselling if the VIA test is < 75% positive.	**0**	**0**	**0**
	COUNSELLING AFTER THERMAL COAGULATION			
1	Reassures the patient about the treatment carried out.			
2	Provides the patient with the necessary recommendations for care at home.			
3	Explains the potential complications if the post-treatment recommendations are not followed and the action to take.			
4	Explains the use of condoms and sanitary towels (if available).			
5	Ensures the patient has properly understood the recommendations by asking open questions to check.			
6	Congratulates the patient on her correct answers and, if necessary, rectifies any incorrect ones.			
7	Makes a follow-up appointment if needed – an appointment for a post-treatment check-up is obligatory in 1 year.			
	Score for counselling after thermal coagulation	**0**	**0**	**0**
	COUNSELLING IF THE VIA TEST IS > 75% POSITIVE OR CONFIRMS A CASE OF CANCER			
1	Explains the result to the patient and what this means for her health, assures her of the fact that treatment is available but at another facility with more advanced medical technology as per the healthcare pyramid.			
2	Establishes the patient's trust in how her care will be managed.			
3	Proposes accredited facilities for referring and treating the patient's case and asks her which facility she would like to attend for her treatment.			
4	Explains to the patient how her care would be delivered in the referral facilities (existing collaboration between the facilities, the names and telephone numbers of the people to contact, appointment days, potential costs of the paraclinical tests to be done and whether support for attending these is available if needed).			
5	Writes out the referral sheet containing additional information to pass on in order to facilitate access to the referral facility.			
	Total score for counselling if the VIA test is > 75% positive or confirms a case of cancer (case to be referred)	0	0	0
	NB: The score is calculated per service provision observed.			

ANNEXE 10. COMMUNITY MOBILISATION/KEY MESSAGES CHECKLIST

STAGE	TOOLS	OBJECTIVES	RESULTS	TIMETABLE OF ACTIVITIES AND IDENTIFYING RESOURCES	CONCLUSIONS
Information gathering	Cervical cancer literature review Socio-anthropological contextual research Think-tank workshops Focus groups Individual interviews	To identify barriers and levers To produce the mobilisation strategy			
Establishing awareness-raising messages and means of disseminating	Collaborating with community actors Target groups among the public Social media and networks	To formulate messaging in a way that is adapted to the context and takes a positive approach to health			
Identifying the mechanisms of community support	Discussing the strategy in collaboration with community support mechanisms and the health authorities	To rely on what exists, to empower the community, drawing on the unique participation of local women's organisations			
Strengthening communities' capacity to act	Drawing up plans to strengthen the capacities of the actors involved Cervical cancer training Cascade training	To mobilise community relays To promote accountable healthcare services			
Creating referral and counter-referral systems	Collaboration with community relays and/or other key community actors Identifying gendered needs	To identify vulnerable populations To strengthen individual and collective capacities To focus on the active participation of the people concerned			

MESSAGES TO AVOID	UNEXPECTED RESULTS	IT'S BETTER TO SAY...
Women who present with cervical cancer or a precancerous lesion have an STI.	Women are less motivated to be screened and to generate problems in their relationship.	• Cervical cancer is caused by a virus called HPV which is transmitted through sexual contact; the majority of people are infected with this virus at some point in their life. • The majority of HPV infections disappear of their own accord without the person knowing they have been infected.
Screening is a test to look for the presence of cervical cancer.	It is logical that people would think a positive test result means the woman is suffering from cancer.	• Screening is done with the help of a simple test (cervical smear, VIA or HPV testing) for the early detection of potential changes to the cervix (also known as precancerous lesions) before any cancer develops.
The use of a coil (or intrauterine device, IUD) or contraceptive pill can lead to cervical cancer occurring.	Women will be afraid to use a method of contraception even if such information is false.	• Using a coil does not increase the risk of cervical cancer in women. • Contraceptive pills can raise the risk very slightly but the advantages of preventing pregnancy far outweigh the marginal increase in the risk of developing cervical cancer. • Furthermore, using contraceptive pills reduces the risk of ovarian and colorectal cancer.
The screening test is painful; when it is done, a part of the woman's body is removed.	Women will be afraid to have a screening test. Their family might also fear the test and prevent them from having it.	• Some women find being examined using a speculum unpleasant, but it is not painful. • During the test, the practitioner delicately passes a swab (cotton on a stick) or a soft brush over the cervix. • The test is straightforward and is completed in a few minutes. • Screening is not the same thing as sampling for a biopsy or a surgical intervention. Screening tests require no incision.
It is not worth getting screened for abnormalities of the cervix because, when the test is positive, it means that the woman is suffering from a fatal illness and is going to die.	Only a small number of women will have the screening test if they think that no solution exists.	• If a woman shows early signs of changes to her cervix, she can benefit from safe, simple treatment. • If screening is carried out among women of the right age, it is possible to prevent cervical cancer developing. • When detected early, cervical cancer is curable.

SUBJECT	KEY MESSAGES
CERVICAL CANCER	▪ Cervical cancer occurs when there is an abnormal growth in the cervical cells. ▪ Cervical cancer is caused by a persistent high-risk HPV infection. ▪ Any irregular vaginal bleeding is a sign of cervical cancer until proven otherwise.
HPV	▪ HPV is an extremely common virus transmitted through sexual contact. ▪ Most people will have an HPV infection during the course of their life. ▪ In the majority of cases, the HPV infection disappears of its own accord. ▪ Some of these infections do not disappear and will cause cervical cancer to develop. ▪ The forms of the virus posing the highest risk are HPV 16, 18, 31, 33 and 58.
RELATIONSHIP BETWEEN HPV AND CERVICAL CANCER	▪ The persistence of high-risk HPV infections is what causes cervical cancer in 10 to 15 years. ▪ Having an HPV infection does not mean that a person has cancer.
RELATIONSHIP BETWEEN HIV AND CERVICAL CANCER	▪ Women living with HIV are 6 times more at risk of developing cervical cancer. ▪ Cervical cancer emerges much earlier in PLHIV (3-5 years between the HPV infection and the cancer). Hence the importance of screening women living with HIV more frequently.
HPV TEST	▪ The HPV test determines the presence of HPV. ▪ The test can be carried out by self-sampling and/or during a gynaecological examination by introducing a swab into the vagina and sampling cells. The swab is then placed in a tube and sent to the laboratory for analysis. ▪ Self-sampling has the advantage of being carried out by the patient herself. ▪ The sensitivity and specificity of self-sampling is similar to the sampling done by a nurse. ▪ Self-sampling: Solid data show that tests to detect the human papilloma virus (HPV) conducted using self-sampling by patients themselves can be similar to those carried out by a clinician.
HPV TEST RESULT	▪ The result is either positive or negative. ▪ A negative result means that a high-risk HPV infection has not been found. ▪ A positive result means that a high-risk HPV infection has been found and that another test such as visual inspection with acetic acid (VIA) must be carried out.
VIA TEST	▪ The VIA test does not require anaesthetic and is painless.
VIA TEST RESULT	▪ The positive result indicates the presence of precancerous lesions that could potentially develop into cervical cancer.
THERMAL COAGULATION	▪ This technique destroys precancerous lesions using a high temperature. ▪ The cervix does not contain any nerves, and the treatment is therefore painless. ▪ This is a safe, effective treatment for precancerous lesions.
FOLLOW-UP TREATMENT	▪ Monitoring women who have tested positive and been treated is extremely important as they are 3 to 7 times more at risk of a recurrence.

ANNEXE 11. CERVICAL CANCER FACTSHEET (1/6)

Cervical cancer, the gender-inequality cancer

MDM KEY ADVOCACY MESSAGES

Since 2010, sexual and reproductive health and rights (SRHR) have been prioritised by Médecins du Monde. The organisation focuses its action on 3 breakpoints in the continuum of care and rights – preventing and treating unintended pregnancies through access to comprehensive sex education, contraception and safe abortion – and by responding to sexual and reproductive health needs in crisis settings. This response includes **preventing gender-based violence (GBV) and treating people who have survived GBV and preventing cervical cancer through the screening and early treatment of precancerous lesions.** Médecins du Monde confirms its commitment to working for universal access to sexual and reproductive health and rights without distinction or discrimination and fosters an approach based on promoting, respecting and guaranteeing human rights.

For Médecins du Monde, its fight against cervical cancer is one of the vital actions it takes to combat gender inequality. **The social, economic and cultural conditions of women worldwide have an impact on their access to cervical cancer information, screening and care.** Cervical cancer is the result of an infection caused by the human papilloma virus (HPV) and transmitted during sexual intercourse. It is the fourth cause of death from cancer among women globally.

To combat morbidity and mortality caused by cervical cancer, **Médecins du Monde is participating in the World Health Organization's global strategy to eliminate cervical cancer,** with the goal between now and 2030 of

- **Vaccinating 90%** of girls against the human papillomavirus by age 15
- **Screening 70%** of women by age 35 and again at age 45[1] using a high-performance test
- **Treating 90%** of women identified with cervical disease

(1) Except women living with HIV. WHO recommends screening them every 3 years from age 25. Seropositive women are six times more likely to develop cervical cancer than seronegative women.

A feminist approach is needed. Eliminating cervical cancer is part of the **fight for gender equality.** Like contraception, pregnancy and abortion, responsibility for dealing with it falls on the shoulders of women and girls, while boys and men can be carriers of HPV. MdM also calls attention to the key role played by the good quality SRH counselling services which are offered to the patients our teams meet daily. These prime instances of interaction represent rare occasions for women to broach questions of sexuality, and for our services to detect cases of gender-based violence.

340 000 WOMEN,
TRANS AND NON-BINARY PEOPLE DIE worldwide from the consequences of this disease.

90% OF CC RELATED DEATHS ARE IN LOW-AND MIDDLE-INCOME COUNTRIES.

CC IS AVOIDABLE AND CAN BE ERADICATED
if detected early and treated correctly.

In this document, women are named to designate people at risk of developing cervical cancer. Please note that our projects and actions are aimed at and include anyone with a uterus, whether they are women, trans or non-binary.

1/6

ANNEXE 11. CERVICAL CANCER FACTSHEET (2/6)

Médecins du Monde adopts and promotes a pragmatic approach, combining efforts to reach out and to strengthen health systems. Although outreach actions are essential to improve coverage of access to healthcare, they are not a substitute for a centralised health system equipped with trained staff and appropriate technical resources.

Aware that this strategy needs to be implemented to achieve the WHO's stated targets, Médecins du Monde is increasing its expertise in strengthening heath systems by introducing effective screening and treatment of cervical cancer in partnership with state and community actors.

Focus on HPV

The human papillomavirus (HPV) group of viruses is among the most common causes of sexually transmitted infections. These viruses are highly contagious and are transmitted through contact with the skin or mucous membranes, particularly during sex that may or may not involve penetration. Therefore condoms do not provide complete protection against HPV infection. Among the 150 types of existing papillomavirus, fifteen are considered carcinogenic and responsible for cancers such as cervical cancer, cancer of the vulva, penis and anus and cancer of the back of the throat (oropharyngeal), particularly the tonsils. Vaccination is the sole effective protection. An illustration of this is the 75% drop in the frequency of precancerous lesions among young Swedish women who were vaccinated prior to 17 years of age. Find out more at http://toutsavoir-hpv.org/

MDM'S INTERVENTIONS

With the support of research bodies, **MdM is implementing two innovative pilot projects to prevent and treat precancerous lesions of the cervix in Burkina Faso and Côte d'Ivoire,** with the particular aim of showing that it is possible to implement high-performance screening projects that are accessible and effective.

MdM's strategy involves strengthening the health system by offering the HPV test to patients via the healthcare provider where possible or in the form of self-sampling conducted by the patients themselves. If a test proves positive, a visual inspection with ascetic acid (VIA) can be carried out and treatment provided using thermal ablation or Loop Electrosurgical Excision Procedure (LEEP), if necessary.

Burkina Faso :

Since 2018, MdM has been assisting Baskuy health district to implement the project 'Reducing morbidity and mortality due to cervical cancer' which covers all nine healthcare facilities. Our actions are based on mobilising the community, strengthening health-training capacity (more than 100 health professionals trained) and advocating greater consideration of the issues surrounding the treatment of precancerous cervical lesions and cervical cancer. Using an opportunistic model (screening is offered during consultations at health facilities), around 15 000 women were screened between 2019 and 2022. Between 2019 and 2021, contact was recorded as lost with just 7% of the women screened, and with just 3% in 2022. In 2022, 100% of those women who were eligible received thermocoagulation treatment.

Côte d'Ivoire :

Since 2021, MdM has been conducting a project to treat cervical cancer in Côte d'Ivoire in association with the Ministry of Health, Hygiene and Universal Health Coverage. Using an organised HPV screening model (created as part of health campaigns) and as a result of community worker input and a reinforced health centre, more than 6000 people were screened using home self-sampling tests in the space of six months. However, just 50% of women who tested positive for HPV have attended the health centre. 10% of HPV-positive women were also revealed as new HIV-positive cases. The project has also promoted the use of thermocoagulation as more suitable than cryotherapy for the treatment of precancerous lesions. To complement this work, prevention and advocacy initiatives have been conducted to develop norms and protocols for eliminating cervical cancer.

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RECOMMENDATIONS FOR IMPLEMENTATION

01. Encourage HPV screening tests.

VIA tests are neither particularly sensitive nor specific[1]. HPV screening can be conducted in low- and middle-income countries and patient diagnosis optimised by using more sensitive, specific tests. Médecins du Monde also promotes the 'screening, triage and treatment' approach involving a limited number of visits to reduce the number of instances patient is lost to follow-up and to optimise the comprehensiveness of the treatments, while guarding against the risk of disrupting the functioning of health centres if this approach is introduced in a single consultation.

The MdM-F programmes in Burkina Faso and the Republic of Côte d'Ivoire have implemented a strategy for screening HPV. In Burkina Faso, the opportunistic strategy[2] has meant that less than 7% of women tested have not received treatment (lost to follow-up). In RCI, an organised screening strategy[3] has resulted in 100% of women who are eligible being treated.

***Example of targets:* The technical directorates and departments of health ministries** *must incorporate HPV screening into framework documents and qualified programmes (depending on the opportunities afforded, these include cervical cancer plans, and cancer, family and HIV planning).*

02. Promote self-sampling.

This approach provides an alternative to cervical screening by a health professional. A wider choice of sampling techniques implies more appropriate patient follow-up. Such choice leads to greater adhesion to treatment and more comprehensive follow-up as well as better screening coverage in areas remote from health centres. To be effective, self-sampling must be accompanied by good quality counselling.

On the Burkina Faso programme, 70% of the patients encountered chose self-sampling. In RCI, 100% of patients opted for HPV self-sampling, and there were no failed samples.

***Example of targets:* The technical directorates and departments of health ministries** *must incorporate self-sampling into framework documents and qualified programmes (depending on the opportunities afforded, these include cervical cancer plans and cancer,*

Self-sampling – the act of taking a sample oneself instead of it being taken by a health professional – is an eminently feminist approach in its capacity to empower women to take ownership of their bodies. This participative procedure places women and trans and non-binary people centre stage as the principal agents in monitoring their health, enhances their knowledge and understanding of their own bodies and thus reinforces their ability to act.

03. Offer HIV screening to all women who have tested positive for HPV.

Our initial results suggest that women who are HPV positive are at much greater risk of being HIV positive. Furthermore, the HIV epidemic is increasingly feminized and yet heterosexual women remain hard to reach. It is therefore desirable to increase research and data analysis to identify the extent to which HPV screening can also become a tool for identifying the group to target to combat HIV (namely, HPV-positive women) and thereby reduce the HIV epidemic.

As a reminder: According to WHO, people who are HIV seropositive are six times more at risk of contracting cervical cancer than people who are seronegative. To ensure that no one who is HIV positive dies of cervical cancer, Médecins du Monde France is actively supporting and promoting the WHO recommendations.
WHO recommends: Targeting PLHIV: Regularly screen people who are HIV-positive for HPV every 3 to 5 years from age 25.

In the context of the MdM project in Burkina Faso, the initial data gathered indicate that 85% of HIV+ women also tested HPV+ at the screening. Where a positive HPV result is obtained, co-HIV infection is 33 times more probable. This trend requires further research at scale for the hypothesis to be proved.

***Example of targets:* The technical directorates and departments of health ministries** *must incorporate HPV-positive women and trans and non-binary people as a target group in the fight against HIV into framework documents and qualified programmes (depending on the opportunities afforded, these include HIV,*

1 The sensitivity of a test is the probability that the test will be positive if the individual has the disease. The more sensitive a test, the less it produces false negatives. The specificity of a test is the probability that the test will be negative if the individual does not have the disease. The greater the specificity of a test, the less likely it is to result in false positives.
2 Screening is offered during health centre consultations.
3 Screening is carried out as part of health campaigns.

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cervical cancer and family planning) and introduce systematic HIV screening for these populations.

04. Promote and introduce systematic HPV vaccination of young men.

Like contraception, pregnancy and abortion, responsibility for cervical cancer rests mainly with women and girls, while boys and men are also carriers of HPV which they pass on to their sexual partners. HPV is also the cause of some cancers affecting men. The pressing issue today is to vaccinate not only all young girls, who are the primary sufferers, but also boys. This will curtail global transmission and better protect boys and men at the same time as affording unvaccinated girls and women better protection. Vaccinating boys also helps reduce gender inequalities associated with health prevention and spreads responsibility for prevention.

***Example of targets:* The technical directorates and departments of health ministries** *must incorporate HPV vaccination of young men and its instigation into framework documents and qualified programmes (depending on the opportunities afforded, these include cervical cancer plans and cancer, HIV and family planning).*

05. Develop organised screening strategies with a community approach

to increase the coverage of screening and reduce the barriers to accessing health. MdM has continuously «outreach» projects with and close to communities, particularly those remote from health systems. This approach reaches a greater number of people in a rapid and efficient way, notably women who do not attend health centres. It also ensures greater adhesion to care by the people concerned. Few organised screening programmes exist today, and the positive feedback from our experience indicates that this promising approach needs to be extended and replicated in a range of contexts. To avoid the health system leaving the community to deal with this, this recommendation must be accompanied by a strengthening of health systems in the form of appropriate equipment and staff training for cervical cancer prevention.

The MdM programme in Côte d'Ivoire has implemented an organised screening strategy. A total of 2475 women were screened for HPV between November 2021 and April 2022 with encouraging results.

WHO recommends: Vaccinating girls aged 9 to 14.

***Example of targets:* The technical directorates and departments of health ministries** *must develop and implement strategies for the organised screening of cervical cancer to maximise the number of beneficiaries and the impact of screening programmes.*

06. Strengthen the palliative care approach beyond the care package

by decentralising access to different levels of painkillers and by providing psychosocial care. There is often a lack of understanding of the concept of using an approach based on palliative care due to it being limited to pain management, a subject which itself is stigmatised and overlooked by health systems and actors. Indeed, the limited knowledge and understanding of palliative treatments hampers their introduction (restrictive legislation governing certain opioids, concerns over misuse and dependency on certain drug formulations, scant end-of-life training, etc.). It is important to adopt a holistic and destigmatising approach.
People with cervical cancer find themselves isolated and even discriminated against as a result of their disease and its accompanying side effects. It is vital to introduce palliative care that is appropriate to their needs so that they can live with dignity despite their illness. Yet few of the actors concerned actively tackle this issue.

Example of targets:
The international community, *and state and civil society actors must take up the palliative approach and develop this field.*
Health ministries *must invest time and effort in this field, remove the barriers to access, equip their technical directorates and departments and disseminate the palliative care approach.*
Regional agencies *implementing health policies must put palliative care into practice.*

WHO definition: Palliative care is an approach that improves the quality of life of adult and child patients and their families who are facing the problems associated with a life-threatening illness. It prevents and relieves suffering through the early identification, correct assessment and treatment of pain and other problems, whether physical, psychosocial or spiritual.

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RECOMMENDATIONS FOR SCALING UP

Médecins du Monde campaigns for the fundamental human right to health and therefore argues for universal health coverage. To achieve this, action to eliminate cervical cancer must be rolled out at scale.

WHO and ExpandNet define the notion of scaling up as 'Deliberate efforts to increase the impact of successfully tested health innovations so as to benefit more people and to foster policy and programme development on a lasting basis'.

07. Promote research into the cost effectiveness of cervical cancer screening tests.

It is essential to optimise cervical screening strategies in line with the organised and/or opportunistic context in which they are applied, using appropriate and effective screening methods (both sensitive and specific) to ensure no woman is left untreated in the case of a false negative test, and similarly to avoid overtreatment in cases of a false positive test. Existing estimated figures enable states in particular to adapt their budgets to put cervical screening more effectively into operation. Promoting research entails collecting data on cervical cancer and making them more visible by including them in national health information systems (NHIS).

The pilot projects conducted by Médecins du Monde in Burkina Faso and Côte d'Ivoire demonstrate that the approaches to screening deployed there are promising. It is important to explore their long-term sustainability and capacity for replication so as to move towards scaling up.

Example of targets:
States *must drive this research, and the* ***technical directorates and departments of health ministries*** *must implement it with a view to scaling up.*
National cancer institutes *and research partners must fund and instigate research into the cost-effectiveness of cervical cancer screening tests.*

08. Pool existing screening equipment and redistribute it to improve geographical coverage.

The irregular coverage provided by screening equipment is proof of geographical inequalities. Some zones, frequently urban, benefit from the majority of screening equipment, while rural zones are inadequately equipped.

Example of targets: ***States and technical directorates and departments of health ministries*** *must map the availability of screening equipment, redistribute it and share its use.*

09. Draw the attention of states and donors to the need to share HPV-diagnostics production technologies, which are in the hands of a few laboratories, and the need to identify and finance alternative production platforms

so as to decentralise production and better respond to needs. The laboratories possessing this technology are not currently capable of absorbing all the production demands as is shown by the tuberculosis-related stockouts during the COVID-19 crisis. Nor do current prices permit many states to obtain these essential technologies for tackling cervical cancer.

Example of targets:
States, health ministries and technical and financial partners *must invest in alternative diagnostic platforms in order to combat the monopoly of HPV-test production technology.*

Médecins du Monde is participating in the Time for $5 campaign which is coordinated by Médecins Sans Frontières and Treatment Action Group and which is calling for the price of tests to be lowered to $5. The campaign is contesting the super profits generated by pharmaceutical companies at the expense of the right to health for all.

10. Facilitate access to funding for cervical cancer.

The complexity of mechanisms to access funding is an obstacle for many countries.
In Africa, just two countries have access to Global Fund financing earmarked for cervical cancer, and both are English-speaking. Yet the indicators for French-speaking African countries are among the most critical. It is therefore vital that these mechanisms are made more

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inclusive, understandable and accessible, particularly as regards language.

Example of targets:
The Global Fund to Fight AIDS, Tuberculosis and Malaria *must make its funding to tackle cervical cancer more accessible and transparent and must assist states, including those which are French speaking, to take the steps required.*
International organisations (such as the Union for International Cancer Control and the World Cancer Congress) *must improve the accessibility of spheres of influence for non-English-speaking actors.*

ADDITIONAL SOURCES

- WHO Key Facts about cervical cancer
- WHO roadmap on cervical cancer (available only in English)
- WHO guideline for screening and treatment of cervical pre-cancer lesions for cervical cancer prevention, second edition. (available only in English)
- Cervical cancer elimination in Africa: where are we now and where do we need to be? (available only in English)
- Range of resources on cervical cancer from WHO *Cervical Cancer Elimination Initiative*

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