CERVICAL CANCER SCREENING POLICY

2015

MINISTRY of HEALTH & MEDICAL SERVICES

Shaping Fiji's Health

CERVICAL CANCER SCREENING POLICY

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Foreword

Cervical cancer is the most common cancer affecting women in Fiji, and is the second highest cause of death by cancer in women. Whilst we have been addressing this issue with various interventions over the past two decades, this is the first time that Fiji has developed a comprehensive cervical cancer screening and treatment policy. In fact, it is the first time for any Pacific Island nation to develop such a policy – Fiji is leading the way!

This policy covers the prevention measures currently being rolled out by the Ministry. These include the immunisation of young women against the human papillomavirus (HPV), the leading cause of cervical cancer; and the screening and treatment of precancerous lesions at the primary health care level, allowing women better access to screening, and cost-effective and timely treatment.

For those that require additional care, the policy sets out clear referral pathways for clients and the various treatment options available to them.

Importantly, this policy provides the Ministry with a strategic approach to reducing the rates of cervical cancer amongst women in Fiji, and helps justify the resources and staffing necessary to deliver the services. It is underpinned by a monitoring and evaluation system, which will enable the Ministry to track performance against its stated goals and objectives.

I encourage all women who are sexually active to utilise their local health services for cervical screening and to have regular follow-ups. For those partners of women, please encourage and support them in accessing these vital services. For parents of young women, ensure they are vaccinated against HPV. We must all work together to achieve better health outcomes for the women of Fiji.

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Without the support of the above, the development of this policy would not have been possible.

Abbreviations

ACS	Australian Cancer Society
AEFI	Adverse events following immunisation
AIS	Adenocarcinoma in situ
CECAP	Cervical Cancer Prevention Program
CIN	Cervical intraepithelial neoplasia
CSN	Clinical Services Network
FAQ	Frequently asked question
FP	Family planning
HIV	Human immunodeficiency virus
HPV	Human papillomavirus
HSIL	High grade squamous intraepithelial lesion
IEC	Information education communication
IUD	Intra-uterine device
LBC	Liquid-based cytology
LEEP	Loop electrosurgical excision procedure
LETZ	Loop excision of the transformation zone
LLETZ	Large loop excision of the transformation zone
LSIL	Low grade squamous intraepithelial lesion
M&E	Monitoring and evaluation
MoHMS	Ministry of Health and Medical Services (formerly Ministry of Health [MoH])
NGO	Non-government organisation
NHN	National Health Number
Pap test	Papanicolaou test
PCR	Polymerase chain reaction
PHSIL	Possible high grade squamous intraepithelial lesion
PLSIL	Possible low grade squamous intraepithelial lesion
QA	Quality assurance
RFHAF	Reproductive Family Health Association Fiji
RH	Reproductive health
SCC	Squamous cell carcinoma
SCJ	Squamocolumnar junction
STI	Sexually transmitted infection
SVA	Single visit approach
TZ	Transformation zone
VIA	Visual inspection with acetic acid
WHO	World Health Organization

Definitions [1,2,3,4,5]

Acetowhite	Abnormal epithelial tissue, especially cervical intraepithelial neoplasia (CIN); turns white after the application of acetic acid, so called the acetowhite reaction.
Adenocarcinoma	A rare cancer of the cervix involving the columnar cells that are involved in glandular activity.
Cancer	A lesion that is 'invasive' – that has breached the basement membrane and involves the subepithelial stroma (as opposed to CIN, which is always intraepithelial) within the epithelium. In the case of the cervix, it is usually a squamous cell carcinoma that starts in the cells of the squamous epithelium in the transformational zone (TZ), near the new squamocolumnar junction (SCJ).
Cervical intraepithelial neoplasia (CIN)	A precancerous condition involving the covering layer (epithelium) of the cervix. The condition is graded as CIN 1, 2, or 3. CIN 1 denotes low-grade changes, whereas CIN 2 and CIN 3 denote progressively higher-grade precursors of cervical cancer.
Colposcopy	The examination of the cervix, vagina, and vulva with an instrument that provides a strong light and magnifies a field, allowing specific patterns in the epithelial layer and surrounding blood vessels to be examined. Similar to VIA, where 5% acetic acid is applied for 1 minute, after which the vagina and cervix are examined using an optic instrument (colposcope) that provides magnification to allow direct observation and study of vaginal and cervical epithelium in vivo.
Cone biopsy	A surgical procedure in which a cone-shaped wedge of cervical tissue is obtained for histopathological analysis. Several techniques exist, such as the more traditional cold knife conization in which a scalpel is used, and laser conization.
Coverage	The proportion of all targeted persons who attend a given service in a specified time.
Cryotherapy	A method of outpatient treatment that uses the gas flow of carbon dioxide or nitrogen into a closed system to freeze a cryotherapy tip and destroy abnormal tissue by freezing.
Cytology	The study of the structure of cells under the microscope; abnormal findings are usually confirmed by biopsy.
Dysplasia	Precancerous epithelial cellular changes on the cervix, where the ratio of the size of the cell nucleus to the size of the cell is increased. Dysplasia is graded as mild, moderate, and severe. This term has been superseded by CIN and correspondingly by CIN 1, 2, and 3.
Ectopy/Ectropion	The presence of columnar epithelium on the ectocervix and is a normal finding.
Health education	An exchange of information with the purposes of increasing awareness and knowledge about how to keep healthy and prevent diseases, including information about resources that are available and the benefits of accessing services.
High-grade squamous intraepithelial lesion (HSIL)	A term used in the Bethesda system to describe moderate and severe dysplasia (CIN 2 and 3).
HPV DNA testing	Cervical cells are tested for DNA of the human papillomavirus (HPV). Multiple technologies are available to identify oncogenic HPV types.
Incidence rate	The number of new cases of a disease in a defined population in a specified time, e.g. if there are 100 new cervical cancer cases every year in a country with a population of 1 million women, the crude (non-age-standardised) cervical cancer incidence rate is 10 per 100,000 (100/1,000,000) per year.
Large loop excision of the transformation zone (LLETZ)	The removal of abnormal areas from the cervix and the entire transformational zone, using a loop made of thin wire powered by an electrosurgical unit. This is an excisional treatment method, which is also known as loop electrosurgical excision procedure (LEEP).

Liquid-based cytology	A cervical cancer screening method, similar to the Papanicolaou test, using a brush to sample the cervix. The tip of the brush is introduced into a liquid vial. When the sample is processed the inflammatory cells and detritus are removed, leaving only the epithelial cells for the final sample.
Low-grade squamous intraepithelial lesion	A term used in the Bethesda system to classify cervical cytology to describe mild dysplasia/low-grade CIN (CIN 1).
Menarche	The age at which a young woman has her first menstruation.
Metaplasia	A transformation of tissue from one type to another, e.g. from columnar to squamous epithelium.
Morbidity rate	The proportion of a population who suffer from a particular disease in a specified time, often expressed as a number of cases per 100,000 population per year.
Mortality rate	The proportion of a population who die from a particular disease in a specified time, often expressed as a number of deaths per 100,000 population per year.
Neoplasia	Process of new growth or tumour formation, sometimes malignant.
Oncogenic	Having the potential or capacity to cause the growth of cancer cells/tumours.
Papanicolaou test	Screening technique, also known as cervical smear and cytology test. A sample of cervical mucus-containing cells is taken and transferred to a glass slide using a brush or sampling device. This slide is then fixed with an alcohol-based solution. The slide is finally coloured and examined with a microscope for abnormal cells.
Prevalence rate	The proportion of persons in a defined population with a condition or disease at a specific point in time.
Punch biopsy	A method in which a small sample of tissue is extracted for histological analysis.
Screening	A public health intervention provided to an asymptomatic target population; it is not undertaken to diagnose a disease, but to identify individuals with increased probability of having either the disease itself or a precursor to the disease.
Squamocolumnar junction (SCJ)	The line of demarcation between columnar and squamous epithelium on the cervix.
Transformation zone	Area of the cervix between the original SCJ and current SCJ. The transformation zone is composed of glandular (columnar) epithelium until the onset of puberty, when the columnar epithelium is gradually replaced by squamous epithelium. Cervical cancer generally originates in the transformation zone.

1. Introduction

The purpose of this document is to outline the cervical cancer screening policy of the Ministry of Health and Medical Services. It maps the framework and strategies to increase community awareness of the need for cervical cancer prevention and screening, the pathway of care for women, and the mechanisms for ensuring the quality of services delivered and the effectiveness and efficiency of the program.

2. Background

Opportunistic cervical cancer screening has been occurring for more than twenty years in Fiji. A more formal program was introduced by the Fiji Cancer Society in collaboration with the Australian Cancer Society (ACS) in 1993, with funding from the Australian Government and the Australian Cancer Society. On 28 March 1994, the Nurses and Midwives Board ratified a policy that extended the Scope of Practice of nurses to do Pap smears independently after appropriate training and certification.

In 1999 the Fiji School of Medicine undertook a pilot village cervical screening program.

In 2008, a pilot project of human papillomavirus (HPV) vaccination was undertaken in Fiji to prevent cervical cancer, using donated HPV vaccines. Immunisation of grade 8 girls with HPV vaccines in a school-based program commenced in 2013 and has been added to the national immunisation schedule.

Despite all of these efforts, Pap test screening in Fiji has reached the capacity of existing technical infrastructure and human resources, and is of questionable effectiveness at its current level of 20,000 Pap tests performed annually.

To address this issue, a pilot project was conducted with Australian aid funding to test the feasibility of using visual inspection with acetic acid (VIA), a low-resource method of cervical screening endorsed by the World Health Organization, followed by cryotherapy as an immediate 'screen and treat' for a suspected pre-cancer. The pilot proved that VIA and cryotherapy are acceptable methods of cervical cancer screening in Fiji. The pilot resulted in a customised training program developed for the Pacific environment. There were 26 nurses and 13 doctors trained, local resources were developed to educate women and men about cervical cancer, and over 3,000 Fijian women received screening.

In 2014 liquid-based cytology (LBC) was introduced with the intention of increasing laboratory productivity via computer-assisted screening and decreasing reporting times.

2.1 Issues Requiring Policy Response/ Rationale

Cervical cancer has been the most common cancer in Fiji over the past decade. Annually, there are approximately 161 new cases of cervical cancer, with an estimated incidence of 37.8 per 100,000. Cervical cancer is the second highest cause of cancer deaths in Fiji, with the burden of the disease higher in Fijian women than Fijian women of Indian descent.[5]

The majority of these deaths can be prevented through universal access to a comprehensive cervical cancer prevention and control program, which has the potential to reach all girls through the HPV vaccination, as well as all women who are at risk with screening and treatment of pre-cancer.[1] To reach all women at risk of pre-cancer, Fiji will implement HPV vaccinations for all grade 8 girls, and cervical cancer screening using either VIA or cytology to all eligible women.

3. Policy Statements

Goal

- To provide a comprehensive and integrated cervical cancer prevention and control program for all women throughout their lifecycle.
- To provide routine cervical cancer screening, using visual inspection with acetic acid or cytology, every three years, for women aged 30 to 49 years, who have no symptoms or history suggestive of cervical pathology.

Objectives

- Screen 80% of women in the target age group (30 to 49 years) over a three-year period.
- All eligible women (26 to 69 years) will have at least one cervical cancer screening test in their lifetime.

Policy Statement

All women will have access to a comprehensive cervical cancer prevention and control program throughout their lives.

Strategic Area 1:	Provide a national coordinated cervical cancer prevention and control program across Fiji.
Strategic Area 2:	Promote access to the program by providing accurate health information to all women and men.
Strategic Area 3:	Ensure a highly trained, up-to-date, sensitive, and effective workforce.
Strategic Area 4:	Ensure cervical cancer prevention and screening supplies and commodities are distributed equitably across Fiji.
Strategic Area 5:	Provide high quality cervical cancer prevention, screening, diagnosis, and treatment to eligible women in the community.
Strategic Area 6:	Ensure the cervical cancer prevention and control program is implemented in a manner to reduce the morbidity and mortality of cervical cancer in Fiji.

Cervical Cancer Screening within the Healthcare System

3.1 Leadership/Governance

3.1.1 National Cervical Cancer Prevention Team

The Fiji Cervical Cancer Prevention Program (CECAP) will be coordinated at a national level by the National CECAP team, who will facilitate the planning, implementation, and monitoring of the national cervical cancer prevention and control program. The team will consist of a National Coordinator and three Divisional CECAP Managers. The CECAP team roles are additional to existing Ministry of Health and Medical Services staff within each Division and are essential to ensure the success of the program.

The Cervical Cancer Prevention Program will be managed within a strong clinical governance framework.

The National CECAP Coordinator will report to the National Advisor Family Health, and will:

- Design and implement the cervical cancer screening program across Fiji.
- Develop key program messages and promotional materials to provide consistent program messaging to women in Fiji.
- Develop and implement a quality assurance program to ensure high quality service delivery.
- Develop and implement the Fiji Cervical Cancer Screening Register.
- Monitor and evaluate the aggregated data in the screening register to review program performance.
- Work with the Divisional teams to plan and implement the program, including developing annual work plans and screening targets, and monitoring and reviewing the program against performance indicators.
- Provide evidence-based feedback and recommendations for program implementation.
- Support ongoing delivery of cervical cancer screening training across the Divisions.
- Advocate at a national level for resources and activities required to strengthen program performance.

3.1.2 Divisional CECAP Team

The Divisional CECAP team will be responsible for the implementation of the cervical cancer screening program in their Division. The team will be led by a CECAP Manager and will include experts in gynaecology and oncology, including the Divisional Director Gynaecology and Oncology, Senior Hospital Sister in Public Health and Midwifery, and a Technical Support Officer. Where possible, the CECAP team should be integrated into existing meeting structures, such as the Western Division Maternity Advisory Committee.

The Divisional CECAP team will:

- Work with key stakeholders to maximise opportunities to promote the program to women, including public health units, community workers, NGOs providing women's health services, women's groups, religious leaders and groups, and other health professionals.
- Provide ongoing mentoring and support to Divisional providers delivering cervical cancer screening, diagnosis, and treatment to ensure high quality service delivery.

- Provide external supervision of the quality of cervical cancer screening and cryotherapy services, including review of participation, positivity rates, and unsatisfactory rates against nationally-agreed performance indicators.
- Monitor and review site level/aggregated data reports to review program performance.
- Work with the Divisional teams to plan and implement the program, including developing annual work plans and screening targets, and monitoring and reviewing the program against performance indicators.
- Provide evidence-based feedback and recommendations for strengthening the program.
- Deliver approved cervical cancer screening training to Divisional staff.
- Facilitate communication about program implementation with the National CECAP team and Clinical Services Network as appropriate.

3.1.3 Local CECAP Teams

Cervical cancer screening will be performed at a local health centre, nursing station, or by NGOs at a local level. These local teams will:

- Provide high quality cervical cancer screening and treatment with cryotherapy to eligible women.
- Work with key stakeholders to maximise opportunities to promote the program to women, including public health units, community workers, NGOs providing women's health services, women's groups, religious leaders and groups, and other health professionals.
- Ensure that the required equipment and medical consumables are available.
- Collect identified data on cervical screening and treatment performed, for inclusion in the national database.
- Review site-level data to review performance.
- Monitor the quality of VIA, cytology, and cryotherapy services.
- Facilitate communication with the Divisional CECAP team.

Local NGOs are important partners of the national program and will deliver cervical cancer screening and treatment of pre-cancer according to Ministry of Health and Medical Services policy. Local NGOs will:

- Provide high quality cervical cancer screening and treatment with cryotherapy to eligible women in accordance with Ministry of Health and Medical Services policy and guidelines.
- Work with Ministry of Health and Medical Services staff to maximise opportunities to promote the program using approved key program messages and materials.
- Monitor the quality of VIA, cytology, and cryotherapy services they provide.
- Provide identified data on cervical screening and treatment performed for inclusion in the national database.
- Review site-level data to review performance.
- Facilitate communication with the Divisional CECAP team to provide feedback and recommendations for strengthening the program.

3.1.4 Clinical Services Network

The Clinical Services Network will provide the forum for national multidisciplinary oversight of program implementation at the Divisional level. This will include:

- Providing support and input to the National CECAP team to implement the program.
- Reviewing work plans and screening targets for the implementation of the program.
- Advising and participating in national, divisional, and local meetings as necessary to review the efficiency and effectiveness of the program.

3.2 Medical Products/Technology

3.2.1 Cervical Cancer Prevention – HPV Vaccination

The most effective strategy to prevent cervical cancer is the provision of a protective HPV vaccine, given at an early age, before sexual activity begins. However, screening and management of screen-detected lesions will still be necessary for all unvaccinated women as they age.

Currently, two HPV vaccines are available:

- Gardasil, which is effective against multiple types of HPV. These are:
  - Types 16 and 18 – These are oncogenic HPV types, which cause 70% of cervical cancer worldwide.
  - Types 6 and 11 – These cause 90% of genital warts.
- Cervarix, which is effective against HPV types 16 and 18.[6,7]

Young women in Fiji who have been vaccinated will still require ongoing screening, as all oncogenic HPV types are not covered by the vaccines. In addition to the vaccine, prevention must focus on educating women (and men) that screening by Pap test or visual inspection with acetic acid is important.[1]

3.2.2 Cervical Cancer Screening Methods

HPV infection is asymptomatic and, as most sexually-active women will have been infected with HPV, all women who have ever been sexually active should be considered to be at risk of cervical cancer. Early identification and treatment of precursor lesions (cervical intraepithelial neoplasia [CIN]) is essential to prevent cervical cancer.

Screening methods to detect CIN include:

- Visual inspection with acetic acid
- Cytology – Pap test and liquid-based cytology
- HPV DNA testing.

Visual Inspection with Acetic Acid

VIA is a method of testing for early cell changes that are visible when using a speculum to inspect the cervix with the naked eye after applying 3–5% acetic acid. VIA is appropriate to use in women whose squamocolumnar junction is visible (typically in those younger than 50).

The provider performs a visual examination of the ectocervix, transformation zone (TZ), and cervical os with the naked eye (unmagnified) after an acetic acid wash. This allows identification of acetowhite areas that need further management.

While normal squamous epithelium is light pink and normal columnar epithelium is red, abnormal epithelial tissue, in particular cervical intraepithelial neoplasia (CIN), turns white after the application of acetic acid, so called the acetowhite reaction. This reaction is caused by the coagulation of cellular proteins, which appear opaque. Abnormal cells have larger nuclei and contain more proteins, which cause them to appear more opaque than surrounding normal tissues. The result of VIA screening is available in 1 minute.

If there are no acetowhite changes visible, a negative result is recorded; the examination is complete and the woman can be told to undergo screening again in 3 years.

If acetowhite changes are visible, the result is positive or suspicious for cancer; the woman should be managed appropriately, with cryotherapy at the same visit or with a referral for further diagnosis and treatment.

If on visualising, the cervix looks suspicious for cancer, VIA screening should not be performed, and referral for diagnosis must be provided.[1,3]

Cervical Cytology – Pap Tests and Liquid-Based Cytology

Cytology-based screening involves taking a sample of cells from the entire transformational zone, either fixed on a slide (Pap test) or placed in a transport medium (liquid-based cytology) to be reviewed at a laboratory for pre-cancerous changes. Both Pap tests and liquid-based cytology are available for screening.

A Pap test is designed to detect changes that may lead to the most common type of cervical cancer, squamous cell carcinoma. It is less effective in detecting adenocarcinoma. A sample of cells is taken and transferred to a glass slide using a cervix sampler +/– cytobrush. Cells smeared on the glass slide are fixed with alcohol to preserve them. At the laboratory the slide is treated with Papanicolaou stains to colour the cells, and is read by a specially-trained cytologist and/or pathologist for signs of cellular changes.[1,3]

Liquid-based cytology is an alternative way of preparing cervical samples for the laboratory. The sample is collected from the cervix in much the same way as required for a conventional Pap test, and the sample is placed into a small individual pot of liquid. The LBC sample can also be used to test for HPV DNA and chlamydia and gonorrhoea using polymerase chain reaction (PCR) technology. LBC can have a role in reducing unsatisfactory samples that are difficult to read due to excess blood or mucous on a conventional slide.[7] In Fiji LBC samples can be read by a machine and this automated method of processing cytology can save laboratory resources.

HPV DNA Test

A cervical cancer prevention program based on primary screening with a HPV test, as an alternative to cytology and VIA, may be an option for Fiji in the future. HPV DNA testing has greater sensitivity than cytology and is a methodologically-viable option for developing countries[1]; however, the current cost of HPV testing is prohibitive to implement as a screening program.

A HPV DNA test is performed on a sample of cells collected by inserting a small brush deep into the vagina and placing it in a small container with an appropriate preservative solution. The sample may be collected by a provider or self-collected by the woman. The HPV test is then processed either at a laboratory or at the clinic using a rapid HPV test.[1]

3.2.3 Diagnosis using Colposcopy

Colposcopy is a diagnostic procedure for detecting precancerous abnormalities of the cervix. Colposcopy is magnified visual examination of the ectocervix, squamocolumnar junction, transformational zone, and endocervical canal using an instrument called a colposcope, which is a type of microscope with a light source attached. The cervix is washed with a 3–5% acetic acid solution and inspected under magnification (4× to 20×). The entire transformational zone is assessed for acetowhite areas. It may be accompanied by a directed punch biopsy of any abnormal-looking tissue for histological assessment to confirm the presence and severity of disease.[2]

3.2.4 Treatment of Precancerous Lesions

Cryotherapy

Cryotherapy is a simple, safe, and effective ablative treatment method for precancerous lesions of the cervix, performed by doctors and nurses who are trained and deemed competent in the procedure.

Cryotherapy involves freezing the cervix, using either compressed carbon dioxide or nitrous oxide gas as the coolant. Freezing and thawing of cervical skin promotes necrosis and destruction of the abnormal cells. Treatment consists of applying the coolant via a probe continuously for 3 minutes, allowing the lesion to thaw for 5 minutes, and then applying the coolant for another 3–5 minute freeze. An ice ball is formed on the cervix as a result of the freezing, and abnormal cervical tissue is destroyed by crystallising intracellular water. This procedure, called the 'double freeze' technique, is easily performed without anaesthesia.[8]

Cryotherapy is not a suitable treatment option for all women. It is not appropriate for women who are pregnant, or non-pregnant women with unsuitable lesions or who have contraindications identified in their medical history.

Cryotherapy is not appropriate for cervical lesions that are:

- suspicious for cancer
- too large
- not fully visible on the ectocervix.[1,8,9]

Large Loop Excision of the Transformation Zone

Large loop excision of the transformation zone (LLETZ) is an excisional treatment method, using a thin electric wire to remove the entire transformation zone and thus remove the affected tissue.

A key feature of LLETZ is that the tissue removed can be examined further in the laboratory, rather than destroying the tissue by freezing. LLETZ is a surgical procedure that requires local anaesthesia. Complications of LLETZ are similar to cryotherapy, but the chance of severe bleeding is slightly higher. Fewer than 2% of women have moderate-to-severe post-procedure bleeding.[1]

WHO recommends treatment with LLETZ, also called loop electrosurgical excision procedure or LEEP, as a screen and treat strategy for women not eligible for cryotherapy. Cone biopsy is not recommended in this circumstance.[9] LLETZ is performed by Gynaecologists and Gynaecology Registrars in Central, Western, and Northern Divisions of Fiji.

3.3 Service Delivery

3.3.1 Health Promotion, Health Education, and Counselling

Health promotion of cervical cancer screening is an integral component of the Fijian screening program. Women and their families must be aware of the problem of cervical cancer, the risk of developing the disease, the screening tests available to them, and how to access the screening. A well-designed coordinated health promotion and communication campaign can help motivate women to access screening services. Once women access services, they should be individually counselled and provided with information about the screening procedure and cervical cancer, and given appropriate support to overcome any fear or embarrassment they may face about having a screening procedure.

A range of strategies will be used, including:

- Developing key program messaging to be used consistently across all information, education, and communication (IEC) materials.
- Developing cervical cancer screening campaign materials, including brochures, posters, and banners to be used in promoting the program across all Divisions.
- Developing a set of consistent lesson plans and materials (such as flip charts) to support delivery of community education.
- Using new technologies to promote cervical cancer screening, such as mobile phone or social media messaging.
- Implementing a national media campaign, using print, radio, and TV to promote key messaging and local outreach events.

Once the promotion materials are developed, a multi-sectorial approach will be used to promote cervical cancer screening. This will include engaging with local village and community groups, women's groups, and church groups to educate and promote screening. It will also include engaging with other government and NGO services involved in working with women in the eligible population group for opportunistic promotion opportunities.

3.3.2 Cervical Screening Pathway

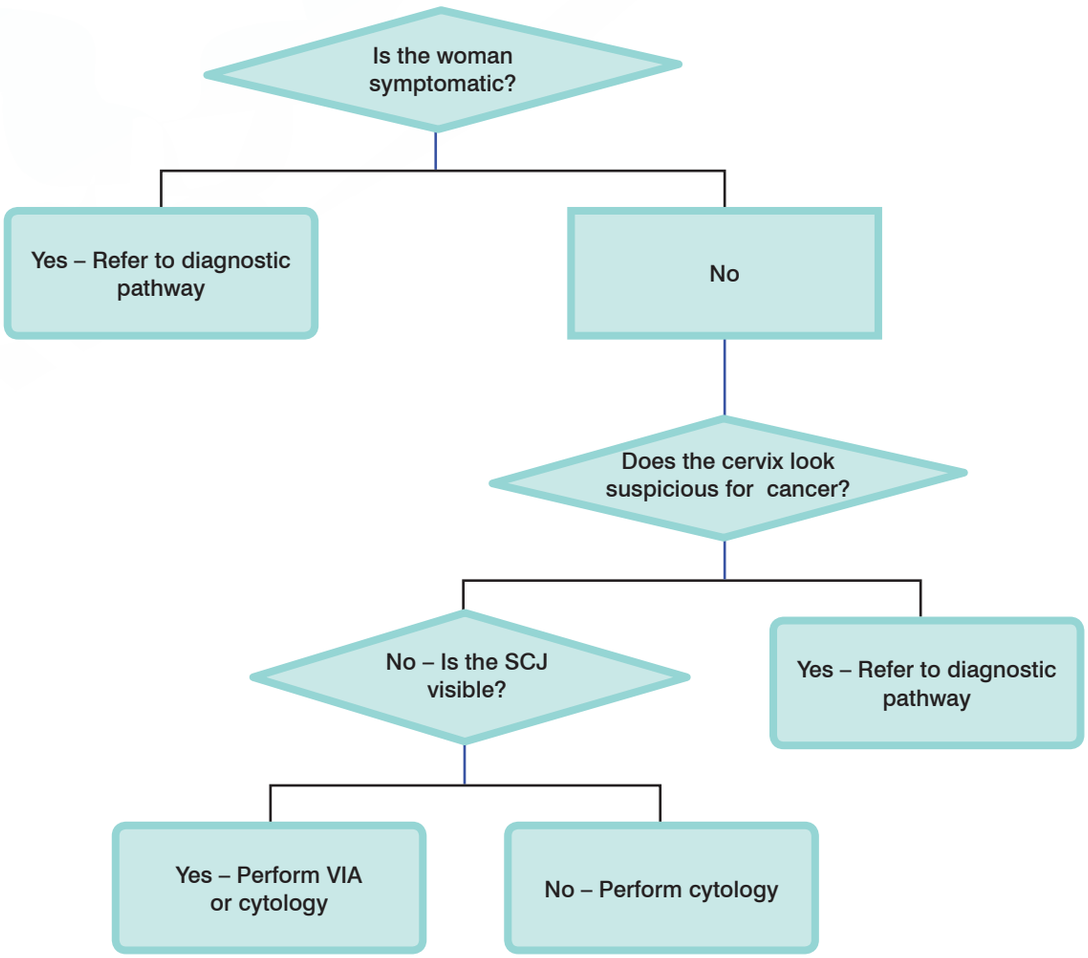
The purpose of all cervical screening is to identify those at higher risk of developing cervical cancer among women without symptoms of disease. Cervical cancer screening is provided for asymptomatic women only. Women who present with symptoms must be referred directly for diagnosis and management.

Cervical cancer screening will be available using visual inspection with acetic acid or cytology. The strategy used for cervical screening is dependent on multiple factors and will differ between geographical areas within each division of Fiji. Each Divisional team will ultimately decide which screening method is most appropriate for women in each area. Flowchart 1 provides the decision-making pathway for cervical cancer screening, and Flowcharts 2 and 3 provide guidance on the screening pathway using VIA and cytology.

If women present without symptoms but their cervix is considered suspicious for cancer when visualised, they must be referred for diagnosis and are not suitable for screening.[3]

A limiting factor in using VIA as a screening method is that it is essential to visualise the squamocolumnar junction (SCJ) to ensure that the whole transformation zone (the area on the ectocervix where a precancerous lesion is most likely) is able to be examined. It is recommended that in women where the SCJ is not visible, cytology is used as the method for screening.[9]

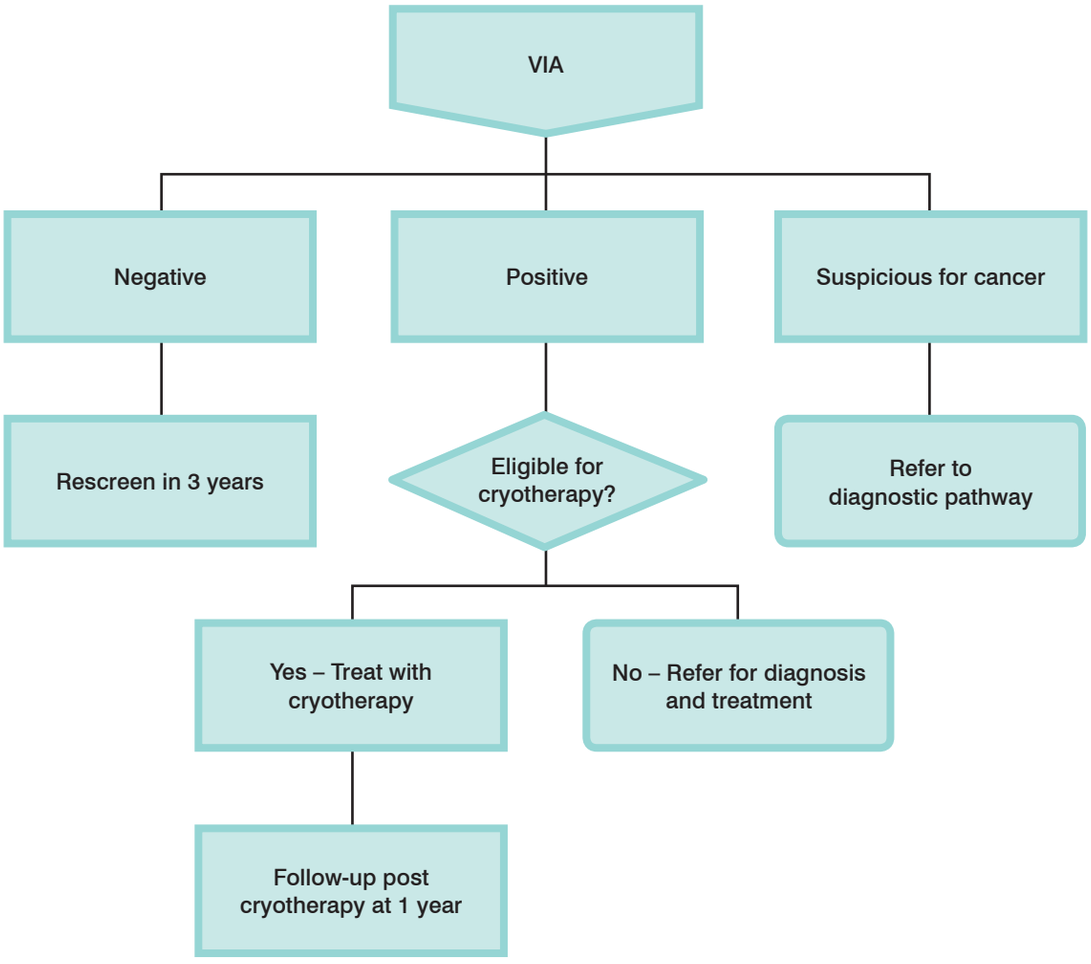
Flowchart 1: Decision-making Pathway for Cervical Cancer Screening Strategies



Pathway for Screening with VIA and Treatment with Cryotherapy

Typically in women under the age of 50 years the outer limit of the transformation zone, identified as the SCJ, will be visible, and VIA will be an appropriate screening method. Flowchart 2 outlines the pathway for VIA screening and treatment with cryotherapy. Where cryotherapy is appropriate (see criteria of limitations in Cryotherapy in 3.2.4), treatment may be provided by nurses and doctors at the same visit using a single visit approach, or at a follow-up visit.[9]

Flowchart 2: Pathway for Screening with VIA and Treatment with Cryotherapy



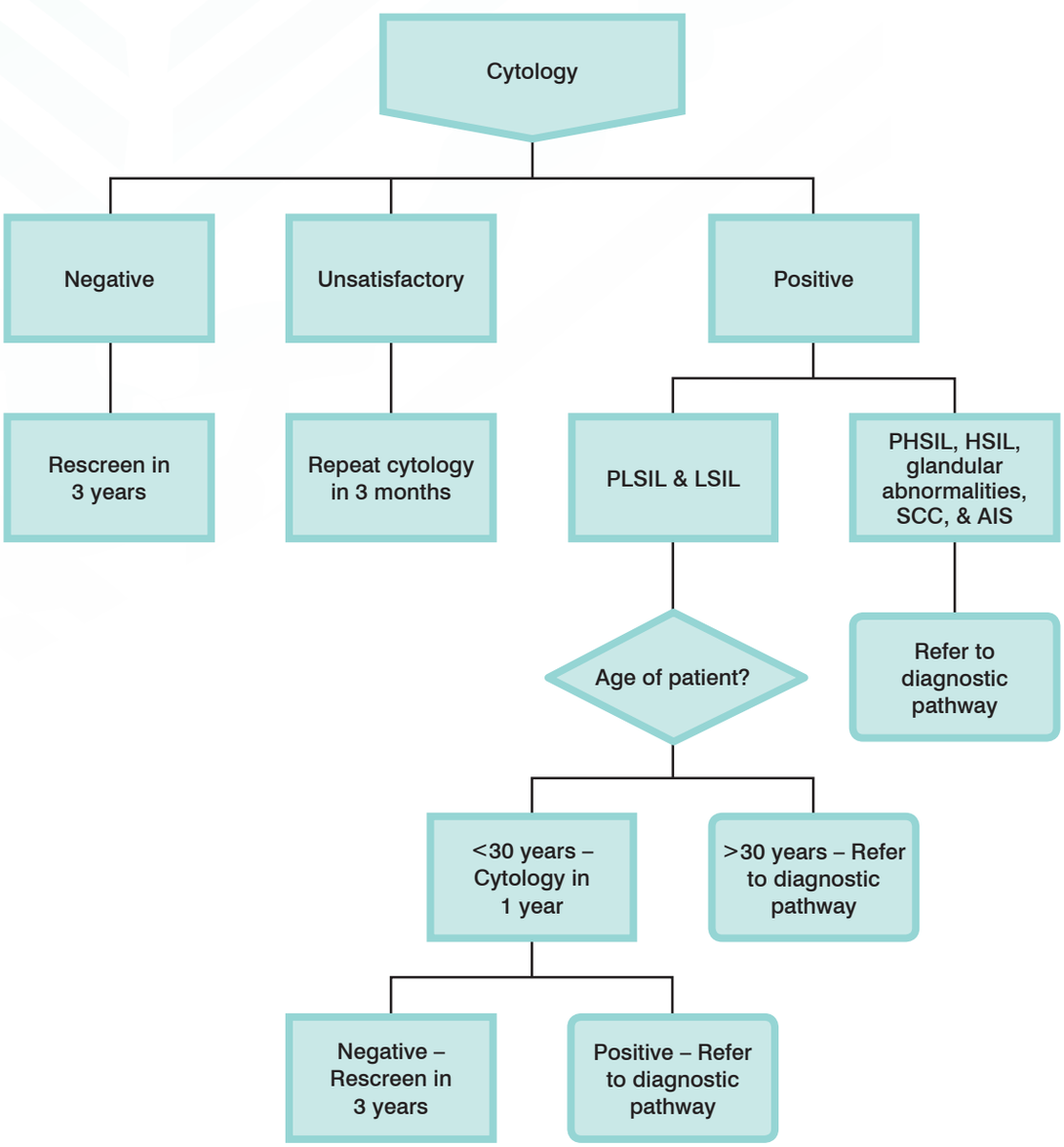
Pathway for Screening with Cytology

Both types of cytology, conventional Pap tests and liquid based, are currently available in Fiji. Regardless of the type of cervical cytology used, providers will follow Flowchart 3.

Fiji Ministry of Health and Medical Services is committed to the use of Australian Modified Bethesda System 2004 Terminology for reporting cytology. In addition to positive and negative results, cytology specimens may be deemed unsatisfactory for reporting and in this case should be repeated in 3 months. While women with an unsatisfactory cytology result are considered unscreened, the test should not be repeated before 6 weeks to avoid a false negative result.[4]

The management of positive cytology results is determined by grade, as outlined in Flowchart 3. All women with cytology reporting glandular abnormalities, regardless of grade, should be referred for diagnosis. Women with cytology reported as squamous cell carcinoma (SCC), adenocarcinoma in situ (AIS), or adenocarcinoma also require immediate referral.[4]

Flowchart 3: Pathway for Screening with Cytology



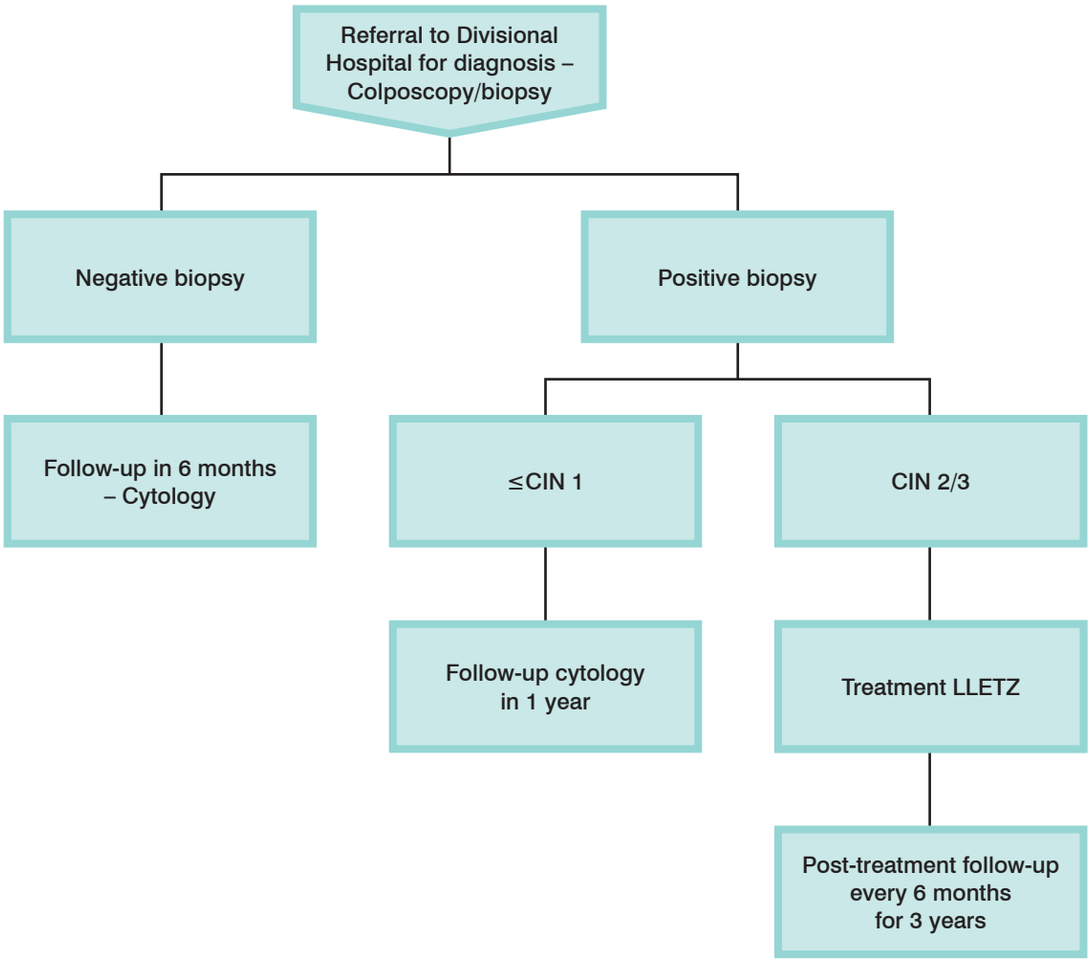
3.3.3 Diagnosis and Treatment Pathway

Referral pathways for diagnosis and treatment are essential to the success of the cervical screening program in preventing cervical cancer. Referral to the Divisional Hospital is required in circumstances indicated in the previous screening flowcharts, including when:

- the woman is symptomatic
- appearance of the cervix is suspicious for cancer
- acetowhite lesions do not meet criteria for cryotherapy
- positive cytology with the exception of initial possible low grade intraepithelial lesion (PLSIL) and low grade intraepithelial lesion (LSIL) under the age of 30 years
- other abnormal findings on gynaecological exam, e.g. polyps.

Following referral to the Divisional Hospital, appropriate diagnosis, treatment, and follow-up requirements will be determined by the individual clinician. Flowchart 4 represents the recommendations following referral for colposcopy and biopsy.[3]

Flowchart 4: Diagnosis and Treatment Pathway



3.4 Health Workforce

Cervical screening using VIA and cytology, and treatment of precancerous lesions using cryotherapy will be performed by registered nurses, midwives, and doctors who are trained and assessed as being competent in the procedures. Training should be completed during a 6-month public health attachment for nurses employed within the Ministry of Health and Medical Services. All nurses and midwives working in the Ministry of Health and Medical Services or NGOs must undergo cervical screening training prior to providing cervical screening services.[10]

Cryotherapy is a nursing intermediate level practice skill that requires specialised training, and is recommended to be undertaken when the nurse has completed 2–5 full-time years of practice.

The Ministry of Health and Medical Services will ensure that all appropriate nurses and midwives providing women's health services in hospitals, health centres, nursing stations, and NGOs have access to appropriate training to ensure the provision of routine and opportunistic screening for women.

3.4.1 Training

Cervical cancer screening training will be provided using a train-the-trainer model, coordinated by the National and Divisional CECAP teams. Regular training will be delivered at a Divisional level to ensure an adequate number of nurses and midwives are trained. The training will ensure that individual providers acquire the knowledge and skills to competently practise cervical screening with a variety of methods, including cytology (conventional and liquid-based), VIA, and cryotherapy treatment.

The competency-based training program will include the knowledge and skills required to support the implementation of this policy. After completing the training course, participants will be able to competently:

- Perform VIA and identify acetowhite lesions of the cervix that require follow-up
- Perform quality cervical sampling for screening purposes
- Perform cryotherapy
- Educate and sensitively counsel women about the importance of screening, how VIA and cryotherapy are done, and what follows after VIA and cryotherapy treatment.

Refresher courses will be delivered to ensure all of the appropriate nurses, midwives, and doctors have been trained and demonstrate competency in VIA, cryotherapy, and cytology.

3.4.2 Quality Assurance

The cervical cancer prevention and control program will be implemented within a quality assurance (QA) framework to ensure that the program is implemented in a manner that maximises the benefit of the program to the target population. QA refers to an overall management plan that guarantees the provision of good quality service delivery, including the application of a series of measurements used to assess the quality of facilities and service delivery provided.

The National CECAP team will coordinate the implementation of QA processes at the local level to ensure the sustained high quality of cervical cancer prevention, screening, and treatment. This will be based on the following:

- Measurable indicators will be used to facilitate assessment of program performance towards achieving the stated goals.
- A supportive supervision framework will be implemented, focusing on improving performance of service delivery to meet expected standards.
- Practical guidance and tools will be available for all nurses and doctors who play an active role in monitoring quality.[11]

The National CECAP team will facilitate QA processes at a Divisional level, and mentor and support Divisional staff to conduct the quality assurance processes at a local level. This includes the provision of an initial QA visit conducted by the trainer within 1 month of completion of the training to ensure proficiency in VIA, cytology, and cryotherapy, as appropriate.

The National CECAP team will meet in the Division to perform QA visits and to provide training, mentoring, and support to the teams in the implementation of all program activities, including the following:

- Review performance standards and indicators
- Perform site assessment
- Review the proficiency of individual providers, including review of self-assessment data of providers and observation of screening procedures
- Review infection control procedures and maintenance of equipment

- Ensure appropriate use of educational materials/job aids
- Review data management, including documentation, checking logbooks for discordance, and reporting
- Make recommendations about performance improvement in action plan
- Review action plan and reassess at follow-up visits.

The Divisional CECAP teams will be responsible for ongoing QA at a Divisional and local level.

Annexes 4–7 provide the program indicators, data collection, and quality assurance forms to be used.

Related Government Documents

The cervical cancer screening policy has been developed in line with the:

- *Fiji Health Strategic Plan 2011–2015.*
- *Ministry of Health Annual Corporate Plan 2014.*
- *Reproductive Health Policy 2011:*
  - Cervical screening is included under Section 1 of Key policy areas of Reproductive Health, and specifically Strategic Area 2 Comprehensive and Integrated Reproductive Health (RH) services, where activities include 'Review of current RH cancer preventative and curative services with a focus on incorporating low technology based strategies to facilitate extension of these services to marginalised population' (p.12).
  - Section 2, Strategic Area 1: Ensuring every pregnant woman is provided with quality antenatal care, lists revising the policy for Pap smear screening in antenatal clinics as an activity.[12]
- *Fiji National Immunisation Policy and Procedure Manual 2013–2016:*
  - HPV vaccine introduced to Class 8 girls in 2013.[13]

Monitoring and Evaluation

Monitoring and evaluation of the program will be conducted to ensure that the processes and systems are implemented in such a way that high quality cervical cancer screening and treatment is delivered and maximises the benefits to the target population.

A national cervical screening register will be developed and maintained by the National CECAP team, recording key program indicators and producing regular reports to monitor performance at a local, divisional, and national level. Key data items will be collected by all providers performing cervical cancer screening (Annex 3) using standardised forms (Annex 5) to capture essential data for monitoring and evaluation. These forms will be forwarded to the National CECAP team on a monthly basis, to enable timely reporting. Standardised reports will be prepared on program performance against key program indicators (Annex 4), and distributed to key stakeholders and providers to monitor program performance. The integration of the national screening data, as well as pathology and histology results into other Fiji electronic medical record systems should continue to be explored.

Following are the core indicators used to monitor and evaluate the cervical cancer prevention program. Additional indicators are included in the annexes to monitor the quality and success of program implementation across the screening pathway, and others may be added as required during the implementation of the program.[11]

Performance indicators for HPV vaccination are:

- Vaccine coverage of the target population: proportion of girls fully vaccinated by the age of 13 every year.
- Rate of adverse events following immunisation (AEFIs): number of AEFIs reported every year.[1]

Performance indicators for cervical cancer screening and treatment are:

- Screening Participation Rate: percentage of women in the target age group (30–49 years) who have been screened (VIA and cytology) for the first time in the previous 36 months.
- Screening Positivity Rate: percentage of women screened aged 30–49 years with a positive result.
- Treatment Rate: percentage of women with a positive VIA or cytology test receiving treatment in the previous 12-month period.
- Coverage Rate: percentage of women in the eligible population (26–69 years) who have been screened (VIA and cytology) at least once.
- Unsatisfactory Cytology Rates: percentage of cytology tests reported as unsatisfactory.
- Single Visit Approach Rate: the number of screen-positive women with lesions eligible for cryotherapy treated during the same visit.

Impact indicator:

- Cervical cancer age-specific incidence and mortality: age-specific incidence and mortality of cervical cancer in the target population.[1]

4. Implementation Plan

Strategic Area 1: Provide a National Coordinated Cervical Cancer Prevention and Control Program across Fiji

Activities	Performance Indicators	Timeframes	Responsibilities
1.1 Establish national and local CECAP teams to implement the program.	National and Divisional CECAP teams established.	Q1 2015	National Advisor Family Health, CECAP
1.2 Develop work plan for each Division to implement the program.	Work plan developed with each Division to include screening targets, workforce, training, equipment, commodities, and monitoring and evaluation systems and processes to be implemented.	Q1–Q2 2015	CECAP, Divisional CECAP team
1.3 Ensure regular project implementation meetings at a national and Divisional level.	CECAP program outcomes and reports reviewed at: • Divisional Plus monthly meeting • Clinical Services Network • Divisional meetings.	Q2 2015 and ongoing	Family Health Unit, CECAP, Divisional CECAP team

Strategic Area 2: Promote Access to the Program by Providing Accurate Health Information to all Women and Men

Activities	Performance Indicators	Timeframes	Responsibilities
2.1 Develop key cervical cancer screening program messaging to promote the program.	Key messages documented and distributed to all Divisions and NGOs participating in screening.	Q1 2015	CECAP, Public Health Unit, Health Promotion Unit
2.2 Develop cervical cancer screening campaign materials to be used to promote the program across all Divisions.	Culturally-appropriate IEC materials designed and printed, including brochures, posters, and banners.	Q1 2015 and ongoing	Public Health Unit, Health Promotion Unit, CECAP
	IEC materials distributed to all Divisions and NGOs participating in screening, and used in local health promotion activities.	Q2 2015 and ongoing	Divisional Public Health Units
2.3 Develop materials consistent with key messages to support the delivery of community education.	Sample lesson plans developed to target population groups and settings (e.g. women's groups, men's groups, church groups, and individual and large groups).	Q2 2015 and ongoing	Public Health Unit, Health Promotion Unit, CECAP
	Activities and materials to support community education produced, such as flip charts and activities.	2015 and ongoing	Public Health Unit, Health Promotion Unit, CECAP, FHSSP
	Training provided to build local capacity to deliver high quality, appropriate community education.	Q3 2015 and ongoing	Health Promotion Unit, RFHAF

Activities	Performance Indicators	Timeframes	Responsibilities
2.4 Deliver information and community education to encourage women in the target age group to attend cervical cancer screening.	IEC materials distributed.	Q3 2015 and ongoing	CECAP, Health Promotion Unit, Divisional Public Health Units, NGOs
	Community education sessions delivered to target population groups and settings (e.g. women's groups, men's groups, church groups, and individual and large groups).	Q3 2015 and ongoing	CECAP, Health Promotion Unit, Divisional Public Health Units, NGOs
	Cervical cancer screening promoted at local community events.	Q3 2015 and ongoing	CECAP, Health Promotion Unit, Divisional Public Health Units, NGOs
2.5 Use new technologies to promote cervical cancer screening.	Establish appropriate social media platform, such as Facebook page or Twitter account for the program.	Q1 2015	Public Health Unit, Health Promotion Unit, CECAP
	Explore opportunities to work with mobile phone carriers to promote the program.	Q2 2015	Health Promotion Unit
	Use social media and mobile phones to promote program messaging and local outreach activities.	Q1 2015 and ongoing	Health Promotion Unit, CECAP
	Capture and share positive program outcomes using social media – such as individual stories of cancers detected and lives saved.	Q3 2015 and ongoing	CECAP, Health Promotion Unit, Divisional Public Health Units
2.6 Identify key ambassadors for the program.	Identify key Fijian women and men to act as ambassadors to encourage women to attend for screening.	Q3 2015	Health Promotion Unit
	Provide ambassadors with key program messaging.	Q3 2015	Health Promotion Unit
	Use program ambassadors in national media, as well as social media and marketing activities.	Q3 2015 and ongoing	Health Promotion Unit
2.7 Implement a national media campaign to promote the program.	Print, radio, and TV used to promote key messaging and local outreach events.	Q3 2015 and ongoing	Health Promotion Unit

Strategic Area 3: Ensure a Highly Trained, Up-To-Date, Sensitive, and Effective Workforce

Activities	Performance Indicators	Timeframes	Responsibilities
3.1 Review and update current VIA training program materials to reflect national policy.	VIA course materials updated to include cytology and reflect national policy.	Q1 2015	FHSSP, CECAP, Family Health Unit
	Train-the-trainer program developed.	Q1 2015	FHSSP, CECAP, Family Health Unit
	Refresher training program developed.	Q1 2015	FHSSP, CECAP, Family Health Unit
3.2 Survey current workforce to determine number of trained screening providers.	Survey developed and distributed to Divisions and NGOs performing cervical cancer screening.	Q1 2015	National Reproductive Health Coordinator – Family Health Unit
	Survey results collated to determine number of providers to be trained by Division.	Q1 2015	National Reproductive Health Coordinator – Family Health Unit
3.3 Deliver refresher training to current trained providers.	Identify 2 trainers from each Division.	Q1 2015	National Reproductive Health Coordinator – Family Health Unit
	Deliver 1-day train-the-trainer session.	Q2 2015	FHSSP, CECAP
	Deliver 2-day refresher training and assessment in each Division.	Q2 2015	FHSSP, CECAP
3.4 Deliver full cervical cancer screening course.	Training course delivered in each Division with Divisional trainers co-facilitating.	Q2–Q3 2015	CECAP, Divisional CECAP teams
	Deliver 2 full courses per annum to maintain skilled workforce.	2016 and ongoing	CECAP, Divisional CECAP teams
3.5 Implement ongoing quality assurance.	QA visit documentation and support materials developed.	Q1 2015	FHSSP, CECAP
	QA visits to all screening providers completed within 1 month of the completion of training.	Q2 2015 and ongoing	CECAP
	Quarterly QA and project implementation visits with each Division.	Q2 2015 and ongoing	CECAP, Divisional CECAP team

Strategic Area 4: Ensure Cervical Cancer Prevention and Screening Supplies and Commodities are Distributed Equitably across Fiji

Activities	Performance Indicators	Timeframes	Responsibilities
4.1 Provide appropriate equipment and commodities to each Division to implement the program.	Review current equipment and commodities at each facility using Cervical Screening Site Assessment – Facility Audit tool.	Q1 2015	CECAP, Divisional CECAP teams
	Equipment requirements per Division documented and equipment ordered.	Q1 2015	CECAP, Divisional CECAP teams
4.2 Ensure cervical cancer screening providers have reliable access to vehicles for outreach clinics.	Access to transport confirmed for outreach clinics.	Q1 2015	CECAP, Divisional CECAP teams

Strategic Area 5: Provide High Quality Cervical Cancer Prevention, Screening, Diagnosis, and Treatment to Eligible Women in the Community

Activities	Performance Indicators	Timeframes	Responsibilities
5.1 Cervical cancer screening, diagnosis, and treatment provided to target population.	VIA and cytology performed, and women referred for diagnosis and treatment according to national guidelines.	Q1 2015 and ongoing	CECAP, Divisional CECAP teams

Strategic Area 6: Ensure the Cervical Cancer Prevention and Control Program is Implemented in a Manner to Minimise the Morbidity and Mortality of Cervical Cancer in Fiji

Activities	Performance Indicators	Timeframes	Responsibilities
6.1 Develop monitoring and evaluation plan to review program implementation.	Data items and definitions and program indicators confirmed.	Q1 2015	National Advisor Family Health, CECAP
	VIA register expanded to include cytology, client recall, and program reporting.	Q1–Q2 2015	FHSSP, CECAP
	Capacity building provided to ensure quality data entry and reporting.	Q1–Q2 2015	FHSSP, CECAP
	Implement data forms and reporting framework.	Q1–Q2 2015	FHSSP, CECAP, Divisional CECAP teams
6.2 Confirm cervical cancer screening targets.	Confirm cervical cancer screening targets to meet program outcomes.	Q1–Q2 2015	FHSSP, CECAP
	Review screening targets by Division to ensure adequately trained workforce to meet targets.	Q1–Q2 2015	FHSSP, CECAP
6.3 Provide regular reports to monitor program effectiveness.	Review and distribute monthly program reports and review at national, Divisional, and local meetings.	Q1 2015 and ongoing	CECAP, Divisional CECAP teams
6.4 Explore opportunities to integrate into existing Ministry of Health and Medical Services processes.	Explore opportunities to use NHN as unique identifier in cervical cancer register.	Q3 2015	CECAP, FHSSP
	Explore opportunities to incorporate cervical screening records into PATIS database using NHN.	Q4 2015 and ongoing	CECAP, FHSSP

Effective/Review Date

The Minister and the Permanent Secretary endorses the policy, while the policy stated in here continues to be carried out in all hospitals, and the review will follow upon developments requiring changes to policy. This policy should be assessed in accordance with all guidelines and will be reviewed in 2018.

5. References

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ANNEXES

ANNEX 1: Key Messages for Cervical Cancer Outreach and Education

(Adapted from *WHO Comprehensive Cervical Cancer Control: A guide to essential practice* – 2nd ed., 2014.[1])

Providing accurate and easy-to-understand information is the first step in helping women and families access services that can prevent cervical cancer. You can use these messages to develop community education sessions.

Health education efforts should result in women and men being able to answer the following questions:

- **What** is pre-cancer?
- **What** is cervical cancer?
- **How** can cervical cancer be prevented?
- **Who** should be vaccinated?
- **Who** should be screened?
- **Which** prevention services are available locally?
- **Where** and **when** can these local services be accessed?

Key messages

You can prevent cervical cancer with vaccination, early detection, and treatment! The following specific messages are the most important ones to convey within your community.

Learn these five simple messages and use them consistently.

1. Cervical cancer is a disease that can be prevented.
2. There are tests to detect early changes in the cervix (known as pre-cancers) that may lead to cancer if not treated.
3. There are safe and effective treatments for these early changes.
4. All women aged 30–49 years should be screened for cervical cancer, and women 26–69 years should be screened at least once in their life.
5. There is a vaccine for girls that can help prevent cervical cancer.

More detailed cervical cancer messages to use in your health promotion talks

Who is at risk?

- Cervical cancer is a leading cause of cancer death in women in Fiji.
- Women 30–49 years old are most at risk for cervical cancer.
- Any woman who has had sex is at risk of developing cervical cancer.

HPV infection

- Cervical cancer is caused by infection with a virus called HPV. This virus is passed during sex and is very common among men and women.
- Almost all men and women will be exposed to HPV in their lifetime. Most HPV infections go away in a short time without treatment.
- In some women, HPV infection continues and can slowly change the cells on the cervix. These changes are called pre-cancer. If not treated, they can develop into cancer of the cervix.

Vaccination

- All girls should be vaccinated with the HPV vaccine in grade 8.
- Vaccination prevents infection with the types of HPV that cause most cervical cancers.
- The HPV vaccines are safe and effective. Adverse reactions, when they occur, are usually minor.
- The HPV vaccine has no impact on a girl's fertility and does not affect her capacity to become pregnant and have healthy children later in life.
- Even after vaccination, all women aged 30–49 years will require cervical cancer screening.

Screening and treatment

- There are screening tests for cervical cancer that can detect early changes of the cervix (pre-cancer).
- The screening tests for cervical pre-cancer are simple, quick, and do not hurt.
- In Fiji, the nurses may test for pre-cancer using VIA or a Pap test.
- If the screening test is positive, it means that there could be early changes (pre-cancer) that can be treated. A positive screening test outcome **does not** mean cancer.

- To prevent cervical cancer, all women with positive screening tests should receive treatment.
- Women should have a screening test at least once between the ages of 30 and 49 years.
- It is important to follow the recommendation of the nurse or doctor as to when to return for screening.
- Women living with HIV are at higher risk for cervical cancer. Screening for cervical pre-cancer and cancer should be done in women and girls who have initiated sexual activity as soon as the woman or girl has tested positive for HIV, regardless of age.

Signs and symptoms of cervical cancer

- Signs of cervical cancer include: foul-smelling vaginal discharge, vaginal bleeding, bleeding after sexual intercourse, or any bleeding after menopause. Women with these symptoms should seek medical care at their health centre or Divisional Hospital promptly.
- There are no signs or symptoms for the early changes of pre-cancer. Screening is the only way for women to know if they have pre-cancer.

Making decisions about health

- Women have a right to make their own decisions about their health. To make informed decisions, women need correct information.
- Women may wish to involve their partners or families in their decision-making.
- While screening for cervical cancer and treatment of pre-cancer are highly recommended, women should know they are free to refuse any test or treatment.

ANNEX 2: Frequently Asked Questions

(Adapted from *WHO Comprehensive Cervical Cancer Control: A guide to essential practice* – 2nd ed., 2014.[1])

Men and women, including healthcare providers, often lack information on cervical cancer. This practice sheet lists some FAQs and provides answers. You and your colleagues should add other questions and answers relevant to the local situation. It should be noted that some of the answers are repetitive, so that when a question is asked you do not need to go through all of the answers in this sheet. If you familiarise yourself with all of the information below, then, when asked a question, you will be able to quickly find the best answer for it.

About cervical cancer

Q: What is cancer?

A: Cancer is the disease caused by uncontrolled growth of certain cells in the body, causing tumours or growths. Not all growths are cancer. When a cancer is allowed to grow and spread it can interfere with the normal functions of the body.

Q: What causes cervical cancer?

A: Cervical cancer is caused by infection with a virus called human papillomavirus or HPV. It is a very common virus that is passed during sex, so most people will have it at some time in their lives. For most people, HPV will go away on its own, but in a small number of infected women the virus will persist. For these women, the virus can cause changes in the cells of the cervix, which might develop into cervical cancer if they are not found during a screening test and removed.

Q: Does HPV cause any other diseases?

A: HPV can cause genital warts in men and women. Genital warts are caused by different types of the HPV virus than cervical cancer. Genital warts will not turn into cancer, although they may require treatment if they do not go away on their own. In rare cases, HPV can cause other types of cancers, including cancer of the vagina, vulva, penis, or anus.

Q: Who gets cervical cancer?

A: Almost all women who have had sexual relations, even without having had sexual intercourse, can be infected with HPV and are therefore at risk of cervical cancer. The women at greatest risk are those who have never been screened. Women who are living with HIV are also at greater risk because HIV makes them more likely to develop cancer when they are younger.

The good news is that most women's bodies will clear the HPV infection on their own and they will never get cancer, but screening is the only way to know who may develop the disease.

Because cervical cancer is not commonly found in women until they are in their 40s and 50s, the best time to screen for pre-cancer is between the ages of 30 and 49 years, before it becomes cancer.

Q: What can I do to prevent cervical cancer?

A: The most effective ways to prevent cervical cancer are for girls to get vaccinated before they start sexual activity and for women 30–49 years old to get screened.

If a woman's screening test is positive, she needs to be promptly treated. This can save her life. If the test is negative, it's a good idea to have repeat screening every three years.

If you have a daughter, make sure she receives all recommended doses of the HPV vaccine. Also, teach her about the importance of screening and early treatment when she is older.

All sexually active people should also practise behaviours that prevent the spread of sexually transmitted infections (e.g. delaying initiation of sexual activity, using condoms, and having as few sexual partners as possible). Smoking tobacco can increase the risk of cervical cancer in women infected with HPV.

About screening (early detection) and treatment

Q: What is cervical screening?

A: Cervical screening is the testing of all women at risk for cervical cancer to detect whether they have pre-cancer. If pre-cancer is found and not treated it may progress to cancer in 10 or more years.

There are several very effective tests that can be used for screening, such as VIA or cytology tests, and the nurse or doctor will decide on what is the most appropriate test for you.

Q: Who should be screened for cervical cancer?

A: Women between the ages of 30 and 49 years should have a screening test every three years to detect early changes on the cervix, called pre-cancer. Women between the ages of 50 to 69 years should have a screening test once to detect any changes.

Screening for cervical pre-cancer and cancer should also be done in women and girls who have initiated sex as soon as the woman or girl has tested positive for HIV, regardless of age.

Q: I don't have any symptoms, why should I be tested?

A: The HPV lives in women's bodies for many years before it causes problems. After many years it starts to cause changes in the cells of the cervix, called pre-cancer. Before they have developed cancer, most women with pre-cancer will not have any symptoms. You can have pre-cancer for 10–15 years without feeling anything abnormal before it becomes cancer.

When symptoms do occur – such as pain in the pelvic region or a foul odour from the vagina – they often are the result of advanced cervical cancer, which is difficult to treat. To avoid advanced cancer, women must be screened for pre-cancer at least once between the ages of 30 and 49 years and must be treated if there are signs of disease. Treatment of pre-cancer is easy and very effective.

Q: What is done during screening?

A: There are different tests that can be used. Your nurse or doctor will tell you about the most appropriate test when you attend. For most tests, the provider will insert a speculum and gently swab the cervix. While the test is not painful, it can be a little uncomfortable to have a speculum in the vagina to see the cervix. Your provider should try to make it as comfortable as possible for you. Some tests give the results right away and others require sending the sample to a lab and waiting for results.

Q: What if my test is negative?

A: If your screening test is negative, it means that you do not have any changes that might develop into cervical cancer. It is important to be screened every 3 years if you are between 30 to 49 years to make sure any pre-cancer changes are caught early and treated right away.

Q: What if my test is positive?

A: In most cases, a positive screening test means you have pre-cancer, a condition that can be easily treated in a clinic setting.

In a few women, you may be referred for further testing to make sure that what you have is pre-cancer and not cancer. For those next steps, the nurse/doctor may send you to another facility, such as your local health centre or Divisional Hospital. You may also be referred to the Divisional Hospital for further care if he or she is not sure of the test results, or if he or she cannot provide the required treatment.

Note for the provider: Unless you have a definitive diagnosis of cancer made using tissue from the cervix, you should not tell the woman she might have cancer, because often the first impressions may be wrong and you may frighten her unnecessarily.

Q: Does a positive screening test mean that I have cancer? Does it mean that I will die from cervical cancer?

A: A positive screening test does not mean you have cancer. Most often it means you have something called pre-cancer, or early changes that could become cancer in many years if not treated. Pre-cancer is easy to treat and is curable. Often pre-cancer goes away following only one treatment.

Very rarely a woman is found to have signs of cervical cancer at the time of screening. If signs of possible cancer are found, your doctor will do further testing or will refer you to your local health centre or Divisional Hospital for testing and/or treatment. It is important to treat both pre-cancer and cancer.

A diagnosis of cancer does not mean you will die from it; if found early, it can be cured with available treatments.

Q: How do we treat pre-cancer?

A: If you have a pre-cancer, your nurse or doctor might be able to treat it on the same day as the screening. The most common treatment for pre-cancer is to freeze it, a treatment called cryotherapy. Cryotherapy is not painful, although like a pelvic examination it can be uncomfortable. It is very effective and safe. In most cases, your cervix will be healthy and normal after cryotherapy. Another treatment is loop excision procedure (LLETZ), although you will need to go to the Divisional Hospital to have this done.

Q: Are screening tests painful? Is part of a woman's cervix or womb removed during screening?

A: Screening tests are painless, though you may feel a little uncomfortable during a pelvic examination. No part of the cervix or womb is removed during screening.

Q: Is one screening enough?

A: Having at least one screening has been shown to decrease a woman's chance of dying from cervical cancer. However, if you are between the ages of 30 and 49 years, it is best to be tested again every 3 years.

Q: I am too shy to show my private parts to a male doctor, what can I do?

A: The screening may be performed by a female nurse, but if that is not possible, you can ask for a female healthcare provider or a friend or family member to be in the room during the screening.

Even if you feel shy or embarrassed, please remember that the male and female nurses and doctors are all trained in the same way and that their goal is to help you prevent cervical cancer. Do the right thing for yourself and for your family – get screened for pre-cancer and treated if you have it. Screening and treatment are not painful. If you do not get screened only because you are shy and the provider is a man, try to overcome this fear and remember that women with cervical cancer suffer much pain and can die from it.

Q: How similar is HPV to HIV, the virus that causes AIDS?

A: The two viruses – HPV (human papillomavirus) and HIV (human immunodeficiency virus) – are very different.

HPV is a much more common infection than HIV – almost everyone who is sexually active becomes infected with HPV at some point in his or her life. HPV lives on the skin and is transmitted when skin touches skin. HIV lives in body fluids like semen and blood, and is transmitted when those body fluids are exchanged between people; this is the reason that condoms are very effective at preventing HIV when sexual intercourse takes place.

However, condoms are not as good at preventing HPV infections because this virus can live on the skin. The best way to prevent HPV infection is through vaccination. Currently, no vaccine for HIV exists.

Common worries about cervical cancer

Q: I have heard that cervical cancer is caused by poor female hygiene or by using sanitary pads more than once. Is that true?

A: No. Cervical cancer is caused by infection with HPV. The cancer has nothing to do with vaginal hygiene or sanitary pads.

Q: Is cervical cancer a sexually transmitted infection (STI)?

A: No. However, it is caused by HPV, which can be passed from one person to another during sex. HPV is quite common in both men and women. Only a few women with HPV will get pre-cancer. If not treated, some of these women will develop cervical cancer many years after they were infected with HPV.

Q: Are women with many sexual partners at higher risk of HPV infection?

A: Yes. People with many sexual partners are at higher risk of all sexually transmitted infections. The fewer sexual partners a person has, the less chance he or she has of becoming infected with any STI, including the many types of HPV, some of which cause cervical cancer.

Q: Is it true that only bad or loose women get cervical cancer?

A: No! All sexually active women are at some risk of cervical cancer. Being screened for pre-cancer can decrease this risk in women over 30, and giving the HPV vaccine to girls in grade 8 will decrease their risk as they grow up.

Q: Do intrauterine contraceptive devices (IUDs) or birth control pills cause cervical cancer?

A: No. IUDs and birth control pills do not cause cervical cancer. They protect against unplanned pregnancies.

ANNEX 3: Data Items and Definitions

The following table contains the data items to be collected and entered into the Fiji National Cervical Cancer Screening Data Registry.

Data Item	Format	Definition
Name – Given name, family name	Text	The given name and family name in the format preferred by the person. The format should be the same as that printed on an identification card, such as a National Health Card or driver's licence, to ensure consistent collection of name data.
Address	Numeric and text	House number/street/town/province name.
Contact phone number	Numeric	The preferred contact phone number to be used to contact for results or follow-up.
Date of birth	DD/MM/YYYY	The date the person was born.
Indigenous status	Text	Whether a person identifies as being i-Taukei or Fijian of Indian descent.
National Health Card Number	Numeric	The number issued on the National Health Card.
Date of cervical cancer screening	DD/MM/YYYY	The date that represents when VIA or a cytology specimen was taken from a person to screen for cancer or precancerous changes to the cervix.
Cervical screening test performed	Text	Whether the screening test performed was VIA, Pap test, liquid-based cytology, HPV DNA, or another test.
Cervical screening result	Text	Whether the screening test result was positive, negative, or suspicious for cancer.
Rescreen date	DD/MM/YYYY	The date the patient is due for VIA or cytology.
Cryotherapy performed	Yes/No	Whether cryotherapy was performed on the patient.
Date of cryotherapy	DD/MM/YYYY	The date the cryotherapy was performed – i.e. was it a single visit?
Date of cryotherapy follow-up	DD/MM/YYYY	The date the patient is due for follow-up post cryotherapy.
Referral to diagnostic pathway	Yes/No	Whether the patient was referred to the diagnostic pathway for further testing and treatment.
Reason for referral	Tick box	The reason the patient was referred to the Divisional Hospital for further testing and/or treatment: • Inability to visualise the cervix • Extensive acetowhite lesions • Abnormal cervix on naked eye examination • Other.
Follow-up date	DD/MM/YYYY	The date the patient is due for follow-up post treatment.

ANNEX 4: Program Indicators

The following core indicators for screening and treatment will be used to monitor the effectiveness of the Fiji cervical cancer screening program. They will be used for monitoring at a national, divisional, subdivisional, and medical area level.

Indicator 1: Screening Participation Rate

Definition: Percentage of women in the target age group (30–49 years) who have been screened (VIA and cytology) for the first time in the previous 36 months.

Calculation: Numerator – Number of women aged 30–49 years who have been screened for the first time in a 36-month period.

Denominator – Estimated number of women aged 30–49 years in the population.

Target: 80% by 2017.

Indicator 2: Screening Positivity Rate

Definition: Percentage of women screened aged 30–49 years with a positive result.

Calculation: Numerator – Number of women aged 30–49 years reported positive in a 12-month period.

Denominator – Number of women aged 30–49 years who have been screened in a 12-month period.

Target: 5–10%.

Indicator 3: Treatment Rate

Definition: Percentage of women with a positive VIA or cytology test receiving treatment in the previous 36-month period.

Calculation: Numerator – Number of women aged 30–49 years receiving cryotherapy or appropriate treatment in a 12-month period.

Denominator – Number of women aged 30–49 years reported positive in a 12-month period.

Indicator 4: Coverage Rate

Definition: Percentage of women in the eligible population (26–69 years) who have been screened (VIA and cytology) at least once.

Calculation: Numerator – Number of women aged 26–69 years who have had a cervical cancer screening test (VIA or cytology).

Denominator – Estimated number of women aged 26–69 years in the population.

Note: In measuring the coverage rate, need to agree on time period, when the starting point is – so it depends on the ability to capture identified cytology data to determine rate, i.e. if a women has had more than one test, it only is captured once in the numerator.

Indicator 5: Unsatisfactory Cytology Rates

Definition: Percentage of cytology tests reported as unsatisfactory.

Calculation: Numerator – Number of cytology tests reported as unsatisfactory.

Denominator – Number of cytology tests performed.

Target: Less than 5%.[14]

Indicator 6: Single Visit Approach Rate

Definition: The number of screen-positive women with lesions eligible for cryotherapy treated during the same visit.

Calculation: Numerator – Number of screen-positive women with lesions eligible for cryotherapy treated during the same visit x 100.

Denominator – Number of screen-positive women with lesions eligible for cryotherapy.

Indicator 7: **Percentage of screen-positive women with lesions not eligible for cryotherapy referred to colposcopy and who complete adequate treatment**

Calculation: Numerator – Number of screen-positive women with lesions not eligible for cryotherapy referred to colposcopy and who complete adequate treatment.

Denominator – Number of screen-positive women with lesions not eligible for cryotherapy.

Indicator 8: **Percentage of women with suspected invasive cancer on a cervical cancer screening test who complete adequate treatment or appropriate follow-up**

Calculation: Numerator – Number of women with suspected invasive cancer on a cervical cancer screening test who complete adequate treatment or follow-up x 100.

Denominator – Number of women with suspected invasive cancer on a cervical cancer screening test.

Other Data Reports

In addition to regular reporting on the program indicators, the following data reports will be reported on a regular basis at a National and Divisional level.

Report	Calculation	Target
Laboratory processing timeframes	Length of time it takes for test results to return from the laboratory	Less than 4 weeks
VIA performed	Number of cervical cancer screening performed using visual inspection with acetic acid by age group by Health Division	n/a
Pap tests	Number of Pap tests performed by age group by Health Division	20,000 per annum
Liquid-based cytology	Number of Thin Prep tests performed by age group by Health Division	30,000 per annum
Cryotherapy	Number of cryotherapy performed	
Community education	Number of cervical cancer screening community education sessions held by Health Division Number of participants by gender and Health Division	
IEC materials	Number of IEC materials produced	

ANNEX 5: Cervical Cancer Screening Data Form

To be filled out for all women who present for cervical screening by VIA, Pap test, or liquid-based cytology.

Date: _____ / _____ / 201____

Health centre/nursing station: _____

National Hospital Number: _____

Name: _____

Address: _____

Settlement/village: _____

Phone number: _____

Date of birth: _____ / _____ / _____

Indigenous status: ☐ i-Taukei ☐ Fijian of Indian Descent ☐ Other _____

Previous cervical screen: ☐ First screen ☐ 0–3 years ☐ >3 years

Date of screen (if known): _____ / _____ / _____

Test performed: ☐ VIA ☐ Pap test ☐ Thin Prep

VIA result: ☐ Normal ☐ Positive with acetowhite lesions

Cryotherapy performed: ☐ Yes – single visit ☐ Yes – return visit – date: _____ / _____ / _____

☐ No

Recommendation: ☐ Rescreen 3 years

☐ Follow-up 1 year (post cryotherapy)

☐ Refer to Divisional Hospital

Other _____

Tests performed by: _____

Original to be kept at health centre/nursing station.

Copy to be sent to National Screening Unit for data entry; if referred, copy to be sent to Divisional Hospital.

ANNEX 6: Cervical Screening Site Assessment – Facility Audit

This form is to be used prior to establishing screening in a new facility.

Date of assessment	
Name of site	
Name of assessor	

Question	Answer/Comment	Prompt
How can women access the site?		*Public transport, car, walk.*
Does this site currently provide cervical screening?		
Is reliable transportation of specimens to laboratory in place?		
Is a clinic room with suitable privacy available?		*Door, window covering;* *Is availability of room restricted some days?*
Does the clinic room have a suitable examination table/bunk?		*Adjustable or high bunk.*
Does the clinic room have a chair/stool available?		*Adjustable/on wheels best.*
Is a suitable examination light available?		
Is there a fan in the clinic room?		
Is there a suitable area for counselling women and discussing results?		*Desk/table/chair where clinician can face client in privacy.*
Does the clinic room have a sink and tap with running water?		*If not, what is available for handwashing?*
Is there a trolley or somewhere similar to set up screening test requirements?		*Area must be cleanable and within reach of bunk.*
What process, if any, does the site use for sterilising instruments?		*Boiling or steriliser; monitoring/condition of steriliser.*
Is there a clean dry area for storage of instruments?		

Question	Answer/Comment	Prompt
Does the clinic room have room near the bunk for cryotherapy equipment?		*Large gas cylinders should not be moved without a trolley; must be close enough for equipment to reach client.*
Does the site usually have gas delivered?		*Explore delivery systems in place that may be used for CO_2, e.g. O_2.*
Is a toilet available for clients/staff at the site?		
Does this site have a medical record system?		
Is there a visit register?		

Equipment for Cytology, VIA, and Cryotherapy

Equipment	Yes	No	Comment
Light source/torch (bright white light best)			
Clock/timer with second hand			
Minimum number of vaginal speculums in a variety of sizes			
Minimum number of sponge holders			
Small bowl for acetic acid			
Cryotherapy tips (3 minimum)*			
Cryotherapy gun*			
Trolley for gas bottle*			
Rubber/plastic sheet for bunk that can be wiped			
Spray bottle for cleaning bunk			
Privacy cover for woman			
Leak-proof containers/bucket for used instruments			
Heavy duty gloves for cleaning			
Toothbrush for cleaning speculums			
Bin for used swabs			

*For service providing cryotherapy

Minimum Instrument Requirement	Nurse Station	Health Centre	Divisional Hospital
Small speculum	2	5	15
Medium speculum	5	10	15
Large speculum	3	5	20
Sponge holder	10	20	50

Consumables	Yes	No	Comment on Supply
Cotton swabs			
Cervix samplers			
Cytobrushes			
Glass slides			
Protective case			
Spray fixative			
LBC bottles			
3–5% acetic acid			
Non-sterile gloves			
Lubricant			
Neutral detergent for cleaning			
Soap for handwashing			
Cloth/paper for wiping bunks			
Cloth/paper for drying hands			
CO_2 gas cylinder (E size suitable)			

Comment on Suitability of Site for Cervical Screening:

ANNEX 7: Quality Assurance Site Visit Form

Date: _____ / _____ / _____

Screening provider name: _____

Health centre/nursing station:_____

Program Indicators	Target	Result	Comments
Screening Participation Rate	80%		
Screening Positivity Rate	5–10%		
Treatment Rate			
Coverage Rate			
Unsatisfactory Cytology Rates	<5%		
Single Visit Approach Rate	100%		
Data collection (concordance between local register and data collection forms)	100%		
Laboratory processing timeframes			
Referral lost to follow-up	N/A		
Individual Provider Indicators			
VIA performed	n/a		
Cytology performed	n/a		
Cryotherapy performed	n/a		
Self-audit – Unsatisfactory Cytology Rates	<5%		

Co-assessment (min. 4)			Yes	No				
Procedure	Counselling	Proficiency						
	VIA							
	Cytology collection							
	Cryotherapy							
Agreement	VIA negative	70%						
	VIA positive	70%						
	Suspicious	90%						
	SCJ position	70%						
Consultation documentation								

Feedback/areas for improvement: _____

_____

_____

Action Plan

Date	Area	Goal	Actions Required	Review Date	Result

ANNEX 8: Observation guide for providing information and counselling skills

Rate the performance of each step or task observed using the following rating scale:

1. **Needs improvement:** Step or task not performed correctly, omitted, or out of sequence (where necessary).
2. **Developing competence:** Some steps or tasks performed correctly in the proper sequence (where necessary), but participant does not yet complete all steps.
3. **Competent:** Steps or tasks correctly performed in the proper sequence (where necessary).

Name of participant being observed: _____

Date _____ / _____ / _____				
Client number	1	2	3	4

1. Establish a cordial relationship

1.1	Greets client in a kind and respectful manner.				
1.2	Assures confidentiality and privacy.				
1.3	Determines the purpose of the consultation.				

2. Identify the client's needs

2.1	Asks questions in a clear and appropriate manner.				
2.2	Inquires about the client's health. Asks the client how she feels.				
2.3	Maintains an attentive posture.				
2.4	Does not criticise or give opinions about the client's comments.				
2.5	Clarifies and repeats the information that the client gives, when appropriate.				
2.6	Asks about the client's partner's opinion.				

3. Respond to the client's needs

3.1	Provides general information about screening to prevent cervical cancer.				
3.2	Describes the process of appropriate method and possible side effects (if applicable).				
3.3	Describes the circumstances in which the client should return to the health centre.				
3.4	Responds with clarity to the client's questions.				
3.5	Speaks with simple non-judgemental language.				
3.6	Uses support material during the counselling where appropriate.				

4. Verify the client's understanding

4.1	Verifies that the client understood information provided, ensuring that the client is making an informed choice.				
4.2	Does not ask leading questions.				
4.3	Clarifies information and any doubts.				
4.4	Asks the client if she would like to participate in the screening exam.				
4.5	Tests for comprehension by asking the client to explain what will happen to her during the exam.				

5. Provide essential follow-up information

5.1	Maintains an approachable posture with the client.				
5.2	For screening with cytology: ensures client is aware of how to obtain and timeframe for obtaining results. For VIA, if the result is negative: instructs the client to return to the clinic for screening in 3 years. For VIA, if the result is positive: provides the client with treatment options as appropriate. For clients with indications for referral: instructs the client that she is being referred to the Divisional Hospital for further investigation and explores support required for the referral visit.				
5.3	Asks client whether she has any remaining questions or concerns.				

Assessor's comments: _____

_____

I consider that _____

has/has not demonstrated competency in providing information and counselling.

Name of Assessor: _____

Signature: _____ Date: _____ / _____ / _____

Signature of Candidate: _____ Date: _____ / _____ / _____

Name of participant being observed: _____

ANNEX 9: Observation Guide for Cervical Sampling Procedure

Rate the performance of each step or task observed using the following rating scale:

1. **Needs improvement:** Step or task not performed correctly, omitted, or out of sequence (where necessary).
2. **Developing competence:** Some steps or tasks performed correctly in the proper sequence (where necessary), but participant does not yet complete all steps.
3. **Competent:** Steps or tasks correctly performed in the proper sequence (where necessary).

Participant's name: _____

Pre-test counselling								
Greets the woman.								
Re-establishes why screening is recommended.								
Describes the procedure.								
Discusses side effects and follow-up treatment requirements.								
Encourages the woman to ask questions.								
Asks the woman for her consent to the procedure.								
Preparation								
Checks that instruments, supplies, light source, and leak-proof container are ready to use.								
Asks woman if she has emptied her bladder recently.								
Helps woman position herself onto exam table, including modesty drape/cover.								
Washes hands thoroughly and dries them.								
Puts a new examination glove on both hands. Puts a second glove on one hand.								
Arranges instruments in clean area.								
Collecting sample								
Inserts speculum and fixes so that entire cervix can be seen clearly.								
Removes outer glove and disposes of it into a leak-proof container/plastic bag.								
Adjusts light source so that cervix can be seen clearly.								
Locates cervix and identifies os.								
Identifies SCJ, ectropion/ectopy, nabothian follicles – normal features of the cervix.								
Identifies signs of infection, polyps, leukoplakia, condyloma – abnormal features.								
Inserts the tip of the cervix sampler into the cervical os and rotates 3 times.								
Uses a cytobrush as appropriate in addition to the cervix sampler to sample the canal.								

For conventional cytology: uses correct technique to spread cervical material onto the labelled glass slide and fixes immediately.								
Places fixed slide into protective case for transport.								
For LBC, pushes the samplers into the labelled vial repeatedly 10 times.								
Disposes of sampling devices into a leak-proof container.								
Re-examines the cervix following sampling.								
Removes speculum and places it in a leak-proof container for sterilising later.								
Post-sampling tasks								
Removes gloves by turning inside out and disposes of gloves in leak-proof container.								
Washes hands thoroughly and dries them.								
Advises the woman that how and when to obtain results will be discussed when she is dressed.								
Asks the woman to sit up and get down off the table to get dressed – assists where needed.								
Changes the exam table covering or cleans before next client.								
Records consultation and follow-up plan in the woman's health record.								
Completes pathology request form.								
Procedure demonstrated satisfactorily								
Signature of Assessor								

Assessor's comments: _____

_____

I consider that _____

has/has not demonstrated competency in cervical sampling.

Name of Assessor: _____

Signature: _____ Date: _____ / _____ / _____

Signature of Candidate: _____ Date: _____ / _____ / _____

ANNEX 10: Observation Guide for VIA Procedure

Rate the performance of each step or task observed using the following rating scale:

1. **Needs improvement:** Step or task not performed correctly, omitted, or out of sequence (where necessary).
2. **Developing competence:** Some steps or tasks performed correctly in the proper sequence (where necessary), but participant does not yet complete all steps.
3. **Competent:** Steps or tasks correctly performed in the proper sequence (where necessary).

Participant's name: _____

Date								
Client number								
Pre-VIA counselling								
Greets the woman.								
Re-establishes why VIA is recommended and describes the procedure.								
Checks that the woman is not pregnant.								
Discusses side effects and follow-up treatment requirements.								
Encourages the woman to ask questions.								
Asks the woman for her consent and to sign consent form.								
Preparation								
Checks that instruments, supplies, light source, and leak-proof container are ready to use.								
Asks the woman if she has emptied her bladder recently.								
Helps the woman position herself onto the exam table, including modesty drape/cover.								
Washes hands thoroughly and dries them.								
Puts a new examination glove on both hands. Puts a second glove on one hand.								
Arranges instruments on sterilised tray/container.								
VIA								
Inserts speculum and fixes so that entire cervix can be seen clearly.								
Removes outer glove and disposes of it into a leak-proof container/plastic bag.								
Adjusts light source so that cervix can be seen clearly.								
Cleans cervix with swab and identifies os.								
Identifies SCJ, ectropion/ectopy, nabothian follicles – normal features of the cervix.								
Identifies signs of infection, polyps, leukoplakia, condyloma – abnormal features.								

Determines whether the cervix is suspicious for cancer.								
Soaks a clean swab in 4% acetic acid and applies to the cervix liberally.								
Waits one full minute for the acetic acid to be absorbed (use a watch/clock/timer).								
Checks the TZ carefully, close to the SCJ, for any dense, non-moveable acetowhite areas in the epithelium.								
When VIA is complete, uses a fresh cotton swab to remove any remaining acetic acid from the posterior vaginal fornix.								
Removes speculum and places it in a leak-proof container for sterilising later.								
Post-VIA tasks								
Removes gloves by turning inside out and disposes of gloves in leak-proof container.								
Washes hands thoroughly and dries them.								
Advises the woman that results will be discussed when she is dressed.								
Asks the woman to sit up and get down off the table to get dressed – assists where needed.								
Changes the exam table covering or cleans before next client.								
Records result and follow-up plan in the woman's health record.								
Procedure demonstrated satisfactorily								
Signature of assessor								

Assessor's comments: _____

_____

I consider that _____

has/has not demonstrated competency in VIA procedure.

Name of Assessor: _____

Signature: _____ Date: _____ / _____ / _____

Signature of Candidate: _____ Date: _____ / _____ / _____

ANNEX 11: Observation Guide for Cryotherapy Procedure

Rate the performance of each step or task observed using the following rating scale:

1. **Needs improvement:** Step or task not performed correctly, omitted, or out of sequence (where necessary).
2. **Developing competence:** Some steps or tasks performed correctly in the proper sequence (where necessary), but participant does not yet complete all steps.
3. **Competent:** Steps or tasks correctly performed in the proper sequence (where necessary).

Participant's name: _____

Date								
Client number								
Pre-cryotherapy counselling								
Explains why the treatment is recommended and describes the procedure.								
Checks that the woman is not pregnant.								
Discusses side effects and post-treatment requirements.								
Encourages the woman to ask questions.								
Asks the woman for her consent to the procedure.								
Preparation								
Checks that instruments, supplies, light source, and leak-proof container are ready to use.								
Checks that cryotherapy equipment and CO_2 gas are ready to use.								
Asks the woman if she has emptied her bladder recently.								
Helps the woman position herself onto the exam table, including modesty drape/cover.								
Washes hands thoroughly and dries them.								
Puts a new examination glove on both hands. Puts a second glove on one hand.								
Arranges instruments on sterilised tray/container.								
Cryotherapy								
Inserts speculum and fixes so that entire cervix can be seen clearly.								
Removes outer glove and disposes of it into a leak-proof container/plastic bag.								
Adjusts light source so that cervix can be seen clearly.								
Cleans cervix with swab and identifies os, SCJ, and size of lesion after applying acetic acid.								
Points probe at ceiling and pulls trigger to check freeze and defrost function before screwing cryotherapy tip on to the end of the probe.								

Applies cryotherapy tip squarely onto the cervix and checks vaginal walls clear of probe.								
Freezes for 3 minutes and waits for tip to release from the cervix (always watching).								
Waits 5 minutes for ice ball to defrost. Repeats step above (second 3 minute freeze).								
Inspects cervix to ensure solid white ice ball present.								
Unscrews cryotherapy tip from probe with gloved hand and places in container for sterilising later.								
Inspects cervix for bleeding and applies pressure with clean swab if needed.								
Removes speculum and places it in a leak-proof container for sterilising later.								
Post-cryotherapy tasks								
Removes gloves by turning inside out and disposes of gloves in leak-proof container.								
Washes hands thoroughly and dries them.								
Ensures CO_2 gas cylinder valve closed and probe cleaned with alcohol.								
Checks if the woman is having excessive cramping before helping her sit up and get down off the table to get dressed.								
Advises the woman about post treatment care and follow-up visit. Gives written handout.								
Records treatment and follow-up plan in the woman's health record.								
Encourages the woman to sit in the waiting area for 15 minutes before leaving the clinic.								
Procedure demonstrated satisfactorily								
Signature of Assessor								

Assessor's comments: _____

_____

I consider that _____

has/has not achieved the necessary standard to receive credentialing in cryotherapy.

Name of Assessor: _____

Signature: _____ Date: _____ / _____ / _____

Signature of Candidate: _____ Date: _____ / _____ / _____

Australian Government

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