STRATEGIC PLANNING FOR CERVICAL CANCER PREVENTION AND CONTROL IN AFRICA TRAINING MANUAL

Participants Manual




World Health Organization
REGIONAL OFFICE FOR Africa

WORLD HEALTH ORGANIZATION
Regional Office for Africa

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Participants Manuel

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Preface

Women's cancers are highly prevalent, specifically breast and cervical cancer. It is estimated that more than 266,000 women die of cervical cancer each year, and 87% of these death are happening in less developed regions of the world such as the WHO African region. This is a major economic and social burden from cancer directly affecting Africa. If nothing is done, the number of death will reach 416,000 in 2035.

Cervical cancer is the most common cancer and the leading cause of cancer mortality among women in developing countries. In sub-Sahara, 34.8 new cases of cervical cancer are diagnosed per 100,000 women annually and 22.5 per 100,000 women die from the disease.

In many countries, several issues and challenges exist when developing strategies for cervical cancer prevention and control – lack of cancer policies, strategies and programmes; lack of recent and comprehensive data; heavy economic and psychosocial burden of the disease; insufficiency or lack of information and skills; high cost of immunization against HPV; unavailability of secondary prevention; unaffordability of therapeutic resources and neglect of palliative care; geographical inaccessibility of tertiary prevention; and lack of collaboration and coordination of interventions.

The burden of cervical cancer can be reduced by implementing evidence-based strategies in the areas of prevention, early detection, and management including diagnosis and treatment. The awareness that cervical cancer is a preventable and controllable disease has started to become established in the Region and need to be strengthened.

This work, presented through series of books on a country capacity baseline report, advocacy, Information, Education and Communication, policies and strategic plans, Visual inspection and cryotherapy practice pursued in relation to cervical cancer.

I would like to thank my colleagues, the scientists and all our partners particularly the Bill and Melinda Gates Foundation, whose efforts contributed to create this invaluable work. We believe this book will serve as a comprehensive resource for many years to come.

Dr Tshidi Moeti
WHO Regional Director for Africa

Foreword

Noncommunicable diseases (NCDs) are the leading cause of global death and disability, creating significant health and economic burdens on individuals, societies and health systems. Cancers, in particular, caused some 8.2 million deaths every year.

Cervical cancer is the most common cancer and the leading cause of cancer mortality among women in developing countries. In sub-Saharan Africa, 34.8 new cases of cervical cancer are diagnosed per 100 000 women annually, and 22.5 per 100 000 women die from the disease. These figures compare with 6.6 and 2.5 per 100 000 women, respectively, in North America.

The major risk factor associated with cervical cancer is Human Papilloma Virus (HPV) infection which generally occurs in adolescence after the first acts of sexual intercourse. In Africa, HPV infection prevalence is estimated at 21.3%, with significant variations from region to region: 33.6% in East Africa, 21.5% in West Africa and 21% in Southern Africa. Other major risk factors include tobacco use and lack of screening and adequate treatment of precancerous lesions. HPV and human immunodeficiency virus (HIV) co-infection accelerates progression towards cancer.

Cervical cancer is preventable and treatable if detected early. WHO recommends a comprehensive approach to cervical cancer prevention and control interventions that span across primary secondary and tertiary prevention.

In Africa, several issues and challenges exist when dealing with cervical cancer prevention and control - Lack of cervical cancer control policy, strategies and programmes; Lack of recent and comprehensive data; Heavy economic and psychosocial burden of the disease; Insu ciency or lack of information and skills; High cost of immunization against HPV; Unavailability of secondary prevention; Una ordability of therapeutic resources and neglect of palliative care; Geographical inaccessibility of tertiary prevention; and lack of collaboration and coordination of interventions.

These findings bring into focus the need to develop/adapt tools to support countries develop and implement strategic planning documents for improving comprehensive cervical cancer prevention and control.

Acknowledgement

The strategic planning for cervical cancer prevention and control in Africa training manual was developed by Daniel Murokora (Uganda Women's Health Initiative), Mary-Anne Land and Prebo Barango (World Health Organization). Contributions to the manual were made by a number of colleagues within and outside WHO. We gratefully acknowledge the inputs from countries in reviewing this manual. Within WHO we wish to thank Jean-Marie Dangou, Nathalie Broutet, Raymond Hutubessy, Dr. Emmanuel Mugisha (PATH Uganda), and Ms. Theopista Wenene (Min of Public Service – Uganda) for their contributions.

WHO thanks the participants of the Experts Meeting to Finalize Cervical Cancer Prevention and Control Toolkits 13-15 April 20015, Brazzaville, Congo Republic, for their review and feedback.

WHO also wishes to express sincere gratitude to the Bill and Melinda Gates Foundation for providing the funding for this toolkit, as part of the Reducing Cervical Cancer Burden in Selected High-Burden Countries in the African Region programme grant.

This manual was informed by evidence and experience of strategy work related to cervical cancer prevention and control in the African Region and globally, and is in line with the WHO – Comprehensive Cervical Cancer Control: A guide to essential practice (second edition - 2014).

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Introduction

Why cervical cancer ?

(Adapted from the WHO guidelines for Comprehensive Cervical Cancer Control)[1].

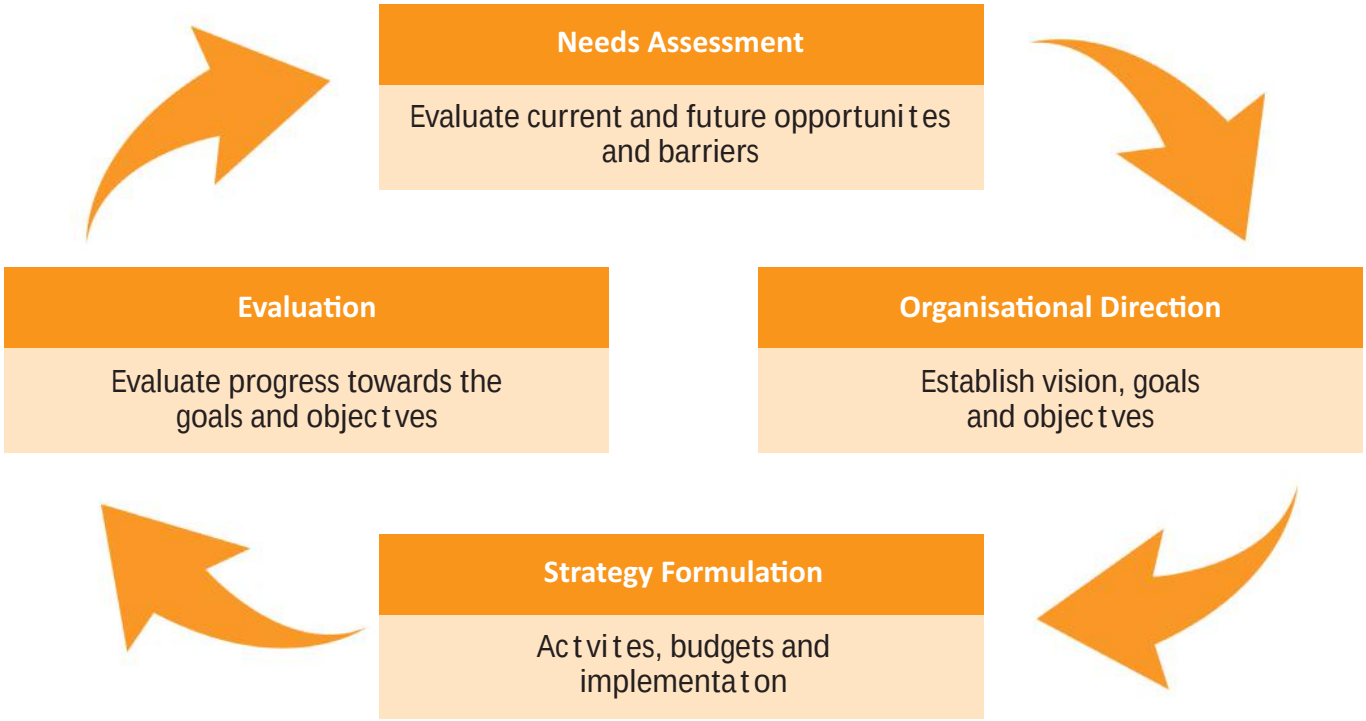
- Cervical cancer is a largely preventable disease, but worldwide it is one of the leading causes of cancer death in women.
- Worldwide, 266 000 women die of cervical cancer each year.
- It is the leading cause of cancer deaths in Eastern and Central Africa.
- The majority of these deaths can be prevented through universal access to comprehensive cervical cancer prevention and control programs, which have the potential to reach all girls through human papilloma-virus (HPV) vaccination and all women with screening and treatment for pre-cancer.
- We know what causes cervical cancer: almost all cases are caused by a persistent (very long-lasting) infection with one or more of the "high-risk" (or oncogenic) types of HPV.
- We understand the natural history of HPV infection and the very slow progression of the disease in immune competent women, from normal (healthy) to pre-cancer, to invasive cancer, which is potentially fatal.
- The 10-20 year lag between pre-cancer and cancer offers ample opportunity to screen, detect and treat pre-cancer and avoid its progression to cancer. However, immunocompromised women (e.g. those living with HIV) progress more frequently and more quickly to pre-cancer and cancer.
- WHO recommends a comprehensive approach, taking into consideration the natural history of the disease, to have interventions directed at various sub groups of the population.
- There are several available and affordable tests that can effectively detect pre-cancer, as well as several affordable treatment options.
- HPV vaccines are now available; if given to all girls before they are sexually active, they can prevent a large portion of cervical cancer.
- Until there is universal access to cervical cancer prevention and control programs, which will require addressing present inequities, the large disparities in incidence rates and mortality rates that exist in different settings will continue to be ample evidence of lack of comprehensive and effective services.

[1] WHO Comprehensive Cervical Cancer Control, 2014 Geneva, Switzerland.

What is strategic planning ?

Strategic planning is an organizat onal management ac t vity that is used to set priori t es, focus energy and resources, strengthen opera t ons, ensure that all stakeholders are working toward common goals, establish agreement around intended outcomes/results, and assess and adjust the organiza t on's direc t on in response to a changing environment. It is a disciplined e ort that produces fundamental decisions and ac t ons that shape and guide what an organiza t on is, who it serves, what it does, and why it does it, with a focus on the future. E ec t ve strategic planning ar t culates not only where an organiza t on is going and the ac t ons needed to make progress, but also how it will know if it is successful (Figure 1)

Figure 1: Strategic Planning Process



Why is strategic planning important for cervical cancer prevention and control ?

- To help focus coordina t on between women, technology and service delivery
- Resource mobilisa t on (human, service and technology)
- A requirement of funding bodies and donors e.g. GAVI

Who should participate in planning ?

Key leaders within government departments, focus on a super sectorial approach to engage all stakeholders (e.g. Ministry of Health, Educa t on, Transport, and Finance), and all actors across the preven t on and control con t nuum. At least one person who has the authority to make strategic decisions and someone who can administrate the process should be included. A list of suggested par t cipants is included within Annex 1.0 but this can change depending on the specific country situa t on.

How to use this manual ?

While awareness strategies for cervical cancer prevention and control have existed for some years, many countries are in various stages of developing and implementing strategies to vaccinate, screen for and treat cervical cancer. This manual offers assistance in developing and scaling-up strategic plans for cervical cancer prevention and control in an integrated and comprehensive manner.

This manual provides a series of information and ideas to help country teams in developing a cervical cancer prevention and control strategy. The information is organised under seven sections:

Section A – Preparation and Background
Section B – Strategic Planning
Session 1 – Setting up for Strategic planning/Leadership
Session 2 – Situational Analysis/Needs assessment
Session 3 - Vision, Goals and Objectives
Session 4 - Action plan
Session 5 - Evaluation
Session 6 - Writing
Session 7 - Dissemination and Implementation

Within each section information is provided to guide the session, and breakout sessions highlight the recommended actions.

This participant's manual/work book is to be completed throughout the sessions.

SECTION A

PREPARATION FOR TRAINING

In order to be ready for the training process:

1. Each participant needs to devote full attention and time to the course
2. Each country team should come to the course with background information about situation of cervical cancer in their country
3. Each country team should also bring to the course existing cervical cancer related guidelines, IEC materials and plans if any

BACKGROUND

(Adapted from the WHO guidelines for Comprehensive Cervical Cancer Control)

Duration: 60 minutes (45 minute presentation and 15 minute question time)

Natural history of cancer of the cervix

What is cancer ?

Cancer is a term used for the malignant, autonomous and uncontrolled growth of cells and tissues. Such growth forms tumours, which may invade the tissues around the cancer and cause new growths similar to the original cancer in distant parts of the body, called metastases. As cancer grows, it destroys normal tissues and competes for nutrients and oxygen.

What is cervical cancer ?

Persistent infection with cancer-causing HPV types is the cause of most cervical cancer. Ninety per cent of cervical cancers are squamous cell cancers and initiate in the transformation zone of the ectocervix; the other 10% are adenocarcinomas, which arise in the glandular columnar layer of the endocervix.

Cervical cancer is preventable by vaccinating girls (9-13 years old) against the human papillomaviruses that cause it and by screening for and treating precancerous lesions in women, since these lesions precede cancer by many years. In addition, if detected early and treated, cervical cancer can still be cured.

What is cervical pre-cancer ?

Cervical pre-cancer is a distinct change in the epithelial cells of the transformation zone of the cervix; the cells begin developing in an abnormal fashion in the presence of persistent or long-term HPV infection.

With the majority of cancers, even if they have a precursor stage, it is too short to be noticed and not amenable to easy diagnosis and treatment. Cervical cancer is one of the very few cancers where a precursor stage (pre-cancer) lasts many years before becoming invasive cancer, providing ample opportunity for detection and treatment.

Unfortunately, although preventable, there are still large numbers of women who die of cervical cancer in many countries. This is because they lack access to services for prevention and treatment – a problem that may be caused by many factors, such as barriers that limit their access to services (e.g. hours of operation, distance, lack of transportation) as well as prevailing cultural and gender barriers. In most cases, though, the overarching cause is poverty.

[2] WHO Comprehensive Cervical Cancer Control, 2014 Geneva, Switzerland.

HPV infection and cofactors that facilitate persistent infections

The primary cause of cervical pre-cancer and squamous cervical cancer is symptom-free, persistent or chronic infection with one or more of the high-risk (cancer-causing or oncogenic) types of HPV. HPV is the most common sexually transmitted viral infection.

Of the more than 100 numbered types of HPV, most of them are not associated with cervical cancer. Seven out of 10 (70%) of all cervical cancer cases reported throughout the world are caused by only two types of HPV: 16 and 18. Another four high-risk HPV types – 31, 33, 45 and 58 – are less commonly found to be associated with cervical cancer, with particular types being more prevalent than others in certain geographical areas.

Two low-risk types of HPV (6 and 11) do not cause cervical cancer but are the cause of most genital warts or condylomas.

Almost all women and men are infected with HPV shortly after initiating sexual activity. Penetration of the vagina by the penis does not have to occur because the virus can be transmitted by skin-to-skin contact of the genital areas near the penis and vagina.

As in women, HPV infections in men are also commonly without symptoms and most infections are short-lived. Men can develop cancer of the anus; this is most commonly associated with HPV type 16, and is more common in men who have sex with men. As in women, HPV types 6 and 11 cause the majority of male genital warts.

In women, during puberty and pregnancy, the transformation zone on the ectocervix is enlarged. Exposure to HPV at these times may facilitate infection and may explain the associations between squamous cell cervical cancer and early sexual activity, young age at first birth, and a history of multiple pregnancies. Behaviours that can also increase the risk of HPV infection (and thus cervical cancer) include having multiple partners, and having partners with multiple partners.

While infection with a high-risk HPV type is the underlying cause of almost all cases of cervical cancer, it is NOT the case that these infections almost always cause cancer. In fact, most women infected with high-risk HPV do not develop cancer because most infections, regardless of HPV type, are short-lived; the body eliminates them spontaneously in less than two years. Infection with high-risk HPV only persists (becomes chronic) in a small percentage of women, and only a small percentage of these chronic infections can progress to pre-cancer; of these, even fewer will progress to invasive cancer. Thus, it is estimated that no more than 2% of all women in low-resource countries will develop cervical cancer during their lifetimes.

The conditions (cofactors) that may lead HPV infection to persist and progress to cancer are not well understood, but the following risk factors probably play a role :

- HPV type – its oncogenicity or cancer-causing strength;
- immune status – people who are immunocompromised, such as those living with HIV, are more likely to have persistent HPV infections and a more rapid progression to pre-cancer and cancer;
- Co-infection with other sexually transmitted agents, such as those that cause herpes simplex, chlamydia and gonorrhoea;
- Parity (number of babies born) and young age at first birth;
- Tobacco smoking;
- Use of oral contraceptives for over five years.

The last cofactor, use of oral contraceptives (OCs) for over five years, is the weakest. This was studied extensively by a WHO expert group, which concluded that the great benefits conferred by use of a very effective contraceptive method for preventing unplanned and unwanted pregnancies (with consequent prevention of morbidity and mortality associated with these pregnancies) far outweigh the extremely small potential for an increased risk of cervical cancer that may result from OC use. Thus, it is not in the woman's

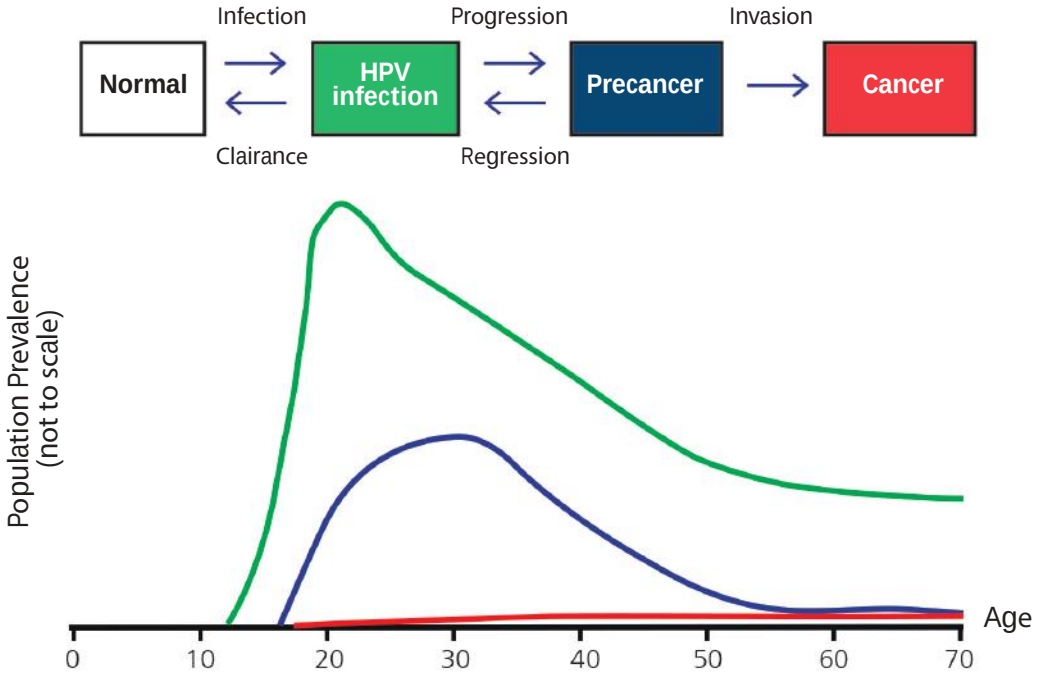
interest to discourage or prevent her from using OCs. All that is needed is for these women, like all other women, to be screened for cervical cancer.

The development of pre-cancer

After entering cervical epithelial cells, high-risk HPV infection interferes with their normal functions, leading to changes characteristic of pre-cancer (also called dysplasia).

Figure 2 depicts the timeline of the progression from a normal (uninfected) cervix to HPV-infected cervix to pre-cancer and invasive cancer. Note that changes occur in both directions because a large proportion of HPV-infected cells return to a normal state and a large proportion of cervical pre-cancers do not become cancer.

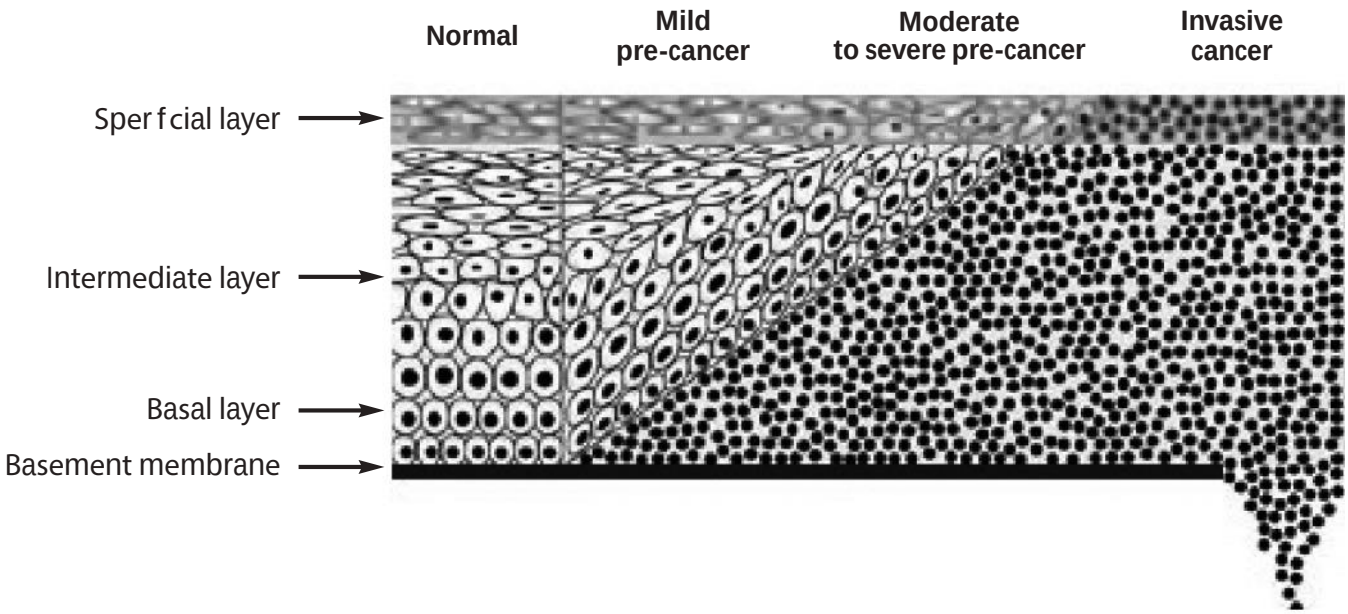
Figure 2: The timeline and natural history of cervical pre-cancer and cancer development



Source : reproduced by permission of the first author from Schiffman M, Castle PE. The promise of global cervical-cancer prevention. N Engl J Med. 2005;353(20):2101–4.

Figure 3 illustrates normal cervical squamous epithelium on the left and progressively thicker layers of new abnormal small cells involving the epithelium in the large intermediate section. As this section in the middle involves more and more of the thickness of the normal epithelium, the epithelium is considered to have mild, then moderate, and finally severe pre-cancer. This sequence leads to invasive cancer if the abnormal cells invade the bottom layer of the epithelium (basement membrane), as shown on the right of the figure.

Figure 3: Progress from normal epithelium to invasive cancer mild pre-cancer moderate to severe pre-cancer



Routes taken by invasive cancer through the body as it progresses
There are four, usually sequential, routes through which invasive cancer progresses.

i. Within the cervix: Spread occurs from a tiny focus of micro invasive cancer until it involves the entire cervix, which can enlarge to 8 cm or more in diameter. The cancer can be ulcerating, exophytic (growing outwards) or infiltrating (invading inwards).

ii. To adjacent structures: Direct spread in all directions is possible – downwards to the vagina, upwards into the uterus, sideways into the tissues supporting the uterus in the pelvis and the ureters, backwards to the rectum, and forwards to the bladder.

iii. Lymphatic: Spread to pelvic lymph nodes occurs in 15% of cases when the cancer is still confined to the cervix, and increases as the cancer spreads. Lymph-node metastases are at first confined to the pelvis and are later found in the chain of nodes along the aorta, eventually reaching the space above the collarbone (supraclavicular fossa). The lymph nodes, once invaded with cancer, are enlarged and, if close to the skin, can be palpated. For example, if the cancer has advanced into the lower third of the vagina, the groin nodes may become involved and will be palpably enlarged, and the supracervical nodes will also feel noticeably enlarged.

iv. Distant metastases through the bloodstream and lymph channels: Cervical cancer cells may spread through the blood stream and lymphatic system to develop distant metastases in the liver, bone, lung and brain.

While invasive cancer initially remains confined within the pelvic area, many cases can still be cured with appropriate treatment. If left untreated, however, cervical cancer progresses in a predictable manner and will almost always lead to death.

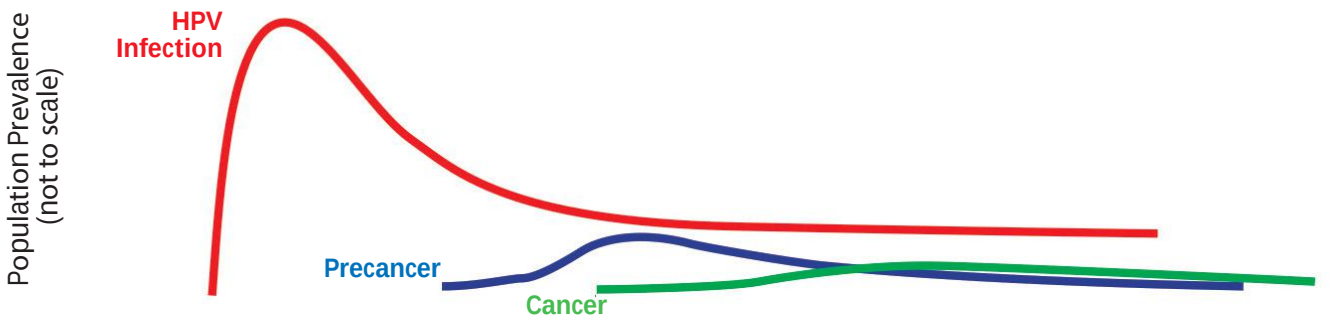
Cervical cancer and human immunodeficiency virus (HIV) infection
Cervical cancer is a defining illness of acquired immunodeficiency syndrome (AIDS) in patients with HIV.

Women living with HIV and other immunocompromised women have a higher prevalence of HPV (the risk of infection increases with the degree of immunosuppression) and a higher prevalence of persistent HPV infection and infection with multiple high-risk HPV types. This increased susceptibility to HPV infection leads to :

- a greater risk of pre-cancer and cancer at younger ages, which increases with the degree of immunosuppression;
- an increased risk of developing invasive disease up to 10 years earlier than in women not infected with HIV; and
- more frequent presentation with advanced disease with smaller chance of survival for five years.

Key components of comprehensive cervical cancer prevention and control
A comprehensive programme includes three interdependent components: primary, secondary and tertiary prevention (Figure 4).

Figure 4 : The WHO comprehensive approach to cervical cancer prevention and control: Overview of programmatic interventions over the life course to prevent HPV infection and cervical cancer



PRIMARY PREVENTION
Girls 9 -13 ans
- HPV vaccination

Girls and boys, as appropriate
- Health information and warnings about tobacco use *
- Sexuality education tailored to age & culture
- Condom promotion/provision for those engaged in sexual ativity
- Male circumcision

SECONDARY PREVENTION
Women > 30 years of age
- «Screen and treat» with low cost technology VIA followe by cryotherapy
- HPV testing for high risk HPV types (e.g. types 16, 18 and others)

TERTIARY PREVENTION
All women as needed
Treatment of invasive cancer at any age
- Ablative surgery
- Radiotherapy
- chemotherapy

* Tobacco use in an additional risk factor for cervical cancer.

Source : Adapted from WHO guidance note: comprehensive cervical cancer prevention and control: a healthier future for girls and women. Geneva: World Health Organization; 2013.

Primary prevention: reduce the risk of HPV infection
The public health goal is to reduce HPV infections, because persistent HPV infections can cause cervical cancer.
Interventions include :

- vaccinations for girls aged 9–13 years (or the age range referred to in national guidelines) before they initiate sexual activity;
- healthy sexuality education for boys and girls, tailored as appropriate to age and culture, with the aim of reducing the risk of HPV transmission (along with other sexually transmitted infections, including HIV) - essential messages should include delay of sexual initiation, and reduction of high-risk sexual behaviours;
- condom promotion or provision for those who are sexually active;
- male circumcision where relevant and appropriate.

Secondary prevention: screening for and treating pre-cancer
The public health goal is to decrease the incidence and prevalence of cervical cancer and the associated mortality, by intercepting the progress from pre-cancer to invasive cancer.
Interventions include :

- counselling and information sharing;
- screening for all women aged 30–49 years (or ages determined by national standards) to identify pre cancerous lesions, which are usually asymptomatic;
- treatment of identified precancerous lesions before they progress to invasive cancer. Even for women who have received an HPV vaccination, it is important to continue screening and treatment when they reach the target age.

Tertiary prevention: treatment of invasive cervical cancer
The public health goal is to decrease the number of deaths due to cervical cancer.
Interventions include :

- a referral mechanism from primary care providers to facilities that o er cancer diagnosis and treatment;
- accurate and timely cancer diagnosis, by exploring the extent of invasion;
- treatment appropriate to each stage, based on diagnosis:
  - Early cancer : If the cancer is limited to the cervix and areas around it (the pelvic area), treatment can result in cure; provide the most appropriate available treatment and o er assistance with symptoms associated with cancer or its treatment.
  - Advanced cancer: If the cancer involves tissues beyond the cervix and pelvic area and/ or metastases, treatment can improve quality of life, control symptoms and minimize su ering; provide the most e ective available treatment and palliative care in tertiary su ering; provide the most e ective available treatment and palliative care in tertiary facilities and at the community level, including access to opioids.
- palliative care to relieve pain and su ering.

Key messages

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 at least once.**
5. **There is a vaccine for girls that can help prevent cervical cancer**

SECTION B

STRATEGIC PLANNING

SESSION 1 SETTING UP FOR STRATEGIC PLANNING

Duration : 01 hour 00 minutes

Establishment of a program leadership

The leadership of the strategic plan will most likely be placed within the Ministry of Health (MoH). To facilitate planning, implementation and evaluation of a strategic plan for cervical cancer, it is important to establish a leadership team, with clear responsibilities and accountability for the plan.

Two groups should be developed at the national level, led by a designated national coordinator:

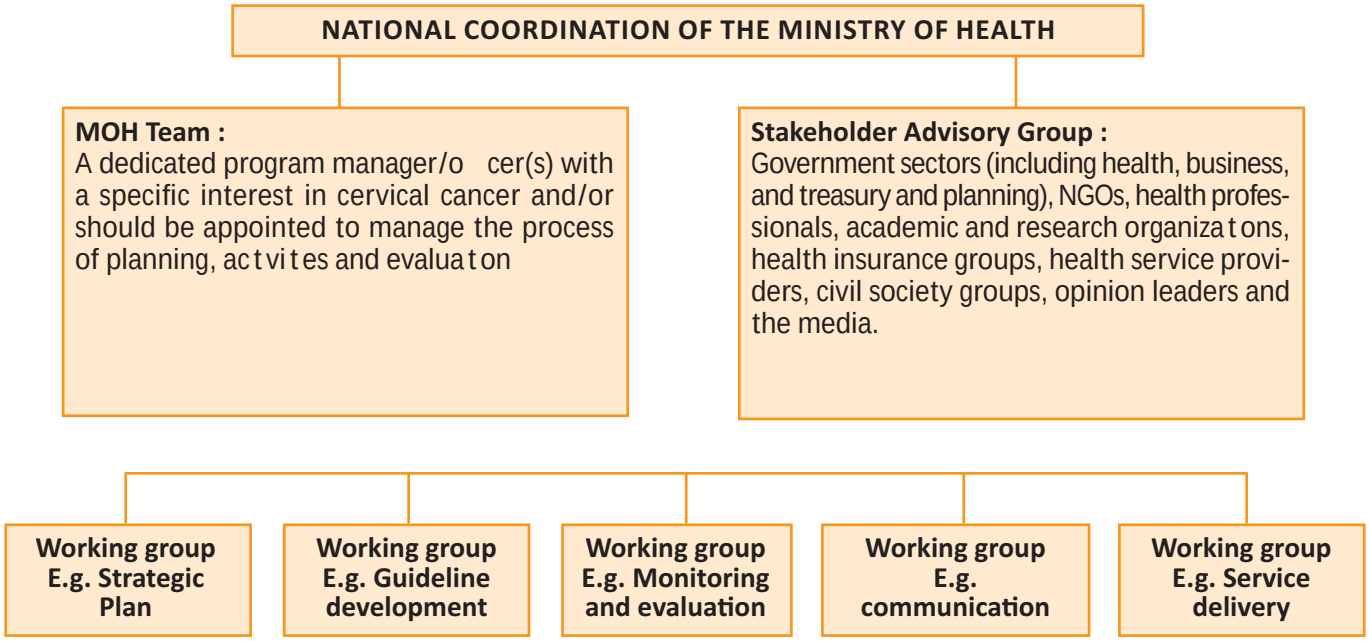
1. A leadership team is responsible for the program and composed of representatives from the MoH;
2. A stakeholder advisory group composed of country representatives and key players including health professionals, civil society and telecommunication companies.

Members of both groups would be selected and invited to participate by the MoH.

Group Discussion Guide 1 :

1. **Select a Team Leader and Rapporteur**
2. **Discuss Existing Leadership and Management Structures at MoH**
3. **Align these structures to create a leadership structure for CCP**
4. **Draft an organogram for cervical cancer control and prevention**
5. **Draft terms of reference for each stakeholder or working group for implementation of the plan**

Figure 5: Proposed structure of a strategic plan management team
(adapted from the WHO guidelines for Comprehensive Cervical Cancer Control)[3]



[3] WHO Comprehensive Cervical Cancer Control, 2014 Geneva, Switzerland

Roles and responsibilities

The MoH team needs to provide decision-making authority, autonomy and resources to direct the planning, implementaton, monitoring and evaluaton of the strategic plan for cervical cancer prevenon and control. A key role will include liaising with representaons of current programs including naonal guidelines for cervical cancer to ensure program synergy.

Stakeholder Advisory group will support, inform and advise the program throughout its incepon, development, implementaon and evaluaon phases. Regular meengs will be required for informaon sharing and progress updates.

Conceptual framework for wring the strategy

SESSION 2 COMPLETING A SITUATIONAL NEEDS ASSESSMENT

Duration : 01 hour 30 minutes

Understanding the rationale for a cervical cancer prevention and control strategy and what the key elements are, is an important starting point.

A situational analysis is a systematic collection and evaluation of past and present economic, political, social, and technological data, aimed at:

(1) Identification of internal and external forces that may influence the performance and choice of strategies; and

(2) Assessment of the current and future strengths, weaknesses, opportunities and threats.

The information may be collected through a series of methods including the review of documents and clinical records, interviewing or focus groups health administration, clinicians, pathologists, health care workers and community members and observing practices within clinics and health care centres.

The information collected should then be reviewed, recommendations formulated and a report produced. Presenting the report and findings to stakeholders is an important step to ensure the collected information is accurate.

There are several themes to be explored when conducting a needs assessment. Participants of the training sessions should be able to identify many of the considerations.

Figure 5: Root Cause Analysis Example

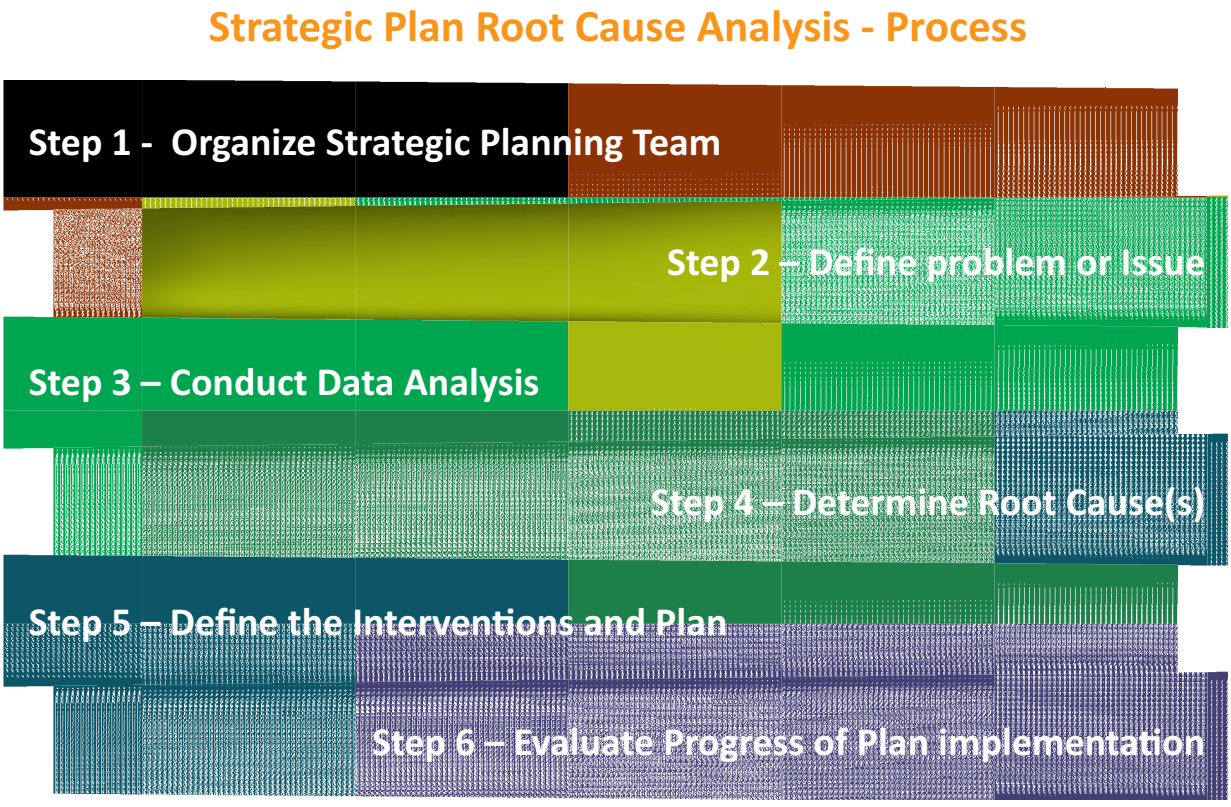


Table 1: provides an example of the process which is overlapping in nature to allow for a thorough information extraction to inform the development and implementation of strategies.

Table 1 : Themes and considerations for a needs assessment

Themes	Considerations
Current situation	- The extend of the health burden - HIV burden - screening and treatment available (frequency of screening) - screening coverage - laboratory services - infrastructure, equipment and supplies - information systems - Current comprehensive national policy or plan on prevention and control - National guidelines for health workers - Financial and technical resources to implement the plan - Communication strategies to educate and advocate support - Training in place for health care providers - HPV vaccination availability and coverage - Screening and treatment availability (including resources) and coverage (e.g. VIA, Cryotherapy) - Referral systems which link screening services with treatment and pre-cancerous lesions - Monitoring system to track HPV vaccination, screening and follow-up treatment - Existence of cancer registries -Integration with existing services
Target groups	- Who are the target populations (size and demographics) - What are the existing barriers and opportunities within the population(s)
Political/Economic barriers	- Political commitment - Priority for women's sexual and reproductive health - Resource levels (cost of programs)
Community/individual barriers	- Knowledge levels, cultural attudes, perception of risk, current behaviours and behaviour trends
Perceptions of the recommended behaviour	- How to promote the strategies - Timeframes - Incentives to encourage participation
Partnerships	- Allies, Partners, stakeholders

HINT: Planning and Implementing Cervical Cancer Prevention and Control Programs - A Manual for Mangers[4] provides sample questions to assess the use of policies, guideline and norms, program management issues, health services, information and education activites, community perspectves, laboratories and information systems.

[4] Alliance for Cervical Cancer Prevention Planning and Implementing Cervical Cancer Prevention and Control Programs: A Manual for Managers. 2004..

Group Discussion Guide 2 :

1. Discuss Key Considerations and Thematic Areas for the Situation Analysis
2. Use the Root Cause Analysis to discuss Cervical Cancer Situation in the country
   a. What is the burden of cervical cancer in the country?
   b. Why is the burden so high?
   c. What can be done to impact this high burden?
3. Discuss the situation analysis using the Root Cause Analysis Problem Tree
4. Agree on the Key Considerations to explore in the Situation analysis
5. Review and adapt the situation analysis questionnaire
6. Discuss the Key Principles required for strategic planning
7. Identify key stakeholders to involve in the strategic planning
8. Identify information sources
9. Identify how the data will be analysed and used for strategic planning

The guiding principles to ensure that the plan is responsive to national priorities and builds on existing platforms while leveraging resources and avoiding duplication include :

- **Leadership** - the plan should create clarity and unity of purpose, and encourage team building, broad participation, and ownership of the process, continuous learning and mutual recognition of efforts made.
- **Integration** - all proposed priority interventions in the plan should be integrated at various levels of the health system in a coherent and effective manner that is responsive to the needs of women
- **Evidence based** - the plan is based on up to date evidence, priority needs and cost effective approaches
- **Equity and accessibility** - a conscious effort should be made to promote equitable access to quality health services which greater attention to women living in rural and underserved areas as well as women living with HIV
- **Partnership** – the plan should promote partnership and joint programing among key stakeholders as well as communities in order to avoid duplication, leverage and maximise available resources.
- **Efficiency** – roles and responsibilities of the stakeholders involved in implementation, monitoring and evaluation of activites should be defined.
- **Transparency and accountability** – the plan should a component on accountability.
- **Appropriateness and relevance** – the plan should reflect a clear understanding of the local status and perspective of cervical cancer prevention and control in the country.

SESSION 3 DEVELOPING A VISION STATEMENT, GOALS AND OBJECTIVES

Duration: 3.0 hour 15 minutes

A Vision statement: defines the optmal desired future state of what the organizaton wants to achieve over tme.

There are certain characteristcs that most vision statements have in common.
In general, vision statements should be:

- Understood and shared by members of the community
- Broad enough to include a diverse variety of local perspectves
- Inspiring and upli fing to everyone involved
- Easy to communicate

Vision Statement Examples:
Ministry of Public Health and Sanitaton and Ministry of Medical Services - Natonal Cervical Cancer Prevenon Program Kenya (strategic Plan 2012-2015)
- Kenyan women free from Cervical Cancer

Ministry of Health -Strategic plan for cervical cancer prevenon and control in Uganda 2010-2014
- Ugandan women free from Cervical Cancer

Group Discussion Guide 3:

1. **Discuss key characteristics of a good vision statement**
2. **Discuss and draft 3 vision statements for cervical cancer prevention and control**
3. **Debate and select one best vision statement**

Goals and objectives:

Goals and objectves are necessary to clarify what your strategy aims to accomplish, as well as to evaluate the extent to which the desired outcomes have been reached. In the context of strategic planning for cervical cancer prevenon and control there may be long-term and short-term objectves.

Each objectve should be:
1. Specific in terms of what is intended to be achieved
2. Measurable to determine whether the objectve has been achieved
3. Achievable to provide a basis for determining the successes and barriers
4. Realistc in relaton to available resources
5. Time bound

Goal Examples:
1. To reduce the incidence, prevalence, morbidity and mortality from cervical cancer and improve the quality of life of cervical cancer patents.

2. To reduce HPV incidence, cervical cancer incidence and mortality, improve quality of life through informaton, educaton and communicaton, HPV vaccinaton, screening and treatment and improved palliatve services

3. To reduce the burden of cervical cancer by (i) reducing human papillomavirus (HPV) infectons, (ii) de-

tec t ng and trea t ng cervical pre-cancer lesions, and (iii) providing t mely treatment and pallia t ve care for invasive cancer

Group Discussion Guide 4 :

1. **Discuss characteristics of a good goal for a strategic plan**
2. **Draft and discuss 3 goals in the groups**
3. **Discuss and select one best goal for cervical cancer prevention and control**
4. **Discuss how the key considerations and information from the situation analysis guided development of the goal.**

Specific objec t ves will provide more informa t on on how the goal will be achieved. Ideally these will focus on not only primary, secondary and ter t ary preven t on, but communica t on/educa t on ini t a t ves and training for health workers.

Specific objec t ves may include:

1. Intensify informa t on and counselling
2. Increase HPV vaccina t on
3. Strengthen screening and pre-cancer treatment
4. Improve training programs for health care workers
5. Strengthen informa t on systems and cancer registries
5. Improve access and quality of cancer treatment and of pallia t ve care

Group Discussion Guide 5:

1. **Discuss characteristics of a good specific objective for a strategic plan**
2. **Draft and discuss at least 2 specific objectives for each thematic area**
   a. **Primary prevention**
   b. **Secondary prevention**
   c. **Tertiary care**
   d. **Palliative care**
3. **Discuss and select one best specific objective for each area.**

Outputs

To accomplish the specific objec t ves, outputs must be achieved within the given t meframe.

Output examples:
1. Communica t on strategy developed and increased awareness about HPV vaccina t on, screening and treatment
2. xx % increase in the number of girls aged 9-13 years old vaccinated against HPV
3. xx % increase in the number of women aged 30-49 screened for the first t me
4. Improved infrastructure (facili t es, equipment and supplies)
5. Capacity and systems built for monitoring
6. Available trained health professionals

Group Discussion Guide 6 :

1. **Discuss characteristics of a good output and or outcome from the specific objectives selected above**
2. **Draft and discuss at least 2 outputs and one outcome for each of the specific objectives for each thematic area**
   a. **Primary prevention**
   b. **Secondary prevention**
   c. **Tertiary care**
   d. **Palliative care**
3. **Draft, discuss and agree at least one measureable indicator for each specific objective for each area.**

Ensure that the participants have the baseline data to measure change.

SESSION 4 SETTING ACTION PLANS/ACTIVITIES

Duration: 3.0 hour 30 minutes

Action plans for achieving each objective including the output and outcomes should detail how, what, where, when, who and whom will be accountable for the activity.

For Example:

Objective : Increase screening coverage

Outcome : xx% screening coverage in the target group

Action :

1. Screening coverage will be increased by the development of communication for behavioural impact promoting screening within the target population. Starting in xxx regions (expanding to xxx), commencing in XX, led by community workers. The ministry of health will be accountable for the development of the communication framework.

2. Screen and treat (VIA and cryotherapy) will be integrated introduced into xx family planning clinics, in xx region by xx. The ministry of health will be accountable for identifying the clinics, training health care professionals, ensuring equipment, supplies and maintenance.

Group Discussion Guide 7:

1. **Discuss characteristics of a good action plan.**
2. **Define key activities required to achieve each output or outcome from the specific objectives selected above**
3. **Draft and discuss sets of activities for each of the specific objectives for each thematic area**
   - **a. Primary prevention**
   - **b. Secondary prevention**
   - **c. Tertiary care**
   - **d. Palliative care**
4. **Draft, discuss and agree; how each activity will be implemented, what will be implemented in the activity, where the activity will be done and who implement or be accountable for each activity in each of the thematic areas.**
5. **Present the group work in a table form**

Example :

Specific Objective	Activity	Output	Indicator	Outcome	Responsible person	Timeline	Venue of activity	Assumptions

SESSION 5 COSTING THE STRATEGIC PLAN

Duration : 2.0 hour 25 minutes

Resource constraints a ect the all dimensions of cervical cancer preven t on and control with regard to: human resources, tools and equipment in health facili t es, drugs, pallia t ve care, informa t on, educa t on and communica t on, and monitoring and evalua t on. This session is aimed at guiding planners in cos t ng, taking in to account the policy framework, target popula t on, realism in the scope of the planned interven t ons and the overall budget of the health sector.

WHO has developed the C4P; a cos t ng tool that will be used in this session to provide a realis t c approach to cos t ng for CCP &C.

Dra f Cos t ng Templates are a t ached in Annex 7.

Par t cipants will conduct cos t ng exercises for each of the key strategies and ac t vi t es using these templates.

Group Discussion Guide 8:

1. **Discuss the key cost items for the strategic plan by thematic area.**
2. **Work through the key strategic plan activities and develop costings for each using the templates in Annex 7.**
3. **Consolidated the individual costed items in to a budget**
4. **Present the group work in a budget form to large group**

SESSION 6 EVALUATING THE STRATEGIC PLAN

Duration: 1.0 hour 30 minutes

The monitoring and evaluaton framework should be established at the beginning of program planning. It is essenal to ensure that all aspects of strategy funcon e ecvely and e ciently.

The needs assessment can provide a baseline to assess the performance and impact e ect of strategy for cervical cancer, this informaon may allow you to compare before and a er quanave informaon (rates of HPV vaccinaon, screening and treatment) and qualitave informaon (awareness levels and percepons of cervical cancer vaccinaon, screening and treatment). Addional data should be connuously sought on the percepons of the cervical cancer prevenon and control strategies (including messaging) to adapt to the paent and provider needs, wants and desires.

Evaluang **process** can be achieved by using table xx.

Table 3: Sample process evaluation questions for Quality, Delivery, Use, Reach, Recruitment and Context.

	Possible Question	Information Needed
Quality	1. To what extent was the iniave implemented consistently with the underlying objecve?	1. What constutes high-quality delivery for each component of the iniave?
Delivery	2. To what extent were all of the intended units or components provided? 3. To what extent were all materials designed for use? 4. To what extent was all of the intended content covered? 5. To what extent were all intended methods, strategies, and/or acvies used?	2. How many components are in the iniave? 3. What specific materials were supposed to be used and when? 4. What specific content should be included? 5. What specific methods, strategies, and/or acvies should be used in which sessions?
Use	6. To what extent were parcipants present at acvies engaged in acvies 7. How did parcipants react to specific aspects of the acvies/messages 8. To what extend did parcipants engaged in recommended follow-up behaviour?	6. What parcipant behaviours indicate being engaged? 7. With what specific aspects of the acvies/ messages do we want to assess parcipant reacon or satsfacon? 8. What are the expected follow-up behaviours?
Reach	9. What proporon of the target audience parcipate/atend in acvity?	9. What is the number of people in the target audience?
Recruitment	10. What planned and actual recruitment procedures were used to aract individuals, groups and or organizaons? 11. What were the barriers to recruing individuals, groups and organizaons? 12. What were the barriers to maintaining involvement?	10. What mechanisms should be in place to document recruitment? 11. How will barriers to parcipaon be identfied and documented? 12. What mechanisms should be in place to identfy and document barriers encountered in maintaining involvement?
Context	13. What factors could potenally a ect either the iniave implementaon or the outcome?	13. What approaches will be used to identfy and systemacally assess factors that could a ect the iniave? How will these be monitored?

The indicators defined Sec t on 3, can be used to monitor **impact** and addi t onal indicators may become apparent as the advocacy programme develops.

Group Discussion Guide 9 :

1. **Develop key evaluation questions to evaluate extent of implementation of each objective and output. The table above provides sample questions to use. Develop specific questions for each specific objective developed before**
2. **Discuss and consolidate the evaluation question into an evaluation framework**
3. **Draft and discuss a monitoring and evaluation framework for the strategic plan**
4. **Present the group work in a budget form to large group**

Scaling up an existing strategy

Duration: 1.0 hour 30 minutes

Scaling up is defined here as - deliberate e orts to increase the impact of successfully tested health innova t ons so as to benefit more people and to foster policy and program development on a las t ng basis.

The review or evalua t on of an exis t ng plan provides a basis for scaling up interven t ons.

SESSION 7 WRITING A STRATEGIC PLAN

Duration: 5.0 hour 45 minutes

Group Discussion Guide 10 :

1. **Discuss and consolidate the sections discussed so far and create an outline for the strategic plan**
2. **Designate specific chapters and arrange them in chronological order**
3. **For each chapter – outline the key points that must be covered based on what has been discussed**
4. **Use the example in table 4 to create and write the draft plan.**
5. **Present the group work to the large group**

Table 4 : Where to input the information developed throughout this manual

Example lay out:	Section on the manual
1. Introduction Provide a brief background on cervical cancer (why is it a problem, who it a ects –include sta st cs if current and available, and what can be done to tackle the problem –preven on, screening and treatment)	Session 2 : Needs Assessment
2. Country situation Provide a brief summary of the challenges and opportuni es	Session 2 : Needs Assessment
3. Vision State the vision for the strategic plan	Session 3: Developing Vision, goals and objec ves
4. Goal State the goal	Session 3: Developing Vision, goals and objec ves
5. Objectives State the objec ves and outputs, ideally objec ves should be devised for primary, secondary and ter ary preven on.	Session 3: Developing Vision, goals and objec ves
7. Actions State the ac ons for achieving the goal and objec ves.	Session 4: Ac ons and ac vi es
8. Evaluation Provide a plan of how the plan will be evaluated	Session 5: Evalua on

SESSION 8 DISSEMINATION AND IMPLEMENTATION OF THE STRATEGIC PLAN

Duration : 3.0 hour 45 minutes

Group Discussion Guide 11 :

1. **Outline the various dissemination channels appropriate for your country**
2. **Outline the advantages and disadvantages of each method of dissemination**
3. **Develop a framework for dissemination of the strategic plan**
4. **Ensure the audiences are defined, the messaging clear and timelines are well set out**
5. **Present the draft dissemination plan to the large group.**

Discuss the standard dissemination channels for medical evidence, protocols, guidelines and how these apply to strategic plans

In the groups, discuss the various strategies such electronic dissemination as well as meetings and conferences. The group work needs to discuss the dissemination avenues relevant for the country, outline feasibility of each in terms of reach, appropriateness, type of audience, cost, and timelines. The groups then concludes the discussion with a timeline for completion of the strategic plan including the approach and timelines for dissemination/utilization of the strategic plan.

Examples of Audiences:

- Policy Makers
  - Select committees in Parliament
  - Ministry of Health Technocrats and program managers
  - Select Departments in other ministries like; Ministry of Gender, Education, Information, Finance,
  - Government Parastatal Bodies like Bureau of Statistics.

- National and International Stakeholders and/or Development Partners
- Academia; Medical and Nursing Schools
- Cancer Registries and Cancer Institutes
- National, Provincial/Regional Hospitals
- Private for profit and Not for Profit Health providers
- Civil Society Organisations

For Each Category; a short synthesis may be required to present the plan in the context relevant to how they can support cervical cancer prevention and control.

The ultimate is for the plenary to complete the session with a draft dissemination plan indicating audience, context, and likely timelines.

Annex 1.0 : Example list of participants and stakeholders

A super sectoral approach should be taken, including participants from the continuum of cervical cancer prevention and control.

Academics
Clinic supervisors/area managers
Community members
Donor agencies
Health Care Workers
Health care workers and clinicians
Health economists
Health facility managers
Health promotion staff
Information system staff
International Agency for Research on Cancer (IARC)
International Atomic Energy Agency (IAEA)
Joint United Nations Programme on HIV/AIDS (UNAIDS)
Laboratory staff
Ministry of Education
Ministry of Finance
Ministry of Health
Ministry of Transport
NGOs
Procurement and supplies staff
United Nations Population Fund (UNFPA)
United Nations International Children's Fund (UNICEF)
World Health Organization (WHO)

Annex 2.0 : List of materials for training

Trainee/participant manual
Flip charts
Marker pens
Pens
Overhead projector OR Computer and projector
Name tags

Annex 3.0 Example scope and purpose, objectives, agenda and list of reading materials

SCOPE AND PURPOSE :

Background

Cervical cancer is one of the most common cancer and the leading cause of cancer mortality among women in developing countries. In sub-Saharan Africa, 34.8 new cases of cervical cancer are diagnosed per 100 000 women annually, and 22.5 per 100 000 women die from the disease. These figures compare with 6.6 and 2.5 per 100 000 women, respectively, in North America.

The major risk factor associated with cervical cancer is Human Papilloma Virus (HPV) infection which generally occurs in adolescence after the first acts of sexual intercourse. In Africa, HPV infection prevalence is estimated at 21.3%, with significant variations from region to region: 33.6% in East Africa, 21.5% in West Africa and 21% in Southern Africa. Other major risk factors include tobacco use and lack of screening and adequate treatment of precancerous lesions. HPV and human immunodeficiency virus (HIV) co-infection accelerates progression towards cancer.

In Africa, several issues and challenges exist when dealing with cervical cancer prevention and control - Lack of cervical cancer control policy, strategies and programmes; Lack of recent and comprehensive data; Heavy economic and psychosocial burden of the disease; Insu ciency or lack of information and skills; High cost of immunization against HPV; Unavailability of secondary prevention; Una ordability of therapeutic resources and neglect of palliative care; Geographical inaccessibility of tertary prevention; and lack of collaboration and coordination of interventions.

These findings bring into focus the need to develop/adapt tools to support countries develop and implement strategic planning documents for improving comprehensive cervical cancer prevention and control.

General Objective

This training program aims to highlight the need for, and steps to develop, disseminate and implement a strategic plan for cervical cancer prevention and control.

Specific Objectives

1. Review and discuss ongoing initiatives, policies and programs aimed at the prevention and control of cervical cancer including recognizing successes, barriers and key factors for sustainability of interventions.
2. Discuss the role of stakeholders in the synergistic development and implementation of strategic planning
3. Identify national objectives and develop action plans for achieving the objectives
4. Discuss methods for evaluating plans
5. Identify opportunities for strategic plan dissemination and implementation

Expected Outcome

1. Understand the concept of a comprehensive approach to cervical cancer prevention and control
2. Draf a strategic plan
3. Develop a dissemination and implementation plan

Reading materials :

WHO Comprehensive Cervical Cancer Control – A guide to Essential Practice (2014);
http://www.who.int/reproductivehealth/publications/cancers/cervical-cancer-guide/en/

WHO Comprehensive cervical cancer prevention and control - a healthier future for girls and women: WHO guidance note
http://www.who.int/reproductivehealth/publications/cancers/9789241505147/en/

Useful websites :

International Agency for Research on Cancer (IARC) : www.iarc.fr

Jhpiego : www.Jhpiego.org

PATH : www.path.org

WHO Department of Reproductive Health and Research: www.who.int/reproductive-health

WHO Department of Immunization, Vaccines and Biologicals: www.who.int/immunization

WHO Department of Maternal, Newborn, Child and Adolescent Health: www.who.int/maternal_child_adolescent

WHO Department of Management of Noncommunicable Diseases : www.who.int/nmh/

WHO Department of Essential Medicines and Health Products : www.who.int/medicines

WHO HPV Vaccine Introduction Clearing House : www.who.int/immunization/hpv

WHO Human papillomavirus (HPV) : www.who.int/immunization/diseases/hpv

Annex 4.0 : Example training evaluation plan

Formal evaluation score card (completed by the participants/trainees)

Please indicate on a scale from 1 to 5 your opinion of the course components:

5 Strongly Agree **4 Agree** **3 Neutral** **2 Disagree 1** **Strongly Disagree**

Course Component	Rating
The information was provided in a clear and concise manner	
The information was easy to understand	
I felt comfortable to ask questions when I did not understand the content	
I enjoyed the group work	
The course material was useful	
The time allocated for each section of the course was appropriate	
I am now confident to develop a strategic plan	

Informal evaluation (completed by the participants/trainees and facilitator)

At the end of the session, ask the participants:
1. What went well in this training session and why?
2. What could I have done differently?
3. Recommendations for future training?

Self-evaluation for the facilitator

think back on the training sessions and consider the answer to the following questions:
1. What went well in this training session and why?
2. What problems did I experience and why?
3. What could I have done differently?
4. What did I learn from this experience that will help me in the future?

Annex 5.0 : Example : Strategic Plan Training Agenda

Title :	Training in Strategic Planning for Cervical Cancer Prevention, Treatment and Control Programs			
Location :	TBD			
Date :	TBD			
Day :	Day 1			
Convenor	MoH/WHO		Rapporteur	WHO/MOH
Start Time	**End Time**	**Time**	**Topic**	**Presenter**
8:00 AM	8:30 AM	0:30	Welcome and Registration	MOH
8:30 AM	9:45 AM	1:15	Introduction to Strategic Planning Course; Climate Setting, Introductions and Administrative issues Objectives of the training; participant Expectations and Pre-course assessment	
9:45 AM	10:15 AM	0:30	Discussion	
10:15 AM	10:45 AM	0:30	Tea Break	
10:45 AM	12:00 PM	1:15	Background to Cervical Cancer Prevention and Control	
12:00 PM	12:30 PM	0:30	Discussion	
12:30 PM	1:30 PM	1:00	Lunch Break	
1:30 PM	2:30 PM	1:00	Setting up for Strategic Planning	
2:30 PM	3:00 PM	0:30	Discussion	
3:00 PM	3:15 PM	0:15	Completing a Situation analysis	
3:15 PM	4:00 PM	0:45	Group work - Situation analysis	
4:00 PM	4:30 PM	0:30	Tea Break	
4:30 PM	5:00 PM	0:30	Presentation from Group work and wrap up	
Location :	TBD			
Date :	TBD			
Day :	Day 2			
Convenor	MoH/WHO		Rapporteur	WHO/MOH
Start Time	**End Time**	**Time**	**Topic**	**Presenter**
8:00 AM	8:15 AM	0:15	Admin issues	MOH
8:15 AM	8:45 AM	0:30	Developing a Vision Statement, Goals, Objectives	
8:45 AM	9:45 AM	1:00	Group Work	
9:45 AM	10:15 AM	0:30	Tea Break	
10:15 AM	11:30 AM	1:15	Presentations from Groups	
11:30 AM	12:00 PM	0:30	Discussion and finalisation of Objectives	
12:00 PM	1:00 PM	1:00	Lunch Break	
1:00 PM	1:30 PM	0:30	Setting Action Plans/Activites	
1:30 PM	2:30 PM	1:00	Group Work - Developing Action Plans	
2:30 PM	3:45 PM	1:15	Presentations from Groups -Draf plan	
3:45 PM	4:15 PM	0:30	Presentation from Groups	
4:15 PM	4:45 PM	0:30	Tea Break	
4:45 PM	5:00 PM	0:15	Group work wrap up	

Date :	TBD			
Day :	Day 3			
Convenor	MoH/WHO		Rapporteur	WHO/MOH
Start Time	**End Time**	**Time**	**Topic**	**Presenter**
8:00 AM	8:15 AM	0:15	Admin issues	MOH
8:15 AM	9:00 AM	0:45	Introduction to C4P and Costing the Strategic Plan	
9:00 AM	10:00 AM	1:00	Group work - Costing the Plan	
10:00 AM	10:30 AM	0:30	Tea Break	
10:30 AM	11:00 AM	0:30	Presentations from Group Work	
11:00 AM	12:30 PM	1:30	Scaling up and Existing Plan	
12:30 PM	1:30 PM	1:00	Lunch Break	
1:30 PM	2:00 PM	0:30	Evaluating the Strategic Plan	
2:00 PM	3:00 PM	1:00	Group Work on Evaluating the Plan	
3:00 PM	3:30 PM	0:30	Presentations from Group Work	
3:30 PM	4:15 PM	0:45	Introduction to Evaluation Tools	
4:15 PM	4:45 PM	0:30	Tea Break	
4:45 PM	5:15 PM	0:30	Evaluation Group work wrap up	

Date :	TBD			
Day :	Day 4			
Convenor	MoH/WHO		Rapporteur	WHO/MOH
Start Time	**End Time**	**Time**	**Topic**	**Presenter**
8:00 AM	8:15 AM	0:15	Admin issues	MOH
8:15 AM	9:00 AM	0:45	Writing A Strategic Plan	
9:00 AM	10:30 AM	1:30	Group Work - Writing the Plan	
10:30 AM	11:00 AM	0:30	Tea Break	
11:00 AM	12:15 PM	1:15	Group Work - Writing the Plan	
12:15 PM	12:45 PM	0:30	Discussion	
12:45 PM	1:45 PM	1:00	Lunch Break	
1:45 PM	2:45 PM	1:00	Presentation of Draf Plans - 1	
2:45 PM	3:15 PM	0:30	Discussion	
3:15 PM	4:15 PM	1:00	Presentation of Draf Plans - 2	
4:15 PM	4:45 PM	0:30	Tea Break	
4:45 PM	5:15 PM	0:30	Group work wrap up	

Date :	TBD			
Day :	Day 5			
Convenor	MoH/WHO		Rapporteur	WHO/MOH
Start Time	**End Time**	**Time**	**Topic**	**Presenter**
8:00 AM	8:15 AM	0:15	Admin issues	MOH
8:15 AM	9:00 AM	0:45	Dissemination and Implementation of the Plan	
9:00 AM	10:00 AM	1:00	Group Work on Dissemination and Implementation Plans	
10:00 AM	10:30 AM	0:30	Evaluation of Training/Feedback	
10:30 AM	11:00 AM	0:30	Tea Break	
11:00 AM	12:30 PM	1:30	Next Steps on Plan Finalisation	
12:30 PM	1:30 PM	1:00	Lunch Break	
1:30 PM	2:30 PM	1:00	Closure and Departure	

Annex 6.0 : Situation Analysis Questionnaire

Situation analysis Sample Questionnaire

Site information

Name of Organisat on : .....

Number of health facili t es : .....

Name of contact person : .....

Phone : .....

E-mail : .....

1. Do current health policies and sector strategic plans address cervical cancer prevention and control ?

.....

.....

2. Are there national, provincial and district coordination and support mechanisms for cervical cancer control ?

.....

.....

3. Do you use the MoH Service standards and Guidelines for Cacx ?

.....

.....

4. What Training Manuals of Materials have been used in your programs

.....

.....

.....

5. How long has your program been in existence

.....

.....

.....

6. Do you report screening data to MoH?

.....

.....

.....

7. Please list the indicators you track and report on

.....

.....

.....

8. What screening methods are used in your program ?

.....

.....

.....

.....

9. What pre-cancer treatment methods are used in your program ?

.....

.....

.....

10. Personnel potentially involved in cervical cancer outreach, screening, and treatment

	2012	2013	2014
Total # of women screened in each of the past three years			
# of women screened in past three years within target age group			
# of Women with Pre-cancerous Lesion (VIA +ve)			
# of Women Receiving Cryotherapy Same Day			
# of Women referred for LEEP or Surgery			
# of women screened positive referred			
# of women referred who completed referral			

11. Women targeted for cervical cancer screening program

Target age for screening: (.....) Years

12. Outreach/community mobilization

Describe the current outreach/community mobilization activites :

.....

.....

.....

13. Location of screening and treatment services

Describe the number and location of your screening and treatment services across the country;

.....

.....

.....

.....

Indicate District name and number of clinics you operate in :

.....

.....

.....

14. Describe your referral system; where does your program refer and what types of clients are referred?

.....

.....

.....

15. Equipment status and needs in your program

a. Supplies

	Desired quantity per room	# currently available in screening room(s)	Is current supply sufficient ? Y/N	# needed for new service
Examination table				
Acetic acid (Vinegar)				
Instrument tray with lid				
Graves speculum				
Sponge holding forceps				
Stainless Gallipots (small bowls)				
Cotton wool				
Gauze swabs				
Rolling stool				
Light Source (gooseneck lamp or flashlight)				
Batteries (if using flashlight)				
Sanitary pads/cotton for post-cryo				
Digital timer or wall clock				
Drapes for table, bed				
Rubber sheet to cover beds				

b. Infection Prevention

	Desired quantity per room	# Currently available for screening and treatment	Is current supply sufficient? Y/N	# needed for new service
Plastic buckets for decontamination				
Plastic bins				
Utility gloves				
Latex disposables gloves				
Chlorine decontaminant (Jik)				
Cidex (2–4% glutaraldehyde)				
Biohazard plastic bags				
Powdered soap				

c. Cryotherapy Equipment

	Desired quantity per room	# Currently available	Is current supply sufficient ? Y/N	# needed for new service
Cryotherapy unit (includes 2 tips)				
Carbon dioxide or nitrous oxide tank				
gas tank carrier with wheels				
gas tank refills				
Washers for cryo machine				
Wrench /spanner to tighten gas connection				
Rubber stoppers for cryo units				

16. Screening in the past three years :

	2012	2013	2014
Total # of women screened in each of the past three years			
# of women screened in past three years within target age group			
# of Women with Pre-cancerous Lesion (VIA +ve)			
# of Women Receiving Cryotherapy Same Day			
# of Women referred for LEEP or Surgery			
# of women screened positive referred			
# of women referred who completed referral			

17. Infection prevention/waste management

What guidelines are used at this health facility for infection prevention/waste management ?

.....

.....

.....

.....

18. Current referral system

a. Where are women detected with a positive screening test currently referred for treatment ?

.....

.....

.....

.....

b. Is there a mechanism in place for tracking treatment follow-up (identifying the number of women who complete the referral?)

19. Current diagnostic services
What diagnostic capacity currently exists at this health facility? (Please describe in the following table)

Diagnostic capacity	Yes or No and comments
Colposcopy	
Biopsy	
ECC	
Pathology unit	
Other: ……	

20. 20. Current treatment services available for pre-cancer and cancer
What treatment services are currently available at this health facility or program? (Please describe in the following table)

Type of treatment	Yes or No and comments
Cryotherapy	
Cold knife cone	
LEEP	
Hysterectomy	
Radiation	
Palliative Care	
Other : ……	

Issues related to current treatment practices: we do only diagnosis of cervical cancer and treatment of early disease by doing hysterectomy

21. Supportive supervision

a. Who is currently responsible for completing daily outreach, screening, and treatment reports ?

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b. Who is currently responsible for compiling monthly outreach, screening, and treatment reports ?

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c. Who analyzes/assesses monthly reports ?

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d. What internal and external clinical supervision is currently in place at this health facility?

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22. Integration of cervical cancer screening and treatment into existing services

a. How would new cervical cancer prevent on screening and treatment services be integrated into exist ng services at this health facility or program?

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b. What challenges does your program face in implement ng screening and treatments ?

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23. Additional comments or recommendations for improving cervical cancer control services

Policy : .....

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Program Implementation and Management : .....

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Treatment and referral .....

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Palliative care .....

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Monitoring/Evaluation and Data Management .....

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Stakeholder Coordination .....

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Annex 7.0 : Costing Materials

World Health Organization
Regional Office for Africa

PO Box 06 Brazzaville, Congo Republic
Telephone : +(47 241) 39100/ +(242) 770 02 02
Fax : +(47 241) 39503 - E-mail: regafro@afro.who.int

www.afro.who.int