

Romanian Family Health Initiative

A Comprehensive Reproductive Health Curriculum

Cervical Cancer Screening / Early Detection – A Training Curriculum for Family Doctors



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**TRAINING OF FAMILY DOCTORS FOR CERVICAL CANCER
SCREENING / EARLY DETECTION**

[cover II]

Title:

Training of Family Doctors for Cervical Cancer Screening / Early Detection

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Forward

This manual was developed based on the materials drawn-up by a group of trainer-physicians from the Health Service Centre in Cluj, and on the experience gathered within the Cluj pilot-project on cervical cancer early detection/screening. This project was focused on Family Doctors and their role in informing, mobilising and monitoring women and fostering cooperative relations with all other actors involved in the screening process. In addition to the activities developed with the support of Family Doctors, at the primary health care level, the cooperation with the Oncology Institute in Cluj and with the Romanian Cancer Society contributed significantly to the project and acted as a model of best practice in medicine.

We would like to thank the entire team who devised and implemented the pilot-project in Cluj, in particular the Family Doctors who were involved in this project (from the needs identification stage, to the training process, and the resolving and monitoring of each case), complying thus with their roles as physicians.

This manual was developed in order to replicate and expand this experience. Its aim is to develop and/or train medical staff providing cervical cancer prevention and supervision services. The purpose of the model proposed is to develop/ improve the skills required for Family Doctors to take part in the screening programmes, and to inform, educate and advise women about correct prevention, early detection and supervision of cervical lesions, including cervical cancer.

Objectives – by the end of the workshop, the participants will be able to:

1. Demonstrate the importance of preventive interventions
2. Demonstrate an basic level of understanding of screening, early cancer detection and testing methods
3. Monitor the clients' health condition in compliance with the algorithm for cervical cancer detection and diagnose
4. Develop individual intervention plans, based on the situation of each client
5. Provide specific advice in order to: mobilise women for cancer screening / early detection programme; train for investigations; adhere to the supervision and/or treatment programme
6. Provide support to individuals and families faced with a diagnosis of cancer.

The **Trainer's Manual** includes all the instructions and materials required to achieve the above-mentioned objectives and to enable facilitation of the training process. The content has been grouped into several sessions, each with specific learning objectives. The activities proposed are based on experiential, interactive learning, with direct involvement of participants in the learning process, in observance of adult learning principles.

Each session contains an introduction, which presents: specific objectives to be followed during the session, estimated duration per session, and a table including activities proposed, training techniques, duration of each activity and a list of required materials. Using this table, trainers may check before each session that all the necessary materials

and supplies are prepared, and may follow the activities carried out in compliance with the programme.

The first part of the session includes a description of the proposed activities, with detailed instructions allowing the trainers to implement the training activities step-by-step and to achieve the objectives listed above.

This is followed by the materials required to carry out the activities: visual aids (flipchart or transparencies), documents for trainers (including technical information necessary to conduct the activities), worksheets and other materials to be handed out throughout the workshop, in close connection with the activities carried out. Trainers may choose to present the visual aids in electronic format (PowerPoint presentation), which will be made available to them on a CD.

Materials for the participants are compiled in a **Participants' Manual**, to be handed out at the beginning of the workshop. It is used throughout the workshop, when references are made to the training materials it includes, and Family Doctors can continue to use it in the course of their professional activities.

Authors

SESSION 1: INTRODUCTION

OBJECTIVE: By the end of this session, participants will be able to:

1. State the name that the trainers and other participants would prefer to be called by throughout the workshop
2. Describe what they would like to learn during the workshop
3. Reconsider their expectations based on the proposed objectives
4. Name at least four rules accepted by the group for optimal implementation of the workshop
5. Assess their knowledge on cervical cancer

| Activities | Methods | Duration | Materials |
|---|--------------------------------------|------------|---|
| Overview Introductions Participants' expectations | Presentation Pair work (dyads) | 20 min | Flip-chart and flip-chart sheets Markers Tags Block-notes Pens Participants' Manuals/ Handouts |
| Purpose and objectives of the workshop | Presentation | 10 min | Flipchart / Handout Goal and objectives of the workshop Handout Workshop agenda |
| Group norms/rules | Brainstorming | 10 min | |
| Initial testing | Individual work (questionnaire) | 10 min | Handout Pre - test Trainer's document Test key |
| TOTAL | | 50' | |

INSTRUCTIONS:

Note: as the participants arrive, hand them a participant's folder/manual, a notebook for notes/ block-notes and a pen and invite them to take a seat. Take into account the importance of this first session, especially in creating an environment where participants feel comfortable, enabling them to get to know each other and become acquainted with the trainers.

I-II. OVERVIEW, INTRODUCTIONS, EXPECTATIONS (20 min)

Welcome participants to the workshop. Introduce yourselves briefly.

Explain that this is a participative workshop and that it is very important for everybody to provide input, to create a good learning opportunity for everyone, including the trainers. Mention that all participants have the same status; the chair display (in half a circle) underlines this, giving everybody the opportunity to speak, see and hear the others.

Distribute the tags and ask participants to write the name they would like to be called by during this workshop.

Then invite participants to introduce themselves individually and include their experience in cervical and breast cancer, providing an answer to the following questions displayed on the flipchart:

- What is your professional experience in the field of cervical cancer?
- Have you been involved in cervical cancer early detection/ screening projects?
- What do you consider to be your “strength” in this field?
- What information would you like to find out, what skills do you hope to acquire after having taken part in this workshop?

As participants reply, make up a list with their expectations, which you should display in a visible place.

III. PURPOSE AND OBJECTIVES OF THE WORKSHOP (10 min)

Display on the flipchart/project the material *Goal and Objectives of the Workshop*. Read it together with the group and ask whether there are any questions or clarifications.

Discuss with participants the similarities/differences between the workshop objectives and their expectations. If there are any differences, discuss the possible ways of responding to the issues raised by the group. If there are proposals that the workshop cannot address, discuss the ways in which they might be approached in the future.

IV. GROUP NORMS (10 min)

Explain to the participants that an important element of creating a suitable learning environment is the way each person understands their responsibilities as a group member.

Invite the group to propose several norms or group rules which everybody present should comply with, in order to facilitate participation from each person and training for all.

List these rules proposed by the participants. Check if all participants agree to them. If there are any similar rules proposed by several participants, try to summarise them; if there are controversial rules, assist the group to reach a consensus.

Suggest the following rules, if they are not mentioned by the participants.

- Be on time
- Respect and encourage participation from the others
- Do not interrupt
- Listen to the others

- Respect confidentiality
- Do not attack the person
- Stick to the point
- Each participant is responsible for what they learn during the workshop
- Do not smoke in the training room
- Do not use mobile phones during the training sessions

Present the *Workshop Programme* to the participants.

[Note for the trainer: the agenda may be adapted to participants' needs, this is why it includes only some time marks; depending on local conditions, the training may include only the aspects related to cervical cancer, or it may include other topics as well, in which case, the programme may be adjusted accordingly].

Provide some general information related to breaks, location of the restaurant, toilets etc. and other administrative aspects (e.g. accommodation, transport reimbursement).

V. PRE-TEST (10 min)

Explain to participants that they will now sit a test and mention that:

- This test shall help the trainers to learn what is the general level of knowledge on proposed topics;
- Based on the replies received, the information provided by the trainers during the training will be adapted to the needs of the group;
- At the end of the course, participants will sit an identical test, which will allow them to assess how much they have learnt.

Distribute a copy of the test to each participant. Mention that they have 10 minutes to complete it.

Collect the completed tests.

[Note: Trainer should: 1) collect the tests; 2) score tests during lunch break or in the evening, if there is a two day workshop, to see what are the strengths and weaknesses of the group; 3) positively underline that, if at this moment participants did not provide answers to all the questions, we hope that by the end of the course everybody present will have improved their knowledge and skills].

Flip chart/ Handout

**TRAINING OF FAMILY DOCTORS FOR CERVICAL CANCER SCREENING /
EARLY DETECTION**

Goal and Objectives of the Workshop

Goal: develop/ improve the skills required for Family Doctors to take part in the cervical cancer screening/ early detection programmes.

General objectives:

By the end of the training course, the participants will be able to:

1. Demonstrate the importance of preventive interventions
2. Demonstrate an understanding of the basic information on screening, early cancer detection and testing methods
3. Monitor the clients' health condition in compliance with the algorithm for cervical cancer detection and diagnosis
4. Develop individual intervention plans, based on the condition of each client
5. Provide specific advice to: mobilize women for cancer screening / early detection programme; train for investigations; adhere to the supervision and/or treatment programme
6. Provide support to individuals and families faced with a diagnosis of cancer.

Handout

WORKSHOP AGENDA

| DAY I | DAY II |
|---|--|
| Session 1 : Introduction (50 min) | Review on the first day (15 min) |
| Session 2 : Importance of Preventive Medicine (1 hour 10 min) | Session 6 : Client – Provider Interaction: Improving Communication Skills (3 hours) |
| COFFEE BREAK | COFFEE BREAK |
| Session 3 : Cervical Cancer Supervision and Control Programmes (1 hour 30 min) | Session 6 : Client – Provider Interaction: Improving Communication Skills (cont.) |
| LUNCH BREAK | LUNCH BREAK |
| Session 4 : Development of a Cervical Cancer Screening Programme (1 hour 15 min) | Session 7 : Counseling and Health Education (3 hours) |
| COFFEE BREAK | COFFEE BREAK |
| Session 5 : Cervical Lesion Detection and Case Management (1 hour 45 min) | Session 7 : Counseling and Health Education (cont.) |
| | Session 8 : Evaluation and Wrap Up (30 min) |
| SUMMARY AND EVALUATION OF THE DAY | SUMMARY |

SESSION 2: THE IMPORTANCE OF PREVENTIVE MEDICINE

OBJECTIVES: by the end of this session, the participants will be able to:

1. Describe main concepts of preventive medicine and list the principles of a screening programme
2. Describe the reference framework to approach oncological diseases in women at the level of primary health care (cervical and breast cancer prevention/early detection strategies)
3. Identify barriers to routine preventive interventions for cervical and breast cancer provided by the Family Doctor

| Activities | Methods | Duration | Materials |
|--|---|----------------|---|
| Preventive medicine – Main concepts Features of a screening programme | Brainstorming Small group work Debate Presentation | 15 min | Flipchart - Preventive interventions Trainer’s documents/ Handouts - Preventive interventions - Screening - Evidence-based preventive interventions and power of recommendations |
| Integration of genital and breast cancer preventive services into Family Doctor’s practice | Group discussion Presentation | 25 min | Flipchart - Early detection of genital and breast cancer Trainer’s document/ Handout - WHO Recommendations for Comprehensive Cervical Cancer Control |
| Barriers to preventive services at the level of Primary Health Care | Small group work | 30 min | Trainer’s document/ Handout - Barriers to the implementation of genital cancer control programmes |
| TOTAL | | 1 h 10’ | |

INSTRUCTIONS:

I. Preventive medicine – Main concepts (15 min)

In the opening to the session mention that the following aspects shall be discussed during this session:

- Main concepts of preventive medicine
- Features of a screening programme
- Integration of genital and breast cancer preventive and early detection services into Family Doctor’s service provision

Invite participants to provide a definition for prevention. Listen to several answers and then rephrase them, in order to develop a definition as close to the one below as possible:

Prevention includes a series of “interventions aiming to eradicate, eliminate, or minimise impact of disease and disabilities. The concept of prevention is best defined in the context of some levels, traditionally referred to as primary, secondary and tertiary prevention”
Dictionary of Epidemiology, Fourth Edition – edited by John M. Last

Ask participants what kind of preventive interventions they are familiar with. Display the answers provided on the flipchart. If necessary, address additional questions to the group, helping them to identify as many examples as possible.

Review the interventions list together with the group, and underline the types of interventions, using different colour pens: primary, secondary and tertiary.

Display on the flipchart the material entitled *Preventive Interventions* (project the first slide in the trainer's material) and explain the types of preventive interventions. Emphasize the importance of counselling in all those interventions.

Invite participants to think and list: types of diseases that can be prevented and methods to prevent them. Then briefly present the method of selecting diseases and targeting populations and criteria for measuring effectiveness of preventive interventions.

Underline that the following aspects are taken into account in the intervention selection process:

- Effectiveness, efficiency and outcomes of the intervention
- Weight of evidence (I-III) and strength of recommendations (A-I), in compliance with the principles of evidence-based medicine.

Present the material entitled *Evidence-based Preventive Interventions and Power of Recommendations*. Underline the interventions related to genital and breast cancer.

[Note for the trainer: prepare copies of this material, to distribute to participants, depending on the interest of the group]

Mention that you will now remind them of some of the notions they have learnt at university. Explain what the screening intervention includes, what its constitutive elements are, the circumstances under which the screening is justified and how we can assess its effectiveness.

Underline the difference between “sensitivity” and “specificity” of screening tests.

II. Integration of genital and breast cancer preventive services into primary health care (25 min)

Mention that we will continue to discuss the role of the Family Doctor in the application of preventive medicine measures.

Referring to the female population in particular, ask participants which preventive interventions they think are the most feasible at the level of primary health care and most applicable by the Family Doctor.

The following answers will probably be among the replies received:

- Screening for early detection of cervical and breast cancer
- Family planning counselling
- STI prevention and treatment
- Hormonal replacement therapy (prevention of osteoporosis and other problems associated to menopause)
- Prevention / identification of domestic violence victims

- Education for a healthy lifestyle

Project/ display on the flipchart the material entitled *Early Detection of Genital and Breast Cancer* and discuss with the group the screening results at individual level (score improvement, reducing the risk of developing invasive cancer) and the general effect upon the health condition of the female population.

Use the following questions to facilitate discussions:

- Are cervical and breast cancer problems to reproductive health? Why?
- How can death caused by cervical/ breast cancer be prevented?
- What is the gain for females? For their families? For the society?

Then ask the participants:

- What screening methods are you aware of for cervical cancer?

Expected replies:

- Papanicolaou test (PAP)
- Visual inspection of the cervix (with Lugol solution or with acetic acid solution)
- HPV test

- What about breast cancer?

Expected replies:

- Mammography (>40 years old)
- Ultrasound exam (<40 years old)
- Laboratory tests (genetic mutations BRCA 1 and 2) and genetic counselling

Add that self-examination and periodic control (carried out by the physician) are some methods which may contribute to breast cancer detection, but which are not screening methods.

- Which ones do you use /have you used?
- Which are the most appropriate ones for the Family Doctor's premises?
- What would be the implications of introducing some services of this type to your units?

Possible answers:

- Procurement of medical equipment and supplies
- Learning/practicing the examination, sample collection technique
- Ensuring the flow of samples collected and results
- Monitoring women
- Mapping target population
- Programming and notifying women on examinations to be done (mobilisation)

[Note for the trainer: some participants may mostly identify negative implications, obstacles]

- What would be the advantages for you?
- What would be the advantages for the population assisted?

[Note for the trainer: the purpose of this discussion is to persuade participants of the importance and effectiveness of screening and to increase their commitment]

Explain that WHO experts have developed the intervention framework to implement effective genital and breast cancer control programmes and make a short presentation of the material entitled *WHO Recommendations for Comprehensive Cervical Cancer Control*.

Mention that later you will present the model developed within the Cluj pilot-project, which may be extended easily to national level.

III. Barriers to preventive services at the level of primary health care (30 min)

Underline that some of the elements mentioned by the participants during the previous discussions as potential obstacles are not the only obstacles to the provision of cancer prevention and early detection services at the level of primary health care.

Split participants into 3 small groups. Group 1 will identify political barriers, group 2 will deal with organisational barriers (health system, infrastructure), and group 3 will tackle individual and community barriers. The 3 groups will also be invited to identify possible ways of removing the barriers identified.

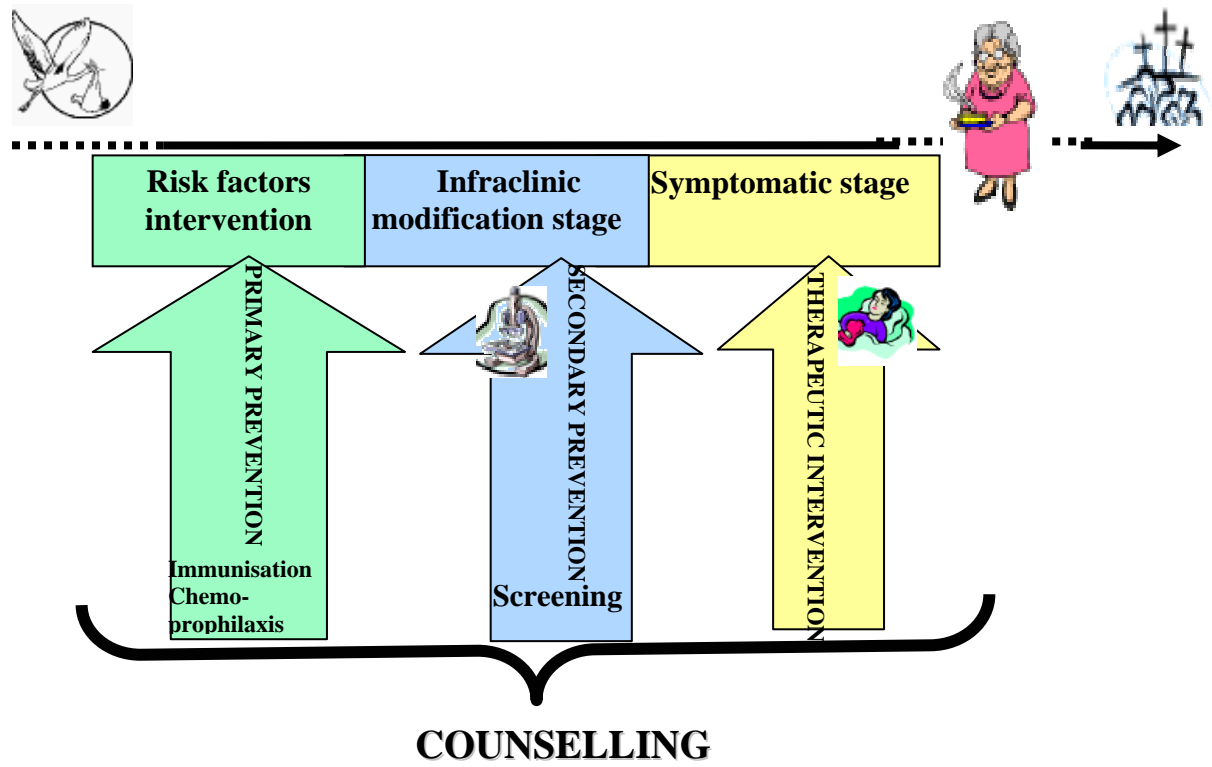
One representative from each group will present the results before their colleagues. Invite participants from the other groups to add to this, if they wish to and if necessary.

Summarise barriers and solutions identified by participants and underline the following:

- Some of these barriers may be removed by the Family Doctor, through the way in which they organise their activities in their unit and through correct information passed on to women about the importance of screening cervical and breast cancer
- To remove political and system-related barriers it takes more effort and a sustained advocacy activity, both from service providers and beneficiaries. Family Doctors may play a very important role, by raising communities' awareness and by lobbying decision-makers to change public health policies
- Reorganisation of the sanitary system and allocation of new roles/ expansion of roles in the field of health for local public authorities (municipalities), represents an opportunity for improvement of health services and associated infrastructure.

Flipchart/ Handout

PREVENTIVE INTERVENTIONS



Trainer's document/ Handout

PREVENTIVE INTERVENTIONS

SELECTION OF TARGET DISEASES

The target disease is the damaged health condition avoided (primary prevention) or early identified (secondary prevention) through preventive intervention.

Selection of preventive intervention is done based on how **frequent** and **severe** the disease is.

The frequency of the disease in population is measured through its rate of

- **incidence** (*number of new cases emerging over a given period of time compared against the number of people*)
- **prevalence** (*total number of cases – old and new – in population over a given period of time compared against the number of people*)

The severity of disease is described by: **mortality, fatality, survival rate, years of life with disability, potential years of life lost** etc.

Selection is done based on:

- **Effectiveness** of preventive interventions, which is given by their capacity to trigger the desired result in the health condition (*the effect on the health condition, the “outcome”*)
- **Efficiency** of preventive interventions, which judges the benefits obtained compared with the risks associated with the intervention, costs and implementation effort
- **Results** of preventive interventions which are measured in QALY (quality adjusted life years), DALY (disability adjusted life years)

CRITERIA TO MEASURE EFFECTIVENESS OF PREVENTIVE INTERVENTIONS

Screening tests

- **Test accuracy**

A screening test is not considered effective if it does not have enough accuracy to detect a disease earlier than it would have been diagnosed in the absence of screening

- **Effectiveness of early detection**

or if there is no adequate proof that detection and treatment in the respective stage significantly improves diagnosis.

Counselling interventions

- **Effectiveness of risk mitigation**

Counselling interventions cannot be considered effective in the absence of solid proof that the change in personal behaviour may improve diagnosis

- **Effectiveness of counselling**

and that physicians may influence this behaviour through their advice.

Immunisation and Chemoprophylaxis

- Vaccine effectiveness
- Chemoprophylaxis effectiveness

EVIDENCE BASED MEDICINE

The decision to recommend a certain intervention and a certain protocol (guidelines or clinical standard) is based on the quality and weight of scientific evidence of the effectiveness and efficiency of a certain intervention.

The weight of evidence of effectiveness is scaled based on the method used to obtain the evidence:

I: Evidence obtained through at least one randomised controlled clinical study (with witness lot)

II-1: Evidence obtained through well devised, non-randomised, controlled clinical studies

II-2: Evidence obtained through well devised analytical surveys, preferably in several independent centres

II-3: Evidence obtained through multiple time series, with or without spectacular intervention or results obtained for non-controlled experiments (for instance: introduction of Penicillin in 1940)

III: Opinions of reputed authorities based on clinical experience, descriptive studies, reports of experts committees.

POWER OF RECOMMENDATIONS for PREVENTIVE INTERVENTIONS

A: There is solid evidence supporting the recommendation to the specific introduction of the intervention in a periodic preventive examination

B: There is acceptable evidence in favour of the specific introduction of the intervention in a periodic preventive examination

C: There is not enough evidence to recommend inclusion or exclusion of the intervention from a periodic preventive examination, the recommendation may be made individually

D: There is evidence leaning against the recommendation to introduce routine preventive service to asymptomatic patients. There is acceptable evidence leaning against the specific introduction of the intervention in periodic preventive examinations.

I: There is not enough evidence for or against the recommendation to introduce routine preventive service. There is solid evidence supporting the exclusion of the intervention from periodic preventive examinations.

Trainer's document/ Handout

SCREENING

Screening includes the application of a test to detect a disease or a potential pathologic condition in a person who does **not** present any sign or symptoms related to the respective disease or condition.

The screening has two basic **purposes**:

- **To detect the disease**, as soon as possible in its natural history, at a moment when treatment is either more effective or less expensive, or both (eg.: *oncology detection*)
- **To detect the risk factors** which predispose the individual to an above-average likelihood of developing the respective disease, with the purpose of modifying the risk factor (or factors) in order to prevent occurrence of disease (eg.: *cardio-vascular risk assessment*)

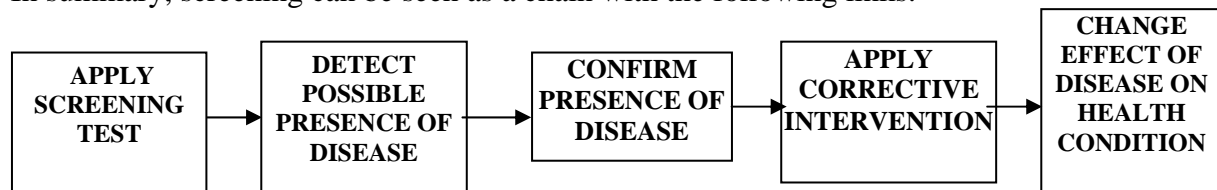
Screening tests – generically refer to a variety of methods including:

- Structured interviews in patient's anamnesis
- Laboratory tests
- Physical examination targeted according to a certain protocols
- Imagistic tests
- Invasive procedures

SCREENING COMPONENTS

The objective of the screening is achieved if detection of health problems is followed by timely interventions and corrections.

In summary, screening can be seen as a chain with the following links:



Introduction of a screening programme includes **two** major stages:

I – estimate the effects of the screening policy on the health condition and the economic results: appreciate benefits (reducing mortality and incidence), risks and costs

II – compare effects to determine whether benefits are higher than risks and costs

The strategy of a screening programme must clearly establish:

- Who is the target population (general population, certain age groups/gender categories, certain geographic regions or only those with a certain risk level)
- What detection tests shall be used, in what order and at what intervals they shall be applied
- Who shall apply the tests and where they shall be carried out

The screening is justified¹ when:

- The disease has a significant impact on quantity and quality of life
- Methods of treatment adequate and acceptable from the patient’s point of view are available
- The disease has an asymptomatic period when diagnose and treatment considerably reduce morbidity and mortality
- The treatment carried out in the asymptomatic stage produces better results than if applied in the symptomatic stage
- There are tests acceptable to the patients,, available at a reasonable cost, which can detect the disease in the asymptomatic stage
- The disease is sufficiently expanded in the population to justify testing asymptomatic persons

Accuracy of the screening test

Screening effectiveness depends, to a wide extent, on the capacity of the test to produce real results = test accuracy

Test accuracy refers to:

- **Sensitivity** = Capacity of the test to show presence of the disease, when it really exists (large number of true positive results)
- **Specificity** = Capacity of the test to deny presence of the disease, when it really does not exist (low number of false negative results)

| | Disease exists | Disease does not exist |
|------------------------|-----------------------|-------------------------------|
| Positive result | True positive | False positive |
| Negative result | False negative | True negative |

¹ Frame & Carlson, 1975

Trainer’s document/ Handout
(optional)

CLINICAL PREVENTIVE INTERVENTIONS – ACCORDING TO WEIGHT OF EVIDENCE AND STRENGTH OF RECOMMENDATIONS

A: There is solid evidence supporting the recommendation to specifically introduce the intervention in a periodic preventive examination
B: There is acceptable evidence in favour of specifically introducing the intervention in a periodic preventive examination.
C: There is not enough evidence to recommend inclusion or exclusion of the intervention from a periodic preventive examination, the recommendation may be made individually
D: There is evidence leaning against the recommendation to introduce routine preventive service to asymptomatic patients. There is acceptable evidence leaning against the specific introduction of the intervention in periodic preventive examinations.
I: There is not enough evidence for or against the recommendation to introduce routine preventive service. There is solid evidence supporting the exclusion of the intervention from periodic preventive examinations

| DISEASE TARGETED | TYPE OF PREVENTIVE INTERVENTION | CLINICAL INTERVENTION | STRENGTH OF RECOMMENDATION |
|--|--|---|-----------------------------------|
| SILENT ISCHEMIC CARDIOPATHY | Screening | EKG during rest and effort, ETT, EBCT low risk adults | D |
| | | EKG during rest and effort, ETT, EBCT high risk adults | I |
| HIPERCOLESTEROLEMY AND DISLIPIDEMIA | Screening | All men above 35 years old and all women above 45 years old | A |
| | | Men between 20-35 years old, women between 20-45 years old with other cardiovascular risk factors as well | B |
| | | Men between 20-35 years old, women between 20-45 years old without other cardiovascular risk factors | C |
| | | Screening by measuring total cholesterol and HDL cholesterol | B |
| | | Screening by measuring triglycerides | I |

| | | | |
|---|------------------|---|---------------------------------|
| HIGH BLOOD PRESSURE | Screening | Periodic measurement of arterial blood pressure for adults >18 years old Periodic measurement of arterial blood pressure for children and Teenagers | A I |
| ASYMPTOMATIC CAROTIDIAN STENOSIS | Screening | Auscultation and/or routine Doppler for elderly people | C 1996 under construction |
| PERIPHERIC ARTERIOPATHIES | Screening | Claudication anamnesis and peripheral pulse palpation, Doppler or others for elderly people | D 1996 under construction |
| ABDOMINAL AORTA ANEURISM | Screening | Routine abdominal echo for male smokers between 65-75 years old Routine abdominal echo for male non-smokers between 65-75 years old Routine abdominal echo for women | B C D |
| BREAST CANCER | Screening | Routine mammography every 1-2 years ± yearly clinical examination: F 40-49 years old 50-69 >70 Yearly clinical examination without mammography: Breast self-palpation Chemoprophylaxis with tamoxifen for woman with average risk Chemoprophylaxis with tamoxifen for woman with high risk | B B B I I D B |
| COLORECTAL CANCER | Screening | Routine testing for men and women over 50 years old by: Yearly or half-yearly testing for occult faeces haemorrhages Routine sigmoidoscopy every 5 years Routine colonoscopy every 10 years Routine barium transit with double contrast Routine rectal examination | A A A A A D |
| CERVICAL CANCER | Screening | Regular BPN sample for sexually active women Stop BPN >65 years old if they had regular testing Women with hysterectomies New technologies | A D D I |

| | | | |
|--------------------------------|--------------------|---|-------------|
| | | Routine cervicography and cervicoscopy Serologic identification of infection type with HPV | D I |
| PROSTATE CANCER | Screening | Routine rectal examination Routine testing for prostate specific antigen or other tumour markers Routine transrectal echography | I I |
| BRONHO-PULMONARY CANCER | Screening | Routine thoracic radiography, computerised tomography or smear cytology | I |
| SKIN CANCER | Screening | Full tegument inspection by the Family Doctor | I |
| | Counselling | Periodic skin self-examination Avoiding sun display and solar protection measures for persons with high risk Routine utilisation or solar screen creams | I |
| TESTICLES CANCER | Screening | Routine self-examination or professional clinical examination | D |
| OVARY CANCER | Screening | Routine gynaecologic examination, echo or tumour serology General female population Female population with high risk | D |
| PANCREAS CANCER | Screening | Routine abdomen palpation, echo or tumour serology | D |
| ORAL CAVITY CANCER | Screening | Routine examination of oral cavity by the Family Doctor | I |
| URINARY BLADDERCANCER | Screening | Routine urine examination (urinary strip/ microscope) Routine urinary cytology | D D |
| THYROID CANCER | Screening | Routine palpation of cervical region or echo General population High risk population | D 1996 C |
| DIABETES MELITUS | Screening | Adults general population Adults with HTA or dislipidemy | I B |
| THYROID MALFUNCTION | Screening | Routine dosage of TSH, FT ₄ General population High risk population | I |

| | | | |
|---|--|--|--------------------------|
| OBESITY | | Periodic measurement of Waist and Weight Routine measurement of the Waist/Hip ratio Counselling to reduce weight | B C I |
| INFECTION WITH B HEPATITIS VIRUS | Screening | Routine measurement of AgHBs Pregnant women High risk persons (assessing the vaccination needs) General population | A C D |
| TUBERCULOSIS | Screening | IDR for tuberculin (for high risk persons *) + BCG vaccination (for high risk persons)* <i>*in USA TBC is considered eradicated from general population)</i> | B B |
| SYPHILIS | Screening | Routine serology testing for High risk population* Pregnant women <i>* in USA syphilis is considered eradicated from general population n</i> | A A |
| GHONOREEA | Screening Primary prevention (chemoprophylaxis) | Culture or ESV Gram colour High risk female High risk pregnant women Pregnant women of general population High risk males General population Primary prevention of gonococcal ophthalmopathy for infants Routine ophthalmic antibiotic administration for infants | A A D A |
| HIV INFECTION | Screening | Enzymatic RIA with confirmation test for positive results High risk adults and Teenagers Pregnant women Teenagers and adults from general population | A A C |

| | | | |
|---|---------------------|---|-----------------------|
| INFECTION WITH CHLAMYDIA TRACHOMATIS | Screening | Routine cultures or immunologic tests High risk sexually active women and Teenagers High risk pregnant women Pregnant women of general population High risk males General population | A A C I C |
| GENITAL HERPES (HSV) | Screening | Culture, serology or other routine viral tests General population Pregnant women Counselling non-infected women with infected partners for use of preservative or sexual abstinence during pregnancy | D D C |
| ASYMPTOMATIC BACTERIURIA | Screening | Routine uroculture for pregnant woman in weeks 12-16 Routine urine examination with urinary strips for: Pregnant women Diabetic women Non-institutionalised elderly women Institutionalised elderly School girls Other people Routine urine microscopic examination | A D |
| RUBEOLA | Screening | Serology or vaccine history Women of a fertile age (including pregnant women) High risk young people Men of general population and women after menopause Routine vaccination without screening | B C D |
| | Immunisation | Children Women of a fertile age (excluding pregnant women) High risk young male Men of general population and women after menopause | A B C D |

| | | | |
|---|------------------|--|----------------------------|
| VISUAL ACUITY | Screening | Routine testing for amblyopy and strabismus for small children Snellen visual acuity test for elderly people Routine ophthalmoscopy at the Family Doctor's unit for elderly people Routine sight screening for big children, Teenagers and adults | B B C C |
| GLAUCOMA | Screening | Routine tonometry Routine ophthalmoscopy at the Family Doctor's unit | I |
| DEAFNESS | Screening | Periodic testing for elderly people through whispered questions Routine audiometry Routine hearing testing for Teenagers and adults of an working age Otoacoustic emissions mentioned with infants Routine testing for children > 3 years old | B 1996 C C C D |
| POSTCLIMACTERIC OSTEOPOROSIS | Screening | Routine bone densitometry for women at postmenopause >65 Routine bone densitometry for women at postmenopause >60, at high risk Women < 60 at risk Women 60-64 at no risk | B B C |
| MADNESS | Screening | Standardised cognitive tests for elderly people | I |
| DEPRESSION | Screening | Standardised tests (questionnaire) at the Family Doctor's unit where there is the possibility to have a clear diagnose, efficient treatment and follow-up | B |
| DOMESTIC VIOLENCE | Screening | Routine standardised interview to detect abuse with elderly people Routine standardised questionnaire to detect domestic violence | I I |
| ALCOOLISM | Screening | Routine interview or standardised questionnaire to detect abusive alcohol consumption and counselling to reduce inadequate alcohol consumption Adults Pregnant women Teenagers | B B I |
| DRUG ADDICTION | Screening | Standardised questionnaires and/or biologic dosage | C |

| | | | |
|-----------------------|--------------------|---|--|
| SMOKING | Counselling | <p>Effectiveness of risk mitigation Avoiding or quitting smoking reduces the risk of cancer, cardio-respiratory diseases, pregnancy and neo-natal pathology</p> <p>Effectiveness of counselling and other clinical interventions Counselling provided by a clinician to all smoking patients to reduce or quit smoking</p> <p>Nicotine patches or chewing gum in parallel with counselling</p> <p>Clonidine as an adjuvant for counselling</p> <p>Counselling provided by a physician to school and high school children to avoid smoking</p> | <p>A</p> <p>A</p> <p>A</p> <p>I</p> <p>I</p> |
| SEDENTARY LIFE | Counselling | <p>Effectiveness of risk mitigation Doing regular exercise to prevent coronary diseases, HTA, obesity and other diseases</p> <p>Counselling effectiveness Counselling provided to patients to include regular exercise into their daily activity</p> | <p>I</p> <p>C</p> |

| | | | |
|--------------------|---------------------------|---|---|
| <p>FOOD</p> | <p>Counselling</p> | <p>Effectiveness of risk mitigation for general population Limiting the (saturated) fat content Limiting the cholesterol content Increasing consumption of fruit, vegetables and cereal rich in fibres Maintaining a balance at the level of calories through diet and exercise Maintaining an adequate content of calcium from food for women Reducing the sodium content in food Increasing the iron content in food Increasing the content of beta-carotene and other anti-oxidants in food Breastfeeding infants Counselling effectiveness Counselling provided to persons at cardiovascular risk and with diet-dependant dislipidemy in order to change their eating habits given by: - Physicians providing primary assistance - Educators specially trained (eg., nutritionists) Supplementing the diet with vitamin A, C, E; multivitamins with folic acid; antioxidant combinations, to prevent cancer or cardiovascular diseases Supplementing with beta carotenes to prevent cancer or cardiovascular diseases</p> | <p>A B B B B C C C C A I B I D</p> |
|--------------------|---------------------------|---|---|

| | | | |
|---|---------------------------|---|---|
| <p>DOMESTIC AND RECREATIONAL ACCIDENTS</p> | <p>Counselling</p> | <p>Effectiveness of risk mitigation</p> <p><i>Fires and burns</i> Smoke detectors Quitting smoking Fireproof clothes Setting water heating to maximum 30° C</p> <p><i>Drowning</i> Pool insulation and supervision Training for basic cardio-pulmonary resuscitation</p> <p><i>Intoxication</i> Drug bottles with special sealing for children Limiting the number of tablets in a package Labels with warning symbols for children</p> <p><i>Accidents related to alcohol consumption</i> Avoiding swimming, hunting, smoking and driving (including bicycles and boats) in the vicinity of alcohol consumption</p> <p><i>Children falling</i> High protection for windows and stairs</p> <p><i>Elderly people falling</i> Balance training exercises Support fittings at home (support bars in the bathrooms, kitchens, etc.) Hip protection (external) for institutionalised elderly people</p> <p>Counselling effectiveness Counselling for parents with small children – measures to mitigate risks of accidents Counselling for teenagers and adults – measures to mitigate risks of accidents Counselling to reduce/avoid alcohol consumption in situations that are prone to accidents Counselling for elderly people and owners on risk of falling</p> | <p>B A A A B B A A D B A B B C B C B C</p> |
|---|---------------------------|---|---|

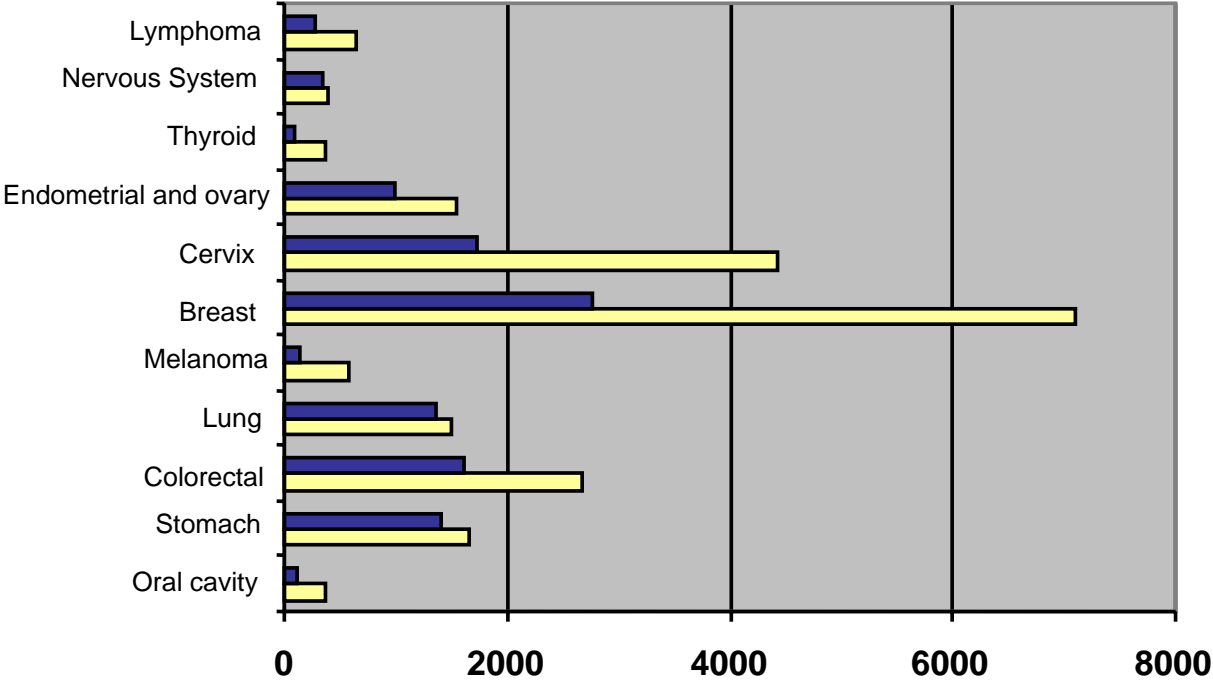
| | | | |
|---|--|---|--|
| LUMBAR PAIN | Counselling | <p>Effectiveness of risk mitigation Exercises to strengthen the paravertebral and abdominal muscles Bodice or belt Risk factors modification (obesity, smoking, psychological factors) Counselling effectiveness Education to prevent back pain At the work place Pregnant women Patients under Primary Assistance</p> | I |
| STI TRANSMISSION (INCLUDING HIV) | <p>Counselling</p> <p>Gonorrhoea screening</p> | <p>Effectiveness of risk mitigation Abstinence or strict monogamy Regular use of preservatives Regular use of barrier contraceptives and spermicidal Avoiding contaminated sharp/cutting instruments Counselling effectiveness Counselling provided by FP to reduce high risk sexual behaviour and /or use of injections All high risk sexually active women, including pregnant women High risk males Low risk male and female Low risk pregnant women</p> | <p>A A B A C B I I I</p> |
| UNWANTED PREGNANCY | Counselling | <p>Effectiveness of risk mitigation Regular use of contraceptives or abstinence Counselling effectiveness Counselling provided by the physician to improve efficient use of contraceptives Counselling provided by the physician to promote abstinence among teenagers</p> | <p>A B C</p> |

| | | | |
|---|--|---|---|
| POST –EXPOSURE (CONTACT) FOR CERTAIN INFECTIOUS DISEASES | Immuno- Chemo- Prophylaxis | H. B type influenza - Rifampicin | A |
| | | Hepatitis A - Immunoglobulin | A |
| | | Hepatitis B - Immunoglobulin/ vaccine | A |
| | | N. meningitides - Rifampicin | A |
| | | - Vaccine | A |
| | | - Ceftriaxon | C |
| | | Rabies - Immunoglobulin / post-exposure vaccination | A |
| - Pre-exposure vaccination for high risk persons | A | | |
| Tetanus - Vaccine/ immunoglobulin | A | | |
| MENOPAUSE | Counselling | Routine counselling for women at peri- and post-menopause on benefits and risks of hormonal prophylaxis | B |
| | | Hormonal substitution therapy for women in general | D |
| | | TSH for women with hysterectomies | D |
| IMA-PRIMARY PREVENTION | Primary prevention Chemo- prophylaxis | Routine prophylactic administration of Aspirin for high risk adults (40 years old men and post-menopause women), up to 75 years old | A |

Adapted after Preventive Clinical Service Guidelines, Report Issued by the USA Commission for Preventive Services, 1998

Flipchart/ Handout

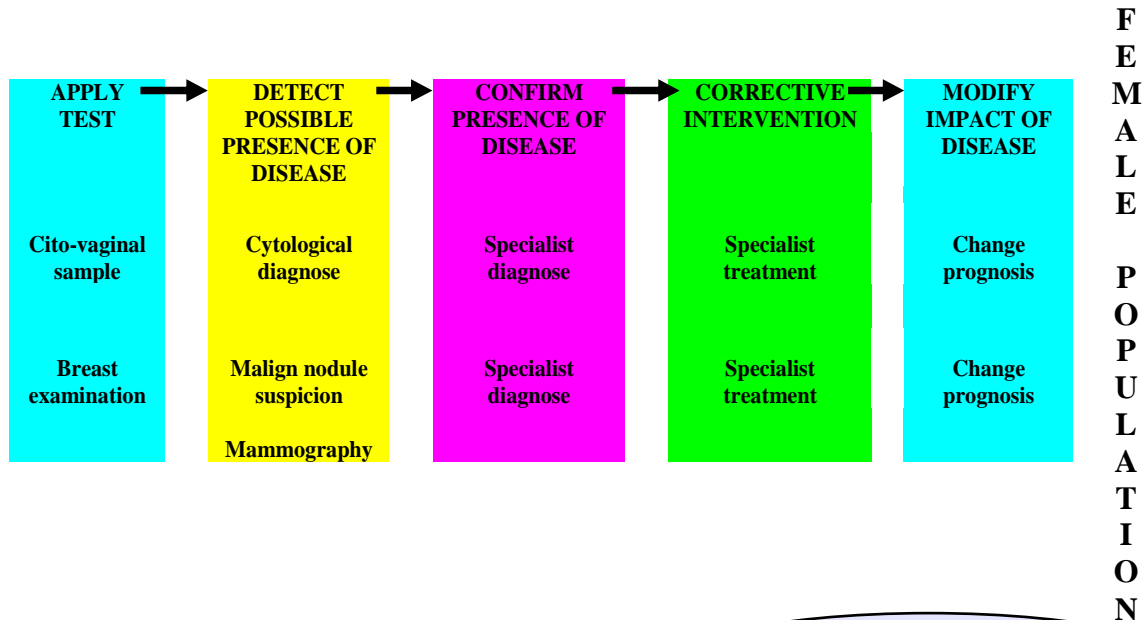
NEW CASES AND DEATHS CAUSED BY CANCER WITH DIFFERENT LOCALISATION, IN WOMEN FROM ROMANIA (2002)



Flipchart/ Handout

EARLY DETECTION OF GENITAL AND BREAST CANCER

Early detection modifies the time and nature of therapy, and its effect changes the impact of disease or risk factors on the health condition.



Decrease likelihood of a woman dying or developing invasive cancer, over an interval of time

**HOW MANY WOMEN?
FOR HOW LONG?**

Trainer's document/ Handout

WHO RECOMMENDATIONS FOR GENITAL AND BREAST CANCER CONTROL PROGRAMMES²

Essential requirements:

- Interventions recommended should rely on scientific evidence
- All interventions should take place within the Cancer Control National Programme
- Screening interventions should be integrated – as far as possible – into reproductive health services provided at the level of primary health care
- To reduce morbidity and mortality, apart from screening, early detection is required as well as a well-established system to follow-up and monitor all patients (with pre-cancer lesions up to invasive cancer)
- It is crucial to ensure necessary resources:
 - Trained staff to collect samples, prepare and interpret tests
 - Equipment and supplies
 - Functional system to refer and communicate between the various layers of the health system
 - Quality control and assurance system

Intervention levels:

- Community
 - Who?*
 - individuals, local organisations
 - community nurses, other community workers
 - What?*
 - House care, palliative care
 - Actions to inform and educate the population
 - Support groups
- Primary health care
 - Who?*
 - Family Doctors, nurses
 - What?*
 - Certain reproductive health services may be available at this level
- Secondary assistance (Policlinic, Municipal/Regional Hospital) – Specialist medical services
 - Patients may be sent here by the Family Doctor
 - Basic tests and investigations (there may also be cytology services, mammography, but this is not the rule)
- Tertiary assistance (District/University Hospital) – Over-specialist services, covering all cases, including complex ones
 - Advanced tests and investigations
 - Complex possibilities for treatment, including difficult surgical interventions, radiotherapy, chemotherapy etc.

² Adapted after *Comprehensive Cervical Cancer Control – A guide to essential practice*, World Health Organization 2006, WHO Library Cataloging-in-Publication Data

Trainer/participants material

BARRIERS TO IMPLEMENTING GENITAL AND BREAST CANCER CONTROL PROGRAMMES³

Political factors

- Sexual and reproductive health is not a priority
- No national policy, protocols and good medical practice guidelines

Economic factors

- Lack of resources
- Incorrect allocation of available resources
- Incorrect management

Technical, organisational factors

- Incorrect organisation of the health system services
- Insufficiently developed infrastructure

Barriers at community and individual level

- Minimising the importance of genito-mammary cancer, not perceiving this disease as a major health issue
- Preconceived ideas and attitudes, prejudices preventing the population from discussing genital diseases

Woman's health is a not a priority

This was underlined starting from 1994, during the International Conference for Population and Development in Cairo. Many participating countries declared their support and will to commit to women health programmes, but everybody's interest was more focused on assistance to birth and family planning.

No national evidence-based medical guidelines

Women cancer control guidelines (cervical and breast) are missing or are not consistent with local epidemiologic data. Guidelines published internationally are often not adapted to meet local needs. Many programmes waste available resources on frequent investigations and sometimes not justified in case of young women asking for FP services and prenatal care, without taking into account the need for screening for older women, for whom the cervical and breast cancer risk occurrence is higher and higher, and addressability is low.

Lack of resources

Cervical and breast cancer prevention and detection programmes are generally outranked by other health issues on the agenda of any government and family medicine unit. Resources, usually limited, should be compared against screening effectiveness and the positive impact on women's lives.

Insufficiently developed health systems

The following aspects are required for cancer control: a well-established service system, state of the art equipment, well trained service providers, patient referral and monitoring systems.

³ Adapted after *Comprehensive Cervical Cancer Control – A guide to essential practice*, World Health Organization 2006, WHO Library Cataloging-in-Publication Data

Only thus may prevention, screening, diagnosis, curative and palliative treatment for population be ensured.

No information provided to the population

In many places, cancer is a problem ignored by both the decision-makers, the providers, and by the population.

The majority of the population does not have any information on cervical and breast cancer forms of manifestation, nor on the importance of periodic controls and tests, required also in case of apparently healthy persons with no risk factors.

Misconceptions, prejudice

There are many misconceptions and prejudices, both among service providers and the general population, which represent barriers to discussions on cervical and breast cancer prevention. Cancer is generally perceived as an incurable disease, leading inevitably to death. Moreover, taboos related to sex and sexuality prevent open discussions on the female genital tract, especially if the service provider is a man or belongs to a different culture.

Changing these mentalities is an important strategy to encourage women to take part in the screening programmes and immediately address the physician when they are faced with reproductive health issues.

SESSION 3: CERVICAL CANCER SUPERVISION AND CONTROL

OBJECTIVES: by the end of this session, the participants shall be able to:

6. Explain the importance of cervical cancer prevention and early detection
7. List risk factors and explain individual cervical cancer risk assessment status
8. Describe the natural history of cervical cancer
9. List the 4 components of a comprehensive cervical cancer supervision and control programme

| Activities | Methods | Duration | Materials |
|---|---|-----------------|--|
| Importance of cervical cancer prevention and early detection | Presentation | 30 min | Flipcharts/ Handouts - Situation of cervical cancer worldwide - Situation of cervical cancer in Romania |
| Risk factors and individual assessment Cervical cancer natural history | Brainstorming Group discussion Presentation | 30 min | Handouts - Cervical cancer risk factors - Relative risk (RR) for individual risk factors - Relation between stage of disease at the time of the intervention and survival rate Flipcharts - Relative risk (RR) for individual risk factors - Cervical cancer natural history |
| Cervical cancer prevention and early detection programmes | Presentation | 30 min | Handouts - Setting up a cervical cancer prevention and early detection programme |
| TOTAL | | 1 h 30' | |

INSTRUCTIONS:**IV. Importance of cervical cancer prevention and early detection (30 min)**

Make a short presentation of worldwide cervical cancer issues, using the material *The Situation of Cervical Cancer at Worldwide Level*.

Underline the following aspects:

- Cervical cancer is a widely spread disease, with the highest mortality in women between 50-60 years old. The highest cervical cancer incidence is in Central and South America, Africa and South-East Asia.
- There are significant differences between developed countries and developing countries – over the past three decades, cervical cancer rates have fallen constantly in

most developed countries (as a result of screening and treatment programmes) while rates in developing countries have remained unchanged, or even risen.

- According to WHO statistics, in 2005
 - 500,000 new cervical cancer case were detected, 90% of which were in developing countries
 - almost 260,000 women died because of cervical cancer, 95% of whom were in developing countries, in absence of these programmes

Next present the cervical cancer situation in Romania. Underline the fact that, unfortunately, Romania ranks first in Europe, with the highest incidence and mortality rate, in the absence of an organised national screening programme.

Highlight the following aspects:

- Between 1982-2003, cervical cancer incidence and mortality had a parallel evolution, rising continuously (the number of new cases diagnosed yearly has risen by 50% and the number of deaths by almost 35%).
- In the period under survey, the risk for a woman in Romania of being diagnosed with cervical cancer in her lifetime increased by 1.7 times (1 of 79 women in 1982, 1 of 65 women in 2000, 1 of 51 women in 2001 and 1 of 46 women in 2003).
- Analysis of incidence per age group highlighted the low number of cancer cases before 20 years old, with the majority of new cases diagnosed in the 45-49 years old age group.
- The most numerous cases diagnosed in 2003 pertained to the 40-54 years old age group, followed by 55-59 and 65-69 years old age groups.

Presently the main reasons for increased incidence and high mortality are:

- Ignoring or minimising the importance of this issue – among general population, but also among decision-makers and professionals in the medical field.
- Absence of screening programmes for early detection of precursor or precancerous lesions (it is common knowledge that, for women who are not regularly screened, cervical cancer is detected in the later stages, when therapeutic interventions are limited)
- Reduced access to medical services
- Absence of a referral system for patients.

Regarding the moment cervical cancer is detected, explain that:

- In developed countries 80% of cervical cancers are cured because of early detection
- In developing countries 80% of cervical cancers are incurable at the moment of detection.

Then explain the relation between the stage of disease at the time of the intervention and the survival rate.

V. Cervical cancer risk factors and natural history (30 min)

Invite participants to list cervical cancer risk factors and write the answers on the flipchart. Make the necessary corrections or additions if applicable.

Expected answers:

- Sexual behaviour

- Early start of sexual life (<17 years old doubles the risk)
- Multiple sexual partners (or partner who has /had multiple partners)
- Sexually transmitted infections
 - HIV infection
 - HPV infection (main initiating agent; risk of cancer 10 times higher in HPV-infected women)
 - Genital herpes (infection with Herpes Virus Simplex type 2 is a cofactor)
- Smoking (double risk of cervical cancer, irrespective of the sexual behaviour)
- Low immunity
- Multiparity
- Low/improper socio-economic environment

Present the material *Relative Risk (RR) for Individual Risk Factors*.

Invite participants to reflect on:

- The frequency with which these risk factors appear among the female population assisted by each of them
- Methods to identify risk factors for each woman
- Strategies to assess individual risk at the level of primary health care.

Facilitate a group discussion on the answers received.

Display on the flipchart/ project the material *Cervical Cancer Natural History* and make a short presentation of the natural evolution of cervical cancer.

VI. Cervical cancer prevention and early detection programmes (30 min)

Present the 4 components of the cervical cancer control natural programme set up by WHO, from the trainer's material *Setting Up a Cervical Cancer Supervision and Control Programme*

- Primary prevention
- Early detection
- Diagnosis and treatment
- Palliative care

Underline that, to ensure success of such a programme, we need to:

- Have a national health policy, based on prevalence and disease incidence in the respective country
- Allocate financial and technical resources in support of this policy
- Conduct public education and advocacy programmes for preventive medicine
- Conduct organised screening (not opportunistic) and results-based patient monitoring
- Ensure quality of service
- Accurately set up target groups (population coverage)
- Implement a referral and cooperation system between various health care levels
- Make use of an information monitoring system.

Mention that primary prevention includes:

- Health promotion

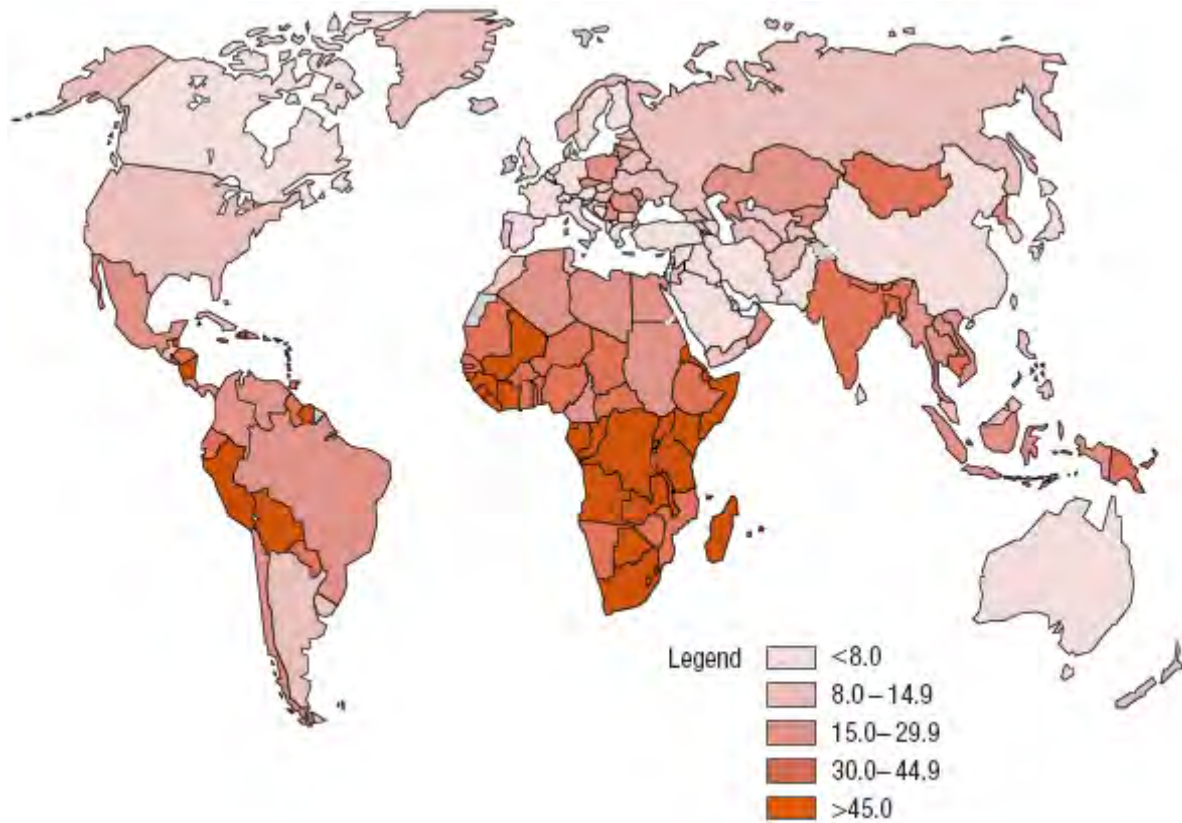
- Use of condoms
- Preventing factors favourable to cervical cancer
- Health education
 - Correctly inform the population about cervical cancer
 - Fighting rumours, myths, correcting wrong information spread in the population
 - Raising awareness of risky behaviours
 - Campaigning to change high risk behaviours
- HPV infection prevention
 - Safe sex
 - Vaccination

Explain that, in this training, special attention shall be paid to early detection of cancer by screening, without excluding discussions on the other components of a complete cervical cancer prevention and early detection programme.

Flipchart / Participants material

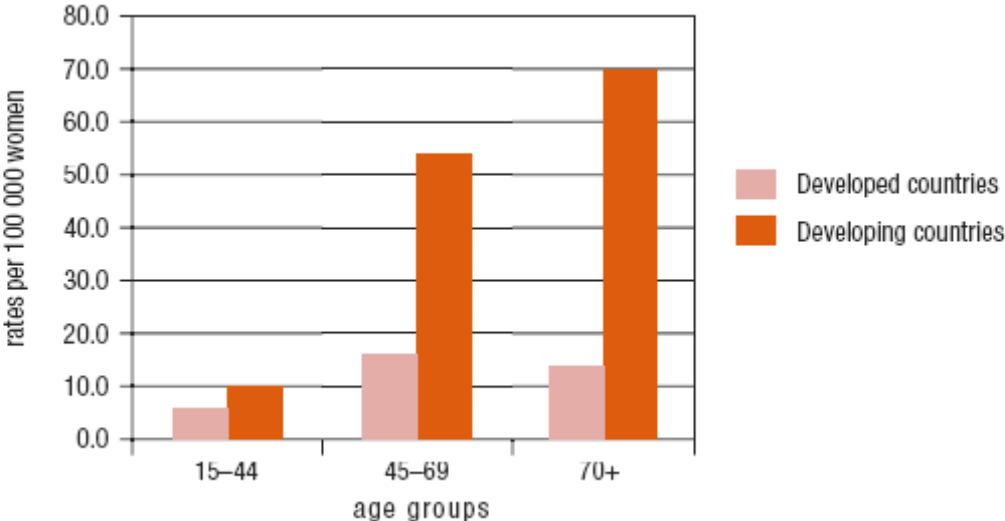
WORLDWIDE CERVICAL CANCER SITUATION⁴

Worldwide incidence rates of cervical cancer per 100,000 females (all ages), age-standardized to the WHO standard population (2005)

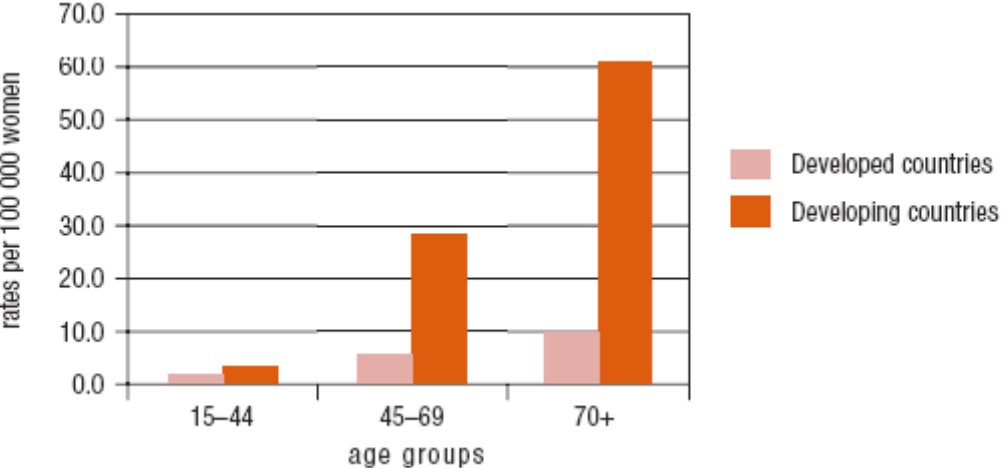


⁴ Source: WHO. Preventing chronic diseases: a vital investment. Geneva, 2005.

Age-standardised incidence rates of cervical cancer in developed and developing countries (2005)



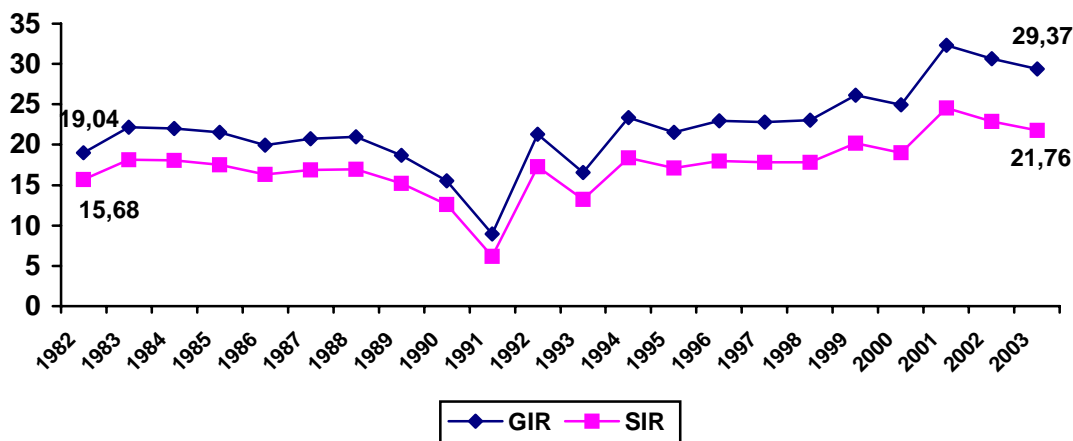
Age-standardised mortality rates of cervical cancer in developed and developing countries (2005)



Flipchart / Participants material

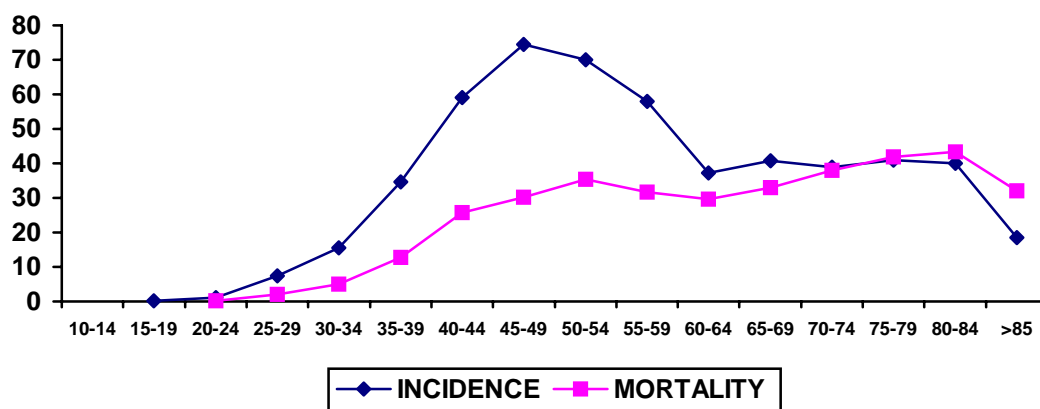
CERVICAL CANCER SITUATION IN ROMANIA⁵

Evolution of cervical cancer incidence 1982 - 2003



GIR: gross incidence rate (cases per 100.000); SIR: age-standardised incidence rate (cases per 100.000 women), compared against Standard World Population.

Age-standardised incidence and mortality rates of cervical cancer (2003)



⁵ Source: National Cancer Registry, Centre for Calculation, Health Statistics and Medical Documentation, M.H. Bucharest.

Trainer's document/ Handout

RELATION BETWEEN THE EVOLUTION STAGE AT THE TIME OF INTERVENTION AND THE SURVIVAL RATE

| Survival rate after 5 years | Stage at the time of intervention |
|------------------------------------|--|
| >90% | 0 |
| 80% | I |
| 60% | IIa |
| 45% | IIb |
| 40% | III |
| <10% | IV |

Trainer's document/ Handout

CERVICAL CANCER RISK FACTORS

- Sexual behaviour
 - Early start of sexual life
 - Multiple sexual partners (or partner who has /had multiple partners)
- Sexually transmitted infections
 - HPV infection (main initiating agent; risk of cancer 10 times higher in HPV-infected women)
 - HIV infection
 - Genital herpes (infection with Herpes Virus Simplex type 2 is a cofactor)
- Smoking (double risk of cervical cancer, irrespective of the sexual behaviour)
- Multiparity
- Socio-economic environment

Flipchart / Handout**RELATIVE RISK (RR) FOR INDIVIDUAL RISK FACTORS**

| | |
|--|---------------------|
| HIV | RR = ↑↑↑ |
| Cytological diagnosis of severe dysplasia in the past 5 years | RR = ↑↑↑ |
| Sexual intercourse < 1 year since menarche | RR = 26 |
| Sexual intercourse < 16 years old | RR = 16 |
| Total absence of screening in personal medical history | RR = 10 |
| HPV (depending on subtype) | RR = 2.5-30 |
| ≥ 6 sexual partners | RR = 5 |
| Low socio-economic status | RR = 5 |
| Smoking | RR = 2 |
| Long use of oral contraceptives | RR = 1.2-1.5 |
| Barrier contraception | RR = 0.6 |

Note:

RR = 1.0 no influence of investigated factor on the prognosis

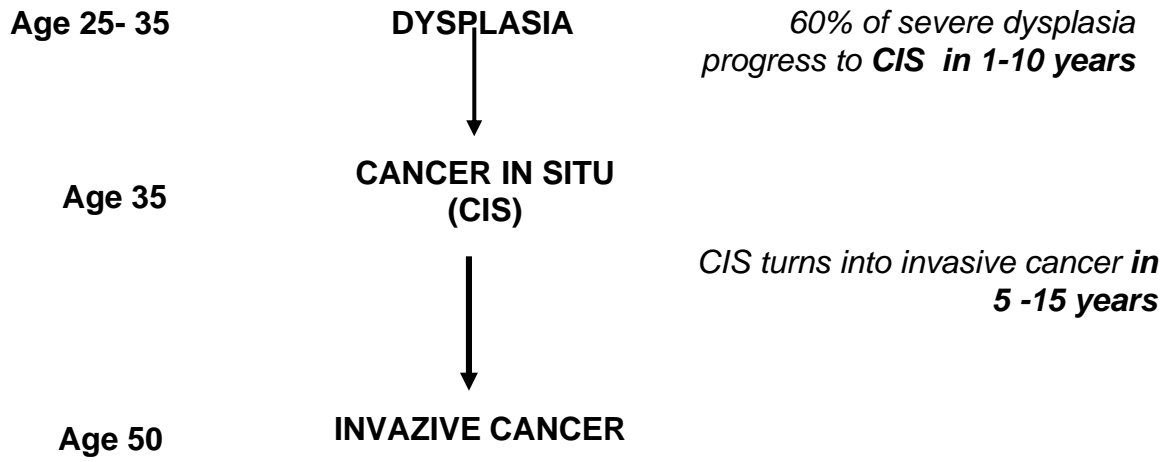
RR < 1.0 probable presence of a protective effect

RR = 10 likelihood to contract the disease is 10 time higher

Source: Mandelblatt, 1999

Trainer's document/ Handout

CERVICAL CANCER NATURAL HISTORY



Rate of lesion regression depends on:

| Dysplasia level | Multiplication of risk of cancer in situ |
|-----------------|--|
| Easy | 1,5 |
| Medium | 20 |
| Severe | 70 |

| age |
|-------------------------|
| • before 35 yrs old 80% |
| • after 35 yrs old 40% |

Trainer's document/ Handout

SETTING UP A CERVICAL CANCER SUPERVISION AND CONTROL PROGRAMME⁶

Any cancer control programme should include the following 4 essential components:

I. Primary prevention – means prevention of HPV infection and cofactors known to increase the risk of cervical cancer. It includes:

- Education and awareness-raising about high-risk sexual behaviour
- Implementation of local strategies to change behaviour
- Introduction of HPV vaccine
- Campaigns to combat smoking, including support actions for people who want to stop smoking

II. Early detection

- Organising screening programmes addressed to most vulnerable age groups
- Setting up effective flows and a referral system between the various health care levels
- Education for population and training for medical staff, stressing the benefits of screening, the vulnerable age groups and the signs and alarm symptoms

III. Diagnosis and treatment

- Follow-up of patients for whom the screening identified modifications, to establish diagnosis and early intervention
- Treatment of pre-cancer, to prevent the development of cancer
- Constant treatment of invasive cancer, including surgery, radiotherapy and chemotherapy.

IV. Palliative care

- Treatment for various symptoms (bleeding, pain) to alleviate patients' suffering, or for side-effects of other drugs
- Psychological support for women in incurable stages
- Involvement of patient's family and community members in caring for patients at home.

To ensure the success of such a programme, we need to:

- Have a national health policy, based on prevalence and disease incidence in the respective country
- Allocate financial and technical resources in support of this policy
- Conduct public education and advocacy programmes for preventive medicine
- Conduct organised screening (not opportunistic) and results-based patient monitoring
- Ensure quality of service
- Include as many women as possible in the target group for screening
- Implement a referral and cooperation system between various health care levels
- Make use of an information monitoring system.

⁶ Adapted after *Comprehensive Cervical Cancer Control – A guide to essential practice*, World Health Organization 2006, WHO Library Cataloging-in-Publication Data

SESSION 4: SETTING UP A CERVICAL CANCER SCREENING PROGRAMME

OBJECTIVE: by the end of this session, the participants will be able to:

1. List features of cervical cancer screening, selection criteria for test types, for age groups
2. Describe Pap test
3. List essential elements to assess individual risk factors

| Activities | Methods | Duration | Materials |
|------------------------------------|----------------------------------|----------------|---|
| Cervical cancer screening | Presentation Group discussion | 30 min | Trainer's documents/ Handouts - Cervical cancer screening - Presentation of the Cluj pilot project |
| PAP test | Presentation | 25 min | Trainer's documents/ Handouts - Pap test (presentation) - Sample collection chart - Correspondence of Bethesda system with other smear interpretation systems |
| Individual risk factors assessment | Group discussion | 20 min | |
| TOTAL | | 1 h 15' | |

INSTRUCTIONS:

I. Cervical Cancer Screening (30 min)

With reference to the previous discussion, ask the participants:

- How would you describe a successful screening programme?

Expected answers are the ones listed under the trainer's material *Cervical Cancer Screening* (section *Features of a Successful Screening Programme*).

- What about an unsuccessful one?

Expected answers are the ones listed under the trainer's material *Cervical Cancer Screening* (section *Features of a Failed Screening Programme*).

Present the objectives on which the performance of a screening programme should be assessed:

- Maximum coverage of population at risk and equal accessibility $\geq 80\%$
- Quality assurance for clinical procedures $\geq 90\%$
- Ensure timely case supervision and finalisation $\geq 80\%$

Ask:

- How can screening be organised?

Expected answers:

- Organised screening
- Opportunistic screening

Using the information in the *Organised screening vs. Opportunistic screening*, explain the two types of screening, underlying the importance of organised screening.

Then highlight the need to weigh the benefits and risks of testing.

Lead a discussion on target population and testing frequency. Present the WHO recommendations.

Mention that in Romania the National Programme of the Ministry of Health ensures testing for women between 25-65 years old, once every 5 years.

This does not exclude testing women outside this age group, if there are resources available and if individual risk factors are identified (for instance, at < 25 years old there is high risk of HPV infection).

Briefly present the different types of tests which may be used in cervical cancer screening programmes.

[Note to the trainer: you may present the results of the Cluj pilot project, from the trainer's material *Presentation of Cluj Pilot Project*. Underline the fact that in this project most cases of diagnosed dysplasia and cervical cancers came from samples collected in the FM units or the mobile unit of the Romanian Cancer Society; the explanation is that women who were screened belonged to high risk groups, and for 91% of them this was their first sample collected.]

II. PAP Smear (25 min)

Using the information in the *Pap Test (presentation)*, give an overview of the test. Underline the importance of respecting the necessary conditions to ensure quality and avoid any errors.

Display on the flipchart/ project the material *Correspondence of Bethesda System with Other Smear Interpretation Systems* and review the content together with the participants.

Mention that the Bethesda system has been used worldwide since 2000, and in recent years it was also introduced in Romania.

[Note to the trainer: the workshop can be organised as part of an extended programme, also including a practical training period; If this is the case, state that during the practical training part of this course, all practical issues related to the Pap test shall be discussed in detail].

III. Individual Risk Assessment (20 min)

Ask participants:

- When is the cervical cancer risk assessment done?

Expected answers:

- Before screening tests
- After getting the result, to establish supervision of future behaviour

- What means can be used for this assessment?

Expected answers:

- Counselling and measures related to health education
- Development of an individual supervision plan, based on the test result

Mention that each client shall be assessed before taking a Pap test.

Ask:

- What elements should this assessment include?

Expected answers:

- Social data
- Anamnesis
- General physical examination
- Gynaecologic examination: examination of external genital warts, cervix visualisation (examination with vaginal speculum)

As well as

- Test information provided to the client, after which her informed consent is obtained.

Based on the data collected during anamnesis, decisions may be made regarding additional tests to be made and the management of each case.

Special attention shall be granted to the following reproductive health issues:

- Sexual anamnesis,
- Previous obstetric and gynaecological history,
- Contraceptive methods,
- STI protection.

Problems, abnormalities and infections identified during anamnesis and physical examination shall be resolved before collecting the cyto-vaginal smear.

To conclude the session, **summarise** the following aspects:

- Cervical cancer screening includes testing for all women at risk, in order to detect precancerous lesions and test them in due time
- Women detected with abnormalities should be followed up, in order to diagnose and treat precancerous lesions or cancer in early stages
- Screening is effective only if it is part of a well organised programme in which
 - There is a high coverage (over 80%) of the target population

- There is a possibility for active monitoring and supervision of patients detected with lesions
- There is a referral system between various layers of the health system
- Sufficient resources are ensured to treat all patients

Trainer's document/ Handout

CERVICAL CANCER SCREENING

Features of a successful screening programme⁷

- Identify and ensure contact with target population (census for female population 25-65 years old; invite/convoke to individual or group counselling)
- Obtain high coverage and participation indicators
- Use explicit protocols (census, programming, invitation, information/counselling, sample collection, sending samples to the laboratory, relation with other specialists, results, results interpretation and communication etc.)
- Adequate facilities for screening on site
- Adequate facilities for diagnose, treatment and supervision
- Fully working, state of the art information system
- Evaluation and monitoring

Features of a failed screening programme

- Incapacity to cover population at risk
- Incapacity to finalise abnormal cases (lack of specialist services; lack of communication between health care levels; lack of cooperation with the patient)
- Too long or too short retest intervals
- Lack of quality control

Performance of the screening programme may be appreciated by following certain objectives:

- Maximum coverage⁸ for population at risk and equal access $\geq 80\%$
- Ensure quality of clinical procedures $\geq 90\%$
- Ensure case supervision and finalisation in due time $\geq 80\%$

Organised screening vs. Opportunistic screening⁹

Organised screening should include as many people as possible from the population at risk of cervical cancer, using available resources. Generally, it is planned nationally or regionally.

An organised screening programme should specify:

- The target population
- The testing interval
- The coverage objective
- The mechanism to inform and notify women to come for testing
- The type of test used
- The results communication strategy
- The mechanism to refer / monitor women for diagnosis and treatment
- The therapeutic recommendations
- The programme monitoring and evaluation indicators

⁷ WHO Collaborating Centre on Human Reproduction, 2000

⁸ „Coverage” represents the proportion of women in target group who are screened at the recommended intervals, in a given period of time. Number of screening tests done is not coverage, since this number may include women outside the target group or women screened more often than recommended.

⁹ In compliance with WHO recommendations, 2006

Opportunistic screening is screening that is done independently of an organised programme, on women who are visiting health services for other reasons.

Screening may be recommended by a provider during a consultation, or requested by the woman herself. Generally opportunistic screening tends to reach younger women, under the age recommended for screening, or women at no risk, who are attending antenatal, child health and family planning services.

It is generally accepted that organized screening is more effective, making better use of available resources and ensuring that a greater number of women will benefit from it. However, both organized and opportunistic screening can fail because of poor quality-control, low coverage of the population at risk, or disregarding women with precancerous lesions.

Benefits and risks of screening

The benefits and possible negative effects of screening should be discussed with women as part of the counselling process and before obtaining informed consent, such as:

- the psychological consequences: anxiety and fear about an undesirable result;
- a mistaken belief that a positive test is a cancer diagnosis;
- false positive test results (which may lead to unnecessary interventions and anxiety);
- false negative test results (which may lead to incorrect monitoring in women with cervix abnormalities);
- identification of other illnesses, for which treatment may not be available.

Counselling and effective communication with women may help to minimize these undesirable outcomes.

Target groups and frequency of screening

Decisions regarding the target age group and frequency of screening are usually made at the national level, on the basis of local prevalence and incidence rates of cervical cancer, and availability of resources and infrastructure.

The WHO makes the following recommendations:

- new screening programmes should be applied first to women over 30 years old, and then later to younger age groups, after having covered the high risk groups; national programmes should avoid including women under 25 years old
- if there are resources available for only one test in a women's lifetime, this should take place between 35-45 years old
- one test every 5 years should be considered for women over 50 years old
- if resources permit, one test every 3 years should be considered for women between 25-49 years old
- annual screening is not recommended, irrespective of age
- screening is no longer required after 65 years old, provided the last two tests were negative

Particular situations

a) *Pregnant women*

Not screening for cervical cancer during pregnancy is sometimes seen as a missed opportunity. However, integrating screening into routine antenatal care should take into account the following aspects:

- Most pregnant women are younger than the target group.
- During pregnancy, interpretation of screening tests, such as cytological tests, is more difficult.

• Regression of CIN during pregnancy is minimal, but there is a significant rate of spontaneous regression postpartum.

- A biopsy for diagnosis should be taken from a pregnant woman only if invasive cancer cannot be ruled out through other methods.
- Treatment of pre-invasive disease is contraindicated during pregnancy.

b) *Family Planning clients*

Opportunistic cervical cancer screening is often integrated into family planning services. Family planning counselling provides a good opportunity to discuss the benefits of preventing genital tract diseases, including sexually transmitted infections. Screening should be performed on all clients of family planning services within the target age group. Contraceptive users do not need to be screened more often than other women, regardless of the method they use.

c) *Women with an STI or other reproductive tract infections*

Presence of an STI is a cervical cancer risk factor. Women who complain about symptoms suggestive of STI, but for whom the clinical and laboratory investigations do not indicate an acute infection, can be examined immediately. If there is evidence of an acute infection, testing shall be done only after treatment.

Health education and counselling shall include information on HPV infection and its relation to cervical cancer. Condoms shall be offered in order to encourage safe sex behaviour. Male partners shall receive the same information when treated.

d) *Other situations / opportunities for screening*

Women at the end of their reproductive years or at menopause are at greatest risk of cervical cancer. At the same time, there is a tendency to stop using reproductive health services. This is why all opportunities should be used to encourage them to come for screening (when they ask for other medical services, or accompany younger persons in their family etc.)

Choice of screening test(s) to be used

The choice of screening test or tests to be used is made at the national or regional level based on the following aspects:

- the organization of the health system
- the funds available
- the number and type of health workers
- the availability of laboratory services and transport

Qualities of a test considered suitable for screening:

- accuracy
- easy to reproduce
- low cost
- easy to apply and interpret
- acceptable (from client's point of view)
- no side effects

These criteria are met by:

- the cytological examination
 - conventional (Pap smear)
 - cytoscreen

Other diagnostic tests can be done in addition to these, contributing to early cervical cancer detection

- ADN test for HPV
- Visual inspection: with Lugol solution or acetic acid

The most extensive experience in cervical cancer screening is with cytology. Cytology-based cervical screening and lesion treatment have reduced cancer incidence and mortality by as much as 80% in Canada, the USA, and by 50–60% in Western European countries.

Alternative methods, such as visual inspection, can be used in countries where the cytological examination cannot be applied because of costs and lack of laboratory equipment or trained staff. Currently no multi-centre studies examining the impact of screening on cervical cancer incidence and mortality are available.

HPV-based tests are now also commercially available in many countries, but the high cost and the need for sophisticated laboratory facilities represent significant obstacles to their utilisation.¹⁰

RECOMMENDATIONS FOR SCREENING FOR CERVICAL CANCER

- Screening for cervical cancer is recommended for all sexually active women without hysterectomies (for Romania, after 25 years old) **(A)**
- Routine screening for cervical cancer is not recommended for women over 65 years old, if they were recently treated, received normal results for an adequate smear test, and are not at high risk of cervical cancer **(D)**
- There is insufficient proof for or against use of new technologies for cervical screening. **(I)**
- There is insufficient proof for or against routine testing for human papilloma virus (HPV) as a method of primary screening for cervical cancer. **(I)**

¹⁰ After *Comprehensive Cervical Cancer Control – A guide to essential practice*, World Health Organization 2006, WHO Library Cataloging-in-Publication Data

Trainer's document

PRESENTATION OF THE CLUJ PILOT PROJECT

A pilot project has been carried out in Cluj from 2000 onwards, setting up working principles for a cervical cancer screening programme with the direct involvement of the family practitioner.

The proposed model was based on the national cervical cancer screening program (where every woman aged between 25 and 65 has the right to a free Babeş-Papanicolau, once every 5 years) and also on European quality standards (including registering cancer and dysplasia, diagnostic and treatment centers, information systems, quality control, principles of treatment and monitoring). The aim of the project was to produce a system of organized screening with population coverage, in addition to the existing opportunistic screening.

The pilot was based on existing resources: The Cluj-Napoca Oncology Institute (IOCN), the Romanian Cancer Society (SRC), experts in the field of cancer, family doctors, gynaecologists and oncologists. Scientific and methodological coordination, as well as test interpretation and database maintenance was ensured by the Cluj-Napoca Oncology Institute. The Romanian Cancer Society provided crucial support for the project by providing the necessary equipment for sample collection, and ensuring the presence of a specialist physician when required, through a mobile unit (van) travelling to remote areas. Another important component of the project was the partnerships created with the Institute for Public Health and various learning institutes, NGOs and professional organisations, which contributed to the success of the program.

At the beginning of the project, a conference was held with all relevant actors, during which European Protocols for diagnosis and gynecological-oncological treatment of cervical lesions were analyzed and accepted, a system of registration of dysplasia was established in three diagnostic and treatment centers and a system of information sharing was established within the program.

Regarding training components, initially the needs of the family doctors were identified in order to establish the eligible categories of the female population on their lists, to inform these populations about genital and breast cancer, to establish sample collection methods in their medical cabinets, to ensure transport of tests and results, to monitor and follow-up on test results, in confirmation with the established protocols. Medical instructors from the Health Services Centre in Cluj created a series of materials that were used during the course and conducted both theoretical and practical training with family doctors. Follow-up meetings were held after the initial courses in order to discuss the initial results and experiences to-date.

A presentation was made of the pilot-project at a dissemination conference, during which the results, difficulties and possibilities of improving the model created were elaborated. It is hoped that the success of the Cluj pilot project will encourage a replication of the model in the rest of the country.

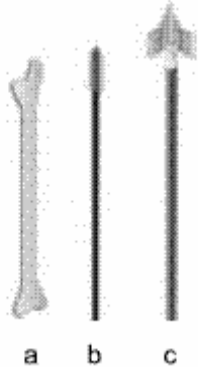
Trainer's document/ Handout

PAP TEST

Presentation

Pap smear (or Babeş-Papanicolaou) involves the collection of cells at the level of cervix, in the squamo-epithelial zone (the transformation zone) and their examination with a view to identifying abnormalities.

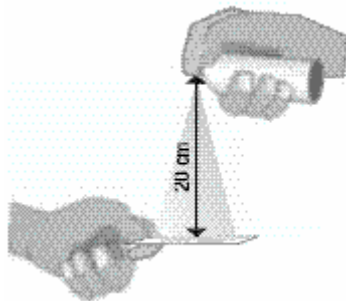
Cells are collected with various devices:



a – wooden spatula
b – endocervical brush
c – plastic brush

Cotton swabs are no longer used to collect samples.

The sample collected is then put on a glass slide and immediately fixed with a special solution.



The slide with the sample collected is then sent to a cytological laboratory, where it is coloured, and the examined under a microscope and classified according to the Bethesda system.

Real performance of the Pap smear

- sensitivity – 0.80
(95% confidence level; 0.51-0.95)
PAP smear has higher accuracy when a higher cytological threshold is selected - HSIL, with a view to detecting high-grade dysplasia lesions.
- specificity - 0.98
(95% confidence level; 0.97-0.99)

Necessary equipment for the sample collection:

- gynaecologic table
- lighting source
- vaginal speculum (or vaginal valves)
- cotton swab clip
- glass slides or Cytoscreen recipient
- slide stand
- fixing spray
- steriliser
- record charts

Necessary conditions to ensure cervical cytology quality

- Correct sample collection
- Correct fixing and colouring
- Careful and correct smear examination
- Laboratory quality control

Error sources

- Sample collection errors – no cells specific to a smear lesion
- Fixing and colouring errors
- Interpretation errors
 - False positive – abnormalities thought to be present do not exist
 - False negative – an abnormality which is present is not detected

Conditions for coming for a PAP sample collection

- Come for examination between days 12-16 of the menstrual cycle
- Avoid sexual contact 24 hours before examination
- Avoid intravaginal washing, 48 hours before examination
- No sample collection for women with hysterectomies for benign diseases

Factors determining sample collection accuracy

- Devices and materials used for sample collection
 - Choosing the sample collection device and slide
 - Using the fixing agent
- Logistical support to record and transport smears

Sampling collection techniques:

I. With spatulas (swabs)

- Prepare glass slide (slides), write identification number on (corresponding to patient's chart).

- Obtain visual of the cervix through use of vaginal speculum (or vaginal valves).
- Remove excessive secretions at the level of the vagina with a cotton swab clip.
- Use 2 spatulas: one to collect samples at the level of the exocervix, through a rotary movement, and the other to collect samples at the level of the endocervix.
- After collection, place sample on a slide: either on the same slide, in different zones, or on 2 different slides one for exocervical cells and the other for endocervical cells.
- Fix sample with a spray, by spraying from a distance of 30 cm. If the jet is too powerful (distance < 30 cm) cells may be washed out from the slide; if the jet is weak (distance > 30 cm) fixing may not be strong enough.
- Put it in the slide stand.
- Fill in data in the collection chart (see appendix), up to the chapter “Laboratory Result”.

II. Cytoscreen

- Notify recipient using the number corresponding to the patient’s chart.
- Obtain visual of the cervix.
- Exocervical and endocervical cells may be collected at the same time with a plastic brush.
- After collection, plunge brush into the recipient filled with liquid.

Flipchart/ Handout

CORRESPONDENCE BETWEEN BETHESDA SYSTEM AND OTHER SMEAR INTERPRETATION SYSTEMS

| Cytologic classification (screening) | | Hystologic classification (anatomo-pathologic diagnose) | |
|---|------------------|---|------------------|
| Bethesda | Papanicolaou | WHO descriptive classification | CIN |
| Normal limits | I | Normal | - |
| Infection (body specific) | II | Inflammatory atypia | - |
| Reactive and reparative changes - squamous ASCUS - glandular AGUS | | Squamous cell abnormalities Glandular cell abnormalities | - |
| LSIL | III | HPV atypia (Coilocytosis) Mild dysplasia | CIN1 |
| HSIL | | IV | Medium dysplasia |
| | Severe dysplasia | | |
| | CIS | | CIN3 |
| Invasive squamous cell carcinoma | V | Invasive squamous cell carcinoma | |

SESSION 5: CASE MANAGEMENT OF THE CERVICAL LESIONS

OBJECTIVE: by the end of this session, the participants shall be able to:

10. Describe the algorithm to detect and diagnose cervical cancer
11. Describe behaviour of the family practitioner in various cases of cervical lesions
12. Develop individual intervention plans, depending on the condition of each client

| Activities | Methods | Duration | Materials |
|--|----------------------------------|----------------|--|
| Describe cervical cancer detection and diagnosis algorithm | Presentation | 15 min | Flipcharts/ Handouts - Cervical cancer detection and diagnosis algorithm - Course of action based on the test result |
| Monitor clients with cervical lesions | Presentation Brainstorming | 15 min | Flipcharts/ Handouts - Inflammation algorithm - ASCUS algorithm - AGUS algorithm - LSIL algorithm - HSIL algorithm |
| Develop individual intervention plans | Small group work Case studies | 60 min | Flipchart/ Handout - Information system Trainer's document - Case studies |
| Patient supervision system | | 15 min | |
| TOTAL | | 1 h 45' | |

INSTRUCTIONS:

VII. Cervical Cancer Detection and Diagnosis Algorithm (15 min)

In the opening to the session, explain to the participants that there shall be an overview of different types of cervical lesions, focusing especially on the diagnosis algorithm and appropriate action of the family practitioner for each type of lesion.

Using training materials, give a presentation on cervical cancer detection, the diagnosis algorithm and recommended course of action after obtaining the Pap test result.

VIII. Monitoring Clients with Cervical Lesions (15 min)

Present each type of lesion described by the Bethesda system in turn and mention the recommended course of action in each case:

- Non-specific inflammation
- Identification of atypical squamous cells of undetermined significance (ASCUS)
- Identification of atypical glandular cells of undetermined significance (AGUS)
- Identification of a low-grade squamous intraepithelial lesion (LSIL)
- Identification of a high-grade squamous intraepithelial lesion (HSIL)

IX. Development of Individual Intervention Plans (1 hour)

Invite the group to take part in a series of practical exercises, which will help them apply the information received.

Split the large group into several small groups (maximum 4 people). Distribute a case to each group and invite the participants to develop together the intervention plan for the given case.

Assign 15 minutes for them to finish the exercise.

Ask each group to assign a representative to present the case study and the intervention plan developed by the group.

After each presentation conduct a short discussion, in order to verify the extent to which the participants correctly applied the notions learnt.

Mention that in the following exercises, participants shall also have the opportunity to practice the counselling skills necessary to correctly monitor women with cervical lesions.

X. Patient Supervision System (15 min)

Display on the flipchart /projector the material *Information System* and explain the importance of:

- Communicating with the patient and ensuring access to the health system
- Sample flow between the various layers in the system
- The existence of a client referral system between the various layers in the system
- Data collection systems.

Invite the participants to name possible errors in implementing the information system. Note on the flipchart all answers received and then analyse them together with the participants and group them as follows:

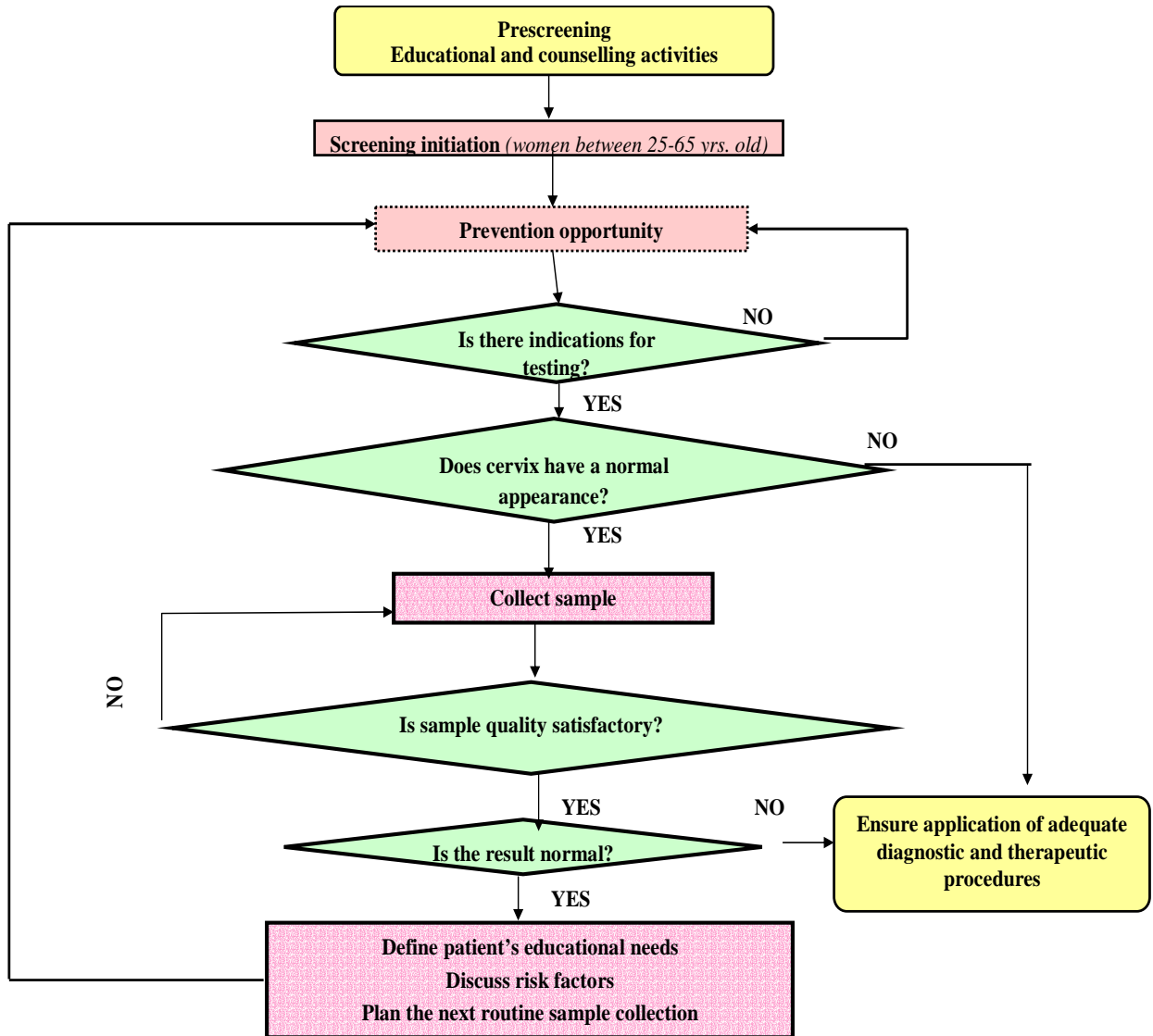
- Errors in recording the data in the form
- Errors in the patients' record keeping system
- Deficiencies in the system of communication
 - with the patient
 - with the specialist
 - with the laboratory

To conclude, underline the need for an effective information system, including:

- The existence of an evaluation and monitoring system from the beginning
- Choosing realistic and measurable indicators
- Setting up an adequate information system
- Rapid action in the evaluation process.

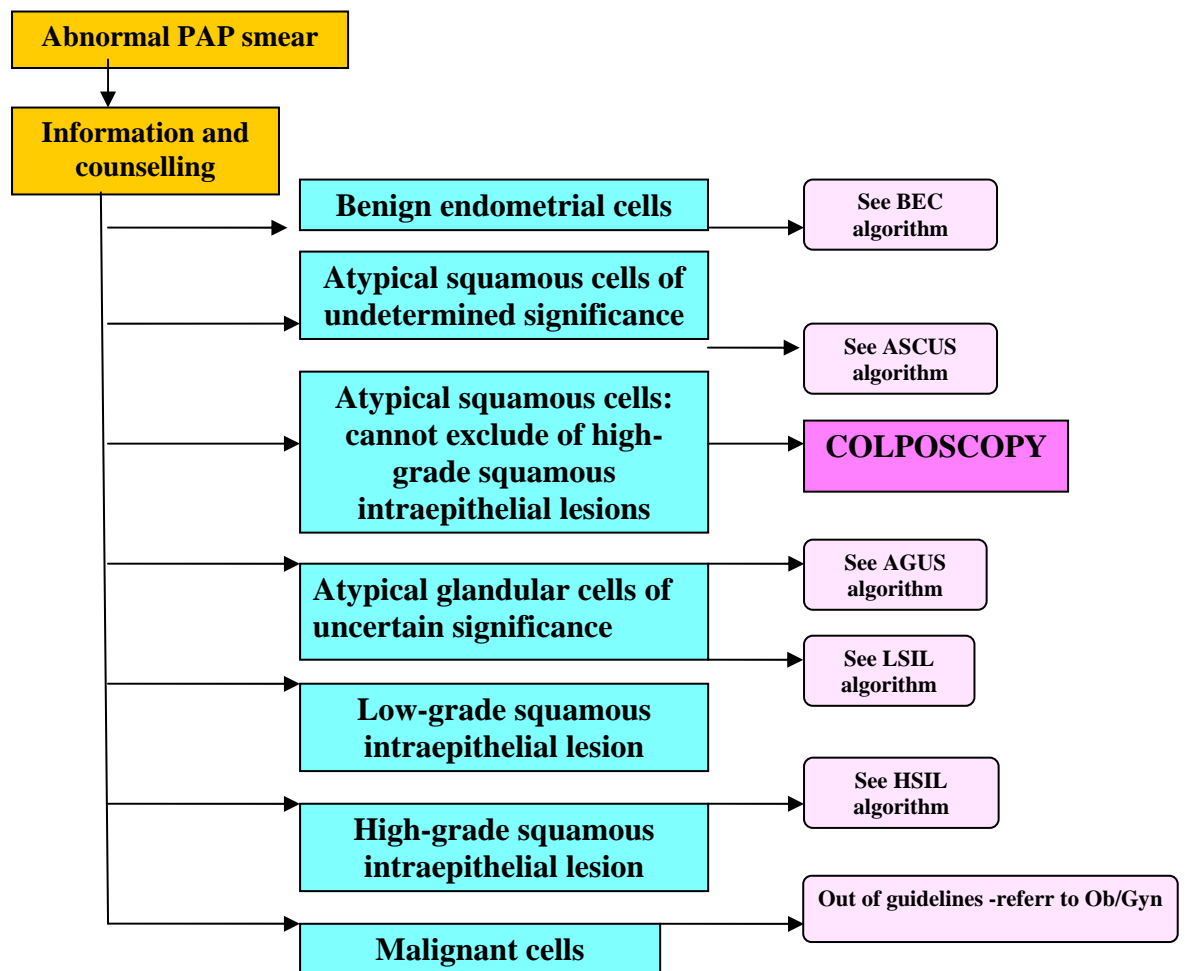
Flipchart/ Handout

CERVICAL CANCER DETECTION AND DIAGNOSIS ALGORITHM



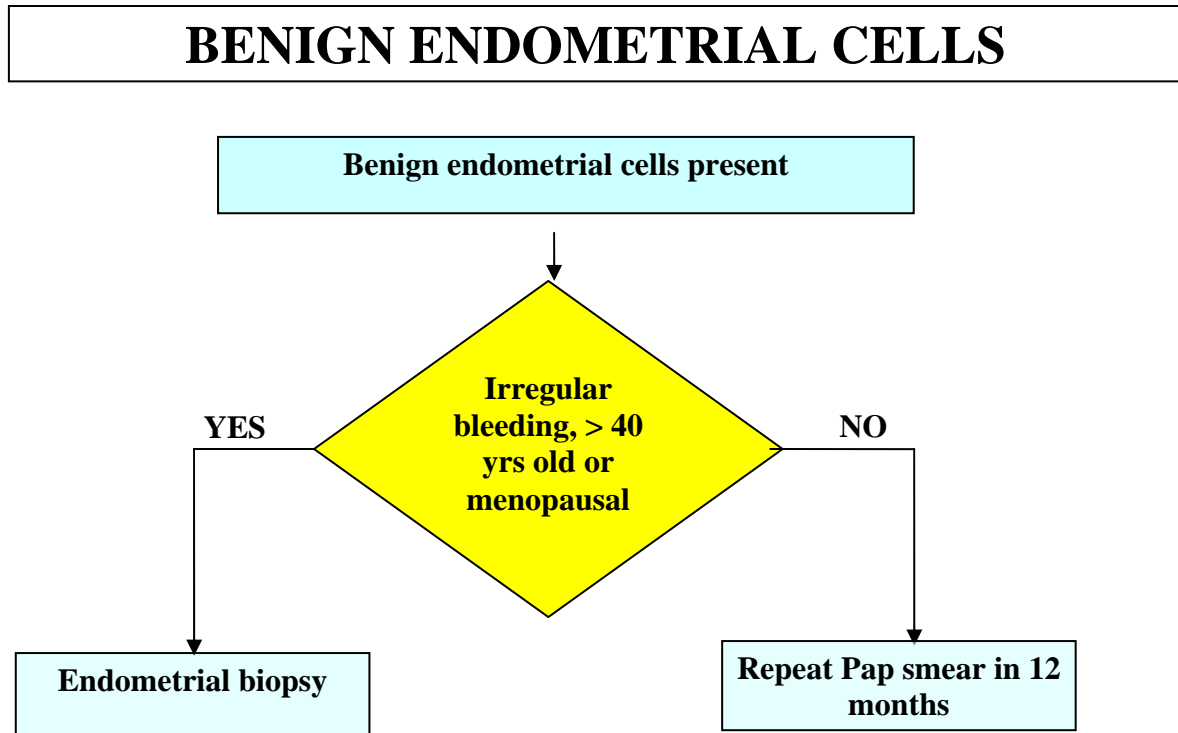
Flipchart/ Handout

COURSE OF ACTION ALGORITHMS BASED ON THE RESULTS OF THE CYTOVAGINAL TEST IN BETHESDA SYSTEM¹¹



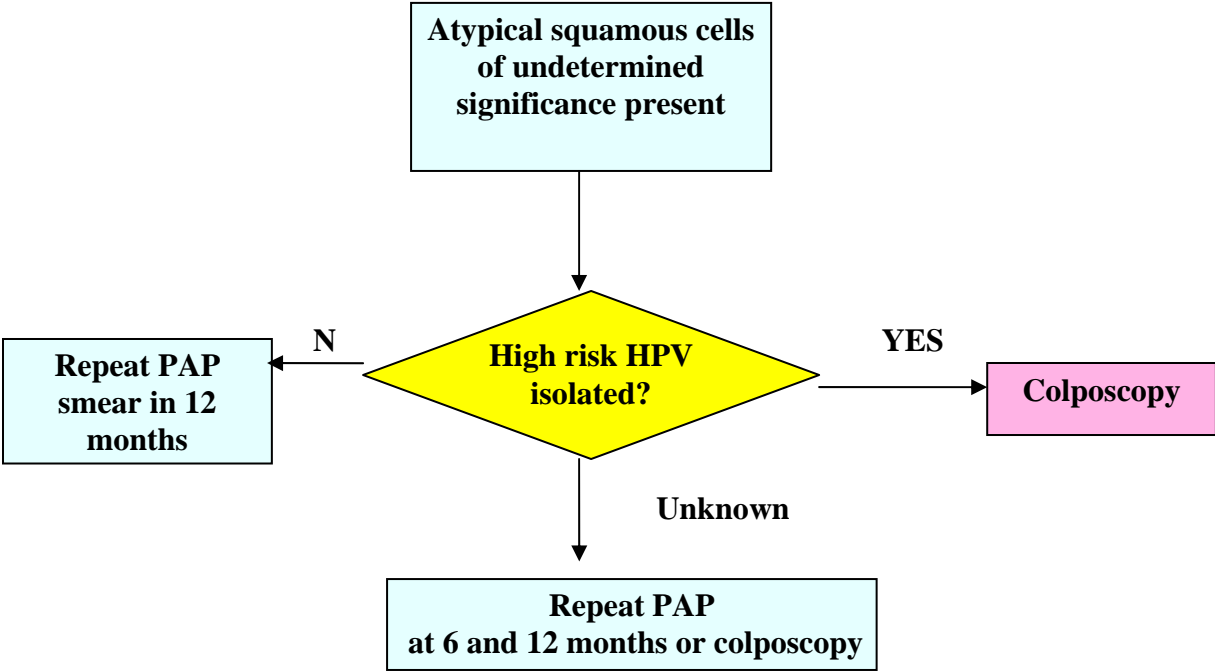
¹¹ Adapted after: „Health Care Guideline: Management of Initial Abnormal Pap Smear” - *Institute for Clinical Systems Improvement, U.S.A, 2005*

Flipchart/ Handout



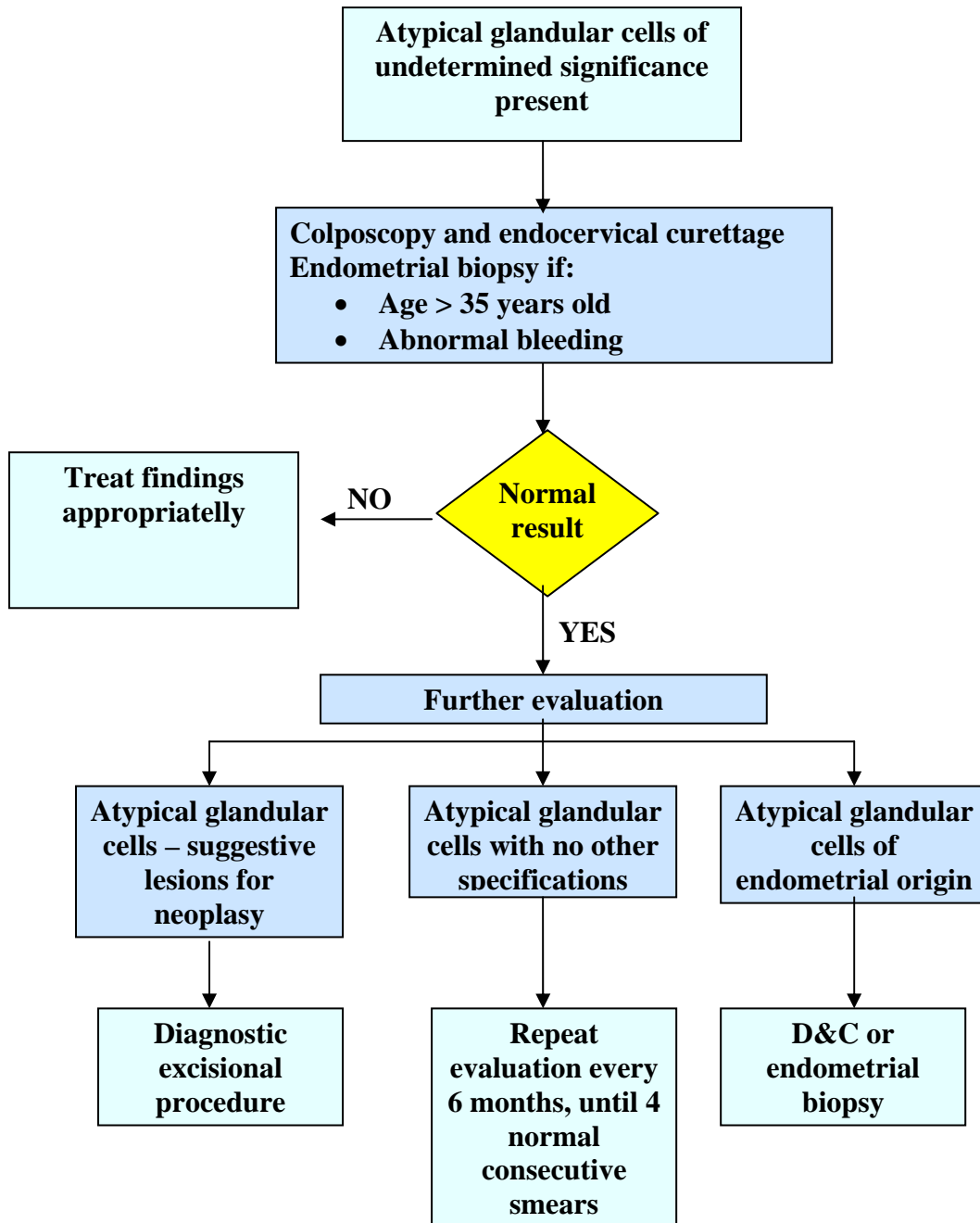
Flipchart/ Handout

ASCUS (Atypical Squamous Cells of Undetermined Significance)

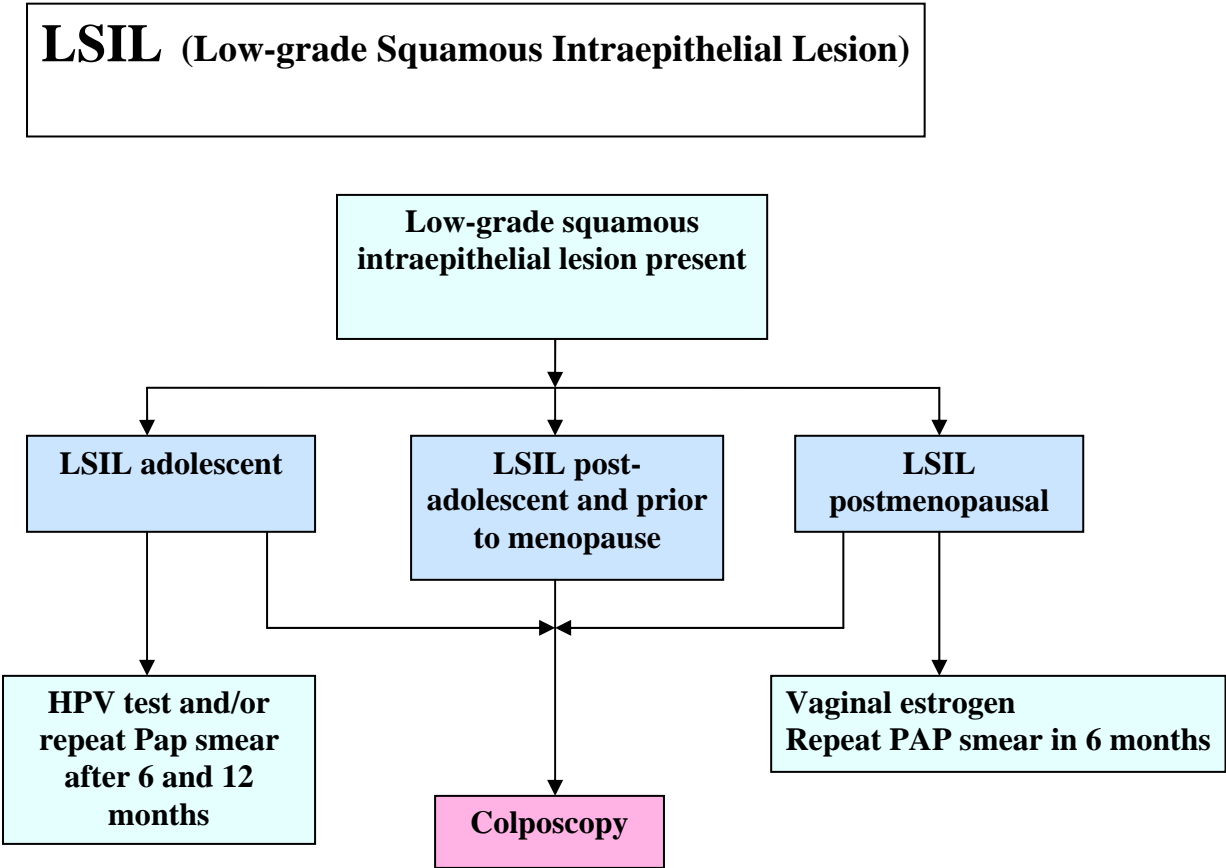


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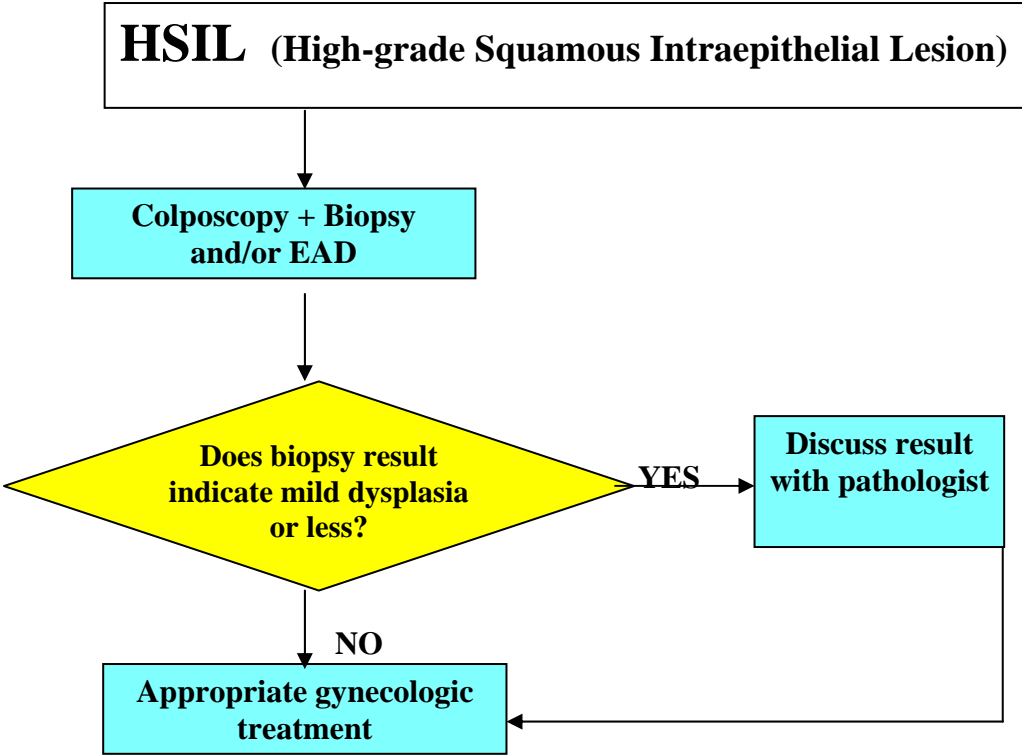
AGUS (Atypical Glandular Cells of Undetermined Significance)



Flipchart/ Handout



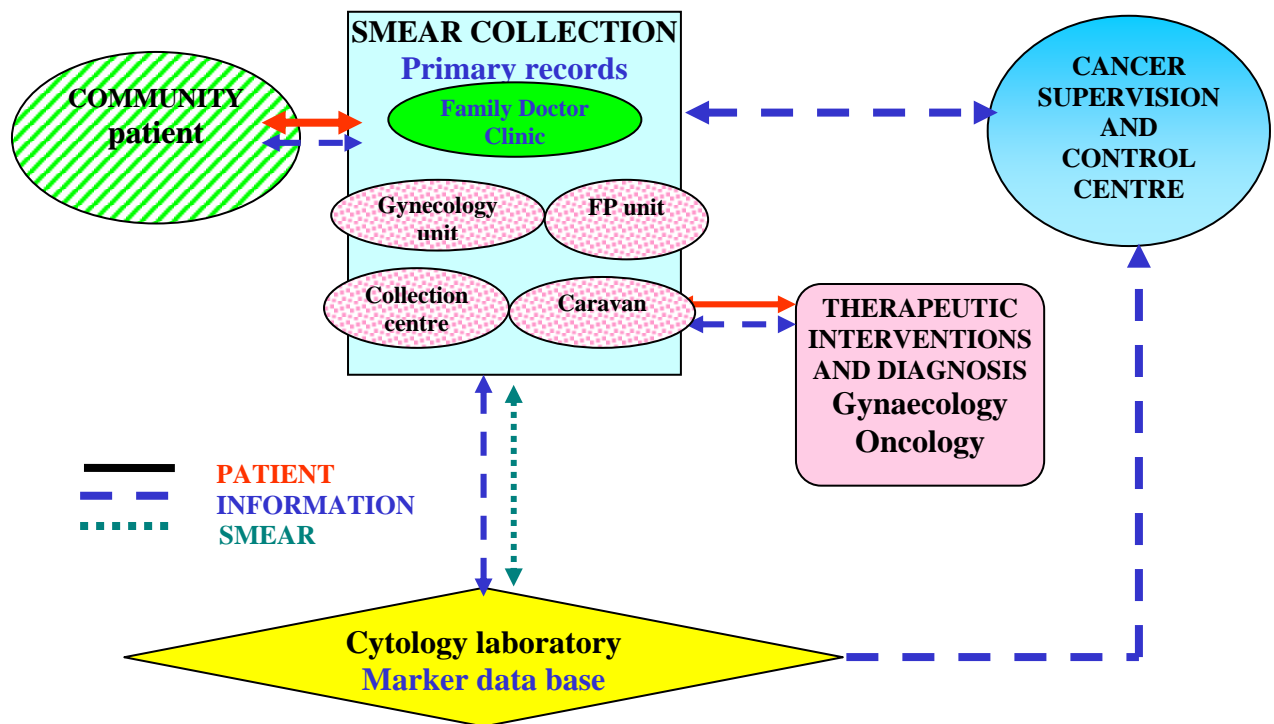
Flipchart/ Handout



Flipchart/ Handout

INFORMATION SYSTEM

**An integrated programme should ensure optimal flow for:
patient, information, smear**



Trainer's document

CASE STUDIES

Case 1.

A 17 year old woman asks for a Pap examination (the first in her life). She has had two sexual partners so far, she has been smoking approximately 10 cigarettes a day for about one year, and occasionally smokes marijuana.

The result indicates a **LGSIL (low-grade intraepithelial lesion)**.

Further colposcopy detects low-grade modifications.

Questions:

- What are the risk factors identified?
- What does the result mean?
- What is the behaviour to use in this case?
- What record keeping system do you have to corroborate the patient's results?
 - The patient has been to the specialist physician. How will you learn the result?
 - How will you contact her?

Case 2.

A 32 year old woman, recently divorced, states that she has had 3 sexual partners, is a non-smoker and is very concerned about sexually-transmitted infections.

Test result indicates **ASCUS**.

Further colposcopy detects low-grade modifications.

Hystopathologic bulletin: CIN 1

HPV type: high risk HPV strain

Questions:

- What are the risk factors identified?
- What does the result mean?
- How do you explain the difference in results?
- What is the relation between HPV and cervical cancer?
- What is the best course of action in this case?

Case 3.

A 21 year old women who is 12 weeks pregnant goes for her first prenatal examination. She has had 4 sexual partners and has been smoking about 20 cigarettes a day for 6 years.

The test result indicates **HGSIL (high-grade intraepithelial lesion)**.

Further colposcopy detects high-grade modifications.

Hystopathologic bulletin: CIN 2-3

HPV type: high risk HPV strain

Questions:

- What are the risk factors identified?
- What does the result mean?
- What elements may interfere with the Pap test result?
- What is the best course of action in this case?
- How does the referral to other service work?

Note to the trainer: other case studies may be added, from the trainers' practical experience, or by the participants.

SESSION 6: CLIENT-PROVIDER INTERACTION (IMPROVING COMMUNICATION SKILLS)

OBJECTIVES: by the end of this session, the participants will be able to:

- 1.
2. Name service quality indicators from the client's perspective
3. Explain advantages of client-centred services
4. Describe the process and elements of communication
5. List conditions that facilitate communication
6. Identify barriers to communication
7. Demonstrate effective communication skills

| Activities | Methods | Duration | Materials |
|--|---|----------------|---|
| Introduction | Presentation | 5 min | |
| Quality of health services | Group discussion | 15 min | Flipchart - Quality service (no title) Handout - Indicators of Quality of Service (as perceived by clients) |
| Client centred approach | Group discussion | 15 min | Flipchart - Maslow pyramid Handouts - Maslow pyramid - Patients' needs |
| Process and elements of communication | Group discussion Presentation | 20 min | Flipchart - Communication process - Living and Learning: People learn what they live Trainer's document - The influence of each component on the effectiveness of the communication process Handout - Communication - Feedback - People learn what they live - Active listening |
| Conditions that facilitate communication | Group discussion | 15 min | Handout - Principles to improve communication |
| Barriers to communication | Individual work Discussions | 30 min | Handout - Obstacles in communication |
| Practice communication skills | Demonstration Role play Discussions | 1 h 20 min | Handout - Principles of using clarifying questions |
| TOTAL | | 3 hours | |

INSTRUCTIONS:

Introduction (5 minutes)

In the introduction, state that the purpose of the current project is to increase patients' access to quality services.

The concept of improving access to quality services mostly refers to preventive medicine services and has the following features:

- Approaches practical, realistic aspects
- Client-centred
- Evidence-based
- Priority focused
- Encourages cooperation

State that this process refers to:

- Technical guidance /standards and protocols
- Client-provider interaction
- IEC
- Management and supervision
- Monitoring and evaluation

Suggest that this session shall underline the importance of interpersonal factors, advising patients and effective communication skills, which may contribute to acceptance and use of preventive services.

State that patients shall be regarded from as "clients" or users of medical services, to underline the provider's need to adapt to the individual characteristics of each person they provide a certain medical service to.

I. Quality of Services (15 minutes)

On the flipchart, display a sheet with the following words (randomly) written on it: organised, professional, warm, clean, flexible, supportive, polite, efficient, understanding, educational, discreet, accessible, competent, achievable, comfortable, productive, neat, friendly, intimacy, confidentiality, empathy, warm welcome, patience.

Ask the group:

- Which of the words listed describe a clinic where you would like to receive medical services, especially preventive ones?
- Which of the words represent behaviours and features indicating good quality service?

While participants indicate a word, underline it on the flipchart. (at the end, probably all words will be underlined)

Ask whether there are other words or features which participants would like to add, then list them on the flipchart.

Invite the group to carefully analyse the quality of their own service. Ask the participants the following questions, in order to help them think about the way they provide the service themselves in their own units:

- What words would you use to describe the services provided in your own units?

Note the answers on the flipchart.

- Are there differences between the features listed for a unit where you would like to receive services and your own unit?
- What are the consequences of providing services which patients do not consider adequate?

- Reduced use of services
- High rate of diseases detected in advanced staged
- Failure of health education programmes and of screening programmes
- Unnecessary follow-up visits (due to poor technique and/or inadequate or incorrect information)

- How can we group factors influencing the quality of medical services?

- Interpersonal relations between medical staff and patients
- General clinic atmosphere
- Technical knowledge and skills of the provider
- Availability of resources

Explain to the group that a sample of reproductive health service beneficiaries, that were part of an international study, defined the term “quality” of service as the way a person is received and treated.

Review together with the participants the material entitled *Indicators of Quality of Service (as perceived by clients)*.

Underline that:

- Generally service providers refer to the technical aspects when they describe the quality of medical services
- Clients refer to the interpersonal aspects (the way they are treated, relation with the staff) when they analyse whether service provision is adequate.

II. Client Centred Services (15 minutes)

State that this opinion of the clients can be explained by the high position which the need for respect occupies in the ranking of fundamental human needs.

Display/project the material entitled *Maslow's Pyramid* and briefly explain its elements.

Ask:

- Taking into account these fundamental needs, what can you do to meet the needs of your patients?

Listen to participants' answers, then review the material entitled *Patients' Needs*, underlying the behaviours of the patients which express a specific need and the way we can answer the need expressed.

Explain that another important element in defining quality of service in the environment is the unit.

Ask participants:

- What is the environment?

Feelings and attitudes present in the place where information, education and advice activities on various medical topics are carried out

- How is it created?

The major role in developing the environment belongs to the staff (medical, para-medical, non-medical), who set the standards, through their:

- Communication style, communication skills
- Interpersonal skills
- Interaction style
- Methods used

Explain the advantages of client-centred services and underline the following:

- A friendly environment set up by the provider demonstrates respect and receptiveness to clients' needs and helps them to openly discuss their problems
- An open discussion, with no barriers (such as use of medical jargon) wins the client's confidence
- An open attitude, without prejudice, proves to the client that they are accepted and not judged
- A client-centred approach increases the probability of satisfying their needs and gives better results, without necessarily involving major changes in the service structure

State that we shall further discuss ways of improving interaction with patients, by using effective communication styles.

III. Communication Process (20 minutes)

Give a short presentation on communication, using the flipchart *Communication Process*.

Explain the influence which each of these elements may have on communication, using the reference material entitled *The influence of each component on the effectiveness of the communication process*.

Ask:

- Why is it important for a service provider to understand these elements of communication? How can I help him/her?

- Any of these elements may positively or negatively influence communication between two people.
- Knowing them allows the provider to positively influence communication with patients, to make it as effective as possible.

Ask:

- How can we know how effective our communication with other people is?

- Through results achieved
- Through the answer received (feedback)

Present the material entitled *Feedback*. Ask for volunteers to read each statement and comment on its meaning and applicability to the workshop, to professional activity, and also in everyday life.

Invite the participants to respect these rules as they provide feedback to their colleagues, in the exercises to follow.

Display the flipchart *Living and Learning: People learn what they live*. Ask the group to read and discuss how to apply this in service provision.

Underline that the way we behave towards people determines:

- The way they feel, in interacting with us
- The way they will react towards others

IV. Conditions Facilitating Communication (15 minutes)

Ask participants:

- When you discuss a personal problem with someone, what do you expect from that person?

To listen to me carefully, not to be distracted by other things.
Not to try to change the subject.
To show interest in the problem I present and help me find a solution for it.

- How do you know whether they are listening carefully?

- Maintains visual contact, leans towards me, nods.
- Provides short replies (aha, yes, I understand etc.) which prove they are interested and encourages me to keep talking, without interrupting me
- Rephrases what I have said with their own words. Thus:
 - They check whether they have understood correctly what I wanted to say
 - They give me the opportunity to reflect on what I have said (hearing the situation as it has been understood by the listener)
- Asks clarifying questions
 - Indicates that they are listening to me and want to help me.

Explain that this way of listening is called active listening, and mention what its elements are:

- **Participative listening: non-verbal communication** through which we demonstrate an interest to what the speaker has said (visual contact, position slightly leaning toward the speaker, nodding), **short replies** through which we encourage them to continue
- **Paraphrasing** – we rephrase what we have heard in our own words
- We ask **open questions** through which we ask for clarifications

Mention that when we talk to a patient, active listening is useful to:

- Unveil questions not asked and address their fears
- Transmit that we are paying attention to them and encourage them
- Help them understand their reactions, attitudes and help them verbalise them, say what bothers them and identify their problems (by focusing on the speaker's feelings)
- Help them develop / strengthen their self-confidence
- Set up an atmosphere of mutual trust in a safe and comfortable environment

In order to achieve this, the physician/listener:

- Shall not judge (nobody and nothing gives them this right)
- Shall not criticise (because they may trigger defensive reactions, generate justifications, block the communication)
- Shall not ask WHY (each person has their own reasons for reacting in one way or another)
- Shall not comment
- Shall try to help the patient /speaker clarify their own feelings

Ask the group:

- How can we help a woman to speak freely about some of her problems, concerns, feelings?

We need to build a relation based on trust and mutual respect:

- Build a positive and constructive relationship with the woman
- Try to understand the woman's condition, feelings and problems she might have when she speaks about her condition
- Be patient and tolerant, ready to accept and respect the woman without judging her
- Be prepared to help her
- Be objective
- Pay attention to non-verbal communication (perception of non-verbal messages is often more important than what is communicated verbally)
- If you are not sure that the information you transmit is useful, ask the woman for feedback; consider the feedback and try to reply constructively.
- Use plain language (plain words, phrases)

V. Obstacles to Communication (30 minutes)

Invite the group to take part in an exercise that will help us to see to what extent our own values influence our communication.

Present in turns some difficult situations from the field of reproductive health (or health in general) that may trigger some improper reactions or questions from the provider.

Ask participants to listen to the presentation of each situation and note down on a sheet of paper what they would say (their immediate verbal answer) to that person. The answer should be spontaneous.

After you have presented all statements and participants have noted their answers, ask them to put the papers aside.

Use the material *Obstacles to Communication*, present them in turns, providing examples of common answers.

[Note to the trainer: While you present the obstacles, keep the ones that you have not yet presented covered. Also, cover the fragment *Possible Reactions Generated by the Answer* until the participants answer the question “What would be your reaction if an adviser answered you in this way?”. Then uncover the information and review it, continue to the next obstacle.]

For each answer, ask participants:

- What would be your reaction if an adviser answered you in this way?
- What is the message behind this type of answer?

Ask participants to individually review the answers they wrote during the previous exercise and to check if any of their answers may represent an obstacle to communication. Ask them to note down the obstacle identified.

Ask how many participants provided answers which represent obstacles to communication; ask several volunteers to share their answers to the group.

Ask the group to summarise what they have learnt, using the following questions:

- How did you feel:
 - ✓ Answering these difficult situations/clients?
 - ✓ Reviewing your answers and reactions?
- If you heard these statements once again, would you react differently?
- Do you have a second chance to reply more adequately to a client whom you replied inadequately the first time?

| |
|--|
| Maybe yes, maybe not. Generally, the first answer of the service provider has a powerful impact – positive or negative – on the client’s perception of the provider. |
|--|

- How could you be better prepared to answer to these types of challenging situations?

- | |
|---|
| <ul style="list-style-type: none">• Acknowledging that the problem belongs to the client and does not affect you directly• Being aware of the different values and recognising that the problem will be solved by the client, in compliance with their set of values (which may be different from the provider’s)• Always remembering that you are there to help the client go through the process, |
|---|

asking questions and providing the information they need.

Explain that:

- All answers are normal. We generally reply in this way because we intend to help the person we are talking to.
- There are situations when some of these answers are suitable.
- However, this type of answer frequently blocks communication, especially when it triggers hostility, resistance or hurts the client.
- Certain answers communicate lack of acceptance of the person or the desire to change or control that person.

Ask:

- Are there any other possible obstacles in communication? (Provide examples, if necessary, in order to help participants name various obstacles.)

- Difference in education, social class, language
- Eccentric characteristics (of the speaker or listener)
- The problem raised by the client is shocking
- The information/message is not what the listener would have liked to hear
- The provider's attention is diverted by another concern (shows lack of interest)
- The environment is not suitable for communication (noise, no intimacy)
- The client is not comfortable, does not have any confidence, is afraid to talk
- The provider does not understand the client's problem
- The provider uses overly-complicated language with non-familiar terms or gives advice which is not relevant or which is impossible to follow
- People who do not know or trust each other have difficulties in listening to one another

Review together with the group the material *Obstacles to Communication*. Check if participants have questions.

Ask:

- Knowing these obstacles, what can we do to improve communication with our patients?

Expected answers:

- Ensure person's comfort and intimacy (a quiet place where we will not be disturbed)
- Listen carefully (to be sure we understood what the client has said and to learn her needs, problems, concerns, values and desires)
- Use simple words that are easy to understand and reduce explanations to the minimum necessary
- Encourage the client to talk, by the use of active listening
- Show that we understand and honestly want to help

Add that, during the following exercises, participants will have the opportunity to practice some techniques which will help them improve their communication skills.

VI. Practicing Communication Skills (1 hour 20 min)

Remember that active listening is based on 3 techniques:

- Participative, reflective listening
- Paraphrasing
- Clarifying questions

Add that you will demonstrate each stage and that the participants will have the opportunity to practice the 3 techniques in turns.

a) Participative listening

Firstly, invite the group to observe a demonstration made by the two trainers, during which one of the trainers plays the role of a service provider, and the other plays the role of a client.

[Note to the trainers: the “provider” shall demonstrate the reflective listening technique, providing a non-verbal reply or a short reply, in order to encourage the woman to go on with her explanations]

Display the following questions on the flipchart:

- What did the “provider” do?
- What gestures did he use?
- What did he communicate to the “client”?
- What was the effect on the client?

Split the participants into groups of 3. In each group, the participants will decide who will be a) the provider, b) the client and c) the observer of the first role play.

State that by the end of exercise all participants will play these 3 roles.

State that the observer’s role is to carefully observe the interaction between the two, attempting to answer the questions above. By the end they should give positive and constructive feedback to the provider (in compliance with the feedback provision rules), in order to help them improve their listening skills.

Grant 2 minutes for selecting the case they would like to use, inspired by an issue raised by a patient at the unit.

The first role play: For 1 minute, in each group, the client presents her problem, and the provider listens to it. The observer pays attention to the provider’s behaviour in order to give feedback.

[Note to the trainer: For all role plays it is important for the trainer to monitor time. Some people may be uncomfortable with role play, especially at the beginning. Limiting time span may reduce this discomfort]

In each group, the observer gives feedback to the provider on the way they used participative listening (2 minutes).

The second and third role plays. In each group participants change roles, as follows:

- Providers become observers
- Observers become clients
- Clients become providers

The same stages are repeated.

To summarise, invite all participants to go back to the large group and facilitate a discussion, using the following questions:

- Addressed to the “clients”
 - How did you feel when you tried to expose your problem?
 - Did you have the impression they were listening? What were the non-verbal communication signs which created this impression?
- Addressed to the providers
 - How did you feel when you practised listening to the client?
- Addressed to the observers
 - What have you noticed? (underline the effect on the clients)
- Addressed to everybody
 - Why is it so difficult to keep quiet sometimes?
 - What is the purpose of this way of listening?

- The provider, learning to keep quiet, may pay greater attention to what the client is saying
- The client has the opportunity to express their needs, problems and to ask questions
- The provider does not influence the client, does not impose their own ideas.

- What are the limits, disadvantages of this way of listening?

It may make the people feel uncomfortable; the provider may step in more actively.

- How was the feedback? Were the feedback rules complied with?

b) Paraphrasing

Invite participants to observe a demonstration on paraphrasing words and emotions behind words (carried out by the two trainers). One trainer adopts the role of a patient who has a problem. The other trainer plays the role of a provider, paraphrasing what the client has said, both words and emotions perceived, encouraging the client to keep talking (2 minutes)

Ask the group:

- What did the service provider do?
- How did paraphrasing contribute to communication between the service provider and the client?

Underline that paraphrasing certain words or feelings requires that the listener should pay attention, without being distracted by other actions.

Split the participants into groups of 3 again. Ask them to change seats, to work with other colleagues as well, in order to benefit from the experience of a number of people as large as possible.

In each group, participants shall decide who will be: a) the service provider, b) the client and c) the observer for the first exercise.

Grant participants 2 minutes to select a problem / a case they would like to use. The problem should have a certain emotional level; the client should be worried or concerned about something specific.

The first exercise. Within each group, the client explains her problem, and the service provider listens to her carefully and paraphrases what the woman has said (2 minutes). The observer pays attention to the service provider's behaviour, in order to give feedback. If the service provider begins to give advice, the observer shall have to remind them of their role in the activity.

In each group, the client and the observer should take turns in giving feedback to the service provider on the way in which they used paraphrasing, as well as on the difficulties faced. (2 minutes)

The second and third exercises. Within each group participants shall change roles as follows:

- Providers become observers
- Observers become clients
- Clients become providers

The same stages are repeated.

To summarise, ask the group:

- Was the activity easy? Was it difficult? In what way?
- Did you have problems in paraphrasing correctly? Why?

Possible answers:

- It is a new technique
- My attention was distracted
- I had the tendency to intervene in what the client was saying
- I focused on my own reply while the client was speaking

- In what way can paraphrasing be of use to you?

- Paraphrasing allows the service provider to:
 - Check whether they understood correctly what the client said
 - Pay attention to the client's concerns
- Paraphrasing confirms to the client that the service provider listened to her and understood what she said

- Are there limits in using paraphrasing?

This component alone is not enough. Questions and dialogue are also very important.

c) Clarifying questions

Ask the group:

- Why do we ask questions during the examination?

- To learn what their needs are
- To assess their knowledge
- To help them make decisions about health
- To help them act based on the decisions made

- What are some of the questions you ask a patient during an examination?

Note the examples on the flipchart. Most of them will probably be closed questions.

- What kind of answers can a person provide to these questions?

Often it is “yes”, “no” or a fact/a reality.

The answers to a question indicate what kind of question was asked:

- Closed question: a single possible answer
- Open question: several possible answers

Explain the following:

- Close questions can be:
 - Neutral: a person may answer with: “yes”, “no” or through a fact. These questions generally have the purpose of obtaining general information or facts (example: How old are you? Are you married? How many children do you have?)
 - Leading: they suggest the “correct” answer to the client (and, in this way, they may be a form of manipulation). In most cases, these questions are statements ending with a question mark or they include a tag question.
- Clarifying questions are open questions which the service provider uses to help the client reflect and make a decision. They aim to:
 - Ask for more information/ details
 - Help the client identify and weight possible options
 - Help the client reflect on their own behaviour, situation, feelings and values
 - Structure the discussion

The two trainers demonstrate the use of open questions (2 minutes)

Ask the group:

- What have you noticed?
- In what way do open questions facilitate communication?

Expected answers:

- Assess client’s needs
- Assess client’s knowledge
- Help the client anticipate future consequences
- Help the client make a decision
- Help the client act based on the decision made

Split participants into groups of three. In each group, participants shall decide who will be: a) the service provider, b) the client and c) the observer for the first exercise.

Grant participants 2 minutes to select a problem / a case they would like to use. It can be the same as in the roles played previously and it should have a certain emotional level, such as worry or concern.

Within each group, the client takes 2 minutes to explain her problem. The service provider asks open questions to help her assess her problem, analyse options and find a solution. The observer pays attention to the quality of questions asked by the service provider, in order to be able to give feedback.

If the service provider begins to give advice, the observer shall have to remind them what their role in this activity is.

In each group, the client and the observer shall take turns in giving feedback to the service provider on the way they used open questions, on their effectiveness and possible problems related to them. (2 minutes)

The second and third exercises: Within each group participants shall change roles as follows:

- Providers become observers
- Observers become clients
- Clients become providers

The same stages are repeated.

Facilitate a discussion with the whole group. Ask the following questions:

- Was it difficult or easy to ask open and relevant questions that should help the client reflect on her condition? In what way?

| |
|---|
| If a person is used to asking closed questions, it will be difficult for them to get used to phrasing open questions. |
|---|

Indicate the material: *Principles of Using Clarifying Questions*. Ask for volunteers to read and comment on each principle.

To conclude, summarise the most important aspects of communication. Review with the group the material *Principles to Improve Communication*, underlying that their application is useful in all circumstances, not just in their professional activities.

Handout

INDICATORS OF QUALITY OF SERVICES (as perceived by clients)

Range of services available

- allows clients to select preventive services:
 - as clients' needs and values modify in the various stages of their reproductive life
 - in situations when the client's health condition limits use of certain services
 - secondary effects are not accepted by certain clients
- allows for alternatives where certain services are not available

2. Information provided to the clients on:

- advantages and disadvantages of preventive services, possible secondary effects
- use of the service chosen
- provider's role and availability to support the client with technical details, necessary treatment, references to other services etc.

Important – provision of adequate information:

- Strengthens the client's level of confidence and comfort. The relation between the client and the provider, as well as what happened during the first visit, are important in establishing further cooperative relations.
- Confidence in the service provider is crucial for the client's adherence to the proposed supervision plan and helps to prevent misunderstandings and concerns.

3. Technical competence of the staff:

- in all aspects of the service they provide
- in conveying information to the clients
- in understanding the client's needs

Important – technical competence:

- Contributes to effective use of preventive services by the clients
- Reduces redundant further visits if indications are clear and correspond to personal choice

4. Interpersonal relations - involve:

- Understanding
- Respect (including respect for privacy)
- Honesty
- Communication in both ways
- Flexible guidance for clients
- Caring attitude
- Identifying with the client and their problems and needs
- Providing information empathically, to help the client get the suitable services and remove their concerns
- Cooperation and coordination between members of staff
- Warm welcome for the clients by the clinic staff
- Personal attention given to the clients

Important – good relations:

- Strengthen the client's trust in the staff

- Enhance client's satisfaction with services provided by the unit and increase likelihood of future visits
- Improve environment in the unit
- Increase work satisfaction

5. Continuity and supervision

- Continuous supervision is focused on solving medical problems
- Supports the client in respecting the proposed plan
- Builds trust

Important:

- Efforts made by a unit to ensure client follow-up are a long-term measure for commitment to clients
- An anticipated model for follow-up visits helps to support steady clients and clients with changing needs

6. Adequate and acceptable services

- Suitable range of services (in order to meet various needs of the client).
- Acceptable services (flexibility as regards age, parity, testing and use of preventive services)

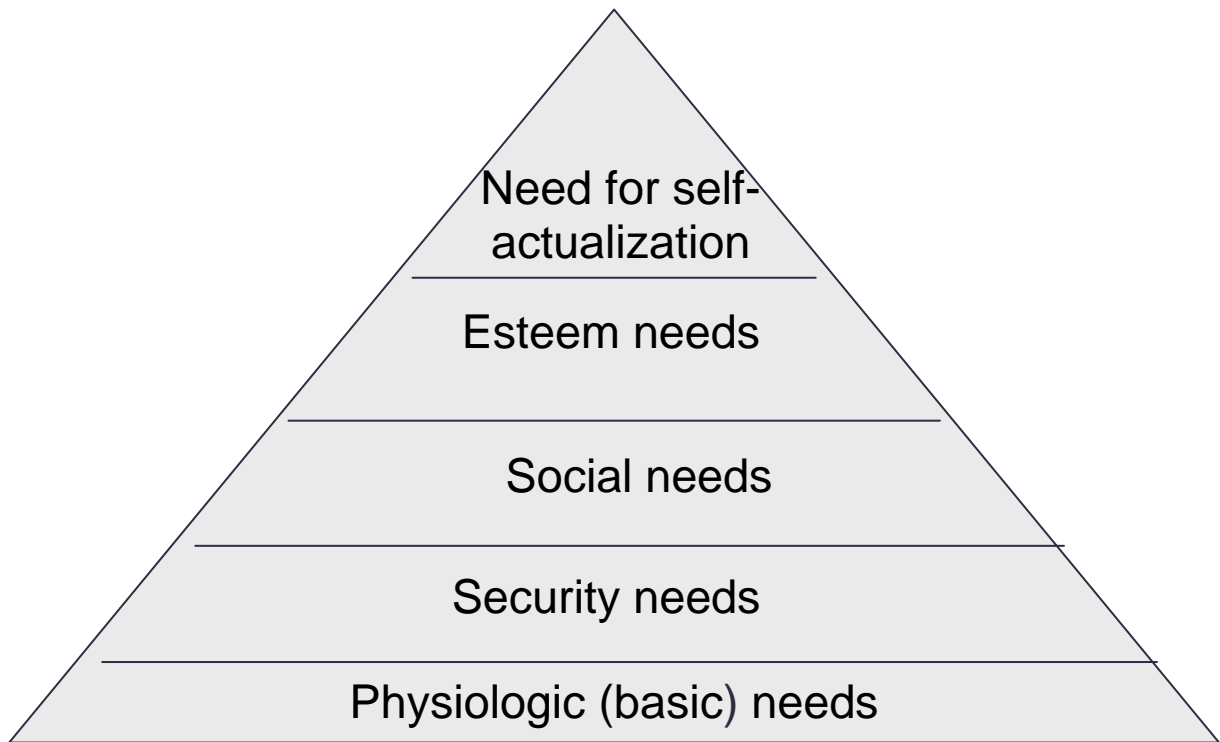
Important:

- Provide higher receptivity to clients' needs.

Flipchart/ Handout

MASLOW'S PYRAMID

RANKING HUMAN NEEDS



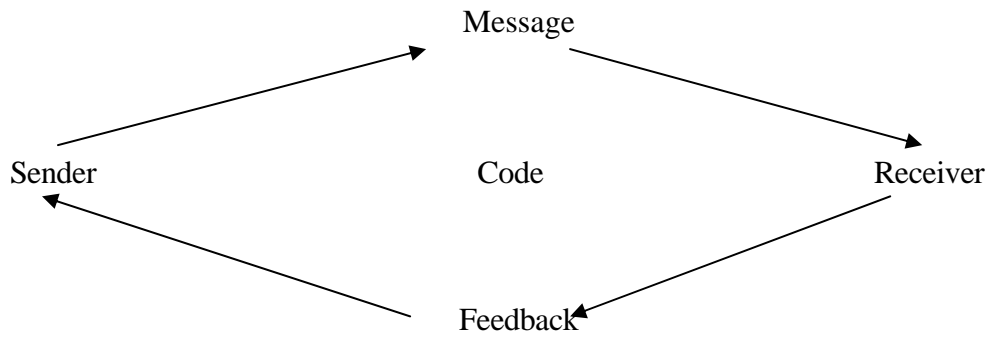
Handout

PATIENTS' NEEDS

| Fundamental needs | Behaviour expressing that need | What can we do to answer that need |
|--|---|---|
| Security needs – need to feel safe, comfortable | Anxious, unsure, afraid | Provide explanations for our actions. Call her by name. Ensure privacy for the discussion. Underline confidentiality. |
| Social needs - need for affection, to feel important | Shakes her bag, jewellery, watch. Wears expensive clothes. | Call her by name. Make protective gestures (for instance put our hand on her shoulder). Ensure her we understand. Smile. |
| Need to feel welcome | Looks around before coming in. Comes accompanied by a close person. | Welcome her. Start a friendly discussion. |
| Need to be listened to | Speaks too loud or too slow. | Listen carefully, trying to understand her feelings, concerns. |
| Need to be understood | Repeats words. Angry (if not understood correctly). | Summarise what she has said. Ask questions to check if we understood correctly. |

Flipchart/ Handout

COMMUNICATION PROCESS



Trainer/participants material

THE INFLUENCE OF EACH COMPONENT ON THE EFFECTIVENESS OF COMMUNICATION PROCESS

Sender (source)

A person inspires trust and is listened to if:

- He/she is competent (message content and the way information is communicated)
- He/she may set up a positive and constructive relation with a group or a person
- He/she proves that verbal and non-verbal messages transmitted are consistent
- He/she shows respect for the listeners (without making use of power or domination)
- He/she has a certain social status or position in community, family
- He/she shows a desire to help the others
- He/she has similar features to the listeners (e.g. age, culture, experience)

Channel (to convey the message)

It should be appropriate for the target group/person.

It may be:

- ***Vocal /oral***

The voice transmits various messages, depending on pace, volume, level, tone. It may be used to:

- Involve the listener/ audience
- Clarify ideas
- Underline attitudes, feelings

If used inadequately, the voice may prevent communication.

Thus, the voice should:

| | |
|---|--|
| Be clear, distinct and easy to understand | Articulate words as clearly as possible |
| Have adequate projection | Adapt volume of voice to the size of the room, audience, and to the content of the message |
| Have a proper pace | Don't talk too fast or too slow |
| Include breaks | Breaks allow the audience to reflect upon certain information, interiorise them |
| Have vitality | A plain, dull voice is more difficult to pay attention or listen to |
| Be adequate for the message | Form should be adapted to content, otherwise it may trigger confusion or disbelief |

- ***Body/ visual***

The body has its own language

- movement / absence of movement
- mimic, posture, gestures, body, look

Message

It should be clear, simple and relevant for the listener (receiver)

Depending on the channel used to transmit the message, which may be:

- ***Verbal***

The verbal message has 2 components:

- Content (words)

- Emotions or feelings (often non-verbally communicated: facial expression, gestures, tone of voice etc)

The feelings behind words are often more important than the content in order to interpret the meaning of the message

- **Non-verbal**

The non-verbal message may strengthen, distort or cancel the verbal message

Important aspects of the non-verbal message are:

| | |
|----------------------------|--|
| Approaching the topic | In everything you do and say, approach all situations positively |
| Body | Avoid having a rigid body; keep your head up, shoulders back and back straight, but without exaggerating |
| Movement is useful | Use certain gestures to underline, strengthen, clarify messages conveyed; Avoid uncontrolled, angry gestures, agitation, tics |
| Face mimic | Face expressivity, movements can either improve or have a negative influence on communication |
| Visual contact | When talking or listening it is important to look the interlocutor in the eyes, but without disturbing, or bothering them, or triggering a reaction of defence, retreat, attack, abandon (thus cancelling the communication) |
| True desire to communicate | Talk with the people, not to them |
| Authenticity | Is the way you communicate suitable for the attitude you would like to transmit, or does it mask/ change /alter the message? |

Receiver

They may show an interest in the subject, or they may have other concerns.

Their attitude towards the issuer is important

– for instance a receiver’s anxiety may trigger a defensive attitude and the tendency to interpret what they are being told incorrectly (they perceive threats which are not real).

Feedback

The receiver’s reply to the issuer is effective if wanted, accepted, respected and constructive.

Channel (for feedback): depends on the language used by receiver and the extent to which the issuer pays attention to the non-verbal channel used by the receiver.

Code: language (words, phrases) should be common for the issuer and the receiver (physician and patient). Pay attention to the technical language, medical terms, correct understanding of the jargon used by certain patients (regionalisms, teenagers’ jargon etc.).

N.B. The issuer’s and receiver’s role change constantly, depending on who “sends the message”, who listens and/or who gives feedback.

Handout

FEEDBACK

Feedback is communication to a person about the effects their attitude or behaviour had on the person listening to or observing them. It includes perceptions, feelings and reactions of the person giving the feedback. It is not critical or evaluative, but rather descriptive. Feedback provides information which the individual receiving feedback may use for self-assessment.

Feedback is more effective if:

1. It is specific, not general. Instead of telling a person that they are “bossy”, it would be better to say: “When you made this decision, you did not listen to the others’ opinion and I felt as if I were obliged to agree with you”.
2. It refers to the person’s attitude or behaviour and not to the person as such. It is more useful to tell a person that “they spoke more than any other participant at the meeting” than to tell them they are “talkative”
3. Takes account of the needs of the person receiving the feedback. Feedback may become destructive if it serves only our own needs and does not take the receiver’s needs into account. Feedback is meant to help others and not to hurt them.
4. It refers to an attitude or behaviour which the person can change. Feedback about a person’s physical features which are not under their control does not do anything else but hurt and frustrate.
5. It is desired and not imposed. Feedback is much more useful if required by the receiver.
6. It is an exchange of ideas more than direct advice. In the exchange of information and ideas we let the person draw their own conclusions and make their own decisions, depending on their goals, needs etc. When we give advice, we tell people what they should do, which means that they are not free to decide for themselves anymore.
7. It is given at the right time. Generally, feedback should be given as soon as possible after the action it refers to (depending on the receptivity of the person receiving it). Feedback may trigger several types of emotional reactions. Even the most effective feedback given at the wrong time may do more harm than good.
8. It includes the quantity of information which the receiver may use and not the quantity we would like to give. If the person is suffocated with a too large a quantity of information, the likelihood of using the feedback received will be reduced. When we offer more than is necessary, we often do so to satisfy our own needs more than to help the other person.
9. It refers to what was said or done and not to why it happened. “Why” leads to explanations and assumptions about the person’s reasons or intentions. In claiming we know the other person’s reasons or intentions, we only create suspicion or disbelief, which does not facilitate learning or change. It is incorrect to assume we know why a person said or did something. If we are uncertain as to the person’s reasons or intentions, we may express this uncertainty in our feedback.

10. It is positive and constructive and not negative. Negative feedback hurts, while the purpose of feedback is to help the other change their behaviour.

The person receiving feedback listens without defending or justifying their behaviour. When someone gives feedback (observing the rules mentioned above) the receiver just listens, unless they do not understand something and then they may ask for clarification.

Flipchart/ Handout

LIVING AND LEARNING: PEOPLE LEARN WHAT THEY LIVE

A person who lives with:

| | |
|---------------------------------|----------------------------------|
| criticism | learns to condemn |
| hostility | learns to fight |
| ridicule | learns to be shy |
| shame | learns to feel guilty |
| tolerance | learns to feel patient |
| encouragement | learns confidence |
| praise | learns to appreciate |
| fairness | learns justice |
| security | learns to have faith |
| approval | learns to like him/herself |
| acceptance and friendship | learns to find love in the world |

Handout

ACTIVE LISTENING

Active listening is a communication technique used by a counsellor, “helper” or facilitator, with the aim of helping the person analyse and solve their problems by themselves. The counsellor or facilitator: 1) listens carefully, without interrupting, providing only short replies, 2) paraphrases or rephrases what has been said and 3) asks questions to help the person think about their problem, options available and to find a solution.

This technique communicates to people that they are accepted, that the “helper” (facilitator) will neither judge them nor indicate solutions but will help them make their own decisions.

Active listening is useful in reproductive health discussions:

Women may have questions, concerns or other problems which influence their behaviour and habits related to reproductive health, including use of available services. They may ask for information, ask questions which reflect certain rumours, myths or concerns, including their partner’s disapproval.

Active listening is useful to highlight what is behind women’s initial statements; the unspoken questions. Thus, we may better answer concerns, prejudice which might prevent them change their behaviour.

1. *(Participative) listening*

- When we keep quiet, we pay more attention to what is being said by the other person
- Purpose of participative listening:
 - Gives the woman the opportunity to explain her needs, the problems she is faced with, and the possibility to ask questions
 - Shows the woman that she is being listened to
 - Prevents the listener from imposing their own ideas

2. *Paraphrasing*

- Paraphrasing involves the listener’s rephrasing what the speaker has said, in their own words, including any perceived feelings behind the words (expressed through tone of voice, facial expression, body language)
- Purpose of paraphrasing:
 - Check whether we understood what the speaker said
 - Helps us not to interrupt the speaker or give advice to them
 - Encourages the person to keep talking

3. *Open questions*

- Open questions are used to help the speaker think and make decisions. They are used to:
 - Ask for more details/ specific information
 - Help the client identify possible options and weigh the advantages and disadvantages of each one
 - Help the client reflect on her own situation, feelings and values, as well as her own behaviour
 - Structure the discussion

Handout

OBSTACLES TO COMMUNICATION

1. Ordering

We tell a person what to do, with no explanations or alternatives.

Examples:

“I don’t care what others say. You have to...”

“Listen to me!”

Possible reactions generated by these answers:

- Fear
- Resentment, fury
- Impression that own feelings and needs of that person are not important

2. Threatening, warning

We only tell a person about negative consequences (to frighten them).

Examples:

“If you do this, you will see what will happen to you, you will be sorry.”

Possible reactions generated by these answers:

- Fear
- Resentment

3. Advising, giving solutions, moralizing

We tell a person what to do, how to solve their problem.

Examples:

“If I were you I would ...”

“You should not do it like that.”

“You should ...”

Possible reactions generated by these answers:

- Resistance, defensive
- Feeling of guilt
- Feeling of inferiority

4. Judging, criticizing, disagreeing, blaming

We judge negatively, contradict or try to impose our own point of view.

Examples:

“You are wrong about that! I cannot agree to you.”

“You make no effort.”

“You did not understand anything that I told you.”

Possible reactions generated by these answers:

- Feeling of inferiority
- Defensive

5. Labeling, stereotyping

We place the woman in a disgraced category.

Examples:

“You act like a child.”

“You women are all the same.”

Possible reactions generated by these answers:

- Feeling of inferiority

6. Interpreting, analyzing, diagnosing

We tell the woman why she is in that situation, we analyse what she did or said.

Examples:

“This is why you are in this situation!”

“You are only trying to avoid the problem.”

“You only say this to trick me.”

Possible reactions generated by these answers:

- If the answer is correct, embarrassment
- If the answer is not correct, hostility, fury

7. Sympathizing

We try to make the person feel better, distracting their attention from their feelings; in fact, we try to minimise their feelings, or not to take them into account.

Examples:

“Tomorrow you will feel better”

“Don’t worry, it will go away.”

“All women pass through something like that once in their life.”

“I felt like that as well.”

Possible reactions generated by these answers:

- Frustration, the feeling that she is not understood
- Sensation that her feelings are not important

8. Distracting, humoring, diverting

We distract woman’s attention from her problems (when we don’t know how to handle it): we joke, change subject etc.

Examples:

“Come on, dear, forget about it, we have all passed through this.”

“This reminds me of ... (diversion)”

Possible reactions generated by these answers:

- Denial
- Frustration and pain

Other possible obstacles to client-provider interaction

Provider:

- Misinterprets what is being said and believes they are criticised.
- Prepares their answers while listening to the client.
- Listens selectively (based on similar experiences with other patients), ignoring details, based on personal values and consequently misinterprets what they are being told.
- Grants more importance to mistakes or things they do not agree to.
- Identifies with something the client said and starts to relive their own experiences.

Other obstacles to communication:

- Differences in values, education, school, language between the provider and the client create difficulties in understanding. The service provider may wrongly interpret their role in communication and:
 - Transform dialogue into monologue (makes a speech, a lecture)
 - Does not show respect for the client
- Some providers' attempt to demonstrate that their ideas are more valuable than the clients'
- Extravagant looks (extreme dress, make up, hair)
- The problem raised by the client is shocking
- The provider or client are concerned with other problems
- Provider's answer is not the one expected by the client
- Environment is not suitable for communication (noisy, no privacy); client is aware that the discussion may be heard by other persons as well
- Client does not feel comfortable because does not trust the provider
- Provider does not understand client's problem and provides advice and information which the latter does not need or cannot apply
- Too much information is provided; the client only remembers fragments of what the provider said, especially when they are worried or scared
- Persons who do not know each other, or trust each other, have difficulties listening to one another.
- Clients may:
 - Be afraid to express their ideas
 - Believe that their problems do not interest the provider
- Previous experience – if previous meetings or discussions did not lead to a change in the clients' behaviour, the provider may infer that other further discussions with "such clients" will have the same outcome and will not bear fruit.
- The client's feeling unsafe or inferior may trigger misinterpretation of some questions asked by the provider, and cause them to justify/defend themselves instead of answering the question.
- Client's perception that the provider is not competent
- Client's interests, other concerns and/or attitudes: if the client is impatient or angry, they may misinterpret what the provider says (they may even feel threatened or criticised, for no reason).

Handout

PRINCIPLES OF USING CLARIFYING QUESTIONS

1. Do not ask open questions too early during the interview. The service provider should listen enough to the client (using participative listening, paraphrasing and closed questions) so that they can ask relevant and useful questions.
2. The service provider should be capable of gaining the client's trust in order for the interview to be productive.
3. Clarifying questions should not sound like an interrogation, but rather they should help the client to reflect on their own condition.
4. Clarifying questions should not start with "Why...?" Questions that start with "Why...?", tend to make the client defensive and feel the need to apologise, even when this is not necessary.

Handout

PRINCIPLES TO IMPROVE COMMUNICATION WITH PATIENTS

- Ensure the person you are talking to is comfortable (find a quiet place, where you will not be disturbed)
- Listen carefully (to be sure you understood what the person you are talking to said and to learn their needs, problems, concerns, values and desires).
- Use simple words that are easy to understand and reduce explanations to those strictly necessary.
- Set up a connection between the new information and what the person already knows, associate new concepts with the ones already known.
- Repeat important and/or difficult information (using concrete, practical examples).

STRATEGIES WHICH MAY HELP YOU IN THE COMMUNICATION PROCESS (Glenn van Ekeren)

- Accept people as they are
- Try to identify what they need to feel at ease
- Make relations with people flourish
- Make yourself understood even by difficult persons
- Approach conflicts effectively
- Show an honest interest in others
- Build relations starting from peoples' qualities
- Forget about previous events that made you suffer
- Make people feel encouraged and motivated to use their potential to the maximum
- Try to become the kind of person whose presence makes gladdens those around you.

SESSION 7: COUNSELLING AND HEALTH EDUCATION

OBJECTIVES: by the end of this session, the participants will be able to:

1. Define the qualities of a good counsellor
2. Explain counselling principles to the clients
3. Describe the GATHER model
4. Explain the influence of their own attitudes and values on clients' decision-making
5. Explain the way they can facilitate clients' decision making and help them take more responsibility for decisions
6. Effectively communicate with the patients in order to mobilise them for the screening programme
7. Provide necessary information on sample collection
8. Provide counselling to clients in order for them to become part of the supervision and/or treatment programme
9. Offer support to people faced with a diagnosis cancer diagnose

| Activities | Methods | Duration | Materials |
|--|--|-----------------|--|
| Ideal counsellor | Questionnaire Small group work | 20 min | Flipchart Questions on qualities of a counsellor Handout material Ideal counsellor |
| Counselling and informed decision | Presentation Group discussion | 30 min | Flipcharts/ Handouts - Counselling - Decision-making process - Counselling principles |
| Counselling model in primary health care | Presentation | 15 min | Flipchart/ Handout GATHER model |
| Influence of perceptions, values and attitudes on relations between people | Dyads Forced choice exercise Group discussions | 45 min | Worksheet Young woman / old woman Trainer's document Statements for the imposed choice exercise Flipcharts/ Handouts - Support strategies: Who is in control? - Provider-client relation during the counselling process |
| Health education in the context of primary health care | Energizer Group discussion Brainstorming | 20 min | Handouts - Information – communication – education - Factors influencing human behaviour - Stages in behaviour change - Model of behaviour change - Types of IEC interventions |
| Specific education and counselling | Small group work | 50 min | Handout - Specific counselling for cervical cancer (FP guidelines) |
| TOTAL | | 3 hours | |

INSTRUCTIONS:

In the introduction, state that we will talk about counselling and education about health and their importance, especially in preventive medicine, to help people adopt healthy behaviour.

I. Ideal Counsellor (20 min)

Display the flipchart with *Questions on Qualities of a Counsellor* (without a title). Bend the flip-chart paper so that it covers the questions.

Ask participants to take a piece of paper and answer some questions. Explain that after they answer the questions, they will be divided into groups of 3 and they will be asked to share 3 answers, at will, with their group members. Underline the right of each participant to take part in discussions to the extent that they feel comfortable.

Unfold the sheet of paper gradually to reveal each question as you read it out to the whole group. Read the questions one by one, allowing the group the time they need to answer.

Divide participants into groups of 3. In each group, participants share the answers they gave to 3 of the questions above (at will); participants shall speak for 2 min each. The rest of the group members listen without interrupting them.

Get the large group together and ask the following questions:

- What did you learn from this experience?
- Why do you feel more comfortable discussing a problem with some people than others?
- What are the characteristics of a good counsellor which you identified through this exercise?

- Respect (counsellor treats me as a responsible adult)
- Value (counsellor accepts me, does not judge me)
- Communication (counsellor listens to me with patience and communicates positively, without imposing their point of view)

II. Counselling and Informed Decision (30 min)

Display the material *Counselling* on the flipchart. Ask a group member to read the definition. Ask the group:

- How would you describe the difference between counselling and medical advice?
- What do we usually provide in our examinations?

- What message do we send to the clients when we:
 - Provide counselling?
 - Give advice?

Using the information in the reference material *Counselling*, explain what the difference between counselling and medical examination is, and what kind of messages we send to our clients / patients during each of those activities.

Ask:

- What is the purpose of counselling?

To help the client to:

- Analyse their own condition, identify problems they are faced with and their causes
- Make an informed decision
- Take responsibility for their problems and decisions.

- What does the concept “informed decision” mean?

Informed decision: voluntary choice/decision based on knowledge and analysis of all relevant data.

- What does the client need to know to make an informed choice/ decision?

To make an informed decision, the client should:

- Be informed of all options available (at the respective unit or in the place they are guided/sent to)
- Know the advantages and disadvantages of each option
- Understand secondary effects, possible complications
- Understand the risks they take through their choice, as well as risks associated with not using any of the proposed options
- Know what they have to do to put the decision in practice

- What is the counsellor’s role in ensuring an informed choice?

Assist the client in analysing all options, in order for the latter to choose what suits them best.

To introduce the next topic, the decision making process, ask a series of questions to the participants on how they proceed when they have to make a decision.

[Note to the trainer: for instance, you may ask them questions about their presence at this workshop]

- How did you receive the information about this workshop?
- How did you decide to take part in it after you learnt about the course?
- What did you do to prepare for the workshop?
- What questions did you ask yourself?

Draw the decision-making scheme on the flipchart, as you address the above questions and receive answers from the participants.

Explain:

Information stage: Participants received information about how this workshop will be conducted

Thinking/reflective stage: Participants thought (about the extent to which they should have reflected before leaving their homes and about the conditions of the workshop)

Decision-making and action-taking stages: Expressed through the fact that the participants are present at the workshop.

Discuss the experience of the participants, addressing the following questions:

- What happens in the thinking /reflective stage?

- People weigh the pros and cons with respect to the situation
- People anticipate the consequences of their decisions
- People ask themselves questions
- People take different options into account

- What is the importance of giving information?

The information given should:

- Be relevant to the clients' interests and needs
- Be complete, accurate and clear; be understood by all clients

- What can /should a service provider do to facilitate the decision-making process for the client?

- Imagine the client's needs /interests, based on their experience as a service provider
- Help the client express themselves and listen to them carefully
- Adapt the information to the client's needs/interests; encourage their questions and reactions (to better understand them and answer their concerns and needs)
- Give them time to think about the information received before making a decision

- Do we generally respect the decision-making process?

No. We often provide information to the clients and expect them to decide immediately what they want to do (as expressed through "you should....., should have....." etc)

- What are the consequences of such rushed /imposed decisions?

Either the client does not react at all, or they make a decision without giving enough thought and without being convinced, they do not make an informed decision. Often, clients do not put such decisions into practice. The client does not accept responsibility for that decision and may even blame the service provider for the negative consequences of that decision.

- What role should the provider have in this process in which the client makes decisions about their own health?

- To provide complete, accurate, objective and clear information
- To ask questions that help the client to think about the information acquired and their options
- To ensure client monitoring in order to reduce the risk of problems occurring, when the decision made is put into practice

Explain that problem solving is a slightly different concept. Explain this process and the role of the provider in both processes:

- Client identifies problem (including causes and effects)
- Client identifies possible problem solving options
- Client identifies possible consequences of each option (pros and cons for each option)
- Client identifies the best option or solution (for themselves), taking account of all possible options and consequences of each of those
- Client puts into practice the solution they found

Add that in each stage of the process, the service provider asks questions and provides information (as applicable) to help the client think about their condition, in order to be able to make the best decision for them and put it into practice.

Review together with the group the material *Counselling principles*. Ask for volunteers to read these principles. Invite the group to make comments, make the necessary clarifications.

III. Counselling Model in Primary Health Care (15 min)

In order to place the counselling process in the context of examinations provided by the family practitioner, ask the participants:

- What are the different stages of an examination (since client arrival to their departure)?
- How and when does counselling fit in?

Stages of an examination:

- Patient reception
- Discussion (to identify the problem they have)
- Examination
- Treatment prescription, therapy and/or prevention plan
- Monitoring

Counselling takes place in all stages

Present the „GATHER” concept which represents the counselling stages during an examination. The GATHER elements correspond to the stages of an examination and specify the counselling content in each stage.

Review with the group the key elements and purpose of each stage (following the *GATHER* document).

G = Greet the client

A = Ask about client needs, medical history, etc

T = Tell client about the services, alternatives

H = Help client to choose an alternative

E = Explain to client what h/she have to do

R = Return visit

Underline that although the GATHER model provides a logical structure for counselling, helping the examination be more effective and efficient, it is not a routine to be applied identically in all situations. During the examination, service providers should be prepared to go back to previous stages, if:

- They have the impression that something was not mentioned/ not understood
- The client has more questions
- They are not happy with the option chosen etc.

Explain that the provider should correctly identify the type and volume of information they provide to each client, in order for the latter to make an informed decision, avoiding, at the same time, providing useless information or information that may make the decision-making more difficult.

IV. Influence of Perceptions, Values and Attitudes on People Relationships (45 min)

Explain to the participants that interaction between speaker and listener is very much influenced by the perceptions, values and attitudes of each of them.

Ask:

- What is the difference between perceptions, values and attitudes?

Perceptions – the way we interpret and understand the message, through senses, depending on personal characteristics (age, gender, social position), knowledge and experience gathered, emotional condition.

Values – beliefs, principles and standards we cherish and which influence our behaviour. They are shaped in childhood, under the influence of family, education, cultural factors, friends, religion, but also based on personal experience.

Attitudes – represent our mental position towards the world at large. They are mostly based on personal values and perceptions and are expressed through opinions shared, positions taken with respect to an idea, behaviours.

For a better understanding of these concepts, invite the group to take part in a series of exercises.

Perception evaluation (10-15 min)

[*Note to the trainer:* based on the group membership and characteristics, choose one of the following options]

Option 1.

Instructions:

- Ask participants to pair with the colleague to their right.
- Without talking between them, invite them to write 10 words that best describe themselves (examples: caring, intelligent, persevering etc.).
- Participants then write 10 words that best describe their partner.
- Finally, each participant then writes what are the needs and concerns of their partner.
- For 5 minutes, participants discuss with their peer, comparing self-perceptions with the ones of their peer and checking whether the needs and concerns list identified by their peer is correct or not.

Lead a discussion facilitated by the following questions:

➤ Has anybody correctly identified their peer's features?

➤ If YES, how was this possible?

Possible answers:

- We have similar education, training
- We have the same gender
- We have the same religion
- We knew each other before
- We have discussed these issues before
- I observed my peer during previous activities and I learnt some things about him/her

➤ If NOT, why do you think you were unable to correctly identify your peer's features?

Possible answers:

- He/she is not as they look at first sight
- We have never talked about these issues
- I don't know him/her very well
- I have my own stereotypes
- I haven't asked him
- I assumed we are similar, we share similar interests

➤ What would have helped you find the correct answers about your peer?

Possible answers:

- If we had talked longer
- If I had known him/her better
- If I had known several persons like him/her

➤ How did you feel when you learnt how you are seen by others?

Possible answers:

- Offended
- Surprised

- Misunderstood
- Judged
- Incorrectly appreciated
- Amused
- Embarrassed
- Flattered

Invite participants to think how easy it is to make a mistake making assumptions about persons they know very little or not at all (as resulted from this exercise).

Option 2.

Give each participant a copy of the drawing *Young woman, old woman*. DO NOT tell them what the drawing represents. Ask them to look at the drawing carefully for a minute, without talking between themselves.

Ask the following questions:

- What do you see?

Answers vary.

Luckily, generally at least one person from each group sees a young or an old woman.

- How many of you see:
 - ✓ A young woman?
 - ✓ An old woman?
 - ✓ Something else?
- Why can't we all see the same thing when looking at the same drawing?

We have different experiences and perceptions

- What can we learn from this experience?

We always need to check whether we understood correctly what was intended

Summarise:

- We need to be aware of the differences between us
- We need to empathise with the others, understand them (“wear their shoes”), if we want to effectively communicate with them
- We can't make assumptions! We always need to ask and check whether our perceptions are right.

Forced choice exercise (20 min)

Instructions:

- Explain that in this exercise they will be asked to express their personal opinion about certain statements.
- Indicate two opposite areas in the room representing the 2 possible options (AGREE or DISAGREE).

- Read the first statement in the trainer's material *Statements for the Forced Choice Exercise*
- Ask participants to go to one of the two areas, based on the opinion they have about the statement delivered. State that there is no other alternative in between, and they have to choose one option or another.
- After participants arranged themselves in compliance with their position, ask several volunteers from each side (pro and con) to explain why they adopted this position.
- By the end of the discussion, ask participants if they want to change positions after they heard the opinions of their peers on the other side.
- Continue the exercise, repeating the same steps for each statement.

[Note to the trainer: heated discussions may appear during this exercise, depending on participants' values and reactions]

Processing: several ideas may be drawn from the group dynamics, depending on the situation created.

If there were any **participants who interrupted or reacted** while a peer expressed a different point of view, ask the group:

- What happened when you had different opinions from the ones of your peers?

Possible answers:

- We tried to persuade them of the validity of our viewpoint
- We lost interest towards them
- We criticised them for their opinions which were different from ours
- We were opposed

- What happens when we start talking while somebody else is trying to explain something?

We stop listening. You cannot listen to what somebody is saying and speak at the same time.

- How did you feel when your peers stopped listening to you? (question to **participants who were interrupted**)

Frustrated, because what I was saying was not taken into account

- What represents the way you answered during this exercise?

Our values.

- What is a value? What is the role of values in our life?

Values represent what we cherish and consequently they guide our behaviour. They do not represent a "truth".

Explain:

- Often, people have different positions or values. There are sound reasons for taking one stand or another. Our values may change while we acquire new information and experience.
- We have the tendency to defend our point of view, as if it were a “truth”, because it represents what we cherish.
- Values are neither good nor bad in themselves. What is important is not to impose them upon others.

Ask the group:

- What did we learn from these exercises?

We are not always aware of our own values until we are confronted with a person with a different opinion, or who makes a decision that we do not agree with.

Our values are shaped unconsciously while we grow up and through the experiences we have. Rarely we think of them as “values”, rather we consider them “truths”. We feel threatened when somebody casts a shade of doubt on our values and we feel obliged to defend them.

Interpersonal conflicts are often the result of a difference in values.

- Under what circumstances are we more prone to impose our values? What triggers this? Are we always aware that we impose our values?

We may be more prone to impose our personal values when:

- We have personal conflicts with respect to a situation or experience associated with that value (for instance: patients who do not follow the medical advice we gave to them; if they belong to a certain group – social, ethnic etc. – we may make the assumption that all people belonging to that group have a similar behaviour)
- We accept certain values without properly analysing them

- How do we apply these exercises in our activity? Why is it necessary to be aware of our own values?

The provider may be tempted to influence the client and to guide them towards what they consider is “good”, to distance them from what they think is “bad”, without realising that they are actually imposing their own values.

Underline the following:

- If provider disagrees with the client, an additional element of client intimidation appears which does not facilitate either mutual respect or client responsibility.
- Values that are imposed:
 - Are often rejected
 - May often lead to a conflict between persons
- The more aware we are about our own values, the easier it is for us to accept the values of others and to differentiate between their values and ours.

Ask:

- How can we help clients take more responsibility for decisions related to their health without imposing our values?

Display on the flipchart the material *Supporting Strategies – Who Is in Control?* Ask the group to interpret the material.

Then review with the group the material *Provider-Client Relation during the Counselling Process* and discuss how to put them into practice within the preventive medicine examinations: when the service provider helps the client analyse their condition and become accountable, the service provider helped the client develop their confidence and problem-solving skills; when the service provider makes decisions instead of the client, they strengthen the client's dependency on the provider.

Summarise: During our interaction with the clients

- Information should be presented neutrally and objectively, so that the one we interact with makes their own decision
- The client is entitled to:
 - Make a different decision than the one we would like to suggest
 - Keep their attitude
 - Change their decision if they want to

V. Health Education at Primary Health Care Level (20 min)

[Note to the trainer: Start this activity with an exercise, which will attract the group to the discussion on behaviour change and health education – 5 minute]

Give each participant a plain pill, that they should not be familiar with (sweetener, vitamin C). Tell them that it is a “pill increasing life expectancy” and they need to take it immediately.

[Note to the trainer: probably you will notice various behaviours – some participants shall swallow it immediately, others shall start making comments or asking questions such as: How much does it increase life expectancy? What is it made of? Does it have any secondary effects? Who uses it? Do you take it? Some of them may refuse to take it]

Try to persuade as many participants as possible to swallow the pill, using various methods:

- Statements: “You should know that I myself (or the peer trainer) have been taking these pills for 2 years and fell great”
- Scientific data: “The product has been approved by the Romanian Academy of Science, after it was tested in several countries by the World Health Organisation”
- Incentives: “If you like it, I can give you a box for free”
- Economic factor: “It's not expensive!”
- Social norms: “All people above a certain age should take these pills”.

Ask:

- What happened?

| |
|--|
| Participants were asked to do a thing they did not want to do. |
|--|

- Was it difficult to persuade you?

Answers will vary. Probably you will have enough forms of resistance to the change proposed.

- What methods did I use to persuade you?

I conveyed information: statements, scientific data, incentives, economic factor, social norms.

Explain the difference between information, education, communication, using the information in the material *Information – communication – education*.

- What is the purpose of health education?

Desired answer:

To produce a behavioural change which should improve / maintain a healthy condition.

- Is what we did previously somewhat similar to what we ask of patients, namely to give up their habits and change their behaviour?

This request is similar to the messages we convey to patients, expecting them to immediately change their daily habits, their behaviour.

- Is it enough to tell people what to do? What elements should be taken into account?

- Adults have different life experiences
- They need us to explain to them the reasons for their health problems
- They need us to demonstrate to them how their life or health condition will be affected by a possible change
- They want to know the consequences of the decisions they will make
- Behaviour changes are not easy, usually they produce discomfort, dislikes

Say that it is very important for people to receive details, explanations when they are asked to do something or change their behaviour (which has been illustrated by participants' reactions during the previous exercise).

- What are the factors influencing human behaviour?

Note answers provided by participants on the flipchart. Then start processing the factors listed and group them, in compliance with the material *Factors Influencing Human Behaviour*.

- Which of these factors may be used in the health education process? How?
- Would you discuss in the same manner with all patients? If not, why?

No. Each person's needs and concerns determine the way they should be approached.

- Which factor do you think is the most important in order for a person to change their behaviour?

The person should want to make the change.

Explain that there are several theories about the way people change their behaviour. I chose a model taking into account people's motivations, as well as the risk of returning to the previous behaviour.

Display on the flipchart *Stages in Behaviour Change*. Use the material *Model of Behaviour Change*, make a brief presentation on this one.

Underline the necessary requirements for change:

- Change should be initiated by the person themselves
- The new behaviour should become effective
- Effectiveness comes after a period of time
- The new behaviour is not part of the individual's adaptation strategies
- The person's life should not be full of problems
- There is social support

Acknowledge that behaviour change is not easy, it is a systematic process, requiring a model, a framework to be enacted.

Based on the research carried out it was found that each individual's reply to the proposal to change their behaviour is different, as were participants' reactions during the exercise at the beginning of the training.

There are 5 categories (based on the moment they start practicing a new intervention):

- Innovators
- Fast adopters
- Fast majority
- Slow majority
- Slow adopters
- Resistants

Ask participants:

➤ Why is it helpful to know these aspects?

- To develop effective communication strategies for behaviour change.
- To choose motivational activities suitable for the groups in various stages, to encourage certain new practices.
- Identification and involvement of innovators and fast adopters of a given population into educational activities, may lead to faster adoption of the new behavior by the population (especially if they are reliable persons, opinion leaders in their community)

Explain that – as we have seen previously – there are several factors, both individual and social, which may influence behaviour change and health behaviour preservation, and identification of these factors and group of persons is extremely important when we want to implement effective interventions, adapted to a certain community.

This is why in health promotion and education campaigns several stimuli are used: emotional, rational, physical factors, family and peer support, social structures, in order to take actions through various channels that may be used to influence or change behaviours.

Review together with the participants the activities generally used for the health education in the material *Types of IEC interventions*. Ask participants to take turns in reading a paragraph from that material and invite the group to say whether they had such experiences. Underline those which may be used to change population's behaviour and attitude to cervical cancer.

VI. Specific Education and Counselling for Cervical Cancer Prevention (50 min)

Invite participants to regroup in the formula in which they worked together the previous day, when they analysed several clinical cases (session 5). Tell them that now they shall identify together and then present to their peers:

- Types of messages suitable for each case
- The most suitable way to provide counselling to each woman
- Examples of interventions at community level.

Grant 20 minutes to complete this group task. Ask each group to assign a speaker to present results.

Invite each group to assign 2 representatives to play the woman's, respectively physician's role, who will enact before the whole group the counselling session to communicate the result.

Ask the rest of participants to carefully follow the interaction between the „physician” and the „woman”.

Check if there are other proposals and invite participants to enact the respective situation again, correcting the errors identified in the „physician's” attitude.

Thank the actors and congratulate all participants for the effort made.

Check if there are proposals for similar interventions proposed by several groups and underline once again the very important role played by the family practitioner in cervical cancer prevention, supervision and control.

To conclude, review with the group *The Cervical Cancer Specific Counselling Guidelines*.

Summarise; mention that through continuous practice of communication and counselling skills, participants shall be able to help their patients to make responsible decisions, and thus their compliance to the proposed therapy will increase.

Flipchart

QUESTIONS

1. Who is the person in your life who helped you most when you had a problem? What did she do to help you?
2. Who is the person who had the most important role in your sexual education? What are their features (positive and/ or negative)?
3. Who is the person whom you had most trouble discussing intimate aspects concerning your sexuality with? Why?
4. What factors and / or people influenced your sexual behaviour?
5. What were the main problems you faced in discussions with clients related to aspects of their sexual life?
6. Do you know a person who had a sexual problem? What were her feelings, reactions at that moment?
7. What can someone say or do to win your trust? What are the qualities / features that inspire confidence to you? What do you appreciate most about a person?

Handout

IDEAL COUNSELLOR

Is committed, involved

Caring, empathic, open

Discreet

Well informed, efficient

Helps me focused

Lets me be myself

Takes me seriously

Is relaxed and calm

Is polite

Is trustworthy

Creates mutual respect

Does not humiliate me

Is warm, friendly

Accepts human individuality

Has the sense of humour

Is willing to listen

Sets up the important points

Analyses

Summarises

Is constructive

Flipchart

COUNSELING

Face-to-face communication in which a counselor helps a client to:

- better understands his/her problem, situation and/or feelings
- identify alternatives for solving the problem
- apply the most appropriate solution to the client's situation.

The action is led by the counsellor, but the decision belongs to the client.

Handout

COUNSELLING

Counseling: face-to-face communication in which one person (the service provider) helps a client to better understand his/her problem, situation &/or feelings so that he/she can make his/her own decision and then act on it.

The counselor does this by:

- Asking open questions that help the client to assess his/her situation, consider his/her options, and identify and apply solutions
- Providing information to assist the client to better understand his/her situation and to consider options so that he/she can make his/her own decisions and then act on them.

Counseling generally communicates the message: “The problem and decision are yours and I have confidence that you are capable of resolving the problem by making the decision that is best for you.”

Medical advice: face-to-face communication in which the service provider tries to solve client's problem, find solution, make his/her decision by giving his/her opinion and/or proposing the solution to the client.

Advice generally communicates the message: "You are not capable of solving this, so I will have to do it for you". It perpetuates the client's dependency on the service provider.

Informed choice/decision: a voluntary choice or decision based on knowledge of all information relevant to the choice or decision.

In order to make an informed choice, the client needs to:

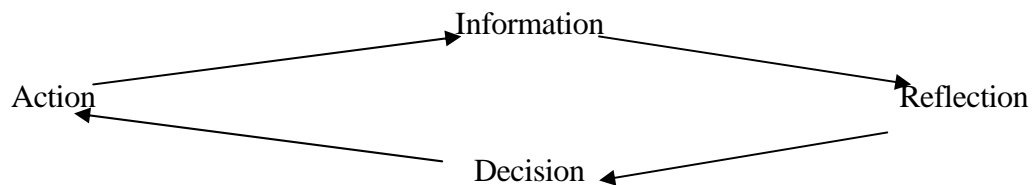
- be made aware of all the alternatives available (at the site or by referral)
- know the (major) advantages and disadvantages of each option
- understand possible side effects, complications
- understand the risks assumed through his/her choice, as well as the risks of not using any service
- know how to put the decision in practice.

Role of counseling in ensuring an informed choice: assist the client to consider all aspects of his/her problem, and his/her choice in order to choose what suits him /her best (the action is lead by the counsellor, but the decision belongs to the client).

Handout

THE DECISION MAKING PROCESS

1. The decision making process is facilitated by real and adequate information. In the diagram below, the provider helps the client reflect on the information they already have (about their condition/problem or needs) and provides additional information to the client, as necessary. This information must be appropriate to the client's needs; be complete, precise, and clear; and be understood by the client.
2. The client reflects on the information about his/her situation, feelings and options available etc. S/he weighs the pros and cons of the situation, anticipates the consequences of his/her decision, asks him/herself questions, considers the alternatives.
3. The client makes a decision.
4. The client acts on his/her decision.



In order to facilitate client's decision making process, the service provider should:

- Imagine client's needs based on previous experience with other clients
- Help the client express him/herself and listen carefully
- Adapt information to the needs/interests of clients; encourage their questions & reactions (in order to better understand, and respond to, their concerns & needs)
- Give clients enough time to reflect on the information before making a decision
- Ensure follow-up visits to reduce the risk of problems once the decision is put into action.

When service providers do not respect the decision-making process, and instead give information and expect clients to decide immediately what they wish to do (as expressed by 'you should . . . , ought to . . .' etc), often clients don't act at all or they make decisions without adequate thought and without conviction; they do not make informed decisions. The client may not accept responsibility for the decision and may even blame the service provider for any negative consequences of the decision.

Handout

PRINCIPLES OF COUNSELING

Counseling: a process in which a person is helped to express his problems and identify possible solutions as well as consequences of his decision.

Principles:

1. Establish a relationship of trust with the client. Use a warm tone of voice, avoid criticisms and judgments. Listen carefully to what the client says & pay attention to any feelings or messages behind what is said. Respect confidentiality.
2. Respect the client's confidentiality: in the process of counseling and in maintenance of client records.
3. Provide concrete, correct, objective information.
4. Ensure a logical sequence to the counseling. Establish a rapport between new ideas and the client's existing knowledge and/or experience; associate the unknown with the known.
5. Gather information about the client's needs, expectations of the consultation and concerns (through open questions). Draw out information which may help the client in making and carrying out her decision.
6. Be empathic. Pay attention to problems and concerns expressed by the client; do not ignore nor negate them. Such acknowledgement contributes to a trusting relationship and allows the service provider to gain information which may be important in the choice of method and instructions to give the client.
7. Support and encourage the client:
 - Be patient and encourage questions; take the time necessary.
 - Verify that you have responded to all the client's questions and concerns.
8. Pay close attention to the client's non-verbal communication.
9. Speak simply and minimize unnecessary explanations. Emphasize the essential.
10. Limit closed questions (with 'yes'/'no' answers) which do not facilitate communication.
11. Correct rumors by questioning the client to see where the rumor comes from and helping her/him to see the lack of logic her/himself.
12. Use visual aids to help clients better understand explanations.
13. Respect the client's privacy.
14. Do not try to convince the client of your point of view nor give her solutions to her problems (except for clinical/medical advice).

Flip chart

GATHER

GREET

ASK

TELL

HELP

EXPLAIN

RETURN VISIT

Handout

“GATHER” COUNSELLING MODEL

GREET the client

- ❖ Welcome the client warmly and with respect
- ❖ Introduce yourself (if the client does not already know you)
- ❖ Offer the client a seat
- ❖ Ask what you can do for the client
- ❖ Assure the client of confidentiality
- ❖ Explain what will happen during the visit. Describe physical examinations and laboratory tests, if any.

ASK/ASSESS the client’s reproductive health needs

- ❖ Help the client talk about her problems, needs, wants, doubts, concerns; keep in mind her reproductive stage and listen to her personal reasons, objectives and/or preferences
- ❖ Determine what decisions or actions the client needs/wants to make in this visit
- ❖ Ask about family and medical history (using a standard checklist which includes: age, marital status, number of pregnancies, number of births, number of living children, family planning use now and in the past, and basic medical information), paying particular attention to those items that relate to the client’s choices or preferences.
 - Explain that you are asking for this information to be able to help her
 - Keep questions simple and brief
 - Look at the client as you speak

TELL: provide information based on the client’s needs and knowledge

Ask the client if she wants to learn more details on a particular procedure, test, treatment etc.

- ❖ If she has a certain preference for a particular topic overlapping with the needs identified, provide the information requested.
- ❖ If the client did not talk too much about her problems and if she did not express a preference for a particular topic, provide her with the information you consider necessary in her condition.

HELP the client to make a decision

- ❖ Ask the client: Based on our discussion, what would you like to do? Listen carefully to the client’s response.
- ❖ If the client is not sure, review the questions already asked about her family situation, plans, lifestyle.
- ❖ If the client makes a choice which does not have any benefit to her health, explain why that is not indicated to her and help her to focus on other possibilities.
- ❖ Ask the client how she thinks she will tolerate potential side effects, explain disadvantages of the test etc.
- ❖ Ask if there is anything that is not clear or that the client does not understand, or if there is other information she would like. Repeat and/or rephrase information as necessary
- ❖ Verify that the client has made a clear decision. Ask: “What have you decided?”

EXPLAIN what will happen

- ❖ Provide the service you have talked about or which the client has chosen.

- ❖ If it cannot be provided the same day, tell the client how, when and where she can get the service.
- ❖ Explain how she should prepare for the test, how to follow the treatment, possible secondary effects, warning signs and what to do in case of a warning sign. Give essential information, do not overwhelm the client with information.
- ❖ Ask the client to repeat the instructions. Listen to make sure that she has understood them. Verify with open questions the client's understanding of what to do in case of problems.
- ❖ Tell the client when to return for a follow-up visit.
- ❖ Explain that the client can return at any time in case of questions, secondary effects or warning signs. Assure the client of your availability in the case of questions or problems.

RETURN VISIT

- ❖ Welcomes the client warmly and with respect
- ❖ Ask the client if she put into practice what was decided during the first visit. If yes, ask her if she is satisfied and/or has had any problems or secondary effects.
 - Reassure the client in the case of minor side effects.
 - Counsel, treat and/or refer the client in case of more serious side effects.
- ❖ If appropriate, explore changes in the client's current health status and/or life style that might indicate need for a different plan.
- ❖ Provide supplies, as appropriate.
- ❖ Makes a return appointment for the client (if appropriate).

Worksheet



Trainer's material

STATEMENTS FOR THE FORCED CHOICE EXERCISE

It is the patients' obligation to follow the physician's instructions.

HIV infected women should not get pregnant.

The patient knows best what is indicated for his/her health.

Drug addicted persons should get free disposable syringes.

The physician is responsible for curing the patient.

A person who does not want any children is selfish.

Girls should not start their sex life before 16 years old.

Generally patients are capable of taking responsibility for their own health.

Flip-chart

HELPING STRATEGIES: WHO IS IN CONTROL?

Helper's Behaviours

Listening

Reflecting back

Clarifying

Open questioning

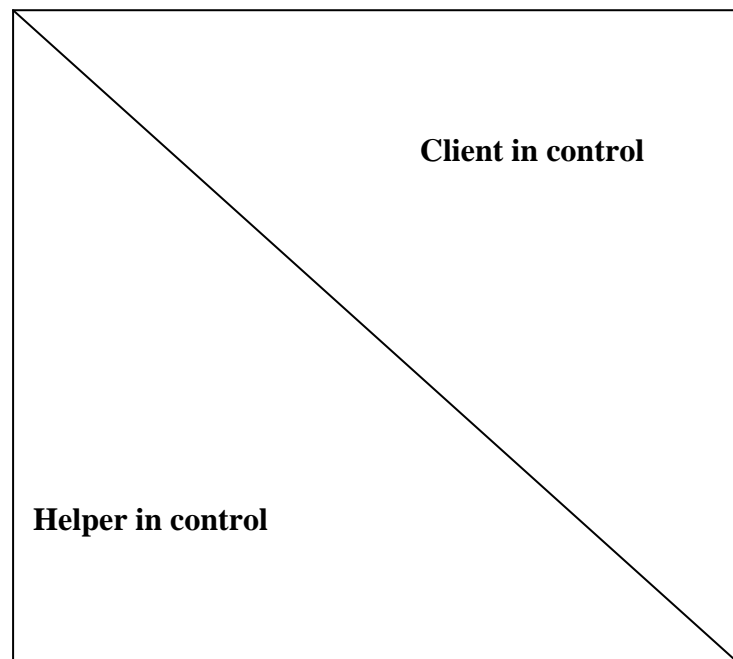
Closed questioning

Suggesting

Advising

Prescribing

Ordering



Handout

HELPING STRATEGIES: WHO IS IN CONTROL?

Whatever goals the clinician may have very little will be achieved without a working relationship with the client. It is the relationship rather than any particular advice or technique that operates as the primary support and/or change agent.

The following diagram illustrates different helping behaviors and what happens to the power relationship depending on the behavior chosen by the helper (clinician).

Helper's Behaviours

Listening

Reflecting back

Clarifying

Open questioning

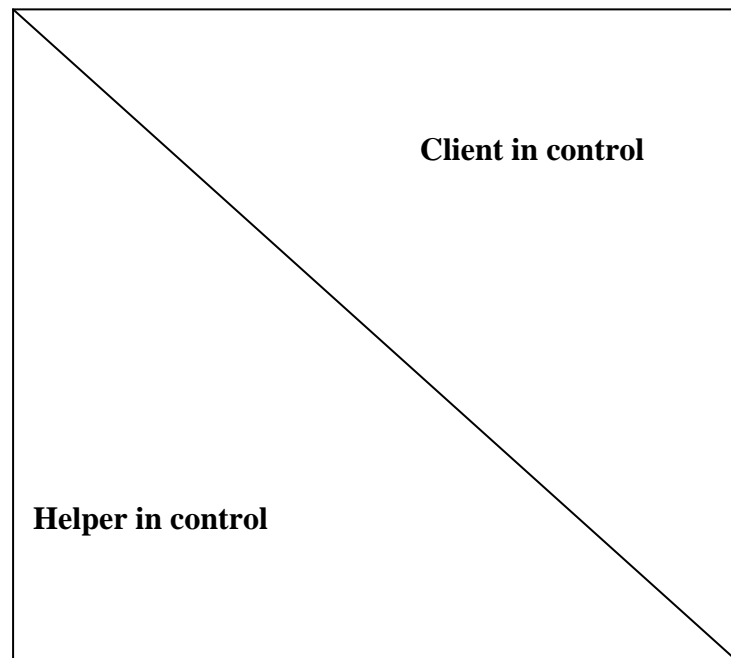
Closed questioning

Suggesting

Advising

Prescribing

Ordering



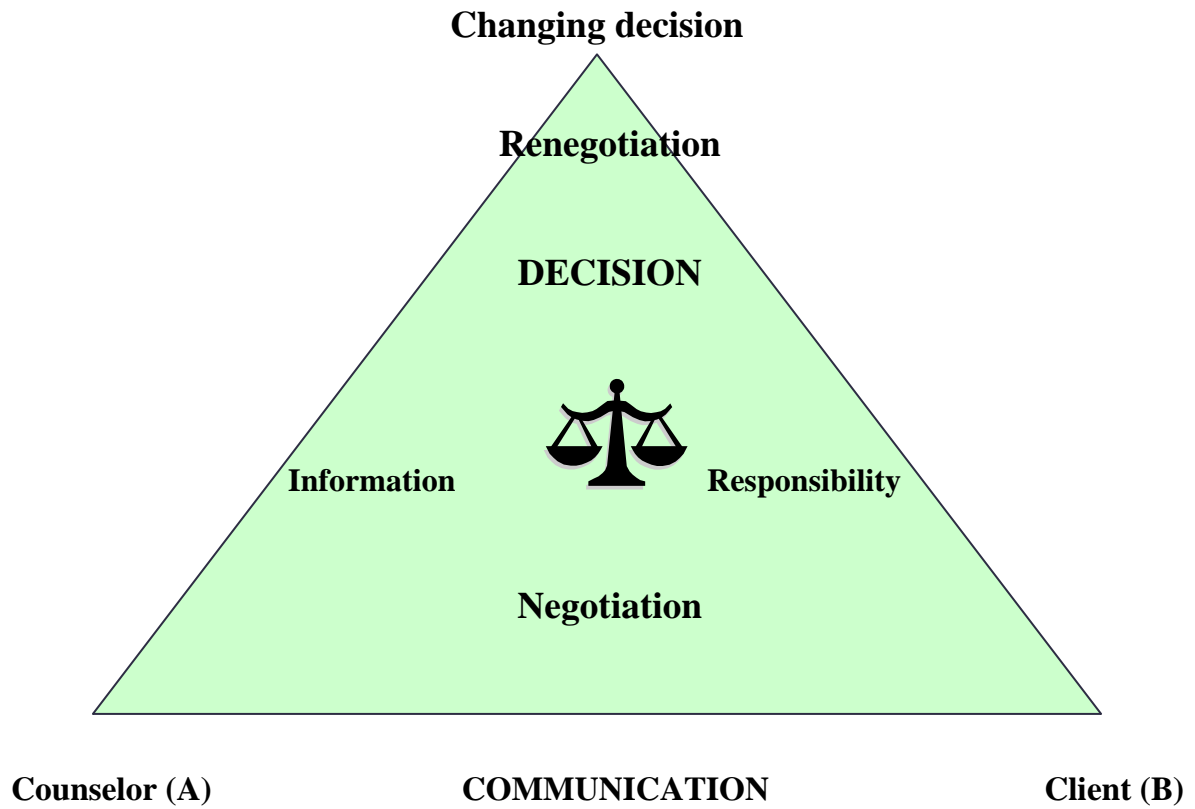
Counsellor behaviors influence the likelihood of power being held by the client and by the helper. If the helper only listens, the client will be largely in control. The helper behaviors in the top half of the list all give the larger part of control to the client. Questioning is at the half-way mark: an open question will send the power back to the client, a closed question will begin to direct the conversation and the helper will begin to control the conversation. Suggestions and advice assume that the helper knows best and can or should offer a solution to the problem, and helper action takes the problem out of the client's control.

Any of these behaviors can be helpful and appropriate, depending upon the situation, but it is those in the top half that are most useful in most cases of problem solving, counseling, or health education with clients. They "empower" the client: that is, they help the client to discover for himself/herself the problem, the options and the chosen solution instead of confirming their powerlessness by needing to be told, advised, or worse, "having it done for them".

Adapted from: Heather, Beryl, *Sharing*

Handout

PROVIDER-CLIENT RELATION DURING THE COUNSELLING PROCESS



Trainer's document / Handout

INFORMATION, COMMUNICATION, EDUCATION

1. INFORMATION

Information circulates in one way

sender -----> receiver

There is no guarantee that the information received by the receiver is put into practice

2. COMMUNICATION

Involves dialogue between issuer and receiver

sender <-----> receiver

Feed back is always present

7. EDUCATION

Involves dialogue between issuer and receiver

sender <-----> receiver

The process takes place in such a way as the ones involved to use the information (internalise it) and apply it into practice.

There is an expectation for the receiver to act in the future based on this educational experience (to produce a positive change in their behaviour).

Handout

FACTORS INFLUENCING HUMAN BEHAVIOURS

Factors generally influencing human behaviour which should be taken into account when we want to help the population change certain behaviours are:

Cultural factors:

- Norms and rules
- Traditions
- Personal beliefs

Social factors: other people's influence (husbands, parents, relatives, friends, priests, traditional healers etc).

Perception: the subjective process through which people understand and interpret messages. It is influenced by:

- Understanding the language and terms used
- Understanding the material used for explanations
- Quantity of information given
- Interpersonal relations

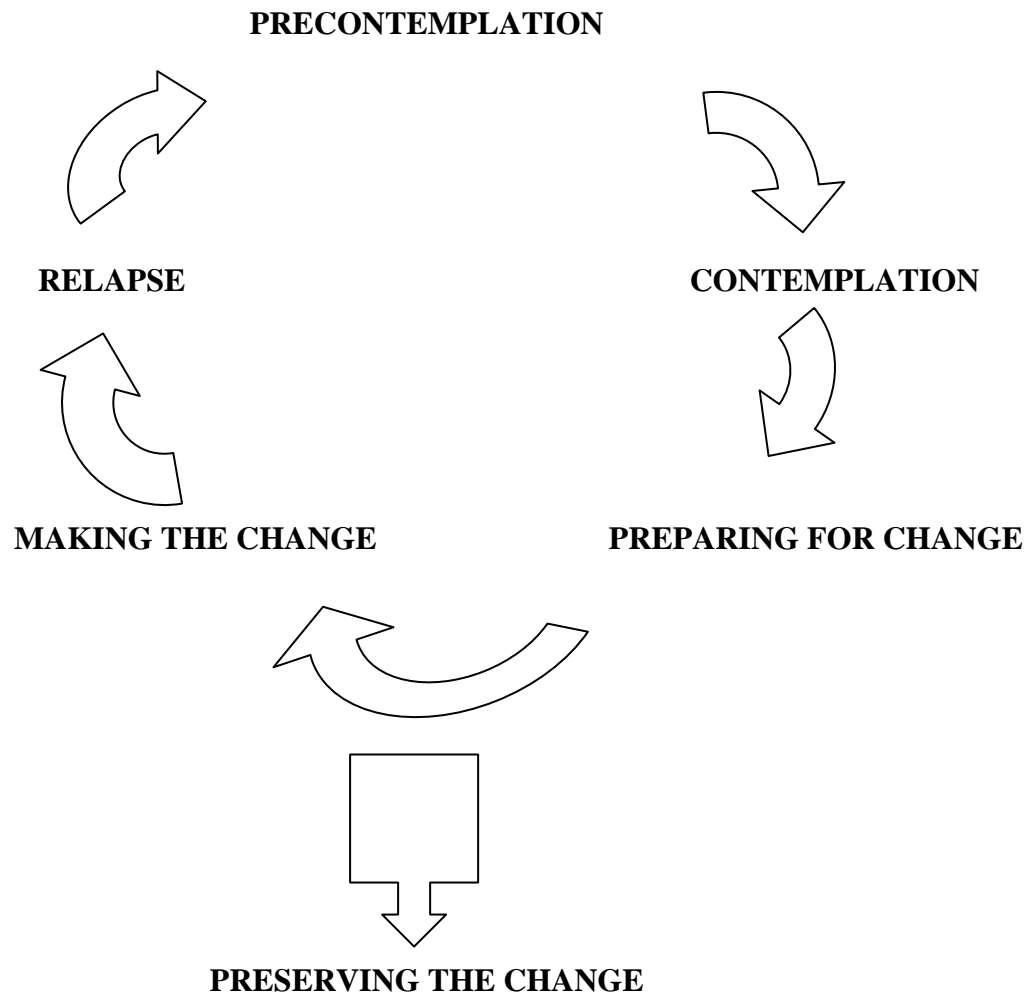
Secondary factors: factors that facilitate or inhibit certain behaviour change (for instance: time, money, skills necessary to practice certain behaviours, medical service quality and accessibility etc).

It is difficult to change those beliefs which:

- Come from the (negative) experience of the person, if you cannot explain the reasons for the event they were confronted with and the reasons why you propose a change to them and demonstrate the benefits of the proposed change.
- They are part of an old and powerful value system (for instance religion, traditions).
- They exist from childhood or were determined by trustworthy persons (parents, community leaders, priests, social role models).

Flipchart

STAGES IN BEHAVIOUR CHANGE



Trainer's material

**BEHAVIOUR CHANGE MODEL
(Prochaska and Diclemente, 1984)**

This is a descriptive rather than a theoretic model, which has the advantage that it takes account of people's motivations, the pre-contemplation stage, as well as the fact that people may go back to the previous behaviour.

At first, the individual is **not interested in changing a risky behaviour** (alcohol consumption, smoking, bad diet). They may not even be aware of the risk involved in their behaviour and may not think of changing it. As G. K. Chesterton said, this « is not caused by the fact that the individual cannot see the solution, but by the fact that they cannot see the problem ».

Once the individual becomes aware of the benefits of change or potential risks of their behaviour, they **think about changing**, they go through a stage of « **contemplating** » the possibility of changing something. They compare the costs and benefits of change and look for information that might help them make a decision. This stage may last from several minutes to several years.

The moment when the benefits of change are obviously outweigh the costs, the individual really starts to believe that change is possible and profitable as well, and he **prepares to change**. He needs new knowledge and skills, as well as support to start changing.

Finally, the individual makes the decision to do things differently and **changes their behaviour**. Sometimes they also need to change other aspects related to their lifestyle, temporarily or permanently. In this stage they need a goal, a plan and support or rewards.

Once the behaviour change occurs, the individual concludes the process of change and adapts to another lifestyle on a long term. Sometimes it is difficult to **preserve** their new behaviour and an inner fight may appear, requiring attention and support to avoid « relapse » to the old behaviour.

Handout

INNOVATION ADOPTION THEORY (ADOPTION PARADYGM)

Based on multiple research carried out throughout time it was found that the reaction of each individual to the proposal to change behaviour is different.

There are 5 categories of people (based on the moment they start practicing a new intervention):

- **Innovators** – represent approximately 5% of the group; they shall accept a new intervention and shall start practicing it immediately after they received information about it. They have a strong self-motivation, they do not need to be persuaded by others. They do not take too much account of public opinion, they are not afraid; they have an educational, economic and social level above the average.
- **Rapid adopters** – represent approximately 6% of the group; they need some time to think, but shall start adopting a new behaviour pretty fast, after they internalised the information passed to them, first of all because of their own motivation.
- **Rapid majority** – represent approximately 39% of the group; they shall try a new behaviour after they saw others adopting it successfully. They need to be persuaded by people like them, but there is no need for much interpersonal communication.
- **Slow majority** – represent approximately 39% of the group; they accept a new behaviour only after they have internalised a lot of information, and observed others using the new practice successfully, when they feel it has become a part of social norms.
- **Slow adopters** – represent approximately 6% of population; it is the group representing the highest challenge to mass-media, since they do not consider it credible, and are not persuaded by other people either to adopt a new behaviour, they are conservatives. Any innovation should be in harmony with accepted social practices. They let themselves be persuaded only by national leaders, but only if they have proved they are credible.
- **Resistants** – represent the rest of approximately 5% of population, they never change, because they cannot accept a new behaviour. Some of them may start practicing the new behaviour in the distant future, when it is no longer « new ».

Handout

TYPES OF I-E-C INTERVENTIONS

Mass information, education and communication

- Group presentations (large groups during cultural-educational activities)
- Presentation of audio-video materials
- Distribution of written materials: leaflets, flyers, posters etc.
- Alternative mass communication methods: theatre plays /role-plays, educational TV series, songs, drawings, comics
- Organising special events: contests, international celebrations of the fight against various problems (smoking, cancer etc.)

Audience: general public

Advantage: information reaches a very large number of people, with a relatively low cost

Disadvantage: information is general and cannot be tailored to individual needs

Goal: teach the public essential things on the topic chosen, promotes pro health behaviour, changes attitudes, prevents discrimination, increases the awareness about the respective issues.

Efficiency: low

Topics approached are selected based on the stage the individual/group is in.

- What is the disease
- What happens if you are ill
- What signs and symptoms does the ill person have
- How is the disease, infection etc transmitted and how is it not
- How can the disease be prevented
- Risk self-assessment
- Testing and the right to confidentiality
- Treatment
- Overcoming difficulties in the behaviour change process

Information, education, communication in small groups

- Presentations, small group discussions (6-10 persons) facilitated by a specialist
- Presentations and discussions led by specially trained peers (part of peer support)

Audience: groups of 5-10 persons

Advantages: information can be adapted to the knowledge level of the beneficiaries, who may discuss and exchange opinions on what they feel, on obstacles they meet in the changing process etc., beneficiaries may learn and practice prevention skills.

Disadvantages: average cost, requires staff trained in group discussions, requires an adequate space.

Goal: provides information, changes attitudes about the topic chosen, increases issue and personal risk awareness, increases participants' self-esteem and the trust they can change their behaviour, provides the basis for practicing prevention skills etc.

Efficiency: average, but it may increase if beneficiaries take part in several educational sessions.

Duration of an educational session with a small group of people: maximum 1 hour

Topics to be approached:

- Basic information on cervical, breast cancer etc.
- Raising awareness about individual risks
- Training the individual on actions through which they may reduce individual risk
- Exploring new communication methods with the others

Activity context

Different aspects of the intervention shall be developed to match participants' cultural background, gender and social norms.

Work strategy: focus on group dynamics, on the relation between the group leader and the participants.

Try to:

- Build trust
- Build group cohesion
- Encourage, build participants' motivation
- Encourage mutual support between the participants
- Group discussions techniques
- Verbal and non-verbal communication etc.

Information, education, communication at individual level

- Information and education by direct interaction (face-to-face)
- Counselling

Audience: the individual

Advantages: information is adapted to the knowledge level of the beneficiary, who may discuss their concrete situation, may be supported to find solutions, may learn and practice prevention skills, may make decisions, receives psycho-social support, beneficiary's self-esteem increases

Disadvantages: high cost, requires staff trained in counselling techniques

Goal: provides information, changes individual's attitude, increases personal risk awareness, increases self-esteem and the trust they can change their behaviour, provides the base for practicing prevention skills, provides psycho-social support, helps the individual solve their problems

Efficiency: high

Duration: from several minutes to one hour.

Peer support

Requires selection of some representatives of the target group (based on certain criteria) and their special training, in order to be able to provide information and support to the other beneficiaries with similar features.

Requires continuous support for educators, to preserve their motivation and help them overcome the difficulties encountered.

Handout

FAMILY PRACTITIONERS' GUIDELINES CERVICAL CANCER SPECIFIC COUNSELLING

Education and information

Basic information about the Pap test:

- Information on Pap test
- Indications, benefits
- Cervical cancer risk factors
- What the test is about, how it is done (no pain, confidentiality, sample collection conditions)
- Further course of action depending on the result
- Description of first symptoms which should alert the woman
- Myth demolition (examples: „I feel well, I don't need a test", „if there is no cure for cancer, I don't want to know if I'm ill", „I don't need a test because I didn't have any children", „now I'm a widow / at menopause, I don't need any more tests and examinations").

This information may be provided directly (orally) to a woman during a regular examination or it may be provided to a group of women during the health education activities.

It is advisable that, at the end of the information session, women also receive written information, in the form of a leaflet or other material.

Set up target group

Women 25-65 years old

Census

Sample collection planning

- Outside examination hours – a day/couple of hours allocated to this activity
- Establish the number of collections /day (based on equipment the unit has and service coverage capacity)
- Programme women for testing – first patients invited for testing should be part of the groups at risk

Invite patients for sample collection

Notification done through:

- Written invitation
- Telephone
- Through influential people at community level, promoters (postman, community women, opinion leaders)
- Community workers: community nurses, Roma health mediators, social workers

Preparation for sample collection

Prepare the room

Sterilise instruments, prepare materials

Ensure proper environment for sample collection

Sample collection as such

Describe sample collection stages and check if the women have any questions, concerns

Determine the risk status

Fill in the referral

Include the data written in the special TBP chart.

Transport of samples and charts to the laboratory for the cytological examination

Explain where the transport shall take place.

Provide several examples from the ones available (different organisation models for FP units, SRC caravan).

Result recovery

How do results get back to the FP unit

How is the client informed when she should come to the unit to receive the TBP result.

Result communication

Counselling depending on the result

1) If the result is negative (normal sample), the client is contacted

- when to do the necessary sample collection

2) If the result indicated modifications (positive result), specific counselling is required, including the following aspects:

- result significance (result is communicated openly, directly, explicitly)
- behaviour to follow
- mediation of patient-specialist physician relation
- support

3) If the result is not satisfactory from the sample collection point of view (the sample does not include endocervical cells):

- it is explained to the client that a new sample collection is required
- the client is programmed for collection
- the conditions for a new collection are explained again.

Monitoring

It is carried out with a special tool – the schedule (description).

Warning systems.

SESSIUN 8: EVALUATION AND WRAP UP

OBJECTIVES: by the end of this session, the participants will be able to:

13. Assess their knowledge and skills acquired and compare them with the ones they had previously to the workshop
14. Assess the workshop

| Activities | Methods | Duration | Materials |
|---------------------|-------------------------------------|-----------------|--|
| Final testing | Individual work | 15 min | Participants materials Post-test |
| Workshop evaluation | Individual work Group discussion | 15 min | Workshop evaluation form |
| TOTAL | | 30 min | |

INSTRUCTIONS:**XI. Final testing (15 min)**

Remind participants of the test they filled it on the first day of the workshop and mention that we shall evaluate workshop efficiency by filling in the final test, identical with the first.

Distribute copies of the test. Ask participants to write their names. State that they have 10 minutes available to fill it in.

One of the trainers shall collect the tests and shall score them while the other activities are conducted, in order to communicate the final results.

Review the difficult questions, where participants had trouble finding the right answer. Check whether there are any other questions, queries.

XII. Workshop evaluation and wrap up (15 min)

Explain to the participants that they shall fill in a questionnaire, which is very important for the final evaluation of the workshop and which shall help the organisers to make improvements for future training activities, if necessary.

Distribute evaluation questionnaires and ask participants to fill them in.

Summarise together with the participants the activities carried out during the workshop. Review workshop objectives and analyse together to what extent participants improved their knowledge and skills. Review expectations expressed by participants at the beginning of the workshop and invite them to analyse whether these expectations were met.

Invite participants to share with the group the benefits that participation in this workshop will bring to their professional life.

To conclude:

- Communicate scores obtained in pre- and post-test (to those interested)
- Distribute participation certificates (if applicable, or explain how to get them)
- Propose a wrap up exercise.

Handout

FINAL EVALUATION OF THE WORKSHOP

Date.....Location.....

Trainers.....

Please answer the following questions to help us evaluate this workshop as correctly as possible.

Achievement of workshop objectives

For each proposed objective, please state to what extent you consider that it was achieved, by circling one of the figures on the scale (1=unsatisfactory, 2=satisfactory, 3=well, 4=very well, 5=excellent). If you consider that the objective was not achieved, please explain why you think this happened: not enough time, unclear explanations from trainers, not enough practice, unsuitable training method, other reasons.

- I am able to demonstrate the importance of preventive interventions
1 _____ 2 _____ 3 _____ 4 _____ 5

- I am able to demonstrate an understanding of basic screening information, early cancer detection, testing methods
1 _____ 2 _____ 3 _____ 4 _____ 5

- I am able to monitor a clients' health condition in compliance with the algorithm for cervical cancer detection and diagnosis
1 _____ 2 _____ 3 _____ 4 _____ 5

- I am able to develop individual intervention plans, based on each client's situation
1 _____ 2 _____ 3 _____ 4 _____ 5

- I am able to provide counselling to women to: mobilise them for the screening programme; prepare for investigations; adhere to a supervision and/or treatment programme
1 _____ 2 _____ 3 _____ 4 _____ 5

- I am able to provide support to people and families dealing with a cancer diagnosis.
1 _____ 2 _____ 3 _____ 4 _____ 5

Organisation

Please score (1=unsatisfactory, 2=satisfactory, 3=well, 4=very well, 5=excellent), for:

| | | | | | |
|--|---|---|---|---|---|
| Training sessions content | 1 | 2 | 3 | 4 | 5 |
| Trainers' performance | 1 | 2 | 3 | 4 | 5 |
| Utility of materials and handouts | 1 | 2 | 3 | 4 | 5 |
| Efficiency of practical sessions | 1 | 2 | 3 | 4 | 5 |
| Administrative aspects: access to location, training room, meal etc. | 1 | 2 | 3 | 4 | 5 |

Other questions

1. What topics/sessions do you think you should study or practice more?

2. Would you have liked to include other topics in this workshop as well? Which ones?

3. What suggestions do you have to improve this workshop?

Thank you and good luck!

Trainer's document

WRAP UP EXERCISES (examples)

- One of the trainers holds a ball of thread/yarn, which he throws to one of the participants as if it were a ball, making a wish or a compliment to him/her. Each participant throws and receives the “ball”, keeping a part of the thread, finally building a “network”.
- Each person draws the shape of their hand on a piece of paper, writes their first name in the middle and “passes” it to the colleague to their right. Sheets of paper shall circulate fast from one person to another (to the right). Each one writes a positive message, a wish, a quality of the person. Continue until everybody has written a message to all people and the sheets go back to their owners. Do not allow participants to read what the colleagues have said on the spot. Tell them that this shall be a „gift” from the group, which they shall „open” at home.
- Participants stand up, make a circle, hold hands and everybody makes a wish to the whole group.