

Launch of ICTPH Women's Health Intervention at Karambayam Rural Micro Health Centre

Aarti Sahasranaman



IKP Centre for Technologies in Public Health

Tamil Nadu, India

www.ictph.org.in

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Abstract

The ICTPH women’s health intervention was launched at the Karambayam rural micro health centre (RMHC) on October 14th, 2011. Women in the catchment area are currently being screened for cervical cancer using the visual inspection tests, VIA and VILI. Additionally, treatment is also being provided for reproductive tract infections (RTIs). This report details preparations made before the launch of the women’s health intervention, our observations from the field on the day of launch, and an analysis of data from the women’s health programme in the first two weeks of its implementation. The data analysis has also been used to make recommendations for improvements to the existing programme.

1. Introduction

With the exception of pregnant women, health systems in India have generally tended to ignore the healthcare needs of the large majority of women. As a result of this focus on maternal health, certain services such as antenatal care are much more likely to be found at the primary care level than others, such as cervical screening and care. Furthermore, there are other important women’s health issues where opportunities to make a significant difference have been missed. In order to address this disparity in services and provide more comprehensive care for women at the primary care level, ICTPH recently launched the women’s health programme at the Karambayam rural micro health centre (RMHC). The first edition of the women’s health programme will focus on reproductive health of women (**Sahasranaman *et al.*, 2011**). Eligible women who consent to undergo the examination will be screened for cervical abnormalities by visual inspection with acetic acid (VIA) and visual inspection with Lugol’s iodine (VILI). Also, women experiencing specific symptoms will be treated for reproductive tract infections (RTIs). The addition of the women’s health examination to the list of services offered in our RMHCs takes us closer to realising the ICTPH vision of providing broad-based and comprehensive healthcare services to rural populations (**Johar, 2010**). Furthermore, the success of the women’s health intervention will have important consequences for the overall well-being of the communities we serve. This report details preparations made before the launch of the women’s health intervention, our observations from the field on the day of launch, and an analysis of data from the women’s health programme in the first two weeks of its implementation. The data analysis has also been used to make recommendations for improvements to the existing programme.

2. Infrastructure and Technology Requirements for the Women’s Health Programme

2.1 Infrastructure Requirements

As mentioned in the proposal for the women’s health intervention, the most important consideration for the women’s health examination is ensuring total privacy so that women feel comfortable and secure during the examination. We believed that the best way to guarantee privacy would be to conduct the examination in a separate room that would be used exclusively for cervical screening.

The cervical screening room and its components were designed by Sabyasachi Das who heads the Innovation and Design team at ICTPH. The SVG training room in the Karambayam RMHC was partitioned with a sliding door to create the cervical screening room (**Refer Appendix 1**). The other half of the room will continue to be used for SVG training. A cervical examination table was specially designed and built keeping our specifications in mind. The table was fitted with stirrups whose height and orientation are adjustable. A strong light source with an adjustable gooseneck was also attached to the table to enable adequate light availability. Furthermore, a groove was made in the examination table to allow the examiner to approach the patient and get a closer look at the cervix during the pelvic/speculum examinations. The design of the cervical examination table can be seen in **Appendix 1**. Additionally, the cervical examination room was also fitted with a sink for the examiners to wash their hands between examinations. Apart from the table and the sink, a trolley containing sterile speculums, other instruments, and reagents for VIA/VILI examinations was also placed within the cervical examination room.

2.2 Technology Requirements

New additions were made to the HMIS in the chief complaints, review of systems, physical examination, diagnosis, protocol information, and pharmacy menus. Screenshots of the women’s health examination-specific parts of the HMIS can be seen in **Appendix 2**. The HMIS requirements of the women’s health interventions can be found at <https://sites.google.com/a/ictph.org.in/wiki/main-wiki/product-management/requirements-for-women-s-health-intervention> . Changes that were introduced are detailed below-

Chief Complaints – The following chief complaints have been added to the HMIS:

- Genital ulcers
- Dyspareunia
- Bleeding during sexual intercourse
- Post-coital bleeding
- Inter-menstrual bleeding

Also, one of the chief complaints that was originally listed in the HMIS was discharge-p/v. This has now been modified to two separate options – vaginal discharge and penile discharge.

Review of Systems – A new system, reproductive, has been introduced under review of systems. The following symptoms have been added:

- Genital itching
- Burning sensation in the genital region
- Lower back ache
- Dyspareunia
- Abnormal vaginal bleeding
 - Bleeding during sexual intercourse
 - Post-coital bleeding
 - Inter-menstrual bleeding
 - Dysmenorrhoea
- Tenesmus

Physical Examination – The genitourinary (GU) tree under physical examinations has been completely revamped. Instead of the original single list, the GU tree now has three sections – General, Male, and Female. Currently, the GU tree looks as follows:

General

Inguinal Hernia – Y / N

Localised enlargement of Inguinal lymph nodes – Y / N

Inflammation of skin over swelling - Y /N

Sinuses – Y / N

Single

Multiple

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Oedema of genitals – Y / N

Oedema of lower limbs – Y / N

Presence of vesicles – Y / N

Single	Multiple	Painful	Painless
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Genital ulcers – Y / N

Single	Multiple	Painful	Painless
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Male

Absent Testicle

High Riding Testicle

Scrotal Swelling

Urethral Discharge

Testicular Pain

Testicular Swelling

Testicular Erythema

Penile Discharge

White discharge	Blood	Pus
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Female

Pelvic Examination

Vaginal Discharge

Colour

White	Yellowish	Greenish	Grey
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Consistency

Thin	Curd-like	Frothy	Adherent / Sticky
------	-----------	--------	-------------------

Odour

Normal	Fish-like
--------	-----------

Speculum Examination

Abnormal Cervix (If this is chosen, the following options appear)

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	Cervical Erosion	Cervical Ulcer	Cervical Discharge
	Cervical Polyp	Nabothian Follicles	Leukoplakia
	Condyloma	Growth/ Tumour	
VIA / VILI Examination			
VIA:	Squamocolumnar Junction		
	Fully Seen	Partially Seen	Not Seen
Acetowhite Lesion			
	Positive		Negative
	Positive, Invasive Cancer		
	Does acetowhite lesion extend into endocervical canal? – Y / N		
	Number of Quadrants Involved?		
	<2	Three	Four
VILI:	Findings after application of Lugol’s Iodine		
	Positive	Negative	Positive, Invasive Cancer

Diagnosis – The following diagnoses were added:

- Cervical Abnormalities
- Chlamydia
- Gonorrhoea
- Syphilis
- Lymphogranuloma Venereum
- Chancroid
- Genital herpes
- Cervicitis
- Vaginitis (Trichomoniasis)
- Vaginitis (Bacterial Vaginosis)
- Vaginitis (Candidiasis)

Protocol Information – Information that we want to collect about the women’s health intervention has now been included under protocol information:

Women's Health - Y / N / N/A

- If no, why was examination not performed? (*Reschedule at appropriate time.*)
 - {Pregnant, Menstruating, Hysterectomy done, Insufficient time during current visit, Needs to consult with spouse / family members, Concern about privacy and confidentiality, Unclear about benefits of examination, Other}
- Diagnosis

- Cervical Abnormalities
 - Referral {Colposcopy/Biopsy, Cryotherapy, LEEP/Conization}
 - Follow-up
- Invasive Cancer
 - Referral
 - Follow-up
- Reproductive Tract Infection
- Next Steps
 - Action Taken
 - Re-screening
 - Follow-up for RTI
 - Referral/Follow-up
 - Date (Enter date on which action will be taken based on the protocol.)

3. Women’s Health Examination

The women’s health examination currently focuses on reproductive tract health of women. Our objective is to screen and treat women for infections of the reproductive tract. There are two specific components to the examination-

- Married women over the age of 26 years are offered cervical screening by VIA/VILI. All women, both symptomatic and asymptomatic, will be screened.
- Women exhibiting specific symptoms, for example vaginal discharge, or discovered to exhibit signs of RTIs during the pelvic/speculum examinations, are offered treatment.

Evidence-based practice was followed to design the protocols for the VIA/VILI examinations and treatment of RTIs. These protocols have been provided to the nursing officer and physician at the RMHC.

Women in the community were informed about this programme through multiple channels, such as community meetings with self-help groups (SHGs), information provided by SughaVazhvu guides (SVGs) during enrolment and rapid risk assessment (RRA), and also when they visited the Karambayam RMHC with unrelated complaints.

The current procedure followed at the RMHC with regard to the women’s health examination is as follows-

- i. Women visiting the clinic with other complaints are examined by the physician in the consultation room. At the end of the visit, the physician talks to the patient about the women’s health examination and its benefits.
- ii. If patient is willing to undergo the examination, the informed consent form is read to her and any further doubts are clarified. At this point, if the patient chooses to not undergo the examination, the physician enters this into the women’s health protocol information in the HMIS. This page also includes the reason for not undergoing the examination.
- iii. After signing of the consent form, the patient is led by the nursing officer to the cervical examination room. Here, the sexual history of the patient is recorded, and risk factors, if any, are determined. (The sexual history is currently not in the HMIS, and is being recorded on paper.)

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- iv. Once sexual history has been recorded, the patient is asked to lie down on the cervical examination table, find a comfortable position, and place her feet on the stirrups.
- v. VIA/VILI examination is now done by the trained nursing officer or physician.
- vi. After completion of the examination, the patient is led outside to the patient waiting area. The nursing officer/physician fills relevant sections of the HMIS including diagnosis and treatment, and the follow-up action that needs to be taken. A report is then printed out for the patient.
- vii. The nursing officer/physician talks to the patient about the results of the examination, and next steps to be taken by the patient.

4. Launch of the Women’s Health Intervention

The women’s health intervention was launched in the Karambayam RMHC on Friday, October 14th, 2011. In addition to the regular RMHC staff (Dr. Suganya, and the health extension workers (HEWs) Ayilrani and Vanasundari), two nursing officers, Viji Govintharajan and Menaka Subramaniyam, and a second physician, Dr. Priya Parimalam, were also posted to the Karambayam RMHC on the day of launch. Viji, Menaka, and Dr. Priya had received training for VIA/VILI examinations at the Adyar Cancer Institute, and were in-charge of implementing the women’s health examination.

Three women underwent the women’s health examination on the day of launch. Our first patient had heard about the women’s health examination from community members who had attended one of the meetings organized by us. The remaining women had visited the Karambayam RMHC with unrelated complaints, and agreed to undergo the examination after being convinced of its benefits by the physician and nursing officers. (**Refer Appendix 1** for pictures from the day of launch.)

Of the three VIA/VILI examinations, two were performed by Viji, and the third by Menaka. All women reported that the cervical examination table was comfortable. Furthermore, they felt that the speculum examination itself was only mildly painful as had been communicated to them prior to signing of the consent form.

One patient was diagnosed to be positive for cervical abnormalities by VIA/VILI examination. She was referred to a higher centre (Jeeva Memorial Hospital) for further care, and a follow-up was scheduled to keep track of her treatment. In addition to testing positive by VIA/VILI, this patient was also diagnosed with cervicitis and vaginitis. Of the remaining two patients, one was diagnosed with vaginitis, and the other was not suffering from any infection. In fact, our last patient of the day had been diagnosed with cervical cancer a year earlier, and had undergone chemotherapy at Thanjavur Medical College Hospital. Her negative VIA/VILI results indicated that she was well on her way to recovery.

While the launch got off to a smooth start in general, there were some minor speed bumps that we had to overcome. On the day of launch, we learned that Karambayam was scheduled for a power shutdown from 9 am to 5 pm on October 14th, spanning most of the operating hours of the RMHC. As a result, our autoclave could not be used for sterilizing instruments. Our nursing officer Menaka had planned ahead and autoclaved a few sets of instruments in advance, which allowed us to proceed as planned. The examination lamp connected to the table could also not be used because of the power outage. Fortunately, our neighbours at the cycle shop generously provided us with a

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strong torch light, which proved to be quite effective for cervical visualization! However, these inconveniences were rather short-lived because power returned by around 1 pm. There was also a small problem with crowding within the examination room, and our staff walking in and out of the cervical examination room. To correct this problem, we decided that only two RMHC staff members would be present in the examination room, in addition to the patient. Furthermore, it was also decided that to avoid alarming the patient unnecessarily, movement into and out of the room would be restricted. With regards to the HMIS, a problem we encountered was that some of the chief complaints had not been updated. However, this was quickly taken care of by the technology team. Another problem that is currently being resolved by the technology team is that of the print version of the report given to patients. The printed report did not show the details of the VIA/VILI examination, and the observed results. Since it is important that the results be clearly mentioned, especially when patients are referred to higher centres of care, this is an issue that needs to be worked on immediately.

5. Analysis of Data from the Women’s Health Intervention

The following table details the number of women who have undergone the women’s health examination, since its launch on October 14th, 2010-

Date	Total Number of Patients	Number of Women Eligible for Examination	Number of Women’s Health Examinations Performed	Number of VIA/VILI Positive Women	Number of Women Diagnosed with RTIs
14/10/2011	4	4	3	1	2
15/10/2011	3	1	-	N/A	N/A
17/10/2011	13	10	2	1	2
18/10/2011	8	8	2	-	1
19/10/2011	<i>Municipal Elections – RMHC Closed</i>				
20/10/2011	11	7	2	-	-
21/10/2011	3	2	1	-	1
22/10/2011	7	3	-	N/A	N/A
24/10/2011	1	0	N/A	N/A	N/A
25/10/2011	0	0	N/A	N/A	N/A
26/10/2011	<i>Deepavali – RMHC Closed</i>				
27/10/2011	1	1	-	N/A	N/A
28/10/2011	4	4	1	-	1

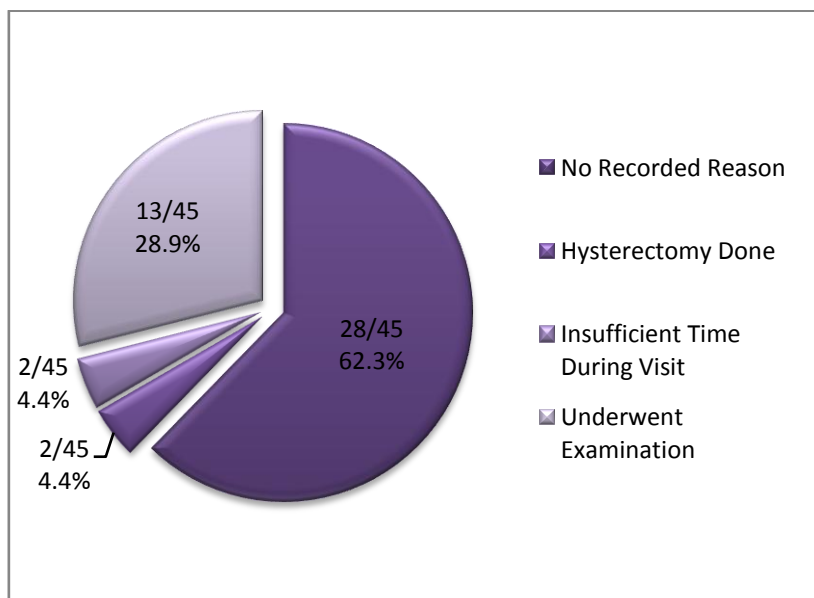
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29/10/2011	5	5	2	-	1
Total	60	45	13	2	9

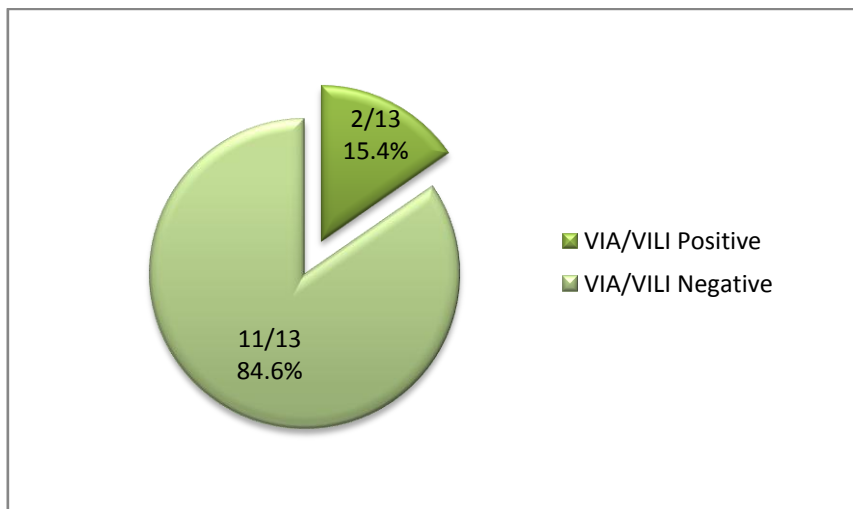
Table 1 – Data collected from the HMIS detailing patient inflow, uptake of women’s health services, and diagnoses made from October 14 – 29, 2011.

Since the launch of the women’s health intervention on 14th October till the 29th of October, 2011, 60 patients visited the Karambayam RMHC. Of these, 45 were adult women who were eligible for the women’s health examination. This skewed usage of our services by women at Karambayam has been reported earlier by Deepak Rajanna (<http://share.ictph.org.in/profiles/blogs/data-insights-visits-by-gender>). 13 of the 45 women consented to the women’s health examination, and VIA/VILI was performed (**Figure 1A**). Two of the 13 women have been found to be positive by VIA/VILI examinations, and have been referred to a higher centre for care (**Figure 1B**). Of these two, one woman has already undergone a confirmatory Pap smear test and is awaiting the results. Nine of the 13 women who underwent the examination were also diagnosed with RTIs. Of these nine women, four had vaginitis, and five suffered from cervicitis (**Figure 1C**). Interestingly, both women who were found to be VIA/VILI positive were also found to have other RTIs. Additionally, two women who were VIA/VILI negative and not diagnosed with any RTIs, were detected to have cervical abnormalities such as erythroplakia and Nabothian follicles. The patient with Nabothian follicles has also been referred to a higher centre for care.

A



B



C

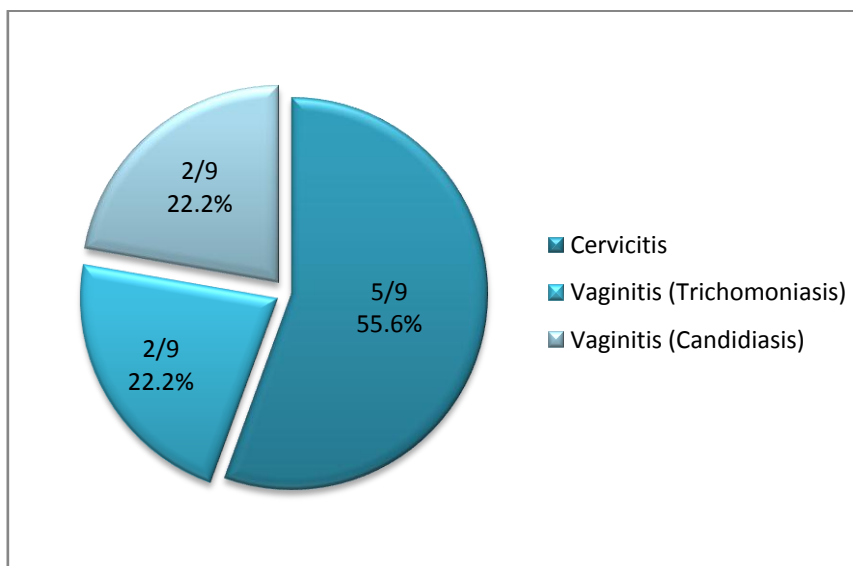


Figure 1. The women’s health intervention by numbers. (A) Graphical representation of proportion of women who chose to or not to undergo the women’s health examination, and reasons for not undergoing examination. (B) Graphical distribution of women who tested positive and negative for cervical abnormalities by VIA/VILI. (C) Proportion of various RTIs in women diagnosed to be suffering from infections.

Based on an analysis of the data from the HMIS, it immediately became apparent that there are some very important issues that must be resolved for the women’s health intervention to be truly successful. One of the major outputs of this programme is that **all** eligible women within our catchment area in Karambayam are screened. In the first two weeks of our intervention, out of around 2,670 eligible women in Karambayam, we have screened 13 women. If we were to continue at the current rate, we would only have screened 156 women in one year, and it would take us close

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to 17 years to screen our entire target population, which is an altogether unreasonable time frame. In order for us to screen more women, a two-pronged approach must be taken. First, more women should be made aware of the women’s health programme, thus resulting in increased traffic to the RMHC. Only one woman out of the 13 who underwent the examination had heard about the intervention from community members who attended a meeting organized by us. None of the other women were aware of the intervention, highlighting the need for greater community engagement and awareness. Second, more women who visit the RMHC with unrelated complaints must be convinced of the benefits of the women’s health examination. As Figure 1A shows, only 28.9% of women visiting the RMHC underwent the reproductive tract examination. This low number reflects that there is room for improvement in communicating the need for and benefits of the women’s health intervention.

An important question in the women’s health protocol information is the reason for refusal of the VIA/VILI examination. This question was included to gather information on reasons for refusal, so that we might pre-emptively target issues while attempting to convince women, either in the RMHC or during our awareness campaigns, to opt for the examination. However, as Figure 1A reveals, no reason for refusal was recorded in the women’s health protocol information page for 28 out of 32 cases where the examination was not performed. This is a significant oversight by the physician(s), and an opportunity to collect valuable information has been lost.

Of the 32 women who chose to not undergo the women’s health examination, two had undergone hysterectomy, thus precluding the need for VIA/VILI examination (**Figure 1A**). Two women quoted “not having enough time during their current visit” as the reason for not choosing to go through with the examination (**Figure 1A**). Appointments were rescheduled for these women, and they were asked to return at a later date for the examination. One of the women was scheduled to return on October 25th, but as can be seen in table 1, no patients visited the RMHC on that day. Our RMHC staff did not follow-up with the patient to ensure that she received the examination. Omissions of this kind will prevent us from reaching out to our entire target population, and must be kept in check.

6. Way Forward

Moving forward, there are some issues that must be addressed in the short-term for the women’s health intervention to be successful. The first issue that needs to be addressed is that of low participation in the programme of women from the community. Various approaches must be taken to ensure that we reach the maximum number of women possible. In addition to regular meetings with SHGs, awareness campaigns can also be conducted during Panchayat meetings. During these meetings, besides a visual presentation, SughaVazhvu staff members can also distribute pamphlets to aid retention of the information that has been shared. Additionally, it is important to reiterate to SVGs the crucial role they play in ensuring the health and well-being of their communities, especially the women. They must be educated on the women’s health intervention, so that they can be more effective messengers to the community.

Another issue that must be resolved in the short-term is that of incomplete information collection for the women’s health protocol. Physicians and nursing officers will be reminded of all information that must be entered into the HMIS, and how the collected information can be used to improve the implementation of the programme. This will also help to enhance their perception of the value of the information that is being collected.

Finally, it is important for RMHC staff to keep track of all follow-ups, both treatment follow-ups and those for rescheduled appointments. The objective of the women’s health intervention is improvement in the overall health of women. To meet this objective, it is important that we keep track of our patients and ensure that they seek and receive the care they need. VIA/VILI positive women who are referred to higher centres for further confirmatory tests and treatment must be followed up to keep track of their progress. With respect to rescheduled appointments, again, it is imperative that RMHC staff ensure that appointments are honoured by patients. If patients cannot visit the RMHC for the scheduled appointment, they must be rescheduled to a convenient date. The issue of follow-ups will be resolved with the upcoming release of the HMIS, where follow-up tasks can be assigned to specific RMHC staff, and pending follow-ups can be visualised and updated as needed.

The current version of the women’s health intervention is the first step towards the achievement of improved health of women in our communities. In future, we will add components that will be directed towards women of other age and developmental groups. A “pregnancy package” is already in the works, and will provide routine check-ups for pregnant women to prevent or treat any nutritional deficiencies, and pregnancy-specific conditions such as gestational diabetes and pre-eclampsia. The so-called “marriage package” will focus on providing micronutrient supplementation to women pre-conception. For example, good clinical practice recommends that folic acid supplementation be provided to women one month before pregnancy and during the first trimester to prevent congenital malformations. Evidence-based practice will be used to develop a nutritional package that will help in the birth of healthier children. Another intriguing idea is that of a school-based nutritional intervention for adolescent girls. Research supported by the Micronutrient Initiative analysed various studies of iron supplementation, and recommended that weekly iron supplementation of adolescents is as effective as daily supplementation, if strict supervision and high compliance can be assured (**Beaton and McCabe, 1999**). School teachers can likely be convinced to supervise the intake of weekly iron supplementation. Such school-based interventions are an effective way to engage with our communities, and a school-based dental/vision intervention is currently being developed. The lessons from this intervention can be used to design the school-based nutritional intervention for adolescent girls.

7. References

Beaton, GH and McCabe, GP (1999). Efficacy of intermittent iron supplementation in the control of iron deficiency anemia in developing countries – AN ANALYSIS OF EXPERIENCE. Final Report to the Micronutrient Initiative.

Johar (2010). ICTPH Health Systems Approach. <http://ictph.org.in/publications-concept-notes.htm> (Retrieved November 1st, 2011)

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8. Appendix 1 – Images from day of the launch



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Staff at the Karambayam RMHC prepare the instruments tray before launch of the intervention.



Wall-mounted cervical examination table designed by Sabyasachi Das.



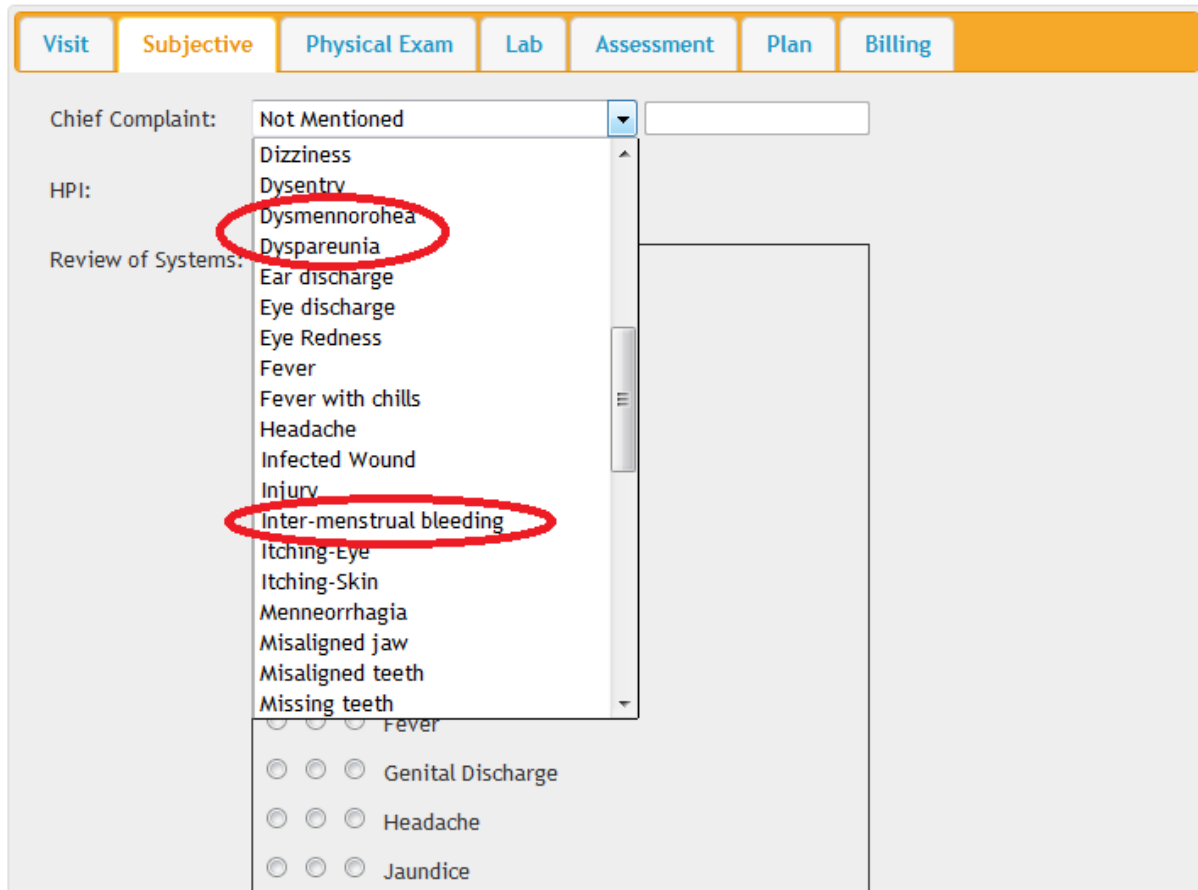
Cervical examination room with fully-equipped instruments tray and newly installed sink.



SughaVazhvu nursing officers look as community member signs informed consent form.

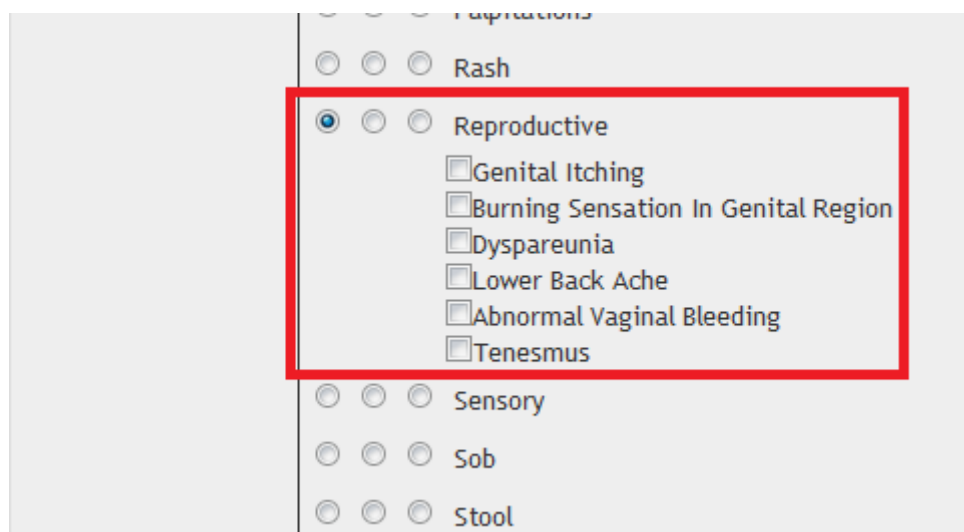
9. Appendix 2 – Screenshots of women’s health intervention specific changes made to the HMIS

Chief Complaints



Some chief complaints added for the women’ health examination are highlighted within the red ellipses.

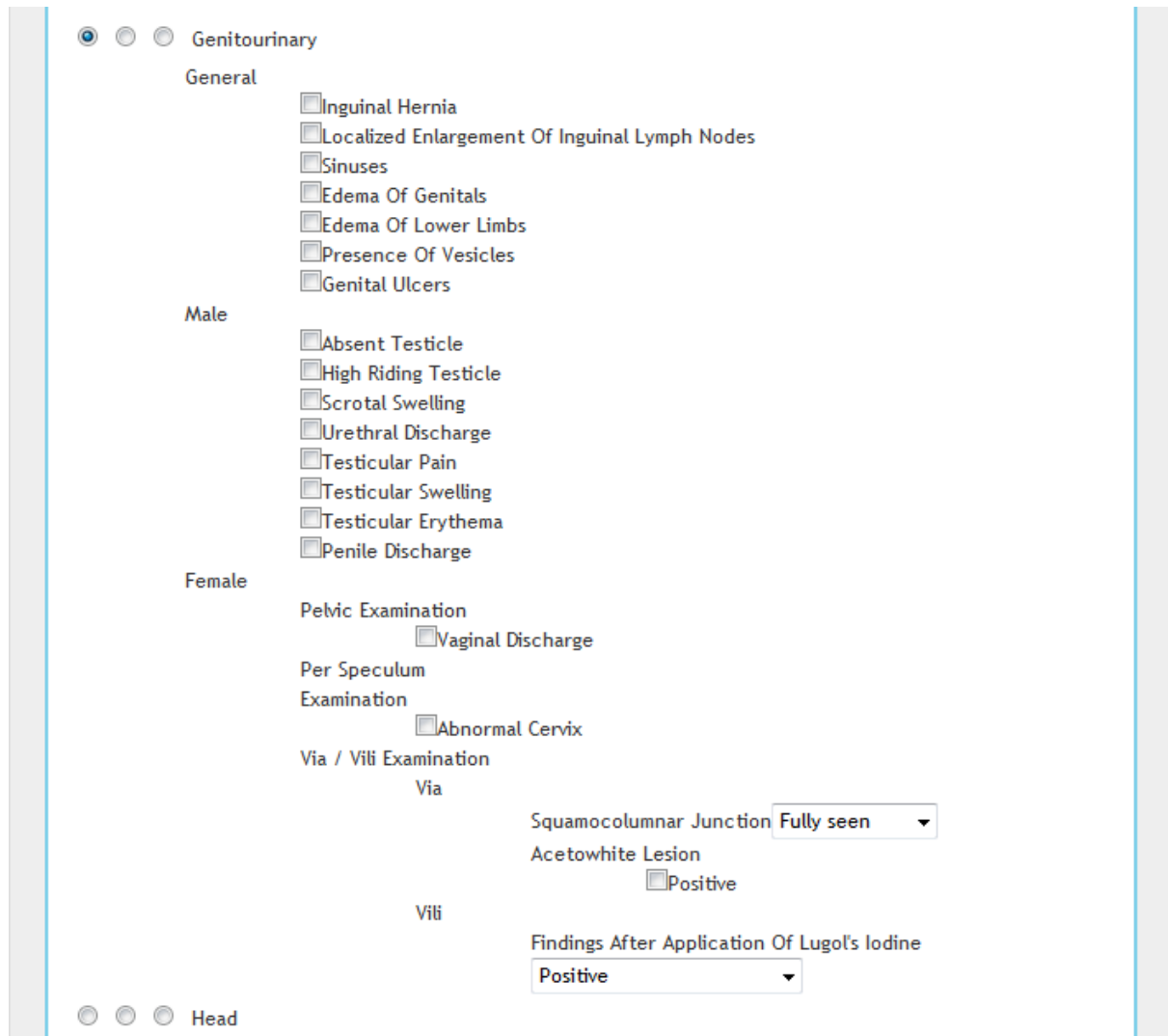
Review of Systems



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A new system titled “Reproductive” has been added to the Review of Systems, and symptoms specific to the women’s health intervention were added, as shown within the red box above.

Physical Examination



Genitourinary
 Head

General

- Inguinal Hernia
- Localized Enlargement Of Inguinal Lymph Nodes
- Sinuses
- Edema Of Genitals
- Edema Of Lower Limbs
- Presence Of Vesicles
- Genital Ulcers

Male

- Absent Testicle
- High Riding Testicle
- Scrotal Swelling
- Urethral Discharge
- Testicular Pain
- Testicular Swelling
- Testicular Erythema
- Penile Discharge

Female

Pelvic Examination

- Vaginal Discharge

Per Speculum Examination

- Abnormal Cervix

Via / Vili Examination

Via

- Squamocolumnar Junction
- Acetowhite Lesion Positive

Vili

- Findings After Application Of Lugol's Iodine

The Genitourinary (Gu) tree of the physical examination page has been updated. There are now three sections – general, male, and female.

General

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Genitourinary

General

Inguinal Hernia
 Localized Enlargement Of Inguinal Lymph Nodes
 Inflammation Of Skin Over Swelling
 Sinuses
 Single Multiple
 Edema Of Genitals
 Edema Of Lower Limbs
 Presence Of Vesicles
 Single Multiple
 Painful
 Genital Ulcers
 Single Multiple
 Painful

This section contains symptoms that are common to both males and females.

Female

Pelvic Examination

The colour of vaginal discharge, if present, is recorded here. Options provided are shown below.

Female

Pelvic Examination

Vaginal Discharge

Colour

Consistency

Odour

Per Speculum Examination

The consistency of vaginal discharge, if present, is also recorded. Options are shown in dropdown list below.

Female

Pelvic Examination

Vaginal Discharge

Colour

Consistency

Odour

Per Speculum Examination

Abnormal Cervix

Odour of vaginal discharge, if present, is also recorded. Options are in the dropdown list below.

Female

Pelvic Examination

Vaginal Discharge

Colour

Consistency

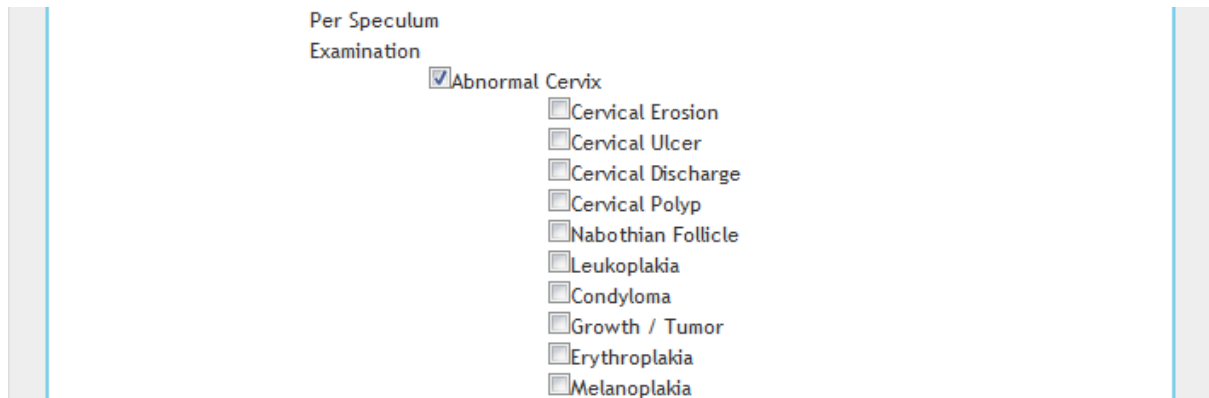
Odour

Per Speculum Examination

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Per Speculum Examination

If any abnormalities are detected during the speculum examination, prior to performing VIA/VILI, they are recorded as shown below. Multiple options can be chosen.



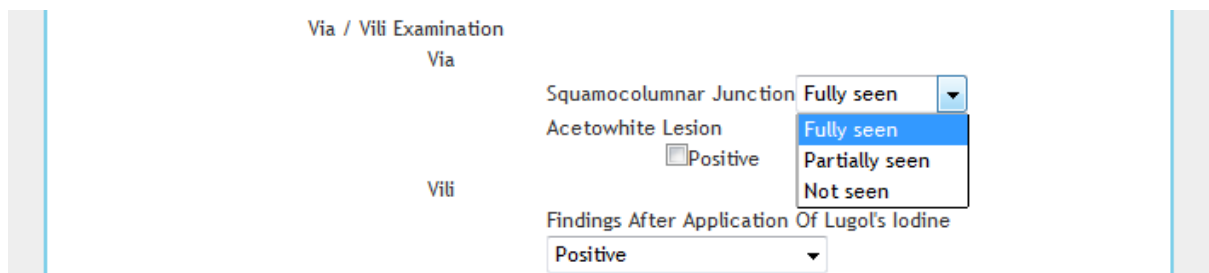
Per Speculum Examination

Abnormal Cervix

- Cervical Erosion
- Cervical Ulcer
- Cervical Discharge
- Cervical Polyp
- Nabothian Follicle
- Leukoplakia
- Condyloma
- Growth / Tumor
- Erythroplakia
- Melanoplakia

VIA/VILI Examination

Observations from the VIA and VILI examinations are recorded in this section. The first observation to be recorded is whether the squamocolumnar junction can be seen. Options are shown in the dropdown list below.



Via / Vili Examination

Via

Squamocolumnar Junction Fully seen

Acetowhite Lesion

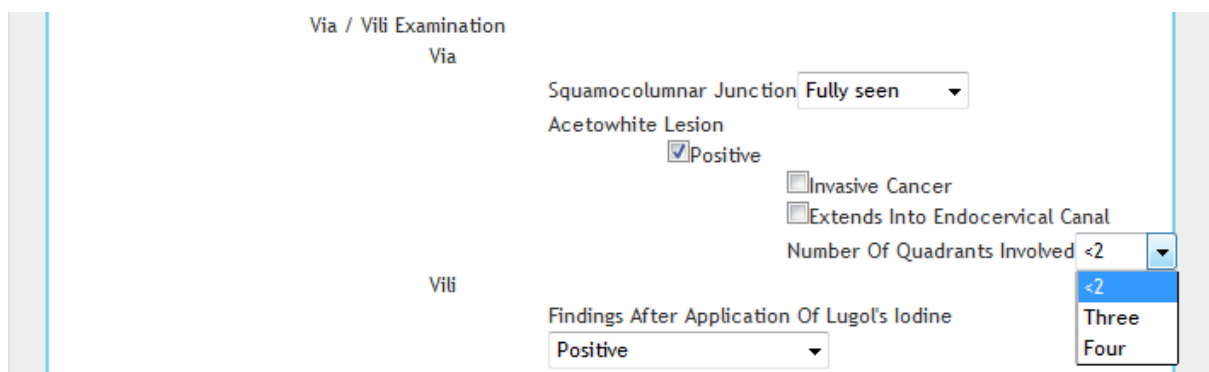
Positive

Vili

Findings After Application Of Lugol's Iodine

Positive

If acetowhite lesions are observed, the positive option is chosen. This leads to whether the lesions appear indicative of invasive cancer, and whether the lesion extends into the endocervical canal. The number of quadrants into which the lesion extends is also recorded.



Via / Vili Examination

Via

Squamocolumnar Junction Fully seen

Acetowhite Lesion

Positive

Invasive Cancer

Extends Into Endocervical Canal

Number Of Quadrants Involved <2

Vili

Findings After Application Of Lugol's Iodine

Positive

The results of the VILI examination are then recorded. Options for the results are shown in the dropdown list below.

Launch Report – Women’s Health Intervention

Female

Pelvic Examination
 Vaginal Discharge

Per Speculum Examination
 Abnormal Cervix

Via / Vili Examination
 Via
 Squamocolumnar Junction Fully seen ▾
 Acetowhite Lesion
 Positive

Vili
 Findings After Application Of Lugol's Iodine
 Positive ▾
 Positive
 Negative
 Positive - Invasive Cancer

Head
 Lymph Nodes
 Neck

Assessment

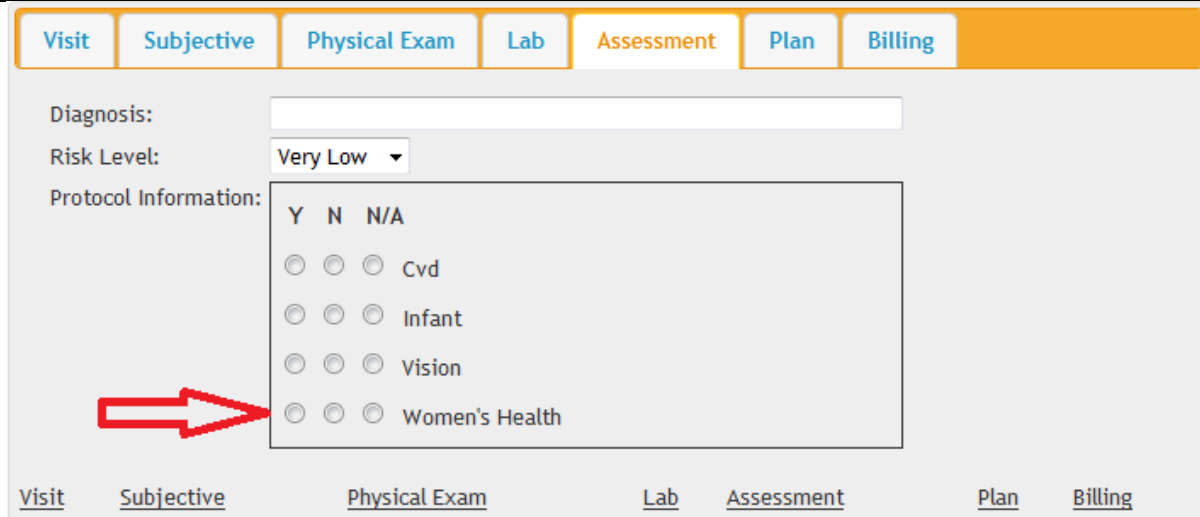
Diagnosis

Some of the diagnoses that have been added to the HMIS are shown in the dropdown list below. Additionally, as mentioned above in section 2.2, a list of RTIs has also been added to this list.

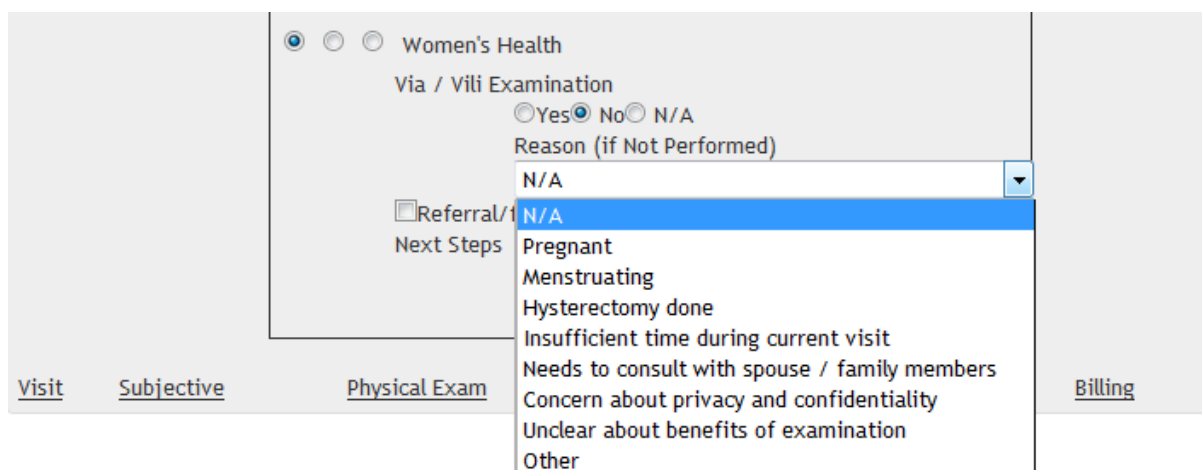
Visit	Subjective	Physical Exam	Lab	Assessment	Plan	Billing
Diagnosis:				cervicitis		
Risk Level:				cervicitis		
Protocol Information:				carcinoma (cervix)		
				cervical abnormalities		
				aphthous ulcer		
				spondylosis - cervical		
				invasive cervical cancer		

Women’s health has now been added to the list of interventions for which information will be collected, as indicated by the red arrow. All women who enter the RMHC will be offered the examination. The protocol information will have to be filled in irrespective of whether the examination is performed.

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The first piece of information to be recorded is whether the VIA/VILI examination was performed. If the examination was performed, further details such as diagnosis and referral must be recorded. If, however, a woman was offered the examination and she did not consent to it, the reason for refusal must be recorded. The reason can be chosen from the dropdown list shown below. It is important to capture this information as it will enable us to tailor our awareness campaigns to tackle specific issues that prevent women from accessing the women’s health intervention.



If the VIA/VILI examination has been performed, the next piece of information to be entered is whether the patient has been referred. Once the referral/follow-up box has been checked, more details must be entered on referrals and follow-ups. First, the diagnosis must be entered. If cervical abnormalities have been detected, and the patient has been referred, the referred box under cervical abnormalities must be checked. Based on the date set for follow-up, the treatment received by the patient must be learned and recorded. Treatment location must be entered as free text.

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Women's Health
 Via / Vili Examination
 Yes No N/A
 Reason (if Not Performed)
 N/A
 Referral/followup
 Diagnosis
 Cervical Abnormalities
 Referred
 Followup
 Invasive Cancer
 Referred
 Followup
 Treatment Received Colposcopy/Biopsy
 Treatment Location Colposcopy/Biopsy
 Stage N/A
 Treatment Location
 Next Steps
 Action Appointment for VIA/VILI
 Date (dd/mm/yyyy)

If invasive cancer has been detected, the same procedure must be followed. Additional information to be included during follow-up is the stage of cancer.

Invasive Cancer
 Referred
 Followup
 Stage N/A
 Treatment Location

The last details to be filled in the protocol information page are the next steps to be taken by the healthcare provider. The dropdown list below shows all actions that might be taken by the provider. The date on which the specified action will be taken must be manually entered by the provider based on the protocol.

Next Steps
 Action Appointment for VIA/VILI
 Date (dd/mm/yyyy) Appointment for VIA/VILI
 Rescreening
 Followup for RTI
 Referral Followup
 Subjective Physical Exam Plan Billing