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**Manual for Routine process flow at Sampoorna clinic**

This document is a guideline for smooth flow of operations at Sampoorna clinic on a daily basis. Full day operations have been categorized into three chapters.

1. **Readiness of clinic**
2. **Activities at station 1 and 2**
3. **Activities at station 3**

A. Readiness of clinic

Readiness of clinic is the first requirement for smooth flow of all activities in the clinic. The checklist mentioned below has to be followed by clinic attendant under the supervision of Screening assistant 2 (SA2).

**Check list for Readiness of clinic**

***Note:*** *Clinic attendant will be responsible for following the below mentioned checklist on a daily basis under supervision of SA2*

1. Opening of clinic
2. Cleaning - Cleaning has been categorized in three different categories. Cleaning will be done in the morning, in between two procedures and at the end of day before closing of clinic. Following are steps mentioned for cleaning procedure at different times.
3. Morning

**Steps:**

1. Clinic attendant opens the clinic at 7: 30 am in the morning
2. Switch on the lights
3. Check water supply
4. Prepare ten liter bleaching solution (Refer annex for preparing bleaching solution – to be developed)
5. Keep 6 liter of bleaching solution for station number 3 (for VIA procedure)
6. Use 4 liters of bleaching solution for Mopping
7. Discard the bleaching solution used for mopping into drain /toilet
8. Clean mop/duster and keep at its designated place
9. Interval cleaning and Instrument procedure

**Steps:**

* + - * 1. At Station 2: Empty the dustbin and place new polybag as per the need (This step to be followed as per the need / instructed by SA1 or SA2)
        2. At Station 3: Empty the dustbin and place new polybag as per the need (This step to be followed as per the need / instructed by SA1 or SA2)
        3. At Station 3: Remove used instruments and clean as needed (Refer annex instrument cleaning– to be developed- This Step to be followed after each client’s procedure)
        4. At Station 3: place clean instrument in boiler and boil for 20 minutes (Refer annex instrument cleaning– to be developed – This Step to be followed after each client’s procedure) (**Cloud 1)**
        5. At Station 3: Place boiled instruments in autoclaved/HLD drum/container (Refer annex instrument cleaning– to be developed – This Step to be followed after each client’s procedure)
        6. At Station 3: Clean the examination table with liquid bleach spray and clean with dry mop after every client (This Step to be followed after each client’s procedure)

**Cloud 1:** what if power is not available?

1. End of the day cleaning - manual

**Steps:**

1. At Station 2 : Empty the dustbin and place new polybag **(Cloud 2)**
2. At Station 3: Empty the dustbin and place new polybag **(Cloud 3)**
3. At Station 3: Remove used instruments from water tub and clean (Refer annex instrument cleaning– to be developed)
4. At Station 3: place clean instrument in boiler and boil for 20 minutes (Refer annex instrument cleaning– to be developed) **(Cloud 1)**
5. At Station 3: Place boiled instruments in autoclaved/HLD drum/container (Refer annex instrument cleaning– to be developed)
6. At Station 1: Empty the dustbin and place new polybag **(Cloud 3)**
7. At Station 3: discard used bleaching solution in toilet/ drain
8. Station 3: clean the bleaching solution tub
9. Place all the tablets and instruments in the cupboard and lock it
10. Switch of all the lights of clinic, close the clinic and lock it
11. Hand over the keys to the hospital administration department **(Cloud 4)**

**Cloud 1:** what if electricity is not available?

**Cloud 2:** color of polybag to be confirmed for infectious and non-infectious wastes

**Cloud 3:** where to dispose different color polybag of dustbins

**Cloud 4:** key person to be identified

1. Ensuring electricity
2. Ensuring proper water availability
3. Prepare infection prevention agent (Refer annex for preparing infection prevention agent - to be developed)
4. Check glucometer and stripes (Refer annex for checking glucometer-- to be developed)
5. Check BP machine, weighing machine, measuring tape, height scale.(Refer annex for Blood pressure measurement and annex for anthropometry measurement)
6. Prepare spirit soaked cotton swabs and keep in a closed container
7. Check Tablets, charger, printer
8. Ensure availability of client information sheet and client record (hard copy)
9. Check hemoglobin instrument ( Refer Annex for checking Hb instrument – to be developed and added in this document)
10. Check gloves, light source, acetic acid, measuring cylinder, sponge holder, Cusco’s speculum, Gas cylinder, Normal saline, cotton balls, dustbin with plastic bag, IP kit. (Refer annex for checking gloves, light source, acetic acid, measuring cylinder, sponge holder, Cusco’s speculum, Gas cylinder, Normal saline, cotton balls, dustbin with plastic bag, IP kit - to be developed and added in this document))
11. Ensure clean dustbin with poly bags
12. The clinic should have facility of drinking water and clean toilet

**FAQs:** To be developed

B. Activities at station 1 and 2

**Pre arrangements before starting activities at station 1 and 2:** SA2 ensures the readiness of clinic (referring protocol of readiness of clinic) at the start of the day at 7:30 am in the morning. Further makes arrangements for queue management. At 8 am, once the center is ready for the processes the following steps have to be followed.

**Steps:**

**Station 1:**

1. Client goes to station 1.SA1 takes the consent of client for procedures to be followed. Consent form – annexure not ready
2. SA1 fills Client information and medical history in tab based Client Record {Refer annexure Client Record (CR) - Detailed information as mentioned in the CR has to be filled}
3. SA1 measures Height in centimeters with the help of Stediometer (The annex for anthropometry measurement has to be followed)
4. SA1 Enters the readings of height in the tab based CR
5. SA1 measures weight in Kg on weighing machine(The Annexure for anthropometry measurement has to be followed)
6. SA1 Enters the readings of weight in the tab based CR
7. SA1 measures waist circumference in centimeters (The Annexure for anthropometry measurement has to be followed)
8. SA1 Enters the readings of waist circumference in the tab based CR
9. SA1 measures Blood pressure with the help of electronic blood pressure machine (The Annexure for Blood pressure measurement has to be followed)
10. SA1 Enters the measurement of Blood pressure (appearing in the electronic blood pressure machine) in the tab based CR

*After SA1 enters the measurement of BP in tab based CR, she asks the client to move to station 2 for further procedure.*

1. Client moves to station 2 (SA2)

**FAQs:** To be developed

**Station 2:**

1. At station 2, SA2 verbally confirms client’s Name, age (referring the tab) and If all procedures finished at station 1.

*By this time IDRS score of the particular client will pop out in the tab based CR*

1. SA2 refers the IDRS score of client in Tab based CR
2. NOW the SA2 will check IDRS score
   1. If IDRS is Negative (Low)
      1. Clean the tip of ring finger of left hand of the client with spirit swab and gloved hands (if not possible in left hand for any reason use right hand ring finger)
      2. Prick the cleaned finger with pre cleaned lancet
      3. Immediately take the blood sample on the strip for HB check from the pricked finger (The Annexure for Hb estimation has to be followed - to be added in this document)
      4. Record Hb reading in CR *(Note - clients whose IDRS score is low need not be screened for RBS)*
   2. If IDRS is positive (moderate/severe)
      1. Clean the tip of ring finger of left hand of the client with spirit swab and gloved hands (if not possible in left hand for any reason use right hand ring finger)
      2. Prick the cleaned finger with pre cleaned lancet
      3. Place a drop of blood on the glucometer strip (The annexure for measuring RBS thru glucometer has to be followed - to be added in this document))
      4. Place the strip into the glucometer and wait for the reading
      5. Immediately take the blood sample on the strip for Hb check from the same pricked finger (The Annexure for Hb estimation has to be followed - to be added in this document)
      6. Record glucometer reading in the CR
      7. Record HB reading in CR
3. SA 2 counsel/refer/follow up client as suggested on tab/ annex (Cloud 1) and Provide life style management leaflet. She shifts the client to station 3.
   1. **Counsel (catagories)**
      1. **Counsel for life style management (A7)**
      2. **Counsel for life style management + adherence to LSM (A8)**
      3. Counsel for protein rich and iron rich diet- (A9)
      4. **Pretest Counselling for VIA (A10)- all**
   2. **Referral- NCD Clinic for treatment and management of complicated case**
   3. **Follow up (Catagories)**
      1. **24 hour**
      2. **3 months**
      3. **6 months**
      4. **1 year**

**Cloud 1:** Should we dispense iron tablets at station 2 or station 3?

**FAQs:** To be developed

C. Activities at station 3

Pre arrangements for the readiness of clinic before the client enters in the station 3 have to be ensured by LMO.

**Station 3:**

1. LMO confirms the client’s identity and detail as forwarded by SA2 in the tab based CR and ensures preparation for Screening and treatment procedure.
2. LMO Ask the client if she understands importance of Ca cervix screening by simple test VIA and if she has any query then answer it. Further, counsels as per the client’s need (The annex for counseling before going to statin 3 has to be referred)
3. LMO ensures that Clinic attendant has done all preparation for screening, all the IP supplies, freshly prepared 5 % acetic acid and instruments are in place
4. Clinic attendant prepares the client for screening (helping client in lying down on the couch, positions the client, exposes the part, ensures the privacy and confidentiality of Client)
5. LMO performs VIA (The annex for VIA screening procedure has to be referred)
6. LMO records the VIA result and other findings in tab based CR
7. If test is Negative (The annex for criteria for positivity of VIA + Atlas has to be referred)
   1. LMO Counsels the client for follow up for VIA after 5 years. Also advices for other referral/Follow up conditions identified at station 2, referring the management protocols suggested by the tab.
8. If test is Positive (The annex for criteria for positivity of VIA + Atlas has to be referred)
   1. LMO Checks if client is eligible for Cryotherapy (The annex for criteria for eligibility of cryotherapy has to be referred)
      1. If Yes,
         1. LMO Performs cryotherapy(The annex for process of cryotherapy has to be referred)
         2. LMO records “cryotherapy performed” in tab based CR
         3. Counsel for Dos and Don’ts just after cryotherapy procedure (The annex for process of cryotherapy has to be referred). Also counsels for follow up after 2 weeks, any time in case of emergency and after one year (The protocol for follow up has to be referred – to be developed and added in this document). At the same time also counsel for other referral/Follow up conditions identified at station 2, referring the management protocols suggested by the tab.
      2. If No,
         1. Refer to referral center and record in tab based CR. Also refer for other referral/Follow up conditions identified at station 2 referring the management protocols suggested by the tab. Further the client has to be tracked through helpline for treatment adherence.
9. Hand over the printed Sampoorna card to the client

**Cloud 1:** What all information would be there in the Sampoorna card

**FAQs:**

1. What if the women cannot be screened (cervix not visible, client refuses)
2. In some cases if the client doesn’t agree to undergo Cryo, LMO should counsel the client and still if she doesn’t agree then record non-performance of Cryo in the CR and reason for it.
3. To be developed further

Annexure:1 Client record

DATE of Regn: \_\_\_\_\_\_\_\_\_\_\_

**A. General Info:**

1. Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

√

X

Y

Y

M

M

Y

D

D

Y

2. Age(yr) OR Date of Birth Sex M F

3. Full Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Pin Code

4. Primary Phone No. Secondary Phone

5. Occupation \_\_\_\_\_\_\_\_\_\_\_\_

1. How physically demanding is your work ? heavy moderate mild sedentary

6. Education

I Primary Education Up to 10 years of formal education and/or informal skills.

II Secondary Education 11-13 years of formal education.

III First University Degree 14-15 years of formal education.

IV Post-Graduate University Degree More than 15 years of formal education

7. Marital Status Y\_\_\_N\_\_\_\_\_\_Years of marriage\_ Children M F

8. Religious background \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**B. Assess for referral need**

1. Medical history
2. Known history of diabetes  Yes  No
3. Any form of heart related disorder.  Yes  No
4. Chest discomfort with exertion.  Yes  No
5. Breathlessness at rest  Yes  No
6. Dizziness, fainting, or blackouts  Yes  No
7. Heart / BP medications  Yes  No
8. Asthma or other lung disease  Yes  No
9. Burning sensation in your lower legs when walking short distances  Yes  No
10. Musculoskeletal problems that limit your physical activity.  Yes  No
11. Currently pregnant.  Yes  No

**Refer to a physician if marked yes to any of the above**

(Adopted from AHA/ACSM recommendation for Risk Stratification )

II. **Cardiovascular risk stratification**

1. FAMILY HISTORY (DM/ HT/Heart Disease/ Heart surgery/Stroke/)

In case of death of the family member below, ask the age at death and record.

|  |  |
| --- | --- |
| Mother Y N Don’t Know  Age at death (if yes) \_\_\_\_\_\_\_ | Father Y N Don’t Know  Age at death (if yes) \_\_\_\_\_\_\_ |
| Brother Y N Don’t Know  Age at death (if yes) \_\_\_\_\_\_\_ | Sister Y N Don’t Know  Age at death (if yes) \_\_\_\_\_\_\_ |

1. MENSTRUAL HISTORY
2. Menopause :  Yes  No

If Yes, when?

1. If no ,

Days of menstruation/Days of cycle:

Regularity:

Flow:

Association with pain:  Yes  No

1. OBSTETRIC HISTORY
2. Parity
3. Hysterectomy  Yes  No
4. PERSONAL HISTORY
5. Do you currently use tobacco?  Yes  No
6. Have you smoked in last six months  Yes  No
7. Do you exercise regularly?  Yes  No

**DECISION TO REFER.**

**Record Anthropometry, B.P. and Blood sugar. Consider the following risk factors.**

1. Woman older than 55 years, have had a hysterectomy, or are postmenopausal  Yes  No
2. Currently smokes, or quit smoking within the previous 6 months.  Yes  No
3. Blood pressure >140190 mm Hg or taking blood pressure medication.  Yes  No
4. Has a close blood relative who had a heart attack or heart surgery before age 55 (father or brother) or age 65 (mother or sister).  Yes  No
5. Physically inactive (i.e., <30 minutes of physical activity on at least 3 days per week). Yes  No
6. BMI > 25 Kg/m2  Yes  No
7. Random blood sugar > 200 mg/dl or diagnosed Diabetic on follow up  Yes  No

**If two or more of the statements above are marked yes, then refer to Physician for further evaluation** (Adopted from AHA/ACSM recommendation for Risk Stratification )**Indian Diabetes Risk Score (MDRF)**

Ask yourself these four questions to calculate your IDRS score (see next slide)

1. What is your age?

2. Do you have a family history of diabetes? If yes, does your father or mother or both have diabetes?

3. Do you exercise regularly?

4. How physically demanding is your work [occupation]?

**Scoring table**

|  |  |
| --- | --- |
| **Particulars** | **Score** |
| **Age [years]** | |
| **< 35 [reference]** | **0** |
| **35 – 49** | **20** |
| **≥ 50** | **30** |
| **Abdominal obesity** | |
| **Waist <80 cm [female], <90 [male] [reference]** | **0** |
| **Waist ≥ 80 – 89 cm [female], ≥ 90 – 99 cm [male]** | **10** |
| **Waist ≥90 cm [female], ≥ 100 cm [male]** | **20** |
| **Physical activity** | |
| **Exercise [regular] + strenuous work [reference]** | **0** |
| **Exercise [regular] or strenuous work** | **20** |
| **No exercise and sedentary work** | **30** |
| **Family history** | |
| **No family history [reference]** | **0** |
| **Either parent** | **10** |
| **Both parents** | **20** |
| **Minimum score** | **0** |
| **Maximum score** | **100** |

**How to interpret**

**Add the scores and then check the following:**

**>60=Very high risk. Requires a glucose test**

**30-50=Moderate Risk. Further test recommended**

**<30= Low Risk**

Annexure 2: Anthropometry measurement techniques

(Adopted from WHO. Physical status: the use and interpretation of anthropometry. Report of a WHO Expert Committee. WHO Technical Report Series 854. Geneva: World Health Organization, 1995.)

1. Measurement of height
   1. Equipment required:
      1. A vertical board with an attached metric rule
      2. A horizontal headboard that can be brought into contact with the uppermost point on the road.
      3. A flat surface at the bottom of the vertical board for the client to stand
   2. Method:
      1. Request the client remove her slippers/shoes. If not barefoot, she can be on thin socks
      2. Ask the client to stand on the flat surface facing the front so that her back faces the metric rule of the vertical board.
      3. Make sure that the client’s weight is distributed evenly on both feet, heels together and the head positioned so that the line of vision is perpendicular to the body.
      4. Observe the client from the side. Her arms should be hanging freely by her sides and the head, back, buttocks and heels should be in contact with the vertical board.
         * If a client is unable to stand straight in the above position, then position her vertically so that the buttocks and the heels or the head are in contact with the vertical board.
         * If the client is unable to stand at all, then discard this measurement procedure.
      5. Ask the client to inhale deeply and maintain a fully erect position.
      6. Bring the moveable headboard onto the topmost point on the head of the client with sufficient pressure only enough to compress the hair.
      7. Record the height on the metric ruler to the nearest 0.1 cm.
2. Measurement of wright
   1. Equipment required
      1. A standard weighing scale, preferably a digital one.
      2. A flat surface.
         * The height scale can be so placed that the client can stand on the weighing scale while height is being measured and the metric scale can be accordingly placed on the vertical board.
   2. Method:
      1. Ask the client to remove shoes/slippers and sweaters, if any.
         * It is ideal to have the client wear comfortable indoor clothes, however may not be possible in a clinical setting.
      2. Ask the client to stand on the scale. Make sure that the body weight is evenly distributed between both feet.
      3. Record the reading on the scale to the nearest 100 gm
3. Measurement of waist circumference:
   1. Equipment: a measuring tape.
   2. Method
      1. Ask the client to stand comfortably, with feet appx. One foot apart
      2. Locate and palpate the lower margin of the last rib on either side of the client’s body.
      3. Locate and palpate the iliac crest on either side.
      4. Locate the midpoint between the above two landmarks on either side and mark with a pen.
      5. Place the measuring tape around the abdomen of the client across the two marks on both sides. Fit the tape snugly but not so tightly as to compress underlying soft tissues.

Measure the waist circumference to the nearest 0.1cm. at the end of normal expiration

Annexure 3: Measurement of Blood pressure

Equipment required:

1. Validated Electronic B.P. measuring instrument
2. Alternatively, mercury sphygmomanometer

Method:

1. Prepare the B.P. instrument by fitting the rubber tube connecting the cuff into the slot in the instrument
2. Ask the client be seated comfortably least 5 minutes in a chair with feet on the floor, and arm supported at heart level, preferably placed on a table/desk..
3. Ensure that the client had had no exercise, tea/coffee or smoking for at least 30 minutes prior to measurement.
4. Use an appropriately sized cuff (cuff bladder encircling at least 80 percent of the arm)
5. Press the start button on the instrument and then wait for the cuff to inflate and deflate on its own until the readings appear on the screen of the instrument.
6. Record the readings.
7. Repeat the procedure and then record the second reading.

The tablet PC should give you the average of the two readings on its own. Use this reading for decision making.

**Annexure 4: Hb estimation – (to be added in this document)**

**Annexure: 5 measurement of RBS through glucometer – (to be added in this document**

Annexure 6: Counselling before going to station 3

* SA2 makes the client feel comfortable
* Smile and use positive tone of voice
* Makes eye to eye contact
* Assesses body language and makes the client comfortable to share the information
* SA2 ensures she listens to the client actively
* Explain why the test is recommended -
* *Shows the picture/tool of Cervix & tells that a large no of women die because of cancer cervix which is a slowly progressive disease and has a long pre disease phase which can be detected by a simple screening test and the result of the test is immediately available*
* *It is painless procedure*
* *Treatment is immediately available, effective, safe and acceptable.*
* Explain how it is done

-The doctor will apply acetic acid for one minute on cervix and if there is whitening of cervix then client needs to be treated by Cryotherapy (freezing of affected tissue) in the same sitting. If the test is negative she needs to get rescreened after five years

* Questions answered and client concerns addressed by SA2
* Use simple language and be non-judgemental

Annexure 7: VIA Screening Procedure

**Screening**

* Wash hands thoroughly and dry them, Palpate the abdomen
* Put one pair of new examination or high-level-disinfected surgical gloves on both hands
* Arrange instruments and supplies on high-level disinfected tray or container
* Inspect external genitalia and check urethral opening for any discharge and Skene’s and Bartholin’s glands
* Insert speculum and adjust it so that the entire cervix can be seen.
* Fix the speculum blades in the open position so that the speculum will remain in place with the cervix in view.
* Examine the cervix for cervicitis, ectropion, tumors, Nabothean cysts or ulcers
* Identify the cervical os, squamocolumnar junction (SCJ) and transformation zone.
* Soak a clean swab in 5% acetic acid and apply it to the cervix. Dispose off the swab in a leak proof container or plastic bag
* Wait for 1 minute, and observe the cervix for acetowhite changes.
* Inspect the SCJ carefully.
* Check whether cervix bleeds easily.
* Look for any raised and thickened white plaques or acetowhite epithelium
* When visual inspection has been completed, use a fresh swab to remove any remaining acetic acid from the cervix and vagina
* Remove the speculum.
* Place speculum in 0.5% chlorine solution for 10 minutes for decontamination

**Post VIA Task**

* Wipe light source with 0.5% chlorine solution or alcohol.
* Immerse both gloved hands in 0.5% chlorine solution. Remove gloves by turning inside out.
* If disposing the gloves, place them in leak proof container or plastic bag. Gloves must be disposed off if rectovaginal examination performed.
* If reusing surgical gloves, submerge in 0.5% chlorine solution for 10 minutes for decontamination.
* Wash hands thoroughly with soap and water or use hand sanitizer and dry with clean, dry cloth or air dry
* If VIA test is negative, ask woman to sit up, get down from the examining table and get dressed
* Record the VIA test results and other findings in Sampoorna card.
* Discuss the results of the VIA test and pelvic examination with the woman and answer any questions.
* *If VIA test is negative, tell her when to return for repeat VIA testing after 5 years and hand over Sampoorna card.*
* *If VIA test is positive or cancer is suspected, discuss recommended next steps.*

*After counseling provide Cryotherapy treatment.*

Annexure 8: Criteria for VIA Positivity **( Refer Atlas for pictorial presentation)**

**A VIA test is positive-**

* if there are raised thickened white plaques adjacent to SCJ
* distinct acetowhite epithelium adjacent to SCJ .

**A VIA test is negative-**

* if the cervical lining is smooth,
* uniform,
* pink with acetic acid
* Featureless.

**A test is suspicious for cancer-**

* if a cauliflower-like fungating mass /ulcer is noted on the cervix

**Annexure: 9 Eligibility for Cryotherapy**

**VIA positive client with lesions -**

1. Occupying less than 70% of cervix
2. Not extending into cervical canal
3. Can be completely covered by cryo probe

Annexure 10: Process of Cryotherapy

**Pre Cryotherapy Counselling**

* Explain why the treatment is recommended and describe the procedure
* Tell her about the side effects# to expect
* Re-ensure woman’s consent for treatment.

**Getting Ready**

* Check that instruments, supplies and light source are available and ready to use.
* Check that cryotherapy instrument and gas (CO2,N2O) are ready to use.
* Tell the woman what is going to be done and encourage her to ask questions.
* Check that woman recently (30 minutes) has emptied her bladder, help her onto examination table and drape her.
* Wash hands thoroughly and dry them.
* Put one pair of new examination or high-level disinfected surgical gloves on both hands.
* Arrange instruments and supplies on high-level disinfected tray or container.

**Cryotherapy procedure**

* Insert speculum and fix blades so that entire cervix can be seen clearly.
* Fix the speculum blades in the open position so that the speculum will remain in place with the cervix in view.
* Move the light source so that you can see the cervix clearly.
* Use a clean cotton swab to remove any discharge, blood or mucus from the cervix (if required). Dispose of swab in a leak proof container or plastic bag.
* Identify the cervical os, SCJ and site and size of the lesion. (If necessary, apply 5% acetic acid with a clean swab again so that lesion can be seen. Dispose off swab.)
* Screw cryo tip with sleeve onto end of probe.
* Apply the cryotip to the cervix ensuring that the nipple is placed onto the os. Check to be sure the cryotip is not touching the vaginal walls.
* If the lesion extends more than 2 mm beyond the probe, discontinue the procedure and counsel/ refer appropriately.
* Set timer for 3 minutes. Press freeze button. Apply pressure to the cervix as the gas begins to flow to the cryoprobe. Watch as the ice ball develops.
* Thaw for 5 minutes.
* Use 2 cycles of ‘freeze-thaw-freeze’ technique.
* Wait for the cryotip to detach from the cervix. Remove cryoprobe from vagina and places it on a clean instrument tray
* Inspect the cervix carefully to ensure that a hard, white completely frozen ice ball is present.
* Close master cylinder valve.
* Inspect cervix for bleeding. If there is bleeding, apply pressure to area using a clean cotton swab. Do not pack the vagina.
* Dispose of swab in a leak proof container or plastic bag.
* Remove the speculum and place it in 0.5% chlorine solution for 10 minutes for decontamination

**Post Cryotherapy Task**

* Wipe light source with 0.5% chlorine solution or alcohol.
* Immerse both gloved hands in 0.5% chlorine solution. Remove gloves by turning inside out.
* Wash hands thoroughly with soap and water and dries with clean, dry cloth or air dry.
* Check that the woman is not having excessive cramping before she sits up, gets off the table and gets dressed.
* Advise the woman about post-treatment care, common side effects#, warning signs\*, post Cryotherapy care^ and follow-up instructions.
* Record the results of treatment and follow-up schedule in client case record form and follow up/ report card.
* Observe the woman for at least 15 minutes. Asks her how she feels before sending her home.
* *Counsel for follow-up after 2 weeks, address client’s concern & query if any and give Sampoorna card*.

**Cryotherapy Instrument processing**

* Clean and disinfect the cryoprobe and decontaminate the cryogun, tubing, pressure gauge and gas tank.
* Decontaminate the cryotherapy unit, hose and regulator by wiping them with alcohol.
* Wash the cryotip and the plastic sleeve with soap and water until visibly clean.
* Rinse the cryotip and plastic sleeve thoroughly with clean water.
* High-level disinfect the cryotip and plastic sleeve by one of the following methods:
  + - boil in water for 20 minutes; or
    - steam for 20 minutes; or
    - soak in chemical disinfectant (0.1% chlorine solution or 2% glutaraldehyde) for 20 minutes and then rinse with boiled water.
* It is critical that the hollow part of the cryotip is completely dry when next used, otherwise the water will freeze and the probe could crack or the treatment will not work.
* Either use a rubber cap to seal off the hollow part of the cryoprobe during processing, or thoroughly dry the cryoprobe before it is reused.

***^Post cryotherapy care***

* *To abstain sex for 4 weeks or use condom*
* *To avoid putting anything into vagina (such as douching , using tampons )*

***#Common side effects of cryotherapy***

* *Cramping*
* *Profuse vaginal discharge (2-4 weeks)*
* *Spotting/light bleeding (1-2 weeks)*

***\*Warning signs-***

* + - *fever with temperature higher than 100 F or shaking chills*
    - *severe lower abdominal pain*
    - *foul-smelling or pus-like discharge*

*bleeding for more than two days or bleeding with clots.*