

HRSA Office of Women's Health

January 20, 2022

10:00-11:00 AM EST

The Current State of Cervical Health Domestically and Internationally - An Opportunity for Knowledge Exchange and Bidirectional Learning

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>> Good morning, thank you so much for being here.

Nancy, I will pass it over to you. The floor is yours.

>> Thank you, Jane. Thank you everyone. Thank you very much for joining us for today's HRSA Office of Women's health leadership series on domestic and international cervical cancer response and safety network settings of care

I'm Nancy Mautone-Smith, and I'm the Director of the HRSA Office of Women's Health.

Today is a collaboration between the office of women's health, HRSA office of global health and the NIH national cancer institute.

The United States Congress designated January as cervical cancer awareness month. While there's been significant progress and many advances in prevention and treatment over the past 40 years, cervical cancer remains the fourth most common cancer among women in the United States.

We also know that cervical cancer screenings declined nationally throughout the COVID 19 pandemic, underscoring the importance of prioritizing cervical health now more than ever.

I'm pleased for today's event, which will include perspectives from federal efforts within domestic and global health programs. This type of collaboration embodies the spirit of our women's health leadership series.

Throughout 2022, we will aim to continue to bring you collaborative content designed to advantageous public health approaches to improve women's health outcomes. Now I would like to turn it over to Miss Jane Segebrecht who leads the cervical cancer collaborative. Thank you and over to you, Jane.

>> Wonderful, thank you so much, Nancy.

We are really looking forward to today's event and greetings everyone. Today you'll hear from the office of women's health about our partnership to promote cervical cancer control and prevention in settings of care then the national Institutes of Health national cancer Institute healthcare delivery program. We'll share updates on the landscape analysis research, and then we'll move to perspectives with Jhpiego with the growing inequities cervical cancer WHO acceleration plans and Jhpiego cervical cancer prevention in Nambia, and office the global officer of health for summarize and reflections. Please ask questions for today's prevention and today's event will be recorded and made available on our website.

First, about our agency, as you get to know us, please help us to get to know you too. You can add to the chat your name, your organization and where you are joining us from. As you know we have an international audience for today's event.

So HRSA is an operating division within the U.S. Department of Health of Human Services, and we support more than 90 programs to provide healthcare who are geographically isolated, economically or medically challenged and our programs serve tens of millions of people including people with HIV AIDS, pregnant women, mothers and their families, and those, otherwise, unable to access to healthcare.

The Office of Women's healthcare provides leadership on women's health and sex and gender specific issues and to promote the health, wellness and safety of women, and we do that by providing subject matter expertise and technical expertise to HRSA's administrator on health issues impacting women.

We lead cross agency collaborations and consult with investments in women's health.

Cervical cancer is a sentinel malignancy of health disparities. Women with access to accurate screening which can identify and remove precancerous lesions rarely develop the cancer and even less frequently die from it.

And women with fewer resources you and limited healthcare access are less frequently vaccinated, screened and treated particularly at the precancerous stage, and we know that cervical cancer does not discriminate so cervical health warranties sensitive prevention screening and treatment for all patients at risk for cervical cancer.

So cervical carcinogenesis provides a flow HPV persistence and progression to precancer, and then cervical cancer. In addition to cervical cancer HPV is a risk factor for 5 additional cancers, and public health prevention through HPV vaccination is one of the best tools in our arsenal to prevent several cancer causing types of HPV especially HPV type 16.

However, control efforts based on vaccination solely vaccination alone of adolescents are estimated to take another 40 plus years so screening and management advantages are of critical import to public health and women's health.

In response, HRSA office of women's health are working on efforts to advance clinical management guidelines such as the risk based guidelines released by ASCCP.

In response to this identified public health need, HRSA and our HHS people the NIH, HHS OASH office of population affairs and CDC division of cancer prevention and control are cosponsoring the federal cervical cancer collaborative.

And you may be familiar with the accelerate cervical cancer control project as part of the NIH NCI moonshot. It aims to accelerate research to make more therapies available to more patients while providing the ability to prevent cancer and detect it at an early stage, and our collaborative bridges the federal priorities of cancer research at NCI and healthcare delivery and what we're doing in HRSA's settings to implement and realize the outcomes of the cancer moonshot in safety net settings.

And the collaborative is first our first activity together as a group is hosting a roundtable series, and this will focus on bidirectional sharing of provider experiences, guidelines, technical assistance needs and opportunities to advance evidenced based innovations such as self collections in safety nets of care, and we will host three round tables this year. We are starting first with an event on opportunities and territories including Guam and the U.S. affiliated Pacific islands.

Then Puerto Rico, and then the U.S. Virgin Islands.

And then next we will have a roundtable to engage perspectives from the stakeholder community and the third, a roundtable to strengthen federal coordination, and this series will inform a provider toolkit so providers and safety net of care of the outcomes moon and help the communities they serve.

It is now my pleasure to introduce Veronica Chollette from the national cancer institute, and she's a program health systems and interventions research branch and the naming the for NIH, and they fund social and behavioral directives at multiple contextual levels. Factors associating with disparities in

prostate cancer, PSA and the downstream consequences following streaming and leads to interprofessional teamwork in healthcare delivery. She's a co-lead of the healthcare teams initiative which address strategies to improve patient outcomes through the delivery of healthcare grounded in principles of the evidenced based team research.

Veronica, I will now pass it on to you. Thank you so much.

>> Thank you simply, Jane, for the introduction and thank you to the planning committee for giving me the opportunity to share one of the activities the NIH health kit program is doing in the resource based in the cervical cancer collaborative that Jane so eloquently provided in her remarks.

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Next slide, thank you.

A high priority of the federal partnership is to ensure that efforts of current research approaches to prevention, screening and treatment of abnormal cancer screenings tests and cancer precursors particularly as it relates to safety nets settings of care and to accomplish that interest, one of our early activities was to conduct a cervical landscape analysis, and we wanted the landscape analysis for the effective cervical cancer screening and to inform of the content of the roundtable series and toolkit of providers of safety net settings of care as Jane mentioned as one of the products of the safety net collaboratives.

What we learned significantly will strengthen our ability to accelerate cervical cancer control prevention and safety net settings of care.

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The for the sake of time this slide shows our three overarching questions what are the current range of approaches she's to manage an abnormal cervical cancer test and other evidence of cancer precursors? What is the readiness of HRSA's supported settings and other safety net settings of care to successfully implement recent cervical cancer guidelines and what are the multiple level factors and barriers to adapting new screening guidelines in safety net settings of care?

Going beyond the traditional approach a literature review our efforts went a step further included a on screening interventions in the low resource settings, outcome reviews of CDC cervical cancer programs, and we also reviewed resources to support evidenced based strategies and our one on one conversation withes HHS and grantees to conduct cancer screen research to acknowledge gaps of current approaches to enhance effectiveness of screening in underserved populations.

Our data sources included the NCI branch portfolio and our etched based cancer program cervical cancer screening database and our programs preventive services task force community guides, a report on cancer screenings in low resource settings and bring the cervical cancer early detection surveys.

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So for the near term, we have completed the landscape analysis. It is currently under review. By NCI, and it will be reviewed by the cervical cancer collaborative team and posted on the NCI and HRSA websites this month. We plan to publish a commentary on our approach, methods and findings. And in the future we hope to consider the findings of the landscape analysis in the context of other cancer screen guessed behaviors such as breast and colorectal cancer.

We also plan to stimulate research on the interplay of adopting new screening guidelines and the implementation of practices that are outdated or that provide low value or that are simply ineffective.

I thank you again for the opportunity to share our approach to understanding the landscape of cervical cancer screening in low resource setting.

Next Dr. Aday Adetosoye the director of HRSA's Office of Global health will provide a brief overview of the office of global health and how it works as an implementing agency of the president's emergency plan for aid relief and for partnerships of eradication of cervical cancer for people living with HIV.

Doctor, over to you now.

>> Thank you so much, Ms. Chollette. I really appreciate those remarks that you provided about the great work NCI is doing, so greetings, everyone.

I am Dr. Aday Adetosoye, with HRSA's Office of Global health.

It is a great pleasure to partnership with NCI and the HRSA's global partnerships to really understand recent innovations in cervical health.

Diverse partnerships working together to achieve HIV epidemic control and improve the future of women is a cornerstone of the president's emergency plan for aids relief, otherwise, known as PEPFAR. PEPFAR is one of the longest and proudest agencies, and we'll discuss the worldwide problem of cervical cancer with you today. Alongside our funded partnership Jhpiego.

Next slide, please.

The office of global health exists as one of the offices in the office of special health initiatives at HRSA. Our vision is to improve the health of Americans through global action, and our mission and goals align with this vision through supporting HRSA's contributions to U.S. diplomacy and global health priorities. Elevating U.S. representation, policy and technical engagement with multilateral organizations, contributing HRSA program expertise and strategic dialog with other countries, advancing health and mitigating disease threats in the U.S. Mexico border region, advancing women's health domestically and abroad with a focus on addressing maternal mortality and cervical cancer, enhancing global dialog in telehealth to improve and expand access to care and leveraging HRSA's success as domestically to improve health outcomes globally.

I'll now hand over to Commander Patel Larson who will give some brief remarks about the PEPFAR program. Over to you.

(Inaudible.)

>> My apologies. My other mic was not working. I think you can hear me?

>> We can hear you.

>> I can hear myself twice.

So, yes, greetings to everyone. Thank you, Aday.

My name is Dr. Larson and so the PEPFAR program does develop the guidance to frame the presentation and shared annually through its country and regional operations plans called COP/ROP. These include how the countries will continue to enhance, and we sustain services for the benefit for HIV epidemic control especially for priority populations such as adolescent girls and young women.

And cervical cancer is the No. 1 cause of cancer mortality for women in African countries served by PEPFAR and HIV infection magnifies that risk 6-fold.

Ending HIV ending AIDS and cervical cancer is a prominent part of the current 2022 guidance for PEPFAR implementation. We anticipate this continuing for improving services among women and educating men about the importance of screening and being supportive for their female partners.

COP/ROP it's screening is in the screenings in the go further partnership, and that's selected based on high HIV prevalence among women in the 15 to 49 year old age group and all using COP/ROP funding, and all countries using these PEPFAR resources for cervical cancer prevention services are expected to adhere to that 2022 specific guidelines and report on the indicators developed.

Next slide.

So the go further campaign is a public/private partnership which aims to reduce new cervical cancer cases by 95% among the estimated 7.1 million women who are living with HIV, and these exist in the 12 country African countries which has some of the highest HIV prevalence and cervical cancer in the world. They will integrate and treatment services for all women living with HIV. From that 15 to 49 age group mentioned, and that is with the national guidelines as well in those countries in an effort to support mothers, sisters and brothers and sisters who suffer from cervical cancer diagnoses every day.

And those 12 countries, African countries highlighted oh, on that slide is is Botswana, Eswatini, Ethiopia, Malawi, Namibia, Zambia and Zimbabwe and others.

HRSA OGH PEPFAR next slide, my apologies.

HRSA OGH PEPFAR remains steadfast on its commitment to fight cervical cancer elimination so now we'd like to introduce our two esteemed speakers.

First Dr. Veronica Reis is a technical adviser with HW21 who's an OB/GYN of more than 20 years of experience in cervical cancer.

And our next speaker is Dr. Cornelia Osim Ndifon, a practitioner and health expert who also joins us in Jhpiego, Namibia with more than 19 years' experience of healthcare plan implementation in HIV care and Freemont prevention of motherhood childhood transmission, tuberculosis, cancer and now cervical cancer prevention.

So they're going to discuss cervical cancer with women living with HIV and World Health Organization updates and barriers to program models that may promote scaling up cervical cancer prevention and closing those treatment gaps.

And, of course, that further knowledge building the bidirectional learning that we're excited to be presenting today, thank you.

>> Hi, good morning, good afternoon, everyone.

It's my pleasure today to present Jhpiego supporting for the global effort to advancing cervical cancer prevention. Thank you very much for these opportunities.

Next slide, please.

So I'd like to start to highlight today growing inequities around cervical cancer. We know that it's completely preventable disease but still we have women die from the disease and most of the new disease and also the death occurs in low economic countries where we know the access to vaccination screening and treatment is limited.

And we also know if we keep doing what they want doing so far it has worsen. We know women who have HIV is in a more challenging condition because they're 6 more times likely to develop 6 more times to develop cervical cancer than the general population.

Next slide, please.

We know what to do to prevent and even eliminate cervical cancer, so this graphic from WHO from 2013 showed us what is a main intervention to prevent cervical cancer in the life course of women.

So we invest in primary prevention mainly in HPV vaccination. Secondary prevention we say screening and treatment of precancer lesions and if we fail in the first and the secondary prevention, we should go to the territory year prevention in cancer diagnosis, treatment, palliative care.

Next, please.

The situation is that the access of the intervention is very limited in low economic countries, but the good news is that is that we have the renewed effort to lead by WHO to prevent cervical cancer in the journal for the elimination so mainland mark in this journey is that in May 2018, we had WHO call to action to eliminate cervical cancer that were supported by many countries, and we had the global the strategy to eradicate cervical cancer in 2020, and we also had a continuous fortitude to update it, recommendation for screening treatment which was launched last year in July, and I had the honor to participate in the expert group to update the recommendation which we'll talk a little bit more later. Thank you, next, please.

So the global strategy for cervical cancer prevention was set out and the goal we had below 4 cases of cervical cancer per 100,000 women, and the activities go we also have it targeted by 2030 with just related to 90% of the girls fully vaccinated with HPV vaccine by 15 years. 70% of women screened with a high-performance tests at 35 and 45 and 90% of women is screened positive receive treatment for precancerous lesion or invasive cancer.

In doing that, we'll have the 30% of the reduction in mortality by 2030, in what we hope to achieve, next, please.

To achieve these target -- these goals and target it's important to assess where we are in terms of I understand dense, so this incidents the goal you can see we have some countries that already achieving their goals and targets, but we have all the countries that is very far from from this goal and target so when we work with countries it's really important to identify where countries are in these in these

Next, please.

And it's also important to assess the coverage vaccination screening treatment, and this graph shows the situation of the several low economic countries, and we have some countries in terms of screen, they are above the target, more than 70% of the coverage of the screen but many countries are below this target.

Next, please.

In 2020, we had an assessment that showed the situation of main intervention around the world, so for HPV vaccination, in 2020, we had 85 countries with HPV vaccines in immunization programs, but most of them are below the target of 90%. And in terms of screening treatment, most of the countries, especially low and low economic countries were below 70% and also they had issue with quality of the screen and also they were below the 90% of the of treatment.

And we also have a large gap in terms of access to cancer treatment and palliative care in countries.

Next, please.

The new recommendation from to screening and treatment launched in July 2021, in this document we can have the the we can access these documents through the link in this presentation. We had among 23 recommendations and 7 good practice statements. Some of these statements are identical for the general population and the women living with HIV, but most of them are different for the two different groups.

Next?

And I'd like to highlight that the recommendation is to mover from a screen with more complex or low sensitive method to a screen with a high performance out there so it's moving with cytology and VIA with mainly with HPV DNA testing, but it's important to note the recommendation is that countries have a problem screening with the VIA and cytology and should continue the program until they have the capacity to introduce and to scale up HPV testing in countries.

Next?

So some highlight about the new recommendation in terms of the target population and frequency of screen. The for the target population for HIV negative women we should prioritize women aged 30 to 49 years for screen and for women living with HIV, we should prioritize women aged 25 to 49 years.

You remember the previous recommendation was to start regardless of age, but the evidence has been showing that the best use of the resources to focus on women between 25 and 49 years.

But if we have the resources available, we can prioritize women beyond 50 especially those that have never had been screened.

In terms of frequency forensic sense, it's for HIV negative women should be screened every 5 or 10 years and for women living with HIV, rescreening every 3 or 5 years pending on the existing resource.

Next?

So here I'd like to highlight highlight some remarks on effective components for CECAP program.

So it is important to prioritize that the priority should be given to maximize the screening coverage and treatment rather than different points of the screen, and testing must be linked to treatment. Testing without treatment is a waste of resource.

Also, it is important to highlight equity. We should make all effort to achieve all women in the target age, especially those that are most vulnerable and the hardest to reach.

And also the importance of integration, so cervical cancer screening and treatment service must be integrated in all the reproductive health services including HIV services.

And it is important to establish a service delivery system.

Next, please.

In Jhpiego, we envision a world where an integrated and coordinated response improves down stage of cancer and the end of preventable death for women's cancers.

Next?

So here we have a list of some countries where Jhpiego helping cervical cancer prevention in the past and currently, and we have mainly invested in advocacy and resources mobilization, strengthen policies and guidelines, health education awareness and demand creation, increase access to vaccination screening and treatment. And also, build a big capacity between monetary evaluation and also resources system.

Next?

So here you can see the example of some countries moving from screening with the VIA to invest integration of the cervical cancer prevention into reproductive health services and also invest to introduce HPV test in global mobilization, next?

And here I'd like to highlight the importance here of the invest in the introduction of innovation. We have a lot of resources around cervical cancer prevention, and it's important to support in countries these invasions in the area of advocacy, products, new products, policy, processing and also technology. I think we are in a very good moment for cervical cancer prevention. We see a lot of technology and in some of the processes that we, have I've had, is that countries are prioritizing COVID 19 response as we all know, and we have a concern about capacity to ensure that HPV testing in countries and the chattel to ensure it is quality training, mentorship and monetary and evaluation in conjunction with the COVID 19 pandemic.

But we also have some success factors that I'd like to highlight. The government commitment and ownership. We have increased the invest of commitment in government and also enabling environment, coordination and partnerships, leverage existing capacity. We should be flexible and creative in embracing an innovative solution and recognize and celebrate effort.

Next, please?

So I'd like to end this presentation and highlight the client's perspective. We need to listen to the client, so here we have some face of a cancer survivor, and I'd like to end this presentation sharing a quote from this guy that's talking talking cervical cancer presence. He said cancer is not a journey for one person. Cancer is a journey for a family, friends, for a society, for a country, for the world, so we must do all of our efforts to really advance the cervical cancer and eliminate this disease. Thank you very much, so maybe I should call my colleague, Cornelia to share her presentation.

>> Hi, everyone. Thank you, Veronique. My name is Dr. Cornelia Osim Ndifon. I'm the technical advisor for cervical cancer prevention in Namibia.

Before we proceed to the next slide, I'd like to say one or two sentences about Namibia from a distance, so that I stimulate your desire to visit Namibia.

It's one of the most beautiful countries in Africa, and it is Namibia is a young country. It became in 1991. It has a population of 2.3 million people, and it has things. The terrain is very rough, and it has the land of the brace, next slide.

So here is window the capital of Namibia, and that is the Namibia Independence Museum, so we will be discussing the goals and objectives of cervical cancer prevention in Namibia for the Jhpiego. We will look at the current interventions and successes, mention challenges, consider lessons learned and opportunities going forward.

Next slide, please.

So Jhpiego in Namibia has one major goal, to provide high call the cervical cancer prevention services to mainly women living with HIV AIDS, but we do not exclude HIV AIDS women who come from screening. These are we do achieve two major objectives provide national level support to PEPFAR and the ministry

of health and social services or MOHSS as it is called here to advance cervical cancer prevention in country.

We also build health system capacity including provider capacity building to implement CECAP services in four regions.

Next slide.

So this is the map of Namibia although it's not the most up to date because there are currently 14 regions, but this is where we work. The we also work in the Omaheke in orange, the Hardap in green, Kunene is pink and Erongo is in blue, so what is our major overall we provide technical assistance in the area of guideline development, training on CECAP, demand creation, screening and treatment as well as monitoring and evaluation.

Next slide, please.

So I will just zero down on the screening and treatment. We have the awareness and demand creation health education and prescreening counseling, after which we provide the actual cervical cancer creek using two methods: The visual inspection with acetic acid and the old-time pap smear. Pap smear we can do with conventional methods using the smear or the liquid based side, but I want take this time to just remind us why we have moved from pap smear to VIA. There are so many steps between the first pap smear and the final outcome or conclusion when we are assessing the woman, so the patient must come for the screening, and then she needs to come back for results.

If the results are positive I mean, negative at test time, you can always get a repeat screening like we have heard from Veronica or 3 to 5 years in HIV positive but if the initial pap smear is abnormal, the woman has to be rescreening for colposcopy, and then she goes for colposcopy and comes back for the actual results so there are so many steps in pap smear, and it's a lot of challenges both for the patient and for the provider. This is where VIA really comes in or V I A or visual inspection. The visual gives you immediate result and immediate opportunity to treat for those who are positive.

Next slide, please.

So they received healthcare services in 2020 so by the time we had people we started the screening from October 2020, so I am presenting to you data between October 2020 and September 2021.

I can say that we have achieved a lot because we all know that January 2020, we all woke up with the COVID 19 pandemic, so between that time we screened 4,616 women, and these are better regardless of the HIV status. Out of that number, 467 was positive.

There was a regular high risk in HIV positive women in terms of it out of that number 436 were screened by VIA. This went 3846 was screened only by VIA. We did this in April the transformation is identifiable because we need this to be able to do adequate job, so from the 3,846 that was screened by VIA alone, 467 were VIA positive giving us a positivity rate of 12%, and this is the benchmark. Out of 467, 439 were treated either by ablative method or ablation or by excision method, which means excision of the transmission zone and in total we achieved a precancer 17% with COVID with several lockdowns, and I think this is just incredible.

Next slide.

So how did we achieve these numbers? Initially, we organized we have nurses that have been hired specifically for the program at the facilities that do HIV screening. At some point as we review the data, we found out that the numbers weren't moving as far as we wanted, so we had to design different demand creation strategies including organizing outreaches, and so we planned to have 19 outreaches to do 11, and we used to pool ART and take out the phone numbers and call these women in some places we were successful and in other cases we weren't.

In other cases once it was organized we called the women, and they come and during those averaging we had direct open air communication.

We also gave radio talks and TV talks to inform the public. We spoke in English, and we also spoke in the Namibian every day women understands, and we also developed and distributed IEC materials and

during the COVID lockdown, we did not really stop, so we encouraged the nurses to call the patients and control the flow and screen those women to control patient flow.

Next slide, please.

Common theme in 2021 the major challenge is COVID, but outside of COVID, we do have other challenges. Top of those challenges is actual number of healthcare workers available and the health workforce that is available. The government the district has just one VIA nurse and when that VIA nurse goes on leave for any reason, the VIA group is locked by VIA women trained in CECAP where we're screening.

Though we have trained quite a lot of healthcare workers, but the nurses leave town to their usual places of assignment, for example, someone could be picked from pediatric or immunization who has training but because this person is not hired as a program nurse, it goes back to continue, and they don't really practice, and they don't have the skills that are needed for them to stand in for the program nurse when that person is not around.

And some of our sites they were not having they were not having doctors that are in clinics. Even when we screen some of them could not get the approach kind of services whereby once you are positive you get treatment whether you have the ablation or excision.

Ablation treatment was fantastic but for laser women had to go to another place to get the surgery.

Next slide, please.

Yes, we faced the challenge of not having a mobile van to go to long distance sites. They have patients and sometimes they are not a lot, so it is very difficult to pick a place to send for training and to maintain that person with equipment and other screening, so some sites have to reach facilities we know they would have benefited from a mobile van that we do not have and a lot of our districts are still without anybody trained in VIA.

Next slide, please.

So what we have we learned use the four regions that we are assigned to? Like I said, we met nurses that have been trained in VIA, and they don't know the old-time pap smear because they don't have the necessary tools but what we found mostly is that there is no HPV testing in any government facility, whether self testing or provider, but it happens to be private sector and, of course, there is no HPV vaccination, and we know that. Namibia is not qualified to benefit from Gardasil, but we are working on a strategy plan and hoping that we will be able to help the government of Namibia source a funding of vaccination through other means.

Next slide, please.

So this is my last slide. What opportunities do we have going forward? I can say that cervical cancer screening stands on three pillars: Vaccination, screening and treatment of precancer lesions and actual treating of cervical cancer because if we screen in the course of trying to screen, we can detect cancer in the very early stage, so if we can do these three things, we are on our way to eliminating cervical cancer. We will not be able to really eliminate cervical cancer if we don't introduce HPV vaccination and do that soon.

We are hoping we can introduce HPV testing including self collection by patients themselves, and then in provider assisted testing as well.

We are right now completing a next review to be able to rye a grant for the national cervical cancer, and we are working on that hoping that we can deliver that to the government before the end of this project.

We also hope to extend training maybe using M health, mobile health to train doctors both in the private sector and other types of the systems that have not been reached just, so we can extend that coverage that we need so much like Dr. Veronica said: Cooperation is about getting one woman to even have a screening in the first time of their lives as opposed to screening so we really need to look for ways to increase coverage.

I'd like to end here. Thank you so much.

>> Thank you so much, doctor, so one of the things we really hoped to highlight in this webinar is that synergy that's possible between our domestic and international efforts to improve women's cervical health.

We've heard about some of those overlapping concerns, maligned innovations and the connected opportunities ahead with both HRSA's office of women's health and HRSA's office of global health, which we hope are recognized by the domestic and international stakeholders in women's health.

And both stateside and globally improving those rates of screening has the potential to significantly improve rates of early and successful treatment.

And while the specifics varies between the United States and internationally a common challenge, of course, is reducing those barriers that women experience to access screenings for cervical cancer.

Another challenge we can all relate to is the COVID 19 pandemic has impacted screenings for cervical cancer. It's another reason to continue to encourage the use of vaccines both for HPV and COVID 19. All available COVID 19 vaccines are highly effective at preventing severe illness, hospitalization and death from COVID 19 and the introduction of HPV vaccinations for adolescent girls and boys or preteens, preadolescents is also very critical for a long term strategy.

And one of those challenges there's hope. We heard from OWH about the new guidelines for screenings and the expanded recommendations for screening and treatment by PEPFAR programs.

We also hope that this webinar encouraging an ongoing conversation between domestic and international stakeholders. To that end we want to thank all of our speakers for sharing their knowledge, all those who contributed to the work described, which is a huge impact and all of you for attending and learning with us.

I now open a brief question and answer period hosted by Alan Hendricks from the office of women's health. Thank you.

>> Thanks so much, for those semi reflections. Yes, we're moving for the question and answer period and our first question is for Dr. Veronica, how feasible is it to migrate from DHA to HPV testing for cervical cancer given the capacity and cost implications especially in low and middle income countries. Any best practices you could share for successful transition?

>> Yeah, thank you for these very important questions. This is the question that countries has been posed to us how they can move from the screening we see VIA and here in Jhpiego, we have been supporting countries to increase the screening with using the VIA, which is a really low cost test. We are convinced about the importance of moving to screening with HPV test.

So what we have been doing with countries is to invest advocacy. We needed to really discuss with countries and show the benefit of moving and invest in this type of test.

When we see the cost of the test, we can say the VIA is much less cost than HPV test but when we talk about the cost 5:00 for HPV we can reduce with women health workers because just those who are HPV positive need to undergo for speck examination for assessment treatment. Most of them will be HPV negative and also the frequency of testing when you use a HPV test it's high than the frequency than the screen of VIA, so when we put together all of the costs, we can see the costs of the HPV test is not as high as VIA and also when we compare the cost of the screen with high performance test with the cost of constant treatment, we can see it's useful to invest in screening and treatment of precancer.

And you can solve best practices and lessons learned, what we have learned it is very important to invest in advocacy and to have this discussion with countries and also invest in partnerships. No one can do it alone. We really need to put it together minds and efforts to support the countries in this, and finally have a good planning, rely in the regional and global experience, so we have been promoting the experience between different countries, countries that are already moving talking to countries that are planning to move, so this is really very helpful. Thank you.

>> Thanks so much, Dr. Ries I love the on partnership.

A participant is interested to know about the treatment methodology that you adapted for trainings of service providers and was the screening and strategy followed up? If so, how many centers of cryotherapy were available?

>> Thank you very much.

We support the minister of health who actually owns the training, and so before the lockdowns became frequent and severe, we could do face to face training, usually starting with the TRE and proceeding to practical demonstrations on models before they went to touch actual women, but I think in June, last year, if I'm not mistaken, Namibia experienced a severe or higher rates of COVID deaths and the numbers were cut down to 10 and below, so at this point, we organized a training that was going to go the usual way, but we switched to a virtual method, and in doing that, the nurses connected from their various districts, and now this is national remember, Jhpiego is just in four regions and the ministry actually meets that and our involvement is in terms of reviewing the training materials of training them and once in a while, I am one of the facilitators, so we were able to have virtual training and people were organized in cohorts to be with the nurses at their facilities to demonstrate in small groups rather than bringing, say, 35 or 40 people to a big space.

And then after that training, we followed up the training in groups where we encouraged people to ask questions or things that are not clear as they proceed to actually do the screening, and so they have a camera pictures of positive lesions and sent to us, you know, for quality check to confirm whether that is a true VIA positive or not, and then give advice.

So I would say that that is how it worked during the most severe times when large numbers were not allowed and most were treated, and we went virtual, and this was just on one occasion.

I don't know if that answers your question.

>> Thank you so much.

And we've, unfortunately, reached the end of our time today. I want to give a special thanks to all of our presenters for sharing their expertise today, and thanks to our audience for joining us in honoring cervical cancer awareness month. A reminder that a recording of this webinar will be made available on the HRSA website in the upcoming weeks.

So behalf of the HRSA office of women's health and office of global health, thank you so much and stay well.