EP377/#1514 FIRST IMPLEMENTATION OF HPV SELF-SAMPLING IN VIETNAM: AN ASSESSMENT OF ACCURACY AND FEASIBILITY

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Introduction WHO recommends HPV self-sampling as a safe and highly accepted additional strategy in cervical cancer screening for women aged 30–60 years [1]. Currently, no research on HPV self-sampling has been conducted in Vietnam. This study aims to evaluate the accuracy, acceptability, and women's experience of HPV self-sampling compared to healthcare provider collection at Da Nang Oncology Hospital.

Methods A cross-sectional study was conducted at Da Nang Oncology Hospital from April to June 2023 for women aged 30–65 years. HPV self-sampling was performed using Copan Self Vaginal FLOQSwabs prior to physician-collected HPV on the same day. Samples were preserved in Thinprep PreservCyt and analysed by Roche Cobas 4800.

Results The study included 108 cases, for which the sample-inadequacy rate was 4.6% (5/108 cases). Patient's mean age was 44.0 ± 8.1 with 75.0% aged 30–49 years. Among 103 qualified cases, positive rates for HPV16, HPV18 and 12 other high-risk HPV types were 0.97%, 0% and 2.91% respectively in self-collected versus 0.97%, 0.97% and 2.91% in physician-collected samples. The accuracy of HPV self-sampling was 99.0% when using physician-sampling as a reference (102/103 cases). 50.0% of women preferred self-collection, 44.4% preferred physician-collection, and 5.6% had no preference. 77.8% believed healthcare provider-sampling was more accurate than self-sampling. Only 8.3% reported painful experience and 9.3% encounted difficulty with self-sampling. The majority (91.7%) would choose HPV self-sampling at home for next screening and 96.3% would recommend it to other women.

Conclusion/Implications HPV self-sampling is an accurate and highly acceptable approach for Vietnamese women to improve the cervical cancer screening rate.

EP378/#519 CERVICAL CANCER PREVENTION PROGRAM IN NEPAL: A COMPREHENSIVE 'TRAIN THE TRAINER' APPROACH

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Introduction Cervical cancer is a leading cancer in Nepal. Lack of access to screening and trained health professionals to manage preinvasive and invasive cervical disease contributes to high cancer incidence and mortality.

Methods Cancer Care Nepal (CCN) and MD Anderson Cancer Center (MD Anderson) partnered to implement a 'train the trainer' (TOT) program to teach cervical cancer screening and management. TOT courses were held for specialists from five institutions throughout Nepal to learn how to deliver these trainings. Each participating institution then held local courses for nurses and doctors. The training was complemented with monthly Project ECHO® (Extension for Community Healthcare Outcomes) telementoring videoconferences.

Results Two TOT and five local training courses were held for providers from 20 centers from November 2021 to October 2022. During COVID-19 pandemic travel restrictions, the MD Anderson faculty joined the courses and provided didactics virtually. In-person, hands-on training using simulation models to teach VIA, colposcopy, ablation and LEEP were led by the Nepalese faculty. The 173 participants included 28 gynecologists, 4 gynecologic oncologists, 1 medical oncologist, 22 general practitioners, and 118 nurses. 126 (73%) completed the pre- and post-course surveys with 86% of respondents expressing their desire to make changes in their practice as a result of the courses. In 2022, CCN became a Project ECHO hub and has held 12 sessions with approximately 20 participants from 11 centers per session.

Conclusion/Implications Our TOT and local training courses have increased the reach of training, with the goal of decreasing the burden of cervical cancer in Nepal.

EP379/#991 PILOT IMPLEMENTATION OF HPV SELF-COLLECTION FOR CERVICAL CANCER SCREENING IN COLOMBIA: CHALLENGES OF NON-ORGANIZED PROGRAMS

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Introduction Objective: to assess acceptability and adherence to cervical cancer screening algorithms based on self-collected HPV testing among hard-to-reach women in Colombia

Methods a randomized trial with three arms included: 1) HPV and pap-smear samples collected by clinicians in one visit and followed by colposcopy/biopsy and treatment; 2) HPV self-collection followed by colposcopy/biopsy and treatment; and 3) HPV self-collected followed by ablative treatment. Women 30 to 65 years without history of cervical cancer screening in the previous 3-years were invited to participate. Invitation and sample collection were planned by home visits and by mail. Acceptability was defined as percentage of women tested among invited, and adherence as percentage of women compliant with the diagnostic and treatment workup among HPV-positive women

Results No women could be recruited as planned given the low efficacy for home visits and mail/post. Alternative strategies were implemented including invitation by phone call, in-person invitation in health centers, and screening campaigns. Two hundred and fifteen women were included. The patients recruited in arms 1, 2 and 3 were 68, 72, and 75,