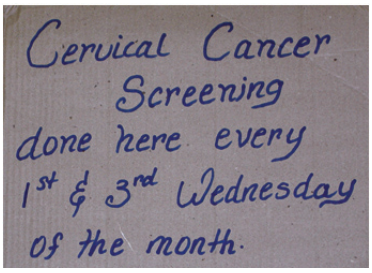
Guyana Cervical Cancer Prevention Project



October 1, 2010–September 30, 2012

USAID FROM THE AMERICAN PEOPLE

MCHIP Maternal and Child Health Integrated Program

The Maternal and Child Health Integrated Program (MCHIP) is the USAID Bureau for Global Health's flagship maternal, neonatal and child health (MNCH) program. MCHIP supports programming in maternal, newborn and child health, immunization, family planning, malaria, nutrition, and HIV/AIDS, and strongly encourages opportunities for integration. Cross-cutting technical areas include water, sanitation, hygiene, urban health and health systems strengthening.

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INTRODUCTION

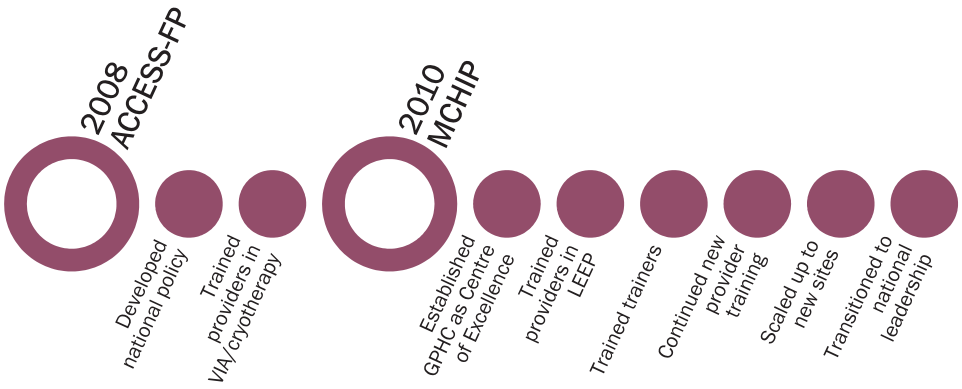
The goal of the Maternal and Child Health Integrated Program (MCHIP) is to assist in scaling up evidence-based, high-impact maternal, newborn, and child health (MNCH) interventions and thereby contribute to significant reductions in maternal and child mortality and progress toward Millennium Development Goals 4 and 5. MCHIP is funded by the U.S. Agency for International Development (USAID).

ACCESS-FP	USAID Associate Award
CECAP	Cervical Cancer Prevention
CTC	Care and Treatment Center
FP	Family Planning
GPHC	Georgetown Public Hospital Corporation
LEEP	Loop Electrosurgical Excision Procedure
M&E	Monitoring and Evaluation
MCHIP	Maternal and Child Health Integrated Program
MNCH	Maternal, Newborn, and Child Health
MOH	Ministry of Health
NAPS	National AIDS Programme Secretariat
SVA	Single Visit Approach
SBM-R®	Standards-Based Management and Recognition
VIA	Visual Inspection with Acetic Acid

In October of 2008, the ACCESS-FP Program, an Associate Award under USAID's ACCESS Leader with Associates Award that preceded MCHIP, expanded and supported cervical cancer screening and treatment activities in Guyana. Following on the success of those efforts, MCHIP's involvement in Guyana began in October 2010 to assist USAID in scaling up and strengthening cervical cancer prevention (CECAP) for women who are HIV+ as well as for women from the general population. MCHIP collaborated closely with the Georgetown Public Hospital Corporation (GPHC) and the Ministry of Health (MOH) to train additional providers in cervical cancer prevention, to raise awareness about the problem of cervical cancer and how it can be prevented, and to improve quality of care at cervical cancer prevention sites.

MCHIP achieved nearly national coverage with cervical cancer screening services, having supported 18 service delivery sites in nine of the 10 regions of the country; these sites include HIV/AIDS care and treatment sites as well as sites visited by the general population. The MOH put into place a national policy on cervical cancer prevention that was harmonized with MCHIP activities and strategies to reach all women with cervical cancer prevention services in Guyana. During the first three years of this project, ACCESS-FP and later MCHIP worked to rapidly expand coverage of cervical cancer prevention services; during the last year, the priorities of GPHC, the MOH, and USAID changed to favor consolidation of gains, transfer of responsibility, and quality improvement over continued expansion to new sites (see Figure 1).

Figure 1. Project Timeline and Major Milestones



Since 2010, MCHIP has worked with local partner organizations to plan for handover of the project management. MCHIP also continued to provide technical assistance on the integration of cervical cancer prevention into HIV/AIDS care and treatment, and trained and updated providers in visual inspection with acetic acid (VIA) and cryotherapy. VIA is a key component of the single visit approach (SVA), pioneered by Jhpiego—a unique, medically safe, acceptable and effective approach to cervical cancer prevention. SVA utilizes VIA to detect cervical precancerous lesions, followed by the offer for treatment using cryotherapy in the same visit, thereby mitigating loss to follow-up. MCHIP also addressed challenges to transitioning project leadership and sustainability.

RESULTS

Guyana Cervical Cancer Prevention Project is fully integrated within the Guyana MOH and GPHC as part of its national program.

The ultimate goal of the Guyana Cervical Cancer Prevention Project was to institutionalize a sustainable and effective national approach to cervical cancer prevention within the MOH and GPHC, as the Centre of Excellence, for the benefit of all Guyanese women, especially those living with HIV. MCHIP achieved this goal. Beginning with the development of a national CECAP policy, MCHIP and its local partners developed the Guyana National Cervical Cancer Prevention and Treatment Programme, which is now led entirely by the MOH. As part of that effort, MCHIP assisted with the development of guidelines and protocols for CECAP implementation. The guidelines were formally adopted by the National AIDS Programme Secretariat and incorporated into HIV patient care and treatment records.

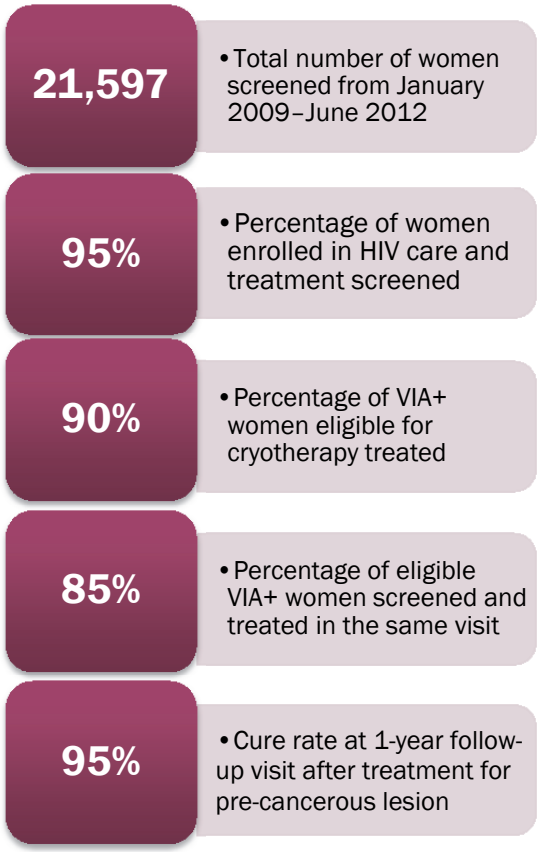
GPHC is now functioning as the Centre of Excellence and Training Resource Centre, where new providers can receive in-service training. The hospital is also working toward including VIA and cryotherapy in the curriculum of the new Obstetrics and Gynecology residency program, as well in the pre-service medical education curriculum. MCHIP trained 11 trainers, of whom eight continue to provide training and supportive supervision through GPHC. In October of 2011 and June of 2012, five trainers planned and implemented a successful new provider training that resulted in 20 trained in VIA and cryotherapy.

Ninety-five percent of HIV+ women enrolled in care and treatment in project sites screened for cervical cancer.

HIV+ women are at the highest risk of developing cervical cancer. From January 2009 through June 2012, the Guyana CECAP Project screened 95% of the women enrolled in HIV care and treatment. In addition, countrywide, the project reached 17% of all women aged 25–49 (the target age group for the project) with at least one cervical cancer screening over the 42-month period and across 18 service delivery sites. This included 25% of the target population in Region 4, the most populous region of the country.

In total, the project screened 21,597 women at least once, and identified 2,806 (13%) VIA+ cases (precancerous lesions or suspected cancer). HIV+ women, who made up 8% (1,699) of the first-time screenings[1], had a higher VIA+ rate than women without HIV (16% versus 13%) (see Figure 2).

Figure 2. Cervical Cancer Screening, Treatment and Cure Rate in Guyana



In addition to tracking new screenings, the project also tracked one-year follow-up results for women who had previously received a VIA+ diagnosis and had treatment (either cryotherapy or loop electrosurgical excision procedure [LEEP]) to document cure rates. Most patients received a client card with follow-up instructions but no formal follow-up with a phone call or postcard was initiated (passive system). The cure rate at the one-year follow-up was 95% (980), meaning that no visible lesions were found at the second screening; however, only 50% (1,027) of those needing a one-year follow-up actually returned for this repeat visit (see Appendix for details).

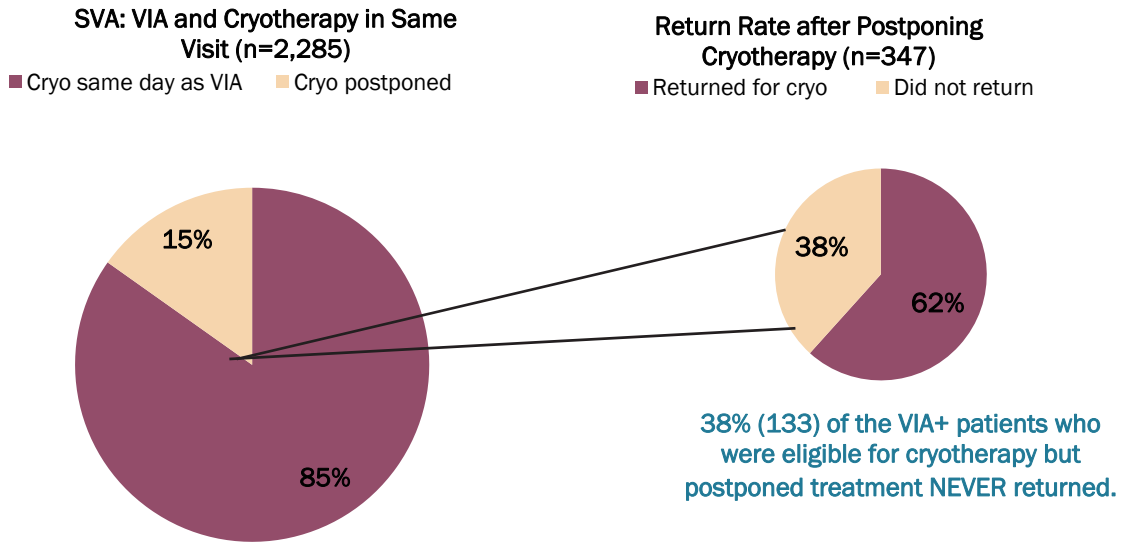
The single visit approach (SVA) links screening with treatment.

VIA provides immediate results, thus promoting linkage of screening with treatment. VIA combined with immediate cryotherapy for women identified with precancerous lesions in a SVA means that women do not have to return for treatment in the case of abnormal results. This minimizes their risk of being lost to follow-up and increases program effectiveness, efficiency, and client satisfaction. Out of the 2,285 VIA+ women found eligible for cryotherapy[2] throughout the 42 months, 85% (1,938) were treated on the same day as their screening (Figure 3); at the GPHC VIA clinic, the flagship clinic in Guyana, the SVA rate was consistently near 100% throughout 2011 and 2012. Over the life of the project, of the 347 women who postponed cryotherapy, 214 (62%) returned for treatment. Improved counseling and tracking of women who postponed treatment increased the return rate from a low of 49% in 2009 to a high of 88% in 2012.

Over the life of the project, 64% of women referred for large lesions received LEEP treatment. In Year 3, a high of 71% of women referred received LEEP treatment. This increase was attributed to a rise in the number of trained LEEP providers, improved counseling and tracking, and better engagement with the GPHC Ob/Gyn Department. Including LEEP (253) and all cryotherapy treatments performed, the overall treatment rate for VIA+ women was 90% (2,405) over the life of the project. This rate steadily improved from a low of 83% in Year 2 to a high of 98% in Year 3 of the project.

[1] HIV prevalence in the general population is 2.5%.
[2] VIA+ women with large lesions and suspected cancer have been subtracted from the total VIA+ women (2,806) for the denominator of this calculation.

Figure 3. SVA and Return Rates



Increasing the number of trained human resources and improving service delivery consolidated project gains.
Beginning in 2010, MCHIP trained VIA and cryotherapy trainers in Guyana to ensure a sustainable source of quality education and supervision for providers. Along with these local trainers, the project also trained 71 providers in VIA, cryotherapy, and LEEP. At the end of the project, 69% of the providers trained by MCHIP were still delivering services (see Table 1).

Provider selection has been very important to provider retention, as can be seen in the table below. Although the sample size is relatively small, it appears that Medex[3], nurses, and midwives are more likely than doctors to continue to provide services once trained, as well as to remain in the country. Based on lessons learned, MCHIP has recommended to the MOH that future in-service training focus primarily on increasing the number of Medex, nurses, and midwives trained, with doctors functioning in a consultative and supportive role.

Table 1. Provider Retention: Guyana Providers Trained since 2009

PROVIDER TYPE	NUMBER TRAINED	NUMBER (%) STILL PROVIDING SERVICES AT END OF PROJECT
Doctor	30	16 (53%)
Medex	7	7 (100%)
Nurses/Midwives	34	26 (76%)
Total	71	49 (69%)
Trainers	11	8 (72%)

Fifteen of the 18 sites provided services for at least three out of the 42 months, with an average of 29 months of services being offered by each of the active sites. Forty-seven percent of the screenings (10,127 of the 21,597) were carried out at one facility, GPHC VIA Clinic, part of the Centre of Excellence; the other clinics screened between 24 and 2,159 new women each over the course of the project (average: 675 screenings/site). High- performing sites benefited from highly committed service providers, supportive facility leadership, consistent human resource

[3] Medex stands for medical extension workers, who are often trained midwives who receive additional training. Their role is to provide primary and secondary levels of care where doctors are not available.

availability, community awareness of services in their catchment area, and few competing priorities or services at the site. Sites that were unable to provide services consistently faced one or more of the following challenges: unexpected personnel changes, lower provider commitment, a lack of support from their facility leadership, inconsistent supplies, a lack of consistently functioning equipment, and competing service-delivery priorities.

Monitoring and evaluation of training improved facility-level use of data for decision-making.
After each new provider training session, providers were trained in data collection and use of data for decision-making. In 2010, each site was provided with a data tracking poster that they could use to visually track their performance on key indicators against project targets. Providers were able to use the data collected to make decisions at the facility level that would improve their ability to provide the SVA. Sites were able to determine the impact of functioning equipment, on-site gas for cryotherapy, adequate supplies, and effective counseling. They tracked their own results and were able to systematically brainstorm solutions to problems and improve their results.

The data collection tools that MCHIP introduced at project sites built on the already-prevalent use of log books and added client cards, a screening map to visually track the pre-cancerous lesions of VIA+ women, a monthly summary form, and a collation and analysis tool in Microsoft Excel, along with the data tracking poster. Every month, data were reviewed by the project manager and Medex at GPHC and reported to MCHIP, which then provided constructive feedback to improve data quality.

In addition to improving facility-level decision-making, the availability of quality data allowed the project to track trends and contributed to program learning (see below). Although not measured, the overall ability of providers to collect, analyze, and use data probably improved, which also should have positively affected their other service delivery activities.

Sharing program learning increased awareness of VIA and cryotherapy success.
During the course of the project, MCHIP staff collaborated on several efforts to expand knowledge about cervical cancer programming, using the lessons learned and results of the Guyana project. In 2011, MCHIP presented a poster at the 2011 Caribbean HIV Conference titled "Integration of Cervical Cancer Prevention with HIV Care and Treatment". Using data from the project, MCHIP contributed to an abstract for the International Federation of Gynecology and Obstetrics, developed with Dr. Ana Tergas from the Johns Hopkins Medical Institute titled "Follow-up care of women with suspected cervical cancer or large lesions after screening by visual inspection with acetic acid in Guyana," which was presented in Rome, Italy, in October 2012. MCHIP has also contributed to a multi-country analysis preliminarily titled "Results from a multi-country cervical cancer screening program in HIV-infected women," which will be submitted for consideration for publication.

In 2011, MCHIP conducted an evaluation of the project's implementation to determine its strengths and weaknesses to that point and to identify any necessary course corrections for the projects' final year. Results and recommendations for strengthening the national cervical cancer program were shared with USAID, the MOH, and GPHC (see below under Recommendations).

In June of 2012, Maureen Reinsel and Dr. John Varallo, along with local consultant Patricia Singh, presented the results of the project to stakeholders representing the MOH, GPHC, and project sites. This presentation focused on the project's success in screening a significant number of women and on MCHIP's recommendations to the Ministry of Health for continuation of the cervical cancer prevention programming.

CHALLENGE: KEEPING THE MOMENTUM IN THE FACE OF POLITICAL CHANGE

Although the trainers and providers voiced their commitment to continuing CECAP services, the maintenance of a truly national program requires national leadership. The MOH provided significant support during project implementation, but a change in the national government caused a leadership shift and administration changes in the MOH that may impact government priorities in the coming years.

Throughout the project, monitoring and evaluation (M&E) was managed by MCHIP, and the project also provided a local consultant and the Medex who worked at GPHC. During the projects' final two years, MCHIP encouraged the MOH to identify someone to take over responsibility for M&E to ensure that services continue to be delivered where and how they are needed. Unfortunately, the MOH was unable to identify an appropriate individual for this responsibility; furthermore, MOH plans for the national health information system changed with the change in government. Consequently, M&E has not been fully integrated with the national M&E system.

A decline in the number of screenings in 2012 was noted and attributed to a combination of factors, including changes in administration at the MOH and the concurrent budget freeze, and a reduction in the number of short-term technical assistance visits from MCHIP headquarters. The MOH and GPHC also assumed a greater role in project management in Guyana, and their reduced budget and conflicting priorities also may have contributed to the decline.

RECOMMENDATIONS

Based on the findings from the process evaluation conducted in 2011 as well as project monitoring in 2012, MCHIP presented the following recommendations to the MOH and GPHC at the project closeout presentation. These recommendations were also included in the final process evaluation report, copies of which were provided to the MOH and GPHC and are on file with MCHIP. Recommendations were as follows:

- In addition to the continued integration of CECAP into HIV counseling and testing services, look for opportunities to integrate CECAP into family planning and postpartum care
- Strengthen and coordinate awareness-raising efforts
- Consider modifying clinic schedules to meet client, provider, and facility needs
- Encourage individual sites to promote the program and conduct patient education
- Incorporate recommendations from remote sites and regions into communications plan
- Use monitoring and evaluation data to motivate providers and make informed programming decisions
- Monitor supplies more accurately to prevent shortages; quickly respond to equipment problems
- Strengthen the CECAP referral and treatment system
- Focus training on cadres with low rates of attrition
- Facilitate supportive supervision visits by trainers to ensure ongoing quality improvement.
- Integrate CECAP into pre-service education
- Develop a five-year CECAP strategy with an M&E plan

With the continued support of the Minister of Health and attention to the recommendations listed above, MCHIP believes that the national CECAP program will continue to be successful in reducing the incidence of cervical cancer in Guyana, especially among HIV+ women.

Appendix: Detailed Monitoring and Evaluation Data

Table A-1. Guyana Performance Monitoring Plan Indicators with Year-by-Year and Life-of-Project Results through June 2012

INDICATOR	DENOMINATOR/ DEFINITION	YEAR 1[4] HIV STATUS			YEAR 2 HIV STATUS			YEAR 3 HIV STATUS			YEAR 4 HIV STATUS			LOP TOTAL HIV STATUS		
		+	-/unk	Total	+	-/unk	Total	+	-/unk	Total	+	-/unk	Total	+	-/unk	Total
Goal: Increased access to quality cervical cancer prevention and treatment services for Guyanese women																
Objective 1: The Guyana CECAP Project is fully integrated within the Ministry of Health and Georgetown Public Hospital Corporation																
Appropriate budget and human resource plan developed by GPHC or MOH for the CECAP Project											1			1		
Cervical cancer indicators are integrated into the national M&E system											0			0		
Number of facilities introduced to the quality improvement approach and the use of CECAP performance standards[5]					7			0			0			7		
Number of supportive supervision visits to project-supported facilities	Visits by GPHC VIA clinic staff and/or trainers to project-supported facilities				15			11			6			32		
Number of health care workers who successfully completed an in-service training program	PEPFAR Next Generation Indicator# H2.3.D. Includes in-service training for providers on VIA and cryo, training of trainers, and SBM-R[6] training	16			32						23			71		

[4] The project YEAR is based on an October–September calendar except for the last year which is based on an October–June calendar.
[5] Reflects both continuing sites and new sites.
[6] SBM-R is a Jhpiego-pioneered practical approach to improving performance and quality of health services.

INDICATOR	DENOMINATOR/ DEFINITION	YEAR 1[4] HIV STATUS			YEAR 2 HIV STATUS			YEAR 3 HIV STATUS			YEAR 4 HIV STATUS			LOP TOTAL HIV STATUS		
		+	-/unk	Total	+	-/unk	Total	+	-/unk	Total	+	-/unk	Total	+	-/unk	Total
Percentage of providers trained still performing VIA at end of project	# of providers trained Used to evaluate provider retention, capacity building, transfer of knowledge, and maintenance of skills													63% (43)		
Number of plans developed or revised and approved by Government of Guyana								*3*			*0*			*3*		
Number of meetings of the National Oversight Committee					*1*			*1*			*1*			*3*		
Objective 2: Existing project sites provide CECAP services to an increased number of HIV+ and general population women																
Percentage (numerator/denominator) of HIV+ new women receiving cervical cancer services at project-supported sites (coverage)	# of women under care and treatment at the same site (2010 counseling and testing enrollment)[7]													95% (1,699/1,795)		
Total number of service outlets providing VIA screening *(not cumulative)*	Provided services the majority[8] of months during the project year	5			10			12			13			15[9]		
Total number of new women screened with VIA		294	2,736	3,030	560	6,545	7,105	627	6,736	7,363	218	3,881	4,099	1,699	19,898	21,597
Percentage (number) of new women screened with a VIA+ result	Total number of new screening visits	20% (58)	17% (465)	17% (523)	20% (112)	16% (1,028)	16% (1,140)	12% (77)	10% (663)	10% (740)	12% (27)	10% (376)	10% (403)	16% (274)	13% (2,532)	13% (2,806)

[7] Denominator includes pre-ART and ART clients from six sites: NCTC, Dorothy Bailey, Campbellville, Mercy, Skeldon, Suddie, West Demerara, Bartica, Wismar, and Mabaruma.
[8] Majority of months: Year 1: 6 out of 9 months, Year 2: 8 out of 12 months, Year 3: 8 out of 12 months, and Year 4: 6 out of 9 months.
[9] Life of Project result is equal to all facilities that have met the criteria for at least one project year.

INDICATOR	DENOMINATOR/ DEFINITION	YEAR 1[4] HIV STATUS			YEAR 2 HIV STATUS			YEAR 3 HIV STATUS			YEAR 4 HIV STATUS			LOP TOTAL HIV STATUS		
		+	-/unk	Total	+	-/unk	Total	+	-/unk	Total	+	-/unk	Total	+	-/unk	Total
Percentage (number) of new women who are referred for large lesions	Number of new VIA+ women identified	33% (19)	9% (40)	11% (59)	29% (32)	22% (225)	23% (257)	13% (10)	6% (40)	7% (50)	11% (3)	6% (29)	8% (32)	23% (64)	13% (334)	14% (398)
Number of new women who are referred for suspect cancer		0	11	11	2	45	47	0	32	32	1	32	33	3	120	123
Percentage (number) of eligible new women with VIA+ results receiving immediate cryotherapy	# new VIA+ - # of new referrals for suspect cancer and large lesions	38% (15)	88% (364)	84% (379)	78% (61)	81% (615)	81% (676)	85% (57)	90% (529)	89% (586)	83% (19)	87% (278)	88% (297)	73% (152)	86% (1,786)	85% (1,938)
Percentage (number) of postponed cryotherapies performed	# of cryotherapies postponed	46% (11)	25% (25)	49% (36)	68% (13)	49% (69)	51% (82)	45% (5)	89% (55)	82% (60)	60% (5)	82% (31)	88% (36)	60% (34)	62% (180)	62% (214)
Percentage of women referred for large lesions who received LEEP	# of VIA+ clients (new, routine and 1-yr follow-up)[10] who were referred for large lesions	50%	55%	53%	9%	63%	56%	17%	84%	71%	50%	53%	53%	28%	64%	64%
Percentage (number) of VIA+ women ever treated (cryotherapy and LEEP)	# new VIA+ - # referred for suspect cancer[11]	62% (36)	91% (411)	87% (447)	70% (77)	85% (831)	83% (908)	83% (64)	99% (627)	98% (691)	*103%* (27)	97% (332)	97% (359)	75% (204)	91% (2,201)	90% (2,405)
Percentage (number) of VIA+ women receiving LEEP treatment for large lesions	# of clients (new, routine and 1-year follow-up)[12] with a VIA+ result	17% (10)	5% (22)	6% (32)	3% (3)	14% (147)	13% (150)	2% (2)	6% (43)	6% (45)	7% (3)	6% (23)	6% (26)	6% (18)	9% (235)	9% (253)
Percentage (number) of previously VIA+ and treated women that returned for a follow-up screening at 1 year	# of VIA+ women treated with cryotherapy or LEEP in previous year				80% (29)	47% (194)	50% (223)	70% (54)	52% (435)	54% (489)	63% (40)	44% (275)	46% (315)	69% (123)	48% (904)	50% (1027)
Percentage (number) of 1-year follow-up screenings with a VIA negative result (cure rate)	# of 1-year follow-up visits				97% (28)	94% (183)	95% (211)	96% (52)	97% (422)	97% (474)	90% (36)	94% (259)	94% (295)	94% (116)	96% (864)	95% (980)

[10] Denominator not displayed in table.
[11] Denominator not included in table.
[12] Denominator not displayed in table.

INDICATOR	DENOMINATOR/ DEFINITION	YEAR 1[14] HIV STATUS			YEAR 2 HIV STATUS			YEAR 3 HIV STATUS			YEAR 4 HIV STATUS			LOP TOTAL HIV STATUS		
		+	-/unk	Total	+	-/unk	Total	+	-/unk	Total	+	-/unk	Total	+	-/unk	Total
Percentage (number) of new women who are referred to another site for advanced care and treatment	# of new women screened	6% (19)	2% (51)	2% (69)	6% (34)	4% (270)	4% (304)	2% (10)	1% (72)	1% (82)	3% (7)	2% (61)	2% (65)	4% (70)	2% (454)	2% (520)
Percentage (numerator/denominator) of women in target age[13] range that received at least 1 screening over the life of the project (coverage)	# of women age 25–49 (Guyana DHS data 2002)													17% (21,597/127,027)		
Objective 3: Knowledge on effective cervical cancer prevention programming was collected and shared with appropriate audiences																
Journal article drafted											2			2		
End-of-project report published											1			1		
End-of-project dissemination meeting in-country											1			1		
Community mobilization and communication strategy developed and disseminated					1									1		
Number of community campaigns including mass screening campaigns carried out		6			12			2			17			37		

[13] Rough coverage estimate because some women screened were outside of the target age group and some women within the target age group would not require a screening.

Table A-2. Key Indicators with Life-of-Project Results by Facility

FACILITY	# OF MONTHS SERVICE DELIVERY	# OF NEW VIA SCREENINGS	# (%) NEW VIA+ CLIENTS	# (%) NEW SVA CLIENTS[14]	# (%) NEW VIA+ CLIENTS EVER TREATED WITH CRYOTHERAPY[15]	# (%) NEW SUSPECT CANCER REFERRALS	# (%) NEW LARGE LESION REFERRALS
Georgetown Public Hospital VIA Clinic	42	10,127	1,303 (13%)	997 (97%)	1078 (83%)	69 (7%)	191 (15%)
National Care and Treatment Center	41	2,159	269 (12%)	143 (76%)	161 (60%)	0 (0%)	84 (31%)
Campbellville	26	300	34 (11%)	10 (38%)	19 (56%)	2 (20%)	6 (18%)
Dorothy Bailey	41	1,264	161 (13%)	115 (85%)	126 (78%)	3 (3%)	23 (14%)
New Amsterdam Hospital	37	1,092	127 (12%)	43 (41%)	62 (49%)	7 (16%)	14 (11%)
Mercy Hospital	36	648	110 (17%)	60 (60%)	72 (65%)	0 (0%)	10 (9%)
Skeldon Hospital	37	702	123 (18%)	91 (80%)	110 (89%)	7 (8%)	3 (2%)
Suddie	24	746	97 (13%)	67 (82%)	71 (73%)	5 (7%)	11 (11%)
Linden	24	714	121 (17%)	83 (98%)	85 (70%)	16 (19%)	20 (17%)
Leonora Cottage Hospital	23	1,026	98 (10%)	71 (82%)	82 (84%)	3 (4%)	8 (8%)
Charity Hospital	26	484	78 (16%)	52 (84%)	57 (73%)	2 (4%)	14 (18%)
Mahicony Hospital	24	922	92 (10%)	71 (84%)	78 (85%)	0 (0%)	7 (8%)
Bartica Hospital	23	259	56 (22%)	36 (69%)	40 (71%)	2 (6%)	2 (4%)
Mabaruma Hospital	16	151	15 (10%)	6 (75%)	6 (40%)	5 (83%)	2 (13%)

[14] Numerator: number of new clients who screened VIA+ receiving immediate cryotherapy. Denominator: number of new clients who screened VIA+ receiving immediate cryotherapy plus the number of new clients with VIA today and cryotherapy postponed.
[15] Numerator: number of new immediate cryotherapies plus number of postponed and returned clients. Denominator: number of immediate cryotherapies plus number of postponed cryotherapies.

FACILITY	# OF MONTHS SERVICE DELIVERY	# OF NEW VIA SCREENINGS	# (%) NEW VIA+ CLIENTS	# (%) NEW SVA CLIENTS[14]	# (%) NEW VIA+ CLIENTS EVER TREATED WITH CRYOTHERAPY[15]	# (%) NEW SUSPECT CANCER REFERRALS	# (%) NEW LARGE LESION REFERRALS
West Demerara Regional Hospital	11	552	76 (14%)	71 (96%)	73 (96%)	1 (1%)	2 (3%)
Wismar Hospital	17	356	35 (10%)	16 (47%)	24 (69%)	0 (0%)	1 (3%)
Davis Memorial Hospital	3	24	3 (13%)	1 (33%)	1 (33%)	0 (0%)	0 (0%)
Lethem Hospital	3	71	8 (11%)	5 (71%)	7 (88%)	1 (20%)	0 (0%)
TOTAL		**21,597**	**2,806 (13%)**	**1,938 (85%)**	**2,152 (77%)**	**123 (6%)**	**398 (14%)**