And what an as as folks are logging in.

Wanna welcome everyone again to Kansas in a grand rounds.

The theme for today is an important one, namely global onkologie and obviously the our attention has been particularly drawn over the past several years. The National Cancer Institute. The World Health Organization. The American side of conchology ACR, among others, have really increasingly...
wanted us to emphasize elements of our work on the global needs.

An global oncology Ann, and

so it’s really my privilege to introduce the introducer.

For today’s session I’ve had the privilege actually of working with Donna Spiegelman for many decades. I guess Don, as you know, is the Susan Dwight Bliss professor by statistics, the director for the Center of Methods and Implementation and Prevention Science, the director of the Interdisciplinary
Research Methods Core for the Center

The Assistant Cancer Center director, Dana, has a wealth of accomplishments, but they include her productive work in global oncology, and I’ll turn it over to Donna to introduce today’s speaker.

Thanks so much Charlie and indeed it’s been a pleasure working with you both at Harvard and now here at Yale. And thank you so much for supporting my work and interest through connecting me to the Cancer Center.
in the global oncology program.

This is our 2nd of this academic years.

Yale Cancer Center grounds.

I’m global Oncologix our first one.

We had an in person this pre covid Dr.

Jorge Sam around from Unum universe

National University Autonomous

University of Mexico City and the

National Institute of Health of Mexico.

Who has been doing work for many many

years on cervical cancer prevention and

screening and we’re continuing to work

with him along with colleagues in a pool.

Today we’re very pleased

to get a very big picture.
Type of you, which I’m really excited about by having our guest Doug Pyle, who unfortunately we can’t drink and dine except in our imaginations. But we’re so happy to have him today for this zoom seminar. He’s the vice president of International Affairs at the American Society of Clinical Oncology, well known as ASCO, and each of us today for a discussion centered around global oncology. He graduated with his MBA from the Yale School of Management. We also found out this morning at a very early.
00:03:01.380 --> 00:03:02.505 Meeting morning call.
00:03:02.505 --> 00:03:05.750 He was so kind to have with myself, Melinda Irwin and Marcella Nunez Smith,
00:03:05.750 --> 00:03:10.632 also leading various related efforts with the El Cancer Center that his wife did her pediatric residency here at Yale,
00:03:10.632 --> 00:03:13.849 so New Haven, Yale is something he’s part of our community as well.
00:03:13.849 --> 00:03:16.069 And after Yale School management, he went on to become Director of Business Solutions International
00:03:16.070 --> 00:03:17.177 and then joined as Co in 20.
00:03:17.177 --> 00:03:19.022 Seven he is responsible for Services for the American Red Cross and then joined as Co in 20.
directing its international programs.

An invite advising the society on the needs and interests of its international members and constituents.

He has more than 25 years of experience in international affairs in the public, nonprofit in corporate center sectors.

Earlier in his career, he was the vice President and Chief Operating Officer for the Center for International Rehab Rehabilitation.

The manager for strategic planning and business development for the US sub Spirit City Area.

East Side and administered technical assistance projects funded by the US.
Agency for International Development, USA, ID.

Today’s talk is Co-sponsored by the El School Public Health Center for Methods and Implementation in prevention science.

See Maps, which I lead.

And I’m very excited to turn things over to Doug to let the audience know you can write questions and comments in the chat box.

I’m not sure if it’s possible to actually activate so you can talk, but Charlie and I are both monitoring.
00:04:38.986 --> 00:04:41.637 the chat box and we welcome your
NOTE Confidence: 0.875739336013794
00:04:41.637 --> 00:04:43.989 comments and we will potentially check
NOTE Confidence: 0.875739336013794
00:04:44.060 --> 00:04:46.664 in with Doug at suitable times to
NOTE Confidence: 0.875739336013794
00:04:46.664 --> 00:04:48.564 inject your questions and comments.
NOTE Confidence: 0.875739336013794
00:04:48.564 --> 00:04:50.524 And presumably they’ll be some
NOTE Confidence: 0.875739336013794
00:04:50.524 --> 00:04:52.912 time at the end as well, so.
NOTE Confidence: 0.875739336013794
00:04:52.912 --> 00:04:54.120 Thank you very much,
NOTE Confidence: 0.833610534667969
00:04:54.120 --> 00:04:55.996 Doug. We’re looking forward to your talk.
NOTE Confidence: 0.83514004945755
00:04:56.910 --> 00:04:58.446 Now this is great.
NOTE Confidence: 0.83514004945755
00:04:58.446 --> 00:05:01.209 I’ve been really looking forward to this
NOTE Confidence: 0.83514004945755
00:05:01.209 --> 00:05:03.883 and thanks so much for the invitation.
NOTE Confidence: 0.83514004945755
00:05:03.890 --> 00:05:06.994 I’m delighted to talk on. Yeah, I agree.
NOTE Confidence: 0.83514004945755
00:05:06.994 --> 00:05:08.835 Important topic, just real quick.
NOTE Confidence: 0.83514004945755
00:05:08.835 --> 00:05:11.320 My also I don’t know if you
NOTE Confidence: 0.83514004945755
00:05:11.407 --> 00:05:13.587 can see but I’m channeling.
NOTE Confidence: 0.83514004945755
00:05:13.590 --> 00:05:14.793 It’s blocked out.
I’m channeling my New Haven by having my 1990s era Doodle mug here. So your first see me question is how many of you know what the Yankee Doodle Diner was in the wave in which I guess, is? Since closed, I had to look that up. But glad to be here and dive right in so Donna and Charlie, yet let me know what kind of questions are coming up. And also let me know how I’m doing on timing. I got a lot of stuff to go through. We want to make sure that we have plenty of time for discussion.
'cause I want to hear what the Yale community thinks about some of these themes were going to talk about. You're my dispute. I'm sorry I said OK, I'll keep an eye on the time for you Doug. Great thank you so no conflicts to disclose. So here are my learning objectives. Give you talking bout the overall global cancer trends, mainly in the context of the rise of non-communicable diseases or NCD’s primarily in low and middle income countries. I'm gonna talk about Ask’s overall strategy and programs to help address these trends.
Then I’m going to get him to the impact of the pandemic on Askos response and what are some of the silver lining? Some of the opportunities for innovation that we discovered during this time and then looking beyond the pandemic. Looking at reviewing Ask’s position on the future of global on College. B as an academic discipline. Why that’s important. And as goes role in supporting Cleveland Cology So first, starting with the global picture here. So I’d like to start actually with the global burden of Disease Study,
00:07:04.980 --> 00:07:07.470 a landmark study that was published
NOTE Confidence: 0.808524370193481
00:07:07.470 --> 00:07:09.610 in The Lancet in 2012.
NOTE Confidence: 0.808524370193481
00:07:09.610 --> 00:07:11.500 The really documented this global
NOTE Confidence: 0.808524370193481
00:07:11.500 --> 00:07:13.947 health shift from child and maternal
NOTE Confidence: 0.808524370193481
00:07:13.947 --> 00:07:15.927 health and infectious diseases,
NOTE Confidence: 0.808524370193481
00:07:15.930 --> 00:07:17.526 which is, I think,
NOTE Confidence: 0.808524370193481
00:07:17.526 --> 00:07:20.560 how most people think of global health.
NOTE Confidence: 0.808524370193481
00:07:20.560 --> 00:07:23.507 Two non communicable diseases or N CDs,
NOTE Confidence: 0.808524370193481
00:07:23.510 --> 00:07:24.430 including cancer.
NOTE Confidence: 0.808524370193481
00:07:24.430 --> 00:07:28.110 And so you can see this shift here,
NOTE Confidence: 0.808524370193481
00:07:28.110 --> 00:07:30.924 just kind of comparing these two columns.
NOTE Confidence: 0.808524370193481
00:07:30.930 --> 00:07:34.442 1990 and 2010 and looking at the main
NOTE Confidence: 0.808524370193481
00:07:34.442 --> 00:07:37.430 risk factors for disease in in 2010,
NOTE Confidence: 0.808524370193481
00:07:37.430 --> 00:07:39.932 these are the top factors
NOTE Confidence: 0.808524370193481
00:07:39.932 --> 00:07:42.619 an all of them relate to.
NOTE Confidence: 0.808524370193481
00:07:42.620 --> 00:07:43.227 NCD’s.
Most of them relate to cancer. So is in this context that ASCO came together with a host of organizations around the world, not only in cancer, but we partnered with our friends at cardiology and across other societies to really press for the importance of a UN high level meeting on CDs. So why is this important? So the UN at the time at only held one other high level meeting on a health topic and that was during the AIDS crisis. So that gives you a sense of the importance of these high level meetings.
And invite the meeting was held in 2011. The world came together and the reason I’m pointing this out is because this was a transformative moment when cancer was really recognized as a global health priority is not only a disease of rich countries, but really seen as a global health issue along with other diseases, including in the NCD kind of framework in the world, came together and it set a world target to reduce overall NCD mortality rates. By 25% by 2025. So it’s now 2020. Well, how are we doing? Anne, how are we doing? Well, unfortunately,
the gains that we saw early on an NCD.

Mortality rates reduction are slowing so.
Up till 2010 to the reduction is about 1.6.
Percent per year and that gave us optimism that 25% was achievable.
Since then it has been slow to about little more than 1%.
Why is that?
One of them, of course, is that this NCD burden is hitting countries that in fact are in transition.
So there are facing infectious diseases
and they have a health system is calibrated to address infectious diseases at the same time they need to re calibrate their health system to address the NCD's. But one other dynamic I just want to slide that is interesting is there is a shift in the risk factor trends, so this is again WHO data. And when we look at some of the risk factors France, DDS, so you see that alcohol consumption has ticked up a little bit. Not too dramatic, but has risen a bit. Not too dramatic, but has risen a bit. While it appears that tobacco use is declining, that rate of decline is starting to slow.
which is concerning and then obesity.

You know, when we talk about cancer and other end CDs, we don’t talk very often about obesity. But this is a growing risk factor and you can see this not only globally, but in regions like the African region, so these are shifts in risk factors that are driving this. This change taken together. Cancer of course, along with cardiovascular diseases,
are the number one killer in the world, and it’s projected to grow quite dramatically.

And most of this growth is going to be hitting low and middle income countries, so both in terms of new cases of cancer and cancer deaths, the bulk of that growth is going to be in the countries they can least afford it and where it’s going to be most challenging.

Now we can draw it.

Specific diseases here you can see that the incidence rates of specific cancer diseases are higher in high income
00:11:36.187 --> 00:11:39.257 countries than low income countries.

00:11:39.260 --> 00:11:43.324 I would caution a bit on this data, so a couple of issues.

00:11:43.330 --> 00:11:45.870 One of course, is the pathology capacity and low income countries is a challenge and so the actual the true incidence rate. In low income countries will likely be be higher.

00:11:50.379 --> 00:11:53.758 income countries is a challenge and so the actual the true incidence rate. In low income countries will likely be be higher.

00:11:53.758 --> 00:11:57.079 But then in also in low income countries that the data and cancer registries is a major limitation.

00:12:01.830 --> 00:12:04.056 But then in also in low income countries that the data and cancer registries is a major limitation.

00:12:04.056 --> 00:12:06.268 So we just you have to take the data with with a grain of salt. But looking at the mortality rates
you can see that in many of the cancer types the mortality rate is the same or higher than in the high income countries and then just kind of looking down at cervical cancer. Now we want to take some time here to pause with cervical cancer. The course the incidence rate is much higher for cervical cancer in low income countries and the mortality rate is significantly higher. And when we look at sort of a map. You can see that in Sub-Saharan Africa this is a mortality data. By the way, mortality rates.
Arquivo candy today’s 2018 and so you can see in separate sub-Saharan African countries and other low-income countries around the world. The rates are quite high so is in this context actually that some of you may know the Director general of The WHO has declared a plan to for the elimination of cervical cancer, the World Health Assembly in August approved a plan. For the elimination of cervical cancer and actually just before this call is on a call with PAJA, the Pan American Health Organization.
to layout the plan for elimination of cervical cancer in the Latin American region. This is going to be a long of obviously a long time to achieve when you have a vaccination campaign, but then acted area of focus for The Who and for the Global community. Stepping back again, so clearly outcomes in cancer is highly correlated to income. The bottom axis there is the segments of countries that the low income countries low, low, middle income countries and so
forth and on the left axis the ratio of mortality to incidence,
and so clearly more resources in different countries across a range of cancer types. Affects the outcomes in those countries. So when we talk about resources, let’s drill into a little more granular detail and this you know, we often talk about. Access to the highest price drugs in other countries. But really these are fundamental aspects of cancer care. Really that the building blocks
that are limited in the lower income countries, so surgical facilities access to key drugs such as essential drugs like tamoxifen, access to palliative care, or a morpheme. And the the percentage of out of pocket health expenditure that the individual faces. I actually think so. That’s about 50% out of pocket in low income countries and low lower middle income countries. I might actually. My sense is out of data to back this up. My sense is that actually understates that when you factor in the cost of
transportation and get to a facility, the expense in many of these countries individuals are going to traditional healers as a first course. So they’re spending money on other approaches, and these expenses are obviously catastrophic for any individual in these countries seeking any kind of cancer treatment. Not on this slide, but equally if not more critical is pathology. Asity access to pathology and laboratory diagnostics,
which is,

as you all know,

is the key part of the cancer care process and a key factor in.

Now comes if you can diagnose it earlier on and get a correct diagnosis at the outcomes.

Of course, are much better access radiotherapy and other issues that is analysis by International Atomic Energy Agency, and you can see again countries in Sub Saharan Africa that have no radiotherapy machines access whatsoever. This data is a little bit dated, so this is 2010,
but really the picture has not changed dramatically since then. Gives you a sense again of where some of those disparities are and in terms of human resources. So there isn’t existing a comprehensive, quantifiable, comprehensive analysis of the global oncology workforce. This is one of the better studies that I’ve seen. This was published in Ask’s Jayceoh Global Oncology Journal, so this is. Not the JC.
Oh, but the sister Journal to the JCO is focused on global oncology. So Doctor Raju and colleagues. Looked at data around the world, different data sources, bearing definitions of what an oncologist is. Again, you need to sort of take the findings with some caution, but they arrive at the ratio of new cancer cases per oncologist and just gives you sort of a benchmark. A sense of what the ratios are. So for example, in the United States, new new case of cancer per oncologists Ethiopia.
00:18:00.000 --> 00:18:03.126 10,000 new cases of cancer for

00:18:03.126 --> 00:18:06.858 oncologists and as some of you may know,

00:18:06.860 --> 00:18:09.665 Ethiopian government has actually launched

00:18:09.665 --> 00:18:12.470 a multiyear program to significantly

00:18:12.547 --> 00:18:15.229 expand its oncology workforce and to

00:18:15.229 --> 00:18:17.532 extend services beyond the capital

00:18:17.532 --> 00:18:20.577 city to other centers across the country.

00:18:20.580 --> 00:18:24.213 But it gives you a sense of

00:18:24.213 --> 00:18:27.070 the magnitude of the issue.

00:18:27.070 --> 00:18:31.183 So with that as the kind of global picture,

00:18:31.190 --> 00:18:34.942 I’ll then now sort of transition to

00:18:34.942 --> 00:18:39.019 what task is doing in this regard.

00:18:39.020 --> 00:18:42.695 So just a primer if you will.

00:18:42.700 --> 00:18:46.095 On Asko, it is more than just

00:18:46.095 --> 00:18:49.519 four days in Chicago in June.
It’s actually quite vibrant oncology society, so our main programs annual meeting we have thematic symposia that some of you may be familiar with. Our journals, cancer.net is our patient information portal. Conquer cancer is our foundation. And cancer link is and I hope there aren’t any questions. I cancelled because of rapidly get on my death but it is our big data platform that is drawing information from HR’s currently in the United States. Analyze overall a patient Terra trends and insights.
So this is the ASKO strategic plan. I’m not going to go through it in detail, but you’ll see the four goals. Kind of running through the. The middle of the slide there and on the right hand side you’ll see making a global impact is front and well, not friends center, but a main component of the ASCO strategic plan. I just think that this really demonstrates the seriousness that ASCO takes. With respect to it, it’s global. Sort of profile its responsibility to
Because Asko is a global organization, so half of our meeting attendance is international. Almost exactly 1/3 of our membership is international. Our journals, the Journal Clinical Oncology, and, as I mentioned, that JC Oaklawn Cology are red around the world and in effect practice around the world. So with that kind of global commitment, an profile.

What is Asco’s international strategy
to address some of these issues? Well, there's three parts. Is the strategy, and I'll go through it. Go through it briefly and happy to talk more about in the Q&A. But there are three components that intersect with each other, so first is leadership development. As a member Society of course we're focused on. Engaging our members and it's really a global health truism if you will, that if you're going to have
00:21:15.728 --> 00:21:17.870 an impact and change practice,
NOTE Confidence: 0.863199234008789
00:21:17.870 --> 00:21:20.390 you need to engage agents of change
NOTE Confidence: 0.863199234008789
00:21:20.390 --> 00:21:22.769 change agents who can incorporate and
NOTE Confidence: 0.863199234008789
00:21:22.769 --> 00:21:25.217 lead those those programs for you.
NOTE Confidence: 0.863199234008789
00:21:25.220 --> 00:21:28.316 So the leadership development is a key piece.
NOTE Confidence: 0.863199234008789
00:21:28.320 --> 00:21:30.875 Then we work with those leaders to
NOTE Confidence: 0.863199234008789
00:21:30.875 --> 00:21:33.738 implement access to quality of care programs,
NOTE Confidence: 0.863199234008789
00:21:33.740 --> 00:21:36.524 which I'll get into and this and then
NOTE Confidence: 0.863199234008789
00:21:36.524 --> 00:21:39.169 underlying all this activity is researched.
NOTE Confidence: 0.863199234008789
00:21:39.170 --> 00:21:41.666 So we have a sense today of how
NOTE Confidence: 0.863199234008789
00:21:41.666 --> 00:21:44.270 we can improve access to care,
NOTE Confidence: 0.863199234008789
00:21:44.270 --> 00:21:46.517 but we always need to be searching
NOTE Confidence: 0.863199234008789
00:21:46.517 --> 00:21:48.322 for those better solutions and
NOTE Confidence: 0.863199234008789
00:21:48.322 --> 00:21:50.272 understand the evidence base and
NOTE Confidence: 0.863199234008789
00:21:50.272 --> 00:21:52.638 going where the evidence takes us.
NOTE Confidence: 0.863199234008789
00:21:52.640 --> 00:21:53.860 And the only way,
as you all know to do that is through research. So just really briefly, I'll go through some of these programs. So in terms of leadership, we engage with oncology leaders around the world. Through we have our International Affairs Committee, which is a global body. And then, more recently we’ve started creating a regional councils, so our first one here is the Asia Pacific Regional Council. In these councils are members who
will help ask a really deep in our engagement in specific regions of the world, understand what are the challenges ways that we can engage the oncology community in each of these regions. So those are current leaders, but then we also have to develop the next generation of oncology leaders. Some of you may be familiar with our idea program. I know many Yale faculty have been idea mentors pictured here. As you can see, I’m yells own doctor in these type ca and her mentee mercy CJ from from Nigeria.
We also have the virtual mentoring program, so these programs identify young emerging onco leaders, primarily in low and middle income countries. Mentor them, bring them into the ASCO fold, and then, as I'll mention more later on, we then work with these leaders and engage the manasco programs and help us to do implement programs in countries around the world. We also have a leadership development program which also.
in and actually how a nice and. I first met each other and we have international participation in this leadership development program. As we work them with these leaders to improve the quality of care delivered in their countries, we do this through a number of modalities versus training. So we do in person training when back when we could do that and hopefully will be able to resume that through ASKO international courses. if care multidisciplinary care. Cancer prevention and in clinical
trials I’m here.
You have picture another picture
of the knees that promises
my last picture of a nice but
doing a training course for us.
I believe in the Philippines.
And then online training through our E
Learning platform and another online.
Mechanisms that we have that I’ll
get into now, ask, of course,
has guidelines that we have.
The ASCO standard ASCO guidelines
and then we also have resource
stratified guidelines so busy you
are not familiar with the concept.
Basically, it goes back to the evidence base and says well if a certain treatment modality is not available, what is the evidence? Say that is the next best and then the next best, and so it enables you to have the best standard of care. In different practice settings, still based on the available admins, so we're incorporating these guidelines into our training. We're also using increasingly internationally quality measures. Some of you may be familiar with Askas kopi program,
the quality Oncology Practice initiative. This takes data from deidentified anonymized data from charts, and compares it against established evidence based quality measures and produces a report card. Back to the practice on how they're doing on their quality and more and more. We're doing this internationally to really assess the quality of care and health practices, improve the quality of care that’s being delivered internationally, and then finally sites. So increasingly,
we are performing these programs at specific sites for ASCO has a multiyear sort of commitment winning relationship. If you will, with hospitals through international cancer core programs that were active in. Nepal and Vietnam and Honduras. W orking with specific hospitals to enhance their cancer care capacity and then through a program started by. Working with specific hospitals to I see see the city cancer talent where we're taking that same kind of long-term collaborative model and applying it to cities. So we're working with colleagues in Cali,
Colombia, Ascencion, Paraguay, Kumasi in Ghana, and Yanggang Mian Mar and we’ll be expanding that so it kinda drill down here. Case example cancer course site in Honduras so we’re working at the hospital Escuela in hospital, San Felipe. Is one of our first programs start in 2010. Now we’ve had about 100 volunteers to date. Travel to Honduras and work with their colleagues there on the focus there is on Kynoch. Safe administration of chemotherapy. Multidisciplinary care in palliative care.
We’ve done this again by working with some pass ID recipients in Honduras, organizing international courses, doing virtual tumor boards, and more recently I mentioned the pathology challenges or recently working with the College of American Pathologists. An apologist in Honduras and as well as the oncology community to develop pathology capacity and. Support their efforts in that regard.

And now they’ve started collecting data and publishing their data again, this is the JCO global oncology. And all of this as I mentioned, needs to be informed by research.
NOTE Confidence: 0.80700671672821
00:27:58.610 --> 00:28:00.800 So when we talk about research,
NOTE Confidence: 0.80700671672821
00:28:00.800 --> 00:28:03.720 there are some key components as you know,
NOTE Confidence: 0.80700671672821
00:28:03.720 --> 00:28:05.540 but just to highlight them,
NOTE Confidence: 0.80700671672821
00:28:05.540 --> 00:28:07.790 you need to be training investigators
NOTE Confidence: 0.80700671672821
00:28:07.790 --> 00:28:09.290 in these resource limited
NOTE Confidence: 0.860995471477509
00:28:09.359 --> 00:28:11.209 settings to conduct the research
NOTE Confidence: 0.860995471477509
00:28:11.209 --> 00:28:13.059 because the research needs to
NOTE Confidence: 0.860995471477509
00:28:13.118 --> 00:28:14.668 be done in these settings.
NOTE Confidence: 0.860995471477509
00:28:14.670 --> 00:28:16.490 That's how you're going to
NOTE Confidence: 0.860995471477509
00:28:16.490 --> 00:28:17.946 move the needle forward.
NOTE Confidence: 0.860995471477509
00:28:17.950 --> 00:28:19.960 So Askos, doing clinical trials workshops
NOTE Confidence: 0.860995471477509
00:28:19.960 --> 00:28:22.329 in low and middle income countries,
NOTE Confidence: 0.860995471477509
NOTE Confidence: 0.860995471477509
00:28:24.600 --> 00:28:27.505 With the conduct of research and also
NOTE Confidence: 0.860995471477509
00:28:27.505 --> 00:28:30.031 working with partner organizations in India
NOTE Confidence: 0.860995471477509
and Australia to do sort of bales type, I believe many of you may be familiar with the Dalek or so this is to design research protocols in Cancer Research. Take that sort of Dale model and apply it to India in Asia Pacific region. Credo in India and Accord in Australia. These are slightly different however, in the topic of the research is being done. Was the veil tends to be on drug development, credo and accord armor. Multi modality and it’s also looking at research where your re purposing low-cost existing drugs to improve outcomes in resource limited settings. So again emphasizing the need for specific
research for a resource limited environment,

ASKO, through its Conquer Cancer Foundation,

provides research funding.

We’re one of the greatest funders of Cancer Research,

specifically for low and middle income countries.

Through innovation grants or fellowships.

And why is in global oncology and then finally,

in terms of research, dissemination.

So this is where I think things that separates ASKO from a typical foundation.

Because then we’re able to marry up that research funding.
Those does findings with the
channels that the global channels
that Apsco has to get that.
Out into practice.
So the JCO global oncology or annual
meeting as a global health track,
and most recently our breakthrough meeting
that we started in Thailand in 2019.
So here is kind of a map
of our activity last year,
this year has been obviously
affected by pandemic.
Not get into that, but just kind of.
I’m not going to go through all these pins,
but just kind of gives you a sense of
the breadth and depth of ask’s activity.
Globally just kind of pick out a few things so that the dark blue pins are the innovation grants. So these are investigators in these countries. Discovering novel cancer control solutions for a lower resource. The purple pens are I mentioned the quality measures. These are copies certified practices, so these are practices that have been certified to be providing the same level of care as the copies survive practices in the United States,
and again is A and we’re looking to move this more into lower resource settings, but we’re hopeful that this can serve as a benchmark for quality care delivery in a range of practice settings. OK, so you may be thinking that all sounds great, but in terms of a pandemic, how are you able to do some of these international programs? Right now, before I talk about the impact of the pandemic on ASKO course, we need to pause here for a moment and justice acknowledges, as you all know,
better than I really.

The impact of cancer of the pandemic on cancer care delivery, and in the Q&A I’d be really interested to hear what you've experienced in this regard.

I just want to like this really interesting study again. Published in the Journal of the National Comprehensive Cancer Network, Oncology 350 cancer centers in about 50 countries.

Snapshot of the impact of the pandemic. So this was what I’ll call the 1st wave.

'cause now we’re in the second wave and the table is just sort
of gives you a sense by encourage you to take a look at it. And the impact of the pandemic on cancer care in low and middle income countries can also be the subject for another talk. You know Asko has its registry there. Other covid registries in other countries think the impact on delay, diagnosis and ultimately, patient outcomes and cancer as a result of the pandemic is yet to be seen. And that will be important data to see. Turning to the impact of the pandemic on asking. The annual meeting.
We had to shift. What is a massive scientific meeting in Chicago and move it all online. Basically in the matter of about 6 to 8 weeks it was a massive undertaking. Those of you who did participate I’d be really interested here. What you thought we were. We were quite pleased with it. We the number of attendees were comparable to the in person in terms of countries we actually got. Even greater participation globally and actually much greater or not surprisingly, greater participation from countries.
00:33:37.602 --> 00:33:40.710 where participation in the in person
NOTE Confidence: 0.819793701171875
00:33:40.787 --> 00:33:43.057 might would be more challenging,
NOTE Confidence: 0.819793701171875
00:33:43.060 --> 00:33:46.276 so just easier for clinicians to
NOTE Confidence: 0.819793701171875
00:33:46.276 --> 00:33:49.602 access the insights that are presented
NOTE Confidence: 0.819793701171875
00:33:49.602 --> 00:33:52.848 at the annual meeting this year.
NOTE Confidence: 0.819793701171875
00:33:52.850 --> 00:33:55.986 So that was that was very helpful,
NOTE Confidence: 0.819793701171875
00:33:55.990 --> 00:33:58.230 very informative and just actually
NOTE Confidence: 0.819793701171875
00:33:58.230 --> 00:34:00.022 a final point there.
NOTE Confidence: 0.819793701171875
00:34:00.030 --> 00:34:03.180 I think we learned a lot from
NOTE Confidence: 0.819793701171875
00:34:03.180 --> 00:34:04.080 this experience.
NOTE Confidence: 0.819793701171875
00:34:04.080 --> 00:34:06.780 The benefits of having that come
NOTE Confidence: 0.819793701171875
00:34:06.780 --> 00:34:09.100 online experience says to us
NOTE Confidence: 0.819793701171875
00:34:09.100 --> 00:34:11.710 that having some kind of hybrid
NOTE Confidence: 0.819793701171875
00:34:11.710 --> 00:34:13.949 experience even after a pandemic,
NOTE Confidence: 0.819793701171875
00:34:13.950 --> 00:34:16.650 I'm in a post pandemic environment,
NOTE Confidence: 0.819793701171875
00:34:16.650 --> 00:34:19.583 will likely have some online or hybrid
components to the annual meeting. Going forward it was.
Extremely helpful. So from the start of the pandemic,
as some of you may know, Asko created a resource library
for care during the pandemic, and I just want to highlight this because
and I just want to highlight this because this is another example of innovation.
Where let’s go really crowd sourced from its membership.
What are the challenges for the practitioner in the pandemic environment?
And then Furthermore, crowd source the solutions and
work with its membership to arrive
NOTE Confidence: 0.819793701171875
at the solution says and answers
NOTE Confidence: 0.819793701171875
those questions and then compiled
NOTE Confidence: 0.819793701171875
it all together into this into
NOTE Confidence: 0.819793701171875
this repository resources.
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So it really kind of shifted.
NOTE Confidence: 0.819793701171875
I think our relationship in a way with
NOTE Confidence: 0.819793701171875
our global membership in a very direct way,
NOTE Confidence: 0.819793701171875
and I think,
NOTE Confidence: 0.819793701171875
operas,
NOTE Confidence: 0.819793701171875
lessons for how we can engage
NOTE Confidence: 0.861002624034882
our global membership going forward.
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So we took the insides from that repository,
NOTE Confidence: 0.861002624034882
worked with our international members to kind
NOTE Confidence: 0.861002624034882
of globalize the guidance and the insights,
NOTE Confidence: 0.861002624034882
translated the report into 7
languages and put it out and to inform practice around the world.

Like everyone else, as goes been organizing webinars, I think for a society like ASCO that again has this global membership. The webinar series was really an incredible experience because again we were able to tap into very early on in the pandemic when it was really drastic way by the pandemic we were able to tap into our members in those countries and.

Host webinars, connect them with
our members in other countries,

understand what they were going through,

what they were learning on the ground,

and incorporate that into lessons for our

members and constituents in other countries.

So is a very helpful way for us to connect

our membership and learn from them.

And these were recorded.

So if you’re interested there

an ask’s YouTube channel.

All of those programs that

I mentioned earlier on.

We’re shifting them over to

virtual frameworks.

I won’t get into this in detail.
Happy to get into the Q&A if there is interest, so some of you may be familiar with Project Echoes, which is sort of a Tele education platform. We’re doing Project Echoes with colleagues around the world and other collaborative projects. What were some of the lessons learned? Even doing some guidelines adaptation example here, working with colleagues and other. Countries around the world and other collaborative projects.

So what were some of the lessons learned? So again,
00:37:34.000 --> 00:37:36.850 I think ask was learned quite
NOTE Confidence: 0.861002624034882
00:37:36.850 --> 00:37:39.178 a bit in terms of.
NOTE Confidence: 0.861002624034882
00:37:39.180 --> 00:37:42.012 It’s meetings and how does it
NOTE Confidence: 0.861002624034882
00:37:42.012 --> 00:37:44.672 help to educate its membership
NOTE Confidence: 0.861002624034882
00:37:44.672 --> 00:37:47.368 in the cancer community?
NOTE Confidence: 0.861002624034882
00:37:47.370 --> 00:37:49.946 There are ways that we can supplement
NOTE Confidence: 0.861002624034882
00:37:49.946 --> 00:37:52.532 the in person education with with
NOTE Confidence: 0.861002624034882
00:37:52.532 --> 00:37:54.877 the online and virtual elements,
NOTE Confidence: 0.861002624034882
00:37:54.880 --> 00:37:56.545 we’ve discovered ways that we
NOTE Confidence: 0.861002624034882
00:37:56.545 --> 00:37:58.776 can scale up our our global
NOTE Confidence: 0.861002624034882
00:37:58.776 --> 00:38:01.241 impact through E volunteering and
NOTE Confidence: 0.861002624034882
00:38:01.241 --> 00:38:03.213 exploring strategies around that.
NOTE Confidence: 0.861002624034882
00:38:03.220 --> 00:38:05.932 And we’ve discovered ways that we
NOTE Confidence: 0.861002624034882
00:38:05.932 --> 00:38:08.885 can engage our members in a much
NOTE Confidence: 0.861002624034882
00:38:08.885 --> 00:38:11.015 more direct way to glean from
NOTE Confidence: 0.861002624034882
00:38:11.015 --> 00:38:13.587 them their insights and put that
00:38:13.587 --> 00:38:16.153 into practice in terms of care,

00:38:16.153 --> 00:38:18.268 delivery, and research, I think.

00:38:18.270 --> 00:38:21.036 Ask as members and practices learned

00:38:21.036 --> 00:38:24.370 quite a bit from this experience.

00:38:24.370 --> 00:38:27.406 Just a preview of coming attractions.

00:38:27.410 --> 00:38:30.068 Asko formed a task force called

00:38:30.068 --> 00:38:33.025 the Road to Recovery Task Force

00:38:33.025 --> 00:38:35.755 that outlines some very specific

00:38:35.755 --> 00:38:38.589 lessons learned from the pandemic,

00:38:38.590 --> 00:38:41.050 so efficiencies and innovations that

00:38:41.050 --> 00:38:44.116 can be applied to practice going

00:38:44.116 --> 00:38:46.208 forward and these recommendations

00:38:46.208 --> 00:38:49.300 will be published I believe soon.

00:38:49.300 --> 00:38:54.600 And JC are so. Keep an eye out for that.

00:38:54.600 --> 00:38:55.755 In the meantime,
turning again to Jaeseok level oncology.

I recommend that you take a look at this.

This really interesting paper by Selene and colleagues.

Serve emphasizing some of these same points.

Ways that we can re imagine global oncology clinical trials.

Driving speedy approvals and always keeping the patient in the center.

So the increased use of technology opportunities to so called cut the clutter, make the regulations and paperwork simplified.

Driving speedy approvals and always keeping the patient in the center.

So, looking beyond the pandemic and future directions in global oncology.

So here I actually just want to step
back in time a little bit to 2016, which is so ask around. This time the Board of directors of ASCO convened a task force called the Global Oncology Leadership Task Force. Charged with helping Oscar to chart the next round of expansion Brasco globally and ask US role in global oncology. One of the recommendations of this task force was the following. As you can see on this slide that there is a roll, there’s an opportunity for ask a transition. From what?
Had husband, largely informal field to a formal field with a strong research component and recognize value to oncology training and the practices oncology. So ask her being ask are then formed another task force to look at this question in detail? And this task force was chaired by Julie Gralow. With the following members and actually we just published the recommendations of this task for us again on JCO Global Oncology. I recommend that you take a look at it. But I’ll go through that.
Some of the highlights with you today.

So first we had to define global on card out there.

Need to have low, more specificity around this generally seen as the oncology as applied to go global health, but the task force felt the need to have some more definition on this.

I’ll pause here to let you read the definition.

So a fairly comprehensive approach and really speaks to the importance of level oncology is not solely the practice of oncology in a resource.
limited setting, but looking at it, holistic Lee across the board, and so I think that holistic approach is really important. So just kind of go through some of the recommendations here. The first was that, and by the way, the Ask a board of directors has approved these recommendations. Anasco is working to implement these and I can provide some some highlights or updates on that. So first and foremost, the importance of raising awareness of global oncology and the importance of our opportunities or
incorporating global oncology in heme ONC and met on training programs. And I’d be really interested to hear. What yells experienced in has been in this regard, and what opportunities, if any, provide your trainees in global programs? Because Asko Ashley and in talking with a CG MA am identified? I think more opportunities for innovation around the training programs that was previously understood. So there’s no. And then beyond.
Demog working with other special societies, Astro and so forth to identify opportunities for global to incorporate global oncology in the training of other subspecialties. So global oncology competency. So what is it? What’s required to do global oncology? ASCA will actually be coming out with a companion publication, hopefully in the soon in the coming year on specifically what global oncology competences are, so some of them are in a traditional sort of global health framework or global health training.
And then there are aspects to onkologie in the practice of oncologix in a resource limited setting that one would not normally receive as part of their standard. Does competency Zaskia perceives them? And then we can. There’s a role for us going creating a repository of these training opportunities and resources as the field develops. As the formal academic discipline. So turning them to research and practice. We need to advocate for the
importance of global oncology research

and I just want to pause here a moment to to make a point that I think is particularly important.

I, you know, I think we have sort of created sort of false distinction between addressing disparities and access to care issues in the United States and disparities in access to care issues outside the United States. So one we sort of think as sort of domestic issues and then press or sort of global health issues.

I think there is a huge opportunity for us to breakdown that barrier.
so the global oncology research can directly inform.
The insights and the improvements to care that we potentially can make in the United States. So, for example, in innovation around access to care, that's this developed in Mumbai or in another setting outside the United States, can provide insights to improve access to care in the rural United States or other disadvantaged areas in populations. So we need to sort of think about the role for this kind of research domestically as well.
Make that case.

So we need to find bridge funding so there is funding for getting started and global oncology research.

But we need to support investigators through the continued part of their profession and keep them on the path. Through Jaeseok live oncology and other channels, we've been to same disseminating global oncology research. But are there opportunities for us to, for example, present more scientific research at the ASCO annual Meeting on Global Oncology?
And how can we do that?

And then we need to promote equitable relationships between the researchers in high resource settings.

An investigators in the lower resource settings, making sure that we’re learning from those layers or resource settings, because that’s the whole point, isn’t it? Making sure that that’s equitable relationship.

This role for ASCO as a professional home.
for the global oncologist community. So for the next generation helping to connect them with networking opportunities to be mentored from The Pioneers in global oncology and being a repository for career opportunities as they emerge in global oncology. As I said, there are many pioneers in this field and the role for professional society like Oscar to recognize these leaders celebrate them and again support the emergence of this as a respected and recognized field and then some overall recommendations. Integrating global oncology into...
all those international programs that I highlighted previously on the importance of partnering with oncology societies another. Organizations including DNC. I've NCI Center for Global Health in the ovary center. So in the time remaining, I hope I'm still doing OK with time. Just a few sort of personal reflections on 10 minutes. Doug perfect. So these are sort of more my personal reflections don’t necessarily reflect ask as formal position,
but as was mentioned in the introduction and thanks again for that very kind introduction. I came to ask. Oh, not from the cancer community. I didn’t have professional background and cancer, certainly not on koleji And I was new to the Medical Association field, so I came from the standard sort of global health international NGO world. So with that sort of outsiders press perspective really kind of actually came clear to me quite quickly. What a huge environment, vibrant and surprisingly for me
surprisingly vibrant community, the oncologist society community is so not just ask, of course.
Ash Astro ACR pathology societies ACP. Mother’s doing great work.
International societies with.
Sigh up in Pediatrics.
I organ geriatric oncology and of course all the national societies in countries around the world.
And so when I look at this community, I just I see a huge opportunity for societies like Oscar to support Global Cancer Control and Global Health.
When I was working with the Red Cross and we would do start a program in another country, there are significant investments that International Energy needs to make. To do programs you know you need to set up the field office hire staff and stones these Jeeps. These international NGOs would give their right arm for the assets that societies potentially can bring to bear to global health. So first and foremost we have our members that depth of the knowledge of our members and their experience.
Which is a huge asset.

These members are in the field, so right now as we speak we have hundreds of ASCO members practicing oncology and low and middle income countries.

This is their day today and the insights and experiences that they have from their practice is a huge asset as we think about how to improve the care in these settings.

The network, so these members all have professional relationships, formal and informal, that we can tap into to improve,
to deliver programs.

Societies are always forward looking, so a big research component always like you know what is the evidence says so in our guidelines. In our presentations, in our publications it's always forward looking and building on the evidence. Societies have authority. It's societies like Oscar. Their opinion is respected and carries weight and related to that we have influence that we have access to policymakers either in the United States or are members in countries around the world.
Often are in position to influence policy makers in their countries. So taken together there is enormous potential life thing for societies to have a positive impact. In global oncology in global health generally it maybe because I’ve two teenagers at home. I sort of think of it this way, but I think the societies and global health are at a sort of an adolescent stage. I think we’re just scratching the surface were growing internationally, starting to apply our strengths.
but I think we can do more where the challenges of the world and figuring out what is the role for societies like Ascot to address these challenges. ASKO, in other societies were not going to do it all. You know. We have our niche you can see in the bottom right of the slide. Our tagline knowledge conquers cancer or focuses on knowledge and capacity building. How does that slot into the other components of global oncology in global health? And overall, I just think it’s a very exciting time of promise and potential in that regard. What are the challenges to realizing this?
So in global health, as many of you know, you have to strengthen the health systems you have to take a systems approach. And quite honestly, this is not always emphasized and so we need to be mindful of that and try to approach it from a systems perspective. Implementation signs.

We always need more data and evidence on how to what programs have impact. Our volunteers are outstanding.
We couldn’t do what we do without our volunteers, but there are those volunteers that are dedicated but they need to be supported and their work needs to be formalized in a way in our in country. Members have multiple demands on their time and that’s always a challenge, so this kind of in my mind points again to the need to formalize global oncology. And doing that, we need to learn from other global health disciplines and experiences. So, just to summarize,
the take home messages, I hope I’ve helped everyone to sort of informed you with about the rising global cancer burden and that this has been this rises private.

Overall shift and CDs and low and middle income countries ask was not just an organization, was not just an organization, the community that can be harnessed to address these challenges, the pandemic, while a global catastrophe, the pandemic, while a global catastrophe, Has Forrest innovations that kind of a lasting and potentially positive impact on this response and
it's critical to formalize global oncology in terms of training, mentorship, research and practice in societies like Costco can have a major role in global health. So I'd like to thank the International Affairs Committee, in particular the chair of our committee Clarissa Mathias or Brazil, and all of our members. You can see from all over the world just a fantastic group volunteers, the international favorite staff, small small team but call them my special forces because we're
small but high impact.

And then finally, if all through all this, some of you have been thinking well, this global health sounds like, well, like the restoration of a vintage car. You’d be spot on because like global health, you need a range of stakeholders to do this work, including your dog Jasmine. And sometimes you need to do things differently. So in this case, installing the engine from underneath the car is supposed to from above and you always have to be thinking about the next generation.
This case, my daughter Taylor and teaching her how to work on cars so that happy to welcome any questions and answer any questions and look further discussion.

Thanks Doug, that for this incredible overview of all the work that ASCO is doing, I was not aware of the breadth and scope of it all and really thought it. But I know many of my Harvard colleagues go to the conference in Chicago, and they’ve presented a lot of the epidemiologic research and so forth, so I had been aware of the extent of your work and global oncology. I’m wondering just to start off,
we have a few other questions as well,
like the NCI has picked up as.
On global oncology being very important.
As Charlie mentioned,
I think early on and I’m wondering
was that just like parallel worlds
or is it a result of sort of some?
The advocacy that your Department
has been doing and you know how are
you working with MCI and where
do you see NCI going with
this? Yeah, no an NCI.
They’ve been terrific partners.
We work very closely together.
I really think Donna,
so this is really emerged and one of the reasons I started with that the UN meeting I really think over the past 10 or 15 years there has been emerging consensus and focus on this issue. I think arising awareness of the rise of cancer in low and middle income countries. And so I think the NCI center was an outgrowth of that rising awareness and. Just sort of been the zeitgeisty. Well they were all working on this step. Yeah, great now I need childcare. is ask can you speak to how institutions and Ella Mai sees low and middle income? Countries can become Q API certified.
I don’t even know what that means so maybe you can answer that for those of us who don’t know and then maybe addressed the question. Yeah, so this is this is the copy program, so this is a quality measurement program and so there is a legal component to it. So you know there’s some time to get into it. But are lawyers need to assess the patient data privacy laws in each countries to see whether we can do copy in those countries? But assuming that we, the legal analysis has been done in a particular country with where center is.
I'd be very happy to connect them with our clinical Ferris staff and start looking at that.

Melinda Irwin said very positively. She loves the ASCO global oncology definition. I do as well and she's wondering if others agree with the focus on disparities in differences and the focus on implementation science and policy.

If others agree with the focus on disparities in differences and the focus on implementation science and policy. So that's sort of a question to others I guess, not necessarily. You presumably you agree with that. Yeah, I mean I, you know I do.

Of course. Of course the volunteers
developed the definition.
I'm just staff but but I think you do have to look at Holistic Lee for the
reasons I tried to share in my talk.
OK, well we're a little a minute over the hour so I think it might make sense to thank you again.
Very much leisure to meet you and for you to reconnect with some of your old friends and we appreciate you virtually coming and giving this presentation today.
Well thanks again and I apologize. I took so much time I meant to leave more time for discussion,
but you know if there are any unanswered questions you have my email, please send them my way. I'd be very happy to answer any of that that I can and look forward to hearing more about the work of Yelling Global Ontology. Great, OK, so thank you Doug and thank you all. Bye bye thank you.