The Department of Health – Philippine Cancer Control Program is a systematic, organized, integrated approach to the control of cancer that can significantly alter or reduce mortality and morbidity utilizing primary and secondary prevention at the community level, and tertiary prevention and rehabilitation at both the community and hospital levels, in all regions of the country.

A. The Philippine Cancer Control Program

The aim of cancer prevention is to develop methods, plans or policy for interventions that will benefit the population, as well as develop systems for monitoring and evaluating these interventions in the future. The purpose of interventions is to reduce the incidence, morbidity, mortality rates of cancer and cost of cancer management. Because the modes of interventions that will be employed involve changes in lifestyles, behavior, and environment, it is logical to assume that complex psychological, physiological and cultural problems may arise. In cancer prevention and control, priority should be given to those that cause the greatest morbidity and mortality, those for which substantial risk is associated with certain exposures, and for which apparently effective interventions are available. A realistic and relevant cancer prevention and control program must utilize Primary Prevention, Secondary Prevention, Tertiary Prevention (Definitive Diagnosis & Management and Supportive Care Rehabilitation and Pain Relief) and Research.

It is on the premise that cancer can be largely prevented mainly as a public health effort that the Philippine Cancer Control Program was established. Originally there was a National Cancer Control Center. By virtue of Executive Order 119, the NCCC was abolished, its planning function was transferred to the newly created Non-Communicable Disease Control Service under the Office of Public Health Service to take charge of the Philippine Cancer Control Program (PCCP), assisted by an Advisory Council. The first phase of the program implementation was conducted in 1988. Administrative Order No. 89-A s. 1990 provided the guidelines for the PCCP, specifying the program policy, components, implementing guidelines and timetable.

The PCCP is a systematic, organized, and integrated approach towards the control of cancer that can significantly alter or reduce morbidity and mortality utilizing primary and secondary prevention at the community level and tertiary prevention in the different regions of the country and rehabilitation activities at both the hospital and community levels. The goal is to establish and maintain a system that integrates scientific progress and its practical applications into a comprehensive program that will reduce cancer morbidity and mortality in the Philippines. The 6 Pillars of the PCCP are Epidemiology & Research, Public Information & Health Education, Prevention & Early Detection, Treatment, Training, and
Pain Relief. Examples of the sub-programs of the PCCP are Breast Cancer Control, Cervix Cancer Control, Lung Cancer Control, Cancer Pain Relief.

B. Assessment of the Cancer Control Program in the Philippines

In 1996, the Asian Development Bank (ADB), working closely with the Philippine Department of Health (DOH), initiated a project called the Philippine Adult Health Project. The ADB hired both international and domestic consultants (Havas S & Ngelangel CA) to assess the current prevention and control efforts in the Philippines regarding several existing or emerging health problems of cancer (among other 7 diseases).

The audit confirmed that mortality from cancer had increased substantially over time in the Philippines and was likely to continue to increase. Significant shortcomings in six areas were identified: 1) existing data and data gaps, 2) programmatic efforts, gaps, and problems, 3) medical education, 4) policy issues, 5) treatment guidelines and problems, and 6) quality control of testing and screening services. Each area is summarized below and recommendations were given to the ADB and the DOH.

EXISTING DATA & DATA GAPS

Available data on mortality and morbidity from cancer in the Philippines underestimate the magnitude of the problem due to under reporting, the lack of reliable death certificate information, and under diagnosis. The situation has worsened under devolution. Despite these problems, the DOH's statistics already list cancer as the fifth leading causes of death in the Philippines. Morbidity data are sparse due to the lack of a national cancer registry. Data on the prevalence of risk factors for cancer are sparse. There are no data on what proportion of the population receives appropriate screening tests for cancer.

Systematic efforts should be taken to increase reporting from district and provincial hospitals, to improve physician performance on filling out death certificates, and to increasing health care worker and patient recognition of signs cancer. Systems should be established to improve reporting of morbidity and mortality from the local level. A national cancer registry should be developed in the Philippines. Reporting of cancer cases should be mandatory for all hospitals, pathology laboratories, and radiotherapy treatment units. Data from the national registry should be used for planning the DOH's cancer prevention and control programs. Both regional and national cancer registries should collect accurate data on smoking and occupation.

Random population surveys should be undertaken on a regular basis to ascertain the prevalence of risk factors for cancer. In particular, assessments should be made of smoking and physical inactivity. These data should be used by the DOH for program planning. Random national population surveys should be undertaken on a regular basis to assess the intake of fat, saturated fat, cholesterol, sodium, dietary fiber, fruits and vegetables, and alcohol. Calculations should be of the following parameters: 1) total caloric intake, 2) percent of calories from fat, saturated fat, carbohydrates, alcohol, and protein, 3) mg of cholesterol consumed daily, 4) dietary fiber consumption, 5) number of servings of fruits and vegetables, 6) consumption of aflatoxin, and 7) consumption of alcohol. Data should be analyzed nationally and by region. These data should be used by the DOH for program planning.
Data should routinely be collected on future national health surveys concerning whether adults have received screening tests for cancers of the cervix, breast, and colon within the past three years.

**PRAGMATIC EFFORTS, GAPS & PROBLEMS**

The DOH has written a comprehensive plan for the prevention of cancer in the Philippines. However, most of the plan has not been implemented and the evaluation of programmatic efforts has been weak. Resources, including screening supplies, are insufficient to implement the plan. Consequently, the DOH’s programs have not reached most of the population. Public knowledge concerning cancer prevention, screening, and warning signs is limited. Their proposed slashing of the budget for this program reinforced perceptions of lack of support for cancer prevention by the DOH leadership. There is great reliance on untrained barangay health workers to implement educational and screening efforts.

Systematic efforts should be made to implement the cancer prevention plans. These efforts should build upon previous successful programs in the United States and elsewhere; lessons learned from such programs should be used to guide and to assist efforts in the Philippines. The cancer prevention efforts should be integrated with those of the Philippine Cardiovascular Disease Prevention Plan. Scientific and administrative support for these efforts should be sought from the University of the Philippines College of Medicine, professional societies, and voluntary agencies.

The DOH should be encouraged not to focus its preventive efforts on only one or two risk factors for cancer and cardiovascular diseases. Because this disease is caused by several different risk factors, each risk factor should be addressed. Risk factors requiring attention include smoking, unhealthy diet (particularly excess dietary fat, excess sodium, and insufficient fiber, fruits, and vegetables) and physical inactivity.

All phases of the implementation of the cancer prevention program should be rigorously evaluated. Outcome measures should be stated for all major components of these programs.

Wide-scale screening programs should be instituted by the DOH for cancers of the cervix, breast, and colon. Screening programs for cervical cancer should target women age 20 through 65; women over age 65 who have not had at least three negative Pap smears in the ten years prior to age 65 should also be screened. Screening programs for breast cancer by means of physical examination should target women age 40 and above. Screening programs for colon cancer should target adults age 50 and above.

Equipment should be purchased by the DOH for performing mammography. Stationary equipment for hospitals as well as mobile vans with such equipment should be obtained. Such tests should be routinely performed every 1-2 years on women age 50 and above. For women with a positive family history of breast cancer, such tests should be initiated at age 40.

Public information campaigns should be initiated using public service announcements (PSAs), billboards, and print media to inform the public about appropriate screening tests, early warning signs of cancer, and the treatability of many forms of cancer if detected early. As part of the national health survey, data should henceforth be collected concerning public knowledge about these issues.

The DOH should give the Philippine Cancer Control Program a sufficient budget to cover supplies needed for screening throughout the Philippines.
Screening for colon cancer by means of a rectal exam and testing for fecal occult blood should be implemented on a nationwide scale. Screening by testing for fecal occult blood and/or sigmoidoscopy has been shown in clinical trials to be effective in reducing mortality from colon cancer. Screening programs for colon cancer should target adults age 50 and above.

The budget which DOH has proposed cutting should be restored. Significant additional resources should be added focused on cancer prevention. These funds should be allocated for the following: 1) additional personnel dedicated solely to the cancer prevention programs at the central and regional levels, 2) supplies for screening programs, 3) drugs for patients with cancer, 4) radiotherapy equipment for hospitals which treat patients with cancer, and 5) informational campaigns and materials.

For the cancer prevention programs to succeed, visible support should be forthcoming from the Secretary of Health and the Undersecretary for Public Health Programs. The cancer prevention and control efforts must be widely perceived as representing a high priority for the DOH. This commitment must be sustained over the next decade.

The capabilities of midwives and barangay health workers should be systematically assessed. Success rates at detecting and modifying risk factors should be evaluated. Great caution should be exercised in giving these workers responsibilities beyond their training. Otherwise, patients could be harmed, both directly through misdiagnosis and indirectly through not receiving appropriate preventive services.

**MEDICAL TRAINING**

Physicians and medical students have received little, if any, training in the prevention of cancer through modification of important risk factors such as smoking, unhealthy diet, physical inactivity, excess alcohol consumption, or occupational toxic exposures. They also devote little attention to performing appropriate screening tests for the early detection of cancer. Physicians are unprepared to handle these issues. Further, many of them smoke, making them poor role models. In a 1999 KAP study (Cornelio GH, Tanael SB, Ngelangel CA, et al) of Metro Manila Filipino community and hospital physicians on early cancer detection, there was little knowledge on early cancer detection. The early and health promotive counseling activities against cancer are not practiced by physicians in the hospital setting, even for age groups at risk. Preventive medicine was given least importance in the overall management in the hospital.

Systematic training programs in preventive medicine should be initiated in all Philippine medical schools. Continuing Medical Education (CME) programs in preventive medicine should also be developed for physicians in practice. These programs should place strong emphasis on the physician's role in the prevention of cancer through reducing lifestyle risk factors for these disease, e.g., smoking and unhealthy diet, and through prevention and control of risk factors for these diseases. The medical student and physician programs should place strong emphasis on the importance of various screening tests for cancer.

All physicians and medical students should be educated concerning the health effects of smoking and exposure to secondhand smoke. Medical educators and leaders should also stress the importance of their serving as role models for their patients.
POLICY ISSUES

Prices for cigarettes and alcohol are very low in the Philippines, encouraging consumption of these products. Cigarettes are heavily advertised as is alcohol, encouraging increased consumption. Warning labels are inadequate on both products. The DOH does not have funds for counter-advertising. The lack of strong smoking restriction policies fails to discourage smoking and also exposes non-smokers to secondhand smoke.

The price of cigarettes, other tobacco products, and alcohol should be raised substantially through government taxes on these products to reduce consumption of these items. The revenues from these taxes should be used to fund programs to combat smoking and excess alcohol consumption, including programs using the mass media. Cigarette advertising on television and radio should either be banned, or it should be countered with an aggressive mass media campaign concerning the dangers of both smoking and exposure to secondhand smoke.

The laws requiring that warning occupy a large portion of the cigarette package and advertisements should be enforced. The warnings should be more specific (e.g., cigarette smoking causes lung cancer). Alcoholic beverages and advertisements should carry warning labels (e.g., excess alcohol consumption causes cancer of the esophagus).

Television and radio stations should be required to provide free airtime for PSAs promoting healthy lifestyles and discouraging unhealthy behaviors such as smoking.

Laws should be enacted prohibiting or severely restricting smoking in all enclosed public places, including government buildings, restaurants, supermarkets, airport terminals, and transport vehicles (e.g., jeepsneys). Such laws should also apply to workplaces. This should be supplemented by a national campaign to inform the public about the dangers of secondhand smoke.

Law should prohibit Cigarette sales to minors, with strict fines for sales to minors.

TREATMENT GUIDELINES & PROBLEMS

Most cancers are detected at very late stages in the Philippines, too late for treatment to be effective. Even when detected early, patients face a severe shortage of chemotherapeutic drugs and radiotherapy equipment, resulting in excess suffering and death. National guidelines for treatment are not widely used.

Systematic efforts should be undertaken to maximize the chances the cancers will be detected at early stages, when treatment is much more likely to reduce morbidity, suffering, and mortality from cancer. Increased resources should be provided to the DOH for the purchase of chemotherapeutic drugs and radiotherapy equipment. Once completed, the cancer treatment guidelines should be disseminated widely to physicians and hospitals treating cancer patients.

QUALITY CONTROL OF TESTING & SCREENING SERVICES

Quality control for the reading of PAP smears has not been established. As a result, the accuracy of these readings is uncertain. Quality control programs should be established to assure the accuracy and reliability of Pap smear readings in laboratories in the Philippines.
It is urged that all of the recommendations are implemented within five years, and provision is given as to which ones should be begun first. If these recommendations are effectively and efficiently implemented, they can prevent the occurrence of the huge toll of premature death, disability, and costs from cancer that will otherwise be forthcoming. A comprehensive, sustained approach will be needed to accomplish this. This project absolutely requires political will and resources to succeed.

REFERENCES


THE COMMUNITY-BASED CANCER CARE/ CONTROL NETWORK

The Community-Based Cancer Care/ Control Network is a DOH-lead Network of communities, government organizations, non-organizations, and individuals aiming for and sharing responsibilities for total quality cancer care in the Philippines.

The underlying concept is – ‘Organizations don’t make progress. PEOPLE do… The organization is just a vehicle for human cooperation.’

It is premised that the Department of Health-Philippine Cancer Control Program (DOH-PCCP) calls for partnership initiatives at both the national and local levels for, among others, joint program undertakings and resource sharing between concerned private and government institutions. Such undertakings include the establishment of a community-based network for cancer control/care in the Philippines. In response to the recommendations above on the problems of the Philippine Cancer Control Program, the Community-based Cancer Care/Control Network began in 1998.

The CCCN vision is as follows - self-sufficient network of empowered communities sharing responsibilities for the total quality cancer care and control in the Philippines. Its mission is to organize, integrate and nurture a network of empowered communities sharing responsibilities for the total quality cancer care and control in the Philippines.

The Network is built around the idea that if many organizations and individuals pool their expertise, skills, resources and experience, and cooperate to achieve a common goal, they become a powerful force.

The Community-Based Cancer Care/Control Network (CCCN) is envisioned to be a multi-sectoral strategic approach to improve and redesign the implementation strategy of anti-cancer control/care in the Philippines. The CCCN is a venue to:

- Continuously update government cancer control program implementers, oncology graduates and caregivers on the advances and experiences in anti-cancer practice (CONTINUING MEDICAL EDUCATION & TRAINING).
- Establish a comprehensive community- and hospital-based Filipino cancer patient data and information based on the paradigm of quality care and evidenced-based care (MONITORING & INFORMATION).
- Serve as the Philippine Cooperative Cancer Study Group (RESEARCH & EVALUATION).
- Provide continuity of cancer care from primary, secondary, tertiary to hospice care, from the community to the hospital to the community (PUBLIC HEALTH & CLINICAL MANAGEMENT).
The CCCN is composed of local community-based cancer control groups called Local Cancer Control/Care Network (LCCAN) or NODE that will network with each other towards a common goal. Each LCCAN or NODE will center on a tertiary government hospital; each node is composed of a network of satellites such as the Department of Health-PCCP local units, Department of Education, Culture & Sports Regional Health divisions, Department of Social Service and Welfare Health units, Department of Interior & Local Governments Health units, the Andres Soriano Cancer Foundation, the Eduardo J Cancer Center, Hospice Care Organization, Kapisanan ng May K Support Groups, Pain Management Society local units, Oncology Medical Societies local units, the Philippine Cancer Society local units, Psychosocial counselor-volunteers, the local Academe, patient/ family support groups, philanthropists, funding agencies and other interested agencies (GOs and NGOs) and individuals (volunteers). The DOH PCCP Unit will be the lead agency. The major cancer control-related NGO in the locality would be the lead NGO agency. These Nodes shall be self-sufficient and self-reliant. The benchmarks for functionality of the nodes are the following:

- Identify and meet with multi-sectoral counterparts.
- Identify and commit an Office for the LCCAN, wherein the secretariat-coordinator will be housed, the communications will be directed, the tumor registry will be pooled, the LCCAN members will meet and plan, preferably in the Regional Hospital where the LCCAN nodal oncologist is practicing.
- Source funds for sustainability of the LCCAN Office and the cancer control activities; funds from DOH (Hospital, RHU, NCDCS), LGU, NGO (Rotary, Lions, etc.), Cancer Foundations-Philanthropists, Fund-raising activities, Philippine Charity Sweepstakes, etc.
- Get collaborators from media – local newsprint, radio, television.
- Establish cancer registry; start data collection and computer entry.
- Establish screening programs: cervical (Pap smear; microscope), breast (breast exam), colon/ prostate (digital rectal exam), oral cavity visual exam, whole body physical exam; high technology screening programs to come later (colposcopy, mammography, colonoscopy).
- Upgrade cancer treatment facilities of the regional hospital (surgery, gyno-oncology, radio-oncology, medical/ pediatric oncology, pain- psycho- spiritual- palliation- rehabilitation); maintain cancer treatment and dedicated screening clinics in the regional hospital.
- Form cancer support groups and community volunteers.
- Technical and logistical support for the National Center for Health Development’s (NCHD) Collaborating Centers to hospitals.

Since 1998, several Network Nodes have been conceived, organized, lead and or collaborated to by the Regional DOH PCCP Coordinator, the area oncologist, and others. These Nodes are more commonly identified by the names of the Support Group established thereof: NCR – KMKP (Kythe, Life, CanSurvive, ARUGA, St. Luke’s Patient Forum, PCSI Support Group, PGH Support Group, Paraiso, etc.), Baguio – Joy Club, San Fernando-La Union – Pagsangiran, Cabanatuan-Nueva Ecija – New Hope in Cancer Care, Bacolod – FACES, Iloilo – ICARE, Cebu – CCNC (CAN with GOD), and Davao – SMILES.

In year 2000, the CCCN started to implement single hospital tumor registry software (CCCN HTR) for the different component hospitals of the Network and the DOH-PCCP. The Philippine College of Surgeons in collaboration with the Philippine Cancer Society and the CCCN joined in the HTR implementation in its accredited surgical training hospitals nationwide.
The DOH-PCCP is under the DOH Program on the Prevention & Control of Cardiovascular Disease and Cancer, one of the top ten priority health programs of the DOH.

REFERENCE