For An Organized Cervical Cancer Screening Program in the Philippines – The Health Policy Brief


The Burden of Cervical Cancer

Cervical cancer is a preventable disease. Yet, it is the 2nd most common cancer among Filipino women. Its incidence rate has persisted from the 1980s up to the present with an annual age-standardized rate of 22.5 cases per 100,000 women.¹

Cervical cancer is also a killer disease. Of the thousands of Filipino women, who are diagnosed with cervical cancer, 56% will die within 5 years from the diagnosis. A killer disease controlled in many developed countries by reductions in incidence and prevalence by as much as 90% - a reduction brought about by well-organized screening programs detecting and subsequently treating cervical cancer precursors and early lesions.²

Indeed, women detected with precursor and/or very early disease stage then managed appropriately, have 5-year survival rates of 100% & 68-90% respectively.³ Detection and management is more efficiently and effectively provided by an organized cervical cancer screening program rather than convenience or spontaneous cervical cancer screening programs.

Sadly, the Philippines does not have any organized cancer-screening program. A cancer registry covers only 25% of the country’s population.⁴ There is no routine recording of the proportion of the population who undertake cancer-screening tests. There is an acknowledged lack of public knowledge and awareness of the benefits of cancer-screening tests. And cancer screening is not given importance in the education and training of health professionals.

The government cancer-screening infrastructure is patchy at best with intermittent supplies, training and service provision. The private health care delivery sector is not even obligated to participate in a convenience-screening program with its screening guidelines always emphasizing its recommendatory nature and the absence of sanctions or incentives for compliance. And there is no mandate for the continuity of care expected from a screening program from health providers.

The Cervical Cancer Screening Health Operations Research Project

The Cervical Cancer Screening Health Operations Research Project (CCSHORP) is a national research project conducted by the University of the Philippines, Manila, and the International Clinical Epidemiology Network, under the directive of the Department of Health.

Its most critical objective was to determine the most cost-effective, cost-beneficial, feasible, and community-acceptable cervical cancer screening modality that can be the core of an organized cervical cancer-screening program. Other study objectives were - a) to assess how the identified screening option can be institutionalized given the health service infrastructure; b) to identify the specific training needs for the identified screening modality; and c) to determine the necessary support from national and local governments for the implementation of an organized screening program.
Indeed, the CCSHORP addressed issues related to the screening program - Whether the country’s present health care delivery and referral system is capable of implementing an organized cervical cancer-screening program; whether our health professionals have the appropriate knowledge, attitude and skills needed by the program; and whether the local health units, provincial health units, district health units, regional and central DOH units are willing to change (including increase in budget allocation, personnel, supplies, equipment) their respective existing health care delivery system and integrate cervical cancer screening elements.

Other issues answered by the CCSHORP included - Are the benefits from an organized cervical cancer-screening program worth the costs of its implementation? What are the necessary actions that will strengthen implementation and overcome potential barriers? Can it overcome allegedly cultural and social aversion of Filipino women to vaginal examinations in general and cervical screening in particular?

 METHODOLOGICALLY, a randomized-controlled trial (RCT) comparing the sensitivity rates of 4 alternative cervical cancer screening methods was done. In the RCT, 13105 women from various health facilities nationwide were included and randomly distributed to the 4 alternative screening methods.

An economic analysis was then conducted with cost analysis of the 4 alternatives and inputted together with the effectiveness results of the RCT.

A knowledge, attitude and practice (KAP) study was also conducted to determine the public acceptability and the accompanying social-cultural barriers to cervical cancer screening.

SUBSEQUENTLY, the study results were enlightening. Acetic acid aided visualization of the cervix (or Acetic acid wash) was unanimously the screening method that was most effective and cost effective among the four screen methods, in the current Philippine setting. Acetic acid wash was not only more sensitive in detection than Pap smear but was more cost effective. Acetic acid wash also requires the least personnel, facilities and other infrastructure needs for an organized cervical cancer-screening program.

With colposcopy or biopsy as the gold standard, acetic acid wash was the most sensitive to detect cervical cancer precursor and very early lesions at 50% compared to magnified acetic acid wash (49%), spatula+swab Pap smear (21%) and cervix brush Pap smear (17%).

Economic analysis of the different screening methods from a societal perspective later reiterated the choice for acetic acid aided visualization of the cervix as the most cost-effective method with a cost-effectiveness ratio PhP 476 or US$ 11 per woman screened. This is in comparison to the PhP 479 or US$ 11 per woman screened for magnified acetic acid aided visualization of the cervix, PhP 608 or US$ 15 per woman for spatula+swab Pap smear and PhP 632 or US$ 15 per woman for cervical brush Pap smear.

Cost-benefit analysis, using different assumptions, shows that acetic acid was the most cost-beneficial of all the screening modalities ranging with a net benefit of PhP 810 million to PhP 3.13 billion (US$ 20 M to 78.25M).

SYSTEM-WIDE, the UP-DOH CCSHORP identified the following guidelines for an organized cervical cancer-screening program.

 Policy-wise, acetic acid wash screen method would be the screening method for the organized screening program. The organized screening program would be named the Cervical Cancer Screening Program of the Philippines. In cases of positive or suspicious lesion on screen, the woman will be immediately referred for colposcopy. Positive or suspicious lesions on colposcopy will then undergo biopsy. In areas without colposcopy, Pap smear and or Acetic-acid guided direct biopsy of the cervix would be done. The biopsy specimens will then be sent to
pathologists for immediate reading and then treatment will be given as needed by the gynecologists.

**Administratively**, there should be identification of pilot local government units (LGU) with a registry of target women 25-55 years of age within each LGU initiated and maintained. Screen coverage of 50-70% of the target women (over 2-7 years per locality) with a screening interval of 5 to 7 years was also set. Non-governmental organizations must be integrated into the program.

Other necessary national policy is a policy for the preparation and motivation of the target women population to attend the screen clinics by a **nationwide public information campaign**.

**Clinically**, there should be dedicated screen centers and or clinics within the barangay or municipality with identified and trained dedicated health personnel for the screen clinics.

In each screen clinic, there should be adequate equipment including exam tables, speculight, heavy-duty sterilizer, speculoscropy with batteries, sterilizing chlorox solution, and other necessary equipment. On the average, the equipment cost PhP 90,000 in 1999. There should also be standardized screening and referral methods for these clinics.

To maintain the continuity of care, dedicated referral hospitals within the municipality or province or region must also be identified with the corresponding dedicated trained health personnel for the hospital screen, colposcopy & treatment clinics. These will be accompanied by standardized screen, colposcopy and treatment methods. The Philippine Association of Hospitals and medical/paramedical specialty societies will help facilitate this process.

**Training-wise** and to support the screening for and treatment of cervical cancer, the Philippine Obstetrical & Gynecological Society (POGS) or the University of the Philippines Department of Obstetrics-Gynecology must train central DOH core health personnel trainers for the screen, colposcopy and treatment methods. Also the Department of Obstetrics & Gynecology of the various Regional Hospitals & Medical Centers of the country in collaboration with the central DOH and the POGS local chapter should train their identified dedicated health personnel for the screen, colposcopy and treatment methods within their locality. Core health personnel per LGU will be also identified and trained to be trainers in their respective regions, in collaboration with DOH and the local POGS chapter, and or other NGOs with similar interest.

Additionally, other medical/paramedical societies, medical schools, and other health professional schools can train health professionals in these screening and treatment methods.

**Involving The Stakeholders**

After the study results and the system recommendations, focus group discussions (FGDs) were then conducted to identify the processes to facilitate the implementation of the proposed organized cervical cancer-screening program.

In the focus group discussions, consensus was attained for an organized screening program for cervical cancer to be funded and set-up with the Department of Health as lead agency. There was acceptance of acetic acid wash as the screening method of choice for cervical cancer in the local setting.

The FGDs also identified 2 major barriers to the proposed program. The first was the acceptability of the acetic acid wash as screen method of choice in the Philippine setting by the clients, health providers, and other practitioners, observers/media. The second was a funding and/or financing barrier as to who pays what.
Other identified barriers were attitudinal problems emanating from providers, the potential loss of income of certain providers, training and competency issues, health human resource needs and continuity of care, and accessibility of referral centers.

In response to the first identified major concern, the ongoing policy advocacy was initiated to generate acceptability. Plans for public information campaign, training of providers and talks of influential persons were also made and implemented.

In response to the second identified major concern, the following table of the critical elements of an organized cervical cancer screening program and the potential sources of financing were elicited from health stakeholders in the FGD.

<table>
<thead>
<tr>
<th>CRITICAL ELEMENTS</th>
<th>POTENTIAL SOURCES OF FINANCING</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TRAINING</strong></td>
<td></td>
</tr>
<tr>
<td>1) Core Provincial Trainers</td>
<td>1) DOH – as lead agency of women’s health &amp; development and the Cervical Cancer Screening Program (CCSP)</td>
</tr>
<tr>
<td>2) Frontline Health Worker Implementers</td>
<td>2) DILG, LGUs – as employers of frontline health workers</td>
</tr>
<tr>
<td>3) DOH – as lead agency of CCSP</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EDUCATIONAL CAMPAIGN (IEC)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Mass media, nationwide</td>
<td>1) DOH – as lead agency for CCSP</td>
</tr>
<tr>
<td>2) Mass media, local</td>
<td>2) DILG, LGU – as part of LGUs health awareness campaign among its local constituents</td>
</tr>
<tr>
<td>3) In-center IEC</td>
<td>3) Schools/ NGOs - in fulfillment of their Vision-Mission-Goals (VMG)</td>
</tr>
<tr>
<td>4) School (medical/ paramedical)</td>
<td></td>
</tr>
<tr>
<td>5) Women work groups</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>QUALITY ASSURANCE</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Registry</td>
<td>1) DOH – as lead agency of CCSP</td>
</tr>
<tr>
<td>2) Screening</td>
<td>2) LGU - as provider of health service to local constituents</td>
</tr>
<tr>
<td>3) Training</td>
<td>3) NGOs - in fulfillment of their Vision-Mission-Goals (VMG)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>INFRASTRUCTURE</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Referral Hospitals</td>
<td>1) DOH – as lead agency of CCSP</td>
</tr>
<tr>
<td>2) Screen Clinics</td>
<td>2) LGUs – as provider of health service to local constituents</td>
</tr>
<tr>
<td>3) DOH - as lead agency for CCSP</td>
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</tbody>
</table>

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<tr>
<th>HEALTH PROVIDERS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Screen Clinics</td>
<td>1) DOH - as lead agency for CCSP</td>
</tr>
<tr>
<td>2) Referral Centers</td>
<td>2) LGUs - as provider of health service to local constituents</td>
</tr>
<tr>
<td>3) DOH - as lead agency for CCSP</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>COST OF SCREENING</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Screen Clinics, LGUs</td>
<td>1) DOH - as lead agency for CCSP</td>
</tr>
<tr>
<td>2) Screen Clinics, Hospitals</td>
<td>2) DILG, LGUs, DOLE – as provider of health service to the various employees and workers in the Philippines</td>
</tr>
<tr>
<td>3) NGOs - in fulfillment of their Vision-Mission-Goals (VMG)</td>
<td></td>
</tr>
<tr>
<td>4) Women – as a benefit for themselves as consumers of health services</td>
<td></td>
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</tbody>
</table>

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<thead>
<tr>
<th>COST OF DIAGNOSIS &amp; TREATMENT</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Women’s Health Care Clinics, LGUs</td>
<td>1) DOH - as lead agency for CCSP</td>
</tr>
<tr>
<td>2) Diagnostic/ Treatment Referral Centers/ Hospitals</td>
<td>2) DILG, LGUs - as provider of health service to local constituents</td>
</tr>
<tr>
<td>3) PHIC – as per ‘benefit package’ for its members</td>
<td></td>
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<tr>
<td>4) DOLE – as provider of health service to the various</td>
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4
**Proposed Policy Tools**

In the end, as we look forward towards an organized cervical cancer screening program and its critical elements that need to be in place for the proposed program to succeed, there are several policy tools that must be implemented.

**POLICIES**

![Diagram 1](attachment:image.png)

Using diagram 1 as the basis for identifying the critical elements, the following policy tools are recommended:

1. **National Legislation**

   In order to build up the providers, facilities and training needs for both the screening and treatment components for the organized cervical cancer screening program, there is a need to legislate for both the institutionalization of the program and the financing of the above enumerated needs.

   The *legislation could be* in the form of the Food Fortification Law or Republic Act 8976 which by analogy would be legislation mandating all health care providers to build their respective capacity to provide cervical cancer screening. This type of legislation will not have any financing or funding component but will only MANDATE all to provide the screening and treatment.

   However, this type of legislation may not be able to elicit the necessary compliance even if it is mandatory. Thus, funding has to be integrated into the proposed law, or parallel legislation on funding has to be enacted.
The second option for legislated funding in support for the program can be of 2 forms. It can be a CAPITAL OUTLAY-based funding legislation which will provide funds for building up the capacity and capability of providers and facilities or it can be a RECURRENT COSTS-based funding to support the recurrent costs of public information and education campaigns, and the screening and/ or treatment costs.

A third option albeit a weaker policy tool can be a legislation that is in effect a resolution. An example of this law is the Diabetes Law, which basically recognizes that diabetes is a problem and that priority should be given to address it. A variant of this law is the AIDS/ HIV law which legislates the creation of a committee to address HIV/ AIDS and set guidelines for combating the disease but does not provide funding for setting up screening clinics nor for the treatment of HIV (+) and AIDS patients. Nonetheless, these laws place the identified diseases into the national policy agenda and facilitate policy responses from other sectors.

2. Local Legislation

In addition to national legislation, local legislation is another policy tool recommended for the program. The recommended local legislation are in the type of funding ordinances for either capital outlays such as facilities, equipment and training or for recurrent costs of the screening and treatment. Indeed, local ordinances are necessary policy tools for the success of the program as stated in the FGDs by the health stakeholders. LGUs must financially support a large part of this proposed screening program.

3. DOH/ DILG/ DOLE and other National Agencies Program Prioritization

Another policy tool is for the DOH (Department of Health), the DILG (Department of Interior & Local Government), and DOLE (Department of Labor & Employment) to prioritize cervical cancer screening in their respective ongoing programs.

Assuming that there will be a national policy declaration for an organized cervical cancer screening program without any accompanying funding, the above national agencies and other national agencies can put the screen program up front.

Particularly, the DOH can set up dedicated cervical cancer screening and treatment facilities in the DOH (soon to be corporatized) hospitals. NGOs like the Philippine Association of Hospitals can facilitate this process. The DILG can mandate the LGUs through its administrative supervisory powers over LGUs to set up the same in their respective locality. The Department of Labor & Employment can mandate that cervical cancer screening be part of the labor-related regular physical examinations.

Other national agencies such as the Department of Education, Culture & Sports (DECS) and the Commission on Higher Education (CHED) can develop and require lessons on the benefits of cervical cancer. The Department of Social Welfare and Development (DSWD) can provide subsidies for indigents in accessing screening and treatment. The Department of Agrarian Reform (DAR), the Cooperative Development Authority, the Department of Agriculture can provide educational and information support on the program focusing on the non-formal sector. The National Economic Development Authority (NEDA) and the Department of Trade & Industry can provide investments and tax incentives for investors into the program.

Pointedly, even in the absence of national legislation which both institutionalize and finance, executive actions can be made in support of the proposed program:
a) Health Insurance Benefit Development

An excellent policy tool would be the inclusion of the elements of the proposed cervical cancer-screening program into the schedule of benefits of the National Health Insurance Program (NHIP). Admittedly, the NHIP cannot afford to pay for the screening given its present capacity. However, a benefit package covering for the confirmatory diagnostics and treatment of those screen (+) and diagnosis (+) cases can be developed and implemented.

b) Private Health Sector Mandatory Recommendations

Another policy tool can be the development of mandatory recommendations on conducting the screening emanating from the professional societies of the front-line health care providers. The Philippine Obstetrics & Gynecology Society (POGS), the Philippine Academy of Family Physicians, the Philippine Medical Association, the Philippine Nurses Association and the Integrated Midwives Association of the Philippines among others can require the training and conduct of the cervical cancer screening as requirement for both admission and continued membership in their societies.

c) Capturing Media & NGO Advocacy

Finally, a quasi-policy tool would be convincing media and NGOs to be advocates of cervical cancer. These two sectors are powerful advocates who can both drive policy by themselves or can generate public demand for the advocated policies.

Additionally, they can partially provide public education and information on cervical cancer screening and its benefits by their very advocacy. So although, capturing media and NGOs to be the advocacy is not a policy by itself, to do so is tantamount to implementing the policies their advocacy will result into.

For An Organized Philippine Cervical Cancer Screening Program

The expected and much-awaited benefits from an organized cervical cancer screening program cannot be and should not be discounted by the difficulties that we expectedly will face in instituting the program. A lot is needed to set up the program but a lot, as already proven, will also be gained.

The steps in attaining and building up the program have been clearly planned and laid. The challenge is to convert these laid up plans into a dynamic, functional and sustainable program. A task that needs policy-makers from all levels to buy in and support.

There is currently a Philippine Cancer Control Program of the Department of Health. This Program has one of its sub-programs, the Cervical Cancer Prevention & Control Program. However the strategy for this Cervical Cancer Screening Program should be an organized cervix cancer-screening program with acetic acid wash as the first screen procedure of choice (see Appendix 1).
Appendix 1: Implications of the UP-DOH CCShor Project - For an Organized Cervical Cancer Screening Program in the Philippines

Fund/ Set-up an organized Cervical Cancer Screening Program in the Philippines.

- Components of the Organized Philippine Cervical Cancer Screening Program:
  - SYSTEMS
    - Financing
    - Infrastructure
    - Training
    - Registry
    - Public Information Education Campaign
    - Screening
    - Diagnosis & Treatment
  - Coordination
    - Department of Health
      - Central/National
      - Regional
    - Department of Interior & Local Government
      - Local/Local Government Units
    - Non-Government Organizations (NGOs)
  - Referral & Follow-up & Recall
    - Screen Clinics
      - Municipal Health Centers
      - Hospitals
      - NGOs
    - Colposcopy & Treatment Clinics
      - District, City & Provincial Hospitals
      - Regional Hospitals & Medical Centers
      - NGOs
    - Registry Stations
  - Quality Assurance
    - Screen Clinics
    - Treatment & Diagnostic Clinics
    - Registry
  - TRAINING
    - Acetic Acid Wash Screen
    - Colposcopy
    - Cervix Pathology
    - Treatment for Precursor & Invasive Cervix Cancer and Common Infections of the Cervix
The following are the proposed steps in the operationalization of the nationwide organized cervical cancer screening program.

- Identify (communities with relative readiness for such a screen program) & prepare screen start-off barangays/municipalities within the Province.
- Schedule & Prepare next barangays/municipalities within the Province for screen coverage in the next years.
- Start a registry of target women 25-55 years of age within each Province, commencing with the screen start-off communities within the Province.
- Target screen coverage of 50% women initially and then aim for 70%.
- Screen at an interval of 5-7 years per woman.

Equally apportion the number of barangays to be covered per year to complete coverage of each municipality/city in 2-7 years.

Apportion number of barangays per year to be covered, according to number of women aged 25-55 years old in each barangay. The UP-DOH CCSHORP indicates that for a 12 months operation, 1,920 women will have been served by a dedicated 1-exam-bed MHU screen clinic. For 100,000 women coverage, about 52 one-exam-bed screen clinics will have to simultaneously operate during the year. Philippines (1995 National Census Statistics) has - 16 Regions, 3 to 11 (average=5; total=79) Provinces per Region, 5 to 225 (average=20; total=1,566) Municipalities per Province, 0 to 12 (average=0.6; total=49) Cities per Province. 25-54 years old women population of each city is 3,638 to 396,023 (average=62,561; total=2,252,197) and 182 to 73,862 (average=6,728; total=8,982,257) for each municipality. The smallest municipality can complete its screen coverage in less than a year; the biggest city in 5-7 years. The Philippines has a growth rate of 2%.
Contract out screen project to NGOs with expertise and equipment to do the screen, if needed; and/or provide incentives to NGOs to join in the screening efforts.

Identify dedicated screen centers and or clinics within the barangay or municipality.

Identify and train dedicated personnel for the screen clinics. The UP-DOH CCSHORP recruited and screened women at a faster rate when clinic schedules dedicated to cervical cancer screening activities were implemented. The UP-DOH CCSHORP trained physicians (hospitals & MHUs) nurse (Bauang) and midwife (Metro Manila MHUs) to perform the screen procedure, with favorable results. The nurse and midwife were under the supervision of the physician. The MHUs have physicians, nurses, and midwives who render service to women’s health and care.

Equip screen clinics. Per screen center needs: 2 exam tables, 2 pairs stirrup, 2 Kelly pads, 2 light sources/ speculights, 2 roller chairs, vaginal speculum (30 medium, 10 small, 10 large), 1 heavy-duty sterilizer, 2 speculoscopy w/ batteries, sterilizing chlorox solution, cotton balls/ applicators, 4 forceps, saline, 3% acetic acid, iodine, gauze, 3 large size stainless steel trays, 2 foot stools, 2 pillows, 8 pillow cases, 8 linen, 8 hand towel, 1 electric fan or 1 aircon (preferred; optional). Average total cost (1999 figure) would be PhP 90,000.

Standardize screen and referral methods. The UP-DOH CCSHORP has prepared screen and referral Standard Operating Procedures (SOPs).

Identify dedicated screen referral hospitals within the municipality or province or region.

Identify and train dedicated personnel for the hospital screen, colposcopy & treatment clinics.

Equip clinics to perform both screen, colposcopy & treatment functions. Most of the Philippine Regional Hospitals and Medical Centers are equipped with gynecological surgery equipment. Currently gynecology, medical and radiotherapy oncologists are undergoing training at the Philippine General Hospital and the Jose R. Reyes Memorial Medical Center, with priority given to physicians who will serve outside of Metro Manila after their training. Drugs for cervix cancer treatment (e.g., cisplatin) are readily available in the Philippines. However, provision for indigents must be made by the DOH and DILG. Radiotherapy facilities are concentrated in Metro Manila, Baguio City, Cebu City, Iloilo City, Davao City, and Zamboanga City. There is a need for placement of radiotherapy machines (cobalt) and personnel (radiotherapy-oncologist & technician) in central Luzon (Paulino J. Garcia Memorial Medical Center), Laoag City in Ilocos Norte, Tuguegarao in Cagayan Valley, and Cagayan de Oro City in Mindanao (Northern Mindanao Medical Center). A cobalt machine (with a simulator) costs about PhP 40 M. Per hospital screen, colposcopy & treatment center – screen equipment as above, plus 1 colposcopy, 1 CKC or LEEP, 5 endocervical curette, 5 Emmet tenaculum, 5 iris hook, 5 endocervical speculum, 5 cervix biopsy, histo/cyto-pathology needs. Average total cost would be about PhP 800,000.

Prepare and motivate the target women population to attend the screen clinics.

Do public information campaign. Mass media campaign: 30 seconds or 15 seconds radio commercial whole month every other month, 30 seconds television commercial for a one month every 6 months. The UP-DOH CCSHORP IEC arm has prepared for mass media campaign: a theme song, a 30 seconds/ 15 seconds radio-commercial, and an educational flip-poster for the screen centers. A 30-second television commercial should also be made. The campaign focuses on acetic acid as the screen method of choice. Encourage cervical cancer screening during any of the women’s pre-natal visits. In-health center focus group or one-on-one campaign: Use educational flip-posters.
/>Tap the Philippine Obstetrical & Gynecological Society or the University of the Philippines Department of Obstetrics-Gynecology initially to train core health personnel for the screen, colposcopy and treatment methods.

/>Identify core health personnel per Province to be trainers in their respective regions. The UP-DOH CCSHORP FGD concluded that training is a must for the CCSP to be successful, and that training should include changes in curricula and teaching strategies in the medical, nursing and midwifery as well as medical technology schools.

/>Request medical (PMA, PAFP, PGOS, SGOP) and paramedical specialty societies (PNA, IMAP, PAMET) to include the screen (acetic acid wash) and diagnostic (Pap smear, colposcopy) and treatment methods of choice, in the curriculum and teaching strategies of physicians, nurses, midwives, medical technologists.

/>PRC, CHED and APMC to institute knowledge and skills in cervical cancer management as core knowledge of all medical & paramedical curricula.

/>Philippine Association of Hospitals to facilitate an organized cervical cancer screening program within their member hospitals.

/>Implement acetic acid wash as the screen method for the Philippine Cervical Cancer Screening Program. 3-5% acetic acid solution can be ordered from the pharmacy or drug store.

/>For positive or suspicious lesion on screen, immediately refer for / do colposcopy.

/>For colposcopy positive or suspicious lesion, immediately do biopsy.

/>Send biopsy specimen to pathology for immediate reading and feedback results.

/>Treat lesions accordingly following SOPs.

/>For negative lesions on screen, counsel against risk factors and advise follow-up for screen after 5 years.

/>Provide facilities for treatment of cervical cancer precursor, early and late cervical cancer lesions.

/>Provide facilities for treatment of common infections seen on cervix exam. The UP-DOH CCSHORP has made SOPs for treatment of cervix cancer precursor, early, and late lesions as well as for common infections seen on cervix exam. Treatment facilities needed: a) For precursor & very early lesions – LEEP, cold knife conization scalpel, hysterectomy needs, brachytherapy machine; b) For early to late lesions – personnel and needs for gynecology surgery, radiotherapy and chemotherapy (cisplatin); c) For infections – antibiotics & antifungals. The UP-DOH CCSHORP yielded 44% infections among colposcopy positive/suspicious lesions during the screen period.

/>Systematize screen registry, recall and referral systems.

/>Standardize screen and treatment data collection form.

/>Register women population per community as they are screened, with complete demographic, screen, and treatment data. Accuracy & confidentiality are guiding principles. The UP-DOH CCSHORP prepared a Philippine Cervical Cancer Screening Registry Software, based on experiences from the study.

/>Do quality surveillance.

/>Regularly update skills of cervix exam health providers in the field.

/>Report feedback summary of screening activities to the field and the DOH central office.

/>Assure sustainability of the CCSP. The UP-DOH CCSHORP Health Policy FGD (focus group discussion) identified the following funding sources for different components to maintain and sustain a successful organized cervical cancer screening program:

- Training –
  - Central DOH for initial training of core trainers of Regions & Provinces; DOH to provide technical expertise to the localities for the training sessions.
  - Medical Societies to provide bureau of trainers for acetic acid wash, colposcopy and cervix pathology.
  - DILG for training of frontlines in the barangays, towns, and cities. LGUs to organize training programs in their locality.
- **Public Information Campaign** –
  - Central DOH for mass media (radio, television) and
  - DILG/LGUs for in-center campaign. Leaflets from DOH (initial), LGUs (subsequent) and
  - NGOs (additional) – Philippine Cancer Society, Avon, Rotary, Lions, etc.

- **Registry & Recall** –
  - Central DOH for software/hardware support and training;
  - DILG/LGU for local registry & recall systems;
  - Philippine Cancer Society for computerized repository of Screen Registry Data nationwide.

- **Screening** –
  - DILG/LGUs for bulk of women in areas of responsibility;
  - NGOs (nurses or midwives or family physicians groups) to provide additional screen clinics under MOA (memorandum of agreement) with central DOH.

- **Treatment** –
  - Infections: DILG/LGUs for treatment of infectious diseases found on cervix screen; Central DOH under the RTD and STD-AIDS program.
  - Cervix Precursor & Cancer Lesions:
    - PHIC to cover diagnostic (colposcopy, biopsy, Pap smear) procedures after a positive or suspicious screen;
    - PHIC to cover treatment of precursor and early cervix cancer lesions (with higher benefits for those women compliant to screen program or were found with lesions during attendance of the screening program and lower benefits for those not compliant).

- **Quality assurance, Monitoring & Training Updates** – Central DOH under the *Sentrong Sigla* program.
- **Central DOH to**:
  - Identify and lobby for support from funding agencies – Philippine Congress & Senate, WHO, Ford Foundation, UNFP, Urban Health, AusAid, USAid, Bill & Melinda Gates Foundation, IARC, etc.
  - Explore possibility of instituting user charges or negotiated subsidies with LGUs or third party payors (i.e., PHIC, local HMOs, other private insurers).

**References**


