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Ovarian Cancer in the Philippines: Situationer, Implications, & NICCA PhilHealth NGO Strategies for Control

Philippine Cancer Society, February 2026

A. Situationer

Ovarian cancer in the Philippines is relatively uncommon compared with breast or lung cancer, but it is a leading cause of gynecologic cancer death and is usually diagnosed at an advanced stage due to the absence of effective population screening and low symptom awareness. [1]

1. Epidemiology (Philippines and global context)

- Globally, ovarian cancer accounts for about 314,000 new cases and 207,000 deaths annually; it ranks around 18th in incidence but 8th in cancer deaths among women because of late diagnosis. [2]
- In the Philippines, ovarian cancer is among the top ten causes of cancer death, after lung, liver, breast, colon, leukemia, and cervical cancers. [1]
- Filipino patients tend to be diagnosed younger than Caucasians: in a population- based comparison (1993–2002), more than 50% of Philippine-resident ovarian cancer patients were younger than 50 years. [3]
- Histologic profile in Filipinas shows relatively higher proportions of endometrioid (22%) and mucinous (24%) tumors and lower serous (20%) compared with Caucasians, which may affect biology and response patterns. [3]

2. Risk factors and prevention in Filipino women

- Core non-modifiable risk factors in Filipinas are similar to global data: increasing age, family history of ovarian/breast cancer, pathogenic BRCA1/2 and other susceptibility genes, prior breast cancer, and late menopause. [4]
- Modifiable or reproductive-hormonal risk factors include nulliparity, low parity, long-term postmenopausal hormone replacement therapy, and possibly obesity and high dietary fat intake; protective factors include multiple pregnancies, breastfeeding, and long-term oral contraceptive use. [5]
- Endometriosis is associated with a higher risk of clear cell and endometrioid ovarian cancers, which are relatively common morphologies in Filipinas. [3]
- For high-risk women (strong family history, known BRCA1/2), risk-reducing salpingo-oophorectomy and earlier, intensified surveillance are recommended in international and local expert opinion, although organized genetic counseling and testing pathways are still emerging locally. [4]
- Primary prevention strategies relevant for Filipino women include promoting healthy weight and physical activity, careful use of HRT, addressing reproductive health access (informed use of contraceptives), and integrating family history assessment into routine OB-GYN care. [6]

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3. Screening and early detection

- There is currently no effective population screening test (CA-125, transvaginal ultrasound, or multi-marker panels) proven to reduce ovarian cancer mortality, so no country-level organized ovarian screening program is recommended, including in the Philippines. [7]
- International and local expert opinion papers emphasize that, in the absence of an effective screening test, only a small proportion of cases are diagnosed at an early stage, when surgery alone can be curative. [7]
- Early detection efforts focus instead on:
  - Prompt evaluation of women with persistent, non-specific symptoms (bloating, early satiety, pelvic/abdominal pain, urinary urgency). [8]
  - Careful assessment of adnexal masses using standardized ultrasound-based risk models (e.g., IOTA-LR2) and selective biomarker panels. [8]
- A recent Filipino study showed that IOTA-LR2 ultrasound rules and a second-generation multivariate index assay (MIA2G) can help classify women with adnexal masses into high- vs low-risk for malignancy, supporting better triage to gynecologic oncologists rather than serving as population screening. [7]

4. Recent advances in early detection tools (Philippines)

- Population screening with CA-125 or transvaginal ultrasound has **not** shown mortality benefit and is not recommended for routine screening in average-risk Filipino women; focus has shifted to improved triage of adnexal masses.[7]
- A recent Filipino study assessed transvaginal ultrasound using the IOTA-LR2 model combined with a second-generation multivariate index assay (MIA2G) to stratify women with adnexal masses into high- vs low-risk for malignancy. This study showed that MIA2G and the combined algorithm improved sensitivity for detecting malignancy compared with CA-125 alone, supporting their use as diagnostic aids to guide referral to gynecologic oncologists rather than as screening tools.[5]
- These tools are particularly relevant for the Philippine setting where many women present with adnexal masses at non-oncology facilities; standardized risk models could help reduce inappropriate “benign” surgery in cancer cases and expedite referral, but cost and availability of assays remain implementation barriers.[7]

5. Diagnosis and staging

- Standard workup includes pelvic examination, transvaginal and/or transabdominal ultrasound, CT/MRI when feasible, serum CA-125, and other markers in selected histologies (e.g., AFP, β-hCG, LDH for germ cell tumors).[8]
- Definitive diagnosis and FIGO staging require surgery—typically exploratory laparotomy or laparoscopy with total hysterectomy, bilateral salpingo-oophorectomy, omentectomy, and systematic staging biopsies for epithelial cancers where fertility preservation is not intended.[3]

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- In the Philippine resident cohort, 78–90% of patients underwent surgery; however, chemotherapy utilization was much lower (24% of cases with known chemotherapy status) than in the US, suggesting access gaps.[3]

6. Treatment patterns and access

- Standard treatments for ovarian cancer in the Philippines largely follow international (NCCN-type) algorithms—modified by access constraints, while survivorship and early detection are limited by system and financial barriers.

a. Epithelial ovarian cancer

- For early-stage, low-risk epithelial disease (e.g., stage I grade 1–2), complete surgical staging may be followed by observation; for higher-risk early-stage and advanced-stage disease, the standard of care is cytoreductive surgery plus platinum-based chemotherapy (e.g., carboplatin-paclitaxel).[8]
- In advanced disease, optimal cytoreduction (no macroscopic residual disease) is strongly associated with improved survival; centers with gynecologic oncologists and multidisciplinary teams achieve higher optimal debulking rates. [9]
- Neo-adjuvant chemotherapy with interval debulking is an option where initial optimal cytoreduction is not feasible due to tumor burden or patient comorbidities.[9]
- Targeted therapies (PARP inhibitors for BRCA-mutated or HRD-positive tumors, anti-angiogenic agents) are standard in high-income settings but remain variably accessible in low- and middle-income countries, including the Philippines, due to cost and limited routine BRCA/HRD testing.[8,9]
- National/Philippine Cancer Society tertiary guidelines recommend treating epithelial ovarian cancer with primary cytoreductive surgery plus platinum-based chemotherapy (typically carboplatin–paclitaxel), similar to NCCN/ESMO.[10]
- For early-stage low-risk disease, surgery with full staging may be followed by observation or 3–6 cycles of adjuvant carboplatin-paclitaxel depending on histology and risk factors. [11]
- For stages II–IV, six cycles of carboplatin-paclitaxel every 3 weeks is standard following optimal or interval debulking surgery; alternative agents (docetaxel, gemcitabine, liposomal doxorubicin) are used when paclitaxel is contraindicated.[10]

b. Non-Epithelial Tumors

For non-epithelial tumors (germ cell, sex-cord stromal), guidelines support fertility-sparing surgery when feasible and BEP-type regimens (bleomycin, etoposide, cisplatin) or other histology-specific chemotherapy.[12]

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7. Survivorship and follow-up

- Follow-up care typically involves[8]:
  - Regular clinical review and symptom assessment (e.g., every 3–6 months for the first 2–3 years, then annually);
  - CA-125 monitoring and imaging, as clinically indicated, rather than routine scans in all patients.
- Recurrence is common in advanced epithelial ovarian cancer, often within the first 2–3 years, and management includes platinum-sensitive vs platinum-resistant treatment algorithms, palliative chemotherapy, and symptom control.[8]
- Survivorship needs for Filipinas with ovarian cancer include:
  - Management of treatment-related effects (premature menopause, neuropathy, fatigue), psychosocial and financial counseling, fertility and sexual health support;
  - Palliative care integration early in the disease trajectory to support symptom relief and decision-making.

a. Survival

- In the Philippine-resident cohort, incidence was about 11.5 per 100,000, similar to Caucasians, but survival was poorer even after adjusting for stage, age, and morphology.[3]
- Chemotherapy use among Philippine residents in that study was only about 24% of those with known data, significantly lower than in US cohorts, suggesting major treatment access gaps.[3]
- Broader international benchmarking finds that survival differences in ovarian cancer across countries correlate with optimal cytoreduction rates, chemotherapy intensity, and access to specialist gynecologic oncology services, all of which are variably available in the Philippines.[10]

b. Survival and disparities

- Five-year relative survival across populations (Philippines, Filipino-Americans, US Caucasians) falls in a relatively narrow band (about 49–54%), but Philippine-resident patients have worse absolute survival, especially in age groups 50–69 years.[3]
- The survival gap between Philippine residents and Filipino-Americans appears related to differences in access: lower chemotherapy use, fewer supportive services, and structural health system constraints rather than stage alone.[3]
- Global surveys of ovarian cancer care highlight similar barriers in LMICs: late presentation, lack of centralized gynecologic oncology services, limited imaging and pathology, and limited access to systemic therapies and clinical trials.[8]

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Survival: Philippines vs other Asian populations

Group / Region	5-year survival (approx.)	Key observations
Philippine residents (population-based)	Absolute ~44%, relative ~50% [3]	Worse survival despite younger age and similar stage vs Filipino-Americans.
Filipino-Americans (US)	Absolute ~51%, relative ~54% [3]	Better survival; same ethnicity but better system access and treatment rates.
Asians vs Whites (US SEER, mixed Asians)	5-yr disease-specific 59% vs 47% [13]	Asians overall have better DSS than Whites in a high-resource system.
Asian countries in ICBP comparison (e.g., Singapore, Hong Kong)	Higher survival than some Western cohorts, especially in younger patients [10]	Differences partly attributed to centralization and treatment intensity.

c. Challenges in survivorship care (Philippines)

- Recurrence is frequent in advanced epithelial ovarian cancer, but structured survivorship programs (scheduled follow-up, late-effects clinics, integrated psycho-oncology) are scarce in many LMIC settings, including the Philippines; follow-up tends to be episodic and physician-driven rather than programmatic.[9]
- Access barriers—out-of-pocket costs, travel from provinces to tertiary gynecologic oncology centers, and limited PhilHealth coverage for some drugs and imaging—constrain consistent follow-up, leading to late detection of recurrence and fragmented palliative care.[10]
- Symptom management for neuropathy, fatigue, premature menopause, sexual dysfunction, and psychological distress is often under-resourced; few centers provide dedicated rehabilitation, menopause counseling, or sexual health services for gynecologic cancer survivors.[8]
- Early integration of palliative care is recommended in global guidance, but implementation is patchy; many patients still access palliative services late, mainly for end-of-life care rather than longitudinal symptom and psychosocial support.[9]

B. Implications for a Philippine pathway

For the Philippines, priority directions emerging from current evidence include:

- Strengthening **timely diagnosis** in primary and secondary care by embedding symptom awareness and standardized adnexal mass assessment (IOTA-LR2, risk-based referral) into women's health services.[5]
- Regionalizing ovarian cancer surgery to centers with trained gynecologic oncologists to maximize optimal cytoreduction and appropriate staging.[9]

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- Improving access to platinum-based chemotherapy and supportive medications across public facilities, given the historically low chemotherapy utilization.[3]
- Building structured survivorship and palliative care programs that address long-term physical, psychological, and financial burdens on patients and families.[9]

C. Key Performance Benchmarks in NICCA 2024-2028 Roadmap

Vision and Mission (NICCP Strategic Framework)

Vision: "A Philippines where cancer is prevented, detected early, and treated effectively with equitable access to quality care and support."

Mission: Strengthen cancer control through integrated prevention, early detection, timely treatment, survivorship care, and palliative services aligned with Universal Health Care

Priority Performance Indicators (2024-2028)

Based on NICCA implementation and international NCCP benchmarking:

Indicator	Baseline (estimated)	2028 Target
Early-stage diagnosis rate (Stage I–II at diagnosis)	20–30%	≥40%
Treatment initiation within 30 days of diagnosis	45–55%	≥70%
Chemotherapy completion rate (full course)	~60%	≥80%
5-year relative survival (all cancers, population-based)	~45%	≥55%
Cancer Assistance Fund beneficiaries	~7,500/year (2023 data)	≥15,000/year
CSPMAP access sites	24 sites (2024)	≥50 sites
Gynecologic oncologist density	0.13 per 100,000 women	≥0.20 per 100,000
Palliative care integration (% of centers)	~30%	≥60%

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NICCA-Specific Ovarian Cancer Metrics (Proposed) For advocacy, push DOH-NCDPC to track:

- **Median time symptom-to-specialist evaluation** (target: <60 days)
- **Optimal cytoreduction rate** at designated centers (target: ≥50%)
- **Carboplatin-paclitaxel availability** (% of cancer centers with uninterrupted supply, target: 100%)
- **Survivorship clinic establishment** (% of tertiary centers, target: ≥40% by 2028)

D. PhilHealth Z-Benefit Details for Advanced Ovarian Cancer

Current Coverage (2026) Gynecologic Cancer Z-Benefit Package:

Procedure/Service	PhilHealth Coverage
Ovarian cystectomy	₱23,300
Gynecologic surgery (comprehensive staging/debulking)	Part of gynecologic disorders package
Chemotherapy (carboplatin- paclitaxel)	Covered under Z-benefit chemotherapy component
Total estimated coverage for advanced ovarian cancer	≈₱100,000–150,000 (surgery + chemotherapy course)

Compare with other gynecologic cancers:

- **Cervical cancer**: ₱125,000 (primary surgery or cobalt radiation) to ₱175,000 (linear accelerator + high-dose brachytherapy)
- **Breast cancer** (Stages 0–IIIA): ₱100,000 to ₱1.4 million depending on stage and treatment modality

Coverage Components

The Z-benefit package typically covers:

- Hospital room accommodation
- Laboratory tests and imaging
- Medicines (chemotherapy drugs on formulary)
- Doctor's professional fees
- Operating room and anesthesia fees
- Post-operative care

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Critical Gap

Targeted therapies NOT routinely covered:

- PARP inhibitors (olaparib, niraparib, rucaparib) for BRCA-mutated or HRD-positive disease
- Bevacizumab (anti-angiogenic therapy)
- These can cost ₱150,000–300,000+ per month out-of-pocket

NGO Advocacy Strategy

Push for PhilHealth expansion:

1. **Pilot coverage** for PARP inhibitors in confirmed BRCA1/2-mutated cases (cost-effectiveness data from SOLO-1, PAOLA-1 trials)
2. **Companion diagnostic coverage** for BRCA/HRD testing (currently not standardized)
3. **Survivorship surveillance package** (CA-125 monitoring, CT scans for recurrence detection—currently episodic, not systematized)

E. NGO Strategies to Address Oncologist Shortages in Rural Philippines

Current Crisis

- **142 gynecologic oncologists nationwide** = 0.13 per 100,000 women
- **Geographic maldistribution:** 70% concentrated in NCR, Central Luzon, Central Visayas
- **Visayas, Mindanao, rural provinces:** Severely underserved (many provinces have ZERO gynecologic oncologists)

Eight Proven NGO Strategies

1. Telemedicine Tumor Boards

- Partner with tertiary centers (PGH, Philippine General Hospital; UP-PGH; Asian Cancer Institute) to conduct weekly virtual MDTs (multidisciplinary team meetings)
- Rural OB-GYNs and general surgeons present cases → specialists provide treatment recommendations remotely
- **Example:** Philippine Society of Gynecologic Oncology (PSGO) pilot programs

2. Hub-and-Spoke Surgical Missions

- Coordinate visiting gynecologic oncology teams to regional hospitals quarterly
- Local teams assist in surgeries, gain training through observation, and co-management
- Build capacity for complex staging procedures where specialist travel isn't feasible regularly

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3. Fellowship Expansion Advocacy

- Lobby CHED and specialty boards to increase gynecologic oncology fellowship training slots from the current ~5–8 per year to 15–20
- Push for DOH scholarships with return-service agreements in underserved regions (DOST-style model)
- Target: 1 gynecologic oncologist per 50,000 women by 2035

4. Surgical OB-GYN Upskilling Programs

- Short-course training (3–6 months) for OB-GYNs in comprehensive staging, basic cytoreduction, and fertility-sparing surgery for early-stage cases
- **NOT replacing specialists**, but enabling earlier intervention and reducing referral delays
- Accreditation model similar to ALSO (Advanced Life Support in Obstetrics)

5. Patient Navigator Networks

- Train lay navigators in rural communities to recognize ovarian cancer symptoms, facilitate referrals, and coordinate transport
- Link to urban tertiary centers for definitive care, but the navigator stays involved to ensure treatment completion
- **Proven model:** Breast cancer navigation in Philippine Cancer Society programs

6. Mobile Ultrasound + Triage Clinics

- Deploy mobile units with IOTA-LR2-trained sonographers to secondary hospitals and rural health units
- High-risk masses → expedited referral to a specialist center
- **Cost-effective:** Prevents unnecessary "benign" surgeries at under-resourced facilities and catches cancers earlier

7. Regional Cancer Center Development

- Advocate for DOH designation of at least one Level 3 cancer center per region with full gynecologic oncology capability
- NGOs can co-fund equipment (surgical instruments, imaging), training, and patient support services
- **NICCA mandate:** "Strengthen network of cancer centers" (Section 10)

8. Advocacy for Competitive Salaries

- Work with LGUs and DOH to create "retention packages" for oncologists willing to practice in underserved areas (housing allowance, research support, CME funding)
- Benchmark: Thailand's rural doctor incentive program increased retention by 40%

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How NGOs Can Expand Cancer Access Sites Beyond 35 Locations

1. Current CSPMAP Infrastructure (2024)

- **24 DOH-accredited access sites** (per latest CSPMAP data)
- **35 Supportive-Palliative Medicines Access sites** (broader NICCA network)
- **Coverage:** Free chemotherapy and palliative medicines for high-burden cancers (breast, lung, cervical, pediatric, gynecologic)

2. Five Expansion Pathways for NGOs

a. Partner with Existing Level 2–3 Hospitals

Strategy:

- Identify provincial/district hospitals with oncology services but NOT yet CSPMAP-accredited
- NGOs fund:
  - Cold chain storage for chemotherapy drugs
  - Training for patient navigators and pharmacists
  - Electronic medicine inventory system
- Hospital applies for DOH CSPMAP accreditation (NGO supports application process)

Target: Add 15–20 sites in underserved regions (BARMM, Caraga, Bicol, Eastern Visayas)

b. Malasakit Center Integration

Strategy:

- 166 Malasakit Centers nationwide (one-stop shops for financial assistance)
- Advocate for mandatory CSPMAP co-location at all Malasakit Centers in hospitals with cancer services
- NGOs provide technical assistance for integration (patient flow, referral protocols)

Target: Could expand CSPMAP coverage to 60–80 sites immediately

c. LGU Co-Financing Models

Strategy:

- Negotiate with provincial/city governments to co-fund cancer medicines through LGU health budgets
- DOH CSPMAP provides formulary guidance, quality assurance, and reporting systems
- LGUs absorb operational costs (staff, logistics), NGOs provide seed funding and monitoring

Target: Pilot in 10 highly motivated LGUs (e.g., Iloilo City, Davao City, Baguio)

d. Private Hospital Partnerships (Charity Care Model)

Strategy:

- Private hospitals (Makati Med, St. Luke's, Asian Hospital) establish "charity care beds" for indigent cancer patients
- NGOs broker agreements where PhilHealth + CAF + private hospital CSR cover full costs
- CSPMAP medicines extended to these charity beds

Target: Add 5–10 private hospitals serving as safety net providers

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e. Mobile CSPMAP Units

Strategy:

- Convert mobile medical units (used for screening/vaccination) into traveling chemotherapy administration sites
- Partner with rural health units and barangay health stations for administration sites
- Gynecologic oncologist supervises remotely (telemedicine), trained nurses administer carboplatin-paclitaxel
- **Precedent:** Mobile TB-DOTS, mobile dialysis units

Target: Reach island provinces and geographically isolated areas (Palawan, Sulu, Mountain Province)

Funding Sources NGOs Can Tap

- **Cancer Assistance Fund (CAF)**: Lobby DOH for expansion allocations (currently ~₱654M distributed to 7,475 patients)
- **PhilHealth expansion**: Advocate for higher case rates and inclusion of CSPMAP sites in Konsulta/Yakap Provider Network
- **International donors**: Global Fund, USAID, Gates Foundation cancer control grants
- **Corporate CSR:** Pharmaceutical companies (patient access programs), banks, telecommunications (telco health initiatives)
- **Crowdfunding:** Community-based fundraising for local cancer center upgrades

Accountability Mechanism

NGOs should demand:

- **Public dashboard** of CSPMAP site locations, medicine availability, and patient enrollment numbers
- **Quarterly NICCA Council reports** on CAF disbursement and site expansion progress
- **Civil society seat** on the NICCA Council (mandated by RA 11215 Section 6)

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