From Evidence to Action: Insights from the Pilot Phase of the Philippine Colorectal Cancer Screening Initiative

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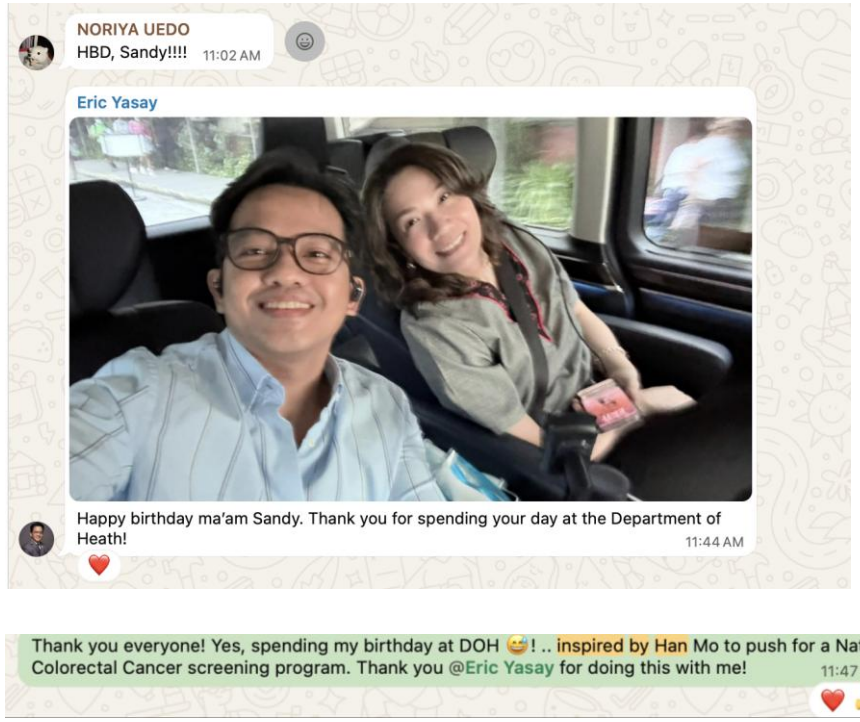
A Conversation that Changed our Direction

"Do you have a national colorectal cancer screening program in the Philippines?"

ANBIIG Workshop. Aug 2019, Manila

Prof. Han-Mo Chiu, PDHW -AC 2024



Filipino Gastroenterologists Committed to CRC Screening

THE PHILIPPINE REALITY

115 Million
population

7,000+
islands

24 Million
adults aged ≥50 years

~600
gastroenterologists

> The question was never whether screening works.
> The question was whether it could work in the Philippines.

THE FOUR CHALLENGES WE IDENTIFIED

GEOGRAPHY

How do we reach people?

PARTICIPATION

How do we get healthy people screened?

CAPACITY

Can the system absorb demand?

DATA

Can we track patients?

These four challenges shaped the design of our pilot.

FROM EVIDENCE TO ACTION: WHY NOW?

GOVERNMENT

NICCA
National Integrated Cancer Control Act

DOH
Cancer Control Program

Financing & policy support

PARTNERSHIP

PROFESSIONAL SOCIETIES

PSG
CRC Task Force

PSDE
Quality initiatives

Training & capacity building

The conditions for implementation finally came together.

NICCA – National Integrated Cancer Control Act | DOH – Department of Health | PSG – Philippine Society of Gastroenterology | PSDE – Philippine Society for Digestive Endoscopy

GOVERNMENT STARTS THE PROGRAM.
SOCIETIES MAKE IT WORK.

GOVERNMENT

- Policy
- Financing
- FIT procurement
- Primary care

PARTNERSHIP FOR IMPACT

PROFESSIONAL SOCIETIES

- Training
- Quality assurance
- Capacity building
- Referral pathways

A strong program needs both: **Government** creates access.
Societies ensure quality and sustainability.

DESIGNING THE PILOT AROUND PHILIPPINE REALITIES

CHALLENGE	PILOT RESPONSE
Geography	Urban and rural pilot sites
Participation	Community-based recruitment
Capacity	FIT-first strategy
Data	Registry and tracking system

The pilot was designed around the **realities of the Philippines**—not around the **experience** of other countries.

Geography Creates Inequity

Where people live can make it harder to access screening and follow-up care.

CHALLENGES

Archipelagic nation
Many islands and remote communities are far from major health facilities.

Long travel distances
Hours of travel by land and sea to reach care.

Indirect costs
Transportation, meals, accommodation, and other out-of-pocket expenses add up.

Lost wages
Time away from work means lost income for many families.

WHAT WE MUST DO

Culturally tailored campaigns
Respect local beliefs, norms, and health-seeking behaviors.

Materials in the same dialect
Use the local language and dialect that people understand best.

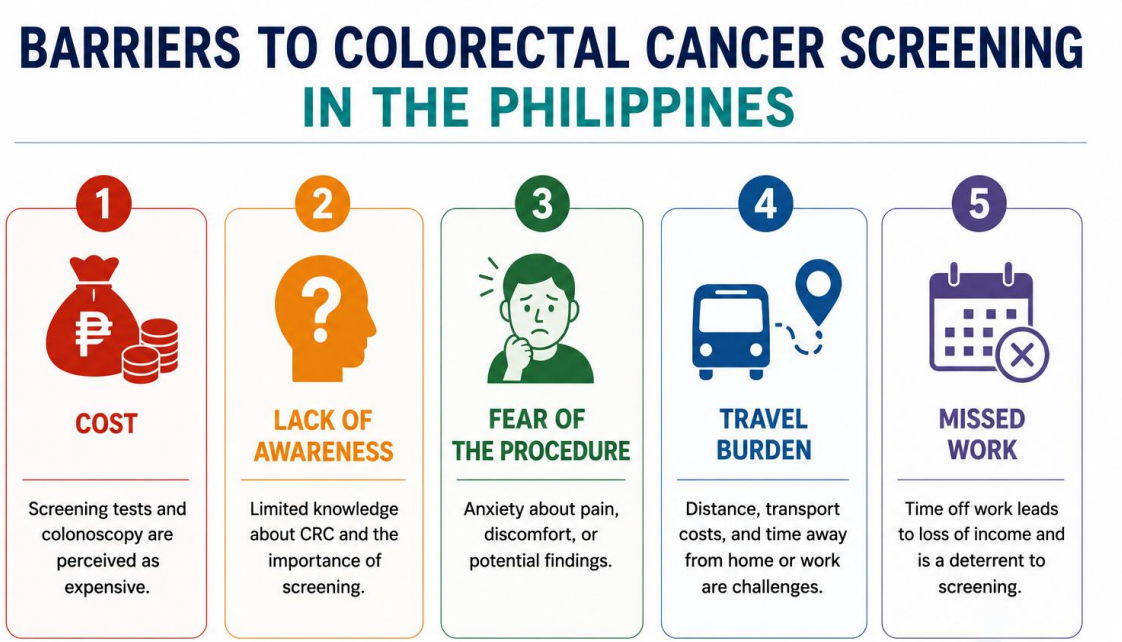
Community-based partnerships
Work with local leaders, barangays, and community organizations.

Decentralize and bring services closer
Mobile clinics, island missions, and partnerships to reduce travel burden.

Access Means More than Geography

Barrier	FOBT/FIT	Colonoscopy
"I have no symptoms"	**79%**	**77%**
Cost / financial burden	**45%**	**72%**
Fear of finding cancer	**49%**	**50%**
Fear/anxiety about procedure	—	**53%**
Lack of time	**38%**	**35%**

Finding	Result
Willing to join government screening programs	**86.1%**
Willing to pay out-of-pocket for screening	**46.9%**



Fernandez JK, et al. Acta Medica Philippina VOL. 58 NO. 22 2024

SCREENING CREATES FUTURE PARTICIPANTS

PATIENT EXPERIENCE SHOULD BE MONITORED AS A QUALITY METRIC

- Understanding
- Trust
- Convenience
- Navigation Support
- Satisfaction
- Willingness to Return

POSITIVE SCREENING EXPERIENCE

FUTURE PARTICIPATION

WHY IT MATTERS IN THE PHILIPPINES

Today many Filipinos:

- Have never heard of FIT
- Have never been invited to screening
- Do not know anyone who has undergone screening

After a positive screening experience:

- Fear decreases
- Acceptance increases
- Follow-up improves
- Word-of-mouth recruitment begins
- Community trust grows

A positive experience today influences participation tomorrow.

Patient experience is not a soft metric. It is a program metric.

DATA: THE LESSON WE LEARNED FROM TAIWAN

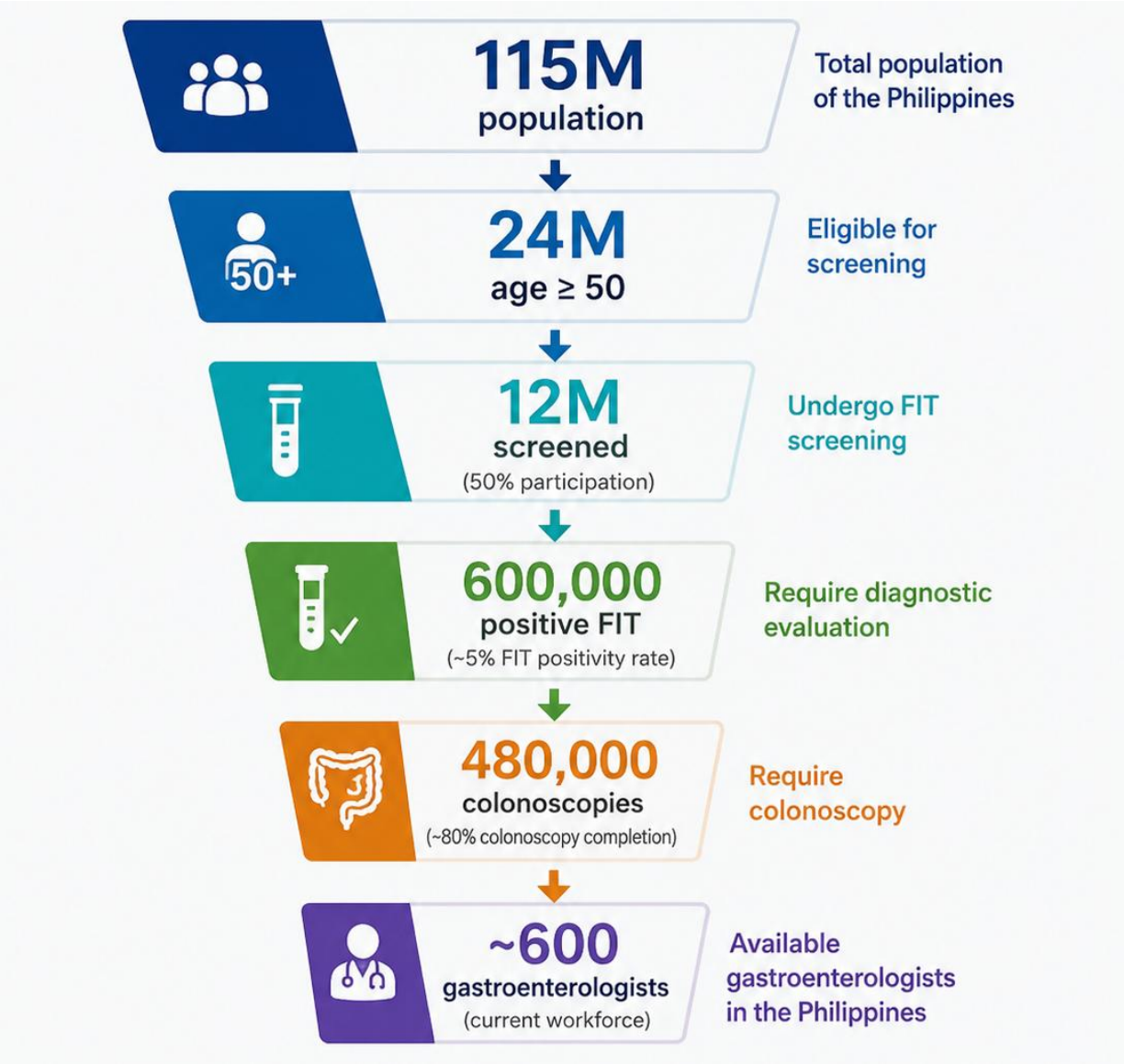
Screening programs do not run on FIT kits.

They run on data.

WHAT WE ARE BUILDING:

- Registry
- Linked screening sites
- EMR integration
- Colonoscopy tracking
- Quality indicators
- Dashboard

Screening Success Creates Colonoscopy Demand



Screening is a workforce and capacity challenge

=

~800
additional colonoscopies per gastroenterologist

OUR CAPACITY SOLUTION

Improving Capacity Without Immediately Expanding the Workforce

FIT-first approach

Use FIT to identify those most likely to benefit and prioritize colonoscopy for higher-risk individuals.

Referral hubs

Develop regional referral hubs to concentrate complex cases and optimize the use of specialist resources.

CSP training

Expand and strengthen CSP training to increase the number of providers who can perform safe and effective colonoscopy.

Quality improvement

Implement quality metrics, feedback loops, and peer learning to improve efficiency and outcomes.

Endoscopy unit readiness

Ensure endoscopy units are properly equipped, staffed, and organized for high-quality, high-volume care.

WHAT KEEPS US UP AT NIGHT?

PARTICIPATION

Will people participate?

COMPLETION

Will FIT-positive patients reach colonoscopy?

QUALITY

Can standards be maintained?

SUSTAINABILITY

Can the program survive beyond the pilot?

FINAL LESSONS FROM THE PHILIPPINE EXPERIENCE

Build partnerships early.

Design around geography.

Capacity planning matters.

Build the registry before you need it.

Patient experience creates future participants.

The challenge is no longer proving that CRC screening works.
The challenge is building the system that makes it work.