Workshop to Develop
National Breast and Cervical Cancer Client Management Guidelines for Prevention, Detection, Treatment and Care in the Federated States of Micronesia

29 August to 2 September 2008
Pohnpei, Federated States of Micronesia

Workshop Report

Sponsored by:
National & State Comprehensive Cancer Control Programs
FSM Department of Health and Social Affairs
Departments of Health Services: Kosrae, Chuuk, Pohnpei and Yap

Technical assistance provided by:
Pacific CEED and the Cancer Information Service-Pacific Region

With financial support from:
Pacific CEED (US-CDC Cooperative Agreement Number 1 U58 DP000976) and C-Change
Workshop to Develop National Breast and Cervical Cancer Client Management Guidelines for Prevention, Early Detection, Diagnosis, Treatment and Care in the Federated States of Micronesia

29 August – 2 September, 2008 in Pohnpei, FSM

Workshop Report

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I. Workshop Planning, Program, Outcomes and Recommendations

Introduction

The Workshop to develop National Breast and Cervical Cancer Client Management Guidelines was convened by the Federated States of Micronesia (FSM) Department of Health and Social Affairs with the State Departments of Health Services for Kosrae, Chuuk, Pohnpei and Yap as a technical meeting to develop National Client Management Guidelines for integrating breast and cervical cancer prevention, early detection, diagnosis, treatment, survivorship and palliative care.

The FSM National Client Management Guidelines (FSM CMG) Workshop was held in Pohnpei, the capital of the FSM, from August 29 through September 2, 2008. A total of thirty-four representatives from FSM National and State government and private stakeholders actively participated in the workshop; including FSM National and State Comprehensive Cancer Control (CCC) Coordinators, CCC Coalition members, health professionals, maternal child health and immunization program staff, cancer survivors, community leaders and women’s groups. A list of workshop participants and technical personnel is appended (Appendix 1). Also attached is the Workshop Program (Appendix 2).

Workshop Purpose and Objectives

The purpose of the FSM CMG Workshop was for participants from all four FSM States and National to review, discuss and reach agreement on a set of resource-appropriate standards and guidelines for FSM designed to:

1. increase and sustain the practice of health promoting behaviors to reduce cancer incidence,
2. increase the uptake of early detection behaviors and services to diagnose cancer early,
3. increase access to and uptake of treatment and palliative care to improve the quality of life for people living with cancer, and
4. improve systems linkages to ensure patients are effectively guided through an integrated continuum of cancer prevention, early detection, diagnosis, treatment and care.

The objectives for the FSM CMG Workshop were:

- To discuss and agree upon minimum standards of practice (based on evidence-based and resource-appropriate sources).
• To identify strategies, roles and resources needed to put the minimum standards into practice (based on the results of Assets Mapping exercises conducted by all four States and FSM National).
• To draft the FSM National Client Management Guidelines for integrating the continuum of breast and cervical cancer prevention, early detection, diagnosis, treatment and care.
• To outline ‘next steps’ to secure institutional support at national and State levels, to finalize the draft guidelines and to adopt and adapt the guidelines at the State level.

Sponsorship and Technical Support

The FSM CMG workshop technical meetings were sponsored by the FSM National and State Comprehensive Cancer Control Programs (CCC) of the FSM Department of Health and Social Affairs and the State Departments of Health Services. Technical support was provided by the Pacific Center of Excellence in the Elimination of Disparities (Pacific CEED) John A Burns School of Medicine at the University of Hawaii (UH), including the Pacific CEED funded partner, the National Cancer Institute’s Cancer Information Service-Pacific Region (CIS) at the UH Cancer Research Center of Hawaii (CRCH).

Financial support was provided under the REACH US cooperative agreement, US Centers for Disease Control and Prevention (CDC) and C-Change, a private not-for-profit organization comprised of the nation’s key cancer leaders from government, business and nonprofit sectors.

Local senior health professionals served as lead resource persons for the FSM CMG workshop, providing essential expertise and experience. The National and State CCC Coordinators provided leadership throughout the four-day workshop, presenting the results of their respective Assets Mapping exercises, chairing the sessions, facilitating group discussions and enabling agreement. A description of workshop leadership roles is appended (Appendix 3).

Senior staff from the Secretariat for the Pacific Community (SPC) were invited to provide expertise in the prevention and control of non-communicable diseases as joint partners with the World Health Organization on the “2-1-22 Pacific Non-Communicable Disease (NCD) Programme 2008 – 2011”. SPC technical advisors focused on standards and Pacific models for health promotion and primary prevention, including nutrition and physical activity. Recognizing the importance of targeting shared risk factors for cancer and NCDs, the FSM National Department of Health and Social Affairs deliberately convened the National Non-Communicable Diseases Workshop immediately prior to the FSM CMG Workshop. In this way, technical and financial support from both SPC and Pacific CEED were maximized.
Comprehensive Cancer Control in the Federated States of Micronesia

FSM, a US-Affiliated Pacific Island jurisdiction, is a nation of 607 islands spread across a million square miles of ocean where the only form of transportation for many people is by boat; a diverse country of over 108,000 citizens residing on 65 of these islands and speaking nine major languages and dialects. FSM has rich cultural traditions and close knit families, traditional leaders, active women’s groups, dedicated health professionals, and a network of health dispensaries across the island nation, and faces a significant cancer burden. At least 10% of all deaths are attributable to cancer, with over 90% of cancer cases diagnosed at late stages. There are limited early detection and treatment services such as no in-country mammography, pathologist or radiation treatment.

Between 2003 and 2006, FSM National and State governments received technical support from the University of Hawaii and funding from the US Centers for Disease Control to develop their Five-Year National Comprehensive Cancer Control (CCC) Plan. The National Plan subsequently guided the development of annual workplans in each State. In 2007, FSM was awarded direct funding from CDC to implement annual work plans, including objectives and activities addressing breast and cervical cancer. In addition, Pacific CEED subcontracts were negotiated with FSM National and the four States to help address policy and infrastructure needs for the CCC programs. In response to the Secretary of Health’s priorities, the subcontracts’ terms of reference for National and all States included the collaborative development of National Client Management Guidelines.

Resource- Appropriate Standards and Guidelines Across the Prevention-Care Continuum

Most cancer control standards and interventions have been developed in high-income countries. Few feasibility studies have been carried out for implementing these standards in limited resource settings. International organizations, including the World Health Organization (WHO), the Breast Health Global Initiative (BHGI), and the Alliance for Cervical Cancer Prevention (ACCP) have published evidence-based, consensus-driven and resource-appropriate standards and recommendations based on extensive research in limited resource settings. By consulting these sources, countries can now make cost-effective, culturally relevant and resource-appropriate decisions that will reduce morbidity and mortality as well as institute health systems innovations and improvements that are internationally recognized.

The US Centers for Disease Control and Prevention’s Comprehensive Cancer Control planning framework is based on six building blocks which span the full prevention and early detection, diagnosis and treatment, and palliative care continuum. This framework provides the rationale for developing a set of national standards that is inclusive of all phases of the cancer continuum. This comprehensive approach enables nations with few resources for diagnosis and
treatment to build upon their assets and develop effective prevention and control programs. A diagram of the cancer continuum presented in the workshop is appended (Appendix 4).

Standards and Guidelines Research

To prepare for this workshop, the Pacific CEED management and technical team, including staff from the UH Department of Family Medicine and Community Health (DFMCH) and the Cancer Information Service-Pacific Region (CIS), researched both US and international standards, guidelines, recommendations and practice for breast and cervical cancer to identify relevant evidence-based and resource-appropriate guidance. In addition, CIS staff met and consulted directly with representatives of two key organizations, the Breast Health Global Initiative (BHGI) and Program for Appropriate Technology in Health (PATH) that work in the field of health development. The technical team consulted frequently with the CDC’s CCC Program Consultant who provided up-to-date resources and informed guidance throughout the research process. Timely review was provided by the Program Manager for the Regional Comprehensive Cancer Control Program, DFMCH-UH. The technical team also consulted frequently with the FSM CCC Coordinators and Lead Resource person to ensure the background research and workshop preparations were on track.

Based upon the results of this research and consultative process, the Pacific CEED technical team drafted a set of Breast and Cervical Cancer Standards Tables from resource-appropriate and technically relevant material extracted from the available US and international standards. The tables included draft standards for each component in the continuum of prevention, early detection, diagnosis, treatment and palliative care. These standards were organized into categories of “Core”, “Expanded” and “Desirable” based upon the WHO STEPwise approach to planning and implementing interventions to prevent and control non-communicable diseases, the WHO’s Global NCD Strategy. Based upon the WHO STEPwise framework definitions, “Core” standards are those that are feasible to implement now, with existing resources; “Expanded” standards are those that are able to be implemented and resourced in the medium term, with a realistically projected increase in, or reallocation of, resources; while “Desirable” standards are those that are beyond the reach of current resources, and would be implemented if and when such resources become available. This resource-appropriate framework and definitions as applied to cancer control can be found in WHO’s Cancer Control: Knowledge into Action, WHO Guide for Effective Programmes (2006). They are also reflected in the WHO Regional Framework for Prevention and Control of Noncommunicable Diseases (2006), the WHO Global Strategy on Diet, Physical Activity and Health (2004), and WHO STEPwise approach to Surveillance (2006). The BHGI (2008) adopts a similar resource-based approach, recommending guidelines for four resource levels instead of three.
The US CDC’s Comprehensive Cancer Control planning framework provides a model for cancer prevention and control planning across the continuum of care. Primary prevention standards were drawn from sources such as the US Preventive Services Task Force (USPSTF), The CDC Community Guide, the National Cancer Institute (NCI) Using What Works: Adapting Evidence-Based Programs to Fit Your Needs, NCI’s Making Health Communications Programs Work Handbook, and the World Health Organization, including the WHO Framework Convention on Tobacco Control (FCTC). Primary sources for early detection, diagnosis, treatment, and palliative care included international sources such as the Breast Health Global Initiative (BHGI), the Alliance for Cervical Cancer Prevention (ACCP), Program for Appropriate Technology in Health (PATH) and WHO, including the International Agency for Research on Cancer (IARC); and US sources such as USPSTF, NCI, CDC, National Comprehensive Cancer Network (NCCN), American Cancer Society (ACS), and Susan G. Komen Race for the Cure.

For the purposes of this workshop, the following terminology and definitions were adopted:

**FSM National Standards** are national standards of practice for breast and cervical cancer organized into tables of Core, Expanded and Desirable standards for each phase in the cancer continuum. The FSM National Standards are based upon evidence-based and consensus-driven standards of practice developed by recognized US and International sources, and adopted or adapted for FSM needs and conditions. While these sources use various terms (standards, guidelines, recommendations, etc), they are referred to in this report as Standards of Practice.

**FSM National Client Management Guidelines** include:
- FSM National Standards of Practice Tables with Core, Expanded, Desirable standards for each phase in the cancer continuum
- US and international sources of evidence for resource-appropriate standards of practice
- Assets Mapping results from FSM National and four States;
- Putting standards into practice, including how, where, who and linkages (to be developed)
- Evaluation methods including performance measures for tracking compliance with standards (to be developed).

**FSM CMG Workshop Organization and Planning**

Under the leadership and guidance of Secretary of Health and Social Affairs Dr. Vita Skilling, the FSM National CCC Coordinator Amato Elymore and Pacific CEED Program Manager Karen Heckert coordinated the workshop planning and preparations in consultation with the State CCC Coordinators: Dr. Kino Ruben of Chuuk, Nena Tolenoa of Kosrae, Xner Luther of Pohnpei, and Martina Reichhardt.
of Yap and with the Lead Resource person, Dr Johnny Hedson, Surgeon and Chief of the Division of Medical Services. Dr Hedson provided expert advice, guidance and support during the workshop planning and recruited and oriented local community health and medical resource personnel to provide additional expertise during the workshop. Dr Hedson expertly prepared and delivered multiple technical presentations throughout the workshop program, significantly enhancing the participants’ understanding of the clinical material, the resource-appropriate standards and building agreement towards adopting National FSM standards (Appendices 5, 6, 7 and 8). The Pacific CEED technical team of Karen Heckert and CIS-Pacific staff Jeannette Kojiane and Doris Segal Matsunaga provided technical assistance to FSM leadership throughout the process of workshop planning, implementation and follow-up.

Coordination and Integration of NCD’s and Cancer: Two Back-to-Back National Workshops

For the FSM leadership, a key consideration in scheduling the FSM CMG Workshop was to coordinate with the workshop on the National Non-communicable Diseases (NCD) Strategy and State Plans. The FSM National Department of Health and Social Affairs deliberately convened the two workshops contiguously recognizing that cancer and non-communicable diseases prevention address the same risk factors and require the similar resources. In this way, technical and financial support from both the Secretariat for the Pacific Community (SPC) and Pacific CEED were maximized. The National NCD Workshop was held first from 25-28 August. The workshop program and selected presentations on the Joint WHO-SPC Pacific Framework for Prevention and Control of NCDs are appended to this report (Appendices 9, 10 and 11). A principle recommendation from the NCD workshop is to include cancer in the 2009 revision of the FSM National Strategic Development Plan which will enable access to the US Compact funds for cancer prevention, treatment and care (Appendix 12).

The FSM CMG Workshop has held immediately following the NCD workshop from 29 August to 2 September. FSM has plans to strategically align the National NCD Strategy and State NCD Plans of Action with the National FSM and State CCC Program and Plans. The alignment of these two programs will enable FSM to maximize institutional and donor support, improve program coordination, enhance community involvement and achieve mutual goals and objectives for a healthier population. The FSM CCC Plan already links to the NCD strategy by identifying the STEPwise surveillance for NCDs as the primary source of baseline data for cancer-related risk factors.

FSM CMG Workshop Program

The four-day FSM CMG workshop technical meetings were held in the government center of Palikir, Pohnpei. The full program for the four-day meeting is appended (Appendix 2).
The FSM CCC Coordinators provided group leadership throughout the four-day workshop, facilitating and documenting group discussion and agreement as they rotated the roles of Chair, Documenter and Rapporteur (Appendix 3). Since this workshop was designed as a technical meeting with the primary purpose of reviewing, developing and agreeing on national standards, it was important to assign these three roles to the CCC Coordinators in order to ensure contributions and leadership from all. While the role assignments tended to be flexible once the workshop was underway, the roles remained throughout the workshop, adding structure and enhancing participation.

The workshop opened with remarks from Dr. Vita Skilling. In her opening statement Secretary Skilling articulated her expectations for the outcomes of the workshop and acknowledged that the workshop objectives for developing national standards of practice for cancer were ambitious (Appendix 13). Each of the four States and National CCC Coordinators then presented the results of their Assets Mapping exercise. In preparation for the workshop, each of the State CCC Coordinators met with members of their Comprehensive Cancer Coalitions and identified the assets and resources available in their State that either already exist or that can be initiated or mobilized to help guide cancer patients through the continuum of care. Examples of assets for prevention and early detection included active women’s groups, traditional leaders, outer island health dispensaries, Community Health Centers and radio health promotion. Extended family, faith-based support and traditional healers were among the assets listed for survivorship and end-of-life care. Reporting on the results of the Assets Mapping exercise enabled workshop participants to begin to talk about how, where and who will be responsible for helping put the National Standards into practice (Appendix 14 and 15).

On the first day of the workshop, members of the Pacific CEED technical team presented an overview of the FSM CMG workshop objectives, the rationale for considering standards for all components in the continuum of care and outlined the process for reviewing, discussing, modifying and deciding on which standards to adopt (Appendices 16 and 17). In addition, the team provided an overview of resource-appropriate US and international standards of care for breast and cervical cancer (Appendix 18). The Pacific CEED technical team also presented material on Palliative Care (Appendix 19). The two colleagues from the SPC provided presentations on the Pacific Region NCD Program and a technical presentation on nutrition in the Pacific.

The lead and local resource persons, Dr Johnny Hedson, Surgeon and Chief of the Division of Medical Services, and Kathleen Benjamin, Chief Nurse at Pohnpei Hospital, provided in-depth presentations on each component of the cancer care continuum (Appendices 5,6,7,8 and 20). For each component, the participants then reviewed and discussed the specific items in each Breast and Cervical Cancer Standards Table. The Chair, with assistance from Pacific CEED technical team, facilitated the group discussions and helped the participants reach
agreement to adopt draft FSM Standards. Approximately half a day was scheduled for each of the five components of care: 1) Primary Prevention, 2) Breast Cancer Early Detection, 3) Cervical Cancer Early Detection, 4) Diagnosis and Treatment, 5) Palliative Care.

On several occasions the workshop schedule was adjusted to accommodate various priorities as the discussions ensued. At one point it became clear that more time was required for reviewing and agreeing upon the standards. At that moment it was decided that the work of ‘putting the standards into practice’ would be postponed until a later discussion. The complete National Client Management Guidelines will include guidance on and examples of ‘putting the standards into practice’. This will include ‘how’, ‘who is responsible’, and ‘where’ the various interventions or strategies will take place. Only one ‘putting into practice’ example was produced in the interest of time. The full set of ‘putting standards into practice’ will be developed during a later process to be determined.

FSM CMG Workshop Outcomes and Recommendations

The first draft of the National Standards of Practice for Breast and Cervical Cancer Prevention, Early Detection, Diagnosis, Treatment and Palliative Care was discussed and agreed upon by the CCC Coordinators, senior health professional resource persons and other workshop participants. At the conclusion of the fourth day, participants reported the results of their work to Secretary Skilling. The workshop results included a summary of key points from the draft standards, a list of trainings required to put the new standards into practice, and the “Next Steps” that each State had outlined for finalizing the standards and guidelines (Appendix 21). In her responding remarks, the Secretary expressed appreciation to the group for its hard work and indicated she was highly satisfied with the draft standards presented to her. Dr Skilling outlined plans at the national level to proceed with the official policy development process, including presentation of the standards for review by the Attorney General and the State Directors of Health. She commended the State CCC Coordinators for their plans to discuss the draft standards with their CCC Coalitions and State Directors of Health and urged them to proceed to finalize the standards and to begin to put the standards into practice.

FSM CMG Workshop Recommendations:

In the process of discussing and agreeing upon draft National Standards of Practice for Breast and Cervical Cancer, workshop participants generated the following recommendations regarding review and approval of the standards and training needed to put the standards into practice. It was recommended:

- That the FSM Department of Health and Social Affairs and the State Departments of Health Services approve the standards agreed upon by consensus during the workshop.
- That the States and National finalize their HPV vaccine implementation plans by the end of September and that;
- That CCC Coalitions & Coordinators work with Immunization Partners to finalize their immunization plans.
- That CCC Coordinators submit implementation plans to National CCC Coordinator/Secretary of Health.
- Immunization partners submit implementation plans to the National Immunization Program.

- That the CCC Coordinators present the DRAFT standards to their respective Directors of Health for review and approval.
- That the FINAL standards be presented by the Secretary for Health to the Directors of Health for final approval at the October meeting.
- That the National and State Comprehensive Cancer Control programs obtain the following training to help put the standards into practice:
  - VIA (Visual inspection of the cervix) training for health providers, including birth attendants, midwives, Maternal Child Health/Family Planning (MCH/FP) staff, health assistants, doctors, nurses (according to State preferences) and training on the treatment of precancerous cells using cryotherapy
  - Palliative Care, including the Complete Life Course
  - Clinical Breast Examination and Ultrasound training for health professionals
  - Appropriate HPV vaccine promotion and community preparedness
  - Clinical Breast Examination training for health professionals
  - Conducting Focus Groups
  - Other key areas of trainings such as: Core biopsy and Colposcopy training; Cancer 101 for health workers and public health practitioners; training for nurses on continuing care for patients having chemotherapy off-island; pain management; data collection, and treating patients with respect.

FSM CMG Workshop Evaluation

All workshop participants and resource persons were invited to complete a workshop evaluation (Appendix 22). The evaluation results were tallied and revealed the results summarized below. In addition, the Chairs for Day 1 and Day 3, went around the room at the end of the day and asked each participant to share at least one new thing she/he had learned that day. In this way, the level of satisfaction with the workshop contents, process and outcomes was assessed.

A majority of workshop participants indicated a high level of satisfaction with the workshop results and process, based on the results of the written evaluations, end of day de-briefings, and informal comments. Seventeen (17) written evaluations were completed on the last day of the workshop. Almost all “Agreed or Strongly Agreed” that the first objective was met: “To discuss and agree upon minimum standards of practice”, while at least three out of four (75%) participants agreed that the other three workshop objectives were met. Almost all found the content of
presentations and the group process for discussing and reaching agreement ‘useful’ (Appendix 23).

Most workshop participants stated they were learning something of value during the workshop. At the end of each day, the daily Chairperson went around the room asking for feedback and one thing each person had learned that day (Appendix 23). The most frequently mentioned topic on Day 1 was VIA (Visual Inspection with Acetic Acid), a screening method for early cervical cancer that is now being implemented in many limited-resource countries. Other items with multiple mentions included Assets Mapping, the resource-appropriate levels in the standards of Core, Expanded, Desirable, and HPV vaccine implementation. More personal comments reflect the diversity of the group:

As a mother and a grandmother I really appreciate all the information for women.

I work for MCH (Maternal Child Health) but never heard of VIA; I am so glad to now tell women about this…

As a politician, I learned about our health priorities so I can talk with other law-makers about appropriations.

The evaluation results indicate that overall the workshop met the needs and expectations of most participants.

**FSM CMG Workshop: Next Steps**

Secretary Skilling scheduled a debriefing meeting with the Pacific CEED technical team, the CCC Coordinators and the SPC consultant on the day following the workshop to discuss the next steps, timetables, workshop products and continuing collaboration. At that meeting, held on 3 September 2008, a summary of workshop outcomes and recommendations, along with a revised draft of the Standards, was provided to the Secretary (Appendix 24).

During this meeting, the following post-workshop steps were agreed upon: A report describing the FSM CMG workshop would be prepared by the Pacific CEED technical team; the CCC Coordinators would present the draft FSM National Standards of Practice to their State CCC Coalitions and the State Directors of Health; a final draft of the standards would be prepared; the standards would be reviewed as needed by the Attorney General; and the standards would be presented for formal review and approval by the State Directors of Health and the National Secretary of Health and Social Affairs.

During the month following the workshop, the FSM National Standards of Practice for Breast and Cervical Cancer were reviewed and revised by the Lead Resource Person in consultation with key FSM health professionals and by the CCC Coordinators, with assistance from the Pacific CEED technical team. The revised
draft is included in this report, and will be presented to the State Directors of Health by Dr. Skilling.

The workshop to develop National Breast and Cervical Cancer Client Management Guidelines for Prevention, Early Detection, Diagnosis, Treatment and Care in the Federated States of Micronesia was successful in developing National Breast and Cervical Cancer Standards of Practice across the prevention-care continuum, and has set the stage for the next steps, which include formal review and approval of these standards as FSM national policy, completion of the guidelines and putting the standards into practice, with the four States and National implementing these standards according to their needs and conditions.

II. National Standards of Practice for Breast and Cervical Cancer Prevention, Early Detection, Diagnosis, Treatment, and Palliative Care in the Federated States of Micronesia
The FSM National Standards of Practice for Breast and Cervical Cancer follow in the next section of this report.

III. Appendices:

Appendix 1: FSM CMG Workshop Participant List
Appendix 2: FSM CMG Workshop Program
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Appendix 5: FSM CMG Presentation: Breast Cancer in FSM
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National Standards of Practice for Breast and Cervical Cancer Prevention, Early Detection, Diagnosis, Treatment and Palliative Care
The Federated States of Micronesia

Introduction:

Technical consultative meeting to develop standards of practice:

• The workshop to develop National Breast and Cervical Cancer Client Management Guidelines for Prevention, Early Detection, Diagnosis, Treatment and Care in the Federated States of Micronesia (FSM) was held 29 August – 2 September 2008 in Pohnpei.

• This national workshop was convened by the FSM Department of Health and Social Affairs with the Departments of Health Services for Kosrae, Chuuk, Pohnpei and Yap as a technical meeting to develop National Client Management Guidelines for integrating breast and cervical cancer prevention and early detection, diagnosis, treatment, survivorship and palliative care.

• Workshop participants from all four FSM States and National were expected to review, discuss and reach agreement on a set of resource-appropriate standards for FSM designed to: 1) increase and sustain the practice of health promoting behaviors to reduce cancer incidence, 2) increase the uptake of early detection behaviors and services to diagnose cancer early, 3) increase access and uptake to treatment and palliative care to improve the quality of life for people living with cancer, and 4) improve systems linkages to ensure patients are effectively guided through an integrated continuum of cancer prevention, early detection, diagnosis, treatment and care.

Workshop objectives:

- To discuss and agree upon minimum standards of practice (based on evidence-based and resource appropriate sources).
- To identify strategies, roles and resources needed to put the minimum standards into practice, based on the results of Assets Mapping exercises conducted by all four States and FSM National.
- To draft the National FSM Client Management Guidelines for integrating the continuum of breast and cervical cancer prevention, early detection, diagnosis, treatment, and care.
- To outline ‘next steps’ to secure institutional support at national and state levels, to finalize the draft guidelines and to adopt and adapt the guidelines at the State level.

• Thirty-four representatives from FSM National and State government and private stakeholders actively participated in the workshop; including FSM National and State Comprehensive Cancer Control (CCC) Coordinators, CCC Coalition members,
health professionals, maternal child health and immunization program staff, cancer survivors, community leaders and women’s groups.

- Local senior health professionals served as lead resource persons for the Client Management Guidelines workshop, providing essential expertise and experience. The National and State CCC Coordinators provided leadership throughout the four-day workshop, presenting the results of their respective Assets Mapping exercises, chairing the sessions, facilitating group discussions and enabling agreement.

**Technical and financial support:**

- Technical support was provided by the Pacific Center of Excellence in the Elimination of Disparities (Pacific CEED) John A Burns School of Medicine at the University of Hawaii, including the National Cancer Institute’s Cancer Information Service-Pacific Region (CIS) at the Cancer Research Center of Hawaii (CRCH).

- Financial support was provided under the REACH US cooperative agreement from the US Centers for Disease Control and Prevention and C-Change, a private not-for-profit organization comprised of the nation's key cancer leaders from government, business and nonprofit sectors.

- Recognizing the importance of targeting shared risk factors for cancer and Non-Communicable Diseases (NCDs), the FSM National Department of Health and Social Affairs deliberately convened the National Non-Communicable Diseases Workshop immediately prior to the Client Management Guidelines workshop. In this way, technical and financial support from both the Secretariat for the Pacific Community (SPC) and Pacific CEED were maximized.

**Resource-Appropriate Evidence-Based Standards Across the Prevention-to-Care Continuum:**

- Internationally recognized organizations such as the Breast Health Global Initiative (BHGI) and the Alliance of Cervical Cancer Prevention (ACCP) have published evidence-based, consensus-driven and resource-appropriate standards and technologies based on extensive research in limited resource settings. The World Health Organization (WHO) recommends tailoring standards and interventions to three levels: “Core, Expanded and Desirable” in its STEPwise Surveillance strategy (2006) and in the WHO Cancer Control: Guide for Effective Programmes (2006).

- By consulting these sources, countries can now make cost-effective, culturally-relevant and resource-appropriate decisions that will reduce morbidity and mortality as well as institute health systems innovations and improvements that are internationally recognized.
The US Centers for Disease Control and Prevention’s Comprehensive Cancer Control planning framework is based on six building blocks which span the full continuum of prevention and early detection, diagnosis and treatment, and palliative care. This framework provides the rationale for developing a set of national standards that is inclusive of all phases of the cancer continuum.

**National Client Management Guidelines:**

When complete, the National Client Management Guidelines will include:

1. National Standards Tables with Core, Expanded, Desirable standards for each phase in the cancer continuum
2. US and international sources of evidence for resource-appropriate standards of practice
3. Assets Mapping results from FSM National and four States;
4. Putting standards into practice, including how, where, who and linkages (to be developed)
5. Evaluation methods including performance measures for tracking compliance with standards (to be developed).
FSM National Standards for Primary Prevention and Risk Assessment

<table>
<thead>
<tr>
<th>Resource Level</th>
<th>Services</th>
<th>Programs</th>
</tr>
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| **Core**       | Providers will ask and advise about risk factors for breast and cervical cancer:  
Breast  
Gender, Age, Family/Personal History, Genetic Alterations, Estrogen Exposure, Reproductive and Menstrual History, Breast Density, Lobular Carcinoma In Situ (LCIS), Atypical Hyperplasia, Radiation Exposure, Alcohol, Obesity, Physical Inactivity, DES (diethylstilbestrol)  
Cervical  
HPV-Human Papillomavirus, Cigarette Smoke, Number of Pregnancies, Number of Sexual Partners, Oral Contraceptives, Weakened Immune System, DES (diethylstilbestrol) |
|                | Prevention programs for patients and community will be evidence-based and adapted to culture and community  
Public health practitioners will gather local evidence regarding women’s knowledge, beliefs and practices re: prevention of breast and cervical cancer (i.e. focus groups, interviews, surveys, etc.) |
FSM National Standards for Primary Prevention – Tobacco (page 1)

<table>
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<tr>
<th>Resource Level</th>
<th>Programs</th>
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<tbody>
<tr>
<td>Core</td>
<td>FSM is a signatory to the WHO Framework Convention on Tobacco Control (FCTC). Health officials will adopt and develop guidelines to implement the provisions of the Framework Convention. The treaty requires ratifying countries to:</td>
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<td>- Enact comprehensive bans on tobacco advertising, promotion and sponsorship</td>
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<td>- Ban the use of misleading and deceptive terms such as “light”, “low-tar” and “mild”</td>
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<td></td>
<td>- Undertake comprehensive bans on tobacco advertising, promotion and sponsorship</td>
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<td>- Require the placement of rotating health warnings on tobacco packaging that cover at least 30 percent (and should cover 50 percent or more) of the principal display areas and may include pictures or pictograms</td>
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<td></td>
<td>- Ban the use of misleading and deceptive packaging and labeling of tobacco products, including use of terms such as “light” and “mild”</td>
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<td>- Protect people from exposure to tobacco smoke in indoor workplaces, public transport and indoor public places</td>
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<td>- Adopt or maintain taxation policies aimed at reducing tobacco consumption, and</td>
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<tr>
<td></td>
<td>- Combat illicit trade in tobacco products, including by requiring markings of origin and destination on packs, monitoring, documenting and controlling the movement of products, and enacting legislation with appropriate penalties and remedies.</td>
</tr>
<tr>
<td></td>
<td>- The core demand reduction provisions in the WHO FCTC are contained in articles 6-14: Price and tax measures to reduce the demand for tobacco, and Non-price measures to reduce the demand for tobacco, namely: Protection from exposure to tobacco smoke; Regulation of the contents of tobacco products; Regulation of tobacco product disclosures; Packaging and labeling of tobacco products; Education, communication, training and public awareness; Tobacco advertising, promotion and sponsorship; and Demand reduction measures concerning tobacco dependence and cessation.</td>
</tr>
<tr>
<td></td>
<td>- The core supply reduction provisions in the WHO FCTC are contained in articles 15-17: Illicit trade in tobacco products; Sales to and by minors; and Provision of support for economically viable alternative activities.</td>
</tr>
</tbody>
</table>
### FSM National Standards for Primary Prevention – Tobacco (page 2)

<table>
<thead>
<tr>
<th>Resource Level</th>
<th>Services</th>
<th>Programs</th>
</tr>
</thead>
</table>
| **Core**       | Health officials will:  
|                | - Recognize tobacco dependence as a chronic disease, like hypertension or diabetes; and make tobacco dependence treatment and counseling services an integral part of national health programs and services, and improve the accessibility and affordability of treatment, including effective medications.  
|                | - When planning tobacco control policy measures – such as tax increases, creation of smoke free environments, advertising bans, public information campaigns, and requirements for warning labels – that will result in large numbers of smokers trying to quit, recognize that treatment services will help dependent tobacco users to quit and will enhance the effectiveness of these policy measures. | Health officials will adopt evidence-based program strategies such as:  
|                | Health providers will:  
|                | - Screen all adults for tobacco use and provide tobacco cessation interventions for those who use tobacco products. Brief tobacco cessation interventions, including screening and brief behavioral counseling (less than 3 minutes), can be delivered in primary care settings.  
|                | - Screen all pregnant women for tobacco use and provide augmented pregnancy-tailored counseling to those who use tobacco. Extended or augmented smoking cessation counseling (5-15 minutes) uses messages and self-help materials tailored for pregnant smokers.  
|                | - Use 5-A framework (Assess, Advise, Agree, Assist & Arrange). | Environmental: Smoking bans  
|                | | Reduce Tobacco Use Initiation:  
|                | - Increasing the unit price for tobacco  
|                | - Mass media education campaigns when combined with other interventions, including school-based interventions | Restrict Minors’ Access to Tobacco Products:  
|                | | - Community mobilization when combined with additional interventions (stronger local laws directed at retailers, active enforcement of retailer sales laws, retailer education with reinforcement) | Tobacco Use Cessation:  
|                | | - Reduce client out-of-pocket costs for effective cessation therapies  
|                | | - Provider reminders (chart prompts, vital signs, etc.)  
|                | | - Multi-component patient support interventions that include telephone support  
|                | | - Mass media education campaigns combined with other interventions  
| **Expanded**   | Offer pharmacotherapy in primary care settings | |

**Note:** October 2008
<table>
<thead>
<tr>
<th>Resource Level</th>
<th>Services</th>
<th>Programs</th>
</tr>
</thead>
</table>
| **Core**       | Health providers will screen all adult patients for obesity (using Body Mass Index (BMI), which is weight adjusted for height) and/or waist to hip ratio, and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults. Health providers will advise patients to:  
  - Achieve energy balance and a healthy weight  
  - Limit energy intake from total fats and shift fat consumption away from saturated fats to unsaturated fats and towards the elimination of trans-fatty acids  
  - Increase consumption of fruits and vegetables, and legumes, whole grains and nuts  
  - Limit the intake of high sugar foods and high sugar drinks  
  - Limit salt (sodium) consumption from all sources and ensure that salt is iodized  
  - Limit consumption of red meat and barbecue cooked food  
  - Increase consumption of fish  
  - Decrease the importation of processed foods with high saturated fat content | Health providers will develop evidence-based, culturally-adapted interventions that combine nutrition education and diet and exercise counseling with behavioral strategies to help patients acquire the skills and supports needed to change eating patterns and to become physically active. The 5-A framework (Assess, Advise, Agree, Assist, and Arrange), which has been used in behavioral counseling interventions such as smoking cessation, may be a useful tool to help clinicians guide interventions for weight loss. Initial interventions paired with maintenance interventions help ensure that weight loss will be sustained over time. |
## FSM National Standards for Primary Prevention - Physical Activity

<table>
<thead>
<tr>
<th>Resource Level</th>
<th>Services</th>
<th>Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core</td>
<td>Health providers will advise people to get at least 30 minutes of regular, moderate-intensity physical activity on most days, as this reduces the risk of cardiovascular disease and diabetes, colon cancer, breast cancer and prostate cancer. Benefits increase with increasing levels of activity. More activity may be required for weight control.</td>
<td>Health providers will develop multi-component interventions combining provider advice with behavioral interventions to facilitate and reinforce healthy levels of physical activity. Such interventions often include patient goal setting, written exercise prescriptions, individually tailored physical activity regimens, and follow up assistance provided by specially trained staff. Linking primary care patients to community-based physical activity and fitness programs may enhance the effectiveness of primary care clinician counseling.</td>
</tr>
</tbody>
</table>

## FSM National Standards for Primary Prevention - Alcohol

<table>
<thead>
<tr>
<th>Resource Level</th>
<th>Services</th>
<th>Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core</td>
<td>Health providers will provide screening and behavioral counseling interventions to reduce alcohol misuse by adults, including pregnant women, in primary care settings. Alcohol misuse includes &quot;risky/hazardous&quot; and &quot;harmful&quot; drinking that places individuals at risk for future problems. &quot;Risky&quot; or &quot;hazardous&quot; drinking has been defined as more than seven drinks per week or more than three drinks per occasion for women, and more than fourteen drinks per week or more than four drinks per occasion for men. &quot;Harmful drinking&quot; describes persons who are currently experiencing physical, social, or psychological harm from alcohol use but do not meet criteria for dependence.</td>
<td>Develop evidence-based community-appropriate interventions aimed at underage drinkers, such as enhanced enforcement of laws prohibiting sale of alcohol to minors, including &quot;sting operations&quot; or retailer compliance checks.</td>
</tr>
</tbody>
</table>
**FSM National Standards for Cervical Cancer Prevention: Sexual Health and HPV**

<table>
<thead>
<tr>
<th>Resource Level</th>
<th>Services</th>
</tr>
</thead>
</table>
| **Core**       | Provide Awareness and Education re: Sexually Transmitted Infections  
• For adolescents  
• For parents of children  

Provide sexual health education and services that meet the client’s cultural, emotional and practical needs  
Administer HPV vaccine to females before debut of sexual activity  
• Priority: ages 9 to 12 |
| **Expanded**   | Administer HPV vaccine to females ages 9 to 26  
• Priority: Ages 9 to 18 |
## FSM National Standards for Cervical Cancer Early Detection (Clinical)

<table>
<thead>
<tr>
<th>Resource Level</th>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Core</strong></td>
<td>Screen with VIA (Visual Inspection with Acetic Acid)</td>
</tr>
<tr>
<td></td>
<td>• Ages 25 to 45, at least twice in a lifetime</td>
</tr>
<tr>
<td></td>
<td>• Referral for Pap test after pre-cancerous cells detected with VIA (until treatment with cryotherapy available)</td>
</tr>
<tr>
<td></td>
<td>Opportunistic screening with Pap test as resources permit</td>
</tr>
<tr>
<td><strong>Expanded</strong></td>
<td>Screen with VIA and treat pre-cancerous lesions with cryotherapy (single visit or two-step)</td>
</tr>
<tr>
<td></td>
<td>• Ages 25 to 45, every 5 years</td>
</tr>
<tr>
<td><strong>Desirable</strong></td>
<td>Screen with Pap test</td>
</tr>
<tr>
<td></td>
<td>• Start at age 25 or 3 years after vaginal intercourse</td>
</tr>
<tr>
<td></td>
<td>• Screen every 2 years</td>
</tr>
<tr>
<td></td>
<td>• Screen every 5 years after 3 consecutive normal test results</td>
</tr>
<tr>
<td></td>
<td>No further screening for:</td>
</tr>
<tr>
<td></td>
<td>• Women age &gt; 60 if no abnormal test in the preceding 10 years</td>
</tr>
<tr>
<td></td>
<td>• Women with total hysterectomy if indication for removal was not related to treatment of cervical dysplasia</td>
</tr>
<tr>
<td></td>
<td>HPV DNA Testing</td>
</tr>
</tbody>
</table>

October 2008
## FSM National Standards for Breast Cancer Early Detection (Clinical)

<table>
<thead>
<tr>
<th>Resource Level</th>
<th>Services</th>
</tr>
</thead>
</table>
| **Core**       | Breast Health Awareness: education with breast self-examination (BSE)  
|                | • Monthly BSE beginning at age 20  
|                | Clinical Breast Examination (CBE)  
|                | • Every 3 years ages 20-39, and every year starting at age 40  
|                | Target Outreach/education encouraging CBE for at-risk groups (with family history) |
| **Expanded**   | Expanded education to women of reproductive age  
|                | Diagnostic Ultrasound  
|                | Diagnostic Mammography  
|                | Opportunistic mammographic screening |
| **Desirable**  | Population-based mammographic screening  
|                | • Beginning at age 40 |
## FSM National Standards for Breast & Cervical Cancer Early Detection

<table>
<thead>
<tr>
<th>Resource Level</th>
<th>Services: Client-Oriented</th>
<th>Provider-Oriented</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Core</strong></td>
<td>Client-oriented interventions to promote awareness of and education about cervical cancer screening will be evidence-based and adapted to target communities, for example: 1-on-1 education, small media, and client reminders</td>
<td>Health Providers will develop and implement protocols for follow-up of patients with abnormal test results</td>
</tr>
<tr>
<td></td>
<td>Target messages to reach women at highest risk:</td>
<td>Health Providers will be monitored and get feedback</td>
</tr>
<tr>
<td></td>
<td>- Cervical cancer: ages 30 to 50</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Breast cancer:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- For Clinical Breast Exam (CBE): ages 35+</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- For Breast Self-Exam (BSE): ages 20+ (women and men)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- For breast health messages: ages 14+</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Involve women in creating awareness and prevention messages and programs.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Involve and train key sources of information and influence, including: Peers who have received messages or services; Cancer survivors; Leaders or members of women’s and men’s groups; Midwives and traditional healers; Community health promoters; Community leaders including church leaders; School teachers and staff; Nurses, nurse practitioners, and doctors</td>
<td></td>
</tr>
<tr>
<td><strong>Expanded</strong></td>
<td>Target CBE breast cancer messages to reach women 30+</td>
<td>Health Providers will develop and implement protocols for patient reminders and recalls of asymptomatic women</td>
</tr>
<tr>
<td>Resource Level</td>
<td>Diagnosis</td>
<td>Treatment</td>
</tr>
<tr>
<td>---------------</td>
<td>-----------</td>
<td>-----------</td>
</tr>
</tbody>
</table>
| **Core**      | Colposcopy: only if suspicion of invasive cancer | Invasive cancer  
   • Hysterectomy |
| **Expanded**  | Colposcopy, biopsy (conization)  
   Staging for invasive cancer:  
   • Examination under anesthesia  
   • Chest x-ray  
   • USS | Precancerous (HGSIL or severe dysplasia only)  
   • Cryotherapy, Conization, Hysterectomy  
   Invasive cancer:  
   • All Stage I as well as Stage IIA  
     - Hysterectomy  
   • Stage IIB to III (refer off-island)  
     - Radiation, Surgery, Chemotherapy |
| **Desirable** | Colposcopy, biopsy (conization)  
   Staging for invasive cancer:  
   • Cystoscopy  
   • Sigmoidoscopy  
   • Chest x-ray  
   • Creatinin  
   • IVP  
   • USS  
   • CT Scan | Precancerous (HGSIL or severe dysplasia only)  
   • Conization, Cryosurgery  
   • LEEP, LETZ, Hysterectomy  
   Invasive cancer:  
   • All Stage I as well as Stage IIA  
     - Hysterectomy  
   • Stage IIB to III  
     - Radiation  
     - Surgery  
     - Chemotherapy |

**Definitions:**  
USS: ultrasound scan; IVP: intravenous pyelogram; CT: computed tomography; HGSIL: high grade squamous intraepithelial lesion; LEEP: loop electrosurgical excision procedure; LETZ: loop excision of the transformation zone.
FSM National Standards for Breast Cancer Diagnosis and Pathology

<table>
<thead>
<tr>
<th>Resource Level</th>
<th>Clinical</th>
<th>Pathology</th>
<th>Imaging and laboratory tests</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core</td>
<td>History  Physical examination Clinical breast examination Surgical biopsy (timely: within 1 month) Fine-needle aspiration biopsy, or Core needle biopsy</td>
<td>Interpretation of biopsies  Cytology or pathology report describing tumor size, lymph node status, histologic type, tumor grade Determination and reporting of ER and PR status</td>
<td>Plain chest radiography  Blood chemistry profile/CBC</td>
</tr>
<tr>
<td>Expanded</td>
<td>Image-guided sampling (ultrasonographic ± mammographic)</td>
<td>Determination of margin status</td>
<td>Diagnostic ultrasound ± diagnostic mammography  Liver ultrasound</td>
</tr>
<tr>
<td>Desirable</td>
<td>Preoperative needle localization under mammographic or ultrasound guidance Stereotactic biopsy Sentinel node biopsy</td>
<td>On-site cytopathologist  HER-2/neu status  IHC staining of sentinel nodes for cytokeratin to detect micrometastases</td>
<td>Diagnostic mammography  Bone scan  CT scanning, PET scan, MIBI scan, breast MRI</td>
</tr>
</tbody>
</table>

Definitions: CBC: complete blood count; CT: computed tomography; ER: estrogen receptor; IHC: immunohistochemistry; MIBI: 99mTc-sestamibi; MRI: magnetic resonance imaging; PET: positron emission tomography; PR: progesterone receptor.
### FSM National Standards for Breast Cancer Treatment: Stage I Breast Cancer

<table>
<thead>
<tr>
<th>Resource Level</th>
<th>Local-regional treatment</th>
<th>Systemic treatment (adjuvant)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Core</strong></td>
<td>Surgery</td>
<td>Radiation therapy</td>
</tr>
<tr>
<td></td>
<td>Modified radical mastectomy</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Expanded</strong></td>
<td>Breast-conserving therapy(^{a})</td>
<td>Breast-conserving whole breast irradiation as part of breast-conserving therapy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Post mastectomy irradiation of the chest wall and regional nodes for high-risk cases</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Desirable</strong></td>
<td>Sentinal node biopsy</td>
<td>Growth factors</td>
</tr>
<tr>
<td></td>
<td>Reconstructive surgery</td>
<td>Dose-dense chemotherapy</td>
</tr>
</tbody>
</table>

---

\(^{a}\)Breast-conserving therapy requires mammography and reporting of margin status.

\(^{b}\)Requires blood chemistry profile and complete blood count (CBC) testing.

Definitions: AC: doxorubicin and cyclophosphamide; CMF: cyclophosphamide, methotrexate, and 5-fluorouracil; EC: epirubicin and cyclophosphamide; FAC: 5-fluorouracil, doxorubicin, and cyclophosphamide; LH-RH: luteinizing hormone-releasing hormone.
<table>
<thead>
<tr>
<th>Resource Level</th>
<th>Local-regional treatment</th>
<th>Systemic treatment (adjuvant)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Core</strong></td>
<td>Surgery</td>
<td>Radiation therapy</td>
</tr>
<tr>
<td></td>
<td>Modified radical mastectomy</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Expanded</strong></td>
<td>Breast-conserving therapy&lt;sup&gt;b&lt;/sup&gt;</td>
<td>Breast-conserving whole breast irradiation as part of breast-conserving therapy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Post mastectomy irradiation of the chest wall and regional nodes for high-risk cases</td>
</tr>
<tr>
<td><strong>Desirable</strong></td>
<td>Sentinel node biopsy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reconstructive surgery</td>
<td></td>
</tr>
</tbody>
</table>

<sup>a</sup>Requires blood chemistry profile and complete blood count (CBC) testing.

<sup>b</sup>Breast-conserving therapy requires mammography and reporting of margin status.

Definitions: AC: doxorubicin and cyclophosphamide; CMF: cyclophosphamide, methotrexate, and 5-fluorouracil; EC: epirubicin and cyclophosphamide; FAC: 5-fluorouracil, doxorubicin, and cyclophosphamide; LH-RH: luteinizing hormone-releasing hormone.
FSM National Standards for Breast Cancer Treatment: Locally Advanced Breast Cancer

<table>
<thead>
<tr>
<th>Resource Level</th>
<th>Local-regional treatment</th>
<th>Systemic treatment (adjuvant)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Core</strong></td>
<td>Surgery</td>
<td>Radiation therapy</td>
</tr>
<tr>
<td></td>
<td>Modified radical mastectomy and/or palliative mastectomy(^a)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Expanded</strong></td>
<td>Breast-conserving therapy(^b)</td>
<td>Postmastectomy irradiation of the chest wall and regional nodes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Breast-conserving whole-breast irradiation</td>
</tr>
<tr>
<td><strong>Desirable</strong></td>
<td>Reconstructive surgery</td>
<td></td>
</tr>
</tbody>
</table>

\(^a\)Palliative mastectomy is equivalent to removing advanced breast cancer which has ulcerated for purposes of local care of wound ONLY. Another term used in the developing world is “Toilet Mastectomy”

\(^b\)Breast-conserving therapy requires mammography and reporting of margin status.

\(^c\)Requires blood chemistry profile and complete blood count (CBC) testing.

Definitions: AC: doxorubicin and cyclophosphamide; CMF: cyclophosphamide, methotrexate, and 5-fluorouracil; EC: epirubicin and cyclophosphamide; FAC: 5-fluorouracil, doxorubicin, and cyclophosphamide; LH-RH: luteinizing hormone-releasing hormone.
### FSM National Standards for Breast Cancer Treatment: Metastatic (Stage IV) and Recurrent Breast Cancer

<table>
<thead>
<tr>
<th>Resource Level</th>
<th>Local-regional treatment</th>
<th>Systemic treatment (adjuvant)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Surgery</td>
<td>Radiation therapy</td>
</tr>
<tr>
<td>Core</td>
<td>Total mastectomy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>for ipsilateral breast</td>
<td></td>
</tr>
<tr>
<td></td>
<td>tumor recurrence&lt;sup&gt;a&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td>Expanded</td>
<td>Palliative radiation</td>
<td>Classical CMF&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>therapy</td>
<td>Taxanes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Trastuzumab</td>
</tr>
<tr>
<td>Desirable</td>
<td>Growth factors</td>
<td>Fulvestrant</td>
</tr>
<tr>
<td></td>
<td>Vinorelbine</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Gemcitabine</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Carboplatin</td>
<td></td>
</tr>
</tbody>
</table>

<sup>a</sup>Required resources are the same as those for modified radical mastectomy.

<sup>b</sup>Requires blood chemistry profile and complete blood count (CBC) testing.

Definitions: CMF: cyclophosphamide, methotrexate, and 5-fluorouracil.
## FSM National Standards for Palliative Care

<table>
<thead>
<tr>
<th>Resource Level</th>
<th>Services</th>
</tr>
</thead>
</table>
| **Core**       | Provide palliative care at all levels of care with emphasis on primary health-care clinics and home-based care, following national protocols.  

Ensure that legislation allows access to oral morphine and other affordable essential medicines according to the WHO list.  

Develop a palliative care reference group that collects best practices and information, supports people and community, and provides training. This is within the Comprehensive Cancer Control Coalition.  

Ensure availability of essential medications to all patients/clients. |
| **Expanded**   | Reinforce the network of palliative care services integrated with cancer care and other related services.  

Establish a Cancer Resource Center: a meeting place providing resources and training to the community.  

Establish a central storage/distribution center of opioid medications in the FSM. |
| **Desirable**  | Provide support to national and international reference centers for palliative care.  

Develop curricula in nursing and medical schools to teach palliative care both at the undergraduate and graduate levels. |
## FSM Client Management Guidelines - Putting Standards into Practice for Breast and Cervical Cancer Early Detection

<table>
<thead>
<tr>
<th></th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Involve women in creating awareness, prevention messages and programs.</td>
<td>Women’s Advisory Councils&lt;br&gt;MCH Coordinator and Programs&lt;br&gt;Cancer Coalitions&lt;br&gt;Cancer Survivors&lt;br&gt;Church Groups&lt;br&gt;Women’s groups Family Planning&lt;br&gt;In-School Programs&lt;br&gt;Reproductive Health Peers (Educators)&lt;br&gt;HIV/AIDS Programs&lt;br&gt;Health Workers&lt;br&gt;Men’s Groups&lt;br&gt;Red Cross</td>
<td>Create a standard curriculum for all the States that can be used for health worker trainings, community workshops and CME presentations&lt;br&gt;• Curriculum will have modules that can be used for different audiences including health professionals and lay people.&lt;br&gt;• Curriculum should cover the whole continuum: prevention, screening, self-exams, awareness and education, treatment, palliative care. (CIS-Pacific Region has developed the “ABCs of Cancer” curriculum, initially for Guam. Will need to localize the data to use in FSM.)&lt;br&gt;• Health worker trainings should be standardized and align with the National Client Management Guidelines for Breast &amp; Cervical Cancer.&lt;br&gt;• Curriculum can be used with both men and women.</td>
</tr>
</tbody>
</table>

- Partner with existing programs to provide trainings and workshops<br>  For example, College of Micronesia courses and Friday afternoon training for nurses in Pohnpei

- How to recruit busy people to workshops:<br>  • Invite them to join Cancer Coalition<br>  • Involve clinical chief of staff<br>  • Identify key people/decision makers/influential people<br>  • Involve politicians<br>  • Involve community leaders, traditional leaders, village chiefs
**Standard – B&C Early Detection**

**Who?**
- Women’s Advisory Councils
- MCH Coordinator and Programs
- Cancer Coalitions
- Cancer Survivors
- Church Groups
- Women’s groups
- Family Planning
- In-School Programs
- Reproductive Health Peers (Educators)
- HIV/AIDS Programs
- Health Workers
- Men’s Groups
- Red Cross

**How? Where?**
- Conduct Focus Group Discussions with girls and with mothers, for example, to prepare for HPV campaigns.
- Based on the results of the Focus Groups, develop campaign messages and approaches.
- Tell women/mothers:
  - The HPV vaccine will protect your daughters
  - Find ways for cancer survivors to share their experiences with others
  - Don’t be ashamed; get screening early so it won’t be too late
- Share stories/best practices among the states to avoid reinventing the wheel.
  - Website (pacificcancer.org)
  - Regular meetings (twice yearly)
  - Conference calls (rotate chair, agenda setting)
  - Emails

At the national level – look to the Secretary of Health for the leadership & decisions
- Ask the Secretary of Health, FSM National Department of Health and Social Affairs, to make core linkages with Maternal Child Health (MCH), HIV/AIDS and Immunization programs. Participate in the new multi-sectoral NCD Program.

Support and strengthen survivors support groups. Have them be spokespeople and promote message of early detection.
References for FSM Standards of Practice

Sources of US and international health standards that informed the decisions of the Federated States of Micronesia in developing resource-appropriate national standards for breast and cervical cancer.

Alliance for Cervical Cancer Prevention (ACCP) http://www.alliance-cxca.org

American Cancer Society (ACS) http://caonline.amcancersoc.org/


Centers for Disease Control and Prevention (CDC) http://www.cdc.gov/cancer/

CDC -The Community Guide http://www.thecommunityguide.org/

National Cancer Institute (NCI) http://www.cancer.gov

National Comprehensive Cancer Network (NCCN) http://www.nccn.org/

Program for Appropriate Technology in Health (PATH) http://www.path.org/

Susan G. Komen http://cms.komen.org/komen/AboutBreastCancer/index.htm


WHO International Agency for Research on Cancer (IARC): http://www.iarc.fr/
References for FSM Standards of Practice – page 2
Links to sources of US and international health standards that informed the decisions of the Federated States of Micronesia in developing resource-appropriate national standards for breast and cervical cancer.

Primary Prevention and Risk Assessment
- US Preventive Services Task Force (USPSTF) http://www.ahrq.gov/clinic/pocketgd05/
- USPSTF http://www.ahrq.gov/clinic/pocketgd05/gcps2.htm#BreastScreening
- NCI http://cancer.gov/bcrisktool/

Tobacco
- USPSTF http://www.ahrq.gov/clinic/uspstf/uspstbac.htm
- CDC Community Guide http://www.thecommunityguide.org/tobacco/

Diet and Obesity
- USPSTF http://www.ahrq.gov/clinic/pocketgd05/gcps2d.htm#Obesity

Physical Activity
- USPSTF http://www.ahrq.gov/clinic/pocketgd05/gcps2d.htm#Physical

Alcohol
- USPSTF http://www.ahrq.gov/clinic/pocketgd05/gcps2c.htm#Alcohol
- CDC Community Guide http://www.thecommunityguide.org/cancer/screening
References for FSM Standards of Practice - page 3
Links to sources of US and international health standards that informed the decisions of the Federated States of Micronesia in developing resource-appropriate national standards for breast and cervical cancer

Cervical Cancer Prevention – Sexual Health and HPV
- ACCP http://www.alliance-cxca.org/english/publications.html#factsheets
- CDC http://www.cdc.gov/STD/HPV/STDFact-HPV-vaccine-hcp.htm#vaccrec
- PATH http://www.rho.org/index.php

Cervical Cancer Early Detection
- ACCP http://www.alliance-cxca.org/english/event08.html
- ACCP http://www.alliance-cxca.org/english/publications.html#journals
- ACS http://caonline.amcancersoc.org/cgi/content/short/52/6/342
- USPSTF http://www.ahrq.gov/clinic/pocketgd05/gcps2.htm#Cervical

Breast Cancer Early Detection
- ACS http://caonline.amcancersoc.org/cgi/content/full/58/3/161
  http://www.komenswmichigan.org/mammographyrecommendations.php
- USPSTF http://www.ahrq.gov/clinic/pocketgd05/gcps2.htm#BreastScreening
References for FSM Standards of Practice – page 4
Links to sources of US and international health standards that informed the decisions of the Federated States of Micronesia in developing resource-appropriate national standards for breast and cervical cancer.

Breast and Cervical Cancer Early Detection
- ACCP http://www.alliance-cxca.org/
- BHGI http://www.fhcrc.org/science/phs/bhgi

Cervical Cancer Diagnosis and Treatment

Breast Cancer Diagnosis and Treatment
- NCI http://www.cancer.gov/cancertopics/pdq/treatment/breast/healthprofessional

Palliative Care
- WHO http://www.who.int/cancer/media/FINAL-Palliative%20Care%20Module.pdf
National Workshop to develop
FSM Breast and Cervical Cancer Client Management Guidelines for Prevention, Early
Detection, Diagnosis, Treatment and Care
29 Aug – 2 Sept, 2008 in Pohnpei, Federated States of Micronesia

Workshop Participants List

<table>
<thead>
<tr>
<th>Name</th>
<th>Department</th>
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<tbody>
<tr>
<td>1. Brenda Hadley Eperiam</td>
<td>Health &amp; Social Affairs, NCC</td>
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<tr>
<td>2. Alison MacConnell</td>
<td>Health &amp; Social Affairs, Tobacco</td>
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<tr>
<td>3. Manuel Umwech</td>
<td>Public Health, Chuuk</td>
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<tr>
<td>4. Ira E. Akapito</td>
<td>Health Planner, Chuuk</td>
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<tr>
<td>5. Martin L. Ruwniyol</td>
<td>COM-Land Grant, Yap</td>
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<tr>
<td>6. Rodson R. Ruben</td>
<td>Education, Health and Science, Yap</td>
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<tr>
<td>7. Oseaia Santos</td>
<td>Health &amp; Social Affairs, NCC</td>
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<tr>
<td>8. Esther Letalimepiy</td>
<td>Public Health, Outer Island, Yap</td>
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<tr>
<td>9. Ansina B. Kony</td>
<td>COM-Land grant, Health and Nutrition, NGO Women Association, CCC Coalition Chuuk</td>
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<tr>
<td>10. Roslyn Reynold</td>
<td>Chief of PH, CCPI, Kosrae</td>
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<tr>
<td>11. Bermin Weibacher</td>
<td>BNN NGO, Survivor, NCC</td>
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<tr>
<td>12. Matchuko Talley</td>
<td>Women’s Interest Group., NGO, IFCK, Former Chief of PH, Kosrae</td>
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<tr>
<td>13. Nena Tolenoa</td>
<td>CCC coordinator, Kosrae</td>
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<tr>
<td>14. Amena V. Yauvoli</td>
<td>SPC Manager, Regional Office (Northern Pacific), Pohnpei</td>
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<tr>
<td>15. Innocente Penno</td>
<td>Agriculture, Chuuk</td>
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<td>16. Marcus Samo</td>
<td>Health &amp; Social Affairs</td>
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<td>19. Dr. Vita Skilling</td>
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<td>20. Donna Amaraich</td>
<td>Health &amp; Social Affairs</td>
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<tr>
<td>21. Marietta Paiden</td>
<td>Congress Librarian; Women Organization of Sekehre, Pohnpei</td>
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<tr>
<td>22. Amato Elymore</td>
<td>CCCP coordinator, National</td>
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<tr>
<td>23. Xner Luther</td>
<td>CCCP coordinator, Pohnpei</td>
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<td>24. Selinna Johnson</td>
<td>NGO/PWAC, Pohnpei</td>
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<td>25. Elizabeth Hadley</td>
<td>NGO/PWAC; Survivor, CCC Coalition, Pohnpei</td>
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<td>26. Enerika Peterson</td>
<td>NGO/PWAC, Pohnpei</td>
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<td>27. Judy Mauricio</td>
<td>NGO/PWAC, CCC Coalition, Pohnpei</td>
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<td>29. Roses B. Donre</td>
<td>Community &amp; Social Affairs, Women Officer, Pohnpei</td>
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<tr>
<td>30. Dr. Kino Ruben</td>
<td>CCC Coordinator, CCPI, Chuuk</td>
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<tr>
<td>Local Resource Persons</td>
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<tr>
<td>31. Dr. Johnny Hedson</td>
<td>Chief of staff, CCC Coalition, CCPI, NCC advisor, Pohnpei and National</td>
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<tr>
<td>32. Kathleen Benjamin</td>
<td>Health Services, Chief Nursing, Pohnpei</td>
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<tr>
<td>33. Carmen Jim</td>
<td>Public Health, MCH/FH, Pohnpei</td>
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<td>34. Sohnel Johnson</td>
<td>Community Health Center, Pohnpei</td>
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<td>Technical Consultants</td>
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<tr>
<td>Karen Heckert</td>
<td>PCEED UH</td>
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<tr>
<td>Jeanette Koijane</td>
<td>PCEED – CIS-Pacific</td>
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<tr>
<td>Doris Segal Matsunaga</td>
<td>PCEED – CIS-Pacific</td>
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<tr>
<td>Karen Fukofuka</td>
<td>SPC - Nutrition Advisor</td>
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<tr>
<td>Dr. Viliami Puloka</td>
<td>SPC - NCD Advisor</td>
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</table>
National Workshop to develop

FSM Breast and Cervical Cancer Client Management Guidelines for Prevention, Early Detection, Diagnosis, Treatment and Care

29 Aug – 2 Sept, 2008 in Pohnpei, Federated States of Micronesia

With technical assistance from Pacific CEED and CIS-Pacific Region

Workshop Objectives:
1. To discuss and agree upon minimum standards of practice.
2. To identify strategies, roles and resources needed to put the minimum standards into practice.
3. To draft the National FSM Client Management Guidelines for integrating the continuum of breast and cervical cancer prevention, early detection, diagnosis, treatment, and care.
4. To outline ‘next steps’ to secure institutional support at national and State levels, to finalize the draft guidelines and to adopt and adapt the guidelines at the State level.

<table>
<thead>
<tr>
<th>PROGRAM OF ACTIVITIES</th>
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<tr>
<td><strong>DAY 1: Friday, August 29</strong></td>
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<tr>
<td><strong>08:00 – 08:30</strong></td>
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<td><strong>1:00 – 2:45</strong></td>
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*Chairperson: Dr Kino Ruben, Chuuk*
*Documenter: Amato Elysmore, National*
*Rapporteur: Nena Tolenoa, Kosrae*
*Chair person: Nena Tolenoa, Kosrae.*
*Documenter: Xner Luther, Pohnpei*
<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Facilitator(s)</th>
<th>Chair/Documenter</th>
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<tbody>
<tr>
<td>2:45 – 3:05</td>
<td><strong>Afternoon tea &amp; coffee</strong></td>
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</table>
| 3:05 – 5:00  | **Resource-Appropriate Guidelines: Overview of US and International Breast & Cervical Standards of Care.**  
* Doris Segal-Matsunaga, CIS-Pacific-Region  
* Primary FSM-Appropriate Guidelines: Achieving the Workshop Objectives  
* Karen Heckert, Pacific CEED  
* Summary of the Day | Rapporteur: Xner Luther, Pohnpei |                                  |
| 08:30 – 9:30 | Breast cancer prevention and early detection; biological risk factors, SBE, CBE, mammography, ultrasound  
* Dr Johnny Hedson, Chief, Division of Medical Services, Surgeon, Pohnpei State Health Services  
* Discussion | Chair person: Xner Luther  
Documenter: Nena Tolenoa |                                  |
| 09:30 - 10:15| Review & Agree on standards for breast cancer prevention & early detection – facilitator |                                  |                                  |
| 10:15 – 10:30| **Morning coffee & tea**                                                  |                                     |                                  |
| 10:30 – 12:00| Group Work: Putting the breast cancer prevention & early detection standards into practice  
* facilitator & co-facilitator (resource person)  
* Summary of the Morning | Facilitator(s) Doris, Karen, Jeannette & local resource persons  
Rapporteur: Martina Reichhardt |                                  |
| 12:00 – 1:00 | **Lunch**                                                                 |                                     |                                  |
| 1:00 – 2:30  | Breast Cancer diagnosis & treatment; Options & Opportunities in FSM  
* Dr Johnny Hedson, Chief, Division of Medical Services, Surgeon, Pohnpei State Health Services  
* Discussion | Chair person: Xner Luther, Pohnpei  
Documenter: Nena Tolenoa |                                  |
<p>| 2:30 – 2:50  | <strong>Afternoon tea &amp; coffee</strong>                                                |                                     |                                  |</p>
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<tr>
<th>Time</th>
<th>Activity</th>
<th>Facilitators/Participants</th>
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<tbody>
<tr>
<td>2:50 – 4:00</td>
<td>Review &amp; Agree on standards for diagnosis and treatment - Facilitator</td>
<td>Facilitator(s) Doris, Karen Jeannette &amp; local resource persons</td>
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<td>Summary of the Day</td>
<td>Rapporteur: Martina Reichhardt</td>
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<td><strong>DAY 3: Monday, September 1</strong></td>
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<tr>
<td>08:30 – 10:30</td>
<td>Cervical Cancer prevention; the role of sexual health, the HPV vaccine</td>
<td>Chair person: Amato Elysmore</td>
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<td><em>Dr Johnny Hedson, Chief of Medical Services</em></td>
<td>Documenter: Martina Reichhardt</td>
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<td>Discussion</td>
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<tr>
<td>10:30 – 10:45</td>
<td>Morning coffee &amp; tea</td>
<td>Facilitator(s) Doris, Karen Jeannette &amp; local resource persons</td>
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<td>10:45-12:00</td>
<td>Cervical cancer early detection, pap smear, VIA</td>
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<td><em>Dr Johnny Hedson, Chief of Medical Services</em></td>
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<td>12:00 – 1:00</td>
<td>Lunch</td>
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<td>1:00 – 2:00</td>
<td>Cervical cancer diagnosis and treatment</td>
<td>Chair person: Dr Kino Ruben</td>
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<td><em>Ms Kathy Benjamin, Chief Nurse</em></td>
<td>Documenter: Martina Reichhardt</td>
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<td><em>Ms Carmen Jim, MCH Division</em></td>
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<td>Discussion</td>
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<td>2:00 – 3:00</td>
<td>Review and Agree on standards for cervical cancer diagnosis and treatment - facilitator</td>
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<td>3:00 – 3:15</td>
<td>Afternoon tea &amp; coffee</td>
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<tr>
<td>3:15 – 5:00</td>
<td>Group Work: Putting cervical cancer prevention and early detection standards into practice</td>
<td>Facilitators: Doris, Karen Jeannette &amp; local resource persons</td>
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<td><em>Facilitator &amp; co-facilitator (resource person)</em></td>
<td>Rapporteur: Amato Elysmore</td>
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<td>Summary of Day</td>
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<tr>
<td>08:30 – 10:00</td>
<td>Survivorship and Palliative Care&lt;br&gt;Jeannette, Koijane, CIS-Pacific Region&lt;br&gt;Kathy Benjamin, Chief Nurse</td>
<td>Chairperson: Martina Reichhardt&lt;br&gt;Facilitators: Doris &amp; Karen &amp; Jeannette</td>
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<td>10:20 – 12:00</td>
<td>Review &amp; Agree on standards for survivorship and palliative care - facilitator</td>
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<td>12:00 – 1:00</td>
<td>Lunch</td>
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<td>1:00 – 2:40</td>
<td>Putting the standards and practice together: The DRAFT National Client Management Guidelines - Reaching Consensus and Agreement</td>
<td>Chairperson: Nena Tolenoa&lt;br&gt;Facilitators: Doris &amp; Karen &amp; Jeannette</td>
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<td>Workshop Evaluation</td>
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<td>2:40 – 3:00</td>
<td>Afternoon tea &amp; coffee</td>
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<tr>
<td>3:00 – 5:00</td>
<td>Report to Secretary Skilling&lt;br&gt;- Standards; Key Points –Amato Elysmore&lt;br&gt;- Trainings required to put standards into practice&lt;br&gt;- Next Steps for National &amp; the States: to seek endorsement from the Directors of Health</td>
<td>State &amp; National Presentations – 3-5 mtes&lt;br&gt;Facilitators: Doris &amp; Karen &amp; Jeannette&lt;br&gt;Rapporteur: Xner Luther</td>
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<td>Closing – Secretary Vita Skilling</td>
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National Workshop to develop FSM Breast and Cervical Cancer Client Management Guidelines for Prevention, Detection, Treatment and Care

Roles and Responsibilities for Chair, Documenter, and Rapporteur

Aug 29 – Sept 2, 2008 in Pohnpei, Federated States of Micronesia

Workshop Objectives:
1. To discuss and agree upon minimum standards of practice and draft the National FSM Client Management Guidelines for integrating the continuum of breast and cervical cancer prevention, early detection, treatment, and care.
2. To identify strategies, roles and resources needed to put the minimum standards into practice.

Overview:
This workshop is a technical working meeting to discuss and agree on minimum standards of practice for breast and cervical cancer prevention & early detection, diagnosis & treatment and survivorship & palliative care. We will also talk about how to put these standards into practice.

Structure:
To maximize contributions from all CCC Coordinators, we have structured the meeting to allow everyone to serve as Chair, Documenter, and Rapporteur for each of the working sessions on a rotational basis. This structure will help us document all inputs and compile the main components into a comprehensive set of Client Management Guidelines.

The National Client Management Guidelines will include:
1) Minimum standards of practice for; a) prevention & early detection, b) diagnosis & treatment, and c) survivorship & palliative care for breast and cervical cancer
2) Preliminary steps for ‘putting the standards into practice’ (based on the Assets Mapping and discussion) – the ‘who’ and the ‘where/what service or resource’
3) Selection of US and International sources of evidence for resource-appropriate practice
4) The CM Guidelines may also include preliminary recommendations for adopting and adapting the national minimum standards in each State

Roles and Responsibilities:

Chair person:
- Preside over the meeting
- Review relevant ‘ground rules’ (e.g. everyone participates, pay attention, keep to the agenda, put ‘training’ and ‘linkages’ ideas on the ‘parking’ lists using post-its, etc.)
- Introduce the speakers and sessions
- Keep the speakers and program ON TIME
- Remind us of the reason for our work; to ensure an integrated, family-centered approach that addresses the needs of individuals and families and motivates their strengths
- Remind us about the Family Story (Amato & Johnny will invite a Family to tell us their Story. You can remind us of the story or Tell A Story from your Island.)
- Ice-breakers & Exercise Breaks – Feel free to energize the group! Be Creative!
- Remind the Documenter to write/type all contributions during the discussions
• Remind the Rapporteur to touch base with you & the Documenter briefly during morning coffee or afternoon tea break to prepare a 5 minute summary of the morning or afternoon session.

**Documenter:**

*Note: Our goal is to prepare a working document of standards to help us guide clients and patients through our systems of prevention, treatment and care so that no one ‘gets lost’! To make sure everyone’s contributions are reflected in the final draft document, we want to write and/or type all comments.*

• Document the questions, answers and discussions following each of the presentations by the resource persons. (A laptop & electronic format will be available. If you prefer to handwrite the notes, no problem. We may also take notes on the flipchart.)
• During the Group Work sessions, document your group’s discussion, using the worksheet.
• Share highlights with the Rapporteur so he/she can report to the group at the end of each morning and afternoon session.
• Give the final notes for the day/session to the Chair and Lead Facilitator at the end of each day. (This is important so the Facilitators can compile the notes and contributions each evening in preparation for the next sessions.)

**Rapporteur:**

• Follow the presentations and discuss.
• Jot done ‘key points’ to summarize at the end of the morning or afternoon session.
• Meet with the Chair and Rapporteur for your session, during coffee or tea break, and agree on key points for your report-back to the workshop
• Deliver a 3-5 minute Report Back to the workshop participants at the end of the morning or afternoon session, highlighting ‘key points’ only (jokes are good too!)
• Introduce the workshop participants to the next session (title of session, speaker, etc.)
• Remind everyone to return to the workshop session ON TIME and to CONTRIBUTE
• Introduce the Chair, Documenter and Rapporteur for the next session
Integrated prevention – care continuum

**Uptake**↑ **high**

- prevention
- early detection
- diagnosis
- treatment

**Drop out**↓ **low**

- recovery
- palliative care

**Linkages in place**
Breast Cancer

MYTH #1

“Cancer is an insignificant health care issue in low and middle income countries (LMCs).”

FACT: Cancer is the second most common cause of death in LMCs, more than respiratory infections and diseases, HIV/AIDS, diarrheal diseases and tuberculosis.

CAUSES OF DEATH:
Low-Income and Lower-Middle Income Countries

- Cancer: 4.4 million
- Respiratory infections: 3.5 million
- Respiratory diseases: 3.0 million
- HIV/AIDS: 2.7 million
- Diarrheal diseases: 1.8 million
- Tuberculosis: 1.5 million


MYTH #2

“Breast cancer only affects wealthy countries.”

FACT: Breast cancer is the most common cancer among women around the globe, and the most likely reason that a woman will die of cancer.

BREAST CANCER EPIDEMIOLOGY:
Breast cancer mortality / incidence ratios

Anatomy and Physiology of the Breast

What makes up the breast?
BREAST CANCER EPIDEMIOLOGY:
Breast Cancer Stage at Diagnosis in India

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<tr>
<th>STAGE</th>
<th>DISTRIBUTION %</th>
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<td>I</td>
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<td>II</td>
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<td>III</td>
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<td>IV</td>
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Source: Cancer Institute Chennai, India
Data provided by Rakesh Chopra, MD

76% locally advanced or metastatic –

NOTE!!

Epidemiology

- FSM data...

Structure of the Breast

- Each breast has 15-20 sections called lobes.
- Each lobe has smaller sections called lobules.
- Lobes, lobules and bulbs are linked by thin tubes called ducts.

Relation of Breast to Chest Wall Structures

- Each breast contains blood vessels and vessels that carry lymph.
- Lymph vessels lead to lymph nodes.
- No muscles in breast but muscles lie under breast and cover ribs.

Location of Lymph Node Drainage

- Main route of spread for breast cancer is lymph system.
- Clusters of lymph nodes found in axilla, above the collarbone and in chest.
- Most breast tumors drain to axillary lymph nodes.

Risks and Prevention

Who is at risk and how can we prevent it?
Risk Factors

- Gender
- Age
- Family/Personal History
- Genetic alterations
- Estrogen Exposure
- Reproductive and Menstrual history
- Race
- Breast Density
- Lobular Carcinoma in Situ (LCIS)
- Atypical Hyperplasia
- Radiation Exposure
- Alcohol
- Obesity
- Physical inactivity
- DES (diethylstilbestrol)

Methods of Breast Cancer Prevention (US)

- Chemoprevention
- Preventative mastectomy
- Genetic Testing: BRCA1 & BRCA2
- Breastfeeding!

Chemoprevention

- Chemoprevention is the use of drugs, vitamins or other agents to try to prevent cancer or its recurrence.
- Tamoxifen and Raloxifene.

Preventative Mastectomy

- Removal of one or both breasts to prevent breast cancer.
  - Performed in high risk women.
  - Still leaves some breast tissue behind.
  - Significantly reduces risk but does not eliminate risk.

Screening, Symptoms and Diagnosis

Methods to find breast cancer early

Clinical Breast Exams (CBE)

- Involves both visually and physically examining the breast and surrounding tissues by a trained health professional.
- Detects changes in tissue using pads of fingers to feel (palpate) for lumps.
Breast Self-Exam (BSE)

- Examination a woman does of her own breasts
- Frequently advocated, but no scientific evidence of its effectiveness
- BSE alone is not recommended by NCI as a breast cancer screening method
- What is best in Limited-Resource Countries? (vs. late presentations)!!

Recognizing Symptoms

- A lump or thickening in or near the breast or underarm area.
- A change in the size or shape of the breast.
- Nipple discharge or tenderness, or the nipple pulled back into the breast.
- Ridges or pitting of the breast (the skin looks like the skin of an orange).

Recognizing Symptoms (cont’d)

- A change in the way the skin of the breast, areola, or nipple looks or feels.
- Early breast cancer usually does not cause pain.

Having these symptoms does not mean that cancer is present. These symptoms can also indicate a benign condition. It is important to see a doctor or health professional to evaluate the symptoms.

Detection and Diagnostic Procedures: Clinical Evaluation

- A health care provider gathers information from the patient’s medical history and conducts a clinical exam of the breast.
- Clinical breast exam may help determine:
  - if a lump is present
  - if a lump feels benign or malignant

US Standards: Screening Mammography X-ray of the breast

- Benefits
  - Detects breast changes in women without symptoms
  - Most effective tool for breast cancer screening
  - Health care providers determine frequency of mammograms

- Risks
  - Does not detect all cancers
  - May identify non-cancerous conditions

US Screening Standards

USPSTF
- Mammography every 1 to 2 years beginning at age 40.
- Not enough evidence to recommend for or against CBE or SSE.

ACS
- Mammography every year beginning at age 40
- CBE: At least every 3 years ages 20-39; every year beginning age 40.
- BSE: Beginning age 20, talk to provider re: benefits

Komen: BSE monthly beginning at age 40
**International Standards**

Low-resource countries:

- Mammography should not be introduced for screening unless resources available to ensure effective & reliable screening of at least 70% of women over age 50. WHO – 2008

- Diagnostic mammography before screening
  WHO – 2008

- Diagnostic ultrasound before mammography
  BHGI - 2005

**UKRAINE P.A.T.H. PROJECT:**

Screening and early detection results

- ~ 4,000 women screened by mammography
- 18,631 women screened by clinical breast exam
- Late stage dropped while early stage increased during 3 years of program

**BHGI - Resource Level Guidelines**

<table>
<thead>
<tr>
<th>Level of resource</th>
<th>Detection method(s)</th>
<th>Evaluation goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>Population-based mammographic screening</td>
<td>Baseline assessment and repeated survey</td>
</tr>
<tr>
<td>Limited</td>
<td>Targeted outreach/education, or imaging for high-risk groups</td>
<td>Early detection of symptomatic disease</td>
</tr>
<tr>
<td>Enhanced</td>
<td>Diagnostic mammography, opportunistic mammographic screening</td>
<td>Opportunistic screening of asymptomatic patients</td>
</tr>
<tr>
<td>Maximal</td>
<td>Population-based mammographic screening</td>
<td>Population-based screening of symptomatic patients</td>
</tr>
</tbody>
</table>

Most Common Detection and Diagnostic Tests

- Diagnostic Mammography: X-ray of the breast to visualize the internal structure of the breast.
  - Alone: Reduce mortality by 1/3 50-69y F
  - Limited evidence for 40-49 yrs F
- Ultrasound: High-frequency sound waves create images of the breast. Used to distinguish between a fluid filled cyst and a solid mass.
- Magnetic Resonance Imaging: Powerful magnet linked to a computer provides detailed pictures of breast tissue.

**Breast Cancer**

- Diagnosis & Treatment

**Detection and Diagnostic Procedures: Biopsies**

- Biopsy is the only way to confirm whether a mass is cancerous.
- Types of biopsies:
  - Surgical
  - Needle
  - Image-guided techniques
    - Stereotactic
    - Other biopsy techniques

Surgical Biopsies

- **Excisional Biopsy:** Surgery to remove an entire lump or suspicious area.
- **Incisional Biopsy:** Surgery to remove only a portion of an abnormal area.

Needle Biopsies

- **Fine needle aspiration:** Uses a very thin needle and syringe to remove either fluid from a cyst or a cluster of cells from a solid mass.
- **Core needle biopsy:** Uses a somewhat thicker needle with a cutting edge to remove a small core of tissue from a mass.

Image-guided Biopsy Techniques

- **Needle-Localization Biopsy:** Mammography used to locate area to be biopsied. Most often done when abnormality is seen on a mammogram but is too small or cannot be felt.

Image-guided Biopsy Techniques (cont’d)

- **Stereotactic localization biopsy:** Uses an imaging device to guide a needle biopsy of a non-palpable mass.
- **Mammotome:** Uses a vacuum-like action to remove abnormal cells for evaluation.

Other Techniques

- **Sentinel Lymph Node Biopsy:**
  - Used to identify, remove, and examine sentinel lymph node(s) for cancer cells.
  - The sentinel lymph node(s) is the first lymph node(s) in a chain or cluster to receive lymphatic drainage from a tumor.

- **Ductal Lavage:**
  - A technique for collecting cells directly from a breast duct(s) using a catheter.

Breast Cancer Classification, Staging and Treatment

Finding the type and extent (stage) of the cancer to determine treatment options and help predict prognosis.
**Types of Breast Cancer**

- **Ductal Carcinoma**: Cancer that starts in the ducts (tubes that carry milk from the lobules to the nipple).
  - Most frequently diagnosed type of breast cancer.
- **Lobular Carcinoma**: Cancer that starts in the lobes (small sacs in the breast that produce milk).
  - Has a higher incidence of bilateral presentation than ductal carcinoma.

**Types of Breast Cancer, (con’t)**

- **Nipple Carcinoma (Paget’s Disease)**: Cancer that begins in the area of the nipple and is associated with bleeding, redness, itching, and burning.
  - This type of breast cancer is usually non-invasive.
- **Inflammatory Breast Cancer**: An uncommon type of breast cancer in which cancer cells block the vessels in the skin of the breast.
  - Inflammatory breast cancer generally grows rapidly and cancer cells often spread to other parts of the body.

**Staging of Breast Cancer**

- Determines extent of disease based on physical examination, imaging tests, and/or surgical findings.
- Tumor size, lymph node involvement and metastases are all evaluated (TNM system).
- Determines the choice of treatment and helps predict prognosis.

**Procedures Used for Staging**

- Mammography
- Lymph Node Biopsy including Sentinel Lymph Node Biopsy
- Chest X-ray
- Blood Tests
- Bone Scan

**Stages of Breast Cancer**

- **In-Situ Carcinoma (DCIS and LCIS)**.
- Stage I and II still considered early stage.
- Stage III is considered locally advanced.
- Stage IV: Cancer has spread to other parts of the body.
- Recurrent: Cancer has returned.

**Factors Influencing Treatment Options**

- Stage
- Type of breast cancer and tumor grade
- Size and location of the tumor
- Proliferative capacity of tumor
- Hormone receptor status
- HER2neu gene amplification
- Woman’s age, menopausal status and general health
Treatment Options:
Breast Sparing Surgery
• Lumpectomy: Removal of lump and surrounding tissue, with/without lymph node dissection (usually followed by radiation therapy).
• Partial/Segmental Mastectomy: Removal of lump, surrounding tissue, and lining of chest muscles, with/without lymph node dissection.

Treatment Options: Surgery (cont’d)
• Total (Simple) Mastectomy: Removal of entire breast.
• Modified Radical Mastectomy: Removal of entire breast, axillary lymph nodes, lining of chest muscles and sometimes chest wall.

Treatment Options: Surgery (cont’d)
• Radical (Halsted) Mastectomy: Removal of breast, chest muscle, and all axillary lymph nodes.
  – Only used when the tumor has spread to the chest muscle.
• “Toilet” Mastectomy – Removal of Ulcerated cancers

Treatment Options: Radiation Therapy
• Use of high energy x-rays to kill cancer cells that may remain after surgery.
• Usually given following lumpectomy as primary treatment for early stage breast cancer.
• May be internal or external; usually external for breast cancer.

Treatment Options: Chemotherapy
• Use of drugs to kill cancer cells.
• Systemic Treatment: Travels through blood stream to kill circulating cells.
• Usually given after surgery; sometimes before, to shrink large tumor.

Treatment Options: Hormone Therapy
• The use or manipulation of natural or synthetic hormones to prevent the growth, spread, or recurrence of breast cancer.
• Most commonly used hormone drug is tamoxifen.
• Aromatase inhibitors
• Systemic treatment.
Treatment Options: Biological Therapy

- Designed to repair, stimulate, or increase the patient’s natural ability to fight the cancer.
- Herceptin is an example of an approved biological therapy for breast cancer that has certain characteristics (Her2 protein).

Treatment Options: Clinical Trials

- Clinical Trials (research studies) test new methods for preventing, screening, diagnosing and treating breast cancer.
Reducing Cervical Cancer Burden through the HPV Vaccine

Dr. Hedson

Extracts from Previous Presentations

Outline

- HPV Epidemiology
- HPV-associated diseases
- HPV Vaccine
- ACIP Recommendations
- Implementation Issues

HPV: Common Infection

Infection Is Sexually Transmitted

HPV types differ in disease association

HPV-Related Disease Burden, U.S.

- Genital warts: 0.5 to 1 million cases
  - 90% caused by types 6,11
- Recurrent respiratory papillomatosis (rare)
  - 90% caused by types 6,11
- Pap tests: 50 million; 2.8 million abnormal
  - Most abnormal cases caused by HPV; as grade increases, more HPV prevalence with HPV 16 being the most common type for most severe
- Precancerous cervical lesions: burden unknown
- Cervical cancer
  - 70% caused by types 16,18
- Other anogenital cancers: (anal, penile, vaginal, vulvar)
  - 40-90% caused by HPV, with HPV 16 being predominant type
- Other cancers: (oropharyngeal, tonsillar)
  - Depends on subsite, HPV 16 being predominant type

- Cutaneous (~60 types)
  - low grade cervical abnormalities
  - genital warts
  - respiratory papillomatosis

- Mucosal (~40 types)
  - high-risk types
    - (16,18, and others)
    - cervical cancer precursors
    - intraepithelial neoplasia (CIN 2/3)
    - adenocarcinoma in situ (AIS)
    - anogenital cancer
  - low-risk types
    - (6,11, others)

"common" warts
(hands/feet)
Genital Warts

- Transmission: Sexual
- Burden of Disease
  - No reporting, imprecise estimates
  - Managed Care Data
    - Peak prevalence: ages 20-29 years
    - Incidence: 157/100,000 persons
    - Frequent recurrences, repeat treatments (average of 3 clinic visits)

Recurrent Respiratory Papillomatosis (RRP)

- Transmission: Vertical--Juvenile
- Burden of Disease
  - No reporting, imprecise estimates
  - Registry data
    - Prevalence: 1.0 – 4.0/100,000 children
    - Debilitating/recurrent disease requiring multiple surgeries
    - Median number of surgeries 13 (range, 2 – 179)

Cervical Cytological and Histological Abnormalities

- Pap test: Checks cervical cells for changes, many which are due to HPV infection
- Biopsies result in histological abnormalities (CIN I to CIN III)

Natural History of HPV Infection and Cervical Cancer

- Initial HPV infection
- Persistent infection
- CIN* 1
- CIN* 2/3 AIS
- Cancer
- Cleared HPV infection

HPV Types in Cases of Cervix Cancer

- Different Regions of the World

<table>
<thead>
<tr>
<th>Region</th>
<th>HPV 16</th>
<th>18</th>
<th>31</th>
<th>45</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>North America</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Europe</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C-S Amer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Africa</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

HPV 16, 18, 31, and 45 Cause Most Cervical Cancer Worldwide

- Bosch et al., JNCI 1993

Cervical Intraepithelial Neoplasia

- CIN1
- CIN2
- CIN3

Bosch et al., JNCI 1993
HPV Clearance

- Approximately 70% of new infections clear within one year, 91% within 2 years
- Most clearance in first 6 months

HPV Persistence

- Infection detected at more than one visit (usually 4-6 months apart)
  - Most important predictor of high grade cervical cancer precursors

HPV Test – Hybrid Capture 2 (HC2)

- A nucleic acid solution hybridization assay with signal amplification that uses long synthetic RNA probes complementary to the DNA sequence of the 13 high risk HPV types.
- Easy to perform in clinical practice and amenable to automation
- The only test approved by FDA

Uses of HPV DNA Test

FDA Approved Use of HPV DNA Test

- Triage: Hybrid Capture II high risk panel (HC2) for ASC-US Pap test results
  - Adjunct Screening: HC2 as adjunct to Pap test in women 30 years of age and older. If both tests are negative, next cervical cancer screening should not occur for at least 3 years.

Not FDA Approved Use of HPV DNA Test

- Primary Screening (used alone): HC2 used first followed by triage with Pap test
- Being Studied Overseas. Not FDA approved

Organization Recommendations for HPV DNA Use in Cervical Cancer Screening

<table>
<thead>
<tr>
<th>ASC-US triage</th>
<th>USPSTF</th>
<th>ACS</th>
<th>ACOG</th>
<th>ASCCP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adjunct screening with Pap test</td>
<td>Insufficient Evidence</td>
<td>Not addressed</td>
<td>Recommended</td>
<td>Recommended</td>
</tr>
</tbody>
</table>

USPSTF – U.S. Preventive Services Task Force
ACS – American Cancer Society
ACOG – American College of Obstetricians and Gynecologists
ASCCP – American Society of Colposcopy and Cytology

HPV Vaccines

- Made from proteins on the outside of the virus
- Contains no mercury
- Contains no infectious material

HPV VLP

Phase III ongoing
Licensed in June, 2006
Licensed in June, 2006

Vaccine/Manufacturer | HPV Types | Schedule | Progress of trials |
--- | --- | --- | --- |
Quadribivalent GARDASIL® | 6/11/16/18 | 3 doses | Phase III ongoing |
Merck | 0, 2, 6 mos | | |
GARDASIL® | | | |
Bivalent CERVARIX® | 16/18 | 3 doses | |
GSK (not yet out) | 0, 1, 6 mos | | |
### Efficacy Analysis Populations for Quadrivalent Vaccine

- Per Protocol Population for Efficacy (PPE)
  Received all 3 vaccinations, naïve to relevant vaccine HPV type through Month 7, did not deviate from protocol; cases counted after Month 7.

### Efficacy for Prevention of Clinical HPV Disease Due to HPV 6/11/16/18

<table>
<thead>
<tr>
<th>Endpoint</th>
<th>Vaccine</th>
<th>N</th>
<th>Cases</th>
<th>Placebo</th>
<th>N</th>
<th>Cases</th>
<th>Efficacy (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HPV 16/18 related CIN2/3 or AIS</td>
<td>8487</td>
<td>0</td>
<td>8460</td>
<td>53</td>
<td>100</td>
<td>(93,100)</td>
<td></td>
</tr>
<tr>
<td>HPV 6/11/16/18 related CIN</td>
<td>7858</td>
<td>4</td>
<td>7861</td>
<td>83</td>
<td>95</td>
<td>(87, 99)</td>
<td></td>
</tr>
<tr>
<td>HPV 6/11/16/18 related genital warts</td>
<td>7897</td>
<td>1</td>
<td>7899</td>
<td>91</td>
<td>99</td>
<td>(94,100)</td>
<td></td>
</tr>
</tbody>
</table>

Package insert: Gardasil® Integrated dataset; results in the per-protocol populations. CIN—cervical intraepithelial neoplasia; AIS—adenocarcinoma in situ.

### Efficacy for Prevention of Clinical HPV Disease, by Baseline Status

**Quadrivalent HPV Vaccine Trials**

<table>
<thead>
<tr>
<th>PCR status</th>
<th>Seronegative</th>
<th>Seropositive</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCR (-)</td>
<td>Prophylactic efficacy in per protocol population</td>
<td>Low recurrence rate 100% efficacy</td>
</tr>
<tr>
<td>PCR (+)</td>
<td>No evidence of efficacy against respective type</td>
<td>No evidence of efficacy against respective type</td>
</tr>
</tbody>
</table>

### Anti-HPV 16 GMTs Through 5 Years

**Protocol 007**

![Graph showing GMTs](Image)

**Merck, unpublished data, Presented at ACIP meeting June 2006**

### US Vaccine Adverse Event Reporting System (VAERS)

- Presented Feb, 2007 ACIP
- 542 reports, 99% females
- 5 Most frequently reported symptoms:
  - Injection site pain: 18%
  - Dizziness: 11%
  - Syncope: 11%
  - Fever: 9%
  - Nausea: 9%

### Safety Update

- No increased number of serious adverse events
- Most events have been local injection site reactions
- There were some cases of fainting after vaccination
- 4 cases of Guillain-Barre Syndrome (GBS) Some of these persons also received other vaccines at the same time as Gardasil
- 3 deaths reported, 2 involving a pulmonary embolism and 1 involving myocarditis

**Merck, unpublished data, Presented at ACIP meeting June 2006**
Quadrivalent HPV Vaccine Summary

• High efficacy in 16 to 26 year-old females who are naïve to the HPV vaccine type
  - HPV 16,18 related CIN 2/3
  - HPV 6,11,16,18 related CIN
  - HPV 6,11,16,18 related external genital lesions

• No evidence of efficacy against disease in persons already infected with 6, 11, 16, 18

• Efficacy data available through 5 years; duration of protection and need for booster unknown

• Safe; side effects mainly local reactions

• >99% seroconversion rates in 9-26 year-olds

• Antibody titers substantially higher than after natural infection; highest in those vaccinated at younger ages

• Antibody titers decline over time after 3rd injection, but plateau by 24 months

• Cross protection data still pending

• Efficacy in men pending

Recommendations

• Routine vaccination
• Catch-up vaccination
• Special situations
• Precautions and contraindications

Routine Vaccination

• ACIP recommends routine vaccination of females 11-12 years of age with three doses of quadrivalent HPV vaccine

• The vaccination series can be started as young as 9 years of age

Rationale: Routine Vaccination Females at 11-12 Years

• Routine
  - Prevalent infection, targeting ‘high risk’ groups not possible
  - Modeling shows greater impact
• 11-12 years
  - Vaccination prior to sexual debut
  - Implementation advantages; consistent with young adolescent health care visit
  - High antibody titers after vaccination at this age
  - Data through 5 years show no evidence of waning immunity; ongoing studies will monitor duration of protection

Percentage of US Adolescents Who Have Had Vaginal Sex, by Gender and Age National Survey of Family Growth (NSFG), 2002

Mosher et al., 2005; Vital and Health Statistics: No. 362
**Females 13-26 Years Recommendation**

- Vaccination is recommended for females 13-26 years of age who have not been previously vaccinated
  - Recent findings effective in up to age 18 only!
- Ideally vaccine should be administered before onset of sexual activity, but females who are sexually active should still be vaccinated.

**Rationale: Vaccination of Females 13-26 Years**

- Females not yet sexually active can be expected to have the full benefit of vaccination.
- Sexually active females may not have full benefit of vaccine because they may have been infected with vaccine HPV types, however:
  - Only a small percentage are likely to have been infected with all four vaccine HPV types.
  - For those already infected with ≥1 vaccine HPV types, vaccine would provide protection against disease caused by the other vaccine HPV types.
  - Therefore, although overall vaccine effectiveness would be lower, most females will still derive benefit from vaccination.

**Special Situations**

- Equivocal or abnormal Pap test
- Positive HPV test
- Genital warts
- Immunosuppression
- Lactating women

*All should receive vaccine*

**Vaccination During Pregnancy Recommendation**

- Initiation of the vaccine series should be delayed until after completion of a pregnancy.
- If a woman is found to be pregnant after initiating the vaccination series, completion should be delayed until after the pregnancy.
- If a vaccine dose has been administered during pregnancy, there is no indication for intervention.

**Precautions and Contraindications**

- Moderate or severe acute illnesses: should be deferred until after the illness improves.
- History of immediate hypersensitivity or severe allergic reaction to yeast or to any vaccine component: contraindication.

**Cervical Cancer Screening among Vaccinated Population**

- Cervical cancer screening – no change
  - 30% of cervical cancers caused by HPV types not in the quadrivalent HPV vaccine.
  - Vaccinated females could subsequently be infected with non-vaccine HPV types.
  - Sexually active females could have been infected prior to vaccination.
- Decision to vaccinate should not be based on Pap testing, HPV DNA testing or HPV serologic testing.
- Providers should education girls and women about the importance of cervical cancer screening.
Future Impact on Cervical Cancer Screening

• Reduction in HPV incidence will lead to reduction in HPV/CIN/cancer prevalence
• This means that for any screening test
  – Positive predictive value will decrease
  – Negative predictive value will increase
• Because age at screening and screening frequency are important determinants of cost-effectiveness, screening at young ages and frequent intervals after vaccine will INCREASE costs at much higher rate than increased effectiveness
• Current screening strategies (ages for screening, screening intervals) need to be reassessed once longer-term data on vaccine effects available

Funding for Vaccines

• Private Insurance
• Vaccines for Children Program (VFC) (0-19 years)
• Section 317 Grant Program
  – State monies for uninsured
• Industry Assistance Program
  – http://www.merck.com/merckhelps/vaccines/home.html
• Out of pocket
Cancer of the Cervix

"The Threat to the very Fabric of our Society"

Why the attention on this cancer?

- It is a cancer that **can be prevented** but is killing millions of women throughout the world and..... it has become the **leading cancer in Pohnpei**.

Global Situation

- Half a million women develop cervical cancer every year of which 50% die.
- 80% found in Developing countries which have only 5% of world resources.
- Rate: 30-70/100 000-Developing countries
- 4-10/100 000-Developed countries

WHO / Western Pacific Regional Office

**Percentages of Three Most Frequent Cancers in Women**

Colorectal 28%
Stomach 23%
Breast 49%

**FSM Cancer Mortality (1990-1997)**

- Lung CA ranks the 5th leading cause of death - both genders
- Lung CA most frequent CA in both
- Predominance in 4th – 6th decades
- Liver CA - male
- CxCA – 2nd CA - Females
Dr B Lazuta (MBBS,DGO,MMED-O&G)


- Total Cancer patients reported 1998 – 2000 was 32 CA cases
- Most common - Cx CA (21% of Cancers/P – 87, I – 3.7)
- 2nd most common - Liver and Lung
- Less common: prostate, breast, leukemia and stomach, etc...
- Two(2) cases Papillary cancer of the thyroid

Current Trend in Pohnpei

- No.of cases: 14
- Rate: 36.8/100,000

It is an emerging major health issue and its disastrous effects will become obvious to every one in the next 5-10 years if we don’t do something now.

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What is Cancer of the Cervix?

- Cancer arising from the Uterine Cervix (Neck of the womb)

Dr B Lazuta (MBBS,DGO,MMED-O&G)

What causes cancer of the Cervix?

- There is strong scientific evidence now to implicate a sexually transmitted virus called Human Papilloma Virus (HPV)

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Risk factors

How does someone become prone to getting the cancer?

- Early age of sexual intercourse
- Multi-parity
- * Number of sexual partners
  - most important factor (Harris et al 1980)
  - both patient and partner
  - independent of age at 1st intercourse

Dr B Lazuta (MBBS,DGO,MMED-O&G)

How do we know someone has this cancer?

- In early cancer they do not have any signs and symptoms so it is difficult to know.
- Most women come when the it is advanced.
  - Smelly vaginal discharge.
  - Bleeding after sex
  - Abdominal pain
What chances of Living do these patients have with treatment?

- Depends on which stage (stage 0-4)
  - Stage 0 – 100% cure
  - Stage 1- 80-100% will live beyond 5 years
  - Stage II- 60-70% will live beyond 5 years
  - Stage III & IV-only 45% will live beyond 5 years.

How can we prevent the cancer

1. Pap smear test:
   - Most reliable test so far.
   - Simple test
   - Sample taken from the Cervix.
   - Can detect more than 90% of cases who are developing cancer.

2. Education:
   - Very important for long term prevention & reduction.
   - Very important for resource poor settings.
   - Avoid early sex (teenage)
   - Stick to one partner.
   - If difficult to avoid early sex or stick to one partner - USE CONDOM

What has been done so far in Pohnpei

- No proper screening is done.
- No results have come back from the Pap smears done in the last 12 months.
- Organized screening was done from January 2001-March 2002.
  - 405 cases screened – 42 identified with cancer.
- No one knows what has happened to these cases.
- Those who have turned up with advanced cancer we do not know where to send them for treatment and follow-up. (esp. Uninsured cases)

What can be done here

- Surgery can be done in Pohnpei for:
  - Stage 0
  - Stage 1a
  - Stage 1b
- Stage II, III, & IV need off Island referral for Surgery & radiation.

A successful screening program must:

1. Identify a target population.
2. Have measures in place for high coverage and attendance.
3. Have clear screening protocols and health objectives.
4. Have adequate field facilities.
5. Have adequate facilities for diagnosis, treatment and follow-up.
6. Information system. (Cancer Registry)
7. Evaluation and monitoring process.
Where do we start?

1. Secure funding
2. Form a Cancer Committee involving people from all levels of our community
3. Establish a cancer registry.
4. Draw up Policy guidelines
   - what target population to screen, how often to screen, how do we ensure high coverage, cultural and legal aspects etc.
5. Establish adequate field facilities.
   - human resource, supplies, transport.
6. Establish a channel where pap smear or other specimen can be sent. It must be reliable, consistent and reasonably quick.
7. Establish an off-Island link for the treatment and follow-up of those that cannot be treated here.
8. Evaluate and monitor our progress regularly according to our guidelines.
Visual inspection with acetic acid (VIA): Evidence to date

Original source:
Alliance for Cervical Cancer Prevention (ACCP)
www.alliance-exca.org

Overview:
- Description of VIA and how it works
- Infrastructure requirements
- What test results mean
- Test performance
- Strengths and limitations
- Program implications in low-resource settings

Types of visual inspection tests:
- **Visual inspection with acetic acid (VIA)** can be done with the naked eye (also called cervicoscopy or direct visual inspection [DVI]), or with low magnification (also called gynoscopy, aided VI, or VIAM).
- **Visual inspection with Lugol's iodine (VILI)**, also known as Schiller's test, uses Lugol's iodine instead of acetic acid.

What does VIA involve?
- Performing a vaginal speculum exam during which a health care provider applies dilute (3-5%) acetic acid (vinegar) to the cervix.
- Abnormal tissue temporarily appears white when exposed to vinegar.
- Viewing the cervix with the naked eye to identify color changes on the cervix.
- Determining whether the test result is positive or negative for possible precancerous lesions or cancer.

What infrastructure does VIA require?
- Private exam area
- Examination table
- Trained health professionals
- Adequate light source
- Sterile vaginal speculum
- New examination gloves, or HLD surgical gloves
- Large cotton swabs
- Dilute (3-5%) acetic acid (vinegar) and a small bowl
- Containers with 0.5% chlorine solution
- A plastic bucket with a plastic bag
- Quality assurance system to maximize accuracy

Categories for VIA test results:

<table>
<thead>
<tr>
<th>VIA Category</th>
<th>Clinical Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Test-negative</td>
<td>No acetowhite lesions or faint acetowhite lesions; polyp, cervicitis, inflammation, Nabothian cysts.</td>
</tr>
<tr>
<td>Test-positive</td>
<td>Sharp, distinct, well-defined, dense (opaque/dull or oyster white) acetowhite areas—with or without raised margins touching the squamocolumnar junction (SCJ); leukoplakia and warts.</td>
</tr>
<tr>
<td>Suspicious for cancer</td>
<td>Clinically visible ulcerative, cauliflower-like growth or ulcer; oozing and/or bleeding on touch.</td>
</tr>
</tbody>
</table>
Accuracy of screening tests in developing countries: range in sensitivity and specificity

<table>
<thead>
<tr>
<th>Test</th>
<th>Sensitivity</th>
<th>Specificity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cytology</td>
<td>31-78%</td>
<td>91-99%</td>
</tr>
<tr>
<td>HPV testing</td>
<td>61-90%</td>
<td>62-94%</td>
</tr>
<tr>
<td>VIA</td>
<td>50-96%</td>
<td>44-97%</td>
</tr>
<tr>
<td>VILI</td>
<td>44-93%</td>
<td>75-85%</td>
</tr>
</tbody>
</table>

Categories for VIA tests results:
- Acetowhite area far from squamocolumnar junction (SCJ) and not touching it is insignificant.
- Acetowhite area adjacent to SCJ is significant.

Negative  Positive

Photo source: JHPIEGO

Management options: What to do if the VIA test is positive?
- Offer to treat immediately.
- Refer for confirmatory diagnosis or adjunctive test.

Test performance: Sensitivity and Specificity

- **Sensitivity**: The proportion of all those with disease that the test correctly identifies as positive.
- **Specificity**: The proportion of all those without disease (normal) that the test correctly identifies as negative.

VIA test performance (n=7):

<table>
<thead>
<tr>
<th></th>
<th>Sensitivity</th>
<th>Specificity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum</td>
<td>65%</td>
<td>64%</td>
</tr>
<tr>
<td>Maximum</td>
<td>96%</td>
<td>98%</td>
</tr>
<tr>
<td>Median*</td>
<td>84%</td>
<td>82%</td>
</tr>
<tr>
<td>Mean*</td>
<td>81%</td>
<td>83%</td>
</tr>
</tbody>
</table>

* Weighted median and mean based on study sample size
Source: Adapted from Gaffikin, 2003
Strengths of VIA:
- Simple, easy-to-learn approach that is minimally reliant upon infrastructure.
- Low start-up and sustaining costs.
- Many types of health care providers can perform the procedure.
- Test results are available immediately.
- Requires only one visit.
- May be possible to integrate VIA screening into primary health care services.

Limitations of VIA:
- Moderate specificity results in resources being spent on unnecessary treatment of women who are free of precancerous lesions in a single-visit approach.
- No conclusive evidence regarding the health or cost implications of over-treatment, particularly in areas with high HIV prevalence.
- There is a need for developing standard training methods and quality assurance measures.
- Likely to be less accurate among post-menopausal women.
- Rater dependent.

Conclusions:
- VIA is a promising new approach.
- Ongoing VIA-based projects by ACCP partners in a number of countries are investigating long-term effectiveness of the VIA test-and-treat approach.
- Several questions remain, including:
  - Which factors maximize VIA’s performance?
  - How can quality of VIA services outside of a controlled setting be ensured?
  - How can VIA best be incorporated into prevention programs?
  - What is the long-term impact on cancer mortality from programs incorporating VIA?

References:

For more information on cervical cancer prevention:
- The Alliance for Cervical Cancer Prevention (ACCP) www.alliance-cxca.org
- ACCP partner organizations:
  - EngenderHealth www.engenderhealth.org
  - International Agency for Research on Cancer (IARC) www.iarc.fr
  - JHPIEGO www.jhpiego.org
  - Pan American Health Organization (PAHO) www.paho.org
  - Program for Appropriate Technology in Health (PATH) www.path.org
AGENDA

Participants:
- CCC Coordinators from FSMN, Chuuk, Kosrae, Pohnpei, and Yap. (confirmed)
- Tobacco person and or SAMH Program managers and staffs (National and State?) invitation
- Diabetes Coordinators (National and State?) invitation
- Representatives from State Education Department, Agricultures, Social Services and Health Services and other relevant Interagency dealing with health promotion, physical activities, nutrition and other chronic diseases prevention and control (National and States?)
- Representative from COM-FSM (National and State land grant ?) invitation
- Partner (National COM-FSM and Island Food Community of Pohnpei) in Pohnpei
- Partner (SPC office in Pohnpei)
- Department of R &D (agriculture and DSAP).
- Secretary, FSM Department of Health and Social Affairs
- Chief, Health Budget, Planning and Statistics
- Women and Youth Organization and Gender Officers and partners?
- Advisors to the National Cancer Coalition (NCC) and NCD?
- Consultants from SPC and WHO.
- Consultant from UH?

Objectives:

1) Obtain a multi-sectoral input into the development of STATE Strategy and Action Plan to prevent and control NCDs for FSM to have a good understanding of the National NCD Strategy and to obtain a multi-sectoral input into the development of the STATES NCD Plan of Action to prevent and control NCDs for the FSM States.
2) Increase knowledge and understanding of non-communicable diseases (NCDs) and unhealthy Lifestyles with focus on the four main Risk Factors; Alcohol misuse, tobacco, lack of physical activity and unhealthy diet and nutrition.
3) Gain understanding of the 2-1-22 Pacific NCD Programme
4) To gain understanding to integrate cancer into the National NCD Strategy, SDP, and MDG…

The expected outcomes at the end of the workshops are:

- Draft Non Communicable Disease Action Plans for each of the STATES based on the FSM National NCD Strategy
- Participants will be able to define Non-communicable disease and it’s relation to the four main risk factors.
- Participants will have a common understanding of the 2-1-22 Pacific NCD Program.
- Participants will have understanding of the NCD framework to be able to integrate priorities in their own plans for policy direction (improve management of clinical endpoints e.g. Cancer, Diabetes and Cardiovascular Disease control).
# AGENDA

<table>
<thead>
<tr>
<th>TIME</th>
<th>TOPIC</th>
<th>Facilitator</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>August 25, 2008</strong></td>
<td><strong>Working together for the FSM (open for suggestions)</strong></td>
<td>TBA</td>
</tr>
<tr>
<td>1:00-1:30 pm</td>
<td>Registration</td>
<td>Donna and Melsi</td>
</tr>
<tr>
<td>1:30-2:00 pm</td>
<td>Blessing</td>
<td>Pastor TBA</td>
</tr>
<tr>
<td></td>
<td>Welcome &amp; Opening Remarks</td>
<td>Sec. Vita Skilling</td>
</tr>
<tr>
<td></td>
<td>Remarks from consultants</td>
<td>Mr Amena Yauvoli</td>
</tr>
<tr>
<td>2:00-2:20 pm</td>
<td>Break</td>
<td>Tea time</td>
</tr>
<tr>
<td>2:20-2:35 pm</td>
<td>Self-introductions and Objectives of the Workshop</td>
<td>Participants/ Amato Elymore</td>
</tr>
<tr>
<td>2:35-2:50 pm</td>
<td>Review and adoption of AGENDA</td>
<td>Participants/</td>
</tr>
<tr>
<td>2:50-3:05 pm</td>
<td>Global / Regional Perspective – NCD,</td>
<td>Dr. Viliami P SPC</td>
</tr>
<tr>
<td>3:05-3:20 pm</td>
<td>Overview of NCD problem in FSM (STEPS Result, other health data)</td>
<td>Carter/Marcus</td>
</tr>
<tr>
<td>3:20-4:00 pm</td>
<td>Short presentations from each State, their activities, accomplishments,</td>
<td>Carter/Kipier</td>
</tr>
<tr>
<td></td>
<td>constraints and sharing of what they have in terms of NCD Profile?</td>
<td></td>
</tr>
<tr>
<td>4:00-4:30 pm</td>
<td>Island Food Community of Pohnpei</td>
<td>Dr. Lois H/TBA</td>
</tr>
<tr>
<td>4:30-5:00 pm</td>
<td>COM-FSM Land grant nutrition program</td>
<td>Jim C /Jackson P</td>
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<tr>
<td>5:00 pm</td>
<td>End DAY 1</td>
<td></td>
</tr>
<tr>
<td><strong>August 26, 2008</strong></td>
<td><strong>DAY 2</strong></td>
<td></td>
</tr>
<tr>
<td>8:00 – 8:30 am</td>
<td>GROUP Physical activity</td>
<td>Frank</td>
</tr>
<tr>
<td>8:30-9:00 am</td>
<td>FSM-DSAP program</td>
<td>Marlyter Silvanus /Arisako Enicar</td>
</tr>
<tr>
<td>9:00-9:30 am</td>
<td>Importance of policy and plans</td>
<td>Karen</td>
</tr>
<tr>
<td></td>
<td>Examples from other countries</td>
<td></td>
</tr>
<tr>
<td>9:30-10:00 am</td>
<td>Overview and status of National NCD Strategy and planning framework</td>
<td>FSM NCD team</td>
</tr>
<tr>
<td>10:00-10:15 am</td>
<td>BREAK</td>
<td>Tea Time</td>
</tr>
<tr>
<td>10:15-12:00 noon</td>
<td>Specific NCD Issues</td>
<td>Kipier/Carter/Amato/Kerio/Brenda/Karen/Viliami</td>
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<tr>
<td></td>
<td>• Nutrition</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Physical Activity</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Cancer, Diabetes and Cardiovascular diseases</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Tobacco, SAMH</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Obesity</td>
<td></td>
</tr>
<tr>
<td>12:00-1:30 pm</td>
<td>BREAK for Lunch : Walking tour of Palikir</td>
<td>Amato</td>
</tr>
<tr>
<td>1:30-2:45 pm</td>
<td>Group work: Each State group to identify priority area of NCD using</td>
<td>Viliami,Karen, Kipier,Carter</td>
</tr>
<tr>
<td></td>
<td>NATIONAL NCD Strategy begin to draft own PLAN of ACTION</td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>Activity</td>
<td>Speaker(s)</td>
</tr>
<tr>
<td>--------------</td>
<td>--------------------------------------------------------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>2:45-3:00 pm</td>
<td>BREAK</td>
<td>Tea Time</td>
</tr>
<tr>
<td>3:00-4:00 pm</td>
<td>Health determinants outside of health and challenges to health program</td>
<td>Amena</td>
</tr>
<tr>
<td>4:00-4:30 pm</td>
<td>Pacific NCD Framework &amp; 2-1-22 NCD Programme</td>
<td>Karen, Viliami</td>
</tr>
<tr>
<td>4:30-5:00 pm</td>
<td>TBD</td>
<td>TBD</td>
</tr>
<tr>
<td>5:00 pm</td>
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</table>

**August 27, 2008  DAY 3**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Speaker(s)</th>
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</thead>
<tbody>
<tr>
<td>8:30- 9:00 am</td>
<td>Group Physical activity</td>
<td>Carter</td>
</tr>
<tr>
<td>9:00-9:30am</td>
<td>Advocacy and Social Marketing</td>
<td>Viliami</td>
</tr>
<tr>
<td>9:30-10:30am</td>
<td>Continue Group work</td>
<td>Participants</td>
</tr>
<tr>
<td>10:30-10:45 am</td>
<td>BREAK</td>
<td>Tea Time</td>
</tr>
<tr>
<td>10:45-12:00 noon</td>
<td>Group work by States continued</td>
<td>TBD</td>
</tr>
<tr>
<td>12:00-1:30pm</td>
<td>BREAK</td>
<td>Lunch</td>
</tr>
<tr>
<td>1:30- 2:45 pm</td>
<td>Continue Group work</td>
<td>Participants</td>
</tr>
<tr>
<td>2:45-3:00 pm</td>
<td>BREAK</td>
<td>Tea</td>
</tr>
<tr>
<td>3:00-4:00 pm</td>
<td>Group Presentations</td>
<td>TBD</td>
</tr>
<tr>
<td>4:00-5:00 pm</td>
<td>Participants feedback by state and recommendations</td>
<td>TBD</td>
</tr>
<tr>
<td>5:00 pm</td>
<td>End of Day 3</td>
<td></td>
</tr>
</tbody>
</table>

**August 28, 2008**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Speaker(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:30- 9:00 am</td>
<td>Group Physical activity</td>
<td>Kipier</td>
</tr>
<tr>
<td>9:00- 10:00 am</td>
<td>Panel Discussion</td>
<td>TBD</td>
</tr>
<tr>
<td>10:00-11:00am</td>
<td>Workshop Recommendations</td>
<td>TBA</td>
</tr>
<tr>
<td>11:00 am</td>
<td>Closing remarks</td>
<td></td>
</tr>
</tbody>
</table>

Note: Outcome and recommendations need to be prepared presented to FSM appropriate leaders and for endorsement support and adoption.
Appendix 10

NCD FRAMEWORK

Dr. Viliami Puloka
NCD Adviser
Secretariat of the Pacific Community

Courtship & Marriage
-Romance of Healthy Islands-

By 2020 70% of deaths worldwide would be from NCDs

Deaths, by broad cause group and WHO Region, 2000

Noncommunicable Diseases
Injuries
Communicable Diseases
Nutritional deficiencies

Deaths in 2000 attributable to selected leading risk factors

- Blood pressure
- Tobacco
- Chlamydia
- Fruit and vegetable intake
- Alcohol
- Indoor smoke from solid fuels
- High Blood Pressure
- Physical inactivity
- Underweight
- Occupational risk factors for injury
- Unsafe water, sanitation, and hygiene
- Unsafe health care injections
- Skin, ear, dental, and eye infections
- Iron deficiency

NCD STEPS Results
We eat too few fruits and vegetables

- CONSUME < 5 SERVES OF FRUIT & VEGETABLES PER DAY
- Prevalence (%)

NCD STEPS Results
We are not physically active

- PHYSICALLY ACTIVE
- Prevalence (%)

NCD STEPS Results:
We are overweight & Obese

- ADULT OBESITY
- Prevalence (%)

Results:
We smoke too much

- DAILY TOBACCO USE
- Prevalence (%)

Results: Blood pressure too high

RAISED BLOOD PRESSURE
- Prevalence (%)

Note: Results are presented for various countries, including the Western Pacific region. The data reflects prevalence rates for different health risks and behaviors among males and females.
Results: Diabetes too high

Causation of Noncommunicable Disease (NCD)

Pacific Framework for Prevention and Control of NCD

2-1-22 Pacific NCD Programme 2008 - 2011

- Based on the framework
- Comprehensive integrated programme of support
- Improve coordination and harmonization of efforts of implementing agencies and donors
- Minimize duplication

- Global & regional burden
- Global & regional goals of NCD
- 4 stages: Profiling, Planning, Implementation, Evaluation
- 5 elements of intervention: Environmental, Lifestyle, Clinical, Surveillance, Advocacy

2-1-22 Pacific NCD Programme 2008 - 2011

- Joint Implementation Plan 2008-2011
  - Common goal and objectives
  - Planned activities under 5 objectives
  - 5 elements of intervention
- M&E Framework
  - Monitor and assess programme implementation
- 4yr programme workplan with detailed annual workplans and indicative budget
- Joint Management
  - Governance, Funding and reporting mechanisms
Summary - 2-1-22 Pacific NCD Programme (2008-2011)

Objective 1 - To strengthen the development of comprehensive, multi-sectoral national NCD strategies

<table>
<thead>
<tr>
<th>Inception Phase (Oct 07 - June 08)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective 1.1</td>
</tr>
<tr>
<td>Objective 1.2</td>
</tr>
<tr>
<td>Objective 1.3</td>
</tr>
</tbody>
</table>

Objective 2 - To support countries to implement their NCD strategies

<table>
<thead>
<tr>
<th>Implementation Phase - Year 1 (July 08-June 2011)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective 2.1</td>
</tr>
<tr>
<td>Objective 2.2</td>
</tr>
<tr>
<td>Objective 2.3</td>
</tr>
<tr>
<td>Objective 2.4</td>
</tr>
<tr>
<td>Objective 2.5</td>
</tr>
</tbody>
</table>

High Priority Areas

- Developing national multi-sectoral NCD Strategies and Plans
- Establishing funding mechanisms to support NCD implementation
- Establishing NCD Coordinator or NCD focal points in country
- Assessing legislative and policy frameworks
- Advocacy
- Improving NCD data availability and application

Medium Priority Areas

- Supporting effective evidence based interventions
- Workforce planning and capacity assessment
- Training of NCD staff / placements
- Implementing communication / social marketing programmes
- Establishment of sustainable funding mechanisms (e.g. Health Promotion Foundations)
Implementation support

- Country focused: 4 stages of country action
- Grants support
  - SPC
  - WHO
- Grant Mechanisms
  - Harmonisation of approaches
    - Avoid duplication, common eligibility criteria and reporting mechanism
  - Ensure evidence-based approaches
- TA support
- Regional support
  - Add value and support country-level activities
  - Tools/guidelines

JMC
Roles & Responsibilities

- Review and endorse proposed joint annual work plans and budget allocations
- Review progress in implementation of activities, and identify and agree on desirable adjustments to implementation based on six-monthly and annual progress reports
- Provide leadership in identifying priorities for NCD prevention and control in the Pacific
- Advocate for and help identify donor funding
- Consider advice provided by the NCD Reference Group
- Appoint members of NCD Reference Group
- Report to Forum Leaders and Ministers of Health, PICTs

NCD Reference Group

The major roles and responsibilities of the NCD Reference Group are to:
- Provide technical advice on the programme as requested by JMC, in the following areas:
  - Annual workplans, budgets and reports
  - M&E framework and implementation
  - External evaluation of the program
  - Other relevant technical programme issues

Funding Flow

Donor

PICT - MOH/DON, NGO, CIVIL SOCIETY

SPC

WHO

Work-plan

Donor

JMC

NCD Secretariat

SPC

WHO

GSM

Reporting

Donor

PICTs - MOH/DON, NGOs, civil society

JMC

SPC

PIMS & Revision

WHO

GSM

Excel worksheet
SHARING

SUPPORTING

PARTNERSHIP

“vision, mission and resource sharing”
Appendix 11
CANCER CONTROL IN THE US AFFILIATED PACIFIC ISLAND JURISDICTIONS

PRESENTED BY:
DEPARTMENT OF FAMILY MEDICINE AND COMMUNITY HEALTH
JOHN A. BURNS SCHOOL OF MEDICINE
UNIVERSITY OF HAWAII

USAPIN
WHAT/WHERE

United States
Flag Territories and Commonwealth
Guam

Affiliated Pacific
American Samoa
Commonwealth of the Northern Mariana Islands (CNMI)

Freely Associated States
Federated States of Micronesia (FSM)
Republic of the Marshall Islands (RMI)
Republic of Palau

HISTORY
1997 - PIHOA (Guam) and PBMA (YAP)
1999 - Evaluation of CA in the USAPI, Nauru and Kiribati
2000 - ICC amends mission statement
2001 - NCI - Center to Reduce Cancer Health Disparities
USAPI Needs & Strengths Assessments 2002
2002-03 - PBMA 2003 - Regionalization
Cancer Council of the Pacific Islands (CCPI)
2004 - CDC Comprehensive Cancer Control 2004
Community-Coalitions

CANCER COUNCIL OF THE PACIFIC
PACIFIC CANCER INITIATIVE GRANT
• 2002-2007
• NCI & NIH Health Disparities Offices
  • Development grant
• University of Hawaii and Papa Ola Lokahi
• Cancer Council of the Pacific Islands initiated
• Jurisdiction cancer assessments completed
• Regional cancer planning started

COMPREHENSIVE CANCER CONTROL PLANNING GRANT
• 2003-2007
• CDC Division of Cancer Prevention and Control
  • Regional Grant – UH PI and Admin
  • Palau – DOH PI and Admin
• Planning grant—direct clinical services not allowed
• Jurisdiction CA coordinators hired
• Jurisdiction CA Coalitions formed
• Jurisdiction Comprehensive CA Plans evolved
• Regional Comprehensive CA Plan evolved

COMPREHENSIVE CANCER CONTROL IMPLEMENTATION GRANT
• 2007-2012
• CDC Division of Cancer Prevention and Control
  • Regional Grant – respective DOH/MOH – PI
  • Administered through jurisdictions
  • Direct clinical services not allowed
• Purpose to:
  • Implement Regional and Jurisdiction Specific Comprehensive Cancer Plans
  • Support Regional and Jurisdiction Specific Coalitions
• Potential to extend beyond 2012

PACIFIC REGIONAL COMPREHENSIVE CANCER CONTROL PROGRAM (PCCCP)

Key features of CCC:
• Infrastructure development – administrative structures, planning tools
• Resources assessment – partnerships formed, support mobilized
• Data use – sources and gaps identified, linkages created
• Strategic planning – prevention & control partners, programs, & services

Pacific Regional Central Cancer Registry (PRCCR)

Key features of Registry:
• Staff & infrastructure development – recruitment, training, database/registry
• Legislative and policy mandate in each jurisdiction – require case reporting
• Data management, flow and use – core data team, standard format, links with Philippines, Guam & Hawaii and each other

Pacific Center of Excellence to Eliminate Disparities (CEED) 2007-2012

Key features of CEED:
• Capacity building – resource development, partnerships, teamwork, & training
• Guiding frameworks – Socio-ecological & Community based participatory approaches
• Knowledge management – information sharing, resource coordination, evidence-based practice
• Systems change – regional policies, national legislation, service standards, quality assurance
• Behavior change – community action plans, healthy lifestyles, services uptake
Pacific Cancer Projects
Performance Management Plan (PMP)

Purpose & Background:
- Link Pacific cancer projects: CCC, Cancer Registry, CEED
- Common goals, objectives, indicators, data methods
- Unique & expanded indicators
- Baselines & targets
- Based on Socio-Ecological model

WHAT IS THE CURRENT STATUS?
- National level Parity
- 9 Jurisdiction-Specific Comprehensive Cancer Control Plans
- 1 FSM National CCC Plan
- Pacific Regional CCC Plan
- Functioning Local Coalitions
- Regional CCPI
- Registry and Pacific CEED
- Total Funding - $ 20 million

SYNERGIES BETWEEN THE 3 PROJECTS
Additive benefits
- Joint human resource development and sharing
- Shared data collection and data utilization for tracking morbidity and mortality and for program evaluation
- Shared knowledge and resource management
- Increased regional coordination, information and resource sharing, exchange of practices and data use for local planning
- Regional adaptation of appropriate motivational and behavior change interventions
- Increased or incidence of referrals for appropriate treatment
- Region-wide adoption of up-to-date policies, standards and guidelines
- Model for replication of all cancer prevention and care and treatment programs in the Pacific

NATIONAL CANCER PARTNERS- LEVERAGING RESOURCES
- CDC, American Cancer Society
- C-Change, Strategic Health Concepts
- NCI, CIS, American College of Surgeons
- Lance Armstrong Foundation
- Intercultural Cancer Council
- Hawaii Tumor Registry
- University of Guam, University of HI
COORDINATION AND COLLABORATION

- Developing ideas synergy/partnership between Pacific cancer programs
  - Logic models
  - Performance Management – Monitoring & Evaluation
  - Technical assistance
  - Content
  - Personnel
  - Technology links
- Discussing and developing ideas synergy/partnership between chronic disease programs
- Application to CDC Pacific Jurisdiction Integration Project
- Application and model for CDC-wide integration project
- Application integrating CDC and other Federal Agency funding to Pacific Cancer

THE JABSOM TEAM

[List of team members with their roles and affiliations]
National NCD Strategy meeting - Wednesday, 27 August, 2008

Recommendations:

1. That the states take the necessary steps to make the necessary organizational and institutional restructuring changes in order to be ready for the upcoming changes in CDC funding whereby tobacco and diabetes and cancer will be integrated as the Pacific Basin Integration Project.

2. That the states communicate their preferences to National for restructuring the National Department of Health and Social Affairs, as soon as possible. (This is very timely because Congress meets soon and Directors of Health meet soon).

3. That CDC, SPC, WHO negotiate a MOU to mutually support the Joint Pacific NCD Strategy. (similar to the MOU between these parties for TB)

4. Recommend that we consider merging the multiple vertical programs and adopt a comprehensive approach, (e.g. multi-sectoral representation in a single committee and to action multiple programs) similar to CCC’s approach, with CCC taking the lead, potentially.

5. Recommend we collectively address any conflict resolutions.

6. Recommend we follow the STATE SDP to develop STATE NCD plans.

7. Recommend that NCDs, including cancer be explicitly incorporated into the National and State SDP update in 2009.

8. Recommend that the specific needs of the outer islands be addressed.

9. Recommend that National clarify with CDC how the indirect costs will be paid to FSM and to the States for CDC funds (e.g. what percent and to whom)
Good Morning Colleagues; Welcome to this technical workshop to develop national client management guidelines for the prevention and treatment of breast and cervical cancer.

Cancer is the fourth leading cause of death for the people of the Federated State of Micronesia, with different cancers ranked variously among the four FSM States. At least ten percent of deaths are attributable to cancer and more than 90% of all cancer cases are diagnosed at late stages. Investment in the prevention of cancer offers the greatest public health value and the most cost-effective long-term approach to cancer control. This is especially true when the prevention of cancer is integrated with the prevention of chronic diseases and other related health priorities, such as reproductive health, hepatitis B immunization and environmental health.

Many of us have just participated in the National NCD Strategic Planning Workshop where we developed inter-sectoral State NCD Plans of Action. One of our objectives in that workshop was to strategically align the new State NCD Plans of Action with our well-developed Comprehensive Cancer Control Plans and Programs. By aligning the two programs together, we will be able to maximize institutional and donor support, improve program coordination, enhance community involvement and achieve our mutual goals and objectives for a healthier population.

In our Comprehensive Cancer Control Plan we already articulated linkages with the NCD strategy by identifying the STEPwise surveillance for NCDs as our primary source of baseline data for cancer-related risk factors. One of the principle recommendations from the NCD workshop addresses another important linkage. I support the recommendation that cancer be included in the 2009 revision of our National Strategic Development Plan to help us access the US Compact funds for cancer prevention, treatment and
care. The best way to include cancer in the SDP is to incorporate key cancer outcome measures from our Comprehensive Cancer Control Plans.

During this workshop we will develop National Breast and Cervical Client Management Guidelines. We will agree upon and establish the standards of practice required to integrate prevention, early detection, diagnosis, treatment and care. Our task is an ambitious one. We have chosen to define the parameters for our guidelines as the complete cancer prevention-care continuum because:

- We must increase and sustain the practice of health promoting behaviors to reduce cancer incidence.
- We must increase the uptake of early detection behaviors and services to diagnose cancer early.
- We must increase access and uptake to treatment and palliative care to improve the quality of life for people living with cancer.

In order to be successful, our technical work begins by documenting our assets, assets in the health service, assets in the community, assets among our families, assets that we already have and those we want to strengthen and develop. These assets will help us focus our efforts on the two overarching and cross-cutting strategies in our Comprehensive Cancer Control Plans;

1. To promote and advocate for community and political support in partnership with health providers to combat cancer in the FSM,
2. To engage technical assistance at all levels that assures efficacy in the prevention, control, identification, care and treatment of cancer and cancer related disease.

This workshop is a technical working meeting. I invite each of you to actively contribute your valuable expertise. Your full participation is vital. You have four full days ahead of you that include presentations from your colleagues and resource persons. Your Group Work is the core of this technical working meeting. In your groups you will discuss and agree on the standards for prevention and early detection, for diagnosis and treatment and for survivorship and palliative care. You will talk about how to put the standards into practice by identifying 'which resource', 'which
service’ and by identifying ‘who is responsible’ for providing the service or the linkages.

The task is ambitious and your time is limited. You will not be able to cover everything. You will want to keep a list of ‘other things we want to do to help put these standards into practice’, such as trainings to strengthen capacity and linkages to ensure the continuum of care, including referral systems, case managers, community and patient navigators and survivor advocates, and other ways to ensure people seeking services don’t fall through the cracks. I know this is an ambitious undertaking. However, it is my expectation that you will work together to develop a good working draft of the National Client Management Guidelines to share with me and your Directors of Health for finalization and to put into action.

In closing, I wish to remind us of the story of Rimansi. We shared Rimansi’s story in our National FSM Comprehensive Cancer Control Plan to remind us all why we need an integrated system of cancer prevention and care. Rimansi was finally diagnosed with uterine cancer in 2004 after many attempts to find out what was wrong. Once properly diagnosed, Rimansi had a hysterectomy in 2004. To my knowledge, Rimansi was living a full life without further treatment at the same time our national plan was being completed in 2007. Rimansi’s story is a success story. There are also many stories that haven’t ended so successfully.

Whether happy or sad, our personal stories remind us that cancer affects all of us. Personal stories also remind us there are many things we can do to help prevent cancer and to help care for those with cancer. Personal stories remind us that we have many assets on our islands to help us live healthier lives to prevent illness and overcome cancer.

Thank you for your hard work over the next few days. I wish you all a successful meeting and look forward to hearing your recommendations.
Assets Mapping: Client Management Guidelines for Breast & Cervical Cancer Prevention, Early Detection, Treatment and Care

For building a comprehensive and coordinated prevention, care, and support system

Please list your assets below. Be sure to indicate if the asset is:

A = ALREADY in place or: T = needs TO BE DEVELOPED

### ASSET IDENTIFICATION

**EXAMPLE: Point 6: Cancer Information** (To type text on a line, place your cursor on the grey box and type. The box will expand to fit your text.)

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<th>Asset Description</th>
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<tr>
<td>Health promotion office, Ministry of Health</td>
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<tr>
<td>Nutrition education classes in schools</td>
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<td>Church-sponsored tobacco cessation program</td>
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1. **Breast Health and Cancer Prevention** (Obesity, Nutrition, Alcohol, Physical Activity - Community Education, Patient Education)

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2. **Cervical Cancer Prevention** (Tobacco, Sexual Health, HPV - Community Education, Patient Education)

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Appendix 14
Assets Mapping: Client Management Guidelines for Breast & Cervical Cancer Prevention, Early Detection, Treatment and Care

For building a comprehensive and coordinated prevention, care, and support system

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Appendix 14

**Assets Mapping: Client Management Guidelines for Breast & Cervical Cancer Prevention, Early Detection, Treatment and Care**

For building a comprehensive and coordinated prevention, care, and support system

Please list your assets below. Be sure to indicate if the asset is:

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5. **Breast Cancer Diagnosis and Treatment** (State, FSM, outside FSM)

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6. **Cervical Cancer Diagnosis and Treatment** (State, FSM, outside FSM)

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7. **Survivorship and Palliative Care**

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Page 3 of 8   Assets Mapping
For building a comprehensive and coordinated prevention, care, and support system
Please list your assets below. Be sure to indicate if the asset is:
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8. Pain & Symptom Management (Clinics, Nurses, Doctors, Traditional Healers)

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9. Traditional Medicine

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10. End-of-life Support (Clinics, Hospice, Health Ministries, Hospitals)

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11. Advance Care Planning (Advance Directives) (Hospital, Clinics, Legal Aid, Insurance Companies)

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For building a comprehensive and coordinated prevention, care, and support system

Please list your assets below. Be sure to indicate if the asset is:

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### 12. In-home services – chores, shopping, bathing, family respite
(Churches, NGOs, Govt. Agencies)

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### 13. Support for Caregivers (Churches, NGOs, Govt Agencies, Respite Care)

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### 14. Support Groups (Groups in Hospitals and Clinics, Psychologists, Therapists, Social Workers)

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### 15. Insurance (Government, Private)

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Please list your assets below. Be sure to indicate if the asset is:  
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### 16. Education and Training (Who could provide? Where can you meet?)
Schools, Clinics, Govt. Buildings, Govt. Agencies

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### 17. Financial Support (Mayor, Church, Foundation, NGOs, Drug Companies, Government)

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### 18. Cancer/Health Organizations (Cancer Societies, NGO, Govt.)

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### 19. Referrals – Patient Care (Clinics, Doctors, Govt. Agencies, Insurance Companies)

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### Appendix 14

**Assets Mapping: Client Management Guidelines for Breast & Cervical Cancer Prevention, Early Detection, Treatment and Care**

For building a comprehensive and coordinated prevention, care, and support system

Please list your assets below. Be sure to indicate if the asset is:

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<td>Legal Support – employment, discrimination, insurance, etc. (Legal Aid, Private Lawyers)</td>
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<td>Food/Meals (Churches, NGOs, Govt. Agencies, Senior Care Providers)</td>
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<td>Transportation (Gov’t Agencies, Maritime Companies, Churches)</td>
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<td>Post Treatment Follow-Up (Screening, Rehabilitation)</td>
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24. Bereavement (Churches, Health Ministries)

25. Other:

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Assets Mapping Instructions

to assist in the development of Client Management Guidelines for Breast &
Cervical Cancer Prevention, Early Detection, Treatment and Care
September 2008 - Pacific CEED

Background:
At the April 2008 Cancer Survivorship Conference, representatives from the FSM Cancer Control Coalitions began an “Assets Mapping” activity to describe the existing community resources available to people living with cancer, along with gaps/areas in need of further development.

To help us all prepare for development of Client Management Guidelines for Breast & Cervical Cancer Prevention, Early Detection, Treatment and Care at the upcoming meeting in September 2008 in Pohnpei, each of the CCC’s are asked to expand upon their previous good work, and complete this revised form.

Instructions:

1. Please review the sample scenario below (feel free to improve upon it, so it better fits your community situation).

2. Discuss and list the strengths and assets your community brings to breast and cervical cancer prevention, treatment and care. Indicate where there are gaps, or areas in need of more development. Consider system linkages and who can help guide clients along the prevention-early detection-treatment-care pathway.

3. Note that on Page 1, we added specific categories for Breast and Cervical Cancer: Prevention; Early Detection; Diagnosis & Treatment; and Survivorship & Palliative Care – this is the only major change to the form used in April 2008—so you can carry over the assets that were previously listed under “Cancer Survivorship”

Sample Scenario: Please change the details of the scenario and family situation to better fit your community and cultural needs

The “client” is an 18-year-old woman who lives in a household with her younger siblings, her parents, a grandmother, and an aunt. All the adults have jobs and the whole family attends church regularly. The young woman is considering enrolling in community college. She smokes cigarettes with her friends at work. The father smokes tobacco at home and chews betel nut. The grandmother has never been to a western medical doctor in her life and uses some traditional remedies with the family. The mother takes the children to the Health Assistant at the Dispensary for immunizations for school and sometimes when they are sick. The aunt has recently felt a lump in her breast, and has mentioned it to her 18-year-old niece.
What assets exist in your community, State or jurisdiction to assist this woman and her family? Assets are resources, services and any type of assistance that can help a person, family and community prevent, control and treat cancer; and can help a person living with cancer and the family maintain quality and comfort in their daily lives. Assets can be found within the family, church, community, in the health system, schools, worksites, and in other sectors.

Please list all assets the family can currently access in the sheet below.

Circle ALREADY. List assets that ALREADY exist. List specific contacts if you know them.

Many resources exist that may not be specifically designated for cancer prevention, treatment and care. But perhaps these resources could be more fully developed or modified to be quite suitable for cancer patients and their families.

Circle TO BE DEVELOPED - Asset exists but needs TO BE DEVELOPED to be 'user-friendly' for people and families for cancer prevention, treatment and care.
Assets Mapping

National Workshop to develop FSM Breast and Cervical Cancer Client Management Guidelines for Prevention, Early Detection, Treatment and Care


National Government
Prepared by Amato Elymore- CCCP Coordinator (have not share with NCC or DHEA)

Primary Prevention; Addressing the Risk Factors & Promoting Healthy Practices

Already exists
- Yearly support to FSM States’ Health Promotion Activities (advocacy, declaration, funding, etc)
- Establishment of Wellness (1 hr/day PA-National employees)
- Establishment of drug free workplace.
- MDG Task Force Committee
- SPC-FSMN DSAP Extension Services
- CCC coalitions, DCP and SAMHI Council
- Preventative health programs
- Law on sin tax

To be developed
- Consolidation of NCD programs (ONE COLAITION?)
- STEP Survey done locally and or data entry procedure currently practice be changed
- Explored establishment of Health Promotion Fund
- Sin tax $ set aside for health promotional activities and NCD

Primary Prevention; Addressing the Risk Factors & Promoting Healthy Practices

Priorities
- Advocacy and awareness of the leaders
- National Strategic plans for risk factors (SNAP)
- Consolidation of NCD programs
- Explored establishment of Health Promotion Fund
- Reassess the tobacco legislation and activities along the implementation
- 3-5 years Step Survey

Action plans
Endorsement of Plans at all level
- Timeline
- Adoption and commitments
- Top down and up
- Integration of NCD priorities into the SDP and MDG

Breast health & cancer prevention

Already exists
- Physical Activity (DPAS)
- Establish women health day
- Establish men health day
- Calendar of World and International health promotional days, month, etc.
- Ultrasound in all FSM States

To be developed
- Establishment of Breast Health day?
- Breast Health and cancer prevention Conference (start at your work place settings and collaborate with PH to community…)
- Training on ultrasound

Breast health & cancer prevention

Priorities
- Tobacco
- PA
- Nutrition

Action plans
- Identification of population
- Policy assessment and enhancement
- Policy enforcement and commitment
- Evaluation and balance

Cervical cancer prevention

Already exist
- MCH/FP/RH program
- Tobacco Control and Prevention
- CCC
- Coalition, Council

To be developed
- Funding mechanism for screening
- Feasibility Study on HPV
- HPV Vaccination Program?
### Cervical cancer prevention

**Priorities**
- Feasibility Study on HPV
- Funding mechanism for screening

**Action plans**
- Standardization of care and treatment (prevention to palliative care)
- Referral policy and procedures to be adopted by Stakeholders and agencies involved

### Breast cancer diagnosis & treatment

**Already exist**
- Specimens sent off island for reading and work up
- Ultrasound in all FSM States

**To be developed**
- Funding mechanism for screening
- Early identification by health providers at all levels
- Establishment of contract with relevant laboratory

### Breast cancer diagnosis & treatment

**Priorities**
- Establish screening program at all settings
- Training for Health Staff

**Action plans**
- Standardization of care and treatment
- Referral policy
- Patient navigation

### Cervical cancer diagnosis & treatment

**Already exist**
- Pre and post natal check ups
- Specimens sent off island
- Surgical treatment

**To be developed**
- Funding mechanism for screening
- Early identification by health providers at all levels

### Survivorship & palliative care

**Already exist**
- Procurement of narcotic for FSM States
- BNN network

**To be developed**
- Establishment of support group inclusive of survivors and families
- Caregiver Training
- Patient Navigation Service and training

### Cervical cancer diagnosis & treatment

**Priorities**
- Establish screening program at all settings
- Training for Health Staff

**Action plans**
- HPV guideline
- National standard from prevention- palliative care
- HRH
Survivorship & palliative care

Priorities
• Establishment of support group inclusive of survivors and families
• Caregiver Training
• Patient Navigation Service and training
• Narcotics Policy Improvement

Action plans
• Survivors Registry (pop)
• Training Program for survivors and family

Work force development
for breast & cervical cancer prevention & control

Priorities
• HRH Plan for FSM
• Training Program for survivors and family

Action plans
• Identification of potential future assets for training.
• Identification of all source of funding (link, commit for supports).
• Mechanism to support Online and/or On-island capacity development with local college or visiting consultants

Summary of key findings

• Strengths
  - Coalition /Partnership
  - Survivors
  - CCC plans
  - Framework

• Gaps
  - Vertical operation
  - Poor infrastructure
  - Poor coordination and communication
  - Sustainability
  - Resources (lack and miss-utilized)

Recommendations for National Client Management Guidelines

• Agree on core for the minimum standard for the FSM and each state can expand as culturally appropriate and affordable.
• Core- should be at least agree by 3 and 4 of the 4 FSM States by voting.
• Ensure sustainability
• Training (HRH plan for FSM)
  • Resources (WHO, CDC, SPC, etc.) for training must be based on HRH plan.

Some sort of national standards and recommendations and others, should there be?

1. Healthy Diet
2. Nutrition programs in the schools (TCP)
3. Food Safety Act (smothing and Exports) and Codex Alimentation (C.B. No. 7-116)
4. Breastfeeding, Infant Formulas and Food Act Legislation
5. National and State (Breastfeeding Week)
7. National Food Inspectors (C.B. No. 7-49; Section 12)
8. National Food and Nutrition Commission (Presidential Executive Order No. 12)
9. World Health Day, April 7
10. World Food Day, October 16
11. National Women's Health Week, 2nd week of May/annually
12. National Men's Health Week, 3rd Week of June/annually
13. National and State (Food Safety Week), 2nd week of June/annually
14. Physical activity
15. National and State No Tobacco Day, May 31 (C.B. No. 8-2)
16. Squirrel-free environment (C.B. No. 6-8)
17. Public Smoking on Commercial and Private Airlines (C.B. No. 9-69)
18. Tobacco-free or similar regulations
19. Alcohol-free or similar regulations
20. Policies/regulations aimed to reduce under-aged access to tobacco and alcohol (PL No. 9-116)
Primary Prevention;
Addressing the Risk Factors & Promoting Healthy Practices

**Already exists**
- Health Promotion Activities during municipal festivities
- Community Workshops for Women and Youth
- Tobacco Legislation
- COM Extension Services
- Coalitions

**To be developed**
- Sustainable Multi-Sectoral Wellness Campaign
- STEP Survey
- Health Promoting Policies

---

Cervical cancer prevention

**Already exist**
- Community Workshops
- Adolescent Reproductive Health Services
- Tobacco Prevention
- Community Organizations
- HPV Prepaid Card

**To be developed**
- HPV Campaign
- HPV Vaccination Program

---

Breast health & cancer prevention

**Priorities**
- Breast Health Campaign
- Staff Training
- Outreach Service

**Action plans**
- Integrated into MSC
- Training of Trainers
- PCEED, SPC, UH Family Medicine, etc.

---

Primary Prevention;
Addressing the Risk Factors & Promoting Healthy Practices

**Already exists**
- Health Promotion Activities during municipal festivities
- Community Workshops for Women and Youth
- Tobacco Legislation
- COM Extension Services
- Coalitions

**To be developed**
- Sustainable Multi-Sectoral Wellness Campaign
- STEP Survey
- Health Promoting Policies

---

Appendix 15b

**Assets Mapping**

National Workshop to develop FSM Breast and Cervical Cancer Client Management Guidelines for Prevention, Early Detection, Treatment and Care


Kosrae State
Nena Tolenoa – Cancer Coordinator
Cervical cancer prevention

Priorities
- HPV Vaccine & Campaign

Action plans
- Focus Group Discussion
- Immunization Program, Cancer Program, Women & Youth Organizations, CDC, FSM National

Breast cancer diagnosis & treatment

Already exist
- CBE integrated into Maternal Health clinics
- BSE workshops and trainings
- Surgery & tissue biopsy
- OBGYN Services
- Off – island Laboratory services

To be developed
- Cancer Revolving Fund
- Mammogram @ National Level?
- Chemotherapy - regional
- Radiation – regional
- Cancer Registry

Breast cancer diagnosis & treatment

Priorities
- Cancer Revolving Fund
- Mammography Services
- Outreach Services

Action plans
- Enabling Legislation to establish fund
- Fundraising
- Government & Private Partnership to establish service in Pohnpei?
- CDC, C-Change, Legislature, FSM National, Private Clinics

Cervical cancer diagnosis & treatment

Priorities
- Establish appropriate screening program for low resource setting
- Training for Health Staff

Action plans
- Conduct Feasibility study
- Provide training on VIA and other methods
- UH Family Medicine, PCEED, CCC, WHO, SPC, Compact Sector

Survivorship & palliative care

Already exist
- Close Knit Society
- Traditional Healers
- Pain Medication
- Constitutional Guarantee

To be developed
- Support Group
- Caregiver Training
- Patient Navigation Service
- Traditional Medicine Efficacy Research
### Survivorship & palliative care

**Priorities**
- Support Group
- Caregiver Training
- Narcotics Policy Improvement

**Action plans**
- Survivor’s Survey
- Legislative Action
- Model Training Program

### Work force development

**Priorities**
- HRH Project
- Outreach Workers Training
- CE for Nurses and Doctors
- Cytology Training

**Action plans**
- Regional Approach
- Module Identification and Development
- Online and On-island
- PCEED, UH Family Medicine, CIS, SPC,

### Summary of key findings

**Strengths**
- Close Knit Community
- Existing Collaborative Efforts
- Development Partners
- NCD Prioritize in SDP

**Gaps**
- Determinants of Health
- Expensive Screening Program
- Limited Infrastructure
- Sustainability

### Recommendations for National Client Management Guidelines

- Creative Utilization of Existing systems
- Appropriate Screening and Treatment Services for low resource settings
- Sustainability Mechanism
- FSM Wide Procurement of supplies and services
- Health Promoting Policies
Appendix 15c

Assets Mapping

National Workshop to develop FSM Breast and Cervical Cancer Client Management Guidelines for Prevention, Early Detection, Treatment and Care


[YAP, FSM]

MARTINA REICHHARDT, CA
COORDINATOR

Primary Prevention;
Addressing the Risk Factors & Promoting Healthy Practices

### Already exists
- Outer Island Dispensary System
- The CHC sites
- The PH programs
- DOE – Health Curriculum Delivery
- Yap Women’s Association

### To be developed
- Youth Congress
- Faith Based groups
- Role of Traditional Leaders
- Traditional Healers

---

Primary Prevention;
Addressing the Risk Factors & Promoting Healthy Practices

#### Priorities
- Outer Island Dispensary System
- DOE – health curriculum delivery
- Youth Congress

#### Action plans
- Training and provide resources to do the work
- Work with Principals & Physicians to go over curricula with teachers from grades 1-8
- Help them organize their activities to include health promotion to youths as prevention efforts

---

Breast health & cancer prevention

### Already exists
- 17 Outer Island Dispensaries
- 4 Community Health Centers
- PH Programs – MCH, FP, Cancer Media (radio/tv)
- YINEC – need to be more active in community
- Yap Women’s Association – need to facilitate education and health promotion
- DOE – health curricula

### To be developed
- YINEC – need to be more active in community
- Yap Women’s Association – need to facilitate education and health promotion
- DOE – health curricula
- High School and College – instructors schooled in female health issues

---

Breast health & cancer prevention

#### Priorities
- Improve all health providers breast health knowledge
- Conduct regular trainings, CME for providers to be up to date on breast health issues
- Educate young girls, youths and adults on breast health issues

#### Action plans
- Source appropriate and relevant materials for use in education effort
- Organize one annual training for all female health providers from YMI and YOI
- Go into schools, high schools and college to raise awareness on breast health issues

---

Cervical cancer prevention

### Already exist
- 17 Outer Island Dispensaries
- 4 Community Health Centers
- PH programs – STI/HIV, SAMHP, MCH, FP, Cancer
- DOE – health curricula

### To be developed
- YINEC – more active in community
- CHC Local Health Councils – more direct participation in health promotion and village policy on health
- Yap Women’s Association – need to help facilitate women’s group discussions

---
<table>
<thead>
<tr>
<th>Cervical cancer prevention</th>
<th>Breast cancer diagnosis &amp; treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Priorities</strong></td>
<td><strong>Already exist</strong></td>
</tr>
<tr>
<td>Education for women on importance of regular screening</td>
<td>• DHS – nurses and doctors during screening make referrals for further testing (biopsy) off island</td>
</tr>
<tr>
<td>Continuing education of all health providers from nurses to health assistants and doctors to keep abreast of latest cervical cancer issues and recruitment of patients to practice skills</td>
<td>• OI Health Assistants screening abilities to be confident to make referrals to YMI for further investigation</td>
</tr>
<tr>
<td><strong>Action plans</strong></td>
<td><strong>To be developed</strong></td>
</tr>
<tr>
<td>• Create culturally appropriate fact sheets</td>
<td>• DHS – nurses and doctors take paps and send off island for testing</td>
</tr>
<tr>
<td>• Work with community groups and faith based groups to facilitate discussion and delivery of materials.</td>
<td>• CHC – four sites have nurses and doctors that can take paps</td>
</tr>
<tr>
<td>• Include outpatients in health education not just clinic settings</td>
<td>• Outer Island Dispensaries capacity to do pap smears for sending to YMI for lab to send off island for testing and then appropriate way to get that result back to the women in the OI in a timely and confidential manner</td>
</tr>
<tr>
<td>• CME for health providers</td>
<td>• Cancer Survivors support group</td>
</tr>
<tr>
<td>• Radio net training for health assistants</td>
<td>• Youth groups to help in education and physical labor work</td>
</tr>
<tr>
<td><strong>Survivorship &amp; palliative care</strong></td>
<td><strong>To be developed</strong></td>
</tr>
<tr>
<td><strong>Already exist</strong></td>
<td>• Church – educate pastors and priests on needs of cancer patients to help when talking to the families about care and other issues</td>
</tr>
<tr>
<td>• DHS Pharmacy – limited stock of pain medication</td>
<td>• OI Health Assistants screening abilities to be confident to make referrals to YMI for further investigation</td>
</tr>
<tr>
<td>• Relatives or Extended family systems to provide food, transport, monetary and other support</td>
<td>• DHS – nurses and doctors take paps and send off island for testing</td>
</tr>
<tr>
<td>• Faith based support</td>
<td>• CHC – four sites have nurses and doctors that can take paps</td>
</tr>
<tr>
<td>• Nurses and Health Assistants need to be more active in this area</td>
<td>• Outer Island Dispensaries capacity to do pap smears for sending to YMI for lab to send off island for testing and then appropriate way to get that result back to the women in the OI in a timely and confidential manner</td>
</tr>
<tr>
<td><strong>To be developed</strong></td>
<td><strong>Action plans</strong></td>
</tr>
<tr>
<td>•Training of all health providers in recruitment of women</td>
<td>• DHS pharmacy to follow up with off island labs to improve turn around time for results</td>
</tr>
<tr>
<td>• CME and cross trainings dedicated to this area</td>
<td>• Work with pharmacy to ensure pain and other medicines available</td>
</tr>
<tr>
<td>• Look for technical assistance for training in vinegar solution reading and continued training in this area</td>
<td><strong>Cervical cancer diagnosis &amp; treatment</strong></td>
</tr>
<tr>
<td>• To improve recruitment of women to have regular pap smears</td>
<td><strong>Breast cancer diagnosis &amp; treatment</strong></td>
</tr>
<tr>
<td>• To continue education and practice by nurses, doctors and health assistants to take paps</td>
<td><strong>Cervical cancer diagnosis &amp; treatment</strong></td>
</tr>
<tr>
<td>• Consider use of vinegar solution reading and training to do such</td>
<td><strong>Already exist</strong></td>
</tr>
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</tbody>
</table>
Survivorship & palliative care

Priorities
- Contact Survivors and hold a focus group to see how best to form a survivors group and what its role would be
- Work with DHS pharmacy to ensure adequate and relevant pain medication on hand always
- Faith based groups more informed on cancer care issues

Action plans
- Hold a meeting with cancer survivors and get views
- Meet with Pharmacist and find out procurement, cost, dispensing and use of pain medications
- Talk to faith based leaders and start dialogue for information dissemination and education

Work force development for breast & cervical cancer prevention & control

Priorities
- Yearly BR and CCA training for Outer Island Health Assistants to upgrade and improve on their limited skills and knowledge
- Work with AHEC to incorporate BR and CCA in their regular CME topics
- Work with PH and CHC to have BR and CCA in their cross trainings with PH nurses and staff
- Work with Faith based leaders and Traditional Healers to undergo trainings

Action plans
- Have meetings with Supervisors and respective Program heads to see how our priorities can be incorporated into their activities
- Identify and meet with Faith based leaders and Traditional Healers willing to undergo basic BR and CCA 101 and cancer care issues to compliment their alternate healing abilities

Summary of key findings

- Strengths – We have skilled and dedicated nurses, doctors, health assistants, community health workers, PH program coordinators
- We have transportation/several communication options to access our target groups
- We have traditional leaders who can organize and encourage community participation in health promotion
- We have traditional healers who are often used before, during and after western medicine is applied
- We have established faith based groups

Gaps - Our systems are not coordinated
- Need more education and training for all above

Recommendations for National Client Management Guidelines

- Standardize breast and cervical cancer training curricula for health providers and one for community
- Standardize breast and cervical cancer education and information materials for public dissemination
- Consider use of faith based groups, traditional leaders and traditional healers support to disseminate information… and they should be all trained in a simpler community training session so all are speaking the same language.
- Consider working with teachers in High School and COM to undergo community training to be able to deliver correct information to their female students
Appendix 15d

**Assets Mapping**

National Workshop to develop FSM Breast and Cervical Cancer Client Management Guidelines for Prevention, Early Detection, Treatment and Care


[X-ner Luther, Cancer Coordinator]

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**What are assets?**

- **Assets** are resources, services, or activities provided by families, the community and the health care system to help people;
  - maintain their health and prevent disease;
    - access to healthy food, exercise, quit programs, knowledge about & practice self-exams, sexual health, health promoting workplace, health education in schools, church leadership in ‘living healthy’, informed media, community public health, health promoting hospitals, etc.
  - obtain screening & early detection;
    - information, transportation, competent & friendly health workers, satisfied customers who advocate & promote regular check-ups, health insurance, employers who support regular health check-ups, community navigation, etc.

---

**What are assets?** (continued)

- **Assets** are resources, services, or activities provided by families, the community and the health care system to help people;
  - receive a proper diagnosis and treatment;
    - well trained doctors and nurses, caring case managers, reliable referral system, accurate and up-to-date patient records, health insurance, off-island treatment, patient navigation, etc.
  - live with cancer and maintain a quality of life;
    - spiritual support, pain and symptom management, good nutrition, exercise, companionship, survivors support group, comfort in their daily lives, end-of-life support, support for the family, etc..

---

**Breast health & cancer prevention**

**Already exists**
- Nutritional Program for Comm. Ed. (ICFP, DOE, PHC)
- CCCP and PCP
- STEPSurvey
- PCCC program

**To be developed**
- Obesity program Community Education
- Obesity for Patient Ed.
- Nutritional Program for Patient Ed.
- Alcohol Program for Community Ed
- Alcohol Program for Patient Ed.
- Physical Act. for Comm. Ed.
- Physical Act. for Patient Ed

---

**Breast health & cancer prevention Priorities**

- Have these program integrated (an obesity program, a nutritional program, a physical activity program and alcohol program) for both the community and patients

---

**Action plans**

- Work with DOE, other health programs, ICFP, churches, and community leaders in developing an integrated IEC materiais

---

**Cervical cancer prevention**

**Already exist**
- Tobacco- Comm Ed. (SAMH)
- Tobacco- Patient Ed. (SAMH, Tobacco Quitline)
- Sexual Health- Comm Ed. (STI?HIV program)
- Sexual Health- Patient Ed. (STI?HIV program)

**To be developed**
- HPV- Comm
- HPV- Patient
### Cervical cancer prevention

**Priorities**
- Have a HPV IEC material in place
- Have PCC members spearhead the awareness campaign w/ confirmation from National to provide vaccine

**Action plans**
- Work with FSM National, Immunization program and other related programs, and the PCC to develop IEC materials

### Breast cancer diagnosis & treatment

**Already exist**
- BSE- Community (HW, PHE)
- BSE- Patient (Physicians, Nurses, HW, PHE)
- CBS (hospital, private health providers)

**To be developed**
- Mammmography- Community
- Mammmography- Patient

### Breast cancer diagnosis & treatment

**Priorities**
- Have a mammogram in place
- All HW are trained in SBE
- To have more female able to do own SBE

**Action plans**
- Conduct a cost benefit analysis on having a mammogram
- Train HW on how to conduct SBE
- Conduct SBE awareness at COM, high schools
- Train Women's group on SBE

### Cervical cancer diagnosis & treatment

**Priorities**
- Improve screening and treatment

**Action plans**
- Worked w/ FSM National, sister states, outside partners in developing training modules
- Conduct training

### Survivorship & palliative care

**Already exist**
- Support Group
- Clinics
- Doctors
- Traditional Healers

**To be developed**
- Professional Counseling
- Patient Navigation
- Local therapies
Survivorship & palliative care

**Priorities**
- Have a patient navigation system in place
- Have a client management guideline in place
- Ensure pain management is available

**Action plans**
- Hire a patient navigator
- Work with FSM National, sister states, and outside partners in developing a CMG
- Work w/ Hospital admin. to ensure pain medicine is available
- Work w/ PHC to admin. Med.

Work force development for breast & cervical cancer prevention & control

**Priorities**
- Improve B&C cancer screening
- Equip dispensaries with supplies

**Action plans**
- Train HW on B&C cancer screening
- Educate HW on CMG
- Institutionalize CMG

Summary of key findings

**Strengths**
- Capable HW, health educators, physicians
- Dispensaries in place
- Physicians visiting comm. Dispensaries 2x a wk
- Other PH programs (STI, NCD, AHD, etc.)
- Youth groups, Women’s Group, other NGOs
- Community Leaders

**Gaps**
- PH program activities are not well coordinated
- Communication between PH programs and division heads need to be improved
- Lack of enabling environment
- Disconnect of services to the communities (OI)

Recommendations for National Client Management Guidelines

- Standardized IEC materials on B&C
- Have a patient navigation system in place
- Work with communities (churches, women’s group community leaders and others) in disseminating IEC B&C materials
- Support system in place to develop or strengthen new and existing cancer support groups in the states
- Have a cancer patient tracking system in place
Assets Mapping

National Workshop to develop FSM Breast and Cervical Cancer Client Management Guidelines for Prevention, Early Detection, Treatment and Care

Chuuk State
Ansina Kony, Ira Akapito, Manuel Umwech & Kino S. Ruben

Chuuk State Geography

Population: 53,000+ (2000 Census)
Inhabited Islands: 24 Outer Islands
17 Lagoon Islands
Health Facilities: 1 Hospital
64 Dispensary
Resources
• Health Budget: $7.77 Million

What are assets?

- **Assets** are resources, services, or activities provided by families, the community and the health care system to help people;
  - maintain their health and prevent disease;
  - access to healthy food, exercise, quit programs, knowledge about & practice self-exams, sexual health, health promoting workplace, health education in schools, church leadership in ‘living healthy’, informed media, community public health, health promoting hospitals, etc.
  - obtain screening & early detection;
  - information, transportation, competent & friendly health workers, satisfied customers who advocate & promote regular check-ups, health insurance, employers who support regular health check-ups, community navigation, etc.

What are assets? (continued)

- **Assets** are resources, services, or activities provided by families, the community and the health care system to help people;
  - receive a proper diagnosis and treatment;
  - well trained doctors and nurses, caring case managers, reliable referral system, accurate and up-to-date patient records, health insurance, off-island treatment, patient navigation, etc.
  - live with cancer and maintain a quality of life;
  - spiritual support, pain and symptom management, good nutrition, exercise, companionship, survivors support group, comfort in their daily lives, end-of-life support, support for the family, etc.

Primary Prevention;
Addressing the Risk Factors & Promoting Healthy Practices

**Already exists**
- NCD Clinics
- Pre/Postnatal Clinics
- COM-FSM Land Grant
- Family Planning
- CCCP Outreach program

**To be developed**
- School Health Education on Cancer & Nutrition
- Public Health Education on Cancer & Nutrition

**Priorities**
- NCD Clinics
- COM-FSM Land Grant
- CCCP Outreach Program

**Action plans**
- Instructions: state how you plan to initiate or develop or strengthen these assets; mention partners, organizations, human resources, material resources, external technical assistance, study tour, training, etc.
## Breast Health & Cancer Prevention

### Already Exists
- NCD Clinics
- OB/GYN Clinics
- Pre/Postnatal Clinics
- HIV/AIDS Clinics
- Food Handlers; New Employment; Travelers; Students Clinics
- COM-FSM Land Grant
- Dispensary Health Assistants

### To be Developed
- Breast Cancer Screening
- School Health Ed x B. CA
- Public Health Ed x B. CA

### Breast Health & Cancer Prevention

<table>
<thead>
<tr>
<th>Priorities</th>
<th>Action Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCD Clinics</td>
<td>To increase public education on food and nutrition, physical activities and health practices</td>
</tr>
<tr>
<td>COM-FSM Land Grant</td>
<td>To increase public education on food safety and physical activities; gardening and food preparation</td>
</tr>
<tr>
<td>School and Public Health Education on Breast Cancer</td>
<td>Do breast cancer education in the high schools and in the communities</td>
</tr>
</tbody>
</table>

## Cervical Cancer Prevention

### Already exists
- Tobacco Coalition
- Law on Tobacco sales to minors
- HIV/AIDS Clinics
- Family Planning
- Pre/Postnatal Clinics
- Food Handlers, New Employment; Students, and Travelers Clinic

### To be developed
- HPV Community health Education
- School Cervical Cancer Health Education
- Community Health Ed on Cervical Cancer

### Cervical Cancer Prevention

<table>
<thead>
<tr>
<th>Priorities</th>
<th>Action Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Middle &amp; High School Ed. On Cervical Cancer</td>
<td>Do aggressive M&amp;H School Education on CX CA</td>
</tr>
<tr>
<td>Family Planning</td>
<td>Encourage CX CA Screening for high Risk Females</td>
</tr>
<tr>
<td>HPV Vaccine</td>
<td>Educate &amp; Provide HPV Vaccine to the most Beneficial Female Population</td>
</tr>
</tbody>
</table>

## Breast Cancer Diagnosis & Treatment

### Already exist
- Chuuk Hospital
- Hawaii Hospitals
- Philippines Hospitals
- Hawaii Labs

### To be developed
- Develop local laboratory capacity for Cancer diagnosis
- Guam Laboratory

### Breast Cancer Diagnosis & Treatment

<table>
<thead>
<tr>
<th>Priority</th>
<th>Action Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chuuk Hospital</td>
<td>Develop Capacity to be able to Diagnose Cancer more Readily and Timely &amp; to be able to do more surgical treatment and follow-up chemotherapy</td>
</tr>
<tr>
<td>Guam Laboratory</td>
<td>Develop UOG Lab to be able to do most Level 2 CA Diagnosing Procedures</td>
</tr>
<tr>
<td>Hawaii Laboratory</td>
<td>Identify a Level 3 lab for breast cancer confirmation testing.</td>
</tr>
</tbody>
</table>
### Cervical cancer diagnosis & treatment

<table>
<thead>
<tr>
<th>Already exist</th>
<th>To be developed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chuuk Hospital</td>
<td>Guam Laboratory</td>
</tr>
<tr>
<td>Hawaii Hospitals</td>
<td></td>
</tr>
<tr>
<td>Philippines Hospitals</td>
<td></td>
</tr>
<tr>
<td>Hawaii Laboratories</td>
<td></td>
</tr>
</tbody>
</table>

### Survivorship & palliative care

<table>
<thead>
<tr>
<th>Already exist</th>
<th>To be developed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chuuk Hospital</td>
<td>Community Support Groups</td>
</tr>
<tr>
<td>Family</td>
<td>Survivorship Conferences</td>
</tr>
<tr>
<td>Church Groups</td>
<td>Pain Medicines</td>
</tr>
<tr>
<td>Dispensary Health Assistants</td>
<td>Cancer Patients follow-up or Tracking</td>
</tr>
</tbody>
</table>

### Work force development for breast & cervical cancer prevention & control

<table>
<thead>
<tr>
<th>Priorities</th>
<th>Action plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors &amp; Nurses Improvement</td>
<td>Train doctors &amp; nurses in the screening &amp; diagnosis of breast and Cx CA for early tx &amp; control</td>
</tr>
<tr>
<td>Health Assistants and Midwives Improvement</td>
<td>Train HA &amp; Midwives on how to screen or suspect breast or cx CA in the community</td>
</tr>
<tr>
<td>Public Education on Breast and Cervical Cancer</td>
<td>Do community health education on breast &amp; cx CA, their risk tx, prevention, and where to go for assistance.</td>
</tr>
</tbody>
</table>

### Summary of key findings

**Strengths**
- Regionalization of USAPI cancer efforts
- Strong family/community ties
- Prevalence of Christianity in the islands
- Availability of human resource for CA health training
- Existence of basic health infrastructure

**Gap**
- No training opportunities for health providers
- Not so educated community on cancer
- Challenging geography of the islands
- No cancer support groups
- No pain medicines for cancer patients
- No local screening, diagnostic, and treatment facilities
Recommendations for National Client Management Guidelines

- Training of doctors, nurses, health assistants, midwives for screening to caring for cancer patients (in their respective levels of care provisions)
- Develop present local laboratories to be able to do basic cancer screening testing
- Develop patient navigation systems in the State DHS
- Provision of pain medicines for cancer patients
- Development of community support groups
- Development of cancer survivorship conferences
- Political commitment to support cancer programs
Appendix 16

FSM Breast & Cervical Cancer Client Management Guidelines for Prevention, Early Detection, Diagnosis, Treatment and Care

Federated States of Micronesia
29 August – 2 September, 2008

Sponsored by the National & State Comprehensive Cancer Control Programs
FSM Department of Health and Social Affairs and the Departments of Health Services: Kosrae, Chuuk, Pohnpei and Yap

Workshop objectives

1. To discuss and agree upon minimum standards.
2. To identify strategies, roles and resources needed to put the minimum standards into practice.
3. To draft the National FSM Client Management Guidelines for integrating the continuum of breast and cervical cancer prevention, early detection, diagnosis, treatment, and care.
4. To outline ‘next steps’ to secure institutional support at national and State levels, to finalize the draft guidelines and to adopt and adapt the guidelines at the State level.

Minimum regional indicators approved by PIHOA & CCPI

Goal: To diagnose cancer in individuals as early as technically possible within the USAPIN region (two of the four priority indicators)
- By 2009, jurisdictions without mammography will demonstrate a 10% increase above their baseline the number of women over 50 who are offered clinical breast exams annually.
- By 2012, each jurisdiction will demonstrate a 10% increase in the number of women age 18-65 who are offered cervical cancer screening at least every 3 years.

Comprehensive Cancer Control; Goals

Goal 1: To prevent occurrences of cancers.
Goal 2: To identify and diagnose cancer in individuals as early as technically possible.
Goal 3: To be able to treat and medically manage every cancer as early as technically possible with the most effective, practical, and evidence-based therapies available.
Goal 4: To provide the best practical and attainable quality of life for cancer patients, cancer survivors, and their families.

Minimum standards; a Regional Goal & a National Goal

The goals of the FSM National CCC plan directly support the Regional CCC plan to develop & attain a set of minimum standards for cancer control throughout the U.S. Associated Pacific island Nations (USAPIN). In doing so, the FSM National Plan also supports the individual State CCC Plans.

Excerpt from:
The National FSM Comprehensive Cancer Control 5-year Plan, 2007-2012

Pacific CEED long-term goal:
Reduce cancer disparities with a focus on breast & cervical cancer.

Operational goals:
- Influence disparities, social determinants and related policy, systems and infrastructural changes
- Serve as a regional resource & expert center
- Support priorities of the Regional Comprehensive Cancer Control Program and USAPI CCC plans
- Carry out comprehensive evaluation
**Why client management guidelines?**

From the FSM CCC 5-year Plan

- **OUR VISION:**
  That FSM citizen’s access to comprehensive cancer services including preventative information, early detection and screening, treatment and care and that all the risk factors are identified and collaboratively address within the national, state and regional plans.

- **OUR FOCUS:**
  The focus of the National Comprehensive Cancer Control plan is on legislation, policy, standards, protocols, training and technical assistance.

**Integrated prevention – care continuum**

<table>
<thead>
<tr>
<th>Uptake ↑ high</th>
<th>prevention</th>
<th>early detection</th>
<th>diagnosis</th>
<th>treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drop out ↓ low</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Linkages in place</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Putting evidence-based & resource-appropriate standards into practice:

BY health workers & providers FOR our people

- The standards are evidence-based.
- How we put them into practice, and
- Where we put them into practice means adopting resource appropriate-standards & practice and putting them into ACTION.

“I want you to quit smoking and lose 35 pounds. Then I want you to come back and tell me how you did it.”

**Workshop program**

Day 1: Friday
- Assets Mapping – States & National presentations
- Resource-appropriate guidelines
- FSM-appropriate guidelines
- Primary prevention; Addressing the risk factors – cancer and Non-communicable diseases

Day 2: Saturday
- Breast cancer prevention & early detection
- Cervical cancer prevention & early detection

Day 3: Monday
- Diagnosis and treatment
- Survivorship & palliative care

Day 4: Tuesday
- Put the standards & practice together
- Reach agreement & Next steps
- Recommendations & workshop evaluation

**Roles & responsibilities**

- **Chair person:**
  - Preside over the meeting
  - Review ‘ground rules’ (e.g. everyone participates, stick to the program, put ‘training’ and ‘linkages’ ideas on the ‘parking’ lists)
  - Introduce the speakers and sessions
  - Keep the speakers and program ON TIME
  - Remind us of the reason for our work, to meet the needs of individuals and families
  - Remind us about the Family Story/Cancer survivor story
  - Ice-breakers & Exercise Breaks – Energize the group! Be Creative!
  - Remind the Documenter to type all contributions during the discussions
  - Remind the Rapporteur to touch base with you & the Documenter during coffee break to prepare a 5 minute summary of the session.
Roles & responsibilities

**Documenter:**
- Document the questions, answers and discussions following each of the presentations by the resource persons. (A laptop & electronic format will be available. If you prefer to handwrite the notes, no problem. We may also take notes on the flipchart.)
- Share highlights with the Rapporteur so he/she can report to the group at the end of each morning and afternoon session.
- Give the final notes for the day/session to the Chair and Lead Facilitator at the end of each day.

**Rapporteur:**
- Follow the presentations and discussion.
- Write down 'key points' to summarize at the end of session.
- Meet with the Chair and Rapporteur for your session, during coffee break and agree on key points for to report.
- Provide short Report Back to the workshop participants at the end of the session, highlighting 'key points'.
- Introduce the workshop participants to the next session (title of session, speaker, etc.)
- Remind everyone to return to the workshop session ON TIME and to CONTRIBUTE.
- Introduce the Chair, Documenter and Rapporteur for the next session.
Appendix 17

National Breast & Cervical Cancer Guidelines:

CM Guidelines will include:
1) Standards tables – minimum, expanded, desired
2) Putting standards into practice; how & where & who & linkages
3) US & International sources of evidence for resource-appropriate standards of practice
4) Adaptation of standards in each State
5) Evaluation – performance measures of quality practice

Steps for developing Client Management Guidelines

- Presentation by resource persons
- Review standards tables
  - Primary prevention
  - Breast cancer prevention & early detection
  - Cervical cancer prevention & early detection
  - Diagnosis and treatment
  - Palliative care and survivorship
- Discuss & agree on resource-appropriate standards
- Group Work on guidelines – putting the standards into practice, use the standards table & worksheet
- Next steps – endorsement & adoption & adaptation

Integrated prevention – care continuum

Uptake high

Drop out low

Linkages in place

Strategies to increase cancer early detection

<table>
<thead>
<tr>
<th>Client-based Interventions</th>
<th>Breast</th>
<th>Cervical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Demand</td>
<td>Strong</td>
<td>Strong</td>
</tr>
<tr>
<td>Client reminder</td>
<td>Strong</td>
<td>Strong</td>
</tr>
<tr>
<td>Client incentive</td>
<td>Insufficient*</td>
<td>Insufficient*</td>
</tr>
<tr>
<td>Mass media</td>
<td>Insufficient*</td>
<td>Insufficient*</td>
</tr>
<tr>
<td>Small media (e.g., pamphlets in local language)</td>
<td>Strong</td>
<td>Strong</td>
</tr>
<tr>
<td>Group education</td>
<td>Insufficient*</td>
<td>Insufficient*</td>
</tr>
<tr>
<td>One-on-one education</td>
<td>Strong</td>
<td>Strong</td>
</tr>
<tr>
<td>Community Access</td>
<td>Strong</td>
<td>Insufficient*</td>
</tr>
<tr>
<td>Reduce structural barrier</td>
<td>Strong</td>
<td>Insufficient*</td>
</tr>
<tr>
<td>Reduce out-of-pocket expense</td>
<td>Strong</td>
<td>Insufficient*</td>
</tr>
<tr>
<td>Provider-oriented Interventions</td>
<td>Provider reminder</td>
<td>Strong</td>
</tr>
<tr>
<td>Provider assessment &amp; feedback</td>
<td>Sufficient</td>
<td></td>
</tr>
<tr>
<td>Provider incentive</td>
<td>Insufficient*</td>
<td></td>
</tr>
<tr>
<td>Multi-component Interventions</td>
<td>Strong</td>
<td></td>
</tr>
</tbody>
</table>

Reason evidence insufficient:
* No studies
** Too few studies
† Inconsistent findings

Increase community demand and access

- Client reminder
- Mass media
- Small media
- Group education
- One-on-one education

- Reduce structural barriers, e.g., provide mobile vans, offer flexible hours
- Reduce out-of-pocket cost to client
Increase provider delivery

- Provider reminders
- Provider assessment and feedback
- Provider incentive, e.g. training, responsibility, decision-making, team leaders

Steps for developing Client Management Guidelines

- Presentation by resource persons
- Review standards tables
  - Primary prevention
  - Breast cancer prevention & early detection
  - Cervical cancer prevention & early detection
  - Diagnosis and treatment
  - Palliative care and survivorship
- Discuss & agree on resource-appropriate standards
- Group Work on guidelines – putting the standards into practice, use the standards table & worksheet
- Next steps – endorsement, adoption & adaptation
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FSM-Appropriate Guidelines

- Researched key US & international standards of care
- Accept and/or adapt standards to FSM needs & resources

Why Standards and Guidelines?

- Guidance and direction as you carry out the Comprehensive Cancer Control Plans
- Can help navigate the rough seas of cancer control
- Showing the best way, based upon expertise and experience
- Precious resources are used most effectively
**What are Standards?**

**Definition**
- Evidence-based and consensus-driven standards of care developed by recognized US and International sources to guide health providers and policymakers.
- Sources use various terms (standards, guidelines, recommendations, etc), but we will refer to them as Standards.

**FSM Client Management Guidelines**

**Definition**
- US and/or international Standards, accepted or adapted as appropriate for FSM national and State needs and resources.
- FSM Guidelines will include your descriptions of how the standards you adopt will be put into practice to guide your citizens through the continuum of cancer prevention and care.

**What is Evidence?**

- Surveillance Data
- Systematic Reviews of Multiple Studies by Panels of Experts
- An Intervention Research Study
- Program Evaluation
- Word of Mouth
- Personal Experience

**Key Sources of Standards**

**US**
- US Preventive Services Task Force (USPSTF)
- National Cancer Institute (NCI)
- Centers for Disease Control (CDC)
- American Cancer Society (ACS)

**International**
- World Health Organization (WHO)
- Breast Health Global Initiative (BHGI)
- Alliance for Cervical Cancer Prevention (ACCP)

**US Standards**

**Advantages**
- Strong evidence-base
- Systematic Reviews of Multiple Studies by Panels of Experts
- “Gold Standard”
- Some standards developed for adaptation of programs to culture and community.

**Disadvantages**
- May not be resource-appropriate for all parts of US, and affiliated jurisdictions
- Limited resource communities and countries cannot realistically meet standards
- Limited evidence-base for minority populations, Pacific Islanders
International Standards

- Evidence-based economically feasible and culturally appropriate guidelines
- Developed to make most effective use of available resources
- For limited-resource countries (“Low and middle-income countries”)
- Resource Levels: Core, Expanded, Desirable (WHO)
- Standards developed by consortiums organizations

Key Sources of Standards

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International
- World Health Organization (WHO)
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US Preventive Services Task Force

- An independent panel of experts in primary care and prevention that systematically reviews evidence of effectiveness and develops recommendations for clinical preventive services

US Centers for Disease Control (CDC)

- US Centers for Disease Control and Prevention
- The major United States government agency for disease prevention
- Funds Pacific CEED
- National Breast and Cervical Cancer Early Detection Program (NBCCEDP)

CDC’s Community Guide

- Systematic reviews of the available evidence
- Formulated by a team of renowned researchers, public health practitioners, representatives of health organizations
- Effectiveness of interventions and program in public health
- Topics include: Cancer, Risk Behaviors, Tobacco, Obesity, Physical Activity, Alcohol

National Cancer Institute
National Cancer Institute

- Primary US agency for cancer research
- Panels regularly review latest scientific information
- Provide information to professionals and the public
- NCI generally does not make screening or treatment recommendations or guidelines (except mammography)
- NCI and CDC usually support the recommendations of the USPSTF for cancer screening and clinical preventive services

www.cancer.gov/cancertopics/pdq

Breast Health Global Initiative

- The Breast Health Global Initiative (BHGI) strives to develop, implement and study evidence-based, economically feasible, and culturally appropriate guidelines for international breast health and cancer control for low and middle income countries to improve breast health outcomes

The BHGI GLOBAL ALLIANCE: Learning Laboratory - Low Income Countries

- Hope Center: Institute for Professional Training
- Training in early detection, diagnosis and treatment adjusted for low-income country resources
- Curriculum based on BHGI Guidelines
- International faculty to teach and learn

BHGI Consensus Guidelines: Early Detection

<table>
<thead>
<tr>
<th>Level of resource</th>
<th>Detection method(s)</th>
<th>Evaluation goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic</td>
<td>Breast health awareness (education + self-examination), Clinical breast examination</td>
<td>Baseline assessment and repeated survey</td>
</tr>
<tr>
<td>Limited</td>
<td>Targeted outreach/education, encouraging CBE for at-risk groups, Diagnostic ultrasound or diagnostic mammography</td>
<td>Downstaging of symptomatic disease</td>
</tr>
<tr>
<td>Enhanced</td>
<td>Diagnostic mammography, Opportunistic mammographic screening</td>
<td>Opportunistic screening of asymptomatic patients</td>
</tr>
<tr>
<td>Maximal</td>
<td>Population-based mammographic screening, Other imaging technologies as appropriate, high-risk groups, unique imaging challenges</td>
<td>Population-based screening of asymptomatic patients</td>
</tr>
</tbody>
</table>

The Breast Health Global Initiative

• A catalyst for cancer control in low and middle income countries

Benjamin O. Anderson, M.D.
Chair and Director
Breast Health Global Initiative
Fred Hutchinson Cancer Research Center
Professor of Surgery, University of Washington

Alliance for Cervical Cancer Prevention

ACCP Members:
• EngenderHealth
• IARC International Agency for Research on Cancer
• JHPIEGO Johns Hopkins Program for International Education in Gynecology and Obstetrics
• PAHO Pan American Health Organization
• PATH Alliance Coordinating Agency
with support from the Bill and Melinda Gates Foundation

Standards Tables

• CEED Team prepared summaries of key US and international standards for each component of care:
  – Prevention
  – Early Detection
  – Diagnosis & Treatment
  – Palliative Care
• Tables are in your binders
• We will review each Table and you will decide which Standards to accept or adapt.

Standards

• Highlight a selection of these Standards

Cervical Cancer Screening

US Standards

National Cancer Institute (NCI) supports cervical screening guidelines of the U.S. Preventive Services Task Force & American Cancer Society

Cervical cancer screening should begin approximately three years after a woman begins having sexual intercourse, but no later than at 21 years old.
• Women should have a Pap test at least once every three years.
• Women 65 to 70 years of age who have had at least three normal Pap tests and no abnormal Pap tests in the last 10 years may decide, upon consultation with their healthcare provider, to stop cervical cancer screening.
**International Standards**

World Health Organization (WHO)

- If there is infrastructure for cytology (pap test) screening:
  - **Core**: Ages 35 to 40, once in lifetime.
  - **Expanded**: Ages 30 to 60 every 10 years


**Alliance for Cervical Cancer Prevention (ACCP)**

If high quality cytology (pap test) difficult to sustain:

- HPV DNA testing or VIA (visual inspection of cervix)
- **Screen and Treat**: VIA + treat pre-cancerous lesions with cryotherapy (freezing) in a single visit

[http://www.alliance-cxca.org](http://www.alliance-cxca.org)

**VIA**

- Visual inspection of cervix after an acetic acid (vinegar) solution is applied; abnormal cells appear white when exposed to the solution.
- Can be carried out by physicians & non-physicians, incl. nurses and midwives.
- Effective screening tool in low-resource countries for pre-cancerous cervical lesions

**CERVICARE Program: Ghana**

- **Problem**
  - Screening largely unavailable
  - Treatment of pre-cancer available only at large hospitals

- **Intervention**
  - 8 rural midwives trained in visual inspection and cryotherapy; the single visit approach: SVA fully integrated in RH services

- **Result**
  - Over 48 months, 19,326 women have been tested
  - 1456 (91.7%) received cryotherapy immediately or return visit
  - 16 cervical cancer patients identified (downstaging)

[CERVICARE Program, JHPIEGO 2004, and Sylvia Deganus, Sydfny Adadevoh, Ghana](http://www.jhpiego.org)

**Standards: Breast Cancer Early Detection (Clinical)**

<table>
<thead>
<tr>
<th>Resource Level</th>
<th>WHO/IARC</th>
<th>BHGI</th>
<th>USPSTF/NCCN</th>
<th>NCI</th>
<th>ACS</th>
<th>Komen</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expanded</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Desirable</td>
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</tr>
</tbody>
</table>

**US Standards**

USPSTF, NCI and CDC:

- Mammography every 1-2 years beginning at age 40; not enough evidence to recommend for or against CBE or SBE.

ACS:

- Mammography every year beginning at age 40. CBE at least every 3 years ages 20-39, every year beginning age 40. SBE Beginning age 20. Talk to provider re: benefits.

Komen:

- SBE monthly beginning age 20.
International Standards
Breast Cancer Early Detection

- Screening mammography should not be introduced unless resources available to ensure effective & reliable screening of at least 70% of women over age 50.

World Health Organization

BHGI- Early Detection and Access to Care

<table>
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<td>Diagnostic mammography</td>
<td>Opportunistic screening of asymptomatic patients</td>
</tr>
</tbody>
</table>

Standard: Breast & Cervical Awareness & Education

Target messages to reach women at highest risk
- Breast cancer (ages 40 to 50 & over)
- Cervical cancer (generally aged 30 - 50).
- Involve women in creating prevention messages and programs.

Sources: ACCP; BHGI

Standard: Breast & Cervical Awareness & Education

Involve and train key sources of information and influence, including:
- Peers who have received messages or services
- Cancer survivors
- Leaders or members of women’s groups
- Midwives and traditional healers
- Community health promoters
- Community Leaders
- Nurse, nurse practitioners and doctors

Source: ACCP

Evidence-Based Programs

- Lay Health Workers
- Promotora
- Navigators

Promotoras/Lay Health Workers/Navigators

- Increase
  - Understanding of disease
  - Access to healthcare and community health services
  - Cost-effectiveness in communities of need
  - Immunization uptake
  - Cancer screening
  - Outcomes for infectious diseases
Waianae Cancer Research Project

Native Hawaiian Breast and Cervical Cancer Control Participatory Research Project

National Cancer Institute Waianae Coast Comprehensive Health Center Cancer Research Center of Hawaii

• Community members & leaders invited their family and friends to home or community-based “Kokua Groups”.
• Community Health navigators led group through culturally tailored breast & cervical cancer education.

Standards: Prevention

• Prevention programs for patients and community will be evidence-based and adapted to culture and community
• Health officials will gather local evidence regarding women’s knowledge beliefs and practices re: prevention of breast and cervical cancer (ie: focus groups, interviews, surveys, etc).

Prevention Programs for Youth

It Can Happen to You!
Teen pregnancy and STI prevention play Developed for multi-cultural youth in Hawaii Performs in schools & community

“Crossroads” Tobacco Prevention Play

• 12,000 6th, 7th & 8th graders in Hawaii
• Focus Groups
• Pre-post test shows significant changes in knowledge, attitudes and intended behavior

Culturally-Tailored Tobacco Brochure

Kalihi-Palama Health Center Honolulu, Hawaii

Chuukese Tobacco brochure

Ifa Usun Om Kopwe Wes Me Supa/Nunu Snaf/Atuf
Priorities

- International organizations recognize limited-resource countries (low income countries) must set priorities.
- International standards evidence-based + economically feasible
- Recommend as “Core” (Minimum) those services a country should provide first
- Build towards “Enhanced” and “Desirable”

Priorities

- Most standards are either for Cervical Cancer or Breast Cancer
- “Core” priorities for Breast and Cervical?

Priorities for different screening programs

- In determining the relative priorities for different screening programmes, it is important to recognize that breast cancer screening is intrinsically less effective than cytological screening for cervical cancer. As a rough guide, screening will produce an equivalent reduction in numbers of deaths in the two conditions only if, in the absence of screening, breast cancer mortality is three times that of cervical cancer in the age groups concerned.

World Health Organization (WHO)
http://www.who.int/cancer/detection/breastcancer/en/

Cervical Cancer Prevention & Early Detection

- Significant cancer burden for FSM
- Leading cause of cancer death in some States
- Highly preventable; Can be cured
- Breast Health Global Initiative’s Dr. Ben Anderson advised: “Focus on Tobacco & Cervical Cancer”

FSM Client Management Guidelines

- Mahalo
- Kalangan
- Kilisou Chapur
- Kulo Malulap
- Komagar

Cancer Information Service
You must matter because you are you, and you matter until the last moment of your life. We will do all we can, not only to help you die peacefully, but also to live until you die.

Dame Cicely Saunders, Founder of the modern Hospice movement

What is Palliative Care?

- Treatment to relieve pain and suffering
- May be combined with therapies aimed at reducing or curing the illness, or it may be the total focus of care
- Can be applied to other chronic fatal diseases

What is Palliative Care? (con't)

- A philosophy of care
  - Patient centered
  - Life enhancing rather than life prolonging
  - Interdisciplinary approach
  - Patient and family are unit of care
- A system of care
- Palliative Care is a medical subspecialty

What is Hospice?

- Hospice is a program that provides coordinated comprehensive palliative care for terminally ill patients and their families
- Provide care in home or facility
- Use an interdisciplinary team of health professionals
Why Palliative Care?

According to WHO:

- Palliative Care is an **urgent** humanitarian need for people with cancer
- Palliative Care is particularly needed where a high proportion of patients are diagnosed in advanced stages and there is little chance of cure

When is palliative care needed?

- Ideally from the time of diagnosis
- Throughout the disease process - adapting to the changing, increasing needs of patients and their families as the disease progresses
- Support for families is important throughout including bereavement

Effective programs

- Integrated into existing health system at all levels of care, especially community and home-based care
- Involve public and private sector
- Adapt to specific cultural, social, and economic setting
- Strategically linked to cancer prevention, early detection, and treatment

Palliative Care provides **Pain and Symptom Management**

Prevalence of Pain

**Up to 80% of people with cancer experience pain.**

*WHO, Cancer Control – Knowledge into Action, 2007*

Different Types of Pain

- Physical Pain – nerve, visceral pain, muscles
- Spiritual Pain
- Emotional Pain
- Social or Interpersonal pain
Cancer Pain

“Pain is more than the hurt…”
"It means fatigue, weakness, weariness, weight loss”

- Patient with advanced cancer

Pain Management is Possible

• Pain can be managed
• Pain control is a part of cancer treatment
• The person with pain is the central person in the health care team
• Different types of treatments
• People who take cancer pain medications rarely become addicted

How Cancer Patients See Pain

• Poor prognosis
• Impending death
• Decreased autonomy
• Threat to enjoyment and quality of life
• Challenge to dignity
• Threat of increased suffering to self and family

Consequences of Pain

• Personal Suffering
  – Reduced Activity, Appetite, Sleep
  – Physical & Mental Weakness
  – Depression; Loss of Hope
• Reduce Functional Capacity
  – Cannot work productively
  – Don’t enjoy usual social & family roles
• Diminished Quality of Life

Common Myths

• Good patients don’t talk about pain
• Patients must accept pain
• Talking about pain distracts my doctor
• Pain signals worsening cancer
• Pain medicine should be "saved"
• It is best to avoid pain medications to avoid side effects

Barriers To Pain Management

• Physicians, nurses, and health care workers lack training
• Lack of pain medications
• Widespread misunderstanding of pain medications. Health professional, policy makers, patients, families - are afraid of addiction to pain medications.
**Mild Pain**

- Analgesics (Non-opioid)
  - Acetaminophen (Tylenol)
  - Paracetamol
  - Ibuprofen
- Helper Drugs for Neuropathic & Bone Pain
  - Amitriptyline
  - Ibuprofen

**Moderate Pain**

- Analgesics (Non-opioid)
  - Paracetemol; Ibuprofen
  - Weak Opioid
    - Codeine phosphate
    - Dihydrocodeine
- Helper Drugs for Neuropathic & Bone Pain
  - Amitriptyline
  - Ibuprofen

**Severe Pain**

- Strong Opioid
  - Morphine


**Faces Pain Rating Scale**

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NO HURT</strong></td>
<td><strong>HURTS LITTLE BIT</strong></td>
<td><strong>HURTS LITTLE MORE</strong></td>
<td><strong>HURTS EVEN MORE</strong></td>
<td><strong>HURTS WHOLE LOT</strong></td>
<td><strong>HURTS WORST</strong></td>
</tr>
</tbody>
</table>

**Evaluation Tools**

- Edmonton Symptom Assessment Scale
- Pain Faces Scale
- Palliative Performance Scale
- Depression Scales
- Quality of Life Scales
Common Emotional and Spiritual Issues

• Depression
• Anger
• Anxiety and Fear
• Guilt

Social Issues

• Family Stress
• Stigma and Avoidance
• Economic Strain
• Sexuality (esp. with cervical cancer)

Support Strategies

• Help sick people stay active and involved
• Acknowledge stress and strain on person and loved ones
• Offer support through faith community
• Caring for caregivers and health workers (e.g. respite)
• Medications for depression

Physical Signs and Symptoms

• Dehydration
  – Nausea and Vomiting
  – Diarrhea
  – Fever
• Constipation
• Appetite Loss and Wasting

Physical Signs and Symptoms (con’t)

• Weakness and Fatigue
• Leg Swelling
• Bed Sores
• Cough or Breathing Difficulties

Treatment of Symptoms

• Medications
• Food
  – Special foods (high energy, body builder, protective, for specific illness)
  – Cooking tips
• Traditional therapies
Cultural Issues in EOL Care

- Talking About or Planning for Death
- Filial Piety
- Collectivism vs Individuality
- Burdening Others
- Experience with and Respect for Healthcare
- Views of the Body


What is needed for good palliative care?

1. **Government Policy** to ensure integration into the structure and financing of the health system.
2. **Education Policy** to train health care professionals, volunteers, and the general public.
3. **Drug Policy** to ensure availability of essential drugs to pain and symptom management
4. **Committed Leadership**

From the Assets mapping:

- Medical
- Psychosocial
- Spiritual

What is the quality of services?
How are they evaluated?

Core Standards for Palliative Care

- Provide palliative care including pain relief with emphasis on home-based care, following national minimum standards.
- Ensure legislation allows access to oral morphine and other affordable essential medicines (WHO list)

Core Standards for Palliative Care (con't)

- Develop a reference center that can provide in-service training to community health-caregivers

Expanded Standards

- Provide palliative care at all levels of care with emphasis on primary health-care clinics and home-based care, following national protocols.
- Ensure availability of essential medications in both rural and urban centers
**Expanded Standards (con’t)**

- Develop reference centers that can provide undergraduate and postgraduate training
- Develop curricula in nursing and medical schools to teach palliative care both at the undergraduate and graduate levels

**Desirable Standards**

- Reinforce the network of palliative care services integrated with cancer care and other related services
- Provide support to national and international reference centers for palliative care
DIAGNOSIS & TREATMENT FOR CERVICAL CANCER
Kathleen Benjamin RN, MPH

CERVICAL CA DIAGNOSIS
- PAP SMEAR-(PH, GENESIS) see pg7 of 15
  - Class I, II, III, & IV
- VIA - ??
- COLPOSCOPY/Biopsy
- OTHER SIGN & SYMPTOMS (More in the advance stage of Cx CA)
  - Heavy Bleeding
  - Foul smelling Discharge
  - Pain

CERVICAL CANCER TREATMENT
- CONIZATION, ELECTROCAUTERY (see pg.10 of 15)
- HYSTERECTOMY
- SEND OFF ISLAND FOR HYSTERECTOMY, RADIATION & CHEMOTHERAPY
- PAIN MEDICATION:
  - Acetaminophen, Ibuprofen & paracetamol
  - TYLENOL WITH CODEINE
  - DEMEROL INJECTION/TABLET
  - MORPHINE INJECTION/SUSPENSION

PALLIATIVE CARE
- IN HOSPITAL:
  - Give Pain Medication as needed
  - Give TLC & Support patient & family members
  - Educate family care giver & Nurses
  - Give spiritual support, etc.
  - Local Healers

PALLIATIVE CARE @ HOME
- CLOSE ATTENTION- (by family members) & TLC
- PAIN MEDICATIONS:
  - TYLENOL
  - IBUPROFEN
  - TYLENOL W/CODEINE
  - DEMEROL OR MORPHINE-be given by an health person or trained person
- LOCAL HEALERS-
- CHURCH COMMUNITIES- Spiritual support
Workshop to develop National Breast & Cervical Cancer Client Management Guidelines

Post-workshop Tasks and Next Steps for Yap Comprehensive Cancer Control Program

<table>
<thead>
<tr>
<th>ACTIVITY(S)</th>
<th>TIMELINE</th>
<th>PERSON(S) RESPONSIBLE</th>
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<tbody>
<tr>
<td>Return to YAP</td>
<td>Sep 4</td>
<td>Workshop participants - CCC Coordinator &amp; Outer Islands</td>
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<tr>
<td></td>
<td></td>
<td>Health Assistant</td>
</tr>
<tr>
<td>Present at PH Meeting (Draft)</td>
<td>Sep 5</td>
<td>None indicated, but assume CCC Coordinator and Coalition</td>
</tr>
<tr>
<td></td>
<td></td>
<td>leadership</td>
</tr>
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<td>CHC Supervisory Meeting</td>
<td>Sept 16</td>
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<tr>
<td>Present to CA Coalition</td>
<td>Sept 17</td>
<td></td>
</tr>
<tr>
<td>Present to Doctors</td>
<td>Sept 19</td>
<td></td>
</tr>
<tr>
<td>Present to Director – DHS (Chiefs Meeting)</td>
<td>Sept 22</td>
<td></td>
</tr>
<tr>
<td>F/up – Final version after FSM Directors Meeting</td>
<td>October</td>
<td></td>
</tr>
<tr>
<td>Community Awareness</td>
<td>Nov on</td>
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<tr>
<td>YMI + YOI</td>
<td>Six months</td>
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<td>- Disp</td>
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<td>- CHC</td>
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<td>- COT/COP</td>
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<td>- DOE</td>
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<td>- YMA</td>
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<td>- YWA</td>
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<td>- YSL</td>
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Workshop to develop National Breast & Cervical Cancer Client Management Guidelines

Post-workshop Tasks and Next Steps for Pohnpei Comprehensive Cancer Control Program

<table>
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<th>ACTIVITY(S)</th>
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<th>PERSON(S) RESPONSIBLE</th>
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</thead>
<tbody>
<tr>
<td>Meet &amp; get approval from Director &amp; appropriate others</td>
<td>Next week (by Sep 10)</td>
<td>Cancer Coordinator, Chief of Medical Serv., Chief Nurse, Elizabeth, MCH Nurse, Women’s Council, National Tobacco Coalition</td>
</tr>
<tr>
<td>CME training on CMG Draft</td>
<td>By the end of Sep 2008 by the approval of Sec. Skilling National Govt through Director PM State</td>
<td>Dept of Health Dr. Hedson / Xner / Kathy Benjamin</td>
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<tr>
<td>Coalition Meeting</td>
<td>By October 2008</td>
<td>CCC Program Staff</td>
</tr>
<tr>
<td>Motivational Training (Train the Trainer) (Prevention Behavior)</td>
<td>Sep 8-10</td>
<td>Dept of Health &amp; Social Affairs</td>
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</table>
Workshop to develop National Breast & Cervical Cancer Client Management Guidelines

**Post-workshop Tasks and Next Steps for Kosrae Comprehensive Cancer Control Program**

<table>
<thead>
<tr>
<th>ACTIVITY(S)</th>
<th>TIMELINE</th>
<th>PERSON(S) RESPONSIBLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Provide Report &amp; Draft CMG to Director of Health</td>
<td>By Sep 12, 2008</td>
<td>Workshop Participants</td>
</tr>
<tr>
<td>2. Develop Informational Package on Draft CMG and Distribute to KCCCP members</td>
<td>By Sep 12, 2008</td>
<td>CCC Coordinator &amp; Admin. Prevention staff</td>
</tr>
<tr>
<td>3. Review and Develop State Guidelines Based on National Standards</td>
<td>By Sep 24, 2008</td>
<td>CCC Coordinator</td>
</tr>
<tr>
<td>4. Continue Development of Guidelines Plan of Action</td>
<td>TBD</td>
<td>CCC Coalition</td>
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Workshop to develop National Breast & Cervical Cancer Client Management Guidelines

Post-workshop Tasks and Next Steps for Chuuk Comprehensive Cancer Control Program

<table>
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<tr>
<th>ACTIVITY</th>
<th>TIMELINE</th>
<th>PERSON RESPONSIBLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Report on CMG to DHS, HS key staff, Gov office, Legislature, CWAC President</td>
<td>9/12/08</td>
<td>CMG Participants</td>
</tr>
<tr>
<td>2. Identification of CMG Members</td>
<td>9/12/08</td>
<td>CCC Coordinator Approved by DHS/Gov.</td>
</tr>
<tr>
<td>3. CMG Education to Health Personnel (three sessions)</td>
<td>By 12/08</td>
<td>CMG Group/Members</td>
</tr>
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Appendix 22

National Workshop to develop

FSM Breast and Cervical Cancer Client Management Guidelines for Prevention, Early Detection, Diagnosis, Treatment, and Care

29 Aug – 2 Sept, 2008 in Pohnpei, Federated States of Micronesia

With technical assistance from Pacific CEED and NCI’s CIS-Pacific Region

Workshop Evaluation

Workshop Objectives:

1. To discuss and agree upon minimum standards of practice.
2. To identify strategies, roles and resources needed to put the minimum standards into practice.
3. To draft the National FSM Client Management Guidelines for integrating the continuum of breast and cervical cancer prevention, early detection, diagnosis, treatment, and care.
4. To outline ‘next steps’ to secure institutional support at national and State levels, to finalize the draft guidelines, and to adopt and adapt the guidelines at the State level.

Please CIRCLE your level of agreement with the following statements.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The workshop objectives were met</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>To discuss and agree upon minimum standards of practice.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>To identify strategies, roles &amp; resources needed to put the minimum standards into practice.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>To draft the National FSM Client Management Guidelines for integrating the continuum of breast and cervical cancer prevention, early detection, diagnosis, treatment, and care.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>To outline ‘next steps’ to secure institutional support at national and State levels, to finalize the draft guidelines, and to adopt and adapt the guidelines at the State level.</td>
<td>1 2 3 4 5</td>
<td></td>
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Additional Comments:
Please CIRCLE your level of agreement with the following statements.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Strongly Disagree</th>
</tr>
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<tbody>
<tr>
<td>2. The presentations were useful</td>
<td>1  2  3  4  5</td>
<td></td>
</tr>
<tr>
<td>3. The agreed standards will help us meet our Comprehensive Cancer Control goals</td>
<td>1  2  3  4  5</td>
<td></td>
</tr>
<tr>
<td>4. The group process for discussing and reaching agreement was useful</td>
<td>1  2  3  4  5</td>
<td></td>
</tr>
</tbody>
</table>

5. Please list at least two things you learned from the workshop that will be most valuable when you go back home to address breast and cervical cancer prevention and control in your State/National.

6. Please tell us how this workshop could be improved and any other comments?

7. During the workshop we listed training needs on the “Parking Lot”. Please indicate your top FOUR training priorities for the upcoming Year.

- Ultrasound training
- Client Breast Examination training for health professionals
- VIA training for health professionals, birth attendants, midwives, MCH/FP, health assistants, doctors, nurses (Circle which health worker group for your state)
- Core Biopsy training
- Training on treating with cryotherapy
- Training on how to conduct Focus Group Discussions
- Cancer 101 for health workers and public health practitioners
- Training for nurses on how to continue care for patients having chemotherapy off island
- Training on CLEAR promotion of HPV vaccine
- Training for colposcopy
- Training in Pain Management for clinicians
- Palliative Care training, including the Complete Life Course

8. Any other comments?

THANK YOU for your feedback
National Workshop to develop
FSM Breast and Cervical Cancer Client Management Guidelines for Prevention,
Early Detection, Diagnosis, Treatment, and Care
29 Aug – 2 Sept, 2008 in Pohnpei, Federated States of Micronesia

Workshop Evaluation Results

Please CIRCLE your level of agreement with the following statements.

1. The workshop objectives were met

<table>
<thead>
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<th>Objective</th>
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<th>3</th>
<th>4</th>
<th>Strongly Disagree 5</th>
<th>No Answer</th>
<th># who Agree or SA</th>
<th>% who Agree or SA</th>
</tr>
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<tbody>
<tr>
<td>To discuss and agree upon minimum standards of practice.</td>
<td>11</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>15/17</td>
<td>93%</td>
</tr>
<tr>
<td>To identify strategies, roles &amp; resources needed to put the minimum standards into practice.</td>
<td>8</td>
<td>6</td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
<td>14/17</td>
<td>82%</td>
</tr>
<tr>
<td>To draft the National FSM Client Management Guidelines for integrating the continuum of breast and cervical cancer prevention, early detection, diagnosis, treatment, and care.</td>
<td>9</td>
<td>5</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td>14/17</td>
<td>82%</td>
</tr>
<tr>
<td>To outline ‘next steps’ to secure institutional support at national and State levels, to finalize the draft guidelines, and to adopt and adapt the guidelines at the State level.</td>
<td>7</td>
<td>6</td>
<td>4</td>
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<td>13/17</td>
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Please CIRCLE your level of agreement with the following statements.

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<th>4</th>
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<th># who Agree or SA</th>
<th>% who Agree or SA</th>
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<tbody>
<tr>
<td>2. The presentations were useful</td>
<td>12</td>
<td>4</td>
<td>1</td>
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<td></td>
<td></td>
<td>16/17</td>
<td>94%</td>
</tr>
<tr>
<td>3. The agreed standards will help us meet our Comprehensive Cancer Control goals</td>
<td>11</td>
<td>5</td>
<td>1</td>
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<td></td>
<td>16/17</td>
<td>94%</td>
</tr>
<tr>
<td>4. The group process for discussing and reaching agreement was useful</td>
<td>11</td>
<td>4</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td>15/17</td>
<td>93%</td>
</tr>
</tbody>
</table>
5. Please list at least two things you learned from the workshop that will be most valuable when you go back home to address breast and cervical cancer prevention and control in your State/National.

Numerous Mentions
- VIA
- Assets Mapping

Others
- Early detection and prevention;
- Standards help to come up with relevant trainings for capacity building and enhance scope of work
- Cervical cancer can be cure if detected early
- To learn how to examine themselves
- Think Resource Availability – Care, Expected, Desirable. We have a lot in common!
- Information on Breast & Cervical Cancer Prevention
- Strategies for low-income countries

6. Please tell us how this workshop could be improved and any other comments?
- Prepare ahead of time; not to rush things
- Role of chairs, documenter and notes to be enforced.
- No weekend workshop
- More pre-work/structured discussion
- More days; More involved people (clinical setting)
- This workshop can be really improved by extended the period of workshop instead of 4 days, making a week (7 days).
- Pick or identify right people who will participate from each State. Those that will make a difference when they go back; Travel arrangements and lodging.
- It will really increase the coverage of patients we service in cancer of cervix and breast.
- Be more prepared with the same understanding by consultants; (2) Send more preparatory work/info to participants beforehand to be more prepared for the workshop.
- Include other partners – i.e., immunization program to share ideas
- Needs a follow up

7. During the workshop we listed training needs on the “Parking Lot”. Please indicate your top FOUR training priorities for the upcoming Year.

- __5__ Ultrasound training
- __8__ Client Breast Examination training for health professionals
- __15__ VIA training for health professionals, birth attendants, midwives, MCH/FP, health assistants, doctors, nurses (Circle which health worker group for your state)
- __5__ Core Biopsy training
- __4__ Training on treating with cryotherapy
<table>
<thead>
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<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>12</td>
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</tbody>
</table>

Any other comments?

- The food provided is not good.
- Snack or refreshments and lunch should include more local food and local drinks (coconut). Conference venue can be better than where it is.
- The food can be a lot better. Please strive to better the food. Thanks.
- Let’s be mindful of what we serve refreshments…let’s “walk the talk.”
- Teach your male partner how to do the BSE. You will have your exam every day. Ha ha.
- You were all great and thank you for all the preparation and facilitating efforts. Need you to continue working with us here.
- Great job!
- I feel I learn a lot from the workshop and I thank you very much for your time and effort. We would like to have you back whenever time permits.
- Workshop could be longer.
- Administrative works not done – e.g., TA and per diem not given until the workshop over.
Report and Overall Recommendations to PIO  3-September-08

Regarding: The workshop to develop National Client Management Guidelines to integrate breast and cervical cancer prevention, early detection, diagnosis, treatment and care

Dates: held in Pohnpei from 29 August – 2 September 2008

Sponsors: National and State Comprehensive Cancer Control Programs

Technical Support: Pacific Center of Excellence in the Elimination of Disparities (Pacific CEED) in partnership with the Cancer Information Service-Pacific Region, University of Hawaii Karen Heckert, PhD, MPH, MSW, Doris Segal-Matsunaga, MPH, Jeannette Koijane, MPH

Financial Support: US Centers for Disease Control, the REACH US program

Local resource persons: Dr Johnny Hedson, Chief, Division of Medical Services & Surgeon, Mrs. Kathy Benjamin, Chief Nurse, Mrs. Carmen Jim, MCH Director, Pohnpei State Health Services

Regional Partners: Secretariat for the Pacific Community
Dr Viliami Puloka, NCD Advisor and Karen Fukofuka, Nutrition Advisor

Participants: National and State Comprehensive Cancer Control Coordinators
Amato Elymore-National, Dr Kino Ruben-Chuuk, Nena Tolenoa-Kosrae, Xner Luther-Pohnpei, Martina Reichhardt-Yap
Teams of 3-4 participants from National and each State, including CCC Coalition members, cancer survivors, nurses, immunization, womens’ groups, community leaders

Purpose of the workshop:
To develop National Breast and Cervical Cancer Client Management Guidelines by; reviewing US and international evidence and agreeing on resource-appropriate standards for FSM across the cancer prevention-care continuum because;

- We must increase and sustain the practice of health promoting behaviors to reduce cancer incidence.
- We must increase the uptake of early detection behaviors and services to diagnose cancer early.
- We must increase access and uptake to treatment and palliative care to improve the quality of life for people living with cancer.

To address the two cross-cutting strategies in the FSM Comprehensive Cancer Control Plan;
1) To promote and advocate for community and political support in partnership with health providers to combat cancer in the FSM, and
2) To engage technical assistance at all levels that assures efficacy in the prevention, control, identification, care and treatment of cancer and cancer related disease.

Workshop Objectives:

1. To discuss and agree upon minimum standards of practice.
2. To identify strategies, roles and resources needed to put the minimum standards into practice.
3. To draft the National FSM Client Management Guidelines for integrating the continuum of breast and cervical cancer prevention, early detection, diagnosis, treatment, and care.
4. To outline ‘next steps’ to secure institutional support at national and State levels, to finalize the draft guidelines and to adopt and adapt the guidelines at the State level.

Workshop Recommendations:

Recommendations from the Workshop on the National & State Non-communicable Diseases Strategy & State Plans (25-28 August) with endorsement from national and state participants in BOTH the NCD workshop and the National Client Management Guidelines Workshop (29 Aug – 2 Sept)

- Recommend that the states make the necessary organizational restructuring changes to prepare for the upcoming changes in CDC funding whereby tobacco, diabetes, other chronic diseases and cancer will become an integrated program under the new Pacific Basin Integration Project.
- Recommend that FSM adopt a comprehensive approach with multi-sectoral representation in a single overarching NCD committee to address multiple risk factors for non-communicable diseases. (Note: The Comprehensive Cancer Control Coalitions and Coordinators could potentially take the lead.)
- Recommend that cancer-related objectives and a summary of the National Comprehensive Cancer Plan 2007-2012 be explicitly incorporated into the National and State SDP updates in 2009.
- Recommend that WHO and SPC negotiate a Memorandum of Agreement with US-CDC to become partners in implementing the Joint Regional 2-1-22 Pacific NCD Programme 2008 - 2011.

Recommendations from the Workshop to develop National Client Management Guidelines for Breast & Cervical Cancer prevention & early detection, diagnosis & treatment, and survivorship & palliative care (29 Aug – 2 Sept)

- Recommend that FSM Department of Health and Social Affairs and the State Departments of Health Services approve the standards agreed by consensus during the workshop. (Summary of highlights from the agreed standards are listed below.)
- Recommend that the States and National finalize their HPV vaccine implementation plans by the end of September and that:
  - CCC Coalitions & Coordinators work with Immunization Partners to finalize.
  - CCC Coordinators submit implementation plans to Amato/Secretary Skilling.
  - Immunization submit implementation plans to Mrs. Louisa, National Immunizations Program
- Recommend that CCC Coordinators present the DRAFT standards to their respective Directors of Health for review and approval.
- Recommend that the FINAL standards be presented by the Secretary for Health to the Directors of Health for final approval at their October meeting.
- Recommend that the FSM National Client Management Guidelines to integrate breast & cervical cancer prevention, early detection, diagnosis, treatment and care contain the following components:
  - Standards tables – Core, Expanded, Desirable
  - Putting standards into practice; how & where & who & linkages
  - US & International sources of evidence for resource-appropriate standards of practice
  - Assets Mapping results for each State and National
  - Evaluation – performance measures for monitoring & evaluating quality practice
- Recommend that the National and State Comprehensive Cancer Control programs obtain the following training to help put the standards into practice.
  - Ultrasound training & Client Breast Examination training for health professionals
  - Core Biopsy training
VIA training for health professionals, birth attendants, midwives, MCH/FP, health assistants, doctors, nurses (according to State preferences) and training on the treatment of precancerous cells using cryotherapy
- Training on appropriate HPV vaccine community preparedness and promotion
- Colposcopy training
- Training on how to conduct Focus Group Discussions
- Cancer 101 for health workers and public health practitioners
- Training for nurses providing continuing care for patients treated off island
- Pain Management for clinicians (and families) and Palliative Care training, including the Complete Life Course for carers, religious leaders, health providers
- Training for doctors & nurses in how to care humanely for people living with cancer (e.g. doctor-patient relationships)
- Training for family members of dying patients, e.g. basic nursing activities such as bed-changing, aseptic techniques, basic hygiene, healthy food and good nutrition

Summary of Core & Expanded standards agreed by workshop participants; Standards for breast & cervical cancer prevention & early detection, diagnosis & treatment, and survivorship & palliative care

- **Breast cancer prevention & early detection, diagnosis & treatment**
  - Primary prevention – CORE - insert FCTC standards & guidelines, strengthen focus on healthy diet & physical activity
  - Early detection – CORE & EXPANDED includes: 1) monthly SBE from age 20, 2) CBE age 20-29 every 3 years. 3) CBE yearly from age 30+, and 4) Diagnostic ultrasound (NOTE: focus on both client & provider-oriented interventions)
  - Diagnosis & treatment – Dr Johnny Hedson will consult with clinical colleagues to finalize.
- **Cervical cancer prevention & early detection, diagnosis & treatment**
  - Primary & secondary prevention - CORE includes: 1) STI awareness & education, 2) sexual health education, 3) HPV vaccine for females before sexual debut, primary ages 9-12, EXPANDED includes: 1) catch-up group age 13-26
  - Early detection – CORE includes: 1) screen with VIA (visual inspection), 2) opportunistic pap smears, 3) screen all women in 30s and 40s at least once before expanding, EXPANDED includes: 1) provide VIA - screen & treat pre-cancerous lesions
  - Diagnosis - CORE includes; 1) screen using VIA, 2) pap smear after VIA detection of pre-cancerous
  - Treatment – Dr Johnny Hedson will consult with clinical colleagues and finalize.
- **Palliative Care**
  - Core – 1) Provide palliative care at all levels of care with emphasis on primary health-care clinics and home-based care, following national protocols, 2) Ensure legislation allows access to oral morphine and other affordable essential medicines (WHO List), 3) Ensure availability of essential medications to all patients/clients, and 4) Develop a reference group that will collect best practices and information, support people and the community, provide training, and be inside the Comprehensive Cancer Coalition.
  - Expanded – 1) Establish a cancer resource center: A meeting place providing resources and training to the community, and 2) Reinforce the network of palliative care services integrated with cancer care and other related services.

**PUTTING Standards into Practice**

- Breast & Cervical Cancer Early Detection – one worksheet produced by group. The other worksheets for putting standards into practice will be developed for all standards and will be included in the full National Client Management Guidelines.