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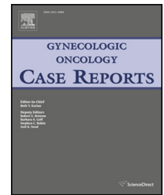

Survey article

Cervical cancer prevention training in South East Asian LMICs

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ABSTRACT

The Association of Southeast Asian Nations (ASEAN) is a confederation of 10 sovereign states occupying approximately 1.7 million square miles of Southeast Asia with an estimated population of just under 630 million. Southeast Asia continues to have one of the world's highest rates of cervical cancer-related death.

Organised training in cervical cancer screening is essential but lacking in low to middle income countries (LMICs). Systematic training of local doctors is an essential part of an effective screening program and an effective strategy to reduce cervical cancer-related mortality.

Singapore is a first-world economy with a healthcare system that can support this mode of training and is geographically proximate to Southeast Asian LMICs that need this training. This makes it possible for model of tiered training with trainers on site in the LMICs and more advanced training where trainees receive training in Singapore. We present a case study where this tiered system of training is applied to Cambodia and demonstrate that this model of training is not only effective but also sustainable.

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1. Introduction

The Association of Southeast Asian Nations (ASEAN) is a confederation of 10 sovereign states occupying approximately 1.7 million square miles of Southeast Asia with an estimated population of just under 630 million (https://www.usasean.org/why-asean/what-is-asean). While there are first world economies like Singapore that are part of this confederation, Southeast Asia continues to have one of the world's highest rates of cervical cancer-related death. Cambodia with a population of 16 million has a reported annual cervical cancer incidence of 27.4 per 100,000 and an annual cervical cancer mortality of 16.2 per 100,000. Myanmar with population of 54 million has a reported annual cervical cancer incidence of 26.4 per 100,000 and an annual cervical cancer mortality of 15 per 100,000. Lao People's Democratic Republic (PDR) has a population of 6.8 million and has a reported annual cervical cancer incidence of 22.1 per 100,000 and an annual cervical cancer mortality of 13.3 per 100,000 (http://globalcancermap.com). While many of these Southeast Asian countries still fall within the established economic definition of low-middle income countries (LMICs), they are also emerging economies which will likely see significant development in the coming decade with increased urbanization and more importantly increased government spending on infrastructure development (http://www.worldbank.org/en/region/eap/overview#1). The primary drivers of growth in these countries is relative political stability and governments that are committed to joining the global economy and therefore actively rolling back decades of isolationism (https://www.cia.gov/library/publications/the-world-factbook/geos/la.html; https://www.cia.gov/library/publications/the-world-factbook/geos/bm.html; https://www.cia.gov/library/publications/the-world-factbook/geos/vm.html). This presents a unique opportunity for women's healthcare to leap forward if infrastructural changes, training and NGO funding are introduced in a culturally-sensitive and politically-astute program of progressive engagement.

2. Objectives and the modus of knowledge transfer

The model which has been shown to be effective in Southeast Asia has been one based on the projection of expertise into the healthcare environment of target LMICs through the systematic and progressive education of primary general health care providers in the use of low-impact modalities such as cryotherapy, cold coagulation and visual inspection with acetic acid (VIA). VIA has been shown to be both clinically effective and acceptable to women in low-resource settings (Selmouni et al., 2015; Gessesse et al., 2015; Deksissa et al., 2015). The key to growing such programs successfully is early recognition that the rate at which information transfer occurs has to be actively modulated and even severely restricted in some cases to ensure that only very rudimentary steps are taken at first. For example, the use of VIA in see-and-treat versus traditional colposcopically-directed biopsy and histological diagnosis, where VIA requires less training, is more easily generalizable and results in better patient access. The principle of “some small steps are better than one big step followed by no steps” has worked well for us in Southeast Asia. Finally, cultural inertia is a real entity and should not be ignored by any program whose intent it is to effect durable change.

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3. Working with the governments of Southeast Asian LMICs

It is important to understand that the governmental structure, especially the civil service is a lot more stable and dictates infrastructure more durably than in the West. The civil service is often not as subject to the whims of an elected presidency or premiership and so has less volatility and less prone to change than an apparently democratically elected presidency or premiership. Changes to the infrastructure will take time, but when changed gradually are unlikely to be changeable. This suggests that forward planning and with a 5, 10 and 20 year plan in place that can be tweaked to accommodate changes in leadership temperament is often a good idea. It is also important in Southeast Asia to respect the concept of *guan xi* (Mandarin for relationship). This roughly translates into developing durable rapport with those in decision-making capacities, and given the relatively unchanging nature of leadership in many LMICs where cervical cancer prevention programs are most needed, this policy of aligning the program with the overall political objectives of leadership makes good sense.

Finally, as societies in Southeast Asian LMICs become more open, the improvement of the overall health of the citizenry also becomes potent political capital to policy and lawmakers. This vested interest should also be taken into account when building cervical cancer prevention programs.

A case report of colposcopy training in Cambodia follows to highlight some of the concepts and challenges outlined above in introducing cervical cancer prevention programs in Southeast Asian LMICs.

4. Formation of collaboration with Cambodia

The Division of Gynecologic Oncology, Department of Obstetrics and Gynecology of the National University Hospital (NUH) in Singapore (henceforth referred to as “the Division”) has an established track record of teaching and training in Singapore and the region in basic and advanced colposcopy and the treatment of preinvasive cervical disease. NUH is an ideal training site because of Singapore's strategic location and training facilities such as the Advanced Surgical Training Centre (ASTC) which is equipped with 6 fully-equipped operating bays able to support live animal lab work and a lecture hall equipped with 3D projection. The ASTC also features a full range of connectivity options to support video-conferencing and transmission and broadcasting.

The creation of the colposcopy training simulator platform through collaboration between the Gynaecology Oncology Division and the National University Hospital (NUS) School of Design, Division of Industrial Design has enhanced the quality of colposcopy training delivering realism and verisimilitude of the vaginal and cervical environment both in texture, space and usability with energy devices. The model is particularly useful as it is highly portable and has been used in off-site training in low resource settings with great success.

Through outreach efforts and in training doctors from neighboring low-middle income countries (LMICs), the Division has become aware of the urgent need for basic training in cervical cancer screening and prevention in Southeast Asia. Access to adequate training facilities, consistent instruction and resource-appropriate treatment and screening recommendations remain the primary challenges in getting more health care providers training in the early detection, screening and prevention of cervical cancer. The Division has consistently sponsored training for doctors from regional LMICs as part of a coordinated and long-term outreach initiative to improve women's healthcare in Southeast Asia. This sponsorship begins with travel, accommodations and registration to attend the annual colposcopy training program of the workshop at NUH. This has helped to establish useful connections with women's healthcare professionals and an ad hoc network in Southeast Asia.

Cambodia was one of the Southeast Asian LMICs identified for outreach with a suitable candidate “point person” for sponsorship. Dr. Sovannara Thay Nara was identified as the first Cambodian candidate to receive sponsorship. Dr. Thay is a women's healthcare physician who manages and runs 2 facilities in Cambodia involved in women healthcare; The Women's Health Clinic at Sihanouk Hospital Centre of HOPE (SHCH). Dr. Thay works very closely with the Ministry of Health (MOH) in Cambodia, especially in establishing a cervical cancer screening program in Cambodia. The Division provided sponsorship for Dr. Nara to attend the advanced colposcopy course and also hosted her for a week during which she was able to observe and make contact with the nursing and operations teams supporting cancer screening and colposcopy services at NUH and NCIS. This program was created to allow providers and administrators from LMICs an idea of how these services are organized and how patients access these services in a sustainable and reproducible fashion.

5. Establishing a tailored colposcopy program

Following her time with us in the Division, Dr. Thay reported back to the Ministry of Health (MOH) in Cambodia and secured funding for the first basic colposcopy course to be held in Cambodia at SHCH. The timing of this course was fortuitous and coincided with the Cambodian government's announcement of the establishment of a national cervical cancer screening program employing visual inspection with acetic acid (VIA) and treatment with cryotherapy. This announcement dovetailed perfectly with our plans to support cervical cancer prevention in Cambodia through training and education.

Following discussions between NUH and SHCH, the components of the first basic colposcopy program were formalized and included:

1. Training of doctors working in hospitals in Phnom Penh, non-governmental organizations (NGO) and Cambodian provinces.
2. Scheduled as a one-day program consisting of lectures and theory presentations in the morning session to be followed by a practical session in the afternoon. The workshop was ultimately carried out over two days to accommodate all the doctors due to overwhelming interest in the program.
3. Lectures on the use of the colposcope, basic cervical anatomy, colposcopic features and the diagnosis of preinvasive cervical disease, VIA and cryotherapy.
4. A hands-on practical session where participants were taken through the use of the colposcope and colposcopy, and treatment with cryotherapy and LEEP (loop electrosurgical excision procedure) using our simulated vaginal and cervical platform. The program is as seen in Table 1.

6. Implementation of Cambodia's basic colposcopy training workshop

The NUH team consisted of 4 members from the gynaecology oncology division:

- Dr. Ida Ismail-Pratt, Consultant gynaecologist and lead colposcopist, NUH
- Dr. Ng Kai Lyn, OBGyn Senior Resident, NUH
- Sister Joyce ER, Gyn Oncology Advanced Practice, NCIS
- Ms. Blyss Kwong, assistant manager and program co-coordinator, Division of Gyn Oncology, NUH.

The Cambodian team consisted of:

- Dr. Sovannara Thay, training program lead
- Mr. Souk Buoy, training program director and co-ordinator
- Dr. Manna, junior gynaecologist at SHCH
- Dr. Yuhin, research fellow in gynaecology in SHCH.

The workshop was planned for 40 doctors from SHCH, private and public hospitals in Phnom Penh, NGOs and the provinces. The plan included running the same workshop in 2 locations over 2 days:

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