

**Legislative Council Panel on Health Services
Cancer Strategy**

PURPOSE

This paper provides information on the current situation of cancer in Hong Kong together with the cancer strategy implemented by the Government covering prevention, treatment, surveillance and research.

BACKGROUND

Current Situation in Hong Kong

2. Cancer is a major public health issue in Hong Kong and the burden of cancer has been increasing in Hong Kong. In 2015, there were 30 318 newly diagnosed cancer cases and the most common cancers were colorectal cancer (16.6%), lung cancer (15.7%), breast cancer (12.9%), prostate cancer (6.0%) and liver cancer (5.9%). In 2016, there were 14 209 cancer deaths and the leading five causes of cancer deaths were lung cancer (26.6%), colorectal cancer (14.7%), liver cancer (10.8%), stomach cancer (5.0%) and breast cancer (5.0%).

3. In view of a growing and ageing population, the number of new cancer cases and related healthcare burden are expected to continue to increase. Nonetheless, after removing the influence of age, the age-standardised incidence rates for all cancers were actually observed to be decreasing steadily during the period from 1983 to 2015 for males, while the similar falling trend in females in the early period from 1983 to 2005 has reverted to an upward trend after 2005. On the other hand, from 1981 to 2016, the overall age-standardised mortality rates for all cancers for both males and females gradually decreased after an initial steady state.

Cancer Coordinating Committee

4. The Government accords high importance to cancer prevention and control. As early as 2001, the Government established the Cancer Coordinating Committee (CCC). Chaired by the Secretary for Food and Health and comprising members who are cancer experts, academics, doctors in public and private sectors as well as public health professionals, the CCC formulates strategies on cancer prevention and control and steers the direction of work covering prevention and screening, surveillance, research and treatment.

5. The Cancer Expert Working Group on Cancer Prevention and Screening (CEWG) set up under the CCC (**Annex A**) regularly reviews international and local evidence and makes recommendations on cancer prevention and screening applicable to the local setting. In 2016, the CEWG updated the recommendations on screening of seven major cancers in Hong Kong (**Annex B**)¹.

6. In addition to CEWG, the structure of the CCC also comprises the Hong Kong Cancer Registry, Hospital Authority (HA) and Research Office of the Food and Health Bureau (RO) which oversees cancer surveillance, cancer treatment and cancer research respectively, and which directly report to the CCC.

PREVENTION AND CONTROL

Primary Prevention of Cancer

7. Risk factors for cancers are closely related to lifestyles. Currently, about 30% - 50% of cancers can be prevented by avoiding or modifying risk factors and implementing existing evidence-based prevention strategies. An individual's risk of developing cancer can substantially be reduced through adoption of healthy lifestyles, such as avoiding smoking and alcohol consumption, having regular exercise, and eating less meat and more vegetables. On the other hand, the risk of cancer increases with

¹ These recommendations are uploaded on the website of the Centre for Health Protection at <http://www.chp.gov.hk/en/content/9/25/31932.html>.

ageing. For some cancers, family history and genetic factors are associated with increased risk. Notwithstanding this, it is noteworthy that having a family history of cancer or carrying deleterious gene mutations does not mean that a person will definitely get cancer. In fact, hereditary cancers are much less common than cancers caused by smoking or other causes.

8. All along, the Government has promoted primary cancer prevention through various health promotion, education and protection efforts in collaboration with community partners, so as to reduce the burden of cancer. Some examples are summarised at **Annex C**. The Government has been deploying a range of communication channels to convey health messages to the public and has been in liaison with community partners, women groups and non-governmental organizations for promotion of cancer prevention.

Principles of Screening

9. Other than primary prevention, screening as a tool for secondary prevention is effective against some cancers such as cervical cancer and colorectal cancer. Cancer screening aims to detect early cancers or to identify precancerous disease in apparently healthy (asymptomatic) individuals, so that treatment can be carried out more effectively.

10. The list of criteria as promulgated by World Health Organization for instituting a screening programme is set out at **Annex D**. Based on these considerations, only a few evidence-based screening methods justify their use on a population scale screening programme. Furthermore, all screening tests have their limitations as they are not 100% accurate. There are false positive and false negative results, possibility of over-diagnosis and over-treatment. Individuals considering cancer screening tests (including commercially available screening tests) should seek advice from doctors for assessment of need and obtain full information on the potential benefits and harms of having the test before making an informed decision.

11. From the public health perspective, the Government must carefully assess a number of factors when considering whether to introduce a population-based screening programme for a specific cancer, such as local prevalence of the cancer, accuracy and safety of the screening tests,

effectiveness in reducing incidence and mortality rates, feasibility of implementation of a screening programme, the capacity of the healthcare system with respect to resources, manpower and infrastructure, and public acceptance. The overriding concern is whether screening does more good than harm to society. Over the years, the Government has launched three territory-wide screening programmes including the Cervical Screening Programme (CSP); the Community Care Fund Pilot Scheme on Subsidised Cervical Cancer Screening and Preventive Education for Eligible Low-income Women; and the Colorectal Cancer Screening Pilot Programme (**Annex E**). We will keep in review of the effectiveness of these screening programmes

TREATMENT

Cancer Service in Public Hospitals

12. Cancer service provided by the HA is based on a coordinated cross-specialty (e.g. pathology, radiology, medicine, surgery, clinical oncology, palliative) and cross-disciplinary service system. The service is organised on cluster basis. HA currently operates six cluster-based oncology centres² and each centre is networked with other hospitals and clinics within the cluster to provide cancer care through in-patient, day-patient, out-patient and outreach home care; from diagnosis to treatment, rehabilitation, palliation and end-of-life care. HA also networks with non-government organisations in providing psychosocial support to cancer patients and their families at the community level.

13. With the increase in new cases every year and the advance in technology, the demand on cancer services from diagnosis, imaging to therapeutic treatment like surgery, radiotherapy and chemotherapy is expected to increase progressively.

14. HA places high importance in providing optimal care for cancer patients. HA reviews on a regular basis the waiting time for patients with

² The six oncology centres are located in Pamela Youde Nethersole Eastern Hospital, Queen Mary Hospital, Queen Elizabeth Hospital, Princess Margaret Hospital, Prince of Wales Hospital and Tuen Mun Hospital.

colorectal cancer, breast cancer and nasopharyngeal cancer to receive their first treatment after diagnosis. During the period between July 2016 and June 2017, the waiting time at the 90th percentile³ for patients with colorectal cancer, breast cancer and nasopharyngeal cancer to receive their first treatment after diagnosis were 80 days, 65.5 days and 54 days respectively. The waiting time at 90th percentile of patients receiving radical radiotherapy⁴ was 28 days in 2016-17, which was stable in the past two years.

15. HA has gradually increased the service capacity along cancer patient journey. For pathology, the capacity of molecular diagnostic services was gradually expanded to improve the access to these tests, for example, by blood, lung, breast, colorectal and gastric cancer patients, in the past few years. In view of the increasing demand on staging imaging for confirmed cancer cases, HA has implemented the “Project on Enhancing Radiological Investigation Services through Collaboration with the Private Sector” (Radi Collaboration) since May 2012 to provide computed tomography (CT) and magnetic resonance imaging (MRI) examinations for selected cancer patients fulfilling pre-defined clinical criteria. The target patient groups of the project have been expanded over the years to benefit patients of more cancer types. HA has also improved its service capacity through installing additional CT and MRI machines in the past few years while two positron emission tomography machines were installed to provide services for patients in need. The overall demand on surgery, chemotherapy and radiotherapy in HA is on the rise and HA has progressively increased the operating theatre sessions, chemotherapy clinic and extended service hours for radiotherapy in various clusters. In recent years, HA has also introduced oncology clinical pharmacy services with a view to enhancing the pharmaceutical care and ensuring the safety of chemotherapy for cancer patients.

16. To further enhance the service capacity, HA will -

(i) continue to increase the operation theatre sessions to augment the

³ The 90th percentile waiting time refers to the number of days between the date when a case is diagnosed with cancer after pathological examination and the date when the patient receives the first treatment. The waiting time of 90 per cent of such cases is shorter than the value indicated.

⁴ The 90th percentile waiting time for cancer patients wait for the first attendance of RT treatment from booking or when patient is ready to treat.

capacity for cancer operations by building up facilities and increase in manpower;

- (ii) commission the seventh oncology centre in United Christian Hospital upon completion of its redevelopment which is scheduled for 2023 to meet the local needs in Kowloon East; and
- (iii) augment radiotherapy and chemotherapy service capacity.

Drug Treatments

17. Under the HA Drug Formulary, cancer drugs are categorised into General Drugs, Special Drugs and Self-Financed Items (SFI) with or without safety net coverage by the Samaritan Fund or Community Care Fund (CCF). The HA has been widening its Drug Formulary to currently cover 44 cancer drugs for treatment of 24 types of cancers. Moreover, HA regularly reviews its Drug Formulary to include new cancer drugs or reposition existing drugs into a different category. For example, the use of Imatinib in Chronic Myeloid Leukaemia (CML) and Acute Lymphoblastic Leukaemia (ALL) was repositioned from SFI with safety net to Special Drug in 2017-18. Currently, the cancer drugs available in the HA Drug Formulary are comparable with those of reference countries, such as England, Scotland and Australia, except the newest drugs which have yet to demonstrate their efficacy and cost-effectiveness.

18. For self-financed drugs that are proven to be of significant benefits to patients but too expensive for HA to provide as part of its subsidised services, HA provides financial assistance for needy patients through the safety net of Samaritan Fund. Currently, the Samaritan Fund covers 29 self-financed drugs for treating different types of diseases (including different types of cancer) and the amount of drug subsidies granted under the Samaritan Fund has increased from \$174.9 million in 2011-12 to \$332.4 million in 2016-17.

19. In addition to the Samaritan Fund safety net, HA launched the First Phase of the Community Care Fund Medical Assistance Programme (First Phase Programme) on 1 August 2011 to provide financial assistance to

HA patients to purchase specified self-financed cancer drugs which have been rapidly accumulating medical scientific evidence and with relatively higher efficacy but have not yet fulfilled the criteria for inclusion into the safety net of Samaritan Fund. Currently, the First Phase Programme covers 16 self-financed drugs for treating 14 types of cancer. The amount of subsidies granted under the First Phase Programme has increased from \$10.3 million in 2011-12 to \$160.4 million in 2016-17. As at 31 December 2017, around 9 050 cases with subsidy amount of around \$636.38 million were approved under the First Phase Programme.

20. HA welcomes every opportunity to collaborate with drug companies in providing affordable, sustainable and appropriate support for patients and would continue to ensure equitable access to cost-effective drugs of proven efficacy and safety in HA hospital and clinics.

Support to Cancer Patients and Their Carers

21. HA has implemented the cancer case manager programme in phases since 2010-11 for patients with complex breast cancer or colorectal cancer. Under the programme, the cancer case managers act as the single contact persons between these patients and the doctors. The programme was extended to all the clusters in 2014-15. In 2016, the HA conducted a patient satisfaction survey on the cancer manager programme, the results of which showed that patients were satisfied with the programme. Another survey on the quality of life conducted at the same time also showed that patients covered by the programme were satisfied with their quality of life.

22. HA has partnered with the Hong Kong Cancer Fund to establish Cancer Patient Resource Centres (CPRCs) in the six oncology centres and United Christian Hospital. The CPRCs provide free resources and services for cancer patients, including a cancer information library, professional counselling services, rehabilitation workshops, peer support activities, services which seek to provide information and assistance to newly-diagnosed patients, as well as rehabilitation or palliative support for those who are going through other stages of the cancer journey. Some activities organised by the CPRCs are funded by the Hong Kong Cancer Fund.

SURVEILLANCE

23. The Hong Kong Cancer Registry (HKCaR) was established in 1963 as a population-based cancer registry and is a member of the International Association of Cancer Registries (IACR). Its main mission is to collect and report the local cancer incidence and mortality rates, by collecting, consolidating and validating basic demographic data, information on the topography and histology of all cancers diagnosed in Hong Kong. In addition, collection of information on staging, initial treatment and survival data has commenced for specific cancers in recent years. Analyses of these information demonstrate variations in cancer pattern in Hong Kong over time, and thus provides a basis for comparative geographical, epidemiological and clinical research.

24. It is noteworthy that the completeness of cancer registration by the HKCaR is reckoned to be 97% or higher though the notification from medical practitioners is not mandatory. It is important to facilitate the HKCaR's continuous efforts to strive for improvement in efficiency and accuracy in the data collection. This can be achieved by better integration of the HKCaR's database with the information systems of hospitals and laboratories in both public and private sectors, and by standardisation of the reporting format. Indeed, future success of local cancer surveillance counts on the continuous collaboration and support the HKCaR has been rendered by all healthcare professionals and medical institutions who collect information on cancer patients in Hong Kong in their clinical service.

RESEARCH

25. FHB provides financial support to research and development projects related to cancer through the Health and Medical Research Fund (HMRF). The HMRF has conducted five open calls for investigator-initiated applications since its establishment in 2011. In the first four open calls 149 projects related to cancer worth \$129.2 million were supported. The main types of cancer addressed by these projects include: liver (47/149), nasopharyngeal/oesophageal (24/149), breast (16/149), colorectal (13/149), lung (12/149), cervical/ovarian/other gynaecological

cancers (12/149). Other cancers addressed through HMRF-funded research include: leukaemia, prostate, stomach, brain, skin and pancreas. The funding process of the fifth open call is underway.

26. The HMRF has commissioned two Phase 1 Clinical Trials Centres with total funding of \$80 million for 5 years, providing infrastructure to support early phase clinical trials. Since January/February 2014, the two Centres have commenced trials on safety, pharmacology and efficacy of various treatments for a range of cancers including liver, lung, breast, colorectal, renal and other solid tumours.

27. Moreover, the HMRF has also supported three commissioned studies, namely the evaluation of the Government's CRC screening pilot programme; the risk of breast cancer in Hong Kong; and the cost-benefit analysis (CBA) for organising a population-based HPV vaccination.

28. The Health Care and Promotion Fund (HCPF) (subsequently incorporated into the HMRF from 2017/18 and renamed as Health Care and Promotion Scheme) has supported a wide range of community-based projects in relation to cancer. Many of these projects relate to identification, understanding and self-management of modifiable health behaviours that may influence development of cancer including smoking, drinking alcohol, low physical activity, unhealthy diet and high-risk sexual activity. Since 2012, the HCPF has supported 51 projects in these areas worth \$14.3 million. The funding process of the latest open call is underway.

WAY FORWARD

29. Going forward, the Government will continue to implement various measures as listed above. In particular, CEWG will keep in view latest evidence, especially the findings of the research studies under HMRF, and regularly review local recommendations.

30. Moreover, HA is developing a Strategic Service Framework for Cancer Service. It aims to identify areas for improvement, guide the development of service model and system infrastructure for cancer services in HA over the next five to ten years. The framework is targeted at cancer

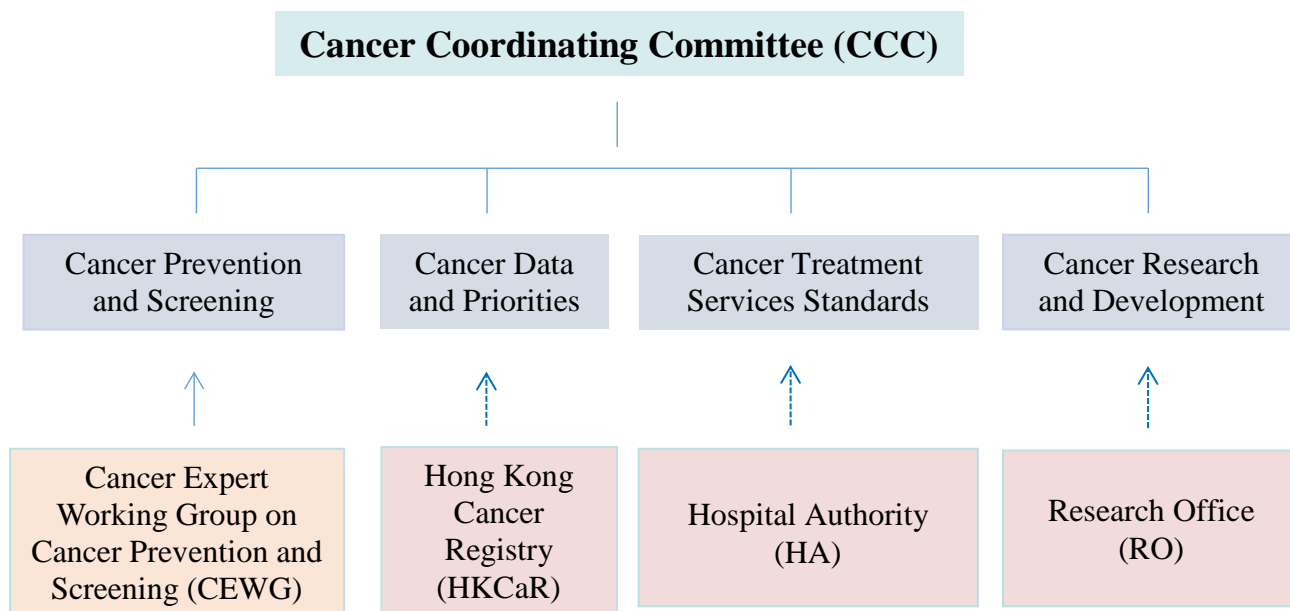
services for adult patients, covering the cancer care pathway from presentation of symptoms, diagnosis, treatment to survivorship and with particular focus on cross-specialty/ disciplinary collaboration and service organisation at cluster level. HA will continue to monitor the service demand, introduce cost-effective treatment, build up capacity and collaborate with community partners to meet the patients' need.

ADVICE SOUGHT

31. Members are invited to note the progress of development of the cancer strategy and provide comments in relation to the strategy.

**Food and Health Bureau
Department of Health
Hospital Authority
February 2018**

**Organisational Structure of
Cancer Coordinating Committee since August 2014**



Current CEWG recommendations on Screening for seven selected cancers (revised in 2016)

Cancer	For asymptomatic population at average risk	For persons at increased risk
A. Cervical cancer	<ol style="list-style-type: none"> 1. Women aged 25 to 64 who ever had sexual experience are recommended to have cervical cancer screening by cytology every three years after 2 consecutive normal annual smears. 2. Screening may be discontinued in women aged 65 or above if three previous consecutive smears within 10 years are normal. 3. Women at or above 65 years of age who have never had a cervical smear should have the test. 	<div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;"> <p>Risk factors for HPV acquisition/persistence or cervical cancer</p> <ul style="list-style-type: none"> (a) early first sexual intercourse (b) multiple sexual partners (c) tobacco use (d) chronic immunosuppression such as HIV-infected individuals, recipients of organ transplant (e) increasing parity (f) younger age at full term pregnancy (g) long term use of oral contraceptive pills for more than five years (h) co-infection with sexually-transmitted diseases (such as chlamydia infection). </div> <ol style="list-style-type: none"> 4. Women aged 21 to 24 years who ever had sexual experience and with risk factors for HPV acquisition/persistence or cervical cancer are considered at increased risk. They may be screened by cytology every three years after 2 consecutive normal annual smears, depending on doctor's assessment. 5. Other women at high risk of developing cervical cancer may require more

Cancer	For asymptomatic population at average risk	For persons at increased risk
		frequent screens based on doctor's assessment.
B. Colorectal cancer	<p>1. Individuals aged 50 to 75 years should consider screening by one of the screening methods including :</p> <ul style="list-style-type: none"> – annual or biennial faecal occult blood test (FOBT); or – sigmoidoscopy every 5 years; or – colonoscopy every 10 years. 	<p>2. For carriers of mutated gene of Lynch Syndrome, the CEWG recommends screening for colorectal cancer (CRC) by colonoscopy every one to two years from age 25 onwards.</p> <p>3. For carriers of mutated gene of familial adenomatous polyposis (FAP), the CEWG recommends screening by sigmoidoscopy every two years from age 12.</p> <p>4. For individuals with one first degree relative diagnosed with CRC at or below 60 years of age, or more than one first degree relatives with CRC irrespective of age at diagnosis, colonoscopy should be performed every three to five years beginning at the age of 40 or ten years prior to the age at diagnosis of the youngest affected relative, but not earlier than 12 years of age.</p> <p><i>* Recommendation on genetic testing for CRC</i></p> <ul style="list-style-type: none"> – <i>For CRC patients with identifiable genetic mutations, two-tier screening by genetic testing followed by endoscopic examination can be offered to their family members to reduce the number of unnecessary investigations, as well as to reduce the risk of potential complications.</i>

Cancer	For asymptomatic population at average risk	For persons at increased risk
C. Breast cancer	<ol style="list-style-type: none"> 1. There is insufficient evidence to recommend for or against population-based mammography screening for asymptomatic women at average risk in Hong Kong. 2. Women considering breast cancer screening should seek advice from doctors for assessment and obtain full information on potential benefits and risks of screening for an informed choice. 	<ol style="list-style-type: none"> 3. Women at high risk (e.g. carrier of BRCA gene mutation, family of breast/ovarian cancer) should seek advice from doctors about whether they should receive breast cancer screening, appropriate screening test and frequency of screening
D. Prostate cancer	<ol style="list-style-type: none"> 1. There is insufficient scientific evidence to recommend for or against population-based prostate cancer screening in asymptomatic men by Prostate Specific Antigen (PSA) and/or Digital Rectal Examination (DRE) 2. For asymptomatic men considering prostate cancer screening, CEWG encourages them to discuss with their doctor about individual circumstances and make informed decision on whether or not to go for prostate cancer screening. 	<ol style="list-style-type: none"> 3. Men at increased risk, namely African American men or those with one or more first-degree relatives diagnosed with prostate cancer before age 65, should consider to seek advice from doctors conversant with the pros and cons of the screening test as well as subsequent clinical management, regarding the need for and approach of screening. While the screening blood test to be considered is PSA, the DRE may also be done as part of screening. The PSA screening should start at an age not earlier than 45 until age 70, and the interval should not be more frequent than once every two years.

Cancer	For asymptomatic population at average risk	For persons at increased risk
E. Lung cancer	<p>For general or high risk populations :</p> <ol style="list-style-type: none"> 1. Routine screening for lung cancer with chest X-ray or sputum cytology is not recommended. 2. There is insufficient evidence to recommend for or against lung cancer screening by low dose computed tomography (LDCT) in asymptomatic persons or for mass screening. 	
F. Liver cancer	<ol style="list-style-type: none"> 1. Routine screening with alpha-fetoprotein (AFP) or ultrasonography (USG) for asymptomatic persons at average risk is not recommended. 	<ol style="list-style-type: none"> 2. People at higher risk of hepatocellular carcinoma (HCC), namely carriers of hepatitis B virus (HBV) or hepatitis C virus (HCV), and those with cirrhosis regardless of cause, may consider receiving periodic screening (e.g. every 6-12 months) with AFP and USG in consultation with doctors with relevant expertise.
G. Nasopharyngeal cancer (NPC)	<ol style="list-style-type: none"> 1. There is insufficient evidence to recommend a population-based NPC screening programme for asymptomatic people using IgA against specific Epstein-Barr virus (EBV) viral antigens and EBV DNA test.. 	<ol style="list-style-type: none"> 2. Family members of nasopharyngeal cancer (NPC) patients may consider to seek advice from doctors with relevant expertise before making an informed decision about screening.

**Examples of Health Promotion, Education and Protection Efforts
to Reduce Cancer Burden**

- (i) Promoting the adoption of a healthy lifestyle, e.g. having a balanced healthy diet, doing regular physical activity, avoiding smoking and alcohol drinking, maintaining healthy body weight and waist circumference etc.
- (ii) Adopting World Health Organization's MPOWER strategies for tobacco control
- (iii) Encouraging exclusive breastfeeding
- (iv) Vaccination against Hepatitis B virus – free immunization to children up to age 5 at Maternal and Child Health Centres (MCHCs)
- (v) Vaccination against human papillomavirus – the Community Care Fund launches a three-year pilot scheme to provide free cervical cancer vaccination for eligible teenage girls from low-income families
- (vi) Reducing occupational and environmental exposure to carcinogens through the work of relevant government departments such as Labour Department and Environmental Protection Department

Criteria for Instituting a Screening Programme⁵

- (i) The condition sought should be an important health problem.
- (ii) There should be an accepted treatment for patients with recognized disease.
- (iii) Facilities for diagnosis and treatment should be available.
- (iv) There should be a recognizable latent or early symptomatic stage.
- (v) There should be a suitable test or examination.
- (vi) The test should be acceptable to the population.
- (vii) The natural history of the condition, including development from latent to declared disease, should be adequately understood.
- (viii) There should be an agreed policy on whom to treat as patients.
- (ix) The cost of case-finding (including diagnosis and treatment of patients diagnosed) should be economically balanced in relation to possible expenditure on medical care as a whole.
- (x) Case-finding should be a continuing process and not a “once and for all” project.

⁵ Source : Wilson JMG, Jungner G. *Principles and practice of screening for disease*. Geneva: WHO; 1968. Available at: <http://www.who.int/bulletin/volumes/86/4/07-050112bp.pdf>

Screening Programmes Launched by the Government

Cervical Screening Programme

1. In March 2004, the Government launched the territory-wide Cervical Screening Programme (CSP), in collaboration with healthcare professionals in the public and private sectors and non-governmental organisations (NGOs), to facilitate and encourage women to receive regular cervical cancer screening. CSP has established a computerised central registry called Cervical Screening Information System (CSIS) for storing the screening records of registrants for issue of reminders and facilitating continuity of care.

2. The CSP encourages women aged 25 to 64 who ever had sexual experience to receive regular screening by cytology every three years after receiving normal pap smear results for two consecutive years. Women aged 65 or above who have not received routine screenings in the past 10 years (including those who have never had cervical screening) should be screened. For women aged 21 to 24 who have risk factors for cervical cancer (such as multiple sex partners, smoking and weakened immunity), they should discuss with their doctors about the need for screening. As at 31 December 2017, around 526 300 women aged between 25 and 64 have registered in CSP, accounting for 20.5% of the Hong Kong female population in the same age group.

3. The major service providers under the CSP include the Maternal and Child Health Centres (MCHCs) and Woman Health Centres (WHCs) of the Department of Health (DH), NGOs and private healthcare service providers. The MCHCs of DH provide subsidised cervical cancer screening to the public at \$100 per visit. Fees are waived for women who are in receipt of the Comprehensive Social Security Assistance, holders of waivers of medical charges under the Medical Fee Waiving Mechanism of Public Hospitals and Clinics, or Level 0 voucher holders of the Pilot Scheme on Residential Care Service Voucher for the Elderly. There are about 100 000 attendances for cervical screening service per year in MCHCs.

Community Care Fund Pilot Scheme on Subsidised Cervical Cancer Screening and Preventive Education for Eligible Low-income Women

4. To strengthen cervical cancer screening services especially among low-income groups, the DH launched the three-year Community Care Fund Pilot Scheme on Subsidised Cervical Cancer Screening and Preventive Education for Eligible Low-income Women on 13 December 2017. The DH is the implementing agent of the Pilot Scheme, acting as the overall administrator and co-ordinator. Three NGOs namely Centre of Research and Promotion of Women's Health of the Chinese University of Hong Kong, The Family Planning Association of Hong Kong and United Christian Nethersole Community Health Service will reach out to and encourage eligible low-income women to receive cervical cancer screening and preventive education.

5. Participants should meet the criteria for cervical cancer screening, hold a valid Hong Kong Identity Card; and are beneficiaries of any of the following assistance –

- (i) Comprehensive Social Security Assistance;
- (ii) Level 0 voucher under the Pilot Scheme on Residential Care Service Voucher for the Elderly;
- (iii) waiver of medical charges under the medical fee waiving mechanism of public hospitals and clinics;
- (iv) Old Age Living Allowance (OALA);
- (v) Low-Income Working Family Allowance;
- (vi) Work Incentive Transport Subsidy; or
- (vii) having household member(s) granted subsidy / remission under the School Textbook Assistance or the Kindergarten and Child Care Centre Fee Remission Scheme.

Colorectal Cancer Screening Pilot Programme

6. On 28 September 2016, the Government launched the three-year Colorectal Cancer Screening Pilot Programme (Pilot Programme) to provide subsidized screening service to asymptomatic Hong Kong residents born in 1946 to 1955 for prevention of colorectal cancer. The screening workflow

comprises two stages. Participants will first undergo the subsidized Faecal Immunochemical Test (FIT) provided by enrolled Primary Care Doctors. If the FIT result is positive, the participant will receive subsidized colonoscopy service provided by enrolled colonoscopy specialist to find out the cause of occult bleeding in stool. As at 28 January 2018, about 62 000 participants have enrolled in the Pilot Programme. In FIT screening, the FIT positivity percentage is 13.1%. In colonoscopy screening, the adenocarcinoma and adenoma pick up rate are 6.5% (386 cases) and 68.0% (3,988 cases) respectively.

7. The experience gained from and evaluation findings of the Pilot Programme will help to inform if colorectal cancer screening programme should be regularized and the mode of service delivery.