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Implementation of the National Breast and Cervical Cancer Early Detection Program:

The Beginning

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Abstract

In 1990, Congress passed the Breast and Cervical Cancer Mortality Prevention Act because of increases in the number of low-income and uninsured women being diagnosed with breast cancer. This act authorized the Centers for Disease Control and Prevention (CDC) to establish the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) to provide high-quality and timely breast and cervical cancer screening and diagnostic services to low-income, uninsured women. The program started in 1991, and, in 1993, Congress amended the act to allow the CDC to fund American Indian and Alaska Native tribes and tribal organizations. By 1996, the program was providing cancer screening across the United States. To ensure appropriate delivery and monitoring of services, the program adopted detailed policies on program management, evidence-based guidelines for clinical services, a systematized clinical data system to track service quality, and key partnerships that expand the program's reach. The NBCCEDP currently funds 67 programs, including all 50 states, the District of Columbia, 5 US territories, and 11 tribes or tribal organizations.

Keywords

cancer prevention; cancer screening program; National Breast and Cervical Cancer Early Detection Program; breast cancer; cervical cancer; screening

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CONFLICT OF INTEREST DISCLOSURES

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INTRODUCTION

In the 1970s, evidence from large clinical trials in Europe and the United States indicated that regular mammography screening substantially reduced the risk of dying from breast cancer. National survey data from 1987 indicated that only approximately 25% of US women aged ≥50 years were receiving regular mammograms; poor and nonwhite women were even less likely to be screened.[1] Among US women aged ≥18 years, 75% had received Papanicolaou (Pap) testing within the preceding 3 years to screen for cervical cancer. However, poor and uninsured women were much less likely to have received a Pap test.[1]

By 1989, mammography and Pap tests were recommended by both the American Cancer Society (ACS) and the US Preventive Services Task Force (USPSTF) as primary cancer screening tests.[2,3] In 1989, the ACS estimated that about 142,000 women would be diagnosed with breast cancer and about 13,000 women would be diagnosed with cervical cancer in that year.[2] During the same year, they estimated that 43,000 women would die of breast cancer and 6000 would die of cervical cancer. Despite a steady increase in breast cancer incidence, death rates had stabilized over the past 50 years.[4] Cervical cancer incidence and deaths declined dramatically during the same time, primarily because of screening with the Pap test.[4]

A Solid Foundation for Cancer Control at the Centers for Disease Control and Prevention

During the 1970s and 1980s, the Centers for Disease Control and Prevention (CDC) conducted research that focused primarily on identifying and understanding the causes of various cancers. Much of this work was done by the CDC at their National Center for Environmental Health (NCEH), where researchers assessed the relations between environmental exposures and cancer. The Office on Smoking and Health focused on population-based interventions to reduce tobacco use to prevent a range of tobacco-related health problems, including cancer. The Division of Reproductive Health conducted research to examine the relation between reproductive-associated exposures and cancer. The National Center for Infectious Diseases researched the relations between infectious agents and cancer, and the National Institute of Occupational Safety and Health studied risks of cancer in occupational settings.

Public health programs in breast and cervical cancer control also were initiated in the 1980s. In 1985, the Rhode Island Department of Health designed a public education program that offered reduced-cost mammography screening and improved quality-assurance standards. In 1986, CDC Director James O. Mason, MD, MPH, established the first organizational unit devoted exclusively to cancer control when a section on cancer control was created in the Chronic Disease Division of the NCEH. Given the impressive reductions in death rates from cervical cancer among women who were screened with the Pap test,[4] Dr. Mason asked CDC scientists to identify barriers to Pap testing among US women. Because of Dr. Mason's commitment, demonstration projects designed to identify barriers to screening with the Pap test were implemented in southeastern Kentucky; Chicago, Illinois; and Atlanta, Georgia.

By 1988, the CDC had funded 8 projects involving breast or cervical cancer control for a total of $1.2 million, and Dr. Mason had established the CDC National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) to bring together chronic disease activities from across the agency. The success of the Rhode Island breast cancer project in providing low-cost mammography screening to 6000 women—and the results from demonstration projects in Colorado, Oklahoma, Maine, Washington, California, and the Navajo Nation— encouraged the CDC to develop a framework for a nationwide breast and cervical cancer screening program. Through these projects, and through collaborations with state health agencies, nonprofit organizations, researchers, and other stakeholders, the CDC laid the groundwork for a CDC-funded early detection program for breast and cervical cancer.

The Breast and Cervical Cancer Mortality Prevention Act of 1990

In 1989, Rep. Henry Waxman (D-CA), Chair of the House Subcommittee on Health and Environment of the Energy and Commerce Committee, supported improvements in the availability of health services for underserved populations and efforts to obtain Medicare coverage for screening mammography. Rep. Waxman and his staff developed a legislative proposal to increase breast and cervical cancer screening among poor and minority women. They proposed that CDC demonstration projects should be used as the foundation for a program that would help states build the infrastructure to provide mammography and Pap testing throughout the United States. The proposal included support for public and provider education, quality assurance of screening, and surveillance systems to track screening efforts. Funding to pay for screening and diagnostic services for underserved women was added later. Rather than authorize payment for cancer treatment with these funds, a decision was made that requires grantees to guarantee that women who are diagnosed with cancer receive treatment services using other resources because of their concern that a small number of advanced cancers could deplete a state's federal funds for screening and diagnostic tests.

In March 1990, the bill House Resolution (H.R.) 4222 was introduced in the House of Representatives by Rep. Waxman[5] with 30 Democratic and 12 Republicans cosponsors. On the same day, Senators Barbara Mikulski (D-MD) and Nancy Kassebaum (R-KS) introduced the bill Senate Resolution (S.R.) 2283. The House bill passed in May 1990 with minor changes and was renumbered as H.R. 4790. Some senators debated the value of creating a new program with categorical funding for cancer screening instead of using the existing funds in the Preventive Health and Health Services Block Grant. However, representatives from the CDC pointed out that few states had used any of their block grant funding for cancer screening. National organizations, including the ACS, the American Public Health Association, and the Susan G. Komen Breast Cancer Foundation, strongly endorsed the categorical funding favored by the Mikulski-Kassebaum Senate bill.

On August 4, 1990, the Senate passed S.R. 2283 by voice vote. The same day, the House agreed to amendments made by the Senate by unanimous consent. Louis W. Sullivan, MD, Secretary of the US Department of Health and Human Services, and Richard Darman, Director of the Office of Management and Budget, both recommended the bill to the White

House. On August 10, 1990, President George H. W. Bush signed the Breast and Cervical Cancer Mortality Prevention Act[6] at a ceremony highlighting women's health care. President Bush specifically commended Marilyn Quayle, wife of Vice President Dan Quayle, whose mother had died of breast cancer, for her role in passage of the legislation. Shortly after the bill was enacted into law, Congress approved $30 million for the first year of the program as part of the fiscal year 1991 federal appropriation.

Program Policies and Guidelines

The new act authorized the CDC to create the National Breast and Cervical Cancer Early Detection Program (NBCCEDP). The program was the NCCDPHP's first clinical service-delivery program, so staff experience in this area was limited. To guide the planning and implementation process, CDC staff drew on their past experiences managing other service-delivery programs, such as the Women, Infants, and Children (WIC) Program of the US Department of Agriculture; the Maternal and Child Health Program (Title V) of the Health Resources Services Administration; and the Family Planning Program (Title X) of the Office of Population Affairs. These federally funded service-delivery programs were located in state and local health departments and community health centers throughout the United States.

The overarching goal of the NBCCEDP was to establish a solid foundation for building a national cancer screening program that was consistent with the provisions outlined in the Breast and Cervical Cancer Mortality Prevention Act but that also allowed sufficient flexibility to accommodate diverse circumstances and health care delivery systems across the United States. The act authorized specific program requirements related to the eligible population, reimbursement for clinical services, and the proportion of funds allocated for different program components (Table 1).

In 1993, Congress amended the act with the Preventive Health Amendments of 1993 (Public Law 103-183) to authorize the CDC to fund American Indian and Alaska Native tribes and tribal organizations through the NBCCEDP.[7] In 1998, Congress passed another amendment, the Women's Health Research and Prevention Amendments of 1998 (Public Law 105-340), to add case management as an authorized part of clinical service.[8]

Income eligibility

Because Congress intended for the NBCCEDP to be for low-income women, an early task was to define *low income*. The CDC has defined eligibility for the program to include women who have incomes at or below 250% of the Federal Poverty Level[9] and who are uninsured or underinsured. The latter category includes women who have insurance that does not cover breast or cervical cancer screening and women who cannot afford their insurance deductibles or copays. States and local programs funded by the NBCCEDP can set lower income eligibility criteria if they are consistent with the eligibility criteria for other public health service-delivery programs.

Screening criteria

The CDC reviewed the scientific evidence available in 1991 on mammography and existing screening practices to develop breast cancer screening policies for the NBCCEDP. Similar to today, consensus was lacking on scientific interpretation and clinical practice related to mammography screening in 1991.[2,3,10–13] However, the CDC recognized that science combined with practicality was important for success. The NBCCEDP developed screening policies for women aged ≥40 years that were intended to ensure regular rescreening of women for breast cancer with mammography. States that were receiving NBCCEDP funding were given the latitude to set screening guidelines in consultation with their medical advisory boards.

Because older women had higher breast cancer incidence and death rates, and because mammography was more effective in these women, targeting women aged ≥50 years became an NBCCEDP priority.[4] In 1996, the program developed a new policy requiring that at least 75% of mammograms provided by the NBCCEDP be among women aged ≥50 years and that no greater than 25% be among women ages 40 to 49 years. This policy is known as the *75/25 rule*. Grantees were allowed the flexibility to screen younger women, especially those who were at greater risk of breast cancer or who were referred into the program because of an abnormal breast examination. When Medicare began to cover breast and cervical cancer screening for women, the NBCCEDP updated its eligibility criteria to exclude women aged 65 years or older except those who are unable to afford deductibles or copays.

During the 1990s, national organizations issued conflicting guidelines on intervals for cervical cancer screening. The NBCCEDP established a program policy to provide annual cervical cancer screening for eligible women aged ≥18 years but emphasized screening for women aged ≥40 years because many younger women could get Pap tests through other federally funded programs. However, because these programs might not provide diagnostic services, women with abnormal Pap test results could receive necessary diagnostic services and treatment referrals through the NBCCEDP. States were given the latitude to adjust their screening guidelines in consultation with their medical advisory boards.

Data for thousands of women receiving Pap tests through the NBCCEDP were examined to assess the effect of different screening intervals. That analysis determined that rates of severe abnormalities on Pap testing were similar for women who were screened 1, 2, or 3 years after a normal test result.[14] The CDC convened an external group in 1999 to review the current scientific literature, the recommendations of national organizations, and NBCCEDP data. In 2000, the program adopted a new policy that provided Pap testing every 3 years after a woman had normal results from 3 consecutive Pap tests within 5 years. The program also placed new emphasis on reaching women who had rarely or never been screened for cervical cancer. The intent of this policy was to make the best use of limited program funds to reach women at the highest risk of cervical cancer and to reduce over screening.

The CDC continues to provide updated clinical services consistent with national screening guidelines. In 2002, the USPSTF recommended mammography screening with or without

clinical breast examination for women aged ≥40 years every 1 or 2 years.[15] In concurrence with the USPSTF conclusion that the evidence was strongest for women ages 50 to 69 years, the NBCCEDP 75/25 rule was maintained. The USPSTF updated its breast cancer screening guidelines again in 2009, recommending biennial screening for women ages 50 to 74 years and stating that the decision to commence regular, biennial screening mammography before age 50 years should be an individual decision and should take patient context into account, including the patient's values regarding specific benefits and harms.[16] This recommendation was considered to be consistent with CDC policy, and the 75/25 rule was maintained. The CDC updated its NBCCEDP cervical cancer screening policies to be consistent with 2012 screening recommendations from the USPSTF and the ACS.[17,18]

New screening technologies

The Breast and Cervical Cancer Mortality Prevention Act authorizes the use of a new screening procedure when it is superior to the current procedure, becomes commonly available, and is recommended for use.[6] When considering changes to its policies, the CDC consults with outside experts and reviews the evidence supporting new technologies and the prevailing standards of practice.

One example of how the NBCCEDP evolves as new screening technologies become available is the program's decision in 2005 to begin reimbursement for the use of liquid-based cytology (LBC) for Pap tests. An initial review of the scientific evidence indicated that, although LBC results may be easier to interpret in the laboratory and this method can decrease the number of inadequate smears, there was no evidence that it was superior to conventional Pap tests in identifying abnormal cervical cytology. However, the CDC also determined that more and more providers were using LBC instead of conventional cytology screening. Consequently, the CDC approved reimbursement for LBC to ensure adequate availability of providers for cervical cancer screening.

A more recent example is the program's decision in 2009 to allow for reimbursement of full-field digital mammography (FFDM). After reviewing the current science, the level of marketplace penetration, and the current effect on the NBCCEDP, a group of outside experts concluded that scientific evidence did not indicate that FFDM was superior to conventional film mammography in identifying breast cancer in older women. However, the marketplace was rapidly transitioning to its use; and, by April 1, 2009, 50% of accredited mammography units were FFDM units, and 50% of certified facilities had 1 or more FFDM units.[19] The CDC decided to reimburse for the new technology to ensure adequate availability of mammography providers for the NBCCEDP. These policy decisions addressed the reality that trends in the use of emerging technologies can significantly affect access to screening.

Administrative policies

The Breast and Cervical Cancer Mortality Prevention Act authorized the CDC to pay for services only if a woman has no other source of payment, and payments for clinical services cannot exceed Medicare reimbursement rates.[6] The CDC had to develop specific administrative policies and guidelines on how NBCCEDP funds can be spent. The act also includes a 60/40 rule, which requires that 60% of awarded funds be used on screening

services and associated case management. The remaining 40% may be used to support public and health professional education, quality assurance, tracking and surveillance, program evaluation, and program management; and no greater than 10% of this portion can be used for administrative costs.[6]

Comprehensive Data System for Management and Evaluation

The Breast and Cervical Cancer Mortality Prevention Act mandated that the NBCCEDP evaluate the appropriate program activities through surveillance or program monitoring activities.[6] In 1991, before the first 8 states were funded, a small group of CDC staff—including program managers, epidemiologists, and a clinician—met weekly to identify the tasks needed to implement the program. The initial design of the NBCCEDP clinical data system, the Minimum Data Elements (MDEs), was based on data collected by a national screening program in Sweden[20] and guidance provided by a visiting scientist from that program. The group, along with input from the managers of the first funded state grantees, defined the required data elements to be submitted to the CDC and the screening cycle for each MDE record.[21,22]

In 1993, the CDC developed the Data Quality Indicator Guides to help the agency and grantees use the MDEs to monitor program quality.[23,24] A review of early program data revealed that grantees needed more guidance on how to provide high-quality data. In 1995, the CDC developed the MDE Edit Program, which allows grantees to identify problems and correct them before they submit their data to the CDC. Routine use of the MDE Edit Program by all grantees improved the quality of the data submitted.

A National Program

In 1991/1992, the CDC funded 12 state health departments for 5 years to establish programs that provided screening services to low-income women who were uninsured or underinsured as part of the NBCCEDP (Table 2). The first US territories, tribes, and tribal organizations were funded in 1994. By 1996, all 50 states, the District of Columbia, and several US territories, tribes, and tribal organizations were participating in the NBCCEDP. In 2014, the CDC funded 67 grantees, including all 50 states, the District of Columbia, 5 US territories, and 11 tribes or tribal organizations.

To help health departments set up screening programs, the CDC developed a capacity-building grant program to provide states, US territories, and tribes or tribal organizations 3 years to develop plans and build the necessary infrastructure before operating a comprehensive program with screening and diagnostic services. The CDC used lessons learned from the first group of comprehensive screening programs to give grantees individualized technical assistance. Grantees switched to comprehensive programs when they were ready to conduct outreach, manage service contracts with clinical providers, collect necessary data to track women screened, and document their progress.

The first NBCCEDP grantees helped test whether the CDC program policies and guidance were practical. The CDC used feedback from these grantees to clarify and refine its policies and guidance and to identify additional needs for technical assistance. For example, the

agency observed that territorial and tribal grantees needed more individualized help to ensure compliance with policies and structures that were initially designed for state health agencies. The CDC realized that they needed staff who understood the unique challenges experienced by these grantees, and they hired staff to work specifically with territorial and tribal grantees. In addition, as the NBCCEDP evolved, the CDC also developed tools and documents to help grantees understand the requirements of the program and create an effective framework for their budget procedures.[25] The CDC also began to institute business practices that rewarded the efficient use of resources. Eventually, funding decisions were made on the basis of grantees' performance.

To reach underserved populations, grantees needed to work with established community organizations and clinics that had links to diverse groups of eligible women. Grantees established partnerships with organizations such as the Young Women's Christian Association (YWCA), the ACS, and Susan G. Komen for the Cure (formerly known as the Susan G. Komen Breast Cancer Foundation) and with federally funded community health clinics to link women with screening services.

Breast and Cervical Cancer Prevention and Treatment Act

The legislation that authorized the NBCCEDP included reimbursement for screening and diagnostic services but prohibited the use of program funds for breast and cervical cancer treatment.[6] However, the legislation also required that grantees ensure that women diagnosed with breast or cervical cancer have access to treatment. Grantees generally were successful in obtaining low-cost or pro bono cancer treatment services, but efforts to identify and broker these services were complex and time-consuming. In addition, the cost of treatment sometimes influenced a woman's options.[26] These issues led to concerns that women with abnormal screening results might not receive timely and appropriate cancer treatment. To address these concerns, the CDC funded the following 3 studies:

- A descriptive study that examined general strategies and activities regarding treatment services in 35 states[27];
- A case study that used interviews with program representatives in 7 states to identify strategies and activities being used at state and local levels to ensure that women screened by the NBCCEDP were receiving diagnostic follow-up and getting treatment[28,29]; and
- A study that used cancer registry data in 3 states to assess the timing and type of initial cancer treatment received by NBCCEDP clients diagnosed with breast or cervical cancer and then compared this information with data from other women who were diagnosed with these cancers during the same period.[30]

The results of these studies indicated that grantees relied on various state and local resources to provide treatment services. Although clients in the NBCCEDP received treatment similar to that received by insured women, identifying and obtaining resources for treatment was labor-intensive and costly. These findings helped to increase awareness of the challenges faced by NBCCEDP grantees and women diagnosed with cancer in securing cancer treatment services. Consequently, advocacy groups called for federal legislation to address

the need for funding of cancer treatment services for women diagnosed through the NBCCEDP.[26]

In 2000, Congress passed the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) (Public Law 106-354).[31] This act authorized states and territories to provide Medicaid coverage as an option for the treatment of women diagnosed through the NBCCEDP with breast or cervical cancer or precancerous conditions. [26] Passage of the Native American Breast and Cervical Cancer Treatment Technical Amendment Act of 2001 (Public Law 107-121) amended the Social Security Act to clarify that American Indian and Alaska Native women with breast or cervical cancer who were eligible for services provided through the Indian Health Service or a tribal organization are also eligible for optional Medicaid coverage.[32]

To implement the BCCPTA, a partnership was established between the CDC, the Centers for Medicare & Medicaid Services, state Medicaid directors, and directors of state and tribal cooperative agreement programs. By January 2003, in total, 49 states and the District of Columbia had decided to cover eligible women, and all 50 states and the District of Columbia were participating by October 2008. Seventeen states follow the minimum requirement by offering Medicaid eligibility to women who are screened or diagnosed with CDC funds. Fifteen states extend this eligibility to women who are screened or diagnosed by a CDC-funded clinical provider, whether or not CDC funds paid for these services. Nineteen states extend this eligibility to women who were screened or diagnosed by a provider not funded by the CDC. In 2009, the US Government Accountability Office[33] reported that most states had extended their Medicaid eligibility to more than what was minimally required by the BCCPTA.

Partnerships: A Key Component of the NBCCEDP

Throughout the history of the NBCCEDP, partnerships with public and private agencies and for-profit and non-profit organizations at local, state, and national levels have been critical to the program's success. These partnerships were instrumental in passage of the laws that established the NBCCEDP. Efforts by several major national partners include the following.

American Cancer Society

The ACS has had a long-standing relationship with the CDC to support prevention, early detection, treatment, survivorship, and intervention activities for several cancers. The ACS advocated for passage of the federal acts that authorized the NBCCEDP and the BCCPTA. Today, the ACS Cancer Action Network continues to support both programs by highlighting the needs of low-income women and the importance of addressing health disparities to members of Congress. The ACS has also advocated in many states for state and local funding to extend breast and cervical cancer screening services to more women. ACS volunteers and staff collaborate with CDC grantees to train health professionals and develop public educational messages that extend the reach of the NBCCEDP through public education and outreach.[34]

Susan G. Komen for the Cure

Susan G. Komen for the Cure (formerly the Susan G. Komen Breast Cancer Foundation) began working with the NBCCEDP in the mid-1990s as a way to promote breast cancer screening among low-income women through its affiliates across the United States. Komen affiliates raise community funds through Komen Race for the Cure and advocate for state funds to extend the reach of federal funds to screen more women for breast cancer. Nationally, Susan G. Komen for the Cure has supported and advocated the reauthorization and funding of the NBCCEDP.

Avon

In October 1993, Avon launched its Breast Cancer Awareness Crusade in the United States as a national campaign to promote breast cancer education and early detection. At the time, the concept of cause-related marketing ("doing well by doing good") and the symbol of the pink ribbon to promote breast cancer awareness were increasingly recognized and supported by for-profit companies. Avon, "the company for women," began designing and selling pink ribbon lapel pins for $2 to raise funds to support breast health education. Through the sale of pink ribbons, other pink products, and the Avon Walks for Breast Cancer, Avon has raised and donated more than $815 million to breast cancer programs around the world over the past 21 years. These funds are used to support research to find a cure and improve access to quality care. In the early years of its efforts, Avon collaborated with the NBCCEDP and the YWCA to deliver breast cancer education and access to early detection services through the ENCORE PLUS program.[35,36] The company then established a breast health education program for community-based organizations around the country. In 2003, Avon partnered with the CDC and provided $3.9 million for the Mobile Access Project to support the integration of mobile mammography units with states participating in the NBCCEDP.

YWCA

In 1994, shortly after implementation of the NBCCEDP, the CDC formed a partnership with the YWCA to help develop ENCORE PLUS, a structured, grassroots out-reach program designed to reach underserved women. ENCORE PLUS provides breast health education and supports or provides access to free or low-cost mammograms through community outreach, transportation support, translation, and follow-up services. The priority population for this program is low-income, medically underserved, uninsured minority women.[37] Avon also has contributed to this collaboration with funding and volunteer support from its national sales force.

Beyond Cancer Screening

At the request of Congress, the CDC created a program called WISEWOMAN (Well Integrated Screening and Evaluation for Women Across the Nation) to provide diabetes and cardiovascular disease screening and prevention services to women ages 40 to 64 years who are receiving cancer screening through the NBCCEDP.[38] WISEWOMAN was authorized as part of the NBCCEDP in 1993 through an amendment. It provides screening services, such as weight, blood pressure, and blood glucose measurement, and lifestyle interventions. WISEWOMAN and the NBCCEDP are coordinated and integrated, as appropriate and

feasible, to provide services to participating women in a more efficient way. CDC researchers also developed culturally appropriate nutrition and physical activity interventions for several racial and ethnic populations as part of the WISEWOMAN program. WISEWOMAN funding as of 2014 supported 22 grantees in 20 states and 2 tribal organizations.

Conclusion

The NBCCEDP is a well established, nationwide cancer screening program that has effectively served low-income, disadvantaged women for more than 20 years. The combined efforts of the CDC, individual grantees, thousands of clinical providers, and key partners have built the NBCCEDP into the only organized, nationwide cancer screening program in the United States. Today, this program offers an effective model for clinical service delivery that is grounded in national screening guidelines, quality standards, and patient tracking. Yet it is flexible enough to adapt to the unique health care systems of funded grantees, including states, US territories, and American Indian/ Alaska Native tribes and tribal organizations. The NBCCEDP is an example of a partnership between public health and private groups that is effectively serving low-income populations.

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TABLE 1

Required Activities of Programs Funded by the Breast and Cervical Cancer Mortality Prevention Act of 1990

Core Program Components	
1	Screen women for breast and cervical cancer as a preventive health measure.
2	Provide appropriate referrals for medical treatment of women screened and to ensure, to the extent practicable, the provision of appropriate follow-up services.
3	Develop and disseminate public information and education programs for the detection and control of breast and cervical cancer.
4	Improve the education, training, and skills of health professionals (including allied health professionals) in the detection and control of breast and cervical cancer.
5	Establish mechanisms through which the states can monitor the quality of screening procedures for breast and cervical cancer, including the interpretation of such procedures.
6	Evaluate these activities through appropriate surveillance or program-monitoring activities.

TABLE 2

First Year of Funding From the Centers for Disease Control and Prevention's National Breast and Cervical Cancer Early Detection Program

First Year Funded	States, Territories, and Tribes or Tribal Organizations[a]
1991	Colorado, Minnesota, South Carolina, West Virginia
1992	California, Maryland, Michigan, Missouri, Nebraska, New Mexico, North Carolina, Texas
1993	Massachusetts, New York, Ohio, Pennsylvania, Washington, Wisconsin
1994	Alaska, **American Samoa**, *Arctic Slope Native Association Limited*, *Cheyenne River Sioux Tribe*, *Eastern Band of Cherokee Indians*,[b] Florida, Georgia, Maine, *Maniilaq Association*,[b] Oklahoma, Oregon, *Pleasant Point Passamaquoddy*,[b] *Poarch Band of Creek Indians*,[b] **Puerto Rico**, Rhode Island, *Southcentral Foundation*, *South Puget Intertribal Planning Agency*, Utah
1995	Arizona, Arkansas, Connecticut, Illinois, Iowa, Kansas, Louisiana, New Jersey, Vermont
1996	Alabama, **Commonwealth of Northern Mariana Islands**, Delaware, District of Columbia, Hawaii, *The Hopi Tribe*, Idaho, Indiana, Kentucky, Mississippi, Montana, *Native American Community Health Service*,[b] *Native American Rehabilitation Association of the Northwest*, *The Navajo Nation*, New Hampshire, Nevada, North Dakota, **Republic of Palau**, South Dakota, Tennessee, Virginia, **Virgin Islands**,[b] Wyoming
1997	*Alaska Native Consolidated Tribal Health*,[b] *SouthEast Alaska Regional Health Consortium*
1999	**Guam**
2001	*Kaw Nation*, *Yukon-Kuskokwim Health Corporation*
2002	*Mississippi Band of Choctaw Indians*[b]

[a] Names of territories are boldface, and names of tribes or tribal organizations are in italics.

[b] These entities are no longer participating in the National Breast and Cervical Cancer Early Detection Program.