SUPPORTING NATIONAL CANCER CONTROL PLANNING: **A TOOLKIT FOR CIVIL SOCIETY ORGANISATIONS (CSOS)**

GENEVA, 2012

ECL
Association of European Cancer Leagues

uicc
global cancer control

FOREWORD FROM THE WORLD HEALTH ORGANIZATION

In September 2011, in a landmark event, Heads of State and Government at the High-Level Meeting of the United Nations General Assembly on Prevention and Control of Non-communicable Diseases (NCDs) committed themselves to integrating non-communicable diseases, including cancer, into health planning process and the national development agenda of each country.

Cancer is one of the leading causes of death worldwide and is set to become a major cause of morbidity and mortality in the coming decades in every region of the planet. However, due to the wealth of available knowledge, all countries can implement the four basic components of cancer control – prevention, early detection, diagnosis and treatment and palliative care – and thus avoid and cure many cancers, as well as palliating the suffering.

Since early 1980, the World Health Organization (WHO) has been promoting well-conceived and well-managed national cancer control programmes as the best approach to translate the evidence into practice. Based on this public health framework, WHO later developed a series of modules – Cancer Control: Knowledge into Action: WHO Guide for Effective Programmes – in response to the increasing demand from governments for further practical guidance. The WHO modules highlight a broad participatory process involving all stakeholders from the beginning as central to the development and implementation of an effective cancer control plan. Setting the right priorities and realistic targets, aligning resources to priorities, establishing information systems and measuring results are essential components of national planning to set the foundation for effective implementation.

WHO's national cancer control framework and tools have guided numerous countries in their efforts to control the cancer burden and cancer risk factors in a more effective way.

Nevertheless the challenge to translate this existing knowledge into effective practice remains high in the vast majority of countries, particularly, in low-and middle-income countries. An increasing number of governments are requesting technical support in the field of Non-communicable Diseases. This demand is likely to increase as a result of the Political Declaration of the High-Level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases and the global mobilisation against Non-communicable Diseases derived from it. A recent analysis of 144 WHO Country Cooperation Strategies stresses that 136 countries have requested technical assistance to develop multisectoral national plans for the prevention and control of cancers and other Non-communicable Diseases.

As the world's leading health agency, WHO is committed to continue supporting countries in their efforts to address cancer and develop effective programmes. WHO is working with others – health is a shared responsibility, comprising all sectors – and WHO and UICC have been long-standing partners in the global fight against cancer, including the promotion of comprehensive cancer prevention and control. WHO therefore welcomes this new UICC publication that encourages the participation of civil society in national cancer control planning and complements existing WHO publications on this topic. WHO hopes that this toolkit will serve as a point of reference for enhancing the participation of nongovernmental actors in the preparation and implementation of effective and sustainable national cancer control plans in the context of Non-communicable Diseases.

Dr Oleg Chestnov
Assistant Director-General
Non-communicable Diseases and Mental Health
World Health Organization (WHO)

LETTERS OF INTRODUCTION

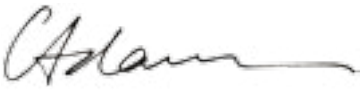
In 2008, UICC and its members launched the World Cancer Declaration – a tool to help bring the growing cancer crisis to the attention of leaders and health decision makers. The Declaration lists 11 targets to be achieved by 2020 to support our fight to eliminate cancer as a life threatening disease for future generations.

It calls upon national governments to address cancer risk factors, improve health systems and cancer information, invest in cancer diagnosis and treatment and in time, deliver major improvements in cancer survival rates. The Declaration's first target states that by 2020 "Sustainable delivery systems will be in place to ensure that effective cancer control programmes are available in all countries".

Such a goal can only be achieved through effective planning and partnerships. We firmly believe that governments working in partnership with civil society and the private sector can significantly improve the way in which cancer is prevented, detected and treated across all societies.

This toolkit, designed for civil society organisations, intends to help them and other parties deliver an effective national cancer control plan – one which is comprehensive, costed and designed so that progress can be measured and assessed. A talented and experienced group of experts have worked diligently to deliver a tool which incorporates best practice from around the world.

I hope that it will contribute significantly to our global effort to address the growing burden of avoidable cancer deaths. Like most tools, their value is determined by the enthusiasm of the user. I hope all of you will be inspired to use it in the coming years.



Cary Adams
Chief Executive Officer
Union for International Control (UICC)

ACKNOWLEDGMENTS

The Union for International Cancer Control (UICC) and European Cancer Leagues (ECL) wish to acknowledge contributions received from members and partners for the production of this toolkit. Special recognition to the editorial committee of the present edition:

- **Dr Renée Otter** (President, Dutch Association of Comprehensive Cancer Centers/Dutch National Cancer Control Plan, UICC /ECL Member)
- **Mr John McCormack** (CEO, Irish Cancer Society, UICC /ECL Member)
- **Dr Wendy Yared** (ECL Director)
- **Dr Hélène Sancho-Garnier** (Head, Preventive Research department, Epidaure", CRLC-Montpellier Cancer Campus, UICC Member)
- **Ms Maria Stella de Sabata**, (former UICC Head of Programmes, coordinator of the editorial process)

LETTER FROM ECL DIRECTOR

Since the creation of the Association of European Cancer Leagues in 1980, we have seen great advances in the fight against cancer. Yet cancer is still the second most common cause of death and morbidity in the European Union. This burden will only grow with the trend of an increasingly ageing population. Our efforts against this disease have been further challenged by harsh economic times. The response in Europe is to encourage collaboration and avoid duplication of efforts among stakeholders and to maximise existing resources in order to make a difference.

Thus, ECL started its project on National Cancer Control Plans in 2009 with the aim of providing a platform for information and experience exchange among cancer leagues on their roles in the a) development and b) implementation of NCCPs in their countries, to identify the current status of the roles of leagues, and to explore opportunities for increasing their contribution to the NCCP process.

It was during our own work in NCCPs, and our constant scan of the cancer control landscape, that we connected with UICC for this joint effort to support this toolkit for NCCPs. We very much appreciate UICC's initiative, and are pleased that we can contribute to this updated edition with our own lessons from Europe.

While this toolkit is designed for civil society organisations, I hope that it can be of use by all stakeholders (governments, private sector, individual citizens) as we all have a role to contribute. We should also be aware that other important resources exist, such as the work on NCCPs within the EU's 'European Partnership for Action Against Cancer' Joint Action. As ECL is in this EU Partnership as the leader on health promotion and prevention, we will be able to provide updates on this and other future initiatives related to NCCPs, and invite you to consult our webpages, as the climate on cancer control is a constantly changing one.

In closing, please do not hesitate to give us your feedback and experiences on this toolkit. Only in the process of sharing experiences and working in partnership can we make substantial and sustainable progress against cancer.

Dr Wendy Yared
Director
Association of European Cancer Leagues (ECL)

This version updates and replaces the first edition of the National Cancer Planning Resources for Non-Governmental Organisations published in 2006 with support from the Centres for Disease Control and Prevention (CDC).

Our appreciation to the contributions of the American Cancer Society (ACS), the Lalla Salma Association Against Cancer (Morocco), PRONACCAN (Uruguay), the International Diabetes Foundation (IDF), and the World Health Organization (WHO) who contributed to the development of this edition of the toolkit.

UICC and ECL would like to acknowledge Pfizer Inc., Novartis and Garnier International for supporting this updated edition through unrestricted educational grants; and greatly appreciate the financial support of the Israel Cancer Association for the finalisation of the present edition.

Special thanks to the Canadian Partnership Against Cancer for their significant role to make the 2012 World Cancer Leaders' Summit a reality, where – given its theme on "Planning for National and Global Impact" – the present toolkit has been launched.

LETTER FROM CANADIAN PARTNERSHIP AGAINST CANCER

It is with great pleasure that the Canadian Partnership Against Cancer (Partnership) endorses the joint Union for International Cancer Control and European Cancer League publication Supporting national cancer control planning: A toolkit for Civil Society Organisations (CSOs).

The Partnership is an organisation funded by the federal government to accelerate action on cancer control for all Canadians. It brings together cancer experts, government representatives, patient and survivor groups, including the Canadian Cancer Society and the Canadian Cancer Action Network, to implement the first pan-Canadian cancer control strategy. The vision is to be a driving force to achieve a focused approach that will help prevent cancer, enhance the quality of life of those affected by cancer, lessen the likelihood of dying from cancer, and increase the efficiency of cancer control in Canada. Our collaborative approach is mindful of the patient voice and strives to be culturally responsive to the needs of First Nations, Inuit and Métis communities.

We are delighted that Canada has the opportunity to host the 2012 World Cancer Leaders' Summit and the World Cancer Congress. As steward of the cancer strategy in Canada, the Partnership is proud to have played a significant role in the design and execution of both events which will bring together cancer practitioners and system leaders from around the world to learn from other experts, exchange knowledge and best practices, and network.

The release of the toolkit at this year's World Cancer Leaders' Summit is particularly relevant as the theme is "Planning for National and Global Impact". This resource is a great example of how international collaboration and sharing of knowledge enables us all to make greater strides toward the shared goal of reducing the impact of cancer.

I hope that this toolkit will prove to be useful for organisations throughout the world that are developing or considering developing a national cancer control plan of their own.

Jessica Hill
Chief Executive Officer
Canadian Partnership Against Cancer (CPAC)

LETTER FROM ICA DIRECTOR GENERAL

It is an honour for the Israel Cancer Association (the ICA) to facilitate the publication and distribution of this important UICC-initiated toolkit, in which the ECL and other entities and professionals collaborated.

ICA activities as an NGO have led to strong results on a national scale. At the ICA, the UICC World Cancer Declaration serves as a yardstick to gauge our activities in various areas of cancer control, according to its eleven targets.

Among its most relevant work, ICA has launched national scale projects, following intensive lobbying and advocacy efforts, like the National Mammography Screening Programme, which has led to a 30% decline in mortality rates over the past decade. Thanks to the ICA-initiated Breast Cancer Screening Programme, and its mobile mammography approach, coverage gaps have been significantly narrowed among the various population segments.

In the 1960s, the ICA initiated and assisted in the establishment of the National Cancer Registry within the Ministry of Health, and is still supporting it. Upon ICA's initiative back in 1983 when smoking rates were 45% in Israel, it became one of the first 10 countries to pass a law prohibiting smoking in public places. Today smoking rates stand at 20.6%.

ICA also runs public campaigns and according to surveys that have been conducted over the years, there is now high public awareness in Israel regarding the possibilities of prevention and the cure of cancer, as a result of the shattering of myths, which prevailed in the past. ICA has also been leading the Skin Cancer Awareness Month for 20 years, and successes include high melanoma early detection rates and a significant drop in incidence.

Around 1,400 training and continuing education activities are held every year at ICA headquarters for multi-disciplinary oncology staff. As well as training of palliative care staff across Israel, where every citizen is entitled to early detection, treatment and/or rehabilitation services. Patients are entitled to expanded treatment options for pain control, though there is room for improvement in this area.

These are undoubtedly significant achievements, so we can look back with great satisfaction, however there is a long road ahead, and we look forward to a future in which we will succeed in furthering our goal to reduce cancer morbidity and mortality, while maintaining quality of life for patients and survivors while promoting their rights. All these under the scope of comprehensive national cancer control plans. I wish us all great success in our common goal.

Miri Ziv
Director General
Israel Cancer Association (ICA)

CONTENTS

HOW TO USE THIS TOOLKIT

This toolkit has been put together to help cancer leagues and other CSOs developing or considering the development of a national cancer control plan in support of government efforts and in the context of a national health plan. The ideas and tools it contains are based on the experiences of those who have already developed cancer control plans and are now implementing them.

Its aim is to provide individuals involved in the process with an overview of cancer control planning, issues to be taken into consideration and tools to help start or enhance existing efforts. Selected references for more detailed information are also provided.

The toolkit is designed around five key questions that cover all of the major elements of a good cancer control plan:

1. What is the country's cancer picture?
2. Who can help develop and implement a cancer control plan?
3. What will be included in the plan?
4. How will the plan be implemented and communicated?
5. What is a successful plan?

It is useful to start by completing the "Before you begin" checklist, and then refer to the individual sections for each of the key questions above.

www.uicc.org/resources

These sections have a common format:

INTRODUCTION

A brief overview of the section and its content.

GUIDING PRINCIPLES

Major lessons learned and considerations based on the experiences of countries which have developed cancer control plans. When reading them, you will find that you begin asking yourself how these principles apply to your country. Some may apply directly, some might be adaptable to your country, and some may not apply at all. It is essential to decide which ones are important for you and your cancer control working group to follow up on. Guiding principles are numbered for easy reference.

CRITICAL QUESTIONS

Going through the critical questions will help the cancer control planning group identify the different ideas and agendas of the participating organisations involved. Taking these into account will inform and improve the implementation of the plan. We suggest you answer these questions collectively with the cancer control group so as to benefit from the different ideas that are offered.

A LIST OF PRACTICAL TOOLS

Tools are available on the UICC website **(www.uicc.org/resources)** to help the planning group start on specific items related to the cancer control plan. These tools are user-friendly and may be used as they are, or they can be adapted to reflect country circumstances. This list will evolve with time and experience.

REFERENCES

Additional details on the major ideas presented can be found at the end of each chapter. Additional references, including those indicated in the various tools, are also available at the end of this toolkit, under "Overall References". These will help the group understand specific aspects of cancer control planning.

ICONS

To support you in the use of this document we have included some icons in the left margins. The meaning of such icons is described below:

SUGGESTS TIPS OR GUIDING PRINCIPLES TO HELP YOU IN THE PLANNING PROCESS

POINTS OUT PRACTICAL TOOLS FOR PLANNING

PRESENTS QUESTIONS TO BE ADDRESSED DURING THE PLANNING PROCESS

CALLS YOUR ATTENTION TO IMPORTANT THINGS TO REMEMBER DURING PLANNING

SITUATED WHERE IMPORTANT DEFINITIONS ARE LOCATED

Icons like this refer to the World Cancer Declaration target the text is linked to

Refer to page 14 for details of each World Cancer Declaration target

Every country will develop its own unique plan because the cancer problems and the systems dealing with these problems are different in each country. Some of the ideas and tools in this toolkit can be used exactly as they are, but any ideas, tools, or words may also be changed to fit the needs and circumstances of your country. We hope you will also come up with new tools, samples, and examples that you can then share with other countries.

We hope you will find this toolkit useful and we wish all cancer control planning groups every success in completing and implementing a national cancer control plan in your country! For questions and feedback about this toolkit, as well as questions on national cancer control planning, please contact UICC at **nccp@uicc.org**.

EXECUTIVE SUMMARY

PLANNING FOR CANCER CONTROL

A national cancer control plan (NCCP) is a sustainable strategic plan to control cancer, based on the country's cancer burden, cancer risk factor prevalence, and the resources available to implement the plan in the context of the socio-economic environment and health-care system in that country. In order to develop a NCCP, the following information should be collected:

The cancer burden – The minimum data needed is a realistic estimate of the number of new cases each year. This data should provide a rank order of the common cancers and indicate those cancers for which prevention and early detection (early diagnosis and screening) is important and those for which treatment and supportive care are available. Cancer mortality, prevalence and five-year survival from diagnosis are helpful additional datasets, although many ountries do not have them.

The cancer risk factor prevalence – Some countries might not have a significant cancer burden but already have a significant prevalence of cancer risk factors. This information allows those concerned to start planning corrective action. The common cancers can give clues to the risks, e.g. lung cancer and smoking. When data are not available, a population-based random survey can measure these risks and indicate priorities for action.

The resources of skills and infrastructure available for cancer control – A realistic inventory of available skills and infrastructure that will enable planners to decide the country's resource level must be undertaken. This will determine what cancer control actions are possible throughout the cancer control continuum. For many countries which are ranked by the World Bank as having a very low level of resources, generally cancer prevention and palliative care are possible for the whole population, although segments of the population may be able to obtain more.

The health care system and socio-economic environment – An overview of the country's health care system and its cultural beliefs should be included in the assessment of the country's cancer picture to understand the existing framework for realistic cancer control planning. This involves being aware of the health care system components (governance, information and data, health financing, available human resources, medicines, technologies, and service delivery) and the beliefs which underlie and affect the way people make decisions regarding their health in that culture.

With this knowledge, planning authorities can decide whether or not to proceed with the development of a NCCP. This will require political will and appropriate resources. A NCCP that does not have the support of the government is most unlikely to be implemented. If planning is to proceed, then a planning framework covering the spectrum of cancer control is strongly recommended, even if the final plan must recommend a restricted range of actions.

Supporting national cancer control planning: a Toolkit for CSOs **takes a step-by-step approach through the different phases needed to achieve a national cancer control plan:**

The basics:	What is the country's cancer picture?
Collaboration:	Who can help develop and implement a cancer control plan?
Content:	What will be included in the plan?
Action:	How is the plan communicated and implemented?
Evaluation:	What is a successful plan?

A checklist called *"Before you begin"* precedes the five sections and is intended to select which sections will be most useful to the reader.

All sections contain:

- An introduction
- Guiding principles
  (e.g. lessons learned and considerations based on the experience of other countries)
- Critical questions to be addressed as the planning process evolves
- Practical tools
- A list of references for additional details

All through the document, reference will be made to the World Cancer Declaration (WCD), a tool that may help CSOs to bring the growing cancer crisis to the attention of government leaders and health policy makers, so that a significant reduction in the global cancer burden can be achieved by 2020 through the 11 targets it proposes.

The Declaration can be downloaded from the UICC website in several languages **www.uicc.org/declaration/download-declaration**

Ultimately, national authorities are responsible for ensuring the sustainability of a cancer control plan. Civil society is a crucial partner for successful cancer control interventions, and it is in the spirit of fostering fruitful collaboration among all stakeholders that UICC and ECL are presenting these resources, which, it is hoped, will assist in a truly formidable task.

Comments and suggestions to improve these resources for the benefit of future users are welcome. Please send them to **nccp@uicc.org.**

INTRODUCTION

NATIONAL CANCER CONTROL PLANNING: RESPONDING TO THE CHALLENGE OF THE CANCER BURDEN

2010 saw cancer become the first cause of death worldwide. Although regional differences exist, cancer trends are globally on the rise, mainly due to a combination of population growth and ageing.

The global burden of cancer has more than doubled over the last 30 years, in 2008 there was an estimated 12 million new cases, 7 million deaths and 25 million people living with cancer. As the majority of the global cancer burden is now found in low- and middle-income countries, the myth of cancer being a disease of the wealthy is now shattered. If no action is taken, estimates predict that by 2030 there will be 21 million new cases and 13 million deaths worldwide .

These staggering figures demand swift and firm action. This action must be carefully thought out, and cancer control plans on a national scale offer effective frameworks for organising activity. Planning for cancer control, in turn, should be considered within the larger picture of planning for Non-communicable Diseases (NCDs), as many risk factors are shared with other diseases.

Cancer risk factors, such as tobacco smoking, excessive alcohol consumption, unhealthy diet and physical inactivity, exposure to infections and carcinogens and, in addition, longer life expectancy, all contribute to these rising trends. And yet research shows that through appropriate lifestyle choices, at least one third of all cancers could be prevented; through early detection and effective treatment, lethal consequences could be avoided for another third; and pain relief and palliative care would increase the quality of life of people living with cancer even in low-resource settings.

Cancer control is a public health approach aimed at reducing the burden of cancer in a population. Planning, evidence-based, and cost-effective interventions across the cancer continuum (prevention, early detection, treatment, supportive and palliative care, research, and training) is the most effective way to tackle the cancer problem and reduce the suffering of patients and their families.

In response to the enormous burden of cancer, some countries have already developed national cancer control plans and others are currently developing them. These plans are based on a systematic review of the national cancer burden and scientific knowledge of what has proven effective in decreasing the burden. The plans identify the priorities a country should set and specific actions it should take to reduce its cancer burden.

Most countries, however, have yet to begin a systematic national cancer control planning effort, taking into account the local possibilities, and many are just becoming aware of the opportunity to do so. Where governments are concentrating on other immediate health priorities, CSOs can play a critically important role in increasing public and leadership awareness of the cancer problem, and develop effective partnerships which can take on the responsibility of cancer control planning.

THE WORLD CANCER DECLARATION: A REFERENCE FOR PLANNING

The Declaration represents a consensus between government officials, public health experts and cancer advocates from around the world who are committed to eliminating cancer as a life-threatening disease for future generations.

The Declaration outlines 11 targets to be achieved by 2020 including: significant drops in global tobacco consumption, obesity and alcohol intake; universal vaccination programmes for hepatitis B and human papilloma virus (HPV) to prevent liver and cervical cancer; dramatic reductions in the emigration of health workers with specialist cancer training; universal availability of effective pain medication; and dispelling myths and misconceptions about cancer.

As the custodian of the Declaration, UICC encourages priority actions to achieve the Declaration's targets locally and nationally and promotes a comprehensive response across the globe, including the consideration of such targets during cancer control planning at all levels

SUPPORTING NATIONAL CANCER CONTROL PLANNING: A TOOLKIT FOR CSOs
A CONTRIBUTION TO CIVIL SOCIETY

UICC is committed to supporting civil society worldwide in its efforts towards cancer control, including participation in planning effective cancer control activities. To this end, UICC, with a pool of experts and the support of the Association of European Cancer Leagues (ECL), has developed practical guidance material aimed at civil society organisations, which illustrates how to prioritise and implement cancer control planning actions for maximum impact.

The needs of the cancer patient have been reflected in this update through ECL's involvement. Many, if not all, national and local patient organisations work closely with and are supported by cancer leagues in their countries. In Europe, patients' issues are considered collectively for action at the European level by ECL through its active Patient Support Working Group.

Supporting national cancer control planning: a Toolkit for CSOs draws on existing literature and feedback both from countries which developed and implemented population cancer control plans and from countries which are working to develop them. It provides practical suggestions that can be applied whatever the cancer and risk factor burdens, health system and care infrastructure, access to care, culture, political support, and level of financial and human resources available. The material is organised by key planning steps with guiding principles, questions to consider and tools to help cancer agencies work towards a cancer control plan. It is intended as an evolving tool: as new material becomes available, it will complement the core material posted on the UICC website.

New and core material will be posted on **www.uicc.org/resources**

THE WORLD CANCER DECLARATION: TARGETS BY 2020

Sustainable delivery systems will be in place to ensure that effective cancer control programmes are available in all countries.

The measurement of the global cancer burden and the impact of cancer control interventions will have improved significantly.

Global tobacco consumption, obesity and alcohol intake levels will have fallen significantly.

Populations in the areas affected by HPV and HBV will be covered by universal vaccination programmes.

Public attitudes towards cancer will improve and damaging myths and misconceptions about the disease will be dispelled.

Many more cancers will be diagnosed when still localised through the provision of screening and early detection programmes and high levels of public and professional awareness about important cancer warning signs.

Access to accurate diagnosis, appropriate cancer treatments, supportive care, rehabilitation services and palliative care will have improved for all patients worldwide.

Effective pain control measures will be available universally to all cancer patients in pain.

The number of training opportunities available for health professionals in different aspects of cancer control will have improved significantly.

Emigration of health workers with special training in cancer control will have reduced dramatically.

There will be major improvements in cancer survival rates in all countries.

It is always possible to take population-based actions that will reduce the burden of cancer or cancer risk factors, no matter what the situation is in the country. Every action, however limited, is a piece of a bigger picture, and by mapping out a plan, even limited actions can be considered beneficial in the overall approach to cancer control.

Planning frameworks which take account of all strategies to reverse the burden of cancer (including prevention, early detection, treatment, supportive and palliative care, research and training) are helpful tools. This applies even when the country's resources may limit the cancer control actions that can be taken.

UICC and ECL operate in a spirit of transparency and collaboration, and believe that CSOs should do the same. CSOs should cooperate to the greatest extent possible with provincial, state, national or supranational authorities, even when cancer is not high on the political agenda for governments, and where people with cancer are best – or only – served by civil society.

Cancer prevention activities for a population – a city, region, state, or country – will be much more effective if government departments and CSOs, including cancer leagues, responsible for these lifestyle diseases plan together, define common goals, and pool resources and skills as needed.

Several national, international and supranational bodies, of which UICC and ECL are partners, are undertaking international activities contributing to cancer control. The World Health Organization (WHO) is a natural partner of UICC: the adoption by the World Health Assembly of the Tobacco Framework Convention in 2003; the global strategy on diet and physical activity in 2004; the resolution on cancer prevention control in 2005; the Non-Communicable Disease action plan in 2008; and the alcohol control strategy in 2010 shows the commitment of this international body, and its Member States, to the issue.

At the European level, the Commission has stepped up its commitment to decrease the burden of cancer. Notably, the Commission launched in 2009 the European Partnership for Action Against Cancer (EPAAC), which led to the highly-visible Commission-funded EPAAC project 2011-2014. This project connects European and global stakeholders to work together in this endeavour on several important work packages, including one on "Health Promotion and Cancer Prevention" under the leadership of ECL. The Partnership's work package on "National Cancer Control Plans" actively involves all EU Member States as well as Norway and Iceland. Information on the progress and outcome of this work package is available on the Partnership's website **www.epaac.eu**.

In May 2010, the United Nations, led by Caribbean Community (CARICOM) Member States and co-sponsored by 130 Member States, voted unanimously in favour of a resolution to hold a United Nations High Level Meeting on Non-communicable Diseases (NCDs), which took place in September 2011. NCDs constitute an important global issue, with WHO estimates of 8 million people yearly dying prematurely from this cause in low- and middle-income countries (LMIC). The World Economic Forum (WEF) has further identified NCDs as the second most severe threat to the global economy in terms of likelihood of the issue occurring and potential economic loss. Despite this compelling data, a recent survey by the Centre for Global Development showed that less than 3% of the US$22 billion spent on health by international aid agencies in LMICs is spent on NCDs. Furthermore, while the Millennium Development Goals state that health is critical to the economic, political and social development of all countries, they contain no goals or targets for NCDs, the largest burden of disease in LMICs.

Cancer organisations represented by the UICC understand the dangers of a global health community in which disease organisations act in isolation and the promises of group action for a world with better health outcomes are foregone. As some risk factors for cancer are shared by other NCDs, notably diabetes, cardiovascular diseases and chronic respiratory diseases, common strategies should indeed be used to effectively address several diseases. Acknowledging this potential for collaboration and joint action, four leading organisations, each dealing with a specific non communicable disease – International Diabetes Federation (IDF), Union for International Cancer Control (UICC), The International Union Against Tuberculosis and Lung Disease (The Union), and World Heart Federation (WHF) – came together under the umbrella of the Non-communicable Disease Alliance (NCD Alliance) to bring a united voice to the global campaign for Non-communicable Diseases.

In preparation of the abovementioned UN High-Level Meeting, the NCD Alliance convened the civil society movement to deliver a strong outcome, bringing together CSOs, the World Health Organization, health professionals, academia, the private sector, and other stakeholders to form a powerful and united voice. The Meeting adopted a Political Declaration on Non-communicable Diseases, agreeing that "the global burden and threat of NCDs constitutes one of the major challenges for development in the twenty-first century, which undermines social and economic development throughout the world".[1]

As a follow-up to the High-Level meeting, WHO is responsible for the development of a monitoring framework of the reduction of NCDs through voluntary targets for countries. Two discussion papers by WHO proposing a list of targets and indicators have been subject to further consultations with Member States and civil society. This process continued throughout the World Health Assembly 2012 and is expected to continue until the Action Plan 2013-2018 is finalised by WHO.

UICC and ECL are determined to contribute to progress in international cancer control through coordinated and synergistic actions undertaken with their members, the NCD Alliance, WHO and its Member States, and other partners by planning together, defining common goals, and pooling skills and resources. The challenge is a global one, as is the ultimate goal of reducing the suffering of all people affected by cancer.

1. UN Official Document A/66/L.1 www.un.org/ga/search/view_doc.asp?symbol=A/66/L.

BEFORE YOU BEGIN – A CHECKLIST

Before you begin using the toolkit, fill out the checklist below. This checklist provides a quick overview of the entire content of the toolkit and your answers will help you decide which parts of the toolkit will be most useful to you.

Place a checkmark (√) beside all the statements that you agree with. Then go back and look at the statements for which you did not place a checkmark. These statements will point out areas where you may need to focus your attention as you work through this toolkit.

In countries that are just getting started with a cancer control planning effort, most of the statements will not be marked. You should not be discouraged if that happens. It merely shows that you are just getting started and may need to use the entire toolkit.

1. WHAT IS THE COUNTRY'S CANCER PICTURE?

- We already know whether data on the cancer burden are available in the country and how reliable they are. ○
- The cancer epidemiologists in the country are involved in our planning group. ○
- We have decided on additional data we will need to collect for our cancer control plan and how to obtain them. ○
- Our whole cancer control planning group has reviewed the cancer data together. ○
- We have already decided what the major cancer control needs or gaps are in our country. ○
- We know how we want to assemble the cancer data and report them to decision-makers. ○
- We know how we would like to discuss these data and report them to decision-makers. ○
- We know what the components of the health systems in our country are. ○

2. WHO CAN HELP DEVELOP A CANCER CONTROL PLAN?

- We have identified leaders for the planning process. ○
- We have already created a cancer control planning group. ○
- We have identified who will write the plan. ○
- We have already invited the major cancer and other experts (public health officials, epidemiologists, clinicians, socio and economic researchers, and patients' representatives) in our country to be involved in our planning process. ○
- We know which commitments we are asking from participants while working on the plan and we have communicated this to them. ○
- We have clear decision-making rules to guide our planning process. ○
- We have a process to recognise the contributions of the cancer control group members to the planning effort. ○
- We know how we are going to divide the cancer control planning group into working groups and what we expect these working groups to bring back to the whole cancer control planning group. ○
- We have administrative personnel to maintain mailing lists, organise meetings, record minutes, keep group planning files up-to-date, etc. ○

3. WHAT WILL BE IN THE PLAN?

- We know which cancer issues will be a part of our plan (scope) and which will not. ◯
- We have defined the broad goals of the cancer control plan. ◯
- We have clear instructions on how to make our objectives measurable and linked to the goals of the plan for each cancer issue. ◯
- We know how we will set priorities for the plan and what criteria we will use to select them. ◯
- We have defined the process for identifying cancer control strategies that have a high likelihood of being successful. ◯
- We know for whom the plan is intended – that is, who we expect to implement it or support it. ◯
- We have an approach for identifying which resources we need to implement the plan. ◯

4.HOW IS THE PLAN IMPLEMENTED AND COMMUNICATED?

- We have defined a process for reviewing and approving the plan, including a process for public input, if appropriate. ◯
- We have a specific strategy to inform our national leaders about the plan. ◯
- We know who else we need to invite to join us in implementing the plan and how we are going to recruit them. ◯
- We know which resources we will need to implement our plan and have a collaborative approach to getting them. ◯
- We have defined the process and timeline for formally and regularly reviewing progress in our cancer control plan. ◯
- We have a communication strategy to make the nation aware of the cancer control plan. ◯
- We know with whom we need to communicate about the plan, how to reach them, and what we want them to do to support it. ◯

5. WHAT IS A SUCCESSFUL PLAN?

- We have defined the objectives of the plan that are SMARTER (Specific, Measurable, Achievable, Reasonable, Time-phased, can be Evaluated, and Revisited). ◯
- We have defined the objectives in short, medium, and long-term goals. ◯
- We have skilled evaluators who are committed to helping design and carry out re-evaluation. ◯
- We have defined the data and other resources needed for the evaluation and know where we will find them. ◯
- We have a strategy to analyse the results and consequences of the evaluation and to report them to decision-makers and the public. ◯

In general, it is important to note that a health system is shaped within the country's social and political context, and will change in response to changes in the environment. Strong policies and leadership are key to a well-functioning health system.

SECTION 1

WHAT IS OUR COUNTRY'S CANCER PICTURE?

Every country should use available or easily obtainable data to develop a picture of the national cancer burden and the factors that either increase the burden or help reduce it. This picture should be used at the beginning of the cancer control planning to identify the country's major cancer control needs, set priorities for action, and serve as a baseline for evaluating progress when the plan is implemented.

Review the "Before you begin" checklist before you begin this section!

CONTENT OF THIS SECTION

INTRODUCTION

Every country should use available or easily obtainable data to develop a picture of the national cancer burden and the factors that either increase the burden or help reduce it. This picture should be used at the beginning of cancer control planning to identify the country's major cancer control needs, set priorities for action, and serve as a baseline for evaluating progress when the plan is implemented.

Some countries have cancer-related data that are readily available, whereas others may need to collect data. Data collection can come from various sources both inside (e.g. reports or raw data from the Ministry of Health, population based cancer registries, hospital based registration, surveys etc.) and outside the country (e.g. from WHO, the International Agency for Research on Cancer (IARC)).

There are two different types of data which may be useful for assessing the cancer burden in a country: quantitative data and qualitative data.

New data collection can be expensive and time consuming. You should find out how the existing data were derived to determine their accuracy, and then decide whether to use the data available until more reliable information sources can be developed.

Aa

QUANTITATIVE DATA

Quantitative data consists of specific numbers which have been obtained through some statistical method (e.g. registry data, survey results, census records, or laboratory test results). Quantitative data assists in measuring the cancer burden and making decisions based upon concrete and measurable information.

QUALITATIVE DATA

Qualitative data are more subjective than quantitative data, and include sources of information based on obtaining ideas and opinions. Qualitative methods include poll studies, focus group interviews and interviews with key experts or decision-makers.

Quantitative data and qualitative data address different questions and are not a substitute for each other. Despite this, in the absence of either data set, you may decide to use the data available until more accurate pieces of information can be elaborated.

GUIDING PRINCIPLES

1. WHAT IS OUR COUNTRY'S CANCER PICTURE?

1.1 It is best to assemble information on your country's cancer burden during the early stages of planning. Examples from some countries that have completed their assessments indicate that it generally takes about nine months to complete a good assessment when data exists and even longer when data needs to be generated.

1.2 The cancer burden should be described in the context of the chronic disease burden of the country as well as the overall disease burden.

1.3 The data should always be interpreted by an epidemiologist, preferably with experience in cancer.

1.4 The cancer burden assessment should include:

- **a.** Demographic information on the overall population.
- **b.** Data on cancer incidence and mortality in the overall population (from cancer registries).
- **c.** Prevalence data related to cancer risks.
- **d.** National health and social system data.
- **e.** Existing cancer resources, including major cancer facilities, cancer workforce, prevention and early detection programmes (screening and early diagnosis), as well as professional education, research units and current funding resources allocated to national cancer control.
- **f.** Political and cancer control leadership.
- **g.** Nationwide capacity to support enhanced cancer control efforts (including strengthening registration capability).

1.5 The quality of cancer data varies widely. For example, some countries may have mortality data but no incidence data or vice versa. Others may have reliable data on the cancer burden, but no data on the prevalence of risk factors – e.g. tobacco use, human papilloma virus (HPV) infection rates – or health services data – e.g. infrastructure, access, coverage. Whatever data is available, a decision will need to be made about whether they can be used for planning purposes. In general, using what data you have is better than using no data; but you should be aware of how reliable the data is, as well as its limitations.

1.6 At the start of the assessment, countries should identify:

- **a.** The most recent, available cancer-related data.
- **b.** Reliable cancer-related data that could be obtained during the cancer control planning process.
- **c.** Cancer-related data that are needed but will not be available during the planning efforts.

1.7 Where historical data are available, trends in the data should be described in the cancer picture, especially trends that illustrate whether the cancer burden is rising or the prevalence of risk factors (such as tobacco use) is changing.

1.8 Where population-based cancer registration exists, variations in the data should be noted including:

- **a.** Age differences
- **b.** Gender differences
- **c.** Stage at diagnosis
- **d.** Incidence differences
- **e.** Mortality differences
- **f.** Geographic variations (e.g. by province)
- **g.** Rural/urban differences
- **h.** Ethnic variations.

1.9 Any needs for new or improved cancer-related data should be included in the cancer control plan (especially to train people in cancer registration).

1.10 The most useful cancer data should include:

- **a.** Ranking of cancer in the overall country disease burden
- **b.** Major cancer sites and stage at diagnosis (TNM)
- **c.** Mortality by major cancer sites
- **d.** Major risk factors
- **e.** Trends in cancer and risk factors
- **f.** Gaps in cancer services delivery
- **g.** Disparities in access to care
- **h.** Targets for specific needs and population groups.

1.11 If possible, the national cancer picture should depict the economic impact of cancer on the country as well as its burden in terms of human suffering.

1.12 You should also make clear what will happen to the cancer burden if nothing new is done to tackle it.

1.13 The cancer picture should note which major cancer control problems, or needs, can be addressed by existing cancer control interventions and which cannot. You must also decide which interventions are feasible in your country.

EXAMPLE

Tobacco-related cancers can be addressed through known smoking cessation or tobacco control policy interventions. At the same time, there are no effective mass screening interventions for detecting hepatic cancer early. Pap tests may be feasible in some countries while in others, visual inspection of the cervix may be more feasible, or a vaccination strategy may be in order.

1.14 It is It is important to understand the health system of your country when assessing a comprehensive cancer picture. While many definitions from various sources exist on what is meant by a health system, a useful reference and guidance is the "World health report 2000: health systems: improving performance", which can be found on the WHO website.

In general, it is important to note that a health system is shaped within the country's social and political context, and will change in response to changes in the environment. Strong policies and leadership are key to a well-functioning health system.

UNDERSTANDING THE HEALTH SYSTEM OF YOUR COUNTRY MEANS UNDERSTANDING THE SIX KEY COMPONENTS THAT MAKE UP A HEALTH SYSTEM:

a. Leadership and Governance The health authorities should have responsibility for the governance of the health sector, and for current and future challenges. There should be national health policies and plans setting the direction for the health sector, with processes that are clear and participatory.

b. Health Information System The health information system component includes the official sources of data available, as a result of household surveys, civil registration systems, and epidemiological surveillance records. It is important to see what indicators and targets are being monitored and surveyed, and how data is collected, managed, analysed and communicated.

c. Health Financing The primary objective of health financing in a country is to remove financial barriers and to prevent financial hardship, by ensuring or facilitating universal coverage. The ideal health financing component would raise funds for health, pool financial resources to share risks, and is supported legislatively.

d. Human Resources for Health The human resources component refers to the health workforce and related mechanisms and processes in the country such as recruitment, education, training, and retention. Human resources also refer to whether a workforce is sufficiently and appropriately staffed; whether there are balanced payment systems; and whether cooperation of all sectors and stakeholders exists.

e. Essential Medical Products and Technologies This health system component helps to assess to what extent essential medicines, vaccines, diagnostics and health technologies are affordable and accessible, and whether they are used appropriately and cost-effectively.

f. Service Delivery Service delivery looks at how services are provided to the people, noting how primary and specialised care are organised and made accessible and how quality guidelines are in place to ensure safety and effectiveness, especially to the vulnerable populations.

1.15 The cancer picture should include the cultural beliefs which shape the people's attitude and behaviour towards health and how they interact with the country's health system. The culture of a country encompasses the society's shared attitudes, knowledge and values, and affects lifestyle choices made at the individual level.

CRITICAL QUESTIONS FOR PLANNING

The following questions should help identify what needs to be done to complete a cancer burden assessment in your country.

- What existing documents and data sources do we already have for the assessment? How can we access them?
- Who are the major experts on cancer data in our country? Are they involved in the planning efforts? If not, how can we invite them to become involved?
- Who exactly are our decision-makers in cancer control?
- What other data do we need in order to have a complete picture of the cancer burden in our country? Do we have the capacity and resources to collect that information before or during the planning process?
- Have all of our cancer control partners reviewed the cancer data together? If not, how will we get their input on interpreting the data?
- What conclusions should be made based on the major cancer needs in our country according to the available data?
- How should we report the cancer burden data to our national decision-makers?
- What are our needs for new or better cancer-related data in future years?
- To what extent do the six basic components of the health system exist in our country?

PLANNING TOOLS TO ESTABLISH A COUNTRY CANCER PICTURE

Tool 1.1 Key steps in conducting a cancer burden assessment – a checklist

Tool 1.2 Assembling and assessing cancer-related data: examples

Tool 1.3 Potential data elements for inclusion in a cancer burden assessment

Tool 1.4 Sample cancer burden assessment

NCCP tools can be accessed through **www.uicc.org/resources**

THE WORLD HEALTH ORGANIZATION (WHO)

WHO has developed a series of six modules that provide practical advice for programme managers and policy-makers on how to advocate, plan and implement effective cancer control programmes, particularly in low- and middle-income countries. These guidelines constitute a response to the World Health Assembly resolution on cancer prevention and control (WHA58.22), adopted in May 2005, which calls on Member States "to intensify action against cancer by developing and reinforcing cancer control programmes".

www.who.int/cancer/modules/en/index.html

REFERENCES AND USEFUL LINKS

- Atun R, Coker R, McKee M. Health Systems and the Challenge of Communicable Diseases: Experiences from Europe and Latin America. In: CokerA, Atun R, et al., editors. Health Systems and Systems Thinking. Open University Press, McGraw Hill Education; 2008. p. 121-140.
- Atun R, Ogawa T, Martin-Moreno JM . Analysis of National Cancer Control Programmes in Europe. London: Imperial College London Business School; 2009
- Australia: National Cancer Prevention Policy 2007-2009. www.cancer.org.au/policy/NationalCancerPreventionPolicy.htm
- Canada: The 2011 Cancer System Performance Report Available from www.cancerview.ca/idc/groups/public/documents/webcontent/2011_system_performance_rep.pdf
- Centres for Disease Control and Prevention. Guidance for Comprehensive Cancer Control Planning – Volume 1: Guidelines and Volume 2: Tools. US Centres for Disease Control and Prevention; 2002. Retrieved from www.cdc.gov/cancer/ncccp/pdf/Guidance-Guidelines.pdf
- Coleman MP Responding to the challenge of cancer in Europe. Ljubljana: Institute of Public Health of the Republic of Slovenia; 2008.
- Corlien M, Varkevisser IP. Designing and Conducting Health Systems Research Projects: Volume 1. Ottawa: International Development Research Centre; 2003.
- Curado MP, Edwards B, Shin HR, Storm H, Ferlay J, Heanue M, Boyle P, editors
- Cancer Incidence in Five Continents, Vol. IX. Lyon, International Agency for Research on Cancer IARC Scientific Publications; 2007. No. 160.
- Dutch National Comprehensive Cancer Control Programme. https://webgate.ec.europa.eu/sanco/heidi/images/3/3e/Netherlands_National_Cancer_Control_Programme_English.pdf
- Ferlay J, Shin HR, Bray F, Forman D, et al. GLOBOCAN 2008, Cancer Incidence and Mortality Worldwide: IARC CancerBase No. 10 [Internet]. Lyon, France: International Agency for Research on Cancer; 2010. Retrieved from http://globocan.iarc.fr/
- France: le Plan Cancer 2009-2013 www.plan-cancer.gouv.fr/le-plan-cancer/presentation.html
- French Institute of Health Surveillance Watch. www.invs.sante.fr/surveillance/index.htm
- Lalla Salma Association Against Cancer. Plan cancer 2010-19. Retrieved from www.contrelecancer.ma/le_pnpcc
- Coleman MP et al. . Cancer survival in five continents: a worldwide population-based study (CONCORD). Lancet Oncology. 2008:730–56.
- National Partners for Comprehensive Cancer Control . Comprehensive Cancer Control Jurisdiction Guidebook for United States Associated Pacific Island Nations, 11-15. 2005.
- State Cancer Profiles. See Step 1 of the Cancer Control PLANET. http://statecancerprofiles.cancer.gov/
- Union for International Cancer Control. The World Cancer Declaration. www.uicc.org/declaration
- Union for International Cancer Control. Evidence-Based Cancer Prevention: Strategies for NGOs: A UICC Handbook for Europe. Geneva: UICC; 2004. 15-33. www.uicc.org/resources/evidence-based-cancer-prevention-strategies-CSOs-uicc-handbook-europe
- Union for International Cancer Control. Evidence-based cancer prevention: strategies for NGOs: A UICC Handbook for Latin America. Geneva: UICC; 2004. www.uicc.org/resources/prevenci%C3%B3n-del-c%C3%A1ncer-estrategias-basadas-en-la-evidencia-america-latina
- Union for International Cancer Control. Cancer Awareness, Prevention and Control: Strategies for South East Asia. Geneva: UICC; 2004. www.uicc.org/resources/cancer-awareness-prevention-and-control-uicc-handbook-south-asia-0
- Uruguay : Programa National de Control del Càncer www.bvsoncologia.org.uy/pdfs/destacados/PRONACCAN_2005-2010.pdf
- World Health Organization. Everybody's business : strengthening health systems to improve health outcomes : WHO's framework. Geneva: World Health Organization; 2007. www.who.int/healthsystems/strategy/everybodys_business.pdf
- World Health Organization. Key components of a well functioning health system. Geneva: World Health Organization; 2010, May. Retrieved September 2010, from www.who.int/healthsystems/publications/hss_key/en/index.html
- World Health Organization. Planning. (Cancer control : knowledge into action : WHO guide for effective programmes ; module 1.). Geneva: World Health Organization; 2006. www.who.int/cancer/modules/PlanningModule.pdf
- World Health Organization. The world health report 2000 : health systems : improving performance. Geneva: World Health Organization; 2000.www.who.int/whr/2000/en/whr00_en.pdf
- World Health Organization. What is a health system? Geneva: World Health Organization; 2005. November 9. Retrieved September 5, 2010, from World Health Organization: www.who.int/features/qa/28/en/index.html
- World Health Organization. "Key components of a well functioning health system". Geneva: World Health Organization; May 2010. www.who.int/healthsystems/publications/hss_key/en/index.html
- World Health Organization. WHO National Cancer Control Programmes. Example: India. www.whoindia.org/EN/Section20/Section385/Section401.htm
- World Health Organization. National Cancer Control Programmes: Policies and Managerial Guidelines. 2nd edition, 119-123. Geneva: World Health Organization; 2002. Retrieved from www.who.int/cancer/media/en/408.pdf
- World Health Organization, International Atomic Energy Agency . National Cancer Control Programmes core capacity self-assessment tool (NCCP core self-assessment tool). 2011. ISBN: 978 92 4 150238 2 www.who.int/cancer/publications/nccp_tool2011/en/index.html

TOOL 1

PLANNING TOOLS FOR CREATING A COUNTRY CANCER PICTURE

TOOL 1.1: KEY STEPS IN CONDUCTING A CANCER BURDEN ASSESSMENT CHECKLIST

The purpose of this checklist is to provide an overview of the key steps needed to complete a cancer burden picture for your country. Completing these steps will ensure that your cancer control planning team will have the best information available to make decisions about what should be included in your country's cancer control plan.

Review all the steps of the checklist. As you go through them, begin to identify which ones require action to be fulfilled, and who will be responsible for taking that action.

STEPS	ACTIONS	RESPONSIBLE PERSON
Recruit major cancer experts in the country for the cancer burden assessment group.		
Develop an outline for assessing the cancer burden picture.		
Identify the writing group to elaborate the cancer burden report.		
Identify all existing sources of cancer data in the country.		
Obtain the most recent data (see Tool 1.3).		
Gather all existing reports that contain data/ information related to cancer.		
If applicable, identify barriers for not being able to access data (e.g. laws).		
Compare existing data sources and reports from above steps with data needed.		
Identify data not currently available and determine how to generate them for the cancer burden picture.		
Assemble the existing data and newly collected data for review and analysis of the quality.		

STEPS	ACTIONS	RESPONSIBLE PERSON
Compare your country results with those reported by countries around yours and with international data.		
Determine what the major findings are for your country.		
Make recommendations to the cancer control planning team with regard to additional data needed to provide a realistic cancer burden picture and/or expanding the national cancer data collection system.		
Write a draft of the cancer burden report (see Tool 1.2).		
Discuss the draft report with the planning group.		
Prepare a final report.		
Consider publishing the report.		
Consider a formal submission of the report to national leaders.		

USEFUL LINKS

- GLOBOCAN 2008 http://globocan.iarc.fr
- Cancer Registration: International Association of Cancer Registries www.iacr.com.fr/
- North American Association of Central Cancer Registries www.naaccr.org/
- WHO-IAEA NCCP core self-assessment tool http://whqlibdoc.who.int/publications/2011/9789241502382_eng.pdf

EXAMPLES

CIA (Central Intelligence Agency)	www.cia.gov/library/publications/the-world-factbook/index.html
Globocan	http://globocan.iarc.fr/
IAEA	www.iaea.org/
UC Atlas	http://ucatlas.ucsc.edu/query.php
UNAIDS	http://data.unaids.org/pub/GlobalReport/2006/2006GR-PrevalenceMap_en.pdf
WB (World Bank)	http://data.worldbank.org/
WHO (World Health Organization)	www.who.int/globalatlas/dataQuery/default.asp www.who.int/countries/en/index.html www.who.int/ncd_surveillance/infobase/web/InfoBasePolicyMaker/CountryProfiles/QCStart.aspx www.who.int/reproductive-health/publications/maternal_mortality_2000/mme.pdf

TOOL 1.2: ASSEMBLING AND ASSESSING CANCER-RELATED DATA: EXAMPLES

This worksheet is designed to help you organise and assess the information which should be included in your country cancer picture. The column on the far left of the worksheet provides space for you to enter the data elements you have decided to include (see Tool 1.1). The remaining columns are self-explanatory. In an electronic form, this may become a worksheet which can be expanded to provide additional rows and columns so that you can adapt it to your planning purposes. Two examples are provided in the table below.

DATA ELEMENT ▾	1. CANCER INCIDENCE (EXAMPLE)	2. KNOWLEDGE AND ATTITUDES OF NATIONAL LEADERS ABOUT CANCER PREVENTION, EARLY DETECTION, AND TREATMENT (EXAMPLE)
Are these data currently available? (yes/no)	Yes	No
Where are these data kept? (sources)	In individual hospital registries	Does not apply
Who will obtain the data from the source?	The chief epidemiologist at the Ministry of Health and a team of data clerks from the ministry.	Does not apply
How reliable are these data for cancer control planning purposes?	The data vary from hospital to hospital, but are of generally good quality; the data can provide an estimate based on about 65% of the population, but they will not be a reliable measure of cancer incidence for the population as a whole.	Does not apply
If the data are not currently available, how will we get them, when will we get them, and who is responsible for getting them?		The National Cancer Society will assemble two focus groups – one with 12 members of the National Parliament; and one with the six top officials of the Health Ministry. A focus group guide will be developed and agreed upon by the national cancer control planning group. These focus groups will take place once the other data elements have been collected, so that the information can be used during the focus group discussion.

TOOL 1.3: POTENTIAL DATA ELEMENTS FOR INCLUSION IN A CANCER BURDEN ASSESSMENT

This tool provides examples of the kinds of data that might be collected and analysed in a cancer burden study. It is not intended to be exhaustive and there may be other data elements your cancer control planning group would like to include. In some cases, the data needed are clearly quantitative in nature (e.g. demographic data or cancer registry reports); for others it may be necessary to gather information in a qualitative form (e.g. from key expert informant interviews or focus groups). In any case, when data are gathered, an assessment of their reliability for drawing conclusions about cancer needs in your country should be made. Decisions will also need to be made about which data items are already available and whether an effort should be made to gather information on those that are not.

COUNTRY PROFILE

1. Demographic and economic data

Number of inhabitants:	
% Urban:	
Life expectancy at birth:	
All (years):	
Male (years):	
Female (years):	
Age distribution (pyramid):	

EDUCATION

Illiterate (%):	
Total health expenditure: (% of GDP)	
Total health expenditure per capita: Local currency/USD equivalent:	

2. Organisation of the health system

% OF POPULATION COVERED BY

National public insurance:	
Professional insurance:	
Private insurance:	
Mutual (without profit) insurance:	
Out of pocket:	

HUMAN RESOURCES

Physicians Density per 100,000 population:	
% Rural:	
Nurses Density per 100,000 population:	
% Rural:	
Midwives Density per 100,000 population:	
% Rural:	
Dentists Density per 100,000 population:	
% Rural:	
Health care workers Density per 100,000 population:	
% Rural:	

INFRASTRUCTURE

Primary care health centres:	
Rural primary care centres:	
Family planning centres:	
Rural primary care centres:	
Total number of public hospitals:	
Rural primary care centres:	
Maternities:	
Rural primary care centres:	
Cancer institutes:	
Rural primary care centres:	
Private clinics specialised in cancer:	
Rural primary care centres:	

National health programmes:

If yes, specify its priorities:

3. Epidemiological data (national level)

A. MORTALITY

Total crude mortality rate per 100,000	
All:	
Female:	
Male:	
Maternal mortality ratio: (maternal deaths per 100,000 live births)	
Mortality rates by causes (First cause of mortality and % of total)	
Cancer mortality All (%):	
Male (%):	
Female (%):	

B. MORBIDITY

Malnourished children <5 years old (%):	
What are the three major health burdens in your country? 1. 2. 3.	
Immunisation coverage rate per 100 population (vaccination)	
Polio:	
BCG:	
DTP:	
Tetanus:	
HBV:	
Other:	

C. CANCER

National mortality cancer rates per 100,000 population	
Crude rate male:	
World standardised rate male:	
Crude rate female:	
World standardised rate female:	
National cancer incidence rate per 100,000 population	
Number of cases	
Male:	
Female:	
Crude rate male:	
World standardised rate male:	
Crude rate female:	
World standardised rate female:	

Three most frequent cancers

Female

SITE	NUMBER	%
1		
2		
3		

Male

SITE	NUMBER	%
1		
2		
3		

NB: If such data are not available from a published source, collect existing data and note their sources.

CANCER REGISTRIES

Do you have population-based cancer registration?	◯ Yes ◯ No
If yes:	◯ National ◯ Regional
% of population covered by cancer registries:	
Do you have hospital-based cancer registration?	◯ Yes ◯ No
Are the data centralised?	◯ Yes ◯ No
Are data available on: Cancer sites	◯ Yes ◯ No
Histological type	◯ Yes ◯ No
Stage at diagnosis	◯ Yes ◯ No
Treatment	◯ Yes ◯ No
Survival	◯ Yes ◯ No

CANCER HEALTH SERVICES

Cancer centers:	
Number of units:	
Number of beds:	
Private clinics specialised in cancer:	
Number of units:	
Number of beds:	
Cancer units in public hospital:	
Number of beds:	

NUMBER OF UNITS

Radiology Units (Number of)	**PUBLIC SECTOR**	**PRIVATE SECTOR**
Mammography machines		
Tomography, X-ray machines		
Magnetic resonance imaging machines		
Scintigraphy machines		
Cyto-Pathology Units		
Unit Performing Cancer Surgery		
Radiotherapy Units Number of cobalt apparatus		
Number of linear accelerators		
Multidisciplinary Treatment Units (comprehensive cancer centre)		
Chemotherapy Units (whether or not it is associated with surgery and radiotherapy):		
Palliative Care Units		

How are cancer medical care services funded?	
By public (state) insurance (proportion): % of patients covered	
By private (workplace or personal) insurance (proportion): % of patients covered	

Availability of medicines 1 = sufficient 2 = acceptable 3 = not available	**PUBLIC SECTOR**	**PRIVATE SECTOR**
Chemotherapy (antineoplastic drug)		
Morphine		
Other analgesics		

Cancer workforce	
Number of trained oncologists in service	
Surgeons	
Radiotherapists	
Chemotherapists	
Psycho-oncologists	
Haematologists	
Others	

Cancer training	
Does your country provide specific training in oncology (as a specialisation)?	◯ Yes ◯ No
If no, where are oncologists usually trained?	
Does your country offer fellowships for oncology training outside the country?	◯ Yes ◯ No

ORGANISED/INDIVIDUAL SCREENING PROGRAMMES

Cervical cancer	◯ Yes ◯ No
Type of test used	
Strategy (e.g. individual, organised)	
Is the test free?	◯ Yes ◯ No
If no, how much?	

Breast cancer	◯ Yes ◯ No
Type of test used	
Strategy (e.g. individual, organised)	
Is the test free?	◯ Yes ◯ No
If no, how much?	

Colon and rectum cancer	◯ Yes ◯ No
Type of test used	
Strategy (e.g. individual, organised)	
Is the test free?	◯ Yes ◯ No
If no, how much?	

Colon and rectum cancer	◯ Yes ◯ No
If yes, which tumour sites and type of test?	

CANCER PREVENTION ORGANISED PROGRAMMES

Is there data available on the prevalence of the following risk factors?	◯ Yes ◯ No
Tobacco	◯ Yes ◯ No
% of male regular smokers	
% female regular smokers	
Alcohol	
% of male regular alcohol drinkers	
% of female regular alcohol drinkers	
Prevalence of adults (15 years and older) who are	
% obese	
Other frequent cancer risk factors e.g. infectious, professional	

Cancer prevention organised programmes	
Tobacco	◯ Yes ◯ No
Signature of WHO FCTC	◯ Yes ◯ No
Ratification?	◯ Yes ◯ No
Alcohol	◯ Yes ◯ No
Diet	◯ Yes ◯ No
Physical activity	◯ Yes ◯ No
Sun protection	◯ Yes ◯ No
Vaccination	◯ Yes ◯ No
HBV % coverage	
HPV % coverage	
Other prevention programmes (specify):	

3. Epidemiological data (national level)

Physicians Are there CSOs involved in cancer control in the country?	○ Yes ○ No

Specify (names and address):

USEFUL LINKS

- Evidence-based Cancer Prevention: Strategies for NGOs. A UICC Handbook for Europe, 2004. www.uicc.org/resources/evidence-based-cancer-prevention-strategies-ngos-uicc-handbook-europe
- China cancer database. http://cancernet.cicams.ac.cn
- National Cancer Registry Programme, India. www.canceratlasindia.org/
- Philippine cancer control programme. http://jjco.oxfordjournals.org/cgi/reprint/32/suppl_1/S52.pdf
- International Agency for Research on Cancer, Section of Cancer Information www.iarc.fr/en/research-groups/sec1/index.php
- WHO-IAEA NCCP core self-assessment tool http://whqlibdoc.who.int/publications/2011/9789241502382_eng.pdf

EXAMPLES

CIA (Central Intelligence Agency)	www.cia.gov/library/publications/the-world-factbook/index.html
Globocan	http://globocan.iarc.fr/
IAEA	www.iaea.org/
UC Atlas	http://ucatlas.ucsc.edu/query.php
UNAIDS	http://data.unaids.org/pub/GlobalReport/2006/2006GR-PrevalenceMap_en.pdf
WB (World Bank)	http://data.worldbank.org/
WHO (World Health Organization)	www.who.int/globalatlas/dataQuery/default.asp www.who.int/countries/en/index.html www.who.int/ncd_surveillance/infobase/web/InfoBasePolicyMaker/CountryProfiles/QCStart.aspx www.who.int/reproductive-health/publications/maternal_mortality_2000/mme.pdf

TOOL 1.4: SAMPLE CANCER BURDEN ASSESSMENT

1. INTRODUCTION

Here you should explain the purpose of the assessment, who was involved in the assessment, how it was assembled, and how the information will be used in developing the national cancer control plan.

NOTES

2. DATA SUMMARY

This section presents the cancer picture of your country. Information might include:

a. Cancer rates (incidence, mortality, risk factor prevalence, etc.)
b. Cancer trends (what is improving, what is worsening, what remains the same).
c. Comparison of your country data to that of bordering countries or other international data.
d. Geographic and demographic (e.g. ethnicity, gender, language) variations in the cancer burden inside your country.
e. The economic cost of cancer in your country.
f. Cancer health services/systems/programmes currently available in your country.
g. Laws and policies that affect the cancer burden (either positively or negatively).

NOTES

3. KEY FINDINGS

This section is an analysis of the key findings of your country's cancer burden data.

a. Cancer rates or trends that are better compared to other countries.
b. Cancer rates or trends that are substantially worse compared to other countries.
c. Gaps between your country's cancer situation and where science and "best practices" say your country should be.
d. Health services/systems/programmes gaps in your country: items which are not covered by health programmes (e.g. cancer early detection)
e. Geographic and demographic cancer disparities.

NOTES

4. CONCLUSIONS

This section suggests to the cancer control planning team how to use key findings for the national cancer control plan.

a. Recommendations on possible strategies.
b. Recommendations for addressing major cancer disparities that may exist.
c. Recommendations for improving the cancer surveillance system for the country (quality control needs, new data collection needs, expansion of the existing surveillance system, etc).
d. Prioritising actions areas.

NOTES

Recommendations should be SMARTER (Specific, Measurable, Achievable, Reasonable and Time-phased, Evaluable, Revisable) formulated.

USEFUL LINKS

- Lalla Salma Association against Cancer and the Moroccan Ministry of Health. Plan Cancer 2010-19: Plan National de Prévention et de Contrôle du Cancer. 2009.www.contrelecancer.ma/le_pnpcc
- World Health Organization. Planning. (Cancer control : knowledge into action : WHO guide for effective programmes ; module 1.). Geneva: World Health Organization; 2006. www.who.int/cancer/modules/Planning Module.pdf

The more involved people are in discussing a plan, the more likely they are to be engaged in its future implementation, which can help to ensure that the plan is realistic and viable.

SECTION 2

WHO CAN HELP US DEVELOP AND IMPLEMENT A CANCER CONTROL PLAN?

A viable and comprehensive plan should involve a group of knowledgeable and influential people who are interested in its development and those who will be directly or indirectly involved in its implementation.

Review the "Before you begin" checklist before you begin this section!

CONTENT OF THIS SECTION

INTRODUCTION

A viable and comprehensive plan should involve a group of knowledgeable and influential people who are interested in its development and those who will be directly or indirectly involved in its implementation. The reasons for this are simple:

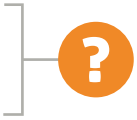
- The more involved people are in discussing a plan, the more likely they are to be engaged in its future implementation, which can help to ensure that the plan is realistic and viable.
- With different stakeholders working together, a country has multiple perspectives about the cancer problem it faces, and multiple ideas about how best to sort through and tackle those issues.
- This group should represent different parts of society, including CSOs, government officials, and both public and/or private health professionals. The number of people involved may depend to some extent on the population of the country as well as the availability and expertise of national stakeholders.
- Recruiting individuals to participate in cancer control planning can sometimes be challenging. The planning process needs to keep people interested and involved so they complete the plan.
- You may also wish to consider interacting with experts and organisations outside your country to share or 'who share' similar experiences.

GUIDING PRINCIPLES

2. WHO TO INVOLVE

2.1 In some cases, the government may develop the cancer control plan and then promote it to healthcare officials and the general public. In other cases, cancer leagues or other CSOs may be requested by the government to develop the plan. Additionally, CSOs may develop the cancer control plan and try to "sell" it to leaders in the government. In any case, the key is to involve the people and the organisations who will take on the responsibility for developing a plan for your country's needs (collaboration between the government and CSOs). It is crucial for the plan to be adopted by the government, so that it is implemented and made sustainable.

2.2 The number of people in the planning group will vary from place to place. The more important question is not "How many people should be included?" but rather "Are we involving all the right people, so when the plan is completed no one can criticise or dismiss it because the 'right' people weren't involved?"



2.3 Some countries choose to set up steering committees to help plan the process for completing a cancer control plan and to make sure the process is working. Those involved in a steering committee will make a special commitment to meet more often than other participants.

2.4 Whatever your country needs, the planning committee should include the major cancer experts in the country, as well as experts in related disciplines (e.g. behavioural scientists) and involve key figures who may be helpful in implementation and represent important stakeholder groups (e.g. cancer patients, the mass media, major employers, elected officials, educators, and religious leaders).

2.5 You may also choose to involve experts or representatives of organisations outside your country. These may be experts in planning or in cancer, or individuals who have been directly involved in developing their own country plans.

2.6 The voice of cancer patients and families, patient organisations, etc., should be included in the planning process as well. Their experiences are important benchmarks of what is and what is not working in the country's current cancer programme.

2.7 When deciding who to invite to participate, consider people who demonstrate the following characteristics and abilities:

- **a.** They have a recognised competence in issues related to cancer.
- **b.** They have a sincere dedication to reverse the current trends in cancer.
- **c.** They are capable and available to contribute to the planning process.
- **d.** They want to actively participate and can work well with others.
- **e.** They can influence the participation of others.
- **f.** They may be able to access resources that are beneficial to the planning process and its efforts.
- **g.** They can advocate to gain support for the plan from those not involved the planning process.

Some characteristics will of course be more relevant to some activities and at specific times in the process. This applies to all people involved in working groups as well as to leadership.

LEADERSHIP

2.8 Like any other effort, cancer control planning must have leaders to be successful. Leaders must be willing to take on extra work in order to help organise the planning effort and make sure it is moving forward. Prominent public figures are often in a position to help in this respect (e.g. First Ladies).

2.9 Leaders are often chosen by the main body leading the planning effort. They need to be seen by others as having expertise in some area of cancer. More importantly, they must be able to think beyond their own area of expertise and help manage the planning discussions

EXAMPLE

Well-known clinical experts (physicians) are often asked to lead the planning. When this is the case, these clinicians must also be able to lead discussions on the nation's non-clinical cancer needs e.g. prevention programmes.

2.10 Many cancer control planning groups choose to have two or three co-leaders to ensure a wide range of expertise in leadership. This also ensures the planning efforts will continue to move forward in case one of the leaders has to leave the process before it is complete.

STRUCTURE, INVOLVEMENT, AND SUPPORT FOR PARTICIPATION

2.11 Cancer control planning groups often divide into smaller groups to discuss specific cancer topics, bringing their recommendations back to the full group. For example, there might be smaller groups on prevention strategies, early detection strategies, or treatment strategies. Or there might be groups focused on specific cancers, such as cervical cancer, breast cancer, or colorectal cancer. When these focus groups are formed they must be given clear instructions on what is expected of them, when their work should be completed, and any resources and/or support that is available to them.

2.12 When recruiting individuals to participate in a planning process, it is important to share the following with them:

- **a.** The importance of a cancer control plan in your country.
- **b.** The reason their input is valuable to the planning committee (e.g. because of special expertise, or because they represent an important group in the fight against cancer).
- **c.** The amount of time they will be expected to contribute until the plan is complete (e.g. over the next year they will attend five one-day meetings, participate in six one-hour conference calls, and spend approximately twenty hours reviewing and commenting on drafts of the plan).
- **d.** The fact that planning and implementation are not two separate "worlds". Planners need to think as implementers – as they may well be one day. Their time commitment may thus extend beyond the official approval of the plan into the implementation phase, say, the first three to five years of the cancer control plan.

2.13 It is important that the planning group knows who will make the final decision on the content of the plan. In some cases, the key health leaders in the country will decide. In others, all those who participate in the planning effort have a vote on whether to accept or reject the plan. Generally speaking, the more people involved in the decision-making process, the easier it will be to implement the plan.

2.14 Some countries are able to devote staff to the planning process, whereas others rely solely on volunteer resources. In either case, it is important that someone is designated to coordinate the overall process and to serve as a point of reference.

TIMEFRAME

2.15 Developing a cancer control plan is a long process; in the experience of the editors of this toolkit, it can take around two years or more.

2.16 It is useful to regularly (e.g. every six months) ask those involved to report on how the planning effort is progressing and if they feel their ideas are being heard. This way individual participants remain well informed and engaged in the overall process.

CRITICAL QUESTIONS FOR PLANNING

The following questions should help identify factors that will need to be carefully considered when assembling a planning committee and to keep it engaged and committed to the cancer control plan's development and implementation.

- Who is responsible for recruiting individuals to participate in the planning process?
- Who are the cancer experts in our country? Have they already committed to help with our plan, or will we need to recruit them?
- Who else needs to be involved in the planning process?
- Have we defined what we expect of each person throughout the planning process?
- Have we communicated our expectations to them?
- How will we choose leaders to guide the planning effort?
- What are our decision-making rules? What will the structure and working plan for our planning group look like?
- Will we have smaller groups focusing on specific parts of the plan? If so, have we clearly defined what is expected of them and when their work is to be completed by? What resources and support will be available to them?
- How will be the cancer control plan endorsed by the government?

TOOLS FOR RECRUITING A CANCER CONTROL PLANNING GROUP

Tool 2.1 Characteristics of government-led, CSO-led, and jointly-led cancer control planning efforts

Tool 2.2 Building and enhancing the comprehensive cancer control partnership

Tool 2.3 Desirable leadership characteristics for cancer control planning – a checklist

Tool 2.4 Tips for starting a cancer control planning group

Tool 2.5 Sample tasks for working groups

Tool 2.6 Resources needed for a cancer control planning effort

NCCP tools can be accessed through **www.uicc.org/resources**

THE INTERNATIONAL AGENCY FOR RESEARCH ON CANCER (IARC)

The International Agency for Research on Cancer (IARC) is an intergovernmental agency forming part of the World Health Organization (WHO). IARC coordinates and conducts both epidemiological and laboratory research into the causes of human cancer. The Agency's work has four main objectives: monitoring global cancer occurrence, identifying the causes of cancer, elucidation of mechanisms of carcinogenesis and developing scientific strategies for cancer control. IARC is currently developing an online bookstore and has a valuable cancer database and other resources to help make a substantial contribution to the development of cancer research.

www.iarc.fr/

REFERENCES AND USEFUL LINKS

- Cancer Control PLANET. Find Programme Partners in Cancer Control and Find Research Partners in Cancer Control (Step 2). Available from http://cancercontrolplanet.cancer.gov.
- Centres for Disease Control and Prevention. Guidance for Comprehensive Cancer Control Planning – Volume 1: Guidelines and Volume 2: Tools. Atlanta: US Centres for Disease Control and Prevention; 2002. Retrieved from www.cdc.gov/cancer/ncccp/pdf/Guidance-Guidelines.pdf
- World Health Organization. Planning. (Cancer control : knowledge into action : WHO guide for effective programmes ; module 1.). Geneva: World Health Organization; 2006. www.who.int/cancer/modules/Planning Module.pdf

TOOL 2

TOOLS FOR RECRUITING AND STARTING A CANCER PLANNING GROUP

TOOL 2.1: CHARACTERISTICS OF GOVERNMENT-LED, CSO-LED, AND JOINTLY-LED CANCER CONTROL PLANNING EFFORTS

It is rare that only the government or only CSOs engage in national cancer control planning. In most cases, there will be some level of involvement of both in the planning process.

At the beginning of the national cancer control planning process, each country should assess the respective level of involvement by CSOs and government and set expectations accordingly.

The following table identifies potential strengths and weaknesses of different approaches to national cancer control planning. Please note that every country is unique, and some of the items listed may not apply to a particular country. It is important to take time early in the cancer control planning process to consider these strengths and weaknesses and adjust the plan accordingly.

	GOVERNMENT-LED PLANNING	CSO-LED PLANNING	JOINT PLANNING
STRENGTHS	• Conveys national authority and support • Public resources can be made available • Commands national visibility • Easier access to national data sources • Better involvement of administrative and health professionals	• Civil society involvement • Political considerations may have less influence • Process may be faster • May reflect the general public perspective	• Demonstrates strong collaboration and commitment between the civil society and government • Less likely to have major disagreements near the end of the planning process • Facilitates implementation of the plan ***Multisectorial planning is usually the best planning approach***
WEAKNESSES	• Politics may influence the plan • General public perception may influence the acceptability of the plan • Government-led processes may take longer to complete • Multiple layers of approval within the government may be required • Multiple government actors need to buy-in into the plan and its implementation	• Fewer resources to draw on • During or after the planning, CSOs will need to convince the government that the plan is valid and important to implement • May not attract the same level of stakeholders to the process without governmental approval • May not convince all professionals • No resources available to implement the plan	• Shared leadership is challenging • There may be times when stakeholders of different sectors have serious difficulties to agree on important matters

USEFUL LINKS

- Guidance for Comprehensive Cancer Control Planning, volume 2: toolkit. See: Tool #14b in Planning Partner Surveys (Utah Comprehensive Cancer Control Organizational Interest Questionnaire). Atlanta: US Centers for Disease Control and Prevention, Division of Cancer Prevention and Control; 2002. p. 42-44.

TOOL 2.2: BUILDING AND ENHANCING THE COMPREHENSIVE CANCER CONTROL PARTNERSHIP

This worksheet will help you identify the types of people you already have on board in your partnership, and who else needs to be involved.

First, identify people who are currently in your partnership and fill in the first two blank columns. You may add extra rows at the bottom of the table to include other types of members.

Then, look at the different rows and identify types of members you need to invite because they are not represented in your group, or additional people who can help others already identified in the row (for example, you may have one business owner involved but decide you need another one on board).

USEFUL LINKS

- American Cancer Society. Partnership-Workbook Exercises. Chicago: American Cancer Society; 2004. p. 26. http://forms.uicc.org/templates/uicc/pdf/nccp/worksheet2-1.pdf
- Cancer Control P.L.A.N.E.T, links to comprehensive cancer control resources for public health professionals, step 2. US National Cancer Institute, Division of Cancer Control and Population Science; 2005. http://cancercontrolplanet.cancer.gov
- Canada: A portal to connect Canadians to cancer resources and tools: www.cancerview.ca

TOOL 2.2: BUILDING AND ENHANCING THE COMPREHENSIVE CANCER CONTROL PARTNERSHIP

ORGANISATION TYPE / AREA OF EXPERIENCE	SPECIFIC ORGANISATION OR INDIVIDUAL	WHAT CAN THIS PERSON OR ORGANISATION DO TO HELP US DEVELOP OR IMPLEMENT OUR PLAN?
Leaders of government agencies/ ministries		
Civil society organisations/cancer leagues		
National and community leaders		
Businesses (major business owners, etc.)		
Health programme leaders		
Religious leaders and workers		
Associations of cancer patients and/or family members		
Media (radio, print, online etc.)		
Legislators/elected officials		
Community organisations (e.g. women's groups)		
Hospitals/health clinics		
Health professionals		
Schools and educational organisations		
Traditional medicine		
Home care/nursery care		
Hospices		

ARE THEY CURRENTLY A MEMBER OR DO WE NEED TO RECRUIT THEM?	WHO IN THE ORGANISATION SHOULD BE CONTACTED TO INVITE THIS PERSON?	WHO IN OUR PARTNERSHIP SHOULD MAKE THE CONTACT, AND BY WHAT DATE?	OTHER HELP

TOOL 2.3: DESIRABLE LEADERSHIP CHARACTERISTICS FOR CANCER CONTROL PLANNING – A CHECKLIST

As you consider who should help lead the cancer control planning effort in your country, consider these leadership characteristics.

You may want to use this checklist for every potential member of the planning group.

REMEMBER: NO ONE PERSON WILL HAVE ALL OF THESE CHARACTERISTICS.

LEADERS FOR YOUR CANCER CONTROL PARTNERSHIP	CHECK
Are committed to the mission of cancer control	○
Are willing and available to spend time in the planning process	○
Have a vision of cancer control for the country	○
Are able to explain this vision to others in a way they can understand	○
Can influence others to participate in the cancer control effort	○
Are able to help others in the partnership to participate in a useful manner	○
Have a history of working well with others (team players)	○
Are respected in the country	○
Are not afraid to take risks	○
Help find and have access to resources for the planning effort	○
Have a good public health vision (even if they are not specialist in this field!)	○

USEFUL LINKS

- US Centers for Disease Control and Prevention. Guidance for Comprehensive Cancer Control Planning (Volume 2: Tools). 2002. Retrieved from www.cdc.gov/cancer/ncccp/pdf/Guidance-Guidelines.pdf
- Association of Community Cancer Centers. Cancer Program Guidelines, Chapter 1: Institutional and Programmatic Resources, Section 1: Program Leadership, Guideline 1. p. 5.2002. www.accc-cancer.org/publications/pdf/publications_cpguidelines.pdf

TOOL 2.4: TIPS FOR STARTING A CANCER CONTROL PLANNING GROUP

If your country is developing a comprehensive cancer control plan for the first time, this factsheet will provide you with some ideas of how to get a partnership group started.

GETTING A PLANNING GROUP STARTED

1. Leaders are needed to form and run a planning group. The government or a CSO may designate (an) appropriate person(s), or a concerned citizen may spontaneously start forming a group.

2. The leader(s) should prepare a one-page summary or five-minute presentation with cancer facts and figures for your country, and reasons why a cancer control plan is needed.

3. The leader(s) should identify a core group of 3-5 people who have different expertise or strong interest in cancer, and recruit them for the group or ask them for help in getting the group started.

   Use Tool 2.2 to identify another group of about ten people who have specific skills useful for the planning process, or who work for important organisations that should help with the plan.

   Make an estimate of the amount of time needed from each member of the planning group (for example, four days over the next twelve months) and schedule dates.

4. You will now have identified about 15 people who will help get the planning started. This group could become the first steering committee for the cancer control plan partnership.

5. This larger group should go back to step 4 above and repeat the process to further expand the group. As the planning process continues, more people can be recruited as members of ad hoc working groups.

USEFUL LINKS

- The Community Tool Box, chapters 13-16. Work Group for Community Health and Development. University of Kansas; 2007. http://ctb.ku.edu/en/dothework/

TOOL 2.5: SAMPLE TASKS FOR WORKING GROUPS

Your cancer control planning group should have enough members and expertise for all specific priorities to be developed. The members will be asked to develop a specific part of the cancer control plan (for example, the early detection or tobacco control sections) and present it to the full planning group for review and approval.

Working groups should consist of people who are experts in the area, have an interest in the topic (refer to Tool 2.2), and/or can help implement that part of the plan later.

For working groups to be effective, they should all receive the same instructions about what to do. Here are three examples of work group tasks that can fit most cancer-related subject areas.

EXAMPLE 1: EARLY DETECTION OF BREAST CANCER WORKING GROUP - TASKS

The early detection of breast cancer working group is assigned the following tasks:

1. To determine our national goal for early detection of breast cancer.
2. To identify major resources currently available in or outside our country to help meet this goal.
3. To identify barriers present in our country that may prevent us from meeting our goal.
4. To identify strategies to overcome the barriers identified; and/or make better use of the resources we have; to look for other resources (national or international).
5. To recommend two or three priority strategies for the short- and medium-term.
6. To determine key action steps for each priority strategy.
7. To present a report of the working group recommendations to the full planning group by (fix a date), based on the decisions made in points 1 – 6 above.
8. To use the feedback received during the presentation to the planning group to finalise the recommendations for early detection of breast cancer.

EXAMPLE 2: TOBACCO PREVENTION WORKING GROUP - TASKS

The tobacco prevention work group is assigned the following tasks:

1. To lobby for the signature and ratification of the World Health Organization's Framework Convention on Tobacco Control (WHO FCTC).
2. To determine a tobacco prevention goal for our country. Examples of possible goals include: to increase the price of tobacco products, to reduce youth tobacco use through interventions in schools, to develop a promotional campaign about the dangers of tobacco use, and to ban tobacco use in public places.
3. To identify tobacco companies working in our country and work towards banning their advertising.
4. To identify barriers present in our country that may prevent us from meeting our tobacco prevention goal (e.g. poverty, advertising, smuggling, low political priority).
5. To identify strategies to overcome the barriers identified and/or make better use of the resources we have (WHO FCTC, taxes, lawyers, religious leaders, etc.).
6. To recommend two or three priority strategies for the short-, medium- and long-term.
7. To determine key action steps for each priority strategy.
8. To present a report of the working group recommendations to the full planning group by (fix a date), based on the decisions made in points 1–7 above.
9. To use the feedback received during the presentation to the planning group to finalise the recommendations for tobacco prevention.

EXAMPLE 3: PALLIATIVE CARE WORKING GROUP - TASKS

The palliative care working group is assigned the following tasks:

1. To determine a palliative care programme for our country.
2. To identify the major human resources (health professionals, NGOs, etc.) currently available in or outside our country to help implement the palliative care programme.
3. To identify the barriers present in our country that may prevent us from meeting our palliative care goal (fear, superstition, lack of knowledge, lack of analgesic medicines (opioids), state licensing laws and regulations, etc.).
4. To identify strategies to overcome the barriers identified, make better use of the resources we have, and look for international help.
5. To recommend two or three priority strategies for the short- and medium-term.
6. To determine key action steps for each priority strategy.
7. To present a report of the working group recommendations to the full planning group by (fix a date), based on the decisions made in points 1–6 above.
8. To use the feedback received during the presentation to the planning group to finalise the recommendations for palliative care.

USEFUL LINKS

- The Community Tool Box, chapters 8-12. Work Group for Community Health and Development, University of Kansas; 2007. http://ctb.ku.edu/en/dothework/

TOOL 2.6: RESOURCES NEEDED FOR A CANCER CONTROL PLANNING EFFORT

Comprehensive cancer control planning requires resources. Resources that are commonly needed during the planning work are included here. Note that some of these may require funding, while others may be donated or volunteered by partnership members or other interested parties.

- Meeting places for the cancer control planning group, working groups, etc.
- Telephone, computer, and/or mail services to contact members.
- Printing or copying services.
- Office supplies.
- Meals or refreshments during meetings.
- Travel expenses for members.
- Staff to support the planning and/or working groups.
- Resources to gather information/data for the country cancer picture.
- Resources to write and edit the plan.

The primary audience for your plan must be clearly defined. Plans are usually made public, but the audience for the specific strategies is often limited.

SECTION 3

WHAT WILL BE INCLUDED IN OUR PLAN?

Your plan must reflect the needs of your people, their culture, and the resources of your nation. However, you may consider examples of cancer control plans that have been developed elsewhere for ideas about possible ways to organise your own plan.

Review the "Before you begin" checklist before you begin this section!

CONTENT OF THIS SECTION

INTRODUCTION

The cancer picture in your country (see Section 1) is the foundation for building your plan. The cancer control planning committee (see Section 2) will use the burden assessment to identify which cancer problems should be dealt with in the plan. The planning committee should organise the discussion of these topics and then assemble the ideas generated into a proper plan that will be embraced by the country's decision-makers and general public.

Your plan must reflect the needs of your people, their culture, and the resources of your nation. However, you may consider examples of cancer control plans that have been developed elsewhere for ideas about possible ways to organise your own plan.

Your group will have to make several decisions in the early stages of your planning process. These decisions include:

WHAT WILL THE SCOPE OF THE PLAN BE?

Some plans are truly comprehensive, covering many cancers and dealing with the whole cancer continuum (prevention, early detection, treatment, supportive and palliative care, research and training) as well as issues facing cancer survivors and cross-cutting issues such as the availability of qualified personnel, professional education and training. Other plans start with a more limited scope. These plans may deal with only a few cancers or focus on a particular aspect of cancer control, such as prevention or palliative care. In either case, it is important to include all political/administrative levels in a country when building the framework for your plan. Depending on the organisational structure of a country, the plan will be rolled out in administrative regions or entire federal states.

WHO IS THE PLAN AIMED AT?

The primary audience for your plan must be clearly defined. Plans are usually made public, but the audience for the specific strategies is often limited. Plans in some countries are intended for all cancer-focused organisations; some plans may be aimed towards only one or a few CSOs, while some plans are only aimed at the government. Therefore, you must ask, "Who do we expect to act on and implement this plan once it is completed?"

AT WHAT LEVEL WILL OUR PLAN BE IMPLEMENTED?

Some plans are developed and implemented at the national level only (as was done in Israel). Some countries develop cancer control plans that are implemented by states or provinces (as was done in the United States). Other countries develop plans that are implemented at both the national and at the state or regional levels (as was done in China and the Netherlands).

GUIDING PRINCIPLES

3. COMPONENTS OF A PLAN

3.1 Some cancer control plans include a mission statement that briefly describes what the planning committee is going to do and how. A mission statement, at the most basic level, might read, "Working together to develop and implement a national cancer control plan."

3.2 Most plans include a brief summary of the current national cancer burden.

3.3 Good cancer control plans will often include:

a. Well-defined goals.
b. Measurable and specific objectives aimed at achieving your goals, which should be divided into short (one year), medium (two to five years), and long-term (more than five years) results.
c. Strategies that impact on the objectives. Objectives differ from goals in that they define what should be done to achieve your goal. Well-founded objectives are Specific, Measurable, Achievable, Reasonable, Time-phased, can be Evaluated and Revisited (SMARTER).

EXAMPLE

A well-defined objective might be, "To increase the percentage of women screened for cervical cancer from 40% to 75% within three years."

d. Clear accountability to the goals.
e. Expected outcomes when the plan is implemented.
f. Action steps to be taken in order to implement your plan

3.4 Some plans include a listing of cancer control assets and liabilities. Assets help achieve cancer control outcomes (e.g. strong public support for a cancer programme, or a well-functioning cancer hospital). Liabilities prevent or hinder goals from becoming reality (e.g. no national budget for cancer programmes, or political opposition to a particular cancer control strategy such as banning tobacco use in public places). As your plan develops, the group should take advantage of the assets and consider how to overcome or lessen the impact of the liabilities. You should assess the strengths, weaknesses, opportunities, and threats (SWOT) of your national cancer control situation.

SETTING PRIORITIES

3.5 It is important that your planning group agrees on the criteria for setting priorities before you start.

EXAMPLE

In France, the criteria included the problems which caused the greatest cancer burden, and strategies which dealt with important issues raised by cancer patients. In Australia, emphasis was placed on strategies that tackled cancer disparities, particularly those with the largest impact on the population. Other countries have chosen to emphasise cancer problems where there is an existing capacity to cope with them and no new resources are needed.

3.6 Once the criteria have been agreed upon, the planning group must set priorities for its working groups. There are two main methods of agreement:

a. **Consensus –** Everyone in the planning group agrees what the priorities should be. This is ideal, but rarely occurs.
b. **Vote –** Everyone has the opportunity to vote on which strategies should be priorities. The strategies with the most votes become priorities.

3.7 A NCCP may include many strategies and usually there will be a need to establish priorities among these because no nation can do everything that is needed. Instead, the cancer control planning group decides which strategies are most important to start with. Some cancer control plans set priorities among objectives as well as strategies.

CANCER CONTROL STRATEGIES

3.8 Strategies for cancer burden intervention fall into three broad categories. A good plan should be a mix of these action strategies:

- **a.** Strategies which focus on individual behaviour change (primary prevention) (e.g. changing smoking behaviour).
- **b.** Strategies which enhance the practices of health professionals (e.g. educating clinical staff in new or improved cancer detection and treatment techniques, data collection and analysis, training registrars, and cancer epidemiologists, etc.).
- **c.** Strategies which focus on changing the policies (e.g. access) and actions (e.g. prices) of systems related to cancer control (e.g. mandating that hospitals provide certain cancer care services for all patients who require them).

3.9 There may be several strategies to achieve a particular objective.

EXAMPLE

To decrease invasive cervical cancer cases several strategies might be used:

- **a.** Every woman who enters a hospital is informed of the importance of having a Pap test or a HPV test.
- **b.** The government pays for all VIA tests (visual inspection after the application of acetic acid) for women who cannot afford them.
- **c.** Every primary care doctor in the country is trained in the latest techniques for performing a screening test (Pap, HPV, VIA, VILI).
- **d.** Religious leaders educate their followers on the need to receive a test for cervical cancer.

3.10 Whenever possible, strategies that are suggested in the plan should be based on existing evidence, derived from scientific studies. Summaries of the evidence that exists for many cancer control strategies have been put together by UICC and others for your use.

3.11 Sometimes there is no evidence for which strategies may work best, or strategies that have worked elsewhere and are not working in your country. Your plan needs to allow for creativity and innovation in developing new approaches relevant to your country's context.

3.12 You should develop a S.M.A.R.T.E.R. formulated action plan for each of your priorities, outlining the major action steps that need to be undertaken to reach the goals.

EXAMPLE

Using the earlier cervical cancer example, if every woman admitted into a hospital was informed about the importance of getting a Pap test, the expected progress from the current 40% of women screened for cervical cancer will be 75% in to 2 years.

3.13 Be sure to take into account the other chronic disease efforts or plans in your country. Some chronic disease strategies already in place connect very well to programmes for cancer control. For instance, women of a certain age group identified for cancer screening may be already being targeted in relation to another chronic disease. You might find that a national diabetes programme is already reaching the same women, and that your plan may then join forces with the diabetes programme in order to reach these women with both messages.

FINDING RESOURCES

3.14 It is important to discuss what resources are needed to make the plan operational and how to obtain them. These cover human, financial resources as well as infrastructure and equipment and they should be included in your plan. The committee needs to develop an overall budget for the plan, including the resources needed for all your priority strategies. Some approaches to find resources include:

a. Reallocating or optimising existing resources.
b. Obtaining grants to implement specific strategies in the plan.
c. Creative means of financing the whole plan (e.g. increasing taxes on the sale of tobacco products and dedicating all or some of the revenue to implementing the cancer control plan).

3.15 Be sure to include a section on how your plan will be implemented (see Section 4).

3.16 Early in the planning process, identify responsibilities for putting your plan into a cohesive written format. Some countries choose a single author; others use a special writing committee. In other cases, sections of the plan are written by several authors and an editor has finalised the overall work.

CRITICAL QUESTIONS FOR PLANNING

The following questions should help identify the major topics that should be included and how to address and organise them. The inclusion, or not, of some of the domains of a national plan (research, training, prevention, early detection, treatment, supportive and palliative care) should be the result of a common agreement.

- What will be the scope of our plan? What parts of the cancer problem will we address in the plan? What parts will we focus on in future plans?
- What are our goals? How will we ensure that our objectives are specific, measurable, and tied to the goals?
- How will we establish priorities? What types of criteria will we use? What method will we use to decide our priorities?
- What is our process for identifying strategies to achieve our objectives and goals? Are we certain they will significantly impact our cancer burden?
- Who is the plan aimed towards? Who/which organisation will help implement it?
- How will we identify the resources needed to implement the plan? What are our strategies for getting those resources?
- What are possible assets and liabilities related to cancer for our country?

TOOLS FOR ORGANISING THE PLAN AND DEFINING ITS CONTENT

Tool 3.1 Selecting an organising framework for the plan

Tool 3.2 Sample timeline for developing a national cancer control plan

Tool 3.3 Sample outline of a national cancer control plan

Tool 3.4 Selecting goals, objectives, strategies, and outcomes - examples

Tool 3.5 Sample methods for setting priorities

Tool 3.6 Developing action plans for our priorities

Tool 3.7 Action plan template

Tool 3.8 Resource assessment form

NCCP tools can be accessed through
www.uicc.org/resources

PROGRAMME OF ACTION FOR CANCER THERAPY (IAEA/PACT)

The International Atomic Energy Agency (IAEA) plays a significant role in providing technical assistance to countries to initiate their cancer therapy centres. In 2004, it established the Programme of Action for Cancer Therapy (PACT) to maximise the public health impact obtained through technology transfer in radiation therapy and nuclear medicine. PACT encourages a stronger coordination among the major players in the field, facilitating communication through a global public-private partnership to:

- assess cancer needs in developing countries
- help to define national plans for cancer prevention and control
- raise funding to improve conditions and outcomes for cancer patients by focusing on timely, planned and balanced investments to maximise the beneficial impact of radiotherapy and all other interventions.

screening.iarc.fr/doc/pact1006.pdf

REFERENCES AND USEFUL LINKS

- National Partners for Comprehensive Cancer Control. Comprehensive Cancer Control Jurisdiction Guidebook for United States Associated Pacific Island Nations. NPCCC, 2005.
- Union for International Cancer Control. Evidence-Based Cancer Prevention: Strategies for NGOs: A UICC Handbook for Europe. Geneva: Union for International Cancer Control; 2004. 15-33. www.uicc.org/resources/evidence-based-cancer-prevention-strategies-NGOs-uicc-handbook-europe
- The Canadian Strategy for Cancer Control: A Cancer Plan for Canada. 2006. Available from www.partnershipagainstcancer.ca/wp-content/uploads/CSCC_CancerPlan_20061.pdf
- Centres for Disease Control and Prevention. Guidance for Comprehensive Cancer Control Planning (Volume 1: Guidelines and Volume 2: Tools). Atlanta: US Centres for Disease Control and Prevention, 2002. Retrieved from www.cdc.gov/cancer/ncccp/pdf/Guidance-Guidelines.pdf
- US National Cancer Institute. Matrix of Evidence Reviews across the Cancer Control Continuum. Available from http://cancercontrol.cancer.gov/IS/info_er.html
- The Cancer Control PLANET. http://cancercontrolplanet.cancer.gov/
- Lalla Salma Association against Cancer and the Moroccan Ministry of Health. Plan Cancer 2010-19: Strategic Axes and Measures. July 2009. Retrieved fromwww.contrelecancer.ma/le_pnpcc

TOOL 3

TOOLS FOR ORGANISING THE PLAN AND DEFINING ITS CONTENT

TOOL 3.1: SELECTING AN ORGANISING FRAMEWORK FOR THE PLAN

Early in your cancer control planning effort, your planning group should decide on an organising framework. Before making decisions, it is necessary to classify the level of your country with regard to gross domestic product (GDP).

1. DEFINING THE LEVEL OF INCOME OF YOUR COUNTRY AND EXISTING HEALTH RESOURCES

Situate your country's income level

Look up your country's GDP and its rank in the latest World Bank International Classification (2012). The listing in Table 1 will then show you how your country is classified in terms of income level.

Click on each income level to get to the World Bank's list of countries classified according to income.

Table 1: World Bank Classification of Countries by Income Level, 2012

CLASSIFICATION	GROSS NATIONAL INCOME PER CAPITA
Low income	$1,005 or less
Lower middle income	$1,006 - $3,975
Upper middle income	$3,976 - $12,275
High income	$12,276 or more

Source: World Bank (2012)

Geographic region: Low-income and middle-income economies are sometimes referred to as developing economies. The use of the term is convenient; it is not intended to imply that all economies in the group are experiencing similar development or that other economies have reached a preferred or final stage of development. Classification by income does not necessarily reflect development status.

Income group: Economies are divided according to 2012 GNI per capita, calculated using the World Bank Atlas method.

Give priority to your actions according to your resources

Classification by income is only one indication of where you stand. For a good analysis of the level and capacities of your country, you will need to know what already exists for cancer control. Table 2 will help you determine where you stand with respect to local resources.

Table 2: Country Classification Based on Cancer Resources

Please tick the box where the situation applies to your country

LOW-INCOME - LEVEL 1		MIDDLE-INCOME - LEVEL 2		UPPER MIDDLE-INCOME - LEVEL 3	
Few or no cancer care facilities	◯	Limited cancer care facilities (number, quality, and accessibility)	◯	Functional cancer centres	◯
No radiotherapy in the country	◯	One or more functional radiotherapy units	◯	Sufficient cancer services (surgery and radio-chemotherapy)	◯
Few or no cancer-trained medical doctors and nurses	◯	Well trained oncologist/nurses in acceptable numbers	◯	Well-trained medical teams	◯
Few or no drugs available	◯	Reliable data available	◯	Operational cancer research	◯
Little or no epidemiological data	◯	Medical insurance partially available	◯	Prevention and early detection programmes	◯
Late cancer diagnoses	◯	Prevention and early detection programmes	◯	Ample resources for the fight against cancer	◯
No medical insurance	◯	Pain control and palliative care available	◯		
Little or no cancer research	◯	Operational clinical cancer research	◯		
Little or no cancer prevention	◯				

Action plan based on classification

Each country has its assets and strengths in the fight against cancer – but also limits and inequalities. This is why you will find three different toolkit levels for actions. Choose the one best suited to your country level.

- **If your country is on level 1 (low income) –** the fight against cancer is not well organised or nonexistent – then the priority objective will be implementing one or two sustainable actions.
- **If your country is on level 2 –** the fight against cancer is not well organised or is in progress – the priority objective will be initiating a cancer control programme adapted to the level of the health system and resources.
- **If your country is on level 3 –** a comprehensive cancer control programme exists and could be enhanced – the priority objective will be enhancing the comprehensive cancer control programme.

Intermediate levels may be identified depending on the local situation.

2. MAKING DECISIONS

The first decision your partnership should make is whether the plan will cover:

- One cancer that is the biggest burden for the country and one or two main risk factors **(level 1)**
- A few priority cancers and the main risk factors **(level 2)**
- All/many cancers and all avoidable risk factors **(level 3)**

The second decision your partnership should make is whether the plan will cover:

- One part of the country (e.g. the capital city) or a defined population (e.g. women) **(level 1)**
- Certain parts of the country (e.g. urban centres, two provinces, the eastern part of the country) or various types of population (children, women, etc.) **(level 2)**
- The entire country and the whole population **(level 3)**

With these two decisions made, your partnership should choose one of the following options for an organising framework, or create its own organising framework:

- **Disease continuum:** prevention, early detection, diagnosis, treatment, palliative care, training and research.
- **Cancer site:** breast, cervix, skin, prostate, lung, colorectal, liver, etc.
- **Cancer risk factors:** tobacco use, Human Papilloma Virus, Hepatitis B virus, alcohol, sun exposure, nutrition and physical activity, environmental and occupational exposures, etc.
- **Cancer control functions and settings:** advocacy, public education, access to care, professional education, eliminating disparities, etc. Your plan can also be structured according to settings such as schools, worksites, health care system, etc.
- **A combination of the above options** can be used – this is often the case in cancer control planning processes.

Once you have chosen a framework it will:

- Help you to gather background material and to identify experts according to the categories of your framework.
- Help you make decisions about what kind of working groups you might want to set up for parts of the plan (e.g. prevention working group, cervical cancer working group, professional education working group, etc.).
- Provide you with an outline for much of the written plan.

A truly comprehensive national cancer control plan will cover many cancer sites and the entire country. If your country is not yet ready to develop a plan on this scale, you may choose to limit its scope. However, even if your scope is limited, you can write a comprehensive plan to cover what you decide to work on – for example, a plan that addresses only cervical cancer can still include sections on prevention, early detection, treatment, and quality of life; and a plan that covers only early detection of cancer can still cover several cancers, and must be connected to plans for providing treatment to cancer patients identified during screening.

USEFUL LINKS

- Canada: Canadian Partnership Against Cancer, country example – www.partnershipagainstcancer.ca
- Cancer Control in Brazil.. Politica Nacional de Câncer, INCA; 2005.www.inca.gov.br/releases/press_release_view_arq.asp?ID=936
- CDC, a Comprehensive Cancer Control Framework, United States. www.cdc.gov/cancer/ncccp
- Institute of Medicine. www.iom.edu/
- National Cancer Control Programmes, country example: India. www.who.int/cancer/nccp/en/
- France: le Plan Cancer 2009-2013. www.plan-cancer.gouv.fr/le-plan-cancer/presentation.html
- Breast Cancer in Limited-resource Countries: an Overview of the Breast Health Global Initiative 2005 Guidelines. Benjamin O, Anderson et al. S-S15. http://screening.iarc.fr/doc/Breast%20Cancer%20in%20Limited-Resource%20Countries%20-%20An%20Overview.pdf
- Breast cancer early detection methods for low and middle income countries, a review of the evidence. Corbex M, Burton R, Sancho-Garnier H, The Breast (on line 01/2012)
- National Cancer Control Programmes, Policies and Managerial Guidelines 2nd edition, WHO, 2002, part 3. www.who.int/cancer/media/en/408.pdf

TOOL 3.2: SAMPLE TIMELINE FOR DEVELOPING A NATIONAL CANCER CONTROL PLAN

Each country will need to develop its own timeline for finishing its national cancer control plan based on local circumstances and culture. However, in the experience of the editors of this toolkit, it can take two years or more. The timeline below features a two-year planning process. You can adjust the timeframes or the steps as you develop your own plan. Note that some steps overlap. Sample agendas for the partnership meetings are provided further below.

1. TIMELINE GRID - EXAMPLE

	PLANNING STEP	PERSON IN CHARGE	TASK	MONTH COMPLETED	DONE
FIRST STEP	**From study to actions**			(6 months)	○
	Obtain approval to start a cancer control plan			Months 1-2	○
	Organise a cancer control planning group			Months 1-4	○
	Obtain resources for the first year			Months 1-6	○
SECOND STEP	**First meeting of the planning group** (see suggested agenda items in point 2 below)			Month 6	○
	Write up results of first meeting			Months 6-8	○
	Second meeting of the planning group			Month 9	○
	Write up results of the second meeting			Month 9-10	○
	Working group meetings			Months 10-14	○
	Third meeting of the planning group			Month 15	○
	Write up results of the third meeting and working group recommendations			Months 15-17	○
	Fourth meeting of the planning group			Month 18	○
	Develop complete draft of the plan			Months 18-19	○
	Review of the draft plan			Months 19-21	○
	Develop a revised draft plan			Months 21-22	○
	Fifth meeting of the planning group			Month 23	○
	Final approval of the plan			Month 24	○
THIRD STEP	**Publicly announce the plan** Dissemination (internet, booklets, libraries, etc)			Months 26-28	○

Once the plan is finally approved, it will need to be printed, placed on a website, or otherwise made available to stakeholders, policy-makers, health professionals and the public.

2. AGENDA ITEMS FOR CANCER CONTROL PLANNING MEETINGS

Here are suggested agenda items for the five planning meetings featured in the sample timeline above. Some cancer control planning efforts will require fewer meetings, others more, depending on the country's specific situation. You can adjust the agenda items below to meet your country's needs.

First planning meeting

- Explain what comprehensive cancer control is.
- Review existing cancer burden data in your country and how to complete the missing data.
- Discuss the value of a national cancer control plan to address the cancer burden, and a planning group to develop a plan.
- Develop a vision statement for the plan and a mission statement for the cancer control planning group.
- Identify major goals to be included in the plan.
- Identify major problems and barriers.

Second planning meeting

- Review the results of the first meeting.
- Form working groups and have the working groups meet to:
  - Review their tasks (Tool 2.5);
  - Identify additional working group participants;
  - Identify specific information needs (data);
  - Start on developing their portion of the plan.
- It might be worthwhile inviting a leading person of the NCCP of a nearby country.

Between the second and third meetings

- Working groups continue to complete their part of the plan and make draft recommendations.

Third planning meeting

- Review results of the second meeting.
- Present and discuss draft working group recommendations for objectives, strategies, and outcomes.
- Identify cross-cutting strategies raised by the working groups (e.g. public awareness campaigns may be identified as a strategy by several work groups).
- Develop cross-cutting recommendations.

Fourth planning meeting

- Set priorities among the proposed strategies.
- Discuss ways to implement the plan (collaboration, participation, accountability, etc).
- Discuss how the identified barriers can be overcome.
- Agree on a process for reviewing the draft plan prior to the fifth meeting.

Between the fourth and fifth meetings

- Draft the plan.
- Send to stakeholders for comment.
- Revise the plan based on comments received.

Fifth planning meeting

- Review changes to the draft plan.
- Approve the plan.
- Prepare a communication plan to announce the national cancer control plan.

TOOL 3.3: SAMPLE OUTLINE OF A NATIONAL CANCER CONTROL PLAN

It may be helpful to develop an outline for the national cancer control plan early in the cancer control planning process. Showing this to partners may give them a better idea of what they will be working on during the planning process. The following outline is drawn from existing plans and can be adapted to the unique needs of your country.

EXECUTIVE SUMMARY

A brief description of the whole plan

THE COUNTRY CANCER PICTURE

This is a short version with key facts taken from the complete cancer picture report

- Geography and demographics of the country
- Cancer data
- Risk factor data
- Health care system data
- Existing resources for cancer control
- Major challenges for cancer control.

VISION STATEMENT

MAJOR GOALS AND BARRIERS

RECOMMENDATIONS FOR ACTION

Organised according to the framework being used (see Tool 3.1)

Goal 1 (see Tool 3.4)

1. Objectives (SMARTER formulated)
2. Priority strategies
   - 2.1 Action steps (some plans include these in the plan while others develop these after the plan is published)
   - 2.2 Timeline
   - 2.3 Responsibility for action
3. Other strategies
4. Expected outcomes

Goal 2

1. Objectives
2. Priority strategies
   - 2.1-2.3 See above goal 1
3. Other strategies
4. Expected outcomes

Goal 3

And so on… using the same format as goals 1 and 2

IMPLEMENTATION OF THE PLAN

The role of the partnership

1. Mission statement for the partnership
2. Description of the partnership
3. Call for others to join

Resource requirements

1. Existing resources
2. New resources needed

Accountability

1. Progress reviews (these are often conducted annually)
2. Communications with leaders and the public
3. Evaluation plans

APPENDIX 1

Partner organisations

APPENDIX 2

Full cancer picture report

USEFUL LINKS

Examples: below are examples of outlines for three different country income levels in three different languages.

Resources in French

- Belgium, National Cancer Plan 2008-2010 https://webgate.ec.europa.eu/sanco/heidi/images/2/27/Belgium_National_Cancer_Plan_2008-2010_English.pdf
- France: le Plan Cancer 2009-2013 www.plan-cancer.gouv.fr/le-plan-cancer/presentation.html
- Morocco: Plan National de Prévention et de Contrôle du Cancer 2010-19 www.contrelecancer.ma/le_pnpcc

Resources in English

- Australia National Cancer Plan and Strategies www.canceraustralia.gov.au/publications-resources/cancer-control-plans-and-reports/state-and-territory-cancer-plans-and-strategies
- Catalonia: Health Plan for Catalonia Generalitat de Catalunya: health department; 2010. Available from www.gencat.cat/salut/depsalut/pdf/plan2010en.pdf
- Canada: Sustaining Action Toward a Shared Vision: 2012 – 2017 Strategic Plan. 2012. Available from www.partnershipagainstcancer.ca/wp-content/uploads/Sustaining-Action-Toward-a-Shared-Vision-Full-Document.pdf
- Denmark cancer plan www.hpm.org/en/Surveys/University_of_Southern_Denmark_-_Denmark/08/National_cancer_plan_(2).html
- Netherlands cancer plan, 2004-2010 https://webgate.ec.europa.eu/sanco/heidi/images/3/3e/Netherlands_National_Cancer_Control_Programme_English.pdf
- Ontario: Cancer Plan 2011-2015. http://ocp.cancercare.on.ca/
- Turkey National Cancer Program, 2009-2015 www.ukdk.org/pdf/NATIONAL%20CANCER%20PROGRAM2.pdf
- UK cancer plan, Improving outcomes: a strategy for cancer 2011 https://webgate.ec.europa.eu/sanco/heidi/images/4/40/UK_Improving_Outcomes_A_Strategy_for_Cancer_2011_English.pdf
- UK Cancer Reform Strategy, 2007 www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081006
- Union for International Cancer Control. Cancer awareness, Prevention and Control: Strategies for South East Asia. UICC; 2004. Retrieved from www.uicc.org/resources/cancer-awareness-prevention-and-control-uicc-handbook-south-asia-0.

Resources in Spanish

- Oral Cancer Case finding Program (OCCFP), Santana JC, Delgado L, Miranda J, Sanchez M, Oral Oncology, Vol 33, issue 1. Cuba; 1997.
- Uruguay Programa Nacional de Control del Cáncer. Available from www.bvsoncologia.org.uy/pdfs/destacados/PRONACCAN_2005-2010.pdf

TOOL 3.4: SELECTING GOALS, OBJECTIVES, STRATEGIES, AND OUTCOMES - EXAMPLES

To help you figure out priorities for the development of your plan, here is a series of examples of some components of a cancer control plan..

1. PRIMARY PREVENTION: TOBACCO CONTROL

INTERVENTION	(1)	(2)	(3)	(4)
GOAL	• To reduce incidence of tobacco-related cancers	• To help smokers quit smoking	• To reduce people's environmental exposure to tobacco smoke	• To reduce youth smoking prevalence (12-18 year olds)
OBJECTIVE	• To ratify the WHO FCTC	• Decrease cigarette use by 20%	• Legislate for the protection of non-smokers	• Prevent the start of tobacco use among young people (12-18 year olds)
STRATEGIES	• To create a special interest group to lobby politicians	• Increase the price of cigarettes • Ban sales by one type of seller • Create a tobacco-free environment • Create tobacco cessation consultations	• Advocate for laws to create tobacco-free environments in public places	• Discourage smoking through health education initiatives in schools • Ban cigarette sales to under 18s
EXAMPLES OF ACTIONS	• To lobby at election time	• Take tobacco out of price index • Tobacco-free schools • Train general practitioners and health workers	• Organise a vote and encourage respect for the law	• Train and sensitise teachers to ensure respect of prohibition
OUTCOMES	• WHO FCTC signature • WHO FCTC ratification	• Tobacco use reduced by 10% per year	• Number of enforced spaces for non-smokers	• Higher age at first cigarette; • prevalence of tobacco use among teenagers reduced by 10% per year
BARRIERS	• Loss of important government income	• Addiction • Changing the "routines" of health professionals • Convincing politicians	• Culture, traditions, and ignorance	• Resistance from educational and cigarette sales environments

USEFUL LINKS

- France: le Plan Cancer 2009-2013 www.plan-cancer.gouv.fr/le-plan-cancer/presentation.html
- Review of National Cancer Control Activity in Australia. Cancer Australia and Cancer Council Australia, 2010. Canberra: Cancer Australia. www.canceraustralia.gov.au/publications-resources/cancer-control-plans-and-reports

2. CERVICAL CANCER CONTROL

INTERVENTION	(1)	(2)	(3)	(4)
GOAL	• To reduce incidence of cervical cancer by 20% in five years	• To reduce cervical cancer mortality by 25% in five years	• To improve quality of palliative care for patients	• To reduce all care management costs
OBJECTIVE	• To prevent and detect pre-cancerous lesions	• Enhance early diagnosis and treatment	• Organise and manage palliative care	• Define better health care priorities based on cost/efficiency • Redistribute costs between prevention/ screening / treatment programmes
STRATEGIES	• Sexual education • HPV vaccination • Screening	• Train health workers • Increase access to quality screening and care for all women	• Organise facilities for patients at the end of their life: quality nursing care, use of morphine, psychological support	• Perform cost/benefit analysis • Promote sex education, well-organised vaccination, and screening programmes • Reduce costly and unnecessary diagnostic procedures and treatments
EXAMPLES OF ACTIONS	• Sexual education programme at school • HPV vaccination plan on the vaccine agenda • Organisation of mass screening	• Training programmes • Multiply number of units performing vaccination and screening tests • Assure test quality control, and treatment for detected lesions	• Training programmes • Access to vaccination, screening and treatment facilities • delete extra line • Set up system for palliative care at home	• Perform cost/benefit analysis before choosing screening strategies • Organise vaccination and screening programmes to make them more efficient
OUTCOMES	• Incidence of pre-cancerous lesions and cancers reduced within five years	• Improvement of the diagnostic stage and quality of care for all women	• Increase of survival in good conditions • Reduction of physical and mental suffering	• Better cost/benefit balance • More possibilities for actions

USEFUL LINKS

- Cancer Control Programme in India, Challenges for the new Millennium, "Strategies for Cancer Prevention in India", Vol XVII, Number 1, India. Page 10. http://medind.nic.in/haa/t05/i1/haat05i1p10.pdf.
- HPV and Cervical Cancer Curriculum, UICC.www.uicc.org/programmes/hpv-and-cervical-cancer-curriculum
- European Guidelines for Quality Assurance in Cervical Cancer Screening. Second edition. European Communities 2008. http://screening.iarc.fr/doc/ND7007117ENC_002.pdf

3. BREAST CANCER CONTROL

INTERVENTION	(1)	(2)	(3)
GOAL	• To stop the increase of incidence of breast cancer by 10% in 10 years	• To reduce breast cancer mortality by 10-30% in 5 years	• To improve quality of palliative care for patients
OBJECTIVE	• To decrease exposure to risk factors	• To organise detection through: • Early diagnosis or • Screening (according to the country's income level)	• To increase access to evidencebased diagnostic procedures and treatments • To organise quality insurance and followup of patients
STRATEGIES	• To plan a prevention programme dealing with all avoidable risk factors	• Detection by clinical examination or • Mammography screening	• Organisation of a global care management programme (from diagnosis to treatment and followup)
EXAMPLES OF ACTIONS	• Information on risks • Education to avoid exposure (e.g. age at first birth, obesity, hormonal therapy…) • Community actions to help (physical exercise) • Legislation to suppress some exposure (alcohol)	• Organised programmes (early detection or screening) with quality control • Increase access to diagnosis and care • Training of health professionals • Organise quality control and improve professional capacities	• Train primary care professionals in early detection procedures • Increase awareness among general population • Improve care infrastructure and equipment • Improve access to care free of charge • Set up system for palliative care at home
OUTCOMES	• Reduction in risk factor exposure • Stop increase of incidence	• Improvement of diagnostic stage • Reduction in mortality	• Decrease in morbidity and mortality • Improved survival rate
BARRIERS	• Difficulties changing behaviours and customs	• Cost • Lack of trained professionals • Strategic errors by decisionmakers or spontaneous practices • Insufficiency of health structures	• Lack of global strategy and political will • Economic difficulties • Breast cancer not considered a health priority

USEFUL LINKS

- The Breast Health Global Initiative, Turkey pilot project
  http://portal.bhgi.org/GlobalPortfolio/easterneurope/default.aspx
- Breast Cancer in limited Resources countries; diagnoses and pathology, Breast Health Global Initiative, National Guideline clearinghouse, 2006. 45 references.
  http://screening.iarc.fr/doc/Breast%20Cancer%20in%20Limited-Resource%20Countries%20-%20An%20Overview.pdf
- European guidelines for quality assurance in breast cancer screening and diagnosis. Fourth edition.
  www.euref.org/index.php?option=com_content&view=article&id=5&Itemid=23

4. ACCESS TO CANCER TREATMENT

INTERVENTION	(1)	(2)	(3)
GOAL (ACTION THAT CAN BE UNDERTAKEN)	• To have enough functional and good quality care facilities of different levels (surgery, radiotherapy, chemotherapy)	• To give access to all types of care for all cancer patients including palliative care	• To improve psychosocial care of patients
OBJECTIVE	• To improve and/or create adapted infrastructures for all levels of cancer care across the whole territory	• Access to care at an early stage for all cancer patients	• To have sufficient numbers of trained health workers and suitable infrastructures
STRATEGIES	• To evaluate existing resources • To fill the gaps, choosing priorities and sustainable actions	• Increase awareness among health professionals and general population • Organise patient navigation • Organise micro-credit for health purpose	• Train and supervise health workers • Build, dedicate, and/or maintain infrastructures and materials in good condition
EXAMPLES OF ACTIONS	• To make an inventory of infrastructures and human resources and define priorities • To lobby for further financial resources • To set up a calendar for interventions	• Training of health professionals (all levels) • Information campaign • Transport facilities to specialised units • Guidelines for professionals	• Create training sessions for specific staff • Create patients' association • Improve quality of care environment (wall paint, furniture, music, etc.)
OUTCOMES	• To increase number of specific infrastructures • To Increase number of trained nurses and physicians • To improve quality care	• Improvement of cancer stage at diagnosis, curability and survival • Changing image of cancer because of improved survival and cure rate	• Improved quality of life for patients and their families • Lower burn-out rate among professionals
BARRIERS	• Absence of coordination between all the actors concerned (private and public) • Lack of resources (financial and human)	• Discordance between goals, strategies, and financial feasibility • Cultural barriers (traditional medicine)	• Cultural barriers (psychological considered as "useless" care) • Insufficient resources

USEFUL LINKS

- Tanneberger, S., Cavalli, F., Pannuti, F., Magrath, I. Bridging the Childhood Cancer Mortality Gap between Economically Developed and Low-income Countries. Cancer in Developing Countries, The Great Challenge for Oncology in the 21st Century, ed. Zuckschwerdt, 42-60.
- Institut National du Cancer, France: le Plan Cancer 2009-2013, www.plan-cancer.gouv.fr/le-plan-cancer/presentation.html
- Public Heath Agency of Canada. (2004). Progress Report on Cancer Control, Cancer Prevention. www.phac-aspc.gc.ca/publicat/prccc-relccc/index-eng.php
- My Child Matters, a UICC and Sanofi Espoir Foundation partnership www.uicc.org/programmes/my-child-matters

5. PALLIATIVE CARE

INTERVENTION	(1)	(2)
GOAL (ACTION THAT CAN BE UNDERTAKEN)	• To organise pain management	• Care management for terminal illness
OBJECTIVE	• To improve access to analgesic drugs (e.g. opioids)	• To set up palliative care teams able to give psychosocial support to patients and their families
STRATEGIES	• To create policies for the regulation, import, manufacture, pricing, and sales of analgesic drugs • To train health professionals in use of analgesic drugs	• Training programmes for health professionals • Medical and social assistance at home • Mobilisation of patients' associations for long-term care management
EXAMPLES OF ACTIONS	• To advocate for analgesic drug policies • To obtain provision in quantities corresponding to patients' needs • To organise training in units where cancer patients are treated	• To organise initial and permanent training • To organise home support care services: counselling, information, volunteer training, legal assistance, financial, and social support
OUTCOMES	• Analgesics and morphine available for patients when necessary • Improved quality of patients' end of life	• Improvement of quality of life for patients and their families
BARRIERS	• Cultural barriers (views on opioids) • Cost • Organisation of import	• Cost • Cancer fear and misinformation • Culture and religion

USEFUL LINKS

- Hospice Africa, Palliative Medicine (2006). Pain and Symptom Control in the cancer and/or Aids patient in Uganda and other African countries. Fourth edition, English and French. Uganda 320 pages. info@hospiceafrica.or.ug
- France: le Plan Cancer 2009-2013
  www.plan-cancer.gouv.fr/le-plan-cancer/presentation.html
- Burton, R., Philippine Coalition for the Prevention and Control of Non-Communicable diseases (PCPCNCD), National NCD. Cancer Planning in Asia and Vietnam. Control Plan 2005-2015, slides 6-13.
  www.hsph.edu.vn/
- Example of Cancer Association in Africa: Association Solidarité Chimiothérapie. Yaoundé, Cameroun.
  www.sochimio.com/

TOOL 3.5: SAMPLE METHODS FOR SETTING PRIORITIES

How can one make good decisions when sufficient data are not available? Priorities must be set according to the estimate of the cancer magnitude, available resources, and the health system's capacity to carry out the most urgent and possible actions.

Three questions must be answered:

1. WHICH ARE THE 5-10 MOST COMMON CANCERS IN OUR COUNTRY, AND WHAT ARE THEIR RATES?

Sources:

- Globocan 2008 on http://globocan.iarc.fr/
- Our national data

Common Cancer	Rates
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

2. FOR THE MOST COMMON CANCERS

Do we know the major risk factors? (from the literature and/or local survey) ○ Yes ○ No

Is exposure to these risk factors avoidable? ○ Yes ○ No

Can these risk factors be detected early or avoided (e.g. vaccine)? ○ Yes ○ No

If yes, using what type of examination?

Are these cancers detectable by screening? ○ Yes ○ No

If yes, by which type of test?

Is this test available and affordable for the target population in our country? ○ Yes ○ No

Is our country ready to organise a screening programme? ○ Yes ○ No

Are these cancers curable? ○ Yes ○ No

What is the success rate with treatment?

Using what treatments?

Are these treatments available in our country? ○ Yes ○ No

Could other protocols (available in our country) be used successfully? ○ Yes ○ No

Is palliative care accessible? ○ Yes ○ No

3. FOR EACH OF THE PREVIOUS ITEMS, WHAT RESOURCES ARE ALREADY AVAILABLE IN OUR COUNTRY AND IS IT POSSIBLE TO INCREASE/IMPROVE THEM?

○ Infrastructure ○ Equipment ○ Human Resources

What new resources can be mobilised to reach a definite goal (priority)?

What are the possibilities for increasing funding within and outside of the country?

USEFUL LINKS

- WHO steps survey
  www.who.int/chp/steps/manual/en/index.html
- World Health organisation cancer fact sheets
  www.WHO.int/mediacentre/factsheets/fs297/en/
- Breast cancer risk factors in south of Islamic Republic of Iran: a case–control study, Eastern Mediterranean Health Journal, vol.13, no.6, (2007)
  www.EMRO.WHO.INT/publications/emhj/1306/article6.htm
- World Health Organization. Cancer control: knowledge into action
  www.who.int/cancer/modules/en/
- Breast Cancer in Limited-Resource Countries: an Overview of the Breast Health Global Initiative 2005 Guidelines, Anderson and Al, Breast Health Global Initiative, 6-9
  www.guideline.gov/summary/summary.aspx?ss=15&doc_id=9027&nbr=4886
- Breast, Colon, and Prostate Screening in the Adult Population of Croatia: does rural origin matter? Polasek, O. et al. Croatia, (2007). 10 pages
  www.rrh.org.au/publishedarticles/article_print_749.pdf
- Sancho-Garnier, H. (2006). Choosing priorities in the French Cancer Control Plan. UICC Congress. Washington
  http://2006.confex.com/uicc/uicc/techprogram/P10179.HTM

EXAMPLES OF PRIORITY SETTINGS FOR FOUR TYPES OF CANCER

Actions are determined according to income level 1 (see Tool 3.1) and the human, financial, and therapeutic resources of the country.

TYPE OF CANCER	LEVEL OF INCIDENCE	MAJOR KNOWN EXOGENOUS RISK FACTORS	PROPORTION OF AVOIDABLE CASES	POSSIBLE EARLY DETECTION
BREAST	• Medium rate	• Obesity • Sedentary lifestyle • Alcohol consumption • Age at first birth • Hormonal treatment	• 30%	• Early diagnosis by clinical palpation • Screening by mammography
CERVICAL	• High rate	• HPV • Tobacco use	• 95%	• Screening: - Pap smear - VIA - HPV test
LUNG	• Medium rate	• Tobacco • Asbestos dust • Radon	• 90%	• No
COLON/ RECTUM	• Low rate	• Obesity • Sedentary lifestyle	• 30%	• Early diagnosis • Symptoms • Screening by FOBT

	SELECTED PRIORITIES/ LOCAL RESOURCES (EXAMPLE LEVEL 1, NO RADIOTHERAPY)			
THEORETICAL EFFICACY OF TREATMENT	PREVENTION	EARLY DIET/ DIAGNOSIS	TREATMENT	SCREENING
• Very good (surgery,± radiotherapy, ± chemotherapy, ± hormonal therapy) • 50-85% (5 year survival)	• Actions on sedentary lifestyle/ obesity	• Early Detection by clinical palpation	• Mammography • Cytology or biopsy	Surgery + (Radiotherapy + Chemotherapy +)* Hormone Therapy
• Good (surgery, radiotherapy, chemotherapy) • 40-65% (5 year survival)	• Education • Vaccination	• VIA • HPV test • Pap smear*	• Colposcopy • Biopsy	Surgery (+ radiotherapy + chemotherapy)*
• Poor (radiotherapy and chemotherapy) • 10-15% (5 year survival)	• Fight again tobacco use and professional exposure	• No *if possible	• Radiology (Endoscopy biopsy)	Palliative care * if possible
• Good (surgery, radiotherapy, chemotherapy) • 40-60% (5 year survival)	• Actions on sedentary lifestyle/ obesity	• Train professionals to recognise early symptoms	• Radiology • Colonoscopy • Biopsy	Surgery ± chemotherapy

USEFUL LINKS

- France: le Plan Cancer 2009-2013 www.plan-cancer.gouv.fr/le-plan-cancer/presentation.html
- Breast Cancer in limited Resources countries; diagnoses and pathology, Breast Health Global Initiative, National Guideline clearinghouse, 2006. 45 references. http://screening.iarc.fr/doc/Breast%20Cancer%20in%20Limited-Resource%20Countries%20-%20An%20Overview.pdf
- Breast cancer early detection methods for low and middle income countries, a review of the evidence. Corbex M, Burton R, Sancho-Garnier H, The Breast www.ncbi.nlm.nih.gov/pubmed/22289154

TOOL 3.6: DEVELOPING ACTION PLANS FOR IDENTIFIED PRIORITIES

BEFORE DEVELOPING AN ACTION PLAN, YOU MUST FIRST DEFINE:

- The **cancers** you want to address
- The actions you are able to carry out (to figure out your strategy): **what do we choose to do?**
- The resources you need to implement and sustain each of the actions, and their cost: **what do we have and what is missing?**
- Make a detailed analysis of existing resources: health infrastructure (private and public), civil society, education, communication, industries (tool 1.3)
- **How can we improve existing resources?** Fundraising (public, private, national, and international sectors)
- **How can we evaluate our actions** (indicators)?
- **What will be our calendar?**

EXAMPLE: BREAST CANCER

Baseline

an analysis of the current situation shows the importance of the problem (number of cases, mortality), and shows that primary prevention is partly possible, that early diagnosis and screening are possible, that there is care and cure in a good proportion of cases, and that the costs should be borne by families and the population as a whole.

The table below will help you analyse the existing resources in your country (according to level of income) and figure out what further resources can be obtained.

Further details on indicators and the timeline can be found in Tool 3.2.

USEFUL LINKS

- My Child Matters Program, a UICC-Sanofi-Aventis partnership to improve pediatric cancer care in developing countries, American Society of Clinical Oncology. www.asco.org/ASCOv2/Meetings/Abstracts?&vmview=abst_detail_view&confID=47&abstractID=35108
- My Child Matters, UICC and Sanofi Espoir Foundation Partnership. www.uicc.org/programmes/my-child-matters
- Overview: National Cancer Control Plan, China, December 2003. Page 1. www.who.int/cancer/modules/China.pdf

WHAT HAVE WE CHOSEN TO DO?

Prevention:
- Fight women's obesity and sedentary lifestyle

Early detection:
- Clinical breast examination
- Screening

Diagnosis:
- Clinical
- Radiology
- Histology
- Bio Markers

Treatment:
- Surgery
- Radiotherapy
- Chemotherapy

Palliative care:
- Analgesics
- Psychological help

Research
- Clinical research
- Epidemiology
- Biology

WHAT RESOURCES DO WE HAVE TO ACHIEVE OUR OBJECTIVE?	WHAT IS MISSING?	HOW DO WE ACHIEVE OUR AIM?
• Information • Education • Weight Watchers (income level 3) • Specialised centres (level 2,3)	• More information on balanced diet and exercise • Low prices for low-fat and low-sugar foods • Access to walking areas • Clear public policy (food prices) • Studies on specific determinants of obesity	• Lobby decision-makers • Inform media • Increase women's awareness campaign • Grants for research on determinants
• Primary care clinics and maternities (levels 1,2,3) • public hospitals and private clinics(level 1,2,3) * • Pathology labs (level 1,2,3) • Specialised centres (level 3)	• Clinical examination for all women within the framework of primary health care and family planning programmes (level 1) • mammography , core biopsy (level1, 2,3) • Pathology labs (level 1,2) • Organised screening (level 3)	• Train health workers • Inform women • Organise detection programmes • Perform cost/benefit analysis • to convince policy-makers to create missing tools and structures
• Clinical exam, cytology, core biopsy (level 1) • mammography and core, RX driven biopsy (level 2,3) • Ultrasound (level 1,2,3) • Pathology labs (level 1,2,3)	• Trained health personnel (level 1,2) • Mammography machines (level 1,2) • Pathology labs (level 1,2) • Receptors' dosage (level 1,2) • Other markers (level 1,2,3) • Scanner (level 1,2)	• Organise training sessions • Improve and organise health system to ensure access to diagnosis • Purchase radiology and pathology lab equipment and organise management • Organise diagnostic programme • Publish diagnostic guidelines
• Surgery (level 1,2,3) • Hormonal therapy (level 1,2,3) • Radiotherapy (level 2,3) • Chemotherapy (level 1,2,3)	• Trained professionals • Specialised surgical unit (reconstructive) • Radiotherapy unit • Drugs • Comprehensive specialised unit • Cancer centre	• Organise training sessions • Improve and organise health system to ensure access to treatment and care • Equipment, infrastructure • Adapted protocols • Guidelines
• Morphine (all levels) • Civil society association for patient support (all levels) • Psychologists (level: 2-3)	• Trained professionals • Access to drugs (analgesics and morphine) • Mobile specialised unit • Home care • Organised psycho-oncology	• Train health workers and volunteers • Lobby for access to analgesics • Organise focus groups and patients' association • Create mobile units
• Patients' records (all levels) • computerised data (all levels) • International cooperation • Local research unit (level 2-3)	• Protocols for clinical trials • Data management • Hospital registration • Population-based registration • Professionals trained in epidemiology and biostatistics	• Adapt clinical trial protocols • Train data managers • Regular patient follow-up • Increase computers know-how • Get support from drug companies • Get support from international organisations

TOOL 3.7: ACTION PLAN TEMPLATE

A model action plan always has the same structure and questions, whatever the resource level of your country. It must consist of an operational programme planned over a certain number of years according to your country and resources.

MODEL

1. **Priorities:** type of cancer and actions (see Tools 3.3 to 3.6)

2. Selection of the leader in charge of each of the chosen actions and responsible for organising a working group

3. Details for each of the actions:
   a. Organisation (who, what, where, how)
   b. Follow-up
   c. Financial and human resources
   d. Calendar
   e. Process indicators
   f. Data collection

4. Permanent analysis of the processes (ad hoc group) and reorientation, if necessary

5. Short-, medium- and long-term reporting and communication

EXAMPLE

- **Priority topic:** organised cervical cancer screening
- Choice of a group leader to write guidelines and follow the processes
- Choice of test: Pap, VIA, HPV
- Set up of all units performing the test (both equipment and professionals)
- Training of laboratories to read the Pap or HPV when chosen
- Creation of a national evaluation team
- Creation of a management organisation at the departmental level
  - Define target population
  - Organise quality assurance
  - Population information and invitation to screening
  - Organise follow-up: send results, perform complementary examinations (colposcopy and biopsy) when tests are positive, and provide access to treatment when necessary
  - Collect data for evaluation (locally and at national level) and set up permanent analysis of the processes.

TOOL 3.8: RESOURCE ASSESSMENT FORM

To ensure your approach is concrete and realistic, you must make a clear appraisal of available resources and existing services in your country. Based on what already exists, it is then possible to reinforce means needed to achieve selected goals.

The following list will help you appraise what is analysed and what is needed in order to plan appropriately.

TYPE OF RESOURCES

Human Resources

- General practitioners
- Specialists
- Nurses
- Technicians
- etc

Budget

- Government
- Private sector
- Multinational cooperation
- Non-governmental organisation
- International cooperation
- etc

Health Care

- Infrastructure
- Services
- Materials
- etc

Legislation and Regulation

- Laws and decrees creating regulatory framework
- Implementation of regulatory framework
- etc

Information & Communication

- Media
- Health personnel
- Traditional healers
- Civil society
- Religious leaders
- etc

Education

- School
- Family
- Volunteers
- Religious institutions
- etc

Implementation creates an on-going need to communicate with the cancer community, keeping them informed on progress and issues that may arise.

SECTION 4

HOW WILL WE COMMUNICATE AND IMPLEMENT OUR PLAN?

Development of a national cancer control plan implies an active implementation of the strategies and actions. Unfortunately, there are cases where substantial effort is put into developing a plan but then the plan is not implemented. Therefore, the planning group need to commit itself to support implementation of the plan according to the planning process. Discussing implementation of the plan is an important first step.

Review the "Before you begin" checklist before you begin this section!

CONTENT OF THIS SECTION

INTRODUCTION

Implementing a cancer control plan requires two types of actions. The first is communicating the plan to cancer-interested organisations, decision-makers, and the general public. The second is reorganising the planning group into an action group.

GUIDING PRINCIPLES

4. COMMUNICATING THE PLAN

4.1 Before the plan is finished, an opportunity should be found to share a draft with people outside the cancer control planning group, inviting them to comment on the content. This begins a process of engaging others who may be important to the implementation process. There may be some cancer experts or leaders who were unable to participate in the planning process, for example, and by inviting them to comment on the draft they remain interested in the next steps. Similarly, asking key leaders in the country (e.g. the Minister of Finance) to comment on the plan raises their interest.

4.2 Implementation creates an on-going need to communicate with the cancer community, keeping them informed on progress and issues that may arise. Your group should decide who will be responsible for initiating the communication.

4.3 Once the plan is finished, it is important that others are aware of its existence and that your planning group intends to see it successfully implemented. Here are some ways to do so:

- **a.** Send copies of the plan to health professionals and ask for comments.
- **b.** Ask each member of your cancer group to communicate the plan to their own organisations.
- **c.** Deliver copies of the plan to key political leaders in the country.
- **d.** Hold community meetings around the country to present the cancer control plan and discuss how communities can implement parts of it.
- **e.** Hold a major public event to announce the plan to the general public, and invite national leaders and mass media. Your event should engage interest, remind people of the major burden that cancer places on the citizens, and invite people to get involved in implementing the plan to reduce the cancer problem in your county.
- **f.** Arrange interviews between key mass media and the leaders of your cancer control planning group. Group members who are interviewed should know the contents of the plan thoroughly, particularly the facts about the cancer burden in the country and the priority strategies you want to adopt and implement. Prepare short, comprehensive answers, and practice them with your leaders prior to interviews to ensure effective communication of your national cancer control plan.

4.4 Every opportunity presented to your group to communicate your plan should end with a call to action. Each call to action will be different depending on the audience. The key issue is to ask people from different organisations and working at different levels to adopt and support one or more of the strategies in the plan using their resources and strengths.

EXAMPLE

If your audience is the general public, you may ask them to adopt certain kinds of behaviour ("eat more vegetables", or "get a breast cancer screening test", or "take your parents for a cancer check-up"). If the audience consists of professionals, you might ask them to work alongside your cancer group on a particular strategy. If the audience consists of national political leaders, you might ask them to support a specific policy.

4.5 Prepare some specific stories about people affected by cancer in your country. These should be real and relate to the priority strategies in your plan.

EXAMPLE

If one strategy is to increase the percentage of eligible women getting cervical cancer screening tests, a story of a woman who used such a test and how that affected her life could be a powerful statement. Organisations that work directly with cancer patients can often help you find people who have moving or inspiring experiences to share.

4.6 Leaders come and go as professional lives change or new politicians come into power. Therefore, there is a need to inform new leaders on who is and who should be involved in implementing the country's plan. It is important to gather information about the individual, particularly any known previous experience with cancer or in cancer control efforts before approaching them on behalf of your national cancer control group.

PREPARING FOR IMPLEMENTATION

4.7 The group that worked on the plan will need to reorganise itself in order to support implementation.

4.8 Some individuals who worked in the development of the cancer control plan may choose to delegate someone else from their organisation to work on implementation. Keep in mind that individuals and organisations who were not involved in developing the plan may want to be active in implementation and should be given the opportunity to do so.

4.9 An effective strategy for implementation is forming a team to oversee the implementation of each individual strategy.

EXAMPLE

If your cancer control plan has six priority strategies, your action group should thus form six smaller action teams to work on implementing each strategy. Each action team would be asked to work on the specific action steps identified in the plan and to report back to the full group on progress and any problems in the implementation. These action teams will need leaders and experts, either chosen or assigned to them. Teams will also need administrative support for their work (e.g. conference calls, or grant writing).

4.10 Implementing the plan is reliant upon resource needs and acquisition. The individual action teams should be able to identify their own needs, but is helpful to consider the resources requested for all the priority strategies and make a coordinated effort to obtain them.

EXAMPLE

It is better to make one request to a foundation for funds for several strategies, rather than having a different and competing funding request for each strategy.

4.11 Accountability is an essential part of implementing the cancer control plan. Some countries respond to this need by conducting an annual review of progress. A progress report is prepared by the leader, experts and the working groups or a steering committee of the plan, but it is often made available to outside professionals and the general public as well.

4.12 Progress reviews typically cover a number of questions including:

a. What progress has been made in implementing our key strategies over the past year?
b. What is working well in the implementation?
c. What is not working well in the implementation? What can be done to implement our strategies better?
d. What will be our priority strategies in the coming year? What strategies will we continue pursuing? What new strategies, if any, will be added?

At the start, a baseline may not be available to measure progress. A situation analysis at the beginning will thus need to be carried out to prepare to answer the above questions.

CRITICAL QUESTIONS FOR IMPLEMENTING THE PLAN

The following questions should help to identify the important actions that will be required to implement your national cancer control plan properly.

- How will we get some feedback on our draft plan and who will collect these from people outside the planning group?
  Who will we ask?
  In what form would we like the feedback?
- Who are the people and organisations we would like to share our plan with most?
  What is our call to action for each of them?
- What changes do we need to make in the way we are organised in order to transition from planning to implementation?
- Who, outside the cancer control planning group, needs to be involved in the implementation process? How will we recruit them?
- How will we select leaders for the implementation phase and how long will we ask them to serve as leaders?
- How can we increase active support for the plan from our national and community leaders? How will we coordinate the effort to obtain the resources needed to implement our plan? How do we prepare for reviewing progress?
- How will we tell the country about our plan (e.g. leaders, general public, health professionals)
- Who is responsible for leading this communications effort?
- How will we prepare our leaders to talk publically about the plan?

TOOLS FOR COMMUNICATING AND IMPLEMENTING THE PLAN

Tool 4.1 Communicating the cancer control plan

Tool 4.2 Expanding the group for implementation

Tool 4.3 Sample organisation chart for implementation

Tool 4.4 Identifying resources for implementation

Tool 4.5 Sample outline for a progress review

NCCP tools can be accessed through **www.uicc.org/resources**

NCD ALLIANCE

The Alliance represents the four main international federations that address key Non-communicable Diseases (NCDs) outlined in the World Health Organization's 2008-2013 Action Plan for NCDs – cardiovascular disease, diabetes, cancer, and chronic respiratory diseases. These conditions share common risk factors (including tobacco use, physical inactivity and unhealthy diets) as well as common solutions, providing opportunities for collaboration and joint advocacy. The membership base of the four federations that constitute the NCD Alliance (nearly 900 national organisations), gives the alliance a unique strength by bringing a united voice to the global campaign for Non-communicable Diseases.

ncdalliance.org/

REFERENCES AND USEFUL LINKS

- Centres for Disease Control and Prevention. Guidance for Comprehensive Cancer Control Planning (Volume 1: Guidelines and Volume 2: Tools). Atlanta: US Centers for Disease Control and Prevention; 2002. Retrieved from www.cdc.gov/cancer/ncccp/pdf/Guidance-Guidelines.pdf
- The Cancer Control PLANET. Steps 3 and 4. http://cancercontrolplanet.cancer.gov/

TOOL 4

TOOLS FOR COMMUNICATING AND IMPLEMENTING THE PLAN

TOOL 4.1: COMMUNICATING THE CANCER CONTROL PLAN

While you finalise the plan, it is important to communicate your intentions and to get feedback and comments on the work in progress from people outside the planning group, who will be directly involved in the implementation of the plan. Make a list of the people and institutions that need to be involved in the plan, and decide the best ways to communicate with them.

Communicating the cancer control plan involves two major steps: the first is to request opinions about the plan, and the second to communicate the final plan widely.

STEP 1: REQUEST FOR FEEDBACK

Objectives: identify resource people able to assess the quality and methods of the plan and, at the same time, identify volunteers who wish to be involved.

List of potential resource people

- Decision-makers in the Ministries concerned (health, finance, education, etc.)
- Key leaders such as medical doctors, or directors of public or private hospitals
- NGOs
- Stakeholders
- Budget institutions/bodies
- Training institutions/bodies
- International experts
- Etc.

Communication tools to collect comments and extend the working group

- Hardcopy documents
- Telephone conferences
- Online fora
- Conferences, debates
- Meetings at cancer wards or units to explain the programme
- Questionnaires to collect comments.

Collecting comments and making use of them

- All comments should be transmitted to the planning group for discussion
- The planning group can be expanded to include reviewers (see Tools 4.2 and 4.3)
- The plan should be modified to take into account suggestions agreed on by all.

STEP 2: DISSEMINATION

Objective: to inform health professionals and the general population about the cancer control plan and its implementation.

Tools for dissemination

- Personal communication to the country's president or chief of government, ministers, and key leaders.
- Official letters sent to, and/or seminars held with, local and regional government ministers, local and regional hospital administrations, private clinics and other health care structures, medical doctors and health workers in the public and private sector, cancer NGOs, stakeholders, and funding providers etc.
- A major launch event to announce the plan to the general public, in conjunction with conferences, radio and television events, newspaper articles, posters, and any other media outreach involving the extended group members and experts.
- Regular information through the media on the implementation and follow-up of the plan.

USEFUL LINKS

Step 1

- Cancer Action newsletter, Cancer Action Team, UK Department of Health. Nov-Dec 1999. Published ten months before the launch of the UK cancer plan. www.dh.gov.uk/en/Healthcare/NationalServiceFrameworks/Cancer/DH_4001773
- Designing print materials: a communications guide for breast cancer screening. chapter 3, 49-86. US National Cancer Institute, January 2007. http://appliedresearch.cancer.gov/icsn/publications/guide.html
- Guidance for Comprehensive Cancer Control Planning. Atlanta: US Centres for Disease Control and Prevention, Division of Cancer Prevention and Control; 2002., vol 2. toolkit, tool # 14a, p. 41. www.cdc.gov/cancer/ncccp/pdf/Guidance-Guidelines.pdf

Step 2

- Ngoma, T. (2007). Cancer control planning and implementation: a view from Tanzania. ORCI. Available at www.afrox.org/docs/CSOma.pdf

TOOL 4.2: EXPANDING THE GROUP FOR IMPLEMENTATION

The objective is to increase the size of the group to implement the plan, according to priorities. It is important to seek the leaders and professionals specifically suited to each type of planned action.

1. IDENTIFY RESOURCE PEOPLE

- People who are strategically important for implementation of the plan
- People who expressed their interest in a positive way (for example those who responded to the request for comments)
- People who are able to provide missing resources (time, financial or technical resources, logistics, etc.)
- External partners (international).

2. WORKING WITH RESOURCE PEOPLE

- Assess their interest and commitment
- Delegate responsibilities
- Provide detailed job description for each person
- Set up a calendar and decide on how they should report back
- Provide logistical support for their work
- Sign charters with new active partners
- For partners with whom contact is less positive, but who are key to implementation, negotiate to try to ensure participation.

3. INTEGRATION WITH THE INITIAL GROUP

- Hold regular meetings with the initial group to discuss progress and difficulties
- Change strategy if plan proves to be unrealistic or cannot be implemented due to lack of resources
- Actively participate in the process of continuing evaluation already set up.

USEFUL LINKS

- Programa de Prevención de Cáncer de Cuello Uterino en el Uruguay «Dr E. Pouey». Montevideo, (2007). 5-19. Available from www.msp.gub.uy/imgnoticias/13586.pdf
- US National Cancer Institute. (January 2007). Designing Print Materials: a Communications Guide for Breast Cancer Screening. Chapter 3, 49-86. Available from http://appliedresearch.cancer.gov/icsn/publications/guide.html
- France: le Plan Cancer 2009-2013 www.plan-cancer.gouv.fr/le-plan-cancer/presentation.html
- Guidance for Comprehensive Cancer Control Planning, Division of Cancer Prevention and Control Centers for Disease Control and Prevention, Atlanta, 2002, volume 2: toolkit, tool # 12, Page 37. www.cdc.gov/cancer/ncccp/pdf/Guidance-Guidelines.pdf

TOOL 4.3: SAMPLE ORGANISATION CHART FOR IMPLEMENTATION

TOOL 4.4: IDENTIFYING RESOURCES FOR IMPLEMENTATION

A good assessment of human, material, and financial needs is key to successful planning and implementation of programmes. The working groups must quantify their needs in detail, and put them together to work out a complete budget.

The table below can serve as a model to be completed by each of the action teams.

	EXPENDITURE FOR EACH ACTION	
POSSIBLE PROVIDERS	INFRASTRUCTURE AND EQUIPMENT	HUMAN RESOURCES: SALARIES, TRANSPORTATION, HEALTH INSURANCE
PUBLIC		
Ministry of Health		
Local and regional government		
Health insurance		
PRIVATE		
Private health insurance		
Industries		
Charities		
Civic groups		
INTERNATIONAL		
United Nations (WHO, UNESCO, IAEA) World Bank, etc		
CSOs		
Foundations		
Others		

LOGISTICS, INSURANCE, TAXES, ETC.	COMMUNICATION COSTS: MEDIA, TELEPHONE, FAX, INTERNET, ETC.	OTHER (E.G. PER DIEM)

The total budget must integrate each working group's needs and consider the possibility of sharing resources between teams. It is necessary to coordinate efforts and avoid competing funding requests.

TOOL 4.5: SAMPLE OUTLINE FOR A PROGRESS REVIEW

Successful action requires good adherence to a plan, and regular reporting. You need some monitoring annually, not only an evaluation at the end of the period. It is mandatory to perform regular progress reviews of each strategy and submit them to the follow-up group. Indicators for the process evaluation, as well as a timeline for the collection of data and reporting, must be defined before the implementation begins.

1. EACH ACTION MUST BE EVALUATED STEP BY STEP.

2. FOR EACH STEP, IT IS NECESSARY TO DECIDE IN ADVANCE BY WHOM, WHERE, WHEN, AND HOW THE STEP WILL BE PERFORMED:

a. By whom

Who is the person in charge?

Who will staff the action?

b. Where

In what setting will the action take place (hospital, prevention centre, community, etc)?

With what equipment?

What is the target population?

c. When

When will the action begin?

How long will it last?

Will it need to be repeated, and, if so, how often?

d. How

What resources are needed?

What are the existing resources, and how will missing resources be found?

How will the action be evaluated: what are the indicators, and how will data be collected (by whom, when, with what tools)?

3. FOR EACH OF THESE POINTS ABOVE, AN EVALUATION FORM CAN BE ESTABLISHED:

a. Is the person in charge doing his/her job properly? ○ Fully ○ Partially ○ No

If partially or no: why?

b. Are staff members doing their job properly? ○ Fully ○ Partially ○ No

If partially or no: why?

c. Is the infrastructure and equipment adequate to perform this step: ○ Yes ○ No

If no, explain why

d. Was the target population well defined? ○ Yes ○ No

Are they well informed of the action? ○ Yes ○ No

Are they participating in the plan? ○ Yes ○ No

What are the problems, if any?

e. Did this step begin at the expected date, and if not, why? ○ Yes ○ No

Is the step being performed at the right pace? ○ Yes ○ No

Is the predicted duration of the action realistic? ○ Yes ○ No

Is the frequency (if any) being respected? ○ Yes ○ No

f. Are the resources adequate, and are they being used appropriately? ○ Yes ○ No

g. Has this step worked well? ○ Yes ○ No

Should it be improved, and if so, how?

h. Has all the evaluation data been collected: ○ Fully ○ Partially ○ No

i. Are there other problems?

EXAMPLE: IMPLEMENTATION OF A PILOT STRATEGY FOR CERVICAL CANCER SCREENING

Step one: Invitation to women

a. Who is the person responsible, and who will work on media, CSO, social workers, etc?

b. How is the target population defined? (who will gather relative information)

c. How will women be invited? (general information, individual invitation by mail, visit by social worker, etc.)

d. When will this process start, and how often will it be repeated?

e. What is the desirable participation rate, and how is it calculated?

Step two: Performing the screening test

a. Who is in charge of performing the test? (doctors, nurses, etc.); where will the screening take place? (primary care centers, hospital, laboratory, specific setting, etc.); what materials are needed? (depending on the type of test); all these points should be detailed in a procedure manual.

b. How is the quality control of the test performed? Specify the indicators, such as percentage (with defined numerator and denominator) of (recall accepted) tests needing to be repeated for technical reasons.

Step three: Reading the test and giving the results

a. Who is in charge of reading the test? (cytologists, biologists, gynaecologists, etc.). Where is the reading done? (authorisation)

b. How is the quality control of the reading performed? (sampling for double reading)

c. What is the recommended time lapse for giving the result?

d. How are the result data collected? (manually, computer, centralisation, etc.)

Step four: Follow-up of women with positive test

a. Who is in charge of recalling the women (if necessary), and how quickly should this be done?

b. Where are the diagnostic examinations performed? (colposcopy, biopsy)

c. Who is in charge of these tests? Who reads the biopsy results? Who pays for them?

d. What are the quality control procedures for these tests?

e. How is the result data collected?

f. Who is in charge of informing the patient of her test result?

Step five: Treatment

a. When a treatment is needed, who is in charge of the decision, where does the treatment take place, and who pays for it?

b. Does a consensus protocol with guidelines exist?

c. How is the quality control organised?

d. How is the result data collected?

Step six: Evaluation

a. Is the data for evaluation computerised and centralised, and if so, where?

b. Who is in charge of performing the analysis?

c. Is there coordination with a cancer registry, if it exists?

d. Who is in charge of examining the results and taking decisions about the programme (continue, modify, stop, etc.)?

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The group in charge of implementation must make a judgment about how the results affect the direction of the programme. A management decision about what direction the programme should take in the future and how much resources need to be allocated to it is an extremely important consideration in achieving your desired goals.

SECTION 5

HOW WILL WE MEASURE OUR SUCCESS?

An evaluation must be carried out to know whether the plan is achieving what it is intended to do, or whether some approaches should be modified. Evaluation uses many of the same methods as epidemiological research (e.g. surveys, cancer registration). Whereas research is designed to provide new information about cancer control, evaluation tells us how well we are reaching the goals and objectives we have set.

Review the "Before you begin" checklist before you begin this section!

CONTENT OF THIS SECTION

INTRODUCTION

EXAMPLE

Using our previous cervical cancer example, if our goal is to increase the percentage of women being tested from 40% to 75%, the evaluation should be designed to show us how far that objective has been achieved since implementing our plan.

Cancer control programme leaders must carefully consider the evaluation results. Here are some possible conclusions that may be reached:

- The programme is going well and achieving good results. We should continue the evaluated strategy.
- In order to meet our objective over the next two years, we need to increase the resources for the strategy.
- The strategy we have been using has achieved all it can and we need to shift to another strategy to meet the objective.
- The programme is not achieving the expected results. We need to analyse the reasons and shift to other strategies.

The group in charge of implementation must make a judgment about how the results affect the direction of the programme. A management decision about what direction the programme should take in the future and how much resources need to be allocated to it is an extremely important consideration in achieving your desired goals. The evaluation provides data on which decisions are based.

To be effective, an evaluation needs to be well planned and properly carried out, and the results need to be analysed, interpreted and carefully considered by decision-makers.

Providing feedback on the evaluation to all people involved in the process will give them a measure of the impact of their contribution to the successes of the plan and/or of the additional efforts required.

GUIDING PRINCIPLES

5. DECIDING WHO WILL DO THE EVALUATION

5.1 Evaluation should be designed and conducted by professionals with the appropriate knowledge, training, and experience.

5.2 When developing the plan, it is important to write objectives that are SMARTER (Specific, Measurable, Achievable, Reasonable, Time-phased, can be Evaluated and Revisited) and aligned with strategies that have well-defined outcomes.

5.3 Evaluators must safeguard their independence and objectivity, and be free from the influence of programme leaders when reporting their results. It is important that they determine together the focus of the evaluation.

5.4 Evaluators should be involved in the planning process as early as possible. If they are involved from the very beginning, evaluators can often help the cancer control planning group develop more specific objectives into the plan, thereby making results more achievable and measurable.

5.5 Evaluation requires resources that need to be identified and budgeted as part of the planning process.

TYPES OF EVALUATION

5.6 The planning group should decide what type of evaluation will be conducted. There are three possible approaches: process, short- and long-term outcome, and impact.

a. Process evaluation measures whether the programme is going as expected.

EXAMPLE

Teams are in place and carry out their tasks as planned; resources needed have been secured.

b. Outcome evaluation measures the extent to which expected outcomes are being met over time. It also measures changes in knowledge, attitude, and behaviours (KAB).

EXAMPLE

A short-term outcome would be the proportion of women who realise the importance of being tested, and know where to get a test. A mid-term outcome might be the number of women who actually receive a test.

c. Impact evaluation measures are more long-term effects such as changes in morbidity and mortality balanced by the cost of the strategy and money spent to obtain better results.

EXAMPLE

A long-term outcome would be a decrease in the number of women diagnosed with late-stage cervical cancer, or decrease in incidence.

DECIDING WHAT TO EVALUATE

5.7 Cancer control plan evaluations can include questions for:

- **a.** Evaluating the planning group
- **b.** Evaluating the planning process
- **c.** Evaluating whether the cancer control plan is appropriate to the country
- **d.** Evaluating the implementation process
- **e.** Evaluating outcomes and impacts.

5.8 Evaluators need to develop questions that will guide the selection of data collection techniques in order to answer the achievements of the SMARTER formulated goals. Once the evaluation questions are agreed on, related to the actions and goals of the plan, the initial measures to develop the plan should be taken into consideration. You can determine the needed data, collection methods, analysis, and reporting methods.

EXAMPLE

- **a.** Developing a simple survey with a standard set of questions.
- **b.** Creating a database with the answers we get by assigning responsible persons to enter the results into a computer programme or a spreadsheet.
- **c.** Analysing the results. The data should be displayed in a way that helps decision-makers understand them. This requires expertise in data analysis and reporting.
- **d.** Reporting the results through written reports or factsheets that are understandable and present results in a clear manner.

USING EVALUATION RESULTS

5.9 Reports of evaluation results need to be comprehensive and objective. They should note the things that are going well, the things that are not going well, why things are going well or not (if the data can provide these details), and conclusions. Decision-makers will consider the results to make decisions on future actions.

RESOURCES

5.10 Evaluation requires resources. These should be identified and budgeted as part of the planning process.

CRITICAL QUESTIONS FOR EVALUATING SUCCESS

The following questions should help clarify the scope of the evaluation included in the cancer control plan and how it will be conducted.

- Are our cancer control plan objectives and strategies stated in such a way that they can be evaluated? Are they SMARTER?
- Do we have people involved in the cancer control planning process who have the skills needed to design and carry out an evaluation?
- What are we going to evaluate?
- What are we evaluating for?
- Will the evaluation help improve unsatisfactory performance?
- Do we have a budget for doing the evaluation as part of the resource needs for cancer control?
- Who will be responsible for reviewing the evaluation results? How often will the review take place?
- How will we communicate the evaluation results to our cancer control planning group and to the public?
- Who will communicate the results and when?

TOOLS FOR EVALUATING THE PLAN

Tool 5.1 Evaluation skill sets

Tool 5.2 Overview of evaluation steps

Tool 5.3 Checklist for choosing evaluators

Tool 5.4 Sample evaluation questions

NCCP tools can be accessed through **www.uicc.org/resources**

GLOBAL INITIATIVE FOR CANCER REGISTRY DEVELOPMENT IN LOW- AND MIDDLE-INCOME COUNTRIES GICR

This initiative has been convened by the International Agency for Research on Cancer (IARC) and backed by several international organisations. It aims at developing – and creating where needed – the capacity to produce reliable, high-quality information on the burden of cancer so that effective policies for cancer control may be developed and implemented.

gicr.iarc.fr/

REFERENCES AND USEFUL LINKS

- US Centres for Disease Control and Prevention. Evaluation Resources (Manuals and Framework for Programme Evaluation). www.cdc.gov/eval/resources/index.htm
- Canada: Sustaining Action Toward a Shared Vision: 2012 – 2017 Strategic Plan. 2012. Available from www.partnershipagainstcancer.ca/wp-content/uploads/Sustaining-Action-Toward-a-Shared-Vision-Full-Document.pdf
- Canada: Impact Report 2010: Partnership makes the difference. 2010. Available from www.partnershipagainstcancer.ca/wp-content/uploads/FINAL-Impact-Report-ENG-for-web1.pdf
- Canada: A portal to connect Canadians to cancer resources and tools: www.cancerview.ca
- Centres for Disease Control and Prevention. Guidance for Comprehensive Cancer Control Planning (Volume 1: Guidelines and Volume 2: Tools). Atlanta: US Centres for Disease Control and Prevention; 2002. www.cdc.gov/cancer/ncccp/pdf/Guidance-Guidelines.pdf
- World Health Organization. National Cancer Control Programmes: Policies and Managerial Guidelines. 2nd edition, 119-123. Geneva: World Health Organization; 2002. www.who.int/cancer/media/en/408.pdf
- University of Wisconsin Extension Service. Planning a Programme Evaluation. 1996. www.uwex.edu/ces/pdande/evaluation/evallogicmodel.html
- Netherlands National Cancer Control Programme. NPK Monitor 2009. https://webgate.ec.europa.eu/sanco/heidi/images/3/3e/Netherlands_National_Cancer_Control_Programme_English.pdf

TOOL 5

TOOLS FOR EVALUATING THE PLAN

TOOL 5.1: EVALUATION SKILL SETS

Prior to implementation, an intervention should be evaluated to assess its relevance. During and after the intervention, three levels must be evaluated:

- the process, to measure whether the intervention is following the proposed protocol;
- the outcome, to assess if the expected results occurred; and
- the impact, to measure if the long-term objectives were accomplished.

All of these evaluation steps are complementary and unavoidable.

1. RELEVANCE OF THE PROPOSED INTERVENTIONS

The plan's proposed interventions must:

- fit with the country's cancer burden and specific needs
- have been proven to be effective (evidence-based)
- be sustainable (in terms of human resources, materials, methods, and budget).

2. PROCESS EVALUATION

- This activity must take place continuously throughout the intervention, to help detect and correct deviations from the proposed plan and overcome unexpected difficulties.
- This step involves assessing how the process compares to what was planned in the protocol. It must be conducted by an independent follow-up committee (professionals not directly involved in the intervention), but requires a high degree of interaction with the actors, since it is an internal evaluation.
- Actors and evaluators should meet regularly to discuss the indicators and decide whether any changes are needed in methods or management, or whether training should be organised.
- Process evaluation should include indicators such as feasibility, acceptability, quality control, participation, observance, etc.
- Data must be collected continuously throughout the intervention by the professionals who have been designated to do so.

3. OUTCOME EVALUATION

- Outcome evaluation should be carried out at different intervals, as specified in the protocol.
- It should be conducted by an external team with good experience of evaluation methods.
- The choice of indicators depends on the type of intervention (prevention, diagnosis, treatment, etc.), and should be defined in the protocol to assess the short-term results of the intervention. For example, for a prevention action, the chosen indicator might be an increase in knowledge, while for an early detection action, it might be a change in the stage of diagnosis, and for a therapeutic intervention, tumour regression.
- Data collection should be carried out at regular intervals by the professionals who have been designated or recruited to do so.
- A proper statistical analysis of the data should be carried out at fixed intervals, and communicated to the people involved in the action and to the plan's follow-up group.

4. IMPACT EVALUATION

- Impact evaluation should be carried out 3-5 years after the start of the intervention, or as specified in the plan.
- It must be carried out by the same specialised team that was in charge of impact evaluation.
- Generally, chosen indicators include incidence, mortality, and survival, and include the global benefits and drawbacks and the costs.
- Such an evaluation requires data collection to be organised from the beginning of the intervention (registry, mortality database, etc.).

5. COMMUNICATION OF THE RESULTS

The results of an evaluation will be used to report on the existing programme, and to make proposals to improve the existing programme, or to create new actions or programmes.

- Regular reports are essential tools for those who are involved in the action, as well as those in charge of following the development of the plan.
- It is useful to send out a short summary of the results at regular intervals to all those involved in the fight against cancer.
- An overall conclusion, synthesising all evaluations, can be very constructive for professionals, stakeholders, decision-makers, and politicians.

TOOL 5.2: OVERVIEW OF EVALUATION STEPS

Evaluation is mandatory to assess if the plan is achieving its objectives. Before drawing up an evaluation protocol, you must answer the following questions: What are we going to evaluate? Who will conduct the evaluation? What methods will be used? The evaluation protocol must be prepared at the same time as the plan itself, and a budget set aside for it.

WHAT ARE WE GOING TO EVALUATE?

- Before the intervention, the plan itself should be evaluated to determine whether the way it was developed was adequate (quality of the group responsible for drawing up the plan, good fit between needs and propositions, quality of the objectives – these should be specific, measurable, attainable, reasonable, and time-phased (SMARTER), and whether the proposed implementation process is realistic and feasible, given the country's health resources.
- During and after the intervention, each of the plan's actions must be evaluated as well as the overall strategy. For each action, three levels must be considered: process, outcomes, and impact. The evaluation of the overall strategy will emerge from the evaluation of the individual actions.
  - Process evaluation assesses whether the action is operating as expected. It must be conducted continuously so that the protocol can be adapted if needed.
  - Impact evaluation measures the short- and mid-term results. These are indicators to predict the success or failure of the long-term effects of the action. Decide beforehand how frequently such an evaluation should be performed.
  - Outcome evaluation assesses whether the action's long-term objectives have been met. Decide beforehand a date by which it is reasonable to expect such an outcome.

WHO WILL CONDUCT THE EVALUATION?

The choice of the appraisal team will depend on the type of evaluation.

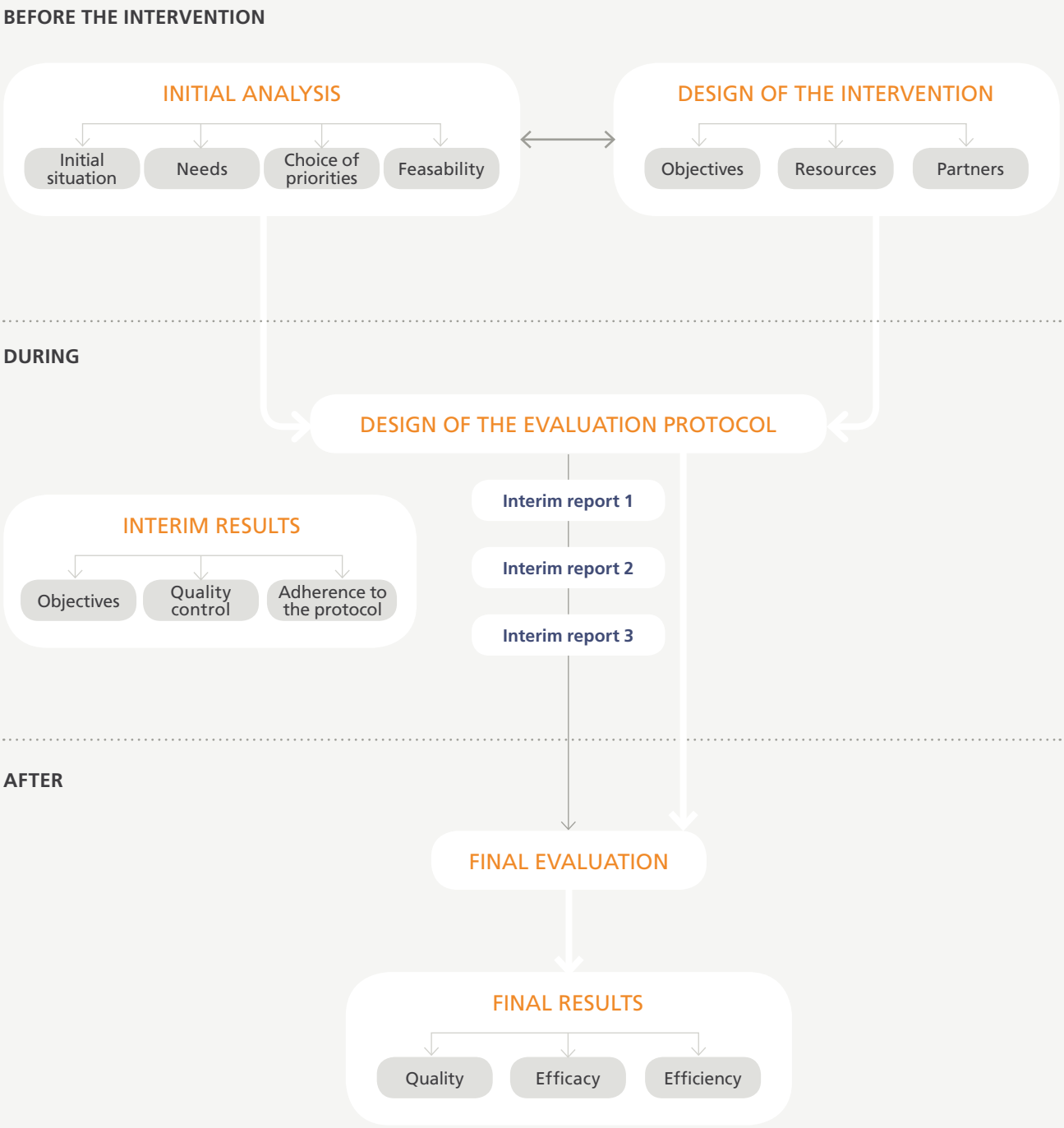
- The evaluation of the plan itself is conducted by professionals who were not involved in developing the plan but who are nevertheless concerned by it.
- The process evaluation is generally an internal evaluation conducted by the professionals involved in the intervention (the "players") themselves, using defined indicators at the start.
- Evaluation of the outcomes and impact must be conducted by professionals who have appropriate knowledge, training and, experience in the evaluation methods. If such a specialist does not exist in your country, invite one from another country.

WHAT METHODS WILL BE USED?

The protocols for the different types of evaluation must be developed at the same time as the plan. Such protocols must consider:

- **The method:** expert group (to evaluate the plan itself), permanent indicators (process), evolution of indicators with time or within geographical areas (outcomes, impact)
- The appraisal team (internal, external) – see Tool 5.2
- The data collection and analysis (who will do it, when, and with what tools)
- The frequency of reporting and who reports will be addressed to.

DIAGRAM: AN OVERVIEW OF EVALUATION STEPS



TOOL 5.3: CHECKLIST FOR CHOOSING EVALUATORS

Knowing whom to entrust with the evaluation of the plan is a complex question. Evaluation requires scientific rigor and a sound methodology. The search for evaluators and the final choice must be made by the plan's steering committee. The choice of the evaluator and/or evaluating team depends on the type of evaluation to be carried out.

1. CHOOSING THE EVALUATION TEAM

Internal evaluation of the process should be conducted in cooperation with the professionals involved in the intervention and external experts; it can be facilitated by a group of communication experts and/or take place through a public debate.

To be involved in the evaluation, good knowledge of the programme and the health issue is mandatory. All professionals involved in the intervention (the "players") must be part of the evaluation team. The external professionals (those not involved in the intervention) must be recognised as experts in the field by the players. They should be appointed by the plan's steering committee.

External evaluation of adequacy impact and outcomes must be conducted by an impartial person or group independent of the intervention, specifically trained to perform evaluations. Such qualified professionals lend external credibility to the evaluation (health professionals, health administrators, fundraisers, politicians, etc.) and can possibly act as mediators in case of problems. Nevertheless, in order to avoid problems, it is important that the indicators and parameters for the evaluation be established together with the steering committee and players themselves.

2. ROLE OF THE EVALUATORS

People conducting internal and external evaluations adopt different approaches. Before the evaluators are appointed, it is necessary to establish the objectives of the evaluation (see detailed evaluation steps in Tool 5.1).

3. CALL FOR AN EXTERNAL EVALUATION

Some advice for choosing a person and/or team in charge of the evaluation:

1. Ask the candidate(s) for a CV and references, and propose an interview to ensure that their training corresponds to your objectives (qualifications and experience in epidemiology and biostatistics). Find out their availability.
2. Ask them to provide information about their evaluation methods, and indicate to them the budget available for evaluation.
3. Prefer people who have already performed evaluations of health interventions, and make sure you have met with several candidates before making a final choice.
4. Choose a candidate with autonomy and independence, who has a very good understanding of the health issue, and who will work well in a group.
5. Ensure that the selected person or team can be involved in the entire process from the beginning.

USEFUL REFERENCE

- Petit guide de l'évaluation en promotion de la santé, Nock, F., Edition (2006/2007), Mutualité Française.

TOOL 5.4: SAMPLE EVALUATION QUESTIONS

The questions below are examples of those you will need to ask to measure your evaluation indicators. The choice of indicators depends on the element you wish to evaluate (the plan itself, the strategy of the plan, the interventions proposed), the goal of the element, and the type of evaluation you wish to perform (adequacy, process, outcomes, or impact evaluation).

EXAMPLES OF QUESTIONS TO BE ANSWERED INCLUDE: (NOT AN EXHAUSTIVE LIST)

Adequacy and relevance

- Do the objectives fit with the identified priority needs?
- Do the proposed actions make it possible to achieve goals?
- Are the human and material resources adequate to undertake the action?
- Is the action culturally acceptable?
- What are the literature references on the efficacy and efficiency of the proposed strategy?

Process (evidence-based, feasible, acceptable, measurable, etc.)

- Has a realistic protocol been written?
- Is the target population defined and able to participate?
- Has quality control been written into the plan?
- Are the evaluation indicators realistic?
- Is there a plan for data collection and analysis?

Outcomes and impact (depending on the type of "element" being evaluated)

- Have indicators been defined, and are they available, to measure an increase in the population's knowledge of risk factors?
- Have indicators been defined, and are they available, to measure a change in the population's behaviour and access to care?
- Is stage of cancer at diagnosis noted in order to be able to observe any changes?
- Have indicators been defined, and are they available, to measure the changes in the population's health (incidence, mortality, survival rate)?
- Have indicators been defined, and are they available, to measure the action's costs?

NOTES

OVERALL REFERENCES

- The ADAPTE Collaboration. . Resource toolkit for guideline adaptation (Version 1.0). 2007. www.adapte.org
- American Cancer Society. The Affordable Care Act: How it helps people with cancer and their families. 2010. www.acscan.org/content/new-simple-guide-explains-how-the-affordable-care-act-helps-cancer-patients-and-their-loved-ones/
- Anderson BO et al. Breast Cancer in Limited-resource Countries: an Overview of the Breast Health Global Initiative 2005 Guidelines, S-S15. http://screening.iarc.fr/doc/Breast%20Cancer%20in%20Limited-Resource%20Countries%20-%20An%20Overview.pdf
- Association of Community Cancer Centers Cancer Program Guidelines, Chapter 1: Institutional and Programmatic Resources, Section 1: Program Leadership, Guideline 1. 2006. p 5. http://accc-cancer.org/publications/pdf/publications_cpguidelines.pdf
- Association Solidarité Chimiothérapie. Yaoundé, Cameroun. www.sochimio.com/
- Atun R, Coker R, McKee M. Health Systems and the Challenge of Communicable Diseases: Experiences from Europe and Latin America. Atun R, Coker R, editors. Health Systems and Systems Thinking. Open University Press, McGraw Hill Education; 2008. p. 121-140.
- Atun R, Ogawa T, Martin-Moreno JM, . Analysis of National Cancer Control Programmes in Europe. London: Imperial College, London Business School; 2009
- Australia: National Cancer Plan and Strategies. www.canceraustralia.gov.au/publications-resources/cancer-control-plans-and-reports/national-cancer-plans-and-strategies
- Australia: National Cancer Prevention Policy 2007-2009. Available from www.cancer.org.au/policy/NationalCancerPreventionPolicy.htm
- Belgium, National Cancer Plan 2008-2010 https://webgate.ec.europa.eu/sanco/heidi/images/2/27/Belgium_National_Cancer_Plan_2008-2010_English.pdf
- Breast cancer risk factors in south of Islamic Republic of Iran: a case–control study, Eastern Mediterranean Health Journal, vol.13, no.6, 2007. www.EMRO.WHO.INT/publications/emhj/1306/article6.htm
- Burton R, Philippine Coalition for the Prevention and Control of Non-communicable Diseases (PCPCNCD), National NCD. Cancer Planning in Asia and Vietnam. Control Plan 2005-2015, slides 6-13. www.hsph.edu.vn/
- Cancer care Ontario. Ontario Cancer 2008-2011. www.cancercare.on.ca/common/pages/UserFile.aspx?fileId=13808
- Cancer Control in Brazil.Politica Nacional de Câncer, INCA; 2005.www.inca.gov.br/releases/press_release_view_arq.asp?ID=936
- Cancer Control P.L.A.N.E.T, links to comprehensive cancer control resources for public health professionals, step 2. US National Cancer Institute: Division of Cancer Control and Population Science; 2005. http://cancercontrolplanet.cancer.gov
- Cancer Control Programme in India, Challenges for the new Millennium, Strategies for Cancer Prevention in India, Vol XVII, Number 1, India. Page 10. http://medind.nic.in/haa/t05/i1/haat05i1p10.pdf
- Cancer Registration: International Association of Cancer Registries. www.iacr.com.fr/
- Catalonia: Health Plan for Catalonia. Generalitat de Catalunya: health department; 2010. Available from www.gencat.cat/salut/depsalut/pdf/plan2010en.pdf
- Centres for Disease Control and Prevention. Guidance for Comprehensive Cancer Control Planning (Volume 1: Guidelines and Volume 2: Tools). Atlanta: US Centres for Disease Control and Prevention; 2002. www.cdc.gov/cancer/ncccp/pdf/Guidance-Guidelines.pdf
- Centres for Disease Control and Prevention. Sun Safety for American Youth Tool Kit. Atlanta: US Centres for Disease Control and Prevention, 2009. www.cdc.gov/cancer/ncccp/suntoolkit.htm
- Centres for Disease Control and Prevention. Success Stories. Atlanta: Centres for Disease Control and Prevention; 2010. www.cdc.gov/cancer/ncccp/state.htm
- Centres for Disease Control and Prevention. The Comprehensive Cancer Control Movement ten Years of Success 1998-2008. Atlanta: US Centres for Disease Control and Prevention; 2009. www.cdc.gov/PCD/issues/2009/oct/09_0072.htm
- China cancer database: http://cancernet.cicams.ac.cn/
- Coleman MP et al. Cancer survival in five continents: a worldwide population-based study (CONCORD). Lancet Oncology, 2008; 730–56.
- Coleman MP. Responding to the challenge of cancer in Europe. Ljubljana: Institute of Public Health of the Republic of Slovenia; 2008.
- Curado MP, Edwards B, Shin HR, Storm H, Ferlay J, Heanue M and Boyle P, editors.
- Cancer Incidence in Five Continents, Vol. IX. IARC Scientific Publications No. 160. Lyon: IARC; 2007.
- Denmark: National Cancer Plan 2010. https://webgate.ec.europa.eu/sanco/heidi/images/9/90/Denmark_National_Cancer_Plan_III_Danish.pdf
- European guidelines for quality assurance in breast cancer screening and diagnosis. Fourth edition www.euref.org/index.php?option=com_content&view=article&id=5&Itemid=23

- Ferlay J, Shin HR, Bray F, Forman D, Mathers C and Parkin D M. GLOBOCAN 2008, Cancer Incidence and Mortality Worldwide: IARC CancerBase No. 10 [Internet]. Lyon: International Agency for Research on Cancer;2010. Retrieved from http://globocan.iarc.fr/
- France: le Plan Cancer 2009-2013 www.plan-cancer.gouv.fr/le-plan-cancer/presentation.html
- French Institute of Health Surveillance Watch. www.invs.sante.fr/surveillance/index.htm
- Hospice Africa, Palliative Medicine . Pain and Symptom Control in the cancer and/or Aids patient in Uganda and other African countries. Fourth edition, English and French. Uganda, 2008. . info@hospiceafrica.or.ug
- Institute of Medicine. www.iom.edu/
- International Diabetes Federation. A guide to National Diabetes Programmes. Brussels: IDF; 2010.
- Lalla Salma Association against Cancer and the Moroccan Ministry of Health. Plan Cancer 2010-19: Plan National de Prévention et de Contrôle du Cancer. July 2009. www.contrelecancer.ma/le_pnpcc
- American Society of Clinical Oncology. My Child Matters Program, a UICC-Sanofi-Aventis partnership to improve pediatric cancer care in developing countries. www.asco.org/ASCOv2/Meetings/Abstracts?&vmview=abst_detail_view&confID=47&abstractID=35108
- UICC and Sanofi Espoir Foundation partnership. My Child Matters www.uicc.org/programmes/my-child-matters
- US National Cancer Institute. Designing print materials: a communications guide for breast cancer screening, chapter 3, 49-86. January 2007. http://appliedresearch.cancer.gov/icsn/publications/guide.html
- UK National Institute for Health and Clinical Excellence-NICE. The Guidelines Manual. 2009. www.nice.org.uk/guidelinesmanual
- National Partners for Comprehensive Cancer Control. Comprehensive Cancer Control Jurisdiction Guidebook for United States Associated Pacific Island Nations, 11-15. NPCCC. 2005.
- Netherlands: Cancer Plan 2005-2010. https://webgate.ec.europa.eu/sanco/heidi/images/3/3e/Netherlands_National_Cancer_Control_Programme_English.pdf
- Ngoma, T. (2007). Cancer control planning and implementation: a view from Tanzania. ORCI. www.afrox.org/docs/CSOma.pdf
- Nock, F. (2006/2007). Petit guide de l'évaluation en promotion de la santé. Mutualité Française.
- North American Association of Central Cancer Registries. www.naaccr.org/
- Ontario: Cancer Plan 2011-2015. http://ocp.cancercare.on.ca/
- Oral Cancer Case finding Program (OCCFP), Santana JC, Delgado L, Miranda J, Sanchez M, Oral Oncology, Vol 33, issue 1. Cuba; 1997.
- Overview: National Cancer Control Plan, China, December 2003. p. 1. www.who.int/cancer/modules/China.pdf
- Philippine cancer control programme. http://jjco.oxfordjournals.org/cgi/reprint/32/suppl_1/S52.pdf
- Polasek O et al. Breast, Colon, and Prostate Screening in the Adult Population of Croatia: does rural origin matter? Croatia, 2007. 10 pages. www.rrh.org.au/publishedarticles/article_print_749.pdf
- Programa de Prevención de Cáncer de Cuello Uterino en el Uruguay «Dr E. Pouey». Montevideo, 2007. p. 5-19. Available from www.msp.gub.uy/imgnoticias/13586.pdf
- Public Health Agency of Canada. Progress Report on Cancer Control, Cancer Prevention. 80 pages. 2004. www.phac-aspc.gc.ca/publicat/prccc-relccc/index.html
- Sancho-Garnier H. Choosing priorities in the French Cancer Control Plan. UICC Congress. Washington. http://2006.confex.com/uicc/uicc/techprogram/P10179.HTM
- Tanneberger S, Cavalli F, Pannuti F Magrath I. Bridging the Childhood Cancer Mortality Gap between Economically Developed and Low-income Countries. Cancer in Developing Countries. The Great Challenge for Oncology in the 21st Century, Zuckschwerdt, editor. p. 42-60.
- The Breast Health Global Initiative, Turkey pilot project. http://portal.bhgi.org/GlobalPortfolio/easterneurope/default.aspx
- The NHS Cancer plan: a plan for investment, a plan for reform. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009609
- The Scottish Government. Cancer in Scotland: Action for Change. National Implementation/Investment Plan 2002-2003. www.scotland.gov.uk/Publications/2002/05/14818/4882
- Turkey: National Cancer Program 2009-2015. www.ukdk.org/pdf/NATIONAL%20CANCER%20PROGRAM2.pdf
- UK cancer plan. Improving outcomes: a strategy for cancer 2011 https://webgate.ec.europa.eu/sanco/heidi/images/4/40/UK_Improving_Outcomes_A_Strategy_for_Cancer_2011_English.pdf
- UK Cancer Reform Strategy, 2007 www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081006
- Union for International Cancer Control. Cancer Awareness, Prevention and Control: Strategies for South East Asia. Geneva: Union for International Cancer Control; 2004. www.uicc.org/resources/cancer-awareness-prevention-and-control-uicc-handbook-south-asia-0
- Union for International Cancer Control. Evidence-Based Cancer Prevention: Strategies for NGOs: A UICC Handbook for Europe. Geneva: Union for International Cancer Control; 2004. p. 15-33. www.uicc.org/resources/evidence-based-cancer-prevention-strategies-NGOs-uicc-handbook-europe

- Union for International Cancer Control. Evidence-based cancer prevention: strategies for NGOs: A UICC Handbook for Latin America. Geneva: Union for International Cancer Control; 2004. . www.uicc.org/resources/prevenci%C3%B3n-del-c%C3%A1ncer-estrategias-basadas-en-la-evidencia-america-latina
- Union for International Cancer Control HPV and Cervical Cancer Curriculum. www.uicc.org/programmes/hpv-and-cervical-cancer-curriculum
- University of Kansas. The Community Tool Box. Work Group for Community Health and Development. 2007 http://ctb.ku.edu/en/dothework/
- Uruguay : Programa Nacional de Control del Cáncer www.bvsoncologia.org.uy/pdfs/destacados/PRONACCAN_2005-2010.pdf
- US National Cancer Institute. Matrix of Evidence Reviews across the Cancer Control Continuum. Available from http://cancercontrol.cancer.gov/IS/info_er.html
- US National Cancer Institute. Designing print materials: a communications guide for breast cancer screening. Chapter 3, p. 49-86. January 2007. http://appliedresearch.cancer.gov/icsn/publications/guide.html
- Varkevisser CM et al. Designing and Conducting Health Systems Research Projects: Volume 1. Ottawa: International Development Research Centre; 2003.
- World Health Organization. The world health report 2000 - health systems : improving performance. Geneva: World Health Organization; 2000.
- World Health Organization. Noncommunicable Diseases and Mental Health Surveillance: The WHO STEPwise Approach to Surveillance (STEPS) of NCD Risk Factors. Geneva: World Health Organization; 2001.
- World Health Organization. National Cancer Control Programmes: Policies and Managerial Guidelines. 2nd edition, 119-123. Geneva: World Health Organization; 2002. www.who.int/cancer/media/en/408.pdf
- World Health Organization. Preparing a Health Care Workforce for the 21st Century: The Challenge of Chronic Conditions. Geneva: World Health Organization; 2005. www.who.int/chp/knowledge/publications/workforce_report.pdf
- World Health Organization. What is a health system? Geneva: World Health Organization; 2005.www.who.int/features/qa/28/en/index.html
- World Health Organization. World Health Assembly Resolution on Cancer Prevention and Control. Geneva: World Health Organization; 2005. www.who.int/mediacentre/news/releases/2005/pr_wha05/en/index.html
- World Health Organization. Planning. (Cancer control: knowledge into action: WHO guide for effective programmes; module 1.). Geneva: World Health Organization; 2006. www.who.int/cancer/modules/Planning Module.pdf
- World Health Organization. Everybody's business : strengthening health systems to improve health outcomes : WHO's framework. Geneva: World Health Organization; 2007. www.who.int/healthsystems/strategy/everybodys_business.pdf
- World Health Organization. Key components of a well functioning health system. Geneva: World Health Organization; 2010. www.who.int/healthsystems/publications/hss_key/en/index.html
- World Health Organization. STEPwise approach to chronic disease risk factor surveillance (STEPS). Geneva: World Health Organization; 2010. www.who.int/chp/steps/riskfactor/en/index.html
- World Health Organization. WHO National Cancer Control Programmes. Example: India. Geneva: World Health Organization. www.whoindia.org/EN/Section20/Section385/Section401.htm
- World Health Organization. Cancer fact sheets. www.WHO.int/mediacentre/factsheets/fs297/en/
- World Health Organization. The world health report 2000 : health systems : improving performance. Geneva: World Health Organization; 2000. www.who.int/whr/2000/en/whr00_en.pdf
- World Health Organization, International Atomic Energy Agency. National Cancer Control Programmes core capacity self-assessment tool (NCCP core self-assessment tool). ISBN: 978 92 4 150238 2 Geneva: World Health Organization; 2011. www.who.int/cancer/publications/nccp_tool2011/en/index.html

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ABOUT UICC

Founded in 1933 and based in Geneva, UICC's growing membership of over 700 organisations across 155 countries, features the world's major cancer societies, ministries of health, research institutes and patient groups. Together with its members, key partners, the World Health Organization, World Economic Forum and others, UICC is tackling the growing cancer crisis on a global scale.

UICC is committed to delivering the targets of the World Cancer Declaration through strategic partnerships involving members and other institutions interested in fighting cancer. Together we aim to save millions of lives by focusing on what needs to be done by taking the lead in:

- Raising awareness and education,
- Global network of influence,
- Taking action where it matters.

THE CURRENT GLOBAL PROGRAMMES INCLUDE:

GAPRI (Global Access to Pain Relief Initiative) seeks to make essential pain medicines universally available. Providing direct support to more government ministries around the world, GAPRI aims to simplify the complicated international regulations around the distribution and use of morphine.

CCI (Cervical Cancer Initiative) advocates for cervical cancer to become a priority at the highest level, increase access to prevention, screening and treatment services and develop crucial information on the cost of scaling up cervical cancer control activities in order to reduce the number of women developing invasive cervical cancer and dying from the disease.

ChiCa (Childhood Cancer) - raise awareness at the global level to the disparity in survival rates among low- and middle-income countries (LMICs) and developed countries, advocating for organisations focused on child health to integrate early detection of childhood cancers into existing programming and supporting country-level projects to develop effective responses to the problem.

GETI (Global Education and Training Initiative) facilitates the professional development of oncology healthcare workers and global leaders in cancer control. Through targeted fellowships, workshops and training the programme helps develop future leaders in cancer control and influence healthcare policy and practice across each of our priority programmes.

GICR (Global Initiative for Cancer Registry Development in Low- and Middle-Income Countries) aims to increase the number and quality of population-based cancer registries in low-and middle-income countries. UICC has a particular advocacy role in this initiative convened by the International Agency for Research on Cancer (IARC).

UICC is also responsible for coordinating World Cancer Day, International Cancer Fellowships, the World Cancer Leaders' Summit and the World Cancer Congress.

For more information
www.uicc.org or info@uicc.org

ABOUT ECL

The Association of European Cancer Leagues (ECL) is an alliance of national and regional cancer leagues. ECL is a non-profit organisation, with its secretariat located in Brussels. Created in 1980, it is represented by member leagues located all over extended Europe stretching from Iceland to Turkey.

ECL's vision is to be a visible and effective player in cancer control and cancer care, in particular in Europe. ECL facilitates the collaboration between cancer leagues throughout Europe and influences EU and pan-European policies. The central purpose of ECL is to identify and promote common strategies in cancer control toward achieving health equity in cancer prevention, treatment and services.

ECL'S MAIN AREAS OF ACTIVITIES ARE IN LINE WITH CURRENT CANCER ISSUES IN EUROPE AND WITH THE PRIORITIES AND INTERESTS OF MEMBER LEAGUES:

- **Leading on Cancer Prevention and Health Promotion** within the European Commission's European Partnership for Action Against Cancer, launched in 2009
- **Participating as a founding member** in the European Commission's Health and Alcohol Forum
- **Providing input to other cancer control efforts** by collaborating with other European and global umbrella organisations
- **Working directly with Members of the European Parliament** (MEPs) on forwarding cancer issues at the political level, especially as it relates to ECL's role as the Secretariat for the MAC (MEPs Against Cancer) group
- **Liaising with its member leagues** and coordinating specific activities related to national cancer control plans, HPV vaccination and cervical cancer issues, and tobacco control
- **Organising meetings, workshops and forums** for information exchange on topics such as patient support, UV radiation and cancer, tobacco control, fundraising.

ECL member leagues support patients and patient organisations through various activities depending on national priorities. Key areas of work include: prevention awareness and promotion of health lifestyles, research and patient support. Many ECL leagues both support and work closely with patients and patient's groups, not only to provide care, psychosocial support, rehabilitation and fundraising but also as partners in decision making processes that inform the priorities of the Leagues themselves. Patients' groups and the cancer leagues in some countries also form alliances to lobby national governments for better care and conditions for patients. The resultant needs and priorities of ECL members inform and guide the activities of the ECL Secretariat in its efforts with the European institutions to support cancer patients all over Europe.

For more information
www.europeancancerleagues.org or info@europeancancerleagues.org

Cancer control is a public health approach aimed at reducing the burden of cancer in a population. Planning integrated, evidence-based and cost-effective interventions across the cancer continuum (research, training, prevention, early detection, treatment, supportive and palliative care) is the most effective way to tackle the cancer problem and reduce the suffering of patients and their families.

Most countries have yet to begin a systematic national cancer control planning effort. Where governments concentrate on other immediate health priorities, Civil Society organisations (CSOs) can play a critically important role in increasing public and leadership awareness of the cancer problem and in developing effective partnerships to take on the responsibility of cancer control planning.

Supporting national cancer control planning: a toolkit for CSOs shows how to prioritise cancer control planning actions and implement them for maximum impact when working towards a national cancer control programme. It is designed around five key questions:

- What is the country's cancer picture?
- Who can help develop and implement a cancer control plan?
- What will be included in the plan?
- How will the plan be implemented and communicated?
- What is a successful plan?

National cancer control planning is examined within the context of health systems and control of Non-communicable Diseases with which cancer shares a number of risk factors.

SUPPORTED BY

UICC global cancer control

ECL Association of European Cancer Leagues

World Health Organization

Israel Cancer Association

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