



THE NATIONAL CANCER CONTROL STRATEGY 2024–2029

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i. Forward

The Ministry of Health has spearheaded the development of this first national cancer control strategic plan building up from lessons from partners and surveys conducted over the years, with a vision of a nation reducing and preventable burden of cancer. The mission of this strategic plan is to implement a coordinated and responsive cancer control framework that leads to reduced morbidity and mortality and improves the experiences and quality of life of patients living with cancer by the year 2030.

The ultimate goal is to move towards Universal Health Coverage (UHC) in reducing cancer incidence, mortality and improve cancer down-staging and survival rates in the Gambia through access to population based primary prevention, early detection, quality diagnostics, treatment and follow-up services by the year 2030.

It is structured along the cancer control continuum and identifies advocacy, partnerships, coordination, and financing, and strategic information, registration, research and surveillance as key pillars in cancer control. Since primary prevention of cancer cuts across several sectors outside the primary domain of the Ministry of Health, this strategic plan also adopts a multi-sectoral approach in reduction of the burden of cancer risk factors, including tobacco and alcohol use, occupational exposures, air pollution, unhealthy diets and physical inactivity.

The main focus of this strategic plan is:

1. To reduce the number of new cancer cases attributable to modifiable risk factors, morbidity and mortality by 2030 by 2%.
2. To strengthen and increase the number of facilities providing screening, early detection, and linkages to care to 20%.
3. To expand the number of facilities offering basic cancer diagnosis, treatment, and palliative care to 30%.
4. To strengthen cancer surveillance, research and strategic information systems.
5. To improve the institutional and technical capacity for cancer prevention and control.
6. To establish a high-level mechanism for multi-sectoral coordination and partnership for prevention, treatment, care and rehabilitation of cancer.
7. To establish a level of advocacy, resource mobilization, communication and social mobilization mechanism for civil societies, communities and development partners

The Ministry through the National Cancer Control Program will work with all stakeholders to guide the implementation of the strategic plan, and track it using a comprehensive monitoring, evaluation, accountability and learning framework, with process, output and outcome indicators for each key result area. This supporting policy document aims at creating a comprehensive M&E framework for the country. The strategic plan has a detailed governance and implementation framework, that outlines the roles of various actors in cancer prevention and control and coordination of technical teams through the Non-Communicable Diseases (NCD) Intersectoral Coordinating Committee.

This strategic plan will be the blueprint document that will provide guidance for cancer prevention and control interventions and priority investments at national and county levels for the next five years. It envisions that prevention, control and management of cancers will be made more

accessible and affordable to the population through collaboration and integration within the health systems to establish a robust platform for effective control of the disease.

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MINISTER OF HEALTH

ii. Acknowledgements

The Ministry of Health wishes to thank all those who contributed to the successful completion of this document. We hope that all partners, stakeholders and health care workers will adopt and continue to support us in implementing cancer prevention and control interventions as outlined in this strategy.

Special appreciation and thanks to the leadership of the Ministry of Health for their stewardship and support especially the Director of Health Services, Division of Non-Communicable Diseases, the Program Manager National Cancer Control Program and WHO and all stakeholders both from the private and public sectors, whose strategic guidance and contributions led to the successful development of this Strategic plan.

Appreciation goes to the team that worked tirelessly to draw and review this document comprising mainly staff drawn from the Ministry of Health, The World Health Organisation - Gambia Country Office, University of The Gambia, private and cancer related CSOs.

The writing of this document was coordinated by the Ministry of Health. Special thanks to the staff of NCCP, all the Officers and WHO representative Mr. Momodou Gassama for his endless and tireless support and contribution.

Lastly, in a special way, we wish to recognize the effort of global bodies, the International Atomic Energy Agency (IAEA), International Agency for Research in Cancer (IARC) and the World Health Organization, for their technical support in conducting an imPACT Review and drafting of the strategic plan. We appreciate financial support from the WHO.

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iii. Executive Summary

Cancer is now recognised globally as one of the leading noncommunicable diseases. Second to cardiovascular diseases, cancers contribute to over 7.9 million deaths (13% of total global mortality) each year and this figure is projected to rise to nearly 10 million unless the problem is addressed urgently.

The National Cancer Control Strategy is a response by the Ministries of Health and stakeholders to the obvious need to prioritise cancer prevention and control in The Gambia. It recognises that the disease cannot be eradicated, but that its effects can be significantly reduced if effective measures are put in place to control risk factors, detect cases early and offer good care to those with the disease. The aims of this strategy are to reduce the number of people who develop and die of cancer. It also aims to ensure a better quality of life for those living with the disease. The strategic plan covers the years 2025 to 2030 and explains the scientific basis for cancer control and prevention; outlines a vision and mission; suggests objectives as well as interventions to prevent and control cancer in The Gambia. The strategy draws from experiences gained in various countries that have similar programmes, and also includes technical advice provided by relevant bodies.

The objectives of this strategy are to cover the entire continuum of cancer prevention and control. It aims to promote cancer prevention and early detection and improve diagnosis and treatment including palliative care. The strategy also aims to promote cancer surveillance, registration and research. To achieve this, the strategy aims to build and promote partnership and collaboration in cancer control. It also aims to integrate cancer prevention and control activities with national health and socio-economic plans and promote community involvement and participation in the same.

This strategy document envisions an effective and efficient National Cancer Prevention and Control Programme in order to achieve the goal of reducing cancer morbidity and mortality in The Gambia. Its mission is to improve community wellbeing by reducing the incidence and impact of cancer through the provision of efficient and evidence-based preventive, promotive, curative and palliative care services accessible to all Gambians.

The National Cancer Control Strategy envisions a scenario where all activities will be carried out equitably, and owned by all implementing agencies and communities. Leadership and fairness as well as adequate coordination among all partners will be expected in running all programmes. All activities undertaken to meet the objectives of this strategy will be evidence based, sustainable and carried out through a systematic and integrated approach. There will be utmost respect for people of both gender as well as respect for religious and cultural diversity. All stakeholders are therefore called upon to embrace this strategy and join hands in confronting cancer in The Gambia.

iv. Acronyms and Abbreviations

CSO	Civil Society Organizations
DHPE	Directorate of Health Promotion and Education
DHRH	Directorate of Human Resources for Health
DPI	Directorate of Planning and Information
EDC	Epidemiology and Disease Control
EFSTH	Edward Francis Small Teaching Hospital
EHP	Essential Health Package EHP
EMR	Electronic Medical Records
EPI	Expanded Program of Immunization
FBO	Faith-Based Organizations
FSQAA	Food Safety and Quality Assurance Authority
GBoS	Gambia Bureau of Statistic
GHIS	Gambia Hepatitis Intervention Study
HCC	Hepatocellular Carcinoma
HMIS	Health Management Information System
HPV	Human Papilloma Virus
IARC	Internal Agency for Research on Cancer
ICO	Institut Catala d'Oncologia
LEEP	Loop Electrosurgical Excision Procedure
MEAL	Monitoring, Evaluation, Accountability and Learning
MoBSE	Ministry of Basic and Secondary Education
MOCDE	Ministry of Communication and Digital Economy
MOFEA	Ministry of Finance and Economic Affairs
MoH	Ministry of Health
MOHERST	Ministry of Higher Education, Research, Science and Technology
MRCG@LSHTM	Medical Research Council Unit The Gambia at the London School of Hygiene & Tropical Medicine
MTWG	Multi-sectorial Technical Working Group
NACP	National Aids Control Program
NBTS	National Blood Transfusion Services
NCCP	National Cancer Control Program
NCCSP	National Cancer Control Strategic Plan
NCCSP	National Cancer Control Strategic Plan
NCD	Non-Communicable Disease
NCR	National Cancer Registry
NEA	National Environment Agency
NHCP	National Hepatitis Control Programme
NHIS	National Health Insurance Scheme
NHP	National Health Policy
PESTELE	Political, Economic, Social, Technological, Environmental, Legal and Ethics
PSA	Prostate Specific Antigen
SWOT	Strengths, Weaknesses, Opportunities and Threats
UHC	Universal Health Coverage
UNDAF	United Nation Development Assistance Framework
VHS	Village Health Services
VIA	Visual Inspection with Acetic Acid
WHO	World Health Organisation

SECTION A: THE NEED FOR A STRATEGY

CHAPTER 1: Introduction

Cancer is a disease that results from failure of the mechanisms that regulate normal cell growth and cell death leading to uncontrollable proliferation of cells, destruction of neighbouring tissues and spread of the disease to other parts of the body. Cancer refers to over 100 different diseases characterized by uncontrolled growth and spread of abnormal cells. Cancer arises from one single cell following abnormal changes in the cell's genetic material. These genetic changes affect the mechanisms that regulate normal cell growth and cell death leading to uncontrolled cell growth.

The abnormal changes are caused by interactions between genetic and environmental factors. Environmental factors include physical carcinogens (e.g. ionizing radiation), chemical carcinogens (e.g. asbestos, components of tobacco smoke and aflatoxins) and biological carcinogens (e.g. certain viruses, bacteria and parasites). Cancerous cells tend to proliferate uncontrollably, invading neighbouring tissues and eventually, spreading to other parts of the body. It can affect almost any part of the body. There are several types of cancer. Carcinoma is the cancer that begins in the skin or tissues that line or cover organs. Sarcoma is a cancer that begins in bone, cartilage, fat, muscle blood vessels or other connective tissue. Leukaemia is cancer that starts in blood-forming tissues such as bone marrow. Lymphoma and multiple myeloma are cancers that begin in cells of the immune system.

Owing to its nature, cancer is difficult to treat, and cannot be eradicated. However, it is possible to significantly reduce the effects of cancer on the society if effective measures are put in place to control risk factors associated with cancer, early detection and offer good care to those affected. The risk factors for cancer are profoundly associated with socio-economic status; they are higher in low social economic status while cancer survival is lower in the poor than in those in higher social settings.

The risk factors for cancer can be broadly categorized into four types namely: behavioural risk factors, biological risk factors, environmental risk factors and genetic risk factors. Behavioural risk factors include: tobacco use, harmful use of alcohol, unhealthy diet and physical inactivity. Biological factors include overweight, obesity, age, sex of the individual and their genetic/hereditary make up. Environmental risks include exposure to environmental carcinogens such as chemicals, radiation and infectious agents.

1.1 Overview

This chapter describes the global and local burden of cancer, as well as the anticipated and projected changes in the future. It provides context to the cancer control continuum, outlining the opportunities for interventions at policy level to reduce the disease burden, mortality and socio-economic impact to households and communities. In addition, a case is made for justification of cancer control planning in addressing the challenges.

The World Health Organization (WHO) defines a National Cancer Control Program (NCCP) as a "public health program designed to reduce the incidence and mortality of cancer and improve the quality of life of cancer patients through the systematic and equitable implementation of evidence-based strategies for prevention, early detection, treatment, and palliation, making the best use

of available resources". It works with health service providers to prevent, diagnose, and treat cancer and increase survival and quality of life for those who develop cancer by converting the knowledge gained through research, surveillance and outcome evaluation into actionable strategies and actions.

1.2 The Global Burden of Cancer

Cancer is a leading cause of death worldwide. Low-and-middle-income countries shoulder most of the cancer burden. In 2020, cancer accounted for nearly 10 million deaths, or nearly one in six deaths, with 70% occurring in low-and-middle-income countries (IARC, 2020; WHO, 2022). The most common cancers are breast, lung, colon and rectum and prostate cancers. While the most common cause of cancer death are lung, colon and rectum, liver, stomach, and breast. Each year, approximately 400 000 children develop cancer (Ferlay et al., 2022)

Around one-third of deaths from cancer are due to tobacco use, high body mass index, alcohol consumption, low fruit and vegetable intake, and lack of physical activity. Cancer-causing infections, such as human papillomavirus (HPV) and hepatitis, are responsible for approximately 30% of cancer cases in low- and lower-middle-income countries. Many cancers can be cured if detected early and treated effectively (WHO, 2022).

In Africa, approximately 1.1 million new cancer cases occur each year, with about 700,000 deaths. The most common cancers in adults include breast (16.5%), cervical (13.1%), prostate (9.4%), colorectal (6%), and liver (4.6%) cancers, contributing to nearly half of the new cancer cases. By 2040, the cancer burden is projected to rise from 1.1 million cases and 711,429 deaths in 2020 to 2.1 million cases and 1.4 million deaths (Sharma et al., 2022; WHO, 2023). Childhood cancer incidence in sub-Saharan Africa is estimated at 56.3 per million population. Current projections show that Africa will account for nearly 50% of the global childhood cancer burden by 2050. Data estimates show a considerable increase in cancer mortality to nearly one million deaths per year by 2030, without urgent and bold interventions (WHO, 2023).

1.3 The Cancer Burden in The Gambia

The Gambia like all other countries is grappling with a high burden of non-communicable diseases (NCD)s, mainly cardiovascular diseases, cancers, chronic lung diseases and diabetes. WHO NCD data on the Gambia suggest that NCDs accounted for about 34% of all deaths in 2016 (WHO, 2018). Cancers were responsible for 4% of these deaths.

The 2019 Health Management Information System (HMIS) report revealed that cervical cancer accounted for more outpatient department (OPD) consultations while liver cancer accounted for more hospital admissions among cancers such as breast cancer, etc. Cervical cancer is the most common cancer among females and the leading cause of death from cancer for women in The Gambia.

In 2020, according to IARC estimates on cancer incidence and mortality in The Gambia, there were approximately 1035 new cancer diagnoses (575 cases among females and 460 cases in men). Among men, it was estimated that liver, lung, prostate, non-Hodgkin lymphoma and

stomach are most common, whereas cervical, breast, liver, colorectal, and stomach, are found in high numbers in women. In terms of mortality, it was estimated that 810 died from cancer in The Gambia in 2020, with 395 among males and 415 among females. The age-standardized rate for cancer incidence per 10, 000 people among men was 74.9, and 83.7 in female (IARC, 2021).

Table 1: Summary statistics on cancer in The Gambia (IARC 2021)

	Male	Female	Both Sexes
Population	1 198 540	1218124	2 416 664
Number of new cancer cases	460	575	1035
Age-standardized incidence rate (World)	74.9	83.7	79.5
Risk of getting cancer before the age of 75 years (%)	7.2	7.9	7.5
Number of cancer deaths	395	415	810
Age-standardized mortality rate (World)	65.8	65.7	65.7
Risk of dying from cancer before the age of 75 years (%)	6.3	6.5	6.4
5-year prevalent cases, adult population	692	919	1611
Top 5 most frequent cancers (ranked by number of new cases)	Liver	Cervix uteri	Cervix
	Lung	Breast	Liver
	Prostate	Liver	Breast
	Non-Hodgkin Lymphoma	Colorectal	Lung
	Stomach	stomach	Prostate

Because the National Cancer Registry (NCR) has not been active since December 2019, no comparison could be made between the above estimates and the actual figures from the registry for the year 2020 to determine the gap and work that may need to be done in early detection and diagnosis of cancer in the country to ensure each confirmed case is counted and linked to care and treatment.

The NCR was established in July 1986 in the framework of The Gambia Hepatitis Intervention Study (GHIS). The GHIS was a collaborative project between the Government of The Gambia, the International Agency for Research on Cancer (IARC), and the Medical Research Council (MRC) of the United Kingdom. The NCR became inactive in December 2019 when the GHIS program ended. This has led to dormancy at the registry, which is housed at the MRC in Fajara. As a result, the actual prevalence of cancers in The Gambia has not been known since then.

Cervical cancer is the most common cancer among females and the leading cause of death from cancer for women in The Gambia ((ICO/IARC, 2023). The burden of cervical cancer in developing countries is huge with an incidence rate that exceeds the average worldwide rates of 15.3 per

100,000 women per year. In The Gambia, it has an age incidence rate of 32.5 per 100,000 women per year (Abiodun et al., 2014).

The Gambia has a population of 660,455 women ages 15 years and older, who are at risk of developing cervical cancer (GBoS, 2022). Current estimates indicate that every year 286 women are diagnosed with cervical cancer and 199 die from the disease (ICO/IARC, 2023).

A large majority of cervical cancer is due to the human papillomavirus (HPV), its oncogenic subtypes which results in carcinogenesis. HPV types 16 and 18 are responsible for nearly 50% of high-grade cervical pre-cancers (Tewari and Monk, 2014; WHO, 2022)

In 2014, The Gambia piloted HPV vaccination among girls aged between 9 and 13 years. By 2019, the programme had achieved 83% coverage with an annual target of 34,000 girls in addition to those receiving the second dose. The advent of COVID-19 has impacted negatively on the coverage of HPV vaccination due to initial movement restrictions and school closures. Currently, the myths and misconceptions around the COVID 19 vaccine have significantly increased the HPV vaccine rejection rate (MoH., 2022).

Health System Organization

The Gambian health system is based on a strong Primary Health Care concept dating back to 1980 and operates a three-tier system consisting of primary, secondary, and tertiary levels. The primary level is village health services (VHS), which consists of village health posts, village clinics and reproductive health outreach clinics. The secondary level consists of minor and major health centres and district hospitals, while the tertiary level is comprised mainly of hospitals (general, specialized, and teaching hospitals). There are four district hospitals and four public general hospital with one teaching hospital. The public health system is complimented by a network of private health facilities across the country consisting of non-governmental organizations (NGOs), private for profit and faith-based health facilities.

Cancer Control Actions in The Gambia

Upholding the country's commitment to Universal Health Coverage (UHC) and as part of a broad range of health-related activities at health facilities in line with the National Health Policy, cancer control activities are currently being developed in The Gambia since from the establishment of the NCCP in September 2022. Prevention activities are focusing on raising awareness of the general population about cancer and other NCD risk factors; on encouraging immunizations, including the importance of immunizing 12-year-old girls against HPV and immunizing infants against hepatitis B; and on engaging the general population at primary health care level.

Early detection interventions especially on cervical screening are mainly conducted at health centres, district and general hospitals, and the teaching hospital. However, the capacity for these interventions is constrained by lack of trained personnel and equipment. A number of population screening interventions for cervical and breast cancers are conducted health by related association and civil society organisation for cancer.

The diagnosis of cancer is conducted at the level of tertiary and teaching hospital where pathology laboratory and a limited medical imaging equipment are available. In the country, treatment of

cancer is currently available in a limited and in a non-coordinated way in a few tertiary level facilities and the teaching hospital in form of surgery and chemotherapy. Radiation therapy is not available in the country. Palliative care, an important component of cancer care, is in the true sense of word, not available in the country too.

Capacity for Cancer Diagnosis and Treatment

Diagnostic Imaging Services

In terms of diagnostic imaging facilities, conventional x-ray machine, ultrasound scanner, mammography machine, computed tomography, magnetic resonance imaging, laparoscopic video and endoscopy unit are available in a number of facilities. Conventional x-ray machine is available in one out of the 4 districts hospitals in the country, four out of 5 general hospitals, at the teaching hospital and a number of private facilities. However, not all the machines at the above public facilities are not functional. Ultrasound scanner is available at a number of secondary and tertiary public health facilities, some of which are not functional, and at a number of private facilities. CT scan is available at one general hospital, teaching hospital and one private facility. MRI is available at the teaching hospital only. Laparoscopic video and endoscopic units are available only at the teaching hospital as public facility and two private facilities. The five mammography machines are available at the teaching hospital and two private facilities. However, the three machines at the teaching hospital are not functional.

In terms of human capacity for diagnostic imaging services, there are four radiologists in the country: three at the teaching hospital and one at one of the general hospitals. There are 36 radiographers cum technicians available at seven health facilities, with majority at the teaching hospital.

Laboratory Services

Histopathology service for confirmation of cancer diagnosis is available only at the teaching hospital. And so is cytology (pap) service. Biochemistry service is available at all the four-general hospitals, one district hospital, the teaching hospital and two private facilities. Bio bank service is only available at MRCG@LSHTM Fajara, private facility. At EFSTH, the teaching hospital, Radioimmuno assay machine has been installed but not yet functional. And so was the frozen section machine. There are no biomarkers in the country.

In terms of human capacity for laboratory service for cancer, histopathologists, three; one medical microbiologist and two haematologists are only found at the teaching hospital while medical laboratory scientists were available at 12 health facilities. There was no chemical pathologist.

Cancer Screening

Cervical Cancer Screening: a number of facilities from secondary level offer VIA cervical screening service. However, only three facilities—one general hospital, the teaching hospital and one private facility— offer treatment services when VIA turns out to be positive. Five facilities

have cryotherapy facility, but they are not operational. Pap smear, HPV screening and colposcopy were available only at the teaching hospital. Breast Cancer Screening— mammography machine is available at the teaching hospital and two private facilities. However, the three machines at the teaching hospital are not functional. For prostate cancer screening, PSA is available at the teaching hospital and one private facility. Stool occult blood screening for colon cancer is available at the teaching hospital only. Colonoscopy is available at three facilities: the teaching hospital and two private facilities.

Cancer Treatment

Surgery is the main treatment modality for majority of the solid cancers. It can be as a stand-alone treatment or in combination with other nonsurgical methods like chemotherapy or chemoradiation therapy. Surgical treatment can also be instituted for precancerous lesion of cervix, vagina, vulva and endometrium.

Surgery for cancers and precancerous lesions is available at three facilities: the teaching hospital, one general hospital and one private hospital. Management of precancerous lesions in the form of excision or ablation therapy (thermal, cryotherapy, laser) is available at the teaching hospital and two general hospitals and one private clinic. Cold knife conization and Loop Electrosurgical Excision Procedure (LEEP) as part of treatment for precancerous lesion are available at the teaching hospital. Five public facilities have surgical management of preinvasive cancer but were not in operation because of interruption of carbon dioxide supply in the past seven years.

Chemotherapy is available only at the teaching hospital and one private hospital. However, radiotherapy, nuclear medicine therapy and patient support groups are not available in the country yet.

There were no tumor boards or multidisciplinary teams for specific cancer sites in any health facility. Only two facilities have existence of protocols for the treatment of common cancers. However, there is no policy for monitoring cancer patients, and no comprehensive quality assurance (QA) audits are being performed periodically in any facility.

In terms of different oncological areas, there is no surgical oncology unit in any facility, but surgical oncology services are offered in three facilities. Medical oncology service is available only at the teaching hospital and one private hospital—chemotherapy and hormonal therapy being available at these facilities only. Pediatric oncology is available at the above stated facilities.

In terms of specialty cancer care, only one oncologist, pediatric oncologist is available at the teaching hospital in the whole country. Radio-oncologists, oncopharmacists, and oncology nurses are not available in the country.

Chemotherapy/Cancer drugs

In terms of chemotherapy or cancer drugs, the country has no list of essential medicines for oncology. Essential cancer drugs are not regularly available.

1.4 Justification for a National Cancer Control Strategic Plan

The National Cancer Control Strategic Plan (NCCSP) aims to build on the existing health system in order to strengthen cancer prevention and control capacities in the country through the control of risk factors associated with cancer, investment in cancer control workforce, use of equipment, and cancer research. This is the first cancer control strategy document to be developed in The Gambia. It is to consolidate aspects in cancer prevention, screening, diagnosis, treatments, and care for cancer patients as well as the investment required to deliver these services.

This strategy seeks to streamline and coordinate cancer care, sharing of resources, and information among health facilities. It will ensure patients, and their families have better support and access to quality treatment including palliative care. Lastly, the strategy will enable the country to improve services through education and research in the field of cancer prevention and control ensuring a culture of evidence-based practice.

The development of the cancer control strategy is necessitated by:

- Lack of comprehensive policy and guidelines for cancer prevention and control
- Uncoordinated activities at different health facilities vis-à-vis cancer care
- Unreliable and inadequate data on cancer
- Limited knowledge among health care staff and population about cancer
- Insufficient research agenda to guide response to cancer in the country
- The high impact of cancer mortality

CHAPTER 2: Situation Analysis

2.1 Overview

A SWOT analysis consisting of strengths, weaknesses, opportunities, and threats in the cancer continuum of care was done based on situational analysis conducted by the NCCP. This analysis was done to establish a more comprehensive and improved strategic plan for cancer control in The Gambia. The table below summarizes the SWOT analysis.

This chapter outlines the situational analysis of cancer in The Gambia, the findings of the final evaluation of the strategy, focusing on the key result areas. The key achievements as well as challenges that will affect the implementation of the strategy are highlighted, and any emerging contextual realities from the implementation period stated. A thorough environmental scan, using both a Strengths, Weaknesses, Opportunities and Threats (SWOT) and Political, Economic, Social, Technological, Environmental, Legal and Ethics (PESTELE) analyses are included. Finally, strategic realities are highlighted, fitting global cancer control into the future of health.

2.2 Strengths, Weaknesses, Opportunities and Threats (SWOT) Analysis

Table 2: SWOT analysis of Cancer situation in The Gambia

STRENGTH	WEAKNESS
<ul style="list-style-type: none"> • Existing decentralized health system • Existing national cancer control program • Existing guidelines for breast and cervical cancers • Existing health policies • Existing strategic plan for NCDS • Political commitment • Availability of pathologists • Availability of HPV vaccine and its integration into the EPI system 	<ul style="list-style-type: none"> • High turnover of health care workers • Inadequate funding for cancer control • Inadequate public private partnership • Inadequate specialists in oncology • Inadequate data collection and management • Inadequate research and surveillance on cancer • Low public awareness on cancer • Inadequate treatment services for cancer • Inadequate screening and diagnostic facilities for cancer • Not readily available chemotherapy drugs • Limited monitoring and evaluation system with poor ownership • Non-availability of paediatric screening and diagnoses • Lack of cancer survivor support system • Inadequate patient follow-up • Lack of structural referral system for cancer • Lack of structural palliative care system

	<ul style="list-style-type: none"> • Poor control on risk factors for cancer e.g. tobacco, alcohol • Dormant national cancer registry • Lack of local oncologist to train and mentor health care workers
OPPORTUNITY	THREATS
<ul style="list-style-type: none"> • Campaigns to raise awareness and community engagement and social mobilization activities • Existence of food based dietary guideline • Existence of civil society groups engaged in cancer screening and advocacy • Existence of directorate of health promotion and education (DPHE) • Existence of dormant national cancer registry • Presence of decentralized health care system • Availability of international donors to fund and support cancer initiatives • Private companies and philanthropists can support cancer care services • Existence of well-established decentralized HIV and TB management • Existing cancer sensitive regulations • Existence of directorate of health research at the MoH • Social media to serve as platform to distribute health education materials / health campaigns. 	<ul style="list-style-type: none"> • Delay in health seeking behaviour • High out of pocket expenditure for patients • Inadequate resources for cancer control especially financing • Weak regulatory frameworks • Weak multi-sectoral mechanism for cancer control • Cancer services not decentralized • Interference of the tobacco industry • Advertisement of tobacco by use of social media • No palliative care structures • Few specializations in oncology • Inadequate infrastructure • Referral infrastructure challenges • Human resource deficient on skilled personnel • Deficiency of medical supplies and drugs

2.3 Political, Economic, Social, Technological, Environmental, Legal and Ethics (PESTELE) Analysis

Table 3: PESTLE analysis of Cancer situation in The Gambia

Category	Factor	Description
Political (driven by government actions and policies)	Primary health care and Universal Health Coverage	PHC providers play an essential role in cancer control through provision of information on prevention, screening, early diagnosis, and referral in an accessible, timely, appropriate manner, as well as providing ongoing care and connection between the community and secondary/tertiary levels of the healthcare system
Economic	Economic transition	The country has to prepare for transition of donor-supported health programs to domestic financing. Strong advocacy is needed for adequate financing of cancer control interventions through mixed financing models for sustainability
Social (shifts or evolutions in society)	Demographic and epidemiologic transition, urbanization (including "urbanization of rural areas)	The epidemiologic and demographic transition implies an increasing cancer burden, which requires robust planning for control. Urbanization favours development of cancers like breast, lung but at the same time lowers risks of infection related cancers like cervix, liver among others.
Technological	Digitization of patient health records, adoption and reintegrated the Cancer Register	The electronic Cancer Registry which is dormant will be revisited and integrated to provide an opportunity for providing accurate cancer prevention and screening services data at all levels. The electronic medical records system will offer an opportunity in improving cancer data and linking it to both policy and practice.
Environmental	Environmental cancer risk factors and their mitigation	Environmental factors that are major cancer risk factors and require clear interventions for control include second-hand cigarette smoke, indoor house pollution, climate change will also have impact on environmental risk factors apart from the physical disruptions and new pathogens it creates.
Legal (regulatory environment)	Devolution of healthcare provision	Interventions need to be aligned with county planning cycles; The Gambia need to domesticate the interventions stated in the cancer control strategic plan
Ethical	Ethical principles of equity and causing no harm	Cancer prevention and screening is supposed to be provided equitably in the population. Cancer diagnosis, treatment and survivorship care should be provided through a multi-disciplinary approach, with informed consent and should involve the patient and their caregivers.

SECTION B: THE STRATEGIC PLAN

CHAPTER 3: Strategic Framework Model

3.1 Vision Statement, Mission Statement and Core Values.

3.1.1 Vision

The vision, which reflects the ultimate goal of the NCCP, **is to reduce the burden of cancer and improve the quality of life for individuals affected by cancer.**

3.1.2 Mission

The mission is to implement compressive and evidence-based cancer control strategies, encompassing prevention, early detection, diagnosis, treatment and palliative care, through a multi- sectoral approach.

3.1.3 Core values

1. **Community and survivor involvement:** Cancer control is a whole-of-society approach, and cancer survivors are an integral part of the control efforts.
2. **Sustainability:** choose interventions that are feasible within the economic context of The Gambia, and advocate for financing from both public and private actors.
3. **Improved access:** this includes financial access (cost of services), geographic access (availability of services within reasonable physical reach of the target population) and social access (acceptance/quality of services).
4. **Patient-centred:** cancer care should address patients' self-identified needs, respect their values, consider their preferences in decision-making and respond to their priorities for better health and wellness.
5. **Evidence based innovations:** selected interventions are backed by scientific evidence of efficacy.
6. **Equity and inclusivity:** everyone have an equal opportunity to prevent cancer, find it early, and get proper treatment and follow-up after treatment is completed.

3.1.4 Goal

Move towards Universal Health Coverage (UHC) in reducing cancer incidence, mortality and improve cancer down-staging and survival rates in The Gambia through access to population based primary prevention, early detection, quality diagnostics, treatment and follow-up services by the year 2030.

UHC is defined as a situation where everyone – irrespective of their ability-to-pay gets the health services they need to be of sufficient quality and effective without suffering any undue financial hardship. The Gambia is moving towards UHC through implementation of the Essential Health Package (EHP), which government and its development partners will endeavour to make accessible to every Gambian free at the point of care.

3.1.5 Objectives

The objective will focus on implementing population-wide interventions to reduce cancer risk factors. The objective will also highlight the importance of vaccination programs, specifically HPV vaccination for cancer prevention.

1. To reduce the number of new cancer cases attributable to modifiable risk factors by 2% by 2030.
2. To strengthen and increase the number of facilities providing screening, early detection, and linkages to care to 20%.
3. To expand the number of facilities offering basic cancer diagnosis, treatment, and palliative care to 30%.
4. To strengthen cancer surveillance, research and strategic information systems.
5. To improve the institutional and technical capacity for cancer prevention and control.
6. To establish a high-level mechanism for multi-sectoral coordination and partnership for prevention, treatment, care and rehabilitation of cancer.
7. To establish a level of advocacy, resource mobilization, communication and social mobilization mechanism for civil societies, communities and development partners

3.1.6 Specific objectives

Specific objectives are to ensure that the plan is responsive to national priorities and builds on existing platforms while leveraging resources and avoiding duplication. These will include:

- **Leadership** - the plan should create clarity and unity of purpose, and encourage team building, broad participation, and ownership of the process, continuous learning and mutual recognition of efforts made.
- **Integration** - all proposed priority interventions in the strategy should be integrated at various levels of the health system in a coherent and effective manner that is responsive to the needs of patients living with cancer.
- **Evidence based** - the strategic plan will be based on up-to-date evidence, priority needs and cost effective approaches.
- **Equity and accessibility** - a conscious effort should be made to promote equitable access to quality health services with greater attention to people living in rural and underserved areas as well as people living with cancer.
- **Partnership** – the plan should promote partnership and joint programming among key stakeholders as well as communities in order to avoid duplication, leverage and maximize available resources.
- **Efficiency** – roles and responsibilities of the stakeholders involved in implementation,

monitoring and evaluation of activities should be defined.

- **Transparency and accountability** – the plan should have a component on accountability.
- **Appropriateness and relevance** – the plan should reflect a clear understanding of the local status and perspective of cancer prevention and control in the country.

3.1.7 Guiding Principles

The implementation of the National Cancer Control Strategic Framework will be guided by the following principles:

- **Universal Access and Equity** – All people should have full access to health care and opportunities for prevention and control of cancer based on need, regardless of age, gender, religion, social status, presence of disabilities and the ability to pay.
- **Ethics** – Confidentiality of intended beneficiaries will be maintained at all levels of service delivery.
- **Evidence-Based Practices** – All interventions and strategies for prevention and control of cancer need to be based on scientific evidence and public health principles.
- **Holistic** – Cancer services assess and support the physical, emotional, social and spiritual needs of the patients and their families.
- **Partnership** – Multidisciplinary and multi-sectoral collaboration and coordination on NCD control interventions will always be promoted and supported
- **Accountability** – Service providers, organizations and government are held responsible for upholding sound and ethical practice.
- **Human Rights** – Respect for human dignity, with specific focus on ensuring that the rights of the beneficiaries are guaranteed. NCD prevention and control strategies must be formulated and implemented in accordance with international human rights conventions and agreements.
- **Compassion** – Cancer services are provided with genuine care and empathy for the patients and their families.

3.2 Strategic Pillars, Objectives and Actions

3.2.1 Strategic Pillar 1: To reduce the number of new cancer cases attributable to modifiable risk factors by 2 % by 2030.

Prevention of cancer is a key element in cancer control. It offers the greatest public health potential and the most cost-effective long-term cancer control. Between 30 and 50% of cancers can be prevented by avoiding risk factors and implementing existing evidence-based prevention strategies (WHO, 2009).

The primary prevention of cancer aims at reducing the number of people who develop the disease. It involves the direct avoidance or reduction in exposure to risk factors that cause cancer. Primary cancer prevention is achieved through empowering and educating people to make healthy lifestyle choices; supporting environmental approaches that make healthy choices easier where people live, play, and work; and promoting and providing vaccines which have demonstrated long-term efficacy for cancer prevention (protective therapeutics).

Risk Factors Associated with Cancer

The causes of most cancers are unknown. However, there are a number of risk factors attributed to the development of cancers in general. Some of these risk factors are also associated with the development of other NCDs. Cancer prevention must be considered in the context of activities to prevent other chronic diseases, especially those with which cancer shares common risk factors, such as cardiovascular diseases, diabetes, chronic respiratory diseases, and alcohol dependence. Common risk factors associated with the development of cancers include: tobacco use, unhealthy diets, overweight and obesity, physical inactivity, harmful use of alcohol, sexually transmitted HPV-infection, HIV infection, environmental and biological carcinogens (WHO, 2007). It is estimated that 40% of cancers can be prevented by risk factor modification. Prevention therefore offers the greatest public health potential and the most cost-effective long-term approach for cancer control (WHO, 2009).

Dietary Factors and obesity

About 90-95% of breast cancer cases is attributable to environmental and lifestyle factors-with diet and obesity contributing ~30-35 and 10-20%, respectively. This provides major opportunities for nutritional prevention and intervention (Anand et al., 2008). Several reports suggest that even low consumption of alcoholic beverages may increase the risk of breast cancer (Michels, 2005).

Obesity has been linked to cancer of the breast, colon and rectum, esophagus, stomach, gallbladder, uterus, pancreas, and ovary. The underlying mechanism of obesity causing cancer is complex and not fully understood. Diets high in saturated fat, red meat, alcohol, and obesity have been associated with an increased risk of colon cancer in both men and women [5] (Pati et al., 2023). Development of liver cancer has been related to consumption of foods contaminated with aflatoxins (Miller, 1990). Prostate cancer is associated with high consumption of animal fats, red meat, dairy products, and high calcium intake.

Physical inactivity

Sedentary lifestyle and lack of physical activity has been shown to independently increase the risk of cancers (Friedenreich et al., 2021).

Tobacco use

Tobacco use is the leading cause of cancer death. Tobacco use causes many types of cancer, including cancer of the lung, larynx (voice box), mouth, esophagus, throat, bladder, kidney, liver, stomach, pancreas, colon and rectum, and cervix, as well as acute myeloid leukemia (NCI, 2017).

Alcohol use

Approximately 4% of cancers worldwide are caused by alcohol consumption. Drinking alcohol increases the risk of several cancer types including liver, colo-rectum, and breast (Rumgay et al., 2021).

Biological carcinogens

It is well established, on a cellular and epidemiological basis, that the sexual transmission of high oncogenic risk (HR) human papillomavirus (HPV) types is the essential prerequisite for cervical carcinogenesis (Wall et al., 2005). Hepatitis B virus (HBV) is the leading cause of hepatocellular carcinoma (HCC) worldwide, particularly in Asia and sub-Saharan Africa (Parkin and Bray, 2000).

Environmental carcinogens

Environmental, exogenous and endogenous factors as well as individual factors, including genetic predisposition, contribute to the development of cancer. About 80–90% of malignant tumors are caused by external environmental factors (carcinogens) (Lewandowska et al., 2009).

Strategic Objectives:

- i. **Create awareness in the general population on modifiable risk factors that predispose to cancer**

Strategic Action:

- Create dialogue with at-risk populations to enhance community participation in cancer prevention.
- Develop and disseminate health education messages aimed at preventing risky behaviours and adopting healthier lifestyles (Tobacco use, harmful use of alcohol, unhealthy diet, physical inactivity, and sexual behaviour).
- Advocate for the incorporation of risk factors reduction strategies into educational curriculum.
- Increase awareness, sensitisation campaign and integrate clinical breast examination during routine anti natal care by 50%.

ii. Control tobacco use and address alcohol abuse, unhealthy diet, physical inactivity and sexual and reproductive factors

Strategic Action:

- Advocate for enforcement of the Tobacco Act which prohibits smoking in public places, advertisement of tobacco and its sale to minors.
- Strengthen and scale up tobacco cessation and rehabilitation centre.
- Capacity building of health care workers on tobacco cessation guideline
- Raise awareness about benefits of physical activity and the dangers of sedentary lifestyle.
- Advocate for an enabling environment for undertaking physical activity by providing safer accessible environments such as parks, walkways and bicycle lanes.
- Collaborate with Food Safety and Quality Assurance Authority (FSQAA) to minimize consumption of carcinogenic food.
- Raise awareness campaigns on the harmful effect of alcohol consumption.
- Advocate for the ban on sale of alcohol to minors.
- Advocate for restriction to access to alcohol by increasing taxes on alcoholic beverages.
- Advocate for legislations to restrict the promotion of unhealthy foods particularly to children.
- Sensitize the public on childhood obesity.

iii. Control of biological agents that cause cancer including prevention through vaccine introduction

Strategic Action:

- Conduct awareness campaigns on screening for infectious diseases related to cancer (HIV, helicobacter pylori, HPV and hepatitis B and C).
- Promote vaccination on HPV and HBV and increase coverage by 60 % within 3 years.
- Raise awareness about the harmful effects of sexually transmitted diseases including HPV.
- Strengthen screening of blood prior to transfusion.
- Raise awareness about the dangers of intravenous drug use.
- Prevent vertical transmission of HBV and HIV infection during delivery.

iv. Control of environmental exposure to carcinogens

Strategic Action:

- Promote policy to minimise occupational related cancers and known environmental carcinogens.
- Conduct awareness campaigns on reducing exposure to air pollution and other carcinogens via contamination of food (aflatoxins).
- Engage with employers to reduce exposure to occupational carcinogens.
- Conduct awareness campaigns on the dangers of exposure to ionizing radiation.

- Advocate for measures to reduce exposure to carcinogenic compounds in the workplace.
- Collaborate with relevant partners to conduct occupational safety and hygiene research on occupational exposures to carcinogens.

3.2.2 Strategic Pillar 2: To strengthen and increase the number of facilities providing screening, early detection, and linkages to care to 20%.

Screening and Early Detection

The goal of cancer screening and early detection is to cure cancer by detecting malignancy, or its precursor lesion, at an early stage prior to the onset of symptoms, when treatment of cancer is most effective. The two components of early detection of cancer are early diagnosis and screening (WHO, 2010; Loud and Murphy, 2017).

Early detection comprises early diagnosis of cancer in symptomatic populations. It greatly increases the chances for successful treatment. Screening for cancer, on the other hand, refers to checking for the presence of disease, in populations at risk, for early detection when no apparent symptoms are present, with an overall goal of decreasing cancer-related morbidity and mortality. For almost all types of cancer, particularly for cancers of the breast, cervix, mouth, larynx, colon and rectum, and skin, improved outcomes are seen when treatment is initiated at the earliest stage possible, hence the importance of early detection (WHO, 2010; Loud and Murphy, 2017). Early detection becomes successful when linked to effective treatment, as 30% of treatable cancers can be cured if detected early. **It is unethical to initiate an early detection programme in the absence of adequate treatment facilities** (WHO, 2009).

Strategic Objectives

i. Expand screening, early detection, and linkages to care services

Strategic Action:

- Develop and rollout basic screening, early detection, and linkage to care package for different levels of the health system.
- Capacitate facilities to implement the minimum package.

ii. Screening of asymptomatic and apparently healthy individuals

Strategic Action:

- Develop guidelines for screening for specific cancers (Cervical, Breast, Prostate, Colorectal, etc.) prevention and treatment into the health training curriculum.
- Conduct awareness campaigns among communities on early warning signs and symptoms of cancer, self-screening methods and participation in screening programmes.
- Conduct cancer screening outreach campaigns by trained teams at all levels.
- Strengthening the Conduct of Screening and vaccination of health workers for HBV within the 3 years.

iii. Enhance early detection of cancer in symptomatic individuals

Strategic Action:

- Create awareness on the early warning signs and symptoms of cancer among at risk populations and health care workers.

- Integrate early detection of cancer into existing health programs.

iv. Streamlining the referral and linkages system for cancer patients

Strategic Action:

- Develop and implement the use of guidelines and standard tools for referral and linkages system.
- Strengthen/ orientation on the referral and linkages pathway.
- Develop and strengthen referral policy / pathway for patients through the continuum of care (patient navigation).

3.2.3 Strategic Pillar 3: To expand the number of facilities offering basic cancer diagnosis, treatment, and palliative care to 30%

Diagnosis and Treatment

Cancer treatment and follow-up care is one of the key components of cancer control. The aims of treatment include: achievement of “cure” through long-term survival (i.e. achieving normal life expectancy), prolongation of life and improvement of quality of life (WHO, 2010ii).

Early detection linked with the most effective and efficient treatment provides a higher probability of cure and better quality of life (Malawi National Cancer Control Strategy, 2019). It has also been established that patients tend to have improved outcomes when managed by a multi-disciplinary team of experts. A typical multi-disciplinary management team for a specific cancer consist of the following: a) Surgeon b) Clinical/Radiation Oncologist c) Medical Oncologist/Hematologist d) Radiologist e) Pathologist f) Nurse Coordinator g) Psychologist h) Social worker) Dietician and Pharmacists (Ghana National Cancer Control Strategy, 20212).

Currently there is no comprehensive cancer treatment center in The Gambia but the only teaching hospital in the country provides basic cancer care

Principles for treatment

Care providers must adhere to the following principles:

- Treatments must be tailored to the best interests of the patient.
- Cancer patients shall be given all the information they require about a procedure before treatment.
- Respect the culture, norms and customs of patients.
- The health care professional should not be deceptive in their answers to questions raised by patients and relatives particularly on prognosis and treatment outcomes through adequate counselling.

Strategic Objective:

Improve cancer diagnosis and treatment services

Strategic Action:

- Advocate for the establishment of national cancer treatment centre.
- Advocate for the establishment of a radiotherapy centre.
- Advocate for introduction of post graduate training programs in cancer surgery, radiotherapy and clinical oncology, oncology pharmacy, pathology, imaging and cancer nursing.
- Advocate for availability of chemotherapeutic agent.
- Develop evidence-based guidelines and standard operating procedures for cancer treatment.
- Strengthen histopathology, cytology, radiology services.
- Develop an essential cancer drug list and integrate it into the national essential drug list.

- Develop clinical protocols and quality assurance (QA) guidelines for cancer management.

PALLIATIVE CARE

Introduction

Palliative care is an approach that improves the quality of life of patients (adults and children) and their families who are facing problems associated with life-threatening illness. It prevents and relieves suffering through the early identification, correct assessment and treatment of pain and other problems, whether physical, psychosocial or spiritual (WHO, 2020). Palliative care is a multidisciplinary process provided by a specially trained team of doctors, nurses and psychologists (CAPC).

Barriers to palliative care include:

- lack of awareness among policy-makers, health professionals and the public about what palliative care is, and the benefits it can offer patients, families and health systems;
- cultural and social barriers, such as beliefs about death and dying;
- misconceptions about palliative care, such as that it is only for patients with cancer, or for the last weeks of life;
- Misconceptions that improving access to opioid analgesia will lead to increased substance abuse (WHO, 2020).

Strategic Action:

- Develop guidelines for palliative care services including pain management.
- Institutionalise operation of multi-Disciplinary Tumour Board for common tumours and childhood cancer to ensure implementation of local guidelines for oncological care.
- Develop Palliative Care Strategy linked to NCD Plan and implementation of WHO PEN Package, Global Fund program for HIV/ AIDS.
- Develop quality assurance mechanism to oversee proper delivery of palliative care for cancer patients.
- Develop and put in place structures to employ and retrain the services of the only Medical Physicist.
- Conduct awareness campaigns on palliative care targeting policy makers, public, media, and health care personnel.
- Strengthen community and home-based palliative care services including establishment of nutritional support services for cancer patients.
- Establish social support services for cancer patients and provide palliative care services for groups with special needs, children and elderly.
- Set up a development plan for human resources involved in the fight against cancer (medical oncologist, pathologist, palliative care physician, oncology nurses)

3.2.4 Strategic Pillar 4: To strengthen cancer surveillance, research and strategic information systems

Research and Surveillance for Cancer Control and Services

Research is needed across the spectrum of cancer control to provide the basis for continual improvement. A coordinated agenda for cancer research is an essential element in the effective prevention and control of cancer.

Cancer surveillance includes the routine collection of data on the incidence, prevalence, mortality, diagnostic methods, stage distribution, treatment, rehabilitation, and survival of cancer patients (Eswatini Cancer Control Strategic Plan, 2019).

A fully functioning and dedicated cancer registry with appropriate expertise is a cornerstone of cancer control.

Strategic Objective:

- i. Improve the availability of comprehensive data on cancer and its risk factors, enhancing capacity for research and surveillance in cancer.**

Strategic Action:

- Reactivate and strengthen the National Cancer Register.
- Establish cancer registries in hospitals.
- Build capacity for cancer registration personnel.
- Integrate cancer registry into existing health surveillance system.
- Dissemination of cancer data to inform policy decision-making.
- Develop a cancer research agenda and ensure adequate capacity for cancer research.
- Strengthen partnerships with cancer registry networks and research institutions (e.g. African Cancer Registry Network and International Agency for Research on Cancer)
- Review and activate existing cancer surveillance and registration tools.
- Conduct a survey on risk factors for common cancers in the Gambia.

3.2.5 Strategic Pillar 5: To improve the institutional and technical capacity for cancer prevention and control

CAPACITY BUILDING TO IMPROVE CANCER SERVICES IN THE GAMBIA

The number of cancer cases in The Gambia is on the increase. In 2011, a total of 103,507 cancer cases were reported to Gambia National Cancer Register (GNCR), and the number had increased to 115,238 cases in 2012 to 2016. In view that more people are affected by cancer, there is also a rapid growth in demand for cancer healthcare services. In order to ensure high-quality cancer care services, it is essential to have a skilled and sustainable workforce and the needed infrastructure in the field. There is also the need to overcome the shortages in some areas of essential workforce and specialization

Strategic Objective:

i. Build workforce capacity and strengthen human capital development

Strategic Action:

1. RADIOLOGY

- Increase the Production/training of radiologists.
- Advocate and develop a curriculum for continuous training of radiologist through the West African College of Surgeon and proposed Gambian college to be modality experts:
 - CT scan
 - MRI
 - Mammography
 - Angiography
 - train radiology nurses
- Curriculum for radiology and other under- represented specialised medical discipline in cancer to be included in the undergraduate medical program to interest graduating doctors in these specialities.
- Develop a framework for the formation of Allied Health professional Council for licensing and re- certification of technicians including radiographic technician.

2. LABORATORY:

I. PATHOLOGIST

- Strengthen specialized human resources by training pathologists.
- Train medical laboratory technologists/ scientists in molecular pathology.

II. CLINICAL HEMATOLOGIST

- Strengthen specialized human resources by training hematologists

3. RADIOTHERAPY IN ONCOLOGY, medical

- Develop a framework and continuous curriculum to train clinical oncologists, medical physicists, radiation therapist, Oncology nurses, oncopharmacists.

4. PEDIATRIC ONCOLOGY

- Train pediatric oncologist

5. ONCOLOGY

- Train oncologist
- Develop an online and onsite training of radiographic technicians in oncology imaging, mammography techniques and radiation safety
- Provide, installed capacity required for practice of Surgical oncology

6. REHABILITATION

- Provide short training for cancer rehabilitation

7. PALLIATIVE CARE

- Train doctors, nurses and psychologists on oncology care.

Strategic Objective:

ii. Build or strengthen infrastructure/equipment

Strategic Action:

1. Establish one oncology center

2. Radiology

- Develop a framework for purchase of radiological and cancer treatment equipment that includes developing specification, tender process, purchase, installation, and maintenance (service contract).
- Provide conventional ultrasound scan (USS) machines at all cancer care service facilities
- Develop a framework for bulk purchase of radiological consumables to reduce cost.
- Provide a high tesla (at least 1.5 T) MRI machine at the oncology center
- Provide high slides CT scanners at 3 General Hospitals
- Equip secondary health centres with cancer imaging equipment – Xray, Ultrasound and mammography.

3. Laboratory

- Provide screening equipment for different cancers
- Provide equipment for tissue biopsy
- Provide reagents for cytology studies
- Provide material for immunohistochemistry

3.2.6 Strategic Pillar 6: To establish a high-level mechanism for multi-sectoral coordination and partnership for prevention, treatment, care and rehabilitation of cancer

Coordination, Partnership and Financing

Coordination

The existing NCCP needs to be strengthened, and the government needs to continue to be committed to implementing the National Cancer Control Strategic Plan (NCCSP). However, the capacity of the NCCP staff has to be strengthened at levels.

It is crucial to note that implementing the NCCSP will require strong coordination and harmonization among all partners, and the MoH will lead the process. A multi-sectoral approach with effective partnership through the involvement of government institutions, the private sector, faith-based organizations (FBOs), non-governmental organizations (NGOs), Civil Society Organizations (CSOs) and communities through local associations will be necessary for the efficient and effective implementation of the NCCSP.

The MoH must collaborate with other sectors to make sure social determinants are taken into account when planning and delivering services to communities. The NCCP will specifically work to ensure that there is improved coordination, strong partnerships, long-term funding, and technical support for cancer control from the MoH and other relevant parties.

All cancer programming initiatives, such as trainings, outreach programs, and technical support visits, should be coordinated by the NCCP. All cancer interventions will be incorporated into the data platforms, such as electronic patient management systems, health information systems, and national health surveys.

Strategic Objective:

i. Improve coordination and governance for cancer prevention and control

Strategic Action:

- Support the establishment of the National Multi-sectoral Steering Committee on Non-Communicable Diseases (NCDs) Prevention and Control chaired by the President's Office.
- Establish a Multi-sectoral Technical Working Group (MTWG) on cancer prevention and control.
- Establish a stand-up National Cancer Steering Committee and technical Sub- Committees for implementation, monitoring and evaluation.

ii. Strengthen national capacity and leadership to accelerate and scale up the national response to cancer epidemic

Strategic Action:

- Strengthen the National Cancer Control Program.
- Increase the number of staffs to manage cancers at different levels.
- Train or orient personnel of stakeholders on cancer prevention and control.
- Strengthen infrastructure and capacity for prevention and early detection of Cancer at all levels.
- Engage and train community-based organizations as “Cancer change agents” to promote/facilitate dialogues that catalyze society-wide change.
- Conduct periodic community-based screening for cancer.
- Conduct periodic public awareness campaigns on cancer and its risk factors.

Partnership

The Gambia, like other low-income countries, faces a challenge in financing access to cancer interventions. Therefore, sustainable improvements in financing cancer intervention will require the participation of state and non-state actors to implement programs and optimize the cancer ecosystem successfully. A comprehensive cancer control framework to stimulate collective action by everyone that defines the value of partnership and multi-stakeholder collaboration is necessary.

The mechanisms for national and international collaboration between the MoH through the NCCP and partners will be under the umbrella of a sector-wide approach.

Effective partnership and participation can contribute significantly to prevention, control and treatment. Therefore, better collaboration mechanisms of all actors and partners in cancer intervention will be required for sustainability and better outcomes.

The NCCSP will give due attention to effective intersectoral collaboration through:

- Encouraging stakeholders' participation in cancer interventions
- Promoting a sector-wide approach to cancer ` interventions
- Establishing NCCP-community partnership
- Promoting effective public-private partnership
- Strengthening partnerships between the NCCP and partners involved in cancer care.

iii. **Build strong public-private Partnerships for Cancer prevention and control.**

Strategic Action:

- a) Organize annual Public Private Partnerships forum for the prevention and control of cancer
- b) Strengthen collaboration at all levels among governmental agencies, intergovernmental organizations, nongovernmental organizations, civil society organisation, communities, and the private sector to prevent and control cancer.
- c) Advocate for implementation of cancer sensitive national frameworks.

- d) Solidify coordination with Ministry divisions around cervical cancer, hepatitis B, HIV/ Aids, TB, NCDs activities
- e) Advocate for the implementation of traffic policy that restrict the use of second-hand vehicle that emit carbon monoxide that are cancer related risk factors.

iv. Increase public awareness on cancer prevention and control

Strategic Action:

- Develop a national cancer advocacy and communication plan.
- Develop communication messages and guidelines on cancer.
- Support commemoration of international days in support of prevention and control of cancer.
- Train stakeholders on the implementation of the national cancer advocacy and communication plan.

2.2.7 Strategic Pillar 7: To establish and strengthen advocacy, resource mobilization, communication and social mobilization mechanism in partnership with civil societies, communities and development partners.

RESOURCE MOBILIZATION

The NCCP will create costed Operational Plans every year to provide funding for the plan's execution. The government will be the main source of funding, together with development partners. To put this goal into practice, the NCCP will create budget requests every year after consulting with relevant parties, which will then be submitted to the government for funding as part of the ministry's planning and budgeting procedures.

Development partners will be systematically engaged, including through proposal writing, to seek their support. Within their designated areas of support, stakeholders or outside development assistance should also be used to support cancer activities. Development partners and the private sector will be required to complement government efforts with technical and financial support through appropriate advocacy.

There will be a variety of financial strategies employed to assist the NCCP sufficient funding for diverse cancer interventions ought to be integrated into the nation's total financial allocation for cancer control, both at the central and regional levels.

Despite the increase in the number of cancer cases, the current allocation of cancer care in the health budget is approximately 11 million dalasi representing 2.3%. It is necessary for the government to devote more funds to the fight against cancer. It is crucial to make sure that medications and chemotherapy agents that are needed for treatment are on the essential medicine list and accessible.

Strategic Objective:

i. Enhance innovative financing of cancer prevention, control and treatment

Strategic Action:

- a) Advocate and strengthen for the increase in the number of cancer services in the benefit package covered by health insurance.
- b) Advocate for subsidizing expensive cancer services for the most vulnerable/poor patients.
- c) Development of proposals for funding specialized cancer services
- d) Advocate for the allocation of some percentage tax collected on cancer-causing agents such as cigarettes, alcohol, and other unhealthy foods etc
- e) Conduct annual donor conference.

Advocacy, Communication and Social Mobilization

Advocacy, communication and social mobilization is an essential component of an effective cancer prevention and control program. This will enhance community empowerment resulting increased

awareness level of the public on cancer screening, prevention, and compliance to treatment. It will also reduce ignorance, fear, embarrassment, and stigma related to cancers.

Advocacy plays a pivotal role in influencing policy decisions, resource mobilization, raising awareness, and shaping policy implementation. Currently, The Gambia faces numerous challenges in cancer control, including limited resources, inadequate infrastructure, and limited awareness of cancer prevention and early detection. The country also experiences barriers to accessing cancer treatment and care, contributing to high mortality rates from the disease. In addition, there are limited highly skilled healthcare professionals in Cancer treatment and management as well as limited availability of essential cancer medications and equipment. Advocacy efforts are, therefore, essential for driving the development and implementation of a comprehensive cancer control strategy. These initiatives involve various stakeholders, including government agencies, non-governmental organizations (NGOs), healthcare professionals, community leaders, and international partners.

ii. Strengthen strategic engagement of stakeholders for prioritization of cancer prevention and control

Strategic Action:

- a) Advocate for the allocation of resources for cancer control, prevention, and management.
- b) Develop advocacy or policy briefs to facilitate engagement with policy makers and other critical stakeholders on cancer.
- c) Organize national forums/seminars for policymakers/ stakeholders on cancer and its impact on development.
- d) Conduct advocacy visits to all relevant sectors to forge a strong multi-sectoral collaboration in the implementation of cancer prevention within the workplace or settings.
- e) Advocate for the development of a regulatory framework for traditional medicine.
- f) Conduct inter-sectoral and multi-stakeholder meetings to strengthen cancer prevention and control.
- g) Conduct engagement with the UN agencies to include cancers in the United Nation Development Assistance Framework (UNDAF).

Communication and Social Mobilization

Key Communication and social mobilization strategies to adopt for cancer prevention and control

The principal communication strategies to inform the NCCP will evolve around advocacy, social mobilization, interactive community engagement and social media engagement.

Advocacy activities will focus on improving commitment and support among key players at national, regional, district, ward and community levels. Social mobilization will target and mobilize regional governors, technical advisory committees at the regional level, religious councils, district chiefs, ward councillors, women councillors, NGOs and CBOs operating at the district and community levels.

Social and behavioral change communication and interactive community engagement will be carried out by front-line health workers and other change agents. In this regard, community and family heads will be engaged and well-sensitized for them to understand the rationale behind NCCP. The women folk will be engaged to patronize and maintain achievements in cancer prevention and control. These will be complemented by communication support materials (leaflets, posters, banners, SMS text messages, T-shirts). Radio and TV programs will also be conducted on different radio stations in different languages in the form of panel discussions and phone-in programs. Radio spots will also be produced and broadcast on the radios to the reach of the public.

iii. Reach 90% of all Gambians with information on cancer by 2030

Strategic Action:

- To inform communities about cancer, and its' causes and natural history.
- To raise awareness around cancer prevention and control and the necessity of early diagnosis, treatment, and control.
- To increase demand for cancer screening, early diagnosis, and treatment as well as utilization of palliative care services.

iv. Strengthen advocacy communication and social mobilisation for cancer prevention and control at all levels

Strategic Action:

- Sensitize women, men, adolescents, policymakers, health care workers, and opinion leaders about the causes of cancers and effective methods of preventing them.
- Sensitize communities on cancer prevention services, including vaccination, screening, diagnostics, and available treatment options, and where to access them to increase service utilization.
- Design, develop, pre-test, and disseminate communication support materials to raise awareness around cancer, methods of prevention, and control. These will include leaflets and posters.
- Develop and implement mass media campaigns, including radio and television messages, radio spots, and billboard advertising to raise awareness on cancer prevention and control.
- Hold talks and presentations with cancer survivors to raise awareness around cancers, methods of prevention, control, and treatment.
- Orient and engage social media influencers such as bloggers, tik-tokers, etc.
- Partner with popular local artists to develop songs about cancer prevention and control.
- Develop youth-focused communication support materials to raise awareness around cancer, its prevention, and its benefits.
- Raise awareness of the public about cancer prevention, using the ABC strategy (Abstain, Be faithful, use Condoms [condom offers only partial protection]) for cervical cancer and early screening.
- Sensitization of public and family members of cancer patients, in particular, to demystify cancer and reduce stigmatization.
- Conduct training for healthcare workers on messaging and communication on cancer prevention, control, diagnosis, and treatment.

- Hold workshops to lobby policymakers and other key stakeholders at the national level to mobilize funds to ensure effective, affordable, and accessible cancer prevention and control services to all needy
- Lobby with the Ministry of Basic and Secondary Education (MoBSE) to include cancer prevention and control in the school curriculum.
- Support local and folk-media groups to raise awareness around cancer.
- Integrate cancer prevention, early diagnosis, and control messages into existing programs in health facilities and health training institutions in the country.

SECTION C: MONITORING AND EVALUATION FRAMEWORK

CHAPTER 4: Monitoring and evaluation

Monitoring and evaluation are crucial components in addressing issues and measuring the process of strategies to help assess the effectiveness of interventions, identify areas for improvement, and guide future decision-making. In the context of The Gambia Cancer Control Strategy, the monitoring and evaluation framework is in line with the National Health Policy (NHP) 2021–2030 to prevent needless redesigning of the wheel and/or duplication of effort. The plan describes the processes, methods and tools that are used to collect, compile, report, analyse and use data, as well as provide feedback on performance and management systems. It also translates the processes into annualized and costed activities and assigns responsibilities for implementation.

This M&E plan has been developed in a participatory approach and shall guide all M&E activities of the Cancer Control Strategy. Moreover, it specifies the type of monitoring, reporting, and timing of evaluations and reviews. Furthermore, it stipulates the roles and partnerships of the MoH and the different stakeholders and emphasizes the importance of timely intervention for each implementer to facilitate robust performance measurement. It also clearly states the data collection platforms through the developed guidelines which has been aligned with the national and international structures and framework in respect of roles, responsibilities data gathering and reporting. M&E are in different stages such as monthly, quarterly, mid and end of term evaluation as stipulated in the framework.

In summary, effective monitoring and evaluation are integral components of cancer control strategy in The Gambia. By systematically collecting data on key indicators related to prevention, early detection, treatment, rehabilitation, access, and outcomes, stakeholders can assess progress towards reducing the burden of cancer in the country. Moreover, robust evaluation processes enable informed decision-making to optimize resource allocation and improve the overall effectiveness of cancer control programs.

Strategic Objective:

- i. **To monitor and evaluate progress (performance) in the implementation of the national cancer control strategy as well as outcome.**
- ii. **Strengthen surveillance and M&E for improved data quality and decision-making**

Strategic Action:

- Development and production of M&E guidelines for cancer control strategy.
- Provision of electronic medical records (EMR) system for all cancers in the clinics to improve patient management and care including referrals between health facilities.

- Conduct periodic cancer surveillance and data collection on risk factors and monitoring national response.
- Develop a mapping tool/ dashboard to facilitate NCCS implementation and Monitoring and Evaluation.
- Support the development of cancer M&E that provide basic information that empowers decision making to improve implementation at each level of access.
- Provision of monitoring vehicle

4.3 Success criteria (performance indicators) for this strategy are as follows:

- Decrease in mortality and morbidity rates due to cancer.
- Decrease in the proportion of patients seen at an advanced stage of the disease.
- Increase in the percentage of conservative surgery.
- Decrease in treatment costs to the health care system.
- Improvement of the quality of life of the patients.

SECTION D: STRATEGIC IMPLEMENTATION

CHAPTER 5 - Implementation and Coordination Framework

5.1 Overview

A coordination and implementation framework guide for the implementation process for the strategic plan, within the governance structure for health care provision in The Gambia in collaboration with WHO recommendations. It recognizes and spells out the roles and responsibilities of all stakeholders involved in cancer control.

The governance structure should be both adaptive and flexible, to guide the country in responding to the rising cancer burden as well as other public health threats that can undermine the control efforts. The prevention and control of cancer will require a well-coordinated multisectoral, multidisciplinary and whole-of-society approach with a focus for health-in-all-policies.

The NCCP under the Division/Directorate of NCD is mandated to formulate cancer policies and guidelines across the cancer care continuum, disseminate them and guide their implementation. It provides capacity building and technical support to all the health facilities as per the policy documents.

The NCCP will coordinate implementation of this strategic plan as well as annual monitoring and evaluation against set targets through the National Steering Committee. The National Steering Committee on Cancer Prevention and Control is one of the committees of the NCCP in collaboration with the NCD and WHO, who will advise on areas of focus for policy formulation for implementation of the national cancer response.

5.2 Roles and Responsibilities

These are in line with the national cancer control strategy 2025-2030 and the NCD strategy 2022-2027.

Table 11: Roles and Responsibilities

Actor	Roles and Responsibilities
NCCP	<ul style="list-style-type: none"> • Disseminate and provide leadership in implementation of the national cancer control strategy. • Provide technical support in the implementation of the national cancer control strategy. • Build capacity on cancer prevention and control as per national cancer guidelines and strategies. • Coordination of partnerships and collaborations for cancer control through the Technical Working Groups reporting to NCD-and MOH

	<ul style="list-style-type: none"> • Oversee operationalization of the National Cancer Control Strategy Monitoring, Evaluation, Accountability and Learning (MEAL) Framework. • Coordinate Cancer advocacy, communication and social mobilization in collaboration with all stakeholders.
Ministry of Health Departments, Divisions and Programs	<ul style="list-style-type: none"> • Support the implementation of the National Cancer Control Strategy 2025-2030. • Participate and collaborate in all cancer related meetings and provide technical support as required. • Integrate cancer prevention and control in their programming as guided by WHO. • Provide guidance for digital health solutions to aid implementation of the national cancer control strategy. • Support community level activities to aid implementation of the national cancer control strategy.
NCD	<ul style="list-style-type: none"> • To collaborate with NCCP in all aspect of the strategy implementation and studies to be conducted. • Provide timely sustainable, comprehensive data on cancer related activities.
Civil Society, religious bodies and Private sector	<ul style="list-style-type: none"> • Support cancer advocacy, communication and social mobilization activities. • Advocate for resources towards implementation of this strategy. • Support cancer prevention and control interventions. • Complement the ministry in service delivery. • Support training and capacity building of oncology health workforce. • Support local manufacturing of quality, health products and technologies.
Development partners, International Non-Governmental Organizations (INGOs), NGOs and CSOs	<ul style="list-style-type: none"> • Mobilise resources for this strategic plan implementation. • Provide technical, logistical and capacity building support
Academic, Research and Health Training Institutions	<ul style="list-style-type: none"> • Conduct cancer education and training.

	<ul style="list-style-type: none"> • Conduct cancer research and apply it to inform and guide policy. • Collaborate to develop mechanisms for research data sharing. • Harmonise and standardise research ethics and approval processes.
Media	<ul style="list-style-type: none"> • Dissemination of accurate cancer information to create public awareness
General public, individuals and communities	<ul style="list-style-type: none"> • Adopt healthy lifestyles and health seeking behaviour. • Participate actively in cancer prevention and control. • Enrol and maintain NHIF and/or other health insurance cover for financial and social protection. • Support cancer patients, survivors and their caregivers and reduce stigma and discrimination

Appendix: Detailed Implementation Matrix

Strategic Objective 1: To reduce the number of new cancer cases attributable to modifiable risk factors by 2030 by 2%

Specific Objectives	Strategic action/activities	Performance indicator	Target	Coordinating/Collaborating Agencies
Create awareness in the general population on modifiable risk factors that pre-dispose to cancer	Create dialogue with at-risk populations to enhance community participation in cancer prevention.	Cancer prevention promoted in the community	Throughout the 6 years	NCCP DHPE Civil Society
	Develop and disseminate health education messages aimed at preventing risky behaviours and adopting healthier lifestyles (Tobacco use, harmful use of alcohol, unhealthy diet, physical inactivity and sexual behaviour)	Healthy life behaviours adopted	Throughout the 6 years	NCCP DHPE Civil Society
	Advocate for the incorporation of risk factors reduction strategies into educational curriculum	Risk factors reductions incorporated into educational curriculum	Within the first 2 years of the plan	NCCP MOBSE MOHERST
Control tobacco use and address alcohol abuse, unhealthy diet, physical inactivity and sexual and reproductive factors	Promote tobacco cessation programs	Smoking in public places prohibited	Throughout the 6 years	NCCP NCD Civil Society MOCDE MOTIE
	Increase tax on tobacco products	Advertisement and sale of tobacco to minors prohibited		

	Capacity building of health care workers on tobacco cessation guideline	Health care workers familiarized with tobacco cessation guideline	Throughout the 6 years	NCCP NCD DHPE
	Raising awareness about benefits of physical activity and the dangers of sedentary life style	Communities engaged in physical activities	Throughout the 6 years	NCCP NCD DHPE Civil Society
	Collaborate with Food Safety and Quality Assurance Authority to minimize consumption of carcinogenic food	Awareness about consumption of carcinogenic food raised	Throughout the 6 years	NCCP FSQAA
	Raise awareness of dangers of alcohol, and advocate for legislation on access to and consumption of alcohol	Awareness about dangers of alcohol raised Legislation on alcohol made and enforced	Throughout the 6 years	NCCP NCD DHPE Civil Society Gambia Police Force
	Advocate for legislations to restrict the promotion of unhealthy foods particularly to children	Legislation on restriction of promotion unhealthy food made and enforced	Throughout the 6 years	NCCP NCD FSQAA National Assembly
	Sensitize the public on childhood obesity	Communities became aware of dangers of obesity	Throughout the 6 years	NCCP NCD DHPE
Control of biological agents that cause cancer including prevention through vaccine introduction	Conduct awareness campaigns on screening for infectious diseases related to cancer (HIV, helicobacter pylori, HPV, hepatitis B and C and Epstein Barr virus)	At risk populations screened for infections Health workers conduct tests	Throughout the 6 years	NCCP NACP Civil Society DHPE
	Promote vaccination on HPV and HBV	Parent and caregivers got their children vaccinated	Throughout the 6 years	NCCP, DHPE EPI

	Raise awareness about the harmful effects of sexually transmitted diseases including HPV	At risk populations practiced responsible sexual behaviour	Throughout the 6 years	NCCP NACP DPHE Civil Society
	Strengthen screening of blood prior to transfusion	Safe blood transfusion enhanced	Throughout the 6 years	NCCP NBTS
	Raise awareness about the dangers of intravenous drug use	At risk populations quit IV drug use	Throughout the 6 years	NCCP DHPE DLEAG
	Prevent vertical transmission of HBV infection during delivery	Prevention of VT of HBV enhanced	Throughout the 6 years	NCCP DHPE NHCP
Control of environmental exposure to carcinogens	Promote policy to minimize occupational related cancers and known environmental carcinogens	Workplaces introduced safety measures	Throughout the 6 years	NCCP Department of Labour Workers Union
	Conduct awareness campaigns on reducing exposure to air pollution and other carcinogens via contamination of food (aflatoxins or dioxins)	Air pollution prevented in communities and food safety procedures observed	Throughout the 6 years	NCCP NEA DHPE FSQAA
	Engage with employers to reduce exposure to occupational carcinogens	Workplaces introduced safety measures	Throughout the 6 years	NCCP Department of Labour Workers Union
	Conduct awareness campaigns on the dangers of exposure to ionizing radiation	At risk populations observed safety measures	Throughout the 6 years	NCCP NEA
	Advocate for measures to reduce exposure to carcinogenic compounds in the workplace	Workplaces introduced safety measures	Throughout the 6 years	NCCP Department of Labour Workers Union

	Collaborate with relevant partners to conduct Occupational Safety and Hygiene research on occupational exposures to carcinogens	Occupational exposures to carcinogens determined	Throughout the 6 years	NCCP Department of Labour Workers Union
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Strategic Objective 2: To strengthen and increase the number of facilities providing screening, early detection, and linkages to care to 20%.

Specific Objectives	Strategic action/activities	Performance indicator	Target	Coordinating/Collaborating Agencies
Expand screening, early detection, and linkages to care services	Develop and rollout basic screening, early detection and linkage to care package for different levels of the health system.	Cancer cases detected early and referred	1 st year	NCCP
	Capacitate facilities to implement the minimum package.	At risk individuals access screening services	Throughout the 6 years	NCCP
Screening of asymptomatic and apparently healthy individuals	Develop guidelines for screening for specific cancers (Cervical, Breast, Prostate. Colorectal).	Health care workers detect cancer early, treat or refer accordingly	1 st year	NCCP
	Conduct awareness campaigns among communities on early warning signs and symptoms of cancer, self-screening methods and participation in screening programmes	Communities take up cancer screening services	Throughout the 6 years	NCCP NCD DHPE
	Conduct cancer screening outreach campaigns by trained teams at all levels.	Health care workers detect and refer cancer early	Throughout the 6 years	NCCP NCD Civil Society
Enhance early detection of cancer in symptomatic individuals	Create awareness on the early warning signs and symptoms of cancer among	Communities take up cancer screening services	Throughout the 6 years	NCCP Civil Society DHPE

	at risk populations and health care workers.			
	Integrate early detection of cancer into existing health programs.	Health care workers detect and refer cancer early	Throughout 6 years	NCCP Public Health programs
Streamlining the referral and linkages system for cancer patients	Develop and implement the use of guidelines and standard tools for referral and linkages system.	Health care workers detect and refer cancer early	Throughout the 6 years	NCCP
	Strengthen/ orientation on the referral and linkages pathway.	Health care workers detect and refer cancer early	Throughout the 6 years	NCCP

Strategic Objective 3: To expand the number of facilities offering basic cancer diagnosis, treatment, and palliative care to 30%

Specific Objectives	Strategic action/activities	Performance indicator	Target	Coordinating/Collaborating Agencies
Improve cancer diagnosis and treatment services	Advocate for the establishment of national cancer treatment centre.	National cancer centre established	1 st year	NCCP
	Advocate for the establishment of a radiotherapy centre.	Radiotherapy centre established	Throughout the 6 years	NCCP
	Advocate for introduction of post graduate training programs in cancer surgery, radiotherapy and clinical oncology, oncology pharmacy, pathology, imaging and cancer nursing	Postgraduate programs in cancer introduced	Throughout the 6 years	NCCP MOHERST UTG
	Develop referral policy specific for cancer.	Cancer referral policy developed	First 2 years	NCCP
	Advocate for availability of chemotherapeutic agent.	Chemotherapy agents available	Throughout the 6 years	NCCP NPS
	Develop evidence-based guidelines and standard operating procedures for cancer treatment.	All cancer diagnoses confirmed by health care workers	Throughout the 6 years	NCCP
	Strengthen histopathology, cytology, radiology services.	All cancer diagnoses confirmed by healthcare workers	Throughout the 6 years	NCCP International Partners

	Develop an essential cancer drug list and integrate it into the national essential drug list.	Essential cancer drugs became in the essential drug list	Throughout the 6 years	NCCP NPS
	Develop clinical protocols and quality assurance (QA) guidelines for cancer management.	Health workers manage Cancer patients according to national guidelines	Throughout the 6 years	NCCP
Manage advance cases of care	Develop guidelines for palliative care services including pain management.	Health care workers provide adequate pain relief	Throughout the 6 years	NCCP NPS APCA
	Develop quality assurance mechanism to oversee proper delivery of palliative care for cancer patients.	Health care workers provide adequate pain relief	Throughout the 6 years	NCCP NPS APCA
	Conduct awareness campaigns on palliative care targeting policy makers, public, media, and health care personnel.	Communities utilize palliative care services	Throughout the 6 years	NCCP APCA CSOs
	Strengthen community and home-based palliative care services including establishment of nutritional support services for cancer patients.	Communities utilize palliative care services	Throughout the 6 years	NCCP APCA CHW CSOs
	Establish social support services for cancer patients and provide palliative care services for groups with special needs, children and elderly.	Cancer patients well supported	Throughout the 6 years	NCCP APCA CHW CSOs

Strategic Objective 4: To strengthen cancer surveillance, research and strategic information systems

Specific Objectives	Strategic Action/Activities	Performance Indicator	Target	Coordinating/Collaborating Agencies
Improve availability of comprehensive data on cancer and its risk factors, enhancing capacity for research and surveillance in cancer.		Functional national population-based cancer registry	1	MoH and Partners
	Establish hospital registries in hospitals.	Number of hospital cancer registries established	10	MoH and Partners
	Build capacity of cancer registration personnel.	Number of personnel trained on registration	20	MoH and Partners
	Integrate cancer registry into existing health surveillance system	The cancer registry data reported through DHIS2	10	MoH and Partners
	Reactivate and strengthen the National Cancer Registry	The National Cancer Registry reactivated and strengthened	1	MoH and Partners
	Dissemination of cancer data to inform policy decision making	Number of annual cancer data dissemination meetings conducted.	6 monthly	MoH and Partners

	Develop a cancer research agenda and ensure adequate capacity for cancer research	1.Availability of cancer research agenda	Yearly	MoH and Partners
		2. number of grants on cancer research successfully mobilized.	2 Yearly	
		3. number of health personnel trained on conducting cancer research	10 yearly	
	Strengthen partnerships with cancer registry networks and research institutions (e.g. African Cancer Registry Network and International Agency for Research on Cancer	Number of partnerships with international cancer registry organizations.	1 per year	MoH and Partners
		Number of manuscripts published into peer reviewed journals.	Yearly	MoH and Partners
	Review and activate existing cancer surveillance and registration tools.	Number of surveillance and registration tools reviewed	Depending on the number of tools available	MoH and Partners
	Conduct survey on risk factors for common cancers in the Gambia	Number of surveys conducted	1 in 6 years	MoH and Partners

Strategic Objective 5: To strengthen cancer surveillance, research and strategic information systems

Specific Objectives	Strategic action/activities	Performance indicator	Target	Coordinating/Collaborating Agencies
A. To build work force capacity and strengthen human capital development				
	1. Radiology			
	<ul style="list-style-type: none"> Increase Production/training of radiologists 	Number of radiologists trained	5 in 6 years	MoH/MOHERST/International partners
	<ul style="list-style-type: none"> Train radiographers Radiographers to go for short course/intensive /advanced diploma programmes locally or international to be modality experts: <ul style="list-style-type: none"> CT scan MRI Mammography Angiography 	Number or percentage trained Number or percentage trained	5 in 6 years 20 in 6 years	MoH/MOHERST/International partners /UTG

	<ul style="list-style-type: none"> Train biomedical engineers 	Number or percentage trained	5 in 6 years	
	<ul style="list-style-type: none"> To train radiology nurses 	Number of nurses who undergo radiology nurse training	20	MoH/MOHERST/International partners /UTG
	2. Laboratory			
	a. Pathologist			
	1. To strengthen specialised human resource by training pathologist	Number of pathologists trained	6 in 6 years	MoH/MOHERST/International partners /UTG
	2. To train medical laboratory technologists/scientists in molecular pathology	Number of laboratory technologist trained	10 in 6 years	MoH/MOHERST/International partners /UTG
	b. Clinical hematologist			
To strengthen specialised human resource by training hematologist	Number of hematologists trained	6 in 6 years	MoH/MOHERST/International Donors/Universities	

	3. Radiotherapy in Oncology			
	a. To train clinical oncologists	Number of clinical oncologists trained	5 in 6 years	MoH/MOHERST/International Donors/Universities
	b. To train medical physicists	Number of medical physicists trained with master's degrees and PhD	5 in 6 years	MoH/MOHERST/International Donors/Universities
	c. To train radiation therapist	Number of radiation therapist trained	5 in 6 years	MoH/MOHERST/International partners /UTG
	d. To train Oncology nurses	Number of onco-trained nurses	10	MoH/MOHERST/International Donors/Universities
	e. To train oncopharmacist	Number of onco-pharmacist trained	10	MoH/MOHERST/International Donors/Universities
	f. Develop radiation safety	Developed radiation safety guideline		MoH/MOHERST/International Donors/Universities
	4. Pediatric Oncology			
	To train pediatric oncologist	Number of pediatric oncologists	2	MoH/MOHERST/International Donors/Universities
5. oncology				

To build or strengthen infrastructure/equipment	To train surgical oncologist	Number of oncologists trained	4	MoH/MOHERST/International Donors/Universities
	6. Rehabilitation			
	To provide short training for cancer rehabilitation	Number of officers trained for cancer rehabilitation	2 for each service in	MoH
	7. Palliative			
	To train doctors, nurses, social workers and psychologist on palliative care	Number of doctors, nurses, social workers and psychologist in palliation	2 doctors, 4 nurses, 2 social workers and 1 psychologist	MoH/MOHERST/International Donors/Universities
	1. To establish one oncology centre	Oncology unit/center established	1 in 6 years	MoH/International donors
	2. Radiology			

	a. To provide conventional Ultrasounds USS machines at all cancer care service facilities	Conventional x-ray machines provided in all cancer care service facilities	9	MoH/International donors
	b. To provide a high tesla (at least 1.5T) MRI machine at the oncology center	MRI provided at the oncology center	1	MoH/International donors
	c. To provide higher CT scanner at 3 General Hospitals	3 general hospitals provided with CT scan machine	3	MoH/International donors
	3. Laboratory			
	a. To provide screening equipment for cancers	Screening equipment for cancer provided		MoH/International donors
	b. To provide equipment tissue biopsy	Tissue biopsy equipment provided in all general hospital		MoH/International donors
	c. To provide reagents for cytology studies	Reagents for cytology provided		MoH/International donors
	d. To provide material for immunohistochemistry	Materials for immunohistochemistry		MoH/International donors
	Teleradiology	Established teleradiology	1 in 6 years	

Strategic Objective 6: To strengthen cancer surveillance, research and strategic information systems

Objective	Strategy	Activity	Indicator	Target	Coordinating agent
To monitor and evaluate progress in the implementation of the national cancer control strategy	Strengthen surveillance and M&E for improved data quality and decision making	Develop and produce M&E guidelines for cancer control strategy.	Cancer control strategy developed	1	NCCP
		provide electronic medical records (EMR) system for all cancers in the NCD clinics to improve patient management and care including referrals between health facilities.	Existence of electronic medical records (EMR)	1	NCCP/DPI
		Conduct periodic cancer surveillance and data collection on risk factors and monitoring national response.	Number of cancer surveillance conducted	Quarterly	NCCP/NCD/EDC
		Support the development of Cancer M&E dashboard	M&E dashboard developed	1	NCCP/DPI

		(preferably electronic) that provide basic information that empowers decision making to improve implementation at each level of access.			
		Provision of monitoring vehicle	Number of vehicles provided	2	MOH/DONORS
Coordination					
To strengthen NCCP capacity, leadership, governance, multi-sectorial action, and partnerships to accelerate country response for the prevention and control of cancer in The Gambia.	Improve coordination and governance for cancer prevention and control	Support the establishment of the National Multi-sectorial Steering Committee on NCDs Prevention and Control chaired by the Office of the President	National Multi-sectorial Steering Committee on of NCDs established with clear TOR	1	NCD sister programs
		Establish a Multi-sectorial Technical Working Group (MTWG) on cancer	MTWG established with clear TOR	1	NCCP

<p>Strengthen national capacity and leadership to accelerate and scale up the national response to cancer epidemic</p>	prevention and control.			
	Strengthen National Cancer Control Program	Number of staff trained. The number of trains conducted Proposition of office equipment provided.	4	NCCP/MOH/Donors
	Expand the availability of program staff to manage Cancers at different levels	Number of staffs enrolled.	25	MOH/DHRH
	Train or orient personnel of other sectors on the complexities of Cancer	Number of personnel trained/oriented	50 annually	NCCP/D. Partners
	Strengthen infrastructure and capacity for prevention and	Number of facilities capacitated for	25	NCCP/MOH/D. Partners

		early detection of Cancer at all levels.	prevention and early detection		
		Engage and train community-based organizations as "Cancer change agents" to promote/facilitate dialogues that catalyse society-wide change.	Number of community-based organizations engaged/trained.	35 annually	NCCP/DHPE/Partners
		Conduct periodic community-based screening for cancer and their risk factors.	Number of community-based screening conducted	35 annually	NCCP
		Conduct periodic public awareness campaign on Cancer and their risk factors.	Number of periodic public awareness campaign conducted	28 annually	NCCP/NCD/DHPE/Partners

Partnership

To enhance the multi-sectoral approach in cancer intervention	Build strong public-private Partnerships for Cancer prevention and control.	Organize annual Public Private Partnerships forum for the prevention	The proportion of annual Public	Bi-annually	NCCP
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		and control of cancer	Private Partnerships meetings conducted		
		Strengthen collaboration at all levels among governmental agencies, intergovernmental organizations, nongovernmental organizations, civil society, communities, and the private sector to prevent and control cancer.	Number of stakeholders engaged. Number of collaboration meetings conducted	40 Once Biannually	NCCP/Partners
Financing					
To ensure the availability of funding for Cancer Intervention	Enhance innovative financing of Cancer prevention, control, and treatment	Advocate for the increase in the number of cancer services in the benefit package covered by health insurance.	Cancer service mainstreamed in the benefit package	1	NCCP/DPI/NHIS

	Advocate for subsidizing expensive cancer services for the most vulnerable/poor patients.	Cancer service subsidized	1	MOH/MOFEA
	Development of proposals for funding specialized cancer services	Number of proposals developed	2 per year	NCCP
	Advocate for the allocation of some percentage of tax collected on cancer-causing agents	percentage of tax collected on cancer-causing agents given	5%	MOH/MOFEA
	Conduct annual donor conference	Proportion of donor conference	Bi-annually	NCCP/MOH

Strategic Objective 7: To strengthen cancer surveillance, research and strategic information systems

Objective	Strategy	Activity	Indicator	Target	Coordinating agent
Advocacy, Communication and Social Mobilization					
	Increase public awareness on cancer prevention and control	Develop national cancer advocacy and communication plan			
		Develop communication messages and guidelines on cancer			
		Support commemoration of international days in support NCD prevention and control including cancer			
		Train stakeholders on the implementation of the national cancer advocacy and communication plan			

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