

ADVOCACY TOOLKIT

WHAT? HOW? WHY?



WHAT?

The Toolkit is grouped into 3 sections for easy use:



KEY ADVOCACY MESSAGES

- A guide to understand how the Political Declaration of the 2011 UN High-Level Meeting on NCDs aligns with the targets of the World Cancer Declaration
- How to get involved in global cancer advocacy
- A visual guide to assist with presentation of key messages



A SERIES OF PRACTICAL TOOLS TO GUIDE YOUR ADVOCACY

- How to work with media
- How to influence your government
- How to build an advocacy plan



EVIDENCE SHEETS

- A series of 15 Evidence Sheets that summarise the supporting data for actions that are aligned with achieving the World Cancer Declaration targets.

A bibliography of materials referred to in the toolkit is included.

WHY?

The toolkit aims to respond to some of the many challenges for cancer advocates in influencing change in public perception, practice and policy:

CREDIBILITY

Evidence is powerful. While the UN High-Level Meeting on NCDs placed cancer on the global political agenda, the challenge remains to convince governments that proven cost-effective solutions exist to reduce the cancer burden. The toolkit provides evidence sheets in 15 key areas in cancer prevention and control to help you support your case for action.

SUSTAINABILITY

Keep up momentum. It is essential that the promises made by governments in the UN Political Declaration on NCDs be turned into action for people affected by cancer. Understanding these promises, how they can be used in cancer advocacy and communicating these messages to government and the media are key to ensuring that momentum is not lost in taking action at country, regional and global levels.

CAPACITY

Be part of the global movement for action. Assisting UICC in its global advocacy campaign is a key way to build capacity for cancer advocacy and ensure that cancer is addressed as part of the global public health and development agenda.

HOW?

The components of this toolkit can be selected depending on your needs and priorities. All of the components can be selected individually and are also available from the UICC website:

www.uicc.org/advocacy/advocacy-toolkit

IF YOU WOULD LIKE TO DISCUSS THE CONTENTS OF THIS TOOLKIT OR SUGGEST ADDITIONAL TOOLS, SKILLS AND STRATEGIES, PLEASE CONTACT

ADVOCACY@UICC.ORG

THE WORLD CANCER DECLARATION AND UN POLITICAL DECLARATION:

UNDERSTANDING THE LINKS



In September 2011, the adoption of the Political Declaration of the High-Level Meeting on the Prevention and Control of Non-communicable diseases (NCDs) by the 193 Member States of the United Nations provided the global cancer community with a robust platform to launch the next phase of advocacy to ensure World Cancer Declaration targets are met by 2020. If we want to achieve real progress towards the 11 targets of the World Cancer Declaration, we must now work together to mobilise our collective resources to maintain pressure on governments to implement the commitments made in the Political Declaration.

A KEY ACTION IS TO UNDERSTAND AND COMMUNICATE TO OTHERS THE PROMISES MADE BY GOVERNMENTS ON CANCER IN THE POLITICAL DECLARATION AND HOW THEY ARE LINKED TO THE WORLD CANCER DECLARATION TARGETS.



WORLD CANCER DECLARATION TARGET 1

ENSURE EFFECTIVE DELIVERY SYSTEMS IN ALL COUNTRIES

WHAT THE UN POLITICAL DECLARATION SAYS

Promote, establish or support and strengthen multisectoral national policies and plans for the prevention and control of NCDs.



WORLD CANCER DECLARATION TARGET 2

SIGNIFICANTLY IMPROVE MEASUREMENT OF CANCER BURDEN

WHAT THE UN POLITICAL DECLARATION SAYS

Strengthen information systems for health planning and management, including through the collection, disaggregation, analysis, interpretation, and dissemination of data and the development of population-based national registries and surveys.



WORLD CANCER DECLARATION TARGET 3

DECREASE TOBACCO, ALCOHOL CONSUMPTION AND OBESITY

WHAT THE UN POLITICAL DECLARATION SAYS

Reduce individuals' exposure to common cancer risk factors namely tobacco use, unhealthy diet, physical inactivity and the harmful use of alcohol through the implementation of relevant international agreements and strategies, and education, legislative, regulatory and fiscal measures.



WORLD CANCER DECLARATION TARGET 4

ENSURE UNIVERSAL COVERAGE OF THE HPV/HBV VACCINE

WHAT THE UN POLITICAL DECLARATION SAYS

Promote increased access to cost-effective vaccinations to prevent infections associated with cancers as part of national immunisation schedules.



WORLD CANCER DECLARATION TARGET 5

DISPEL DAMAGING MYTHS AND MISCONCEPTIONS

WHAT THE UN POLITICAL DECLARATION SAYS

Develop, strengthen and implement multisectoral public policies and action plans to promote health education and health literacy including through evidence-based education and information strategies and programmes in and out of schools, and through public awareness campaigns.



WORLD CANCER DECLARATION TARGET 6

MORE CANCERS DIAGNOSED VIA SCREENING AND EARLY DETECTION

WHAT THE UN POLITICAL DECLARATION SAYS

Promote increased access to cost-effective cancer screening programmes.

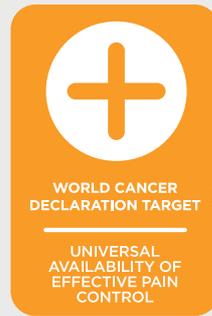


**WORLD CANCER
DECLARATION TARGET 7**
IMPROVE ACCESS TO
DIAGNOSIS, TREATMENT,
REHABILITATION AND
PALLIATIVE CARE

WHAT THE UN POLITICAL DECLARATION SAYS

Increase access to affordable, safe, effective and quality medicines, diagnostics and other technologies to diagnose and treat NCDs.

Improve access to services for prevention, treatment, palliation and rehabilitation particularly at the community level.



**WORLD CANCER
DECLARATION TARGET 8**
UNIVERSAL
AVAILABILITY OF
EFFECTIVE PAIN
CONTROL

WHAT THE UN POLITICAL DECLARATION SAYS

Promote increased access to affordable, safe, effective and quality medicines including generics and sustainable access to medicines through the efficient procurement and distribution of medicines in countries.



**WORLD CANCER
DECLARATION TARGET 9**
IMPROVE TRAINING
OPPORTUNITIES FOR
CANCER CONTROL
PROFESSIONALS

WHAT THE UN POLITICAL DECLARATION SAYS

Promote the production, training and retention of health workers with a view to facilitating adequate deployment of a skilled health workforce within countries and regions in accordance with the World Health Organization Global Code of practice on the International Recruitment of Health Personnel.



**WORLD CANCER
DECLARATION TARGET 10**
REDUCE EMIGRATION
OF HEALTHCARE
WORKERS SPECIALIZED
IN CANCER

WHAT THE UN POLITICAL DECLARATION SAYS

Promote the production, training and retention of health workers with a view to facilitating adequate deployment of a skilled health workforce within countries and regions in accordance with the World Health Organization Global Code of practice on the International Recruitment of Health Personnel.



**WORLD CANCER
DECLARATION TARGET 11**
MAJOR IMPROVEMENTS
IN GLOBAL CANCER
SURVIVAL RATES

WHAT THE UN POLITICAL DECLARATION SAYS

The Political Declaration does not include an overall goal of reducing premature deaths. More work is now needed to convince governments around the world to commit to reduce premature deaths from NCDs by 25% by 2025.

HOLD YOUR GOVERNMENT ACCOUNTABLE

The Political Declaration is a tool to assist you to hold your government responsible for action. Consider using the Political Declaration and the links to the World Cancer Declaration to:

- Remind your government of their commitments to cancer
- Assist governments with proven, cost-effective solutions that address cancer in your country
- Monitor progress against commitments to reducing your national cancer burden



THE POLITICAL DECLARATION IS AVAILABLE IN THE 6 UN LANGUAGES
AT: WWW.UICC.ORG/ADVOCACY/NCDS-POLITICAL-DECLARATION



SUPPORT UICC'S GLOBAL ADVOCACY WORK

HOW UICC MEMBERS CAN GET INVOLVED

UNDERSTAND YOUR GOVERNMENT'S COMMITMENTS, AND IDENTIFY YOUR OWN PRIORITIES

This will help you to identify areas of synergy and the potential for collaboration, as well as key advocacy targets

TAKE ACTION: Find out what your government has agreed to in the 2011 UN Political Declaration on NCDs. Did your government make any financial commitments to cancer as a result of the High-Level Meeting on NCDs? Identify the priorities for cancer control and prevention in your country and assist your government to meet these commitments. Use UICC's Supporting Evidence Sheets to provide governments with evidence for proven, cost-effective solutions and appropriate national targets and indicators.

SHARE KNOWLEDGE, MATERIALS, CASE STUDIES AND GOOD PRACTICES THAT UICC, ITS MEMBERS AND PARTNERS CAN LEARN FROM

This is a great opportunity to learn from UICC's diverse network, as well as to profile your organisation and its achievements

TAKE ACTION: Send us a story about a cancer control programme (prevention, early detection, treatment, or palliative care) that is working well in your country to be featured on: <http://www.uicc.org/advocacy/case-studies>.

DISSEMINATE UICC'S KEY MESSAGES AND MATERIALS TO POLICY-MAKERS, MEDIA, PUBLIC, PARTNERS, DONORS

If UICC's membership network (of over 475 members in 125 countries) can voice the same key messages worldwide, we can ensure that cancer is firmly placed on the global health and development agenda

TAKE ACTION: Use UICC template letters, press releases and evidence sheets when organising strategic meetings, press conferences, and public awareness raising events to raise the profile of cancer and highlight our key messages.

WORK IN PARTNERSHIP, AND PARTICIPATE IN KEY MEETINGS, EVENTS, AND NETWORKS FOR CANCER AND NCD-RELATED ISSUES

This will expand your sphere of influence and impact

TAKE ACTION: Join your national NCD Alliance or start an NCD Alliance in your country, connect with your regional/national WHO office, broaden your network to include organisations in development, law, economics, as well as in the private sector, and join forces with other cancer advocates in your country/region to strengthen the cancer voice.

KEY ADVOCACY MESSAGES

CANCER MUST BE INCLUDED IN THE POST-2015 DEVELOPMENT AGENDA

The global cancer burden is huge and is set to rise to an estimated 21 million new cancer cases and 12 million cancer deaths per year by 2030; with low and middle-income countries bearing a disproportionate burden and millions of people pushed further into poverty as a result. Cancer is not just a health matter; it has wide-reaching social, economic, development, and human rights implications and must be reflected in the Millennium Development Goal (MDG) successor goals that will be adopted in 2015.

A GLOBAL MULTISECTORAL RESPONSE IS NEEDED TO ADDRESS CANCER

The scale of the cancer burden requires a global multisectoral response including governments, academia, private sector, health professionals, civil society and individuals.

THERE ARE PROVEN COST-EFFECTIVE SOLUTIONS FOR REDUCING THE CANCER BURDEN

Proven cost-effective solutions for reducing the burden exist across the whole cancer care continuum (including in prevention, early detection, treatment and care) and are recognised in the 2011 UN Political Declaration on NCDs e.g. tobacco control, cervical and breast cancer screening, and HPV and HBV vaccines.

THE ECONOMIC COST OF CANCER FAR OUTWEIGHS THE COST OF INVESTMENT IN PREVENTATIVE MEASURES

The economic cost of cancer, estimated to reach US\$458 billion in 2030 far outweighs the cost of investing in preventative measures; population-based measures to reduce risk factors (tobacco, unhealthy diet, harmful alcohol use and physical inactivity) for all NCDs including cancer are estimated at just US\$2 billion per year for all low and middle income countries.

WHAT GETS MEASURED GETS DONE

Governments should be held accountable for the commitments made in the 2011 UN Political Declaration. Working in partnership, together we must encourage governments to develop appropriate country-level targets and indicators before the end of 2012, against which progress on cancer-related commitments can be measured.

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CHECKLIST

HOW DO JOURNALISTS WORK



- Journalists want to understand the topic, tell an interesting story and be recognised for bringing subjects to life for their audience.
- Journalists want to provide facts, figures and a credible opinion in order to put their story into context for the audience.

PLEASE CONSIDER:

- 1) **Journalists have rigid professional ethics** that must be taken into account when decisions on the importance or validity of a story must be made.
- 2) **The journalist's job is to write about you and others** – not to write for you.
- 3) **The journalist has the right to quote someone** who might agree or disagree with your opinion.
- 4) **Your message competes with a multitude of other news items** and journalists have to make difficult choices about what to cover.
- 5) **Choices are driven by newsworthiness** (timely, new and relevant) to their readers, listeners and viewers.
- 6) **The news you have to offer may be of interest to you but not necessarily to an objective outsider.**

MEDIA RELATIONS EFFORTS NEED TO BEGIN WITH CLEARLY ARTICULATED STATEMENTS AND ANSWER THE FOLLOWING FIVE "W'S" TO DEFINE THE STORY.

Who is central to the story?

What is the news you want to report? When answering this question think carefully about what you want this story to accomplish.

Why has it happened?

When did it happen?

What will the consequences be?

- A story must be new, or offer a new angle, in order to be considered news.
- Experts must offer reporters something new, a clear opinion and an additional insight, or they may not write the story or use that expert as a resource and look elsewhere to find the facts needed to write the story. In the worst case they may discount the story completely.

HOW TO WORK WITH MEDIA

CONTENTS

HOW DO JOURNALISTS WORK

HOW TO DEVELOP OR LOCALISE A PRESS RELEASE

HOW TO ENGAGE KEY SPEAKERS / CELEBRITIES

HOW TO PUT TOGETHER A CONTACT LIST

WHO YOU'RE TALKING TO

EXAMPLES OF PRESS RELEASES

NOTES



CHECKLIST

HOW TO DEVELOP OR LOCALISE A PRESS RELEASE



HOW TO DEVELOP A PRESS RELEASE

- 1) **Find an interesting news angle** e.g. new data, activities, important event etc.
- 2) **Define your target group** e.g. wire, trade or consumer journalist
➡ See checklist *Who you're talking to*
- 3) **Develop contact list** ➡ See checklist *How to produce a media list*
- 4) **Develop / write your press release and consider the following:**
 - Why the release is being written?
 - Who is the audience
 - Does the release contain invaluable or newsworthy information that will be used by target audience?
 - What do you want recipients to take away from the press release?

Overall tone and structure

 - **Content:** ensure that the release is grammatically correct and doesn't contain any spelling mistakes, errors, and sources are quoted correctly.
 - **Concise:** keep it punchy and don't use unnecessary flowery language e.g. cutting-edge, revolutionary.
 - **Factual:** present the information for distribution that is true, correct.
 - **Objectivity:** virtually impossible to do, but refrain from using over hyped quotes from sources, as they will be presented as being too biased.
 - **Timing:** The press release may not be topical, but it may be possible to link the release with a more recent news event.
- 5) **Obtain approval of press release** by legal team, communications department, CEO or relevant decision maker within your organisation.
- 6) **Distribute press release** via email, mail or fax (as required by journalist)
➡ See checklist *How to produce a media list*

HOW TO ADAPT OR LOCALISE A PRESS RELEASE

- 1) **Review press release** and decide if there is any need or interest group in your local market/ target group
- 2) **Define your media target group** e.g. wire, trade or consumer journalist
➡ See checklist *Who you're talking to*
- 3) **Develop a contact list** ➡ See checklist *How to produce a media list*
- 4) **Adapt the press release with local information** e.g. statements from local experts/celebrities or local data
- 5) **Obtain approval of your press release** by legal team, the communications department, CEO or relevant decision maker within your organisation.
- 6) **Distribute press release** via email, mail or fax (as required by individual journalist) ➡ See checklist *How to produce a media list*



A PICTURE IS WORTH A THOUSAND WORDS

Take into consideration that a picture can increase interest around your story and therefore the likelihood of it being published.

Most wanted and appropriate images include:

- Prominent people: i.e. President, CEO, local expert (i.e. scientist) or celebrity.
- Graphics or illustrations: i.e. microscope picture of a cancer cell, graphs, pie charts etc.
- Images, which best describe your campaign i.e. "Cancer can be prevented", you could use images that represent a healthy diet, exercise, quitting smoking, physical exercise etc.

For more information on how to write the perfect press release visit:

<http://www.journalism.co.uk/skills/how-to-write-the-perfect-press-release-for-journalists/s7/a535287/#before>



CHECKLIST

HOW TO ENGAGE KEY SPEAKERS / CELEBRITIES



Other than trade reporters, the media are usually not experts on the subjects they cover, which means they depend on their sources (the people they interview) and background research to build their story. Working with the media is about building relationships and establishing yourself as an expert in a given field by bringing credentials, experience and reliability to the story.

THE MEDIA EXPECT EXPERTS TO PROVIDE:

- 1) An educated perspective/ opinion on cancer i.e.:**
 - From the perspective of individual patients and others affected by cancer (i.e. family, carers etc)
 - Physicians (GPs and specialised Medics)
 - Policy influencers
- 2) Relevant support for the information** i.e. studies, statistics, personal clinical experience.
- 3) An explanation why something is happening or how something is working** in order for the general audience to understand the context.

THE MEDIA EXPECT CELEBRITIES:

- 4) To be champions/advocates for the cause**
- 5) To represent the interests of the cause** - i.e. patients, institutions etc.

NOTES

INVOLVING KEY SPEAKERS AND CELEBRITIES REQUIRES DETAILED PLANNING

- 1) Define your target audience** and then establish a clearly defined role for the expert/celebrity.
- 2) Define the type of expert/celebrity to suit your cause and messages** (i.e. you don't want to engage a celebrity that smokes – for an anti-smoking campaign).
- 3) Prepare detailed concept**, which includes key messages and activities related to the expert/celebrity involvement.
- 4) Contact the expert/celebrity** and organise a time to present your concept.
- 5) Discuss expert/celebrity fee** and setting in which the expert/celebrity will be available. Develop a consent form, which clarifies what you are allowed to do with the expert/celebrity materials (e.g. images & footage rights etc.)
- 6) After the expert/celebrity has agreed to support the project/campaign** he/she needs to get essential key messages and guidance on how to deal with journalists
- 7) If possible, organise regular meetings with the expert/celebrity** to build a solid relationship and keep track of their role in your project/campaign targets.
- 8) Make sure you involve experts/celebrities into your approval processes.** Experts/ celebrities will want to approve all their statements/quotes/ images etc.



CHECKLIST

HOW TO PUT TOGETHER A CONTACT LIST



It is important for a successful media campaign to produce a detailed contact list. Each press release should have a customised contact list, based on your target group.

Creating and administering a contact list is hard work. You need to update your list at least once a year so that your contact data are always up-to date. It is also important to select the journalist contacts with regard to their focus, e.g. medicine, science, economics, etc.

NOTES

- 1) **Select a target group for your press release/subject** and the search relevant press services to create a list.

Services:

- www.vocus.com
- www.prnewswire.com
- <http://www.mondotimes.com/topic/wire.html>
(this link provides a comprehensive list of global newswire services)

If you can't afford a service, create your own list by researching your local newspapers, magazines, websites, television news stations etc.

- 2) **Check you have the correct person and all their relevant contact information** (i.e. phone number, email address, fax and postal address).
- 3) **Define how the journalist likes to receive press releases** i.e. as an email, fax, or letter.
- 4) **Modify contact list if & when necessary.**
- 5) **Regularly update your contact list.**





CHECKLIST WHO YOU'RE TALKING TO



The media landscape is very broad, and includes trade publications, daily newspapers, special interest magazines, websites, and radio and TV stations. Below are the general categories to consider.

WIRE JOURNALISTS

Newswires are based on an electronic news flow that allows these journalists to publish immediately on a breaking story. As such, newswires essentially set the scene of a story and serve as the basis for stories written by journalists from other types of media. With urgent news, it is critical to reach these reporters first due to their influence on the coverage that follows.

PRINT - CONSUMER JOURNALISTS

The consumer media generally have more time and ability to place a story into a wider context, requiring more background information and simpler language that a general consumer can understand. This journalist wants to empower the consumer to make choices based on the information provided or educate them enough to know where to seek additional information (e.g. a healthcare provider).

PRINT - TRADE JOURNALISTS

Trade journalists have acquired specific industry knowledge and are very well recognised by their target audience. Usually they are well informed and it is important not to underestimate them. Trade journalists relevant to medical news would include those that cover industries such as medicine, pharmaceuticals, payer/access, etc.

BROADCAST

The number of television and radio channels has grown rapidly and is continuing to proliferate. Broadcast news segments are usually very short therefore the story must be kept straight and simple. Some programmes are longer and may involve the opportunity for listeners to call in with comments or questions. Other shows will collect information and sound bites from several sources and put them together, contributing to a longer segment.

WEB PORTALS

In addition to independent news websites, all of these media outlets listed above will often have a corresponding website that will publish some, but not all, of the same news that appears in print, on television or radio.

NOTES



CHECKLIST EXAMPLES OF PRESS RELEASES



EXAMPLE

UICC PRESS RELEASE FOR THE UN HIGH-LEVEL MEETING ON NON-COMMUNICABLE DISEASES (NCDs)

UICC APPLAUDS THE UN FOR RECOGNISING SCALE OF THE GLOBAL CANCER EPIDEMIC

GENEVA, Switzerland, 19 September 2011 - UICC applauds the UN for recognising scale of the global cancer epidemic during historic summit - nevertheless, member states' commitments fall short.

Every month 600,000 people die of cancer, which with the right strategies, could otherwise be prevented or treated.

In response to this situation and the epidemic of other non-communicable diseases (NCDs), the United Nations (UN) authorised a High-Level Meeting (HLM) to address the prevention and control of these diseases. The outcomes document generated by the HLM - known as a Political Declaration - is only the second of its kind to address a health issue on a global scale, the first being the outcomes document from the 2001 UN General Assembly Special Session on HIV/AIDS.

UICC, on behalf of its member organisations, strongly supports the call for global plans for the prevention and control of NCDs, and welcomes cancer specific commitments to:

- Give greater priority to early detection, screening and diagnosis of NCDs including cancer screening programmes (particularly breast and cervical cancer)
- Increase access to Hepatitis B and HPV vaccines as part of national immunisation programmes to prevent infection-related cancers.

"Whilst specific targets to reduce deaths from NCDs may not have been achieved at the HLM, there is much to be encouraged by", commented Cary Adams, CEO of the Union for International Cancer Control (UICC). "More work is now needed to convince governments to commit to reducing avoidable deaths from NCDs by 25% by 2025 - a target that the World Health Organization (WHO) believes is achievable."

Now that the direction of the UN Political Declaration is known, UICC is committed to working with Governments, WHO, UN Agencies, civil society and other stakeholders to implement the Declaration's commitments. UICC will continue to advocate for additional measures to ensure the global cancer burden is reduced.

The Political Declaration of the UN High-Level Meeting on NCDs is now an important campaigning tool for the global cancer community. UICC will use it to scale-up its advocacy campaign and support its member organisations to lobby governments to meet and implement commitments to reduce the overall impact of the global cancer burden.

SHORT TEASER TO GRAB THE READER'S ATTENTION

INCLUDE DATA/STATISTICS THAT WILL DRAW ATTENTION

LINK TO A RECENT NEWS EVENT E.G. A NEW PUBLICATION, A GLOBAL MEETING, POLICY CHANGE ETC

QUOTE FROM A PROMINENT PERSON E.G. CEO, PRESIDENT

“The process of addressing NCDs globally has been set in motion in the most powerful way, said Mr Adams “UICC is serious about holding the UN and the world’s governments’ accountable”.

UICC and its members will begin the next phase of their advocacy campaign at the World Cancer Leaders’ Summit in Dublin in November where a response to the UN HLM will be outlined in detail.

Notes to editors

The Union for International Cancer Control (UICC) has been working to achieve its primary objective of securing an outcomes document from the UN HLM which supports the long term delivery of the 11 targets contained in the World Cancer Declaration.

Additionally, as a founding member of the NCD Alliance, UICC has been at the forefront of the civil society campaign to put NCDs on the global political agenda.

About UICC

UICC is a membership organisation that exists to help the global health community accelerate the fight against cancer.

Founded in 1933 and based in Geneva, UICC’s growing membership of over 460 organisations across 120 countries, features the world’s major cancer societies, ministries of health, research institutes, treatment centres and patient groups. Together with its members, the World Health Organization, World Economic Forum and other key partners, UICC is tackling the growing cancer crisis on a global scale.

It has responsibility for the World Cancer Declaration, World Cancer Day, the World Cancer Congress and the World Cancer Leaders’ Summit. Additionally, it is a founding member of the NCD Alliance, a global civil society network that now represents almost 2000 NCD organisations in 170 countries.

Media contacts

For more information please contact xxxxx

Email: xxxxx

Telephone xxxxx

USE THE “NOTES” SECTION TO INCLUDE ANY ADDITIONAL INFORMATION THAT DOESN’T NEED TO APPEAR IN THE MAIN TEXT E.G. YOUR ORGANISATION’S DETAILS AND CONTACT INFORMATION



HOW TO MAKE YOUR POINT WITH GOVERNMENT



Each sector of government (e.g. health, finance, agriculture, legal) has its own policy development and legislative process.

The issues facing the cancer community and people affected by cancer frequently cross sector boundaries, so it may be relevant to raise issues with a number of different government representatives.

The UN Political Declaration on NCDs highlights the need to work across sectors – go beyond your health minister and communicate key messages that can be understood by other ministers or government officials. For example, Ministers of Finance should know the cost of inaction versus the impact of investment in initiatives to reduce the cancer burden.

RELEVANT ACTIONS:

- Letters to politicians
- Meetings with politicians (or with Ministers or their staff)
- Media release (attracting media that will influence politicians)

CHECKLIST “HOW TO WRITE A LETTER TO A POLITICIAN”

How to write a letter to a government representative, e.g. Minister of Health or Minister of Finance

1) Know your facts

What is the key message to communicate to the politician and what is the evidence that supports your argument e.g. a report, a publication, personal experience.

2) Identify the sector(s) of government that holds responsibility for your issue and the proposed solutions.

For example, Minister of Finance, Minister of Health, Head of Development Agency, Head of Government, etc.

3) Develop a Government contact list

Know who are the key government contacts for your issue.

4) Develop your letter and consider the following:

- Why the letter is being written?
- Who is the audience?
- Are you able to support your request with evidence?
- What is the support at the local, regional and global levels?
- What is the intended impact of the letter?
- Do you intend there to be a follow-up to your letter? For example, request a meeting with the Minister.

5) Write the letter:

- **Content:** Accentuate the positive: while the message you are trying to convey may be critical of the government's position, try to also highlight a positive action, for example, all governments endorsed the UN Political Declaration on NCDs.
- **Concise:** keep it punchy and to the point; make sure the message is clear.
- **Factual:** present the evidence and indicate the level of support – do other countries support your request?
- **Timing:** Indicate if the issue is linked to an upcoming event, e.g., World Cancer Day, World Health Assembly, and state why this event is significant for this issue.

6) Obtain approval of letter by CEO or relevant decision maker within your organisation.

7) Distribute letter by email or post or both depending on context.

8) Alert other organisations in your network of your letter, share it, and ask them to support your efforts.

EXAMPLE

LETTER TO HEAD OF STATE OR GOVERNMENT REGARDING ACTIONS FOR G20 MEETING IN CANNES, FRANCE NOVEMBER 2011

Dear <HEAD OF STATE OR GOVERNMENT>

We are writing on behalf of <ORGANIZATION> ahead of your participation in next week's **G20 Summit in Cannes, France**, where some of the world's most urgent problems will be addressed. As you will know, G20 nations represent some 85 percent of global economic output and two-thirds of the world's population; and therefore share a collective responsibility to provide leadership in global development and poverty eradication.

LINKS TO AN EVENT

Last month, more than thirty Heads of State, including several from the G20, attended a **UN High-Level Meeting in New York** to pledge **their support** for concrete action to prevent and control a major cause of world poverty: non-communicable diseases (NCDs), which include cancer, cardiovascular disease, chronic respiratory diseases and diabetes.

INDICATES HIGH LEVEL SUPPORT

NCDs are a significant driver of economic loss and instability. A recent study by the World Economic Forum and Harvard University estimates that **NCDs will cost the world economy \$47 trillion over the next 20 years**, representing 75 percent of annual global GDP and surpassing the cost of the global financial crisis. Yet, the World Health Organization estimates that a basic package of cost effective strategies to prevent and treat NCDs would cost only \$11.4 billion a year across all low- and middle- income countries.

PRESENTS THE EVIDENCE

This year's Chair, France, along with other G20 members such as Germany and South Africa, has requested your support for a Financial Transactions Tax that would ensure a renewed global effort in the fight against poverty and ill-health.

The G20 Summit is a critical opportunity to reverse the NCD epidemic. We believe the Financial Transactions Tax proposed by G20 members could greatly assist this aim and **urge you to support this initiative at next week's Summit.**

CLEAR REQUEST

We wish you a successful meeting and look forward to your continued support for action on NCDs.

Yours sincerely,

<YOUR DETAILS>

EXAMPLE

LETTER TO MINISTER OF FINANCE REGARDING FOLLOWING UP THE COMMITMENTS IN THE POLITICAL DECLARATION

Dear <MINISTER>

I would like to convey my congratulations on your government's support for the Political Declaration of the High-Level Meeting of the UN General Assembly on the Prevention and Control of Non-Communicable Diseases (UN Resolution A/RES/66/2), which commits governments to take action to reduce the global burden of cancer and other non-communicable diseases (NCDs).

ACCENTUATE THE POSITIVE

I am writing today on behalf of <ORGANIZATION> to assure you of our full support to work in partnership to implement the actions contained within this Political Declaration.

<CLEAR MESSAGES ON NATIONAL CANCER BURDEN, FOR EXAMPLE: Today in Mexico, 2 in 3 people will get cancer and every day 35 women are diagnosed with breast cancer and 14 women will die of their disease.>

STATE THE FACTS!

In acknowledgement of the scale of the problem, we are seeking a commitment from all sectors of government to promote policies and approaches that will strengthen and facilitate multisectoral action and include strong consultation with civil society, UN agencies, donors, employers and individuals, families and communities affected by cancer.

We want to highlight the staggering cost of this crisis to our country's economic development. A recent study by the World Economic Forum and Harvard University estimates that NCDs will cost the world economy \$47 trillion over the next 20 years, representing 75 percent of annual global GDP and surpassing the cost of the global financial crisis. Yet, the World Health Organization estimates that a basic package of cost effective strategies to prevent and treat NCDs would cost only \$11.4 billion a year. It is clear that for every dollar spent on cancer in our country there is a return on investment, yet presently there is an enormous disparity between the size of the burden and the level of investment.

We would greatly appreciate the opportunity to discuss the UN High Level Meeting and share our perspectives with your government.

We hope that you will agree with us that the cost of ignoring the cancer epidemic is too high for our country and that action is needed to reverse the immense burden on our population.

Yours sincerely,

<YOUR DETAILS>



HOW TO BUILD AN ADVOCACY PLAN

A SELF-ASSESSMENT CHECKLIST



Effective advocacy requires clear communication of key messages to the right audience. Strategies need to be developed to target activities to have the greatest impact.

This self-assessment checklist is designed for UICC member organisations that are actively engaged in advocacy or those who are exploring their role as advocates. Its purpose is to provide thinking points to help you identify areas that are already working well, and areas that need to be strengthened.

We hope that you will use this tool when reflecting on your current advocacy plans and practices and that it helps you in planning your future advocacy actions.

THE CHECKLIST CONSISTS OF A SERIES OF QUESTIONS THAT ARE BASED ON THE FOLLOWING THEMES:

- Environment
- Action
- Strategy
- Networking
- Evaluation

ENVIRONMENT

1) Does your organisation map the environment to identify factors that may affect advocacy outcomes, including:

- Current government leadership
- Public support for change
- Policy environment

2) Does your organisation know the key decision makers in your country and region?

- Heads of government
- Ministers of Health, Finance and Education
- WHO Country and Regional office representatives
- Donors and Funding Agencies
- Relevant private sector organisations

3) Are your organisation's advocacy activities aligned with key country and/or regional priorities for cancer?

For example, where it exists, are your organisation's activities aligned with the National Cancer Control Plan?

4) Do your organisation's advocacy efforts actively involve people affected by cancer and community stakeholders?

ACTION

1) Have you identified your target audience e.g., government, media, donors?

2) Are your advocacy resources directed at different audiences?

3) In formulating your advocacy messages for different audiences, do you consider:

- The channel of communication (e.g., personal contact, letter, webinar) that is best for your intended audience?
- The most appropriate messages for that audience?

4) Does your organisation consider the best spokesperson for each audience?

5) Does your organisation align the timing of your advocacy activities with major events, including:

- International or national meetings that bring together the major stakeholders?
- February 4: World Cancer Day?

6) Does your organisation develop and maintain media support through personal contacts, press releases, and press conferences?

STRATEGY

- 1) Has your organisation established a clear long-term goal for its advocacy work?
- 2) Are SMART (specific, measurable, achievable, relevant and time-bound) objectives used to develop your advocacy plan?
- 3) Does your organisation's advocacy strategy for cancer take an integrated approach to preventing and controlling Non Communicable Diseases (NCDs)?
- 4) Will your organisation's advocacy efforts help to progress the World Cancer Declaration targets?
- 5) **Do your advocacy efforts link the action with global treaties, policies or declarations?** For example, are the actions linked to commitments contained in the United Nations Political Declaration on NCDs?
- 6) Are your advocacy messages designed to motivate your audience to act by giving them a proven solution to the issue (e.g., increase taxes, regulate advertising to children, increase training opportunities for health workers).
- 7) Do your advocacy messages include case studies showing the effectiveness of a proven solution to the issue?
- 8) Do your key messages include arguments for the cost-effectiveness of preventing and control of cancer?

NETWORKING

- 1) Does your organisation develop strategic partnerships and coalitions with organisations and institutions that share common goals and policy interests, resulting in joint advocacy action? For example, National NCD Alliances.
- 2) **Does your organisation promote active participation in partnerships and coalitions through:**
 - Participating in discussion forums, e.g., Common Interest Group of the NCD Alliance
 - Sharing of advocacy resources
 - Participation in conferences, e.g., the World Cancer Congress
- 3) Has your organisation identified a staff member to take the lead in working with partnerships and coalitions?

EVALUATION

- 1) Has your organisation developed reliable indicators to evaluate and monitor the effectiveness of advocacy efforts?
- 2) Does your organisation collect data on these indicators to measure the impact of advocacy activities?
- 3) Are the data collected used to assess which strategies and activities have been the most successful, and why? Or why not?
- 4) Does your organisation share the lessons learned with your staff and stakeholders on the effectiveness of your advocacy efforts?
- 5) Do you use the lessons learned to improve your advocacy efforts?
- 6) Are resources allocated to implement changes to improve your advocacy efforts?

NATIONAL CANCER CONTROL PLANS

IMPLEMENTATION OF NATIONAL CANCER CONTROL PLANS WHICH ADDRESS CANCER PREVENTION, DETECTION, TREATMENT, ESSENTIAL MEDICINES, TECHNOLOGIES AND PALLIATIVE CARE



THE FACTS

A National Cancer Control Programme (also referred to as National Cancer Control Plan or NCCP) is a public health programme designed to reduce the number of cancer cases and deaths, and improve the quality of life of cancer patients.

NCCPs promote the systematic and equitable implementation of evidence-based strategies for prevention, early detection, diagnosis, treatment, and palliation, making the best use of available resources¹.

The World Health Organization (WHO) has published several resources to support countries in the establishment of effective NCCPs. It recommends that NCCPs should be informed by a systematic review of the cancer burden of a country and identify structures, service delivery mechanisms and cost-effective interventions to successfully address this burden. NCCPs should also adhere to a set of broad guiding principles including: systematic decision making processes based on evidence, social values and efficient use of resources; partnership among different disciplines and sectors; and continual improvement, innovation and creativity².

While many countries recognise the need to develop NCCPs, few industrialised countries, and even fewer in low- and middle- income countries have done so. Moreover, many of the plans that have been developed contain serious inconsistencies between the goals and the practical actions needed to meet them.

A recent study of NCCPs in European countries found that 19 countries (out of 31 countries studied) had developed NCCPs. In several cases however, elements crucial to the efficacy of the plans such as financing, resource allocation or governance were missing or inadequate. Only nine of the NCCPs stipulated a figure for macro-financing of the plans, and just four detailed how these resources would be allocated³.

NCCPS ARE A VITAL INVESTMENT IN UNDERSTANDING AND RESPONDING TO THE CANCER BURDEN IN ALL COUNTRIES



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“WE HAVE LEARNT THAT NO MATTER WHAT RESOURCE CONSTRAINTS A COUNTRY FACES, A WELL-CONCEIVED, WELL-MANAGED NATIONAL CANCER CONTROL PROGRAMME IS ABLE TO LOWER CANCER INCIDENCE AND IMPROVE THE LIVES OF PEOPLE LIVING WITH CANCER.”

Director General of the World Health Organization (2002)

“THROUGHOUT THE PAST TEN YEARS, THERE HAVE BEEN NUMEROUS ACCOMPLISHMENTS AT THE NATIONAL, STATE AND LOCAL LEVELS ACROSS ALL COMPREHENSIVE CANCER CONTROL PROGRAMMES. THOSE INVOLVED TAKE PRIDE IN THESE ACCOMPLISHMENTS BECAUSE THEY HAVE HAD AN IMPACT IN SAVING LIVES AND BUILDING SUSTAINABLE DIRECTION FOR THE FUTURE.”

CDC, The Comprehensive Cancer Control Movement: Ten Years of Success⁴



The Political Declaration of the United Nations High-Level Meeting on the Prevention and Control of NCDs adopted unanimously in September 2011 by 193 Member States, contains commitments that are aligned with the targets of the World Cancer Declaration.

The Political Declaration promotes the establishment of multisectoral national policies and plans for the prevention and control of NCDs including cancer.

SUPPORTING EVIDENCE

At least one-third of new cases of cancer each year are preventable, for example by controlling tobacco and alcohol use, improving diet and exercise, and immunising against cancer causing infections such as hepatitis B virus and human papillomavirus. Early detection and effective treatment of cancers could avert thousands more deaths every year. However, the lack of comprehensive approaches to cancer prevention, diagnosis and care, weaknesses in organisation and priority-setting, and inefficient use of resources in many countries, result in millions of preventable cancer deaths every year.

In the USA for example, since 1998 the Centre for Disease Control and Prevention (CDC) has been supporting states nationwide to develop and implement Comprehensive Cancer Control Programmes (CCCP) that promote healthy lifestyles and recommended cancer screenings, educate people about cancer symptoms, increase access to quality care, and enhance cancer survivors' quality of life. According to the CDC, Cancer Control Programmes are supporting efforts to: reduce the cancer risk, find cancers earlier, improve treatments, and increase the number of people who survive cancer⁴.



MEETING THE CHALLENGE

A multisectoral approach: The development and implementation of successful NCCPs requires the involvement and commitment of multiple stakeholders including Government, UN agencies, private sector, civil society, and health professionals. Civil society has a particularly important role to play, not only in providing technical support for the development of NCCPs, but also in building the capacity of health systems to implement, monitor and evaluate the agreed plan.

UICC develops practical guidance material aimed at NGOs and other civil society organisations for the development and implementation of cancer planning actions for maximum impact. UICC's National Cancer Control Planning Resources⁵ draws on existing literature and feedback from countries that have developed or are in the process of developing NCCPs, and includes practical suggestions and case studies.

Population-based Cancer Registries: Above all, the development of accurate and effective NCCPs requires up-to-date information on the occurrence and outcome of cancer in a country, which can only be collected through population-based cancer registries.

CASE STUDY

NATIONAL PLAN FOR THE PREVENTION AND CONTROL OF CANCER IN MOROCCO

The development of the National Plan of Action for the Prevention and Control of Cancer in Morocco was the result of strong political leadership, with notable support from Princess Lalla Salma, and a common commitment among health actors to reduce the incidence and mortality of cancer in Morocco where there are 30,000 new cases of cancer each year.

The Moroccan government undertook extensive research to gather data on the national cancer burden. This was used to identify the country's major cancer control needs, set priorities for action, and serve as a baseline for evaluation. The data collected (including incidence data; demographics; information on applicable regulation and legislation, and the needs of health care practitioners and patients) revealed several problems including: inadequate primary prevention activities; lack of structured programmes for early detection; poor management of available resources; and lack of a communication strategy on cancer.

Based on the results of this situation analysis, six workshops were organised by the ALSC (Association Lalla Salma de Lutte Contre le Cancer) and the Ministry of Health to develop a specific strategy for each of the five areas to be covered in the NCCP: prevention, early detection, diagnosis and treatment management, palliative care, communication and legislation. The Plan was accompanied by a clear budget estimate and matched by the required financing. A set of indicators was also defined to be monitored throughout the implementation of the Plan including the number of women screened for breast and cervical cancer, and the number of functional screening structures operating nationwide.

For more information on Morocco's NCCP please visit:
<http://www.contrelecancer.ma/fr/Plan%20Anglais%202010-2019.pdf>



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CANCER REGISTRIES



THE FACTS

Population-based registries collect information on the occurrence and outcome of cancer in defined population groups (usually the inhabitants of a city, region, or country).

For each new cancer case, registries record details of the individual affected, the nature of the cancer, information on treatment, and on follow-up, especially with respect to survival from the disease.

A GLOBAL SOLUTION

Regardless of a country's resource setting, cancer registries play an important role in research into the cause of cancer, by providing data on patterns and trends. They are also crucial for the development and monitoring of successful National Cancer Control Plans, and for identifying priorities in public health. Registries must identify reliable sources of data; establish data validation procedures, and quality control measures. To ensure that cancer cases are properly recorded, and that the statistical data gathered can be used to make valid comparisons, cancer registries should also conform to accepted working practices and standards. The International Agency for Research on Cancer (IARC) only uses regional and national data that are considered to meet high standards of completeness and validity to publish the Cancer Incidence in 5 Continents (CI5) series. In the latest volume IX of CI5, only 8% of the world population is represented, predominantly from high and middle income regions. Working to improve not only the quantity but quality of population-based registries, particularly in low- and middle-income countries (LMICs) is therefore critical.

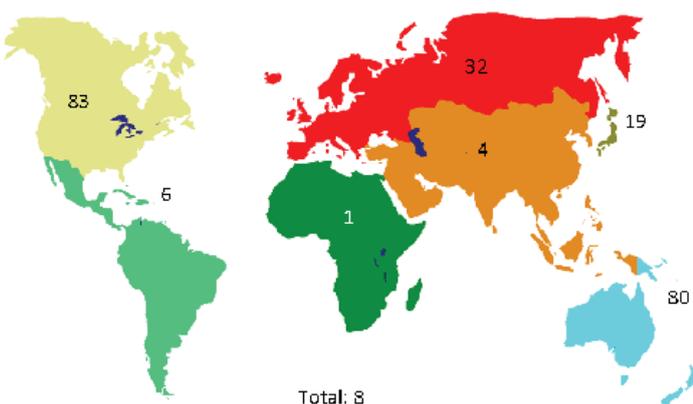
SUPPORTING EVIDENCE

As the only available source of reliable, population-based information on cancer incidence, prevalence and survival rates, cancer registries have an essential role in the implementation and monitoring of initiatives which aim to improve the quality of care and survival prospects for cancer patients. Cancer registries also undertake a range of public health surveillance and health protection functions, with cancer registration information being specifically used to:

- Monitor trends in cancer incidence, prevalence and survival across time, and among different areas and social groups.
- Evaluate the effectiveness of cancer prevention and screening programmes.
- Evaluate the quality and outcomes of cancer care, through the provision of comparative data about treatment patterns and outcomes.

CONTINUED OVERLEAF

FIGURE 1: % POPULATION COVERED BY CANCER REGISTRIES WITH DATA OF SUFFICIENT QUALITY FOR INCLUSION IN CANCER INCIDENCE IN FIVE CONTINENTS, VOLUME IX



SOURCE: INTERNATIONAL AGENCY FOR RESEARCH IN CANCER, 2011



The Political Declaration of the United Nations High-Level Meeting on the Prevention and Control of NCDs adopted unanimously in September 2011 by 193 Member States, contains commitments that are aligned with the targets of the World Cancer Declaration.

The Political Declaration promotes the development of population-based national registries.

AS OF 2006, ALMOST 80% OF THE WORLD POPULATION WAS NOT COVERED BY POPULATION-BASED CANCER REGISTRIES, MOST LIVING IN LOW- AND MIDDLE-INCOME COUNTRIES.

SUPPORTING EVIDENCE CONTINUED

- Evaluate the effect of environmental and social factors on cancer risk and support other investigations into the causes of cancer. In the UK for example, cancer registration information has been used to investigate cancer risks in relation to power lines, landfill sites and mobile phones.
- Investigate differences in cancer incidence, survival and access to treatment among social groups and thus contribute to programmes aimed at reducing inequalities in health outcomes.
- Support the work of cancer genetic counselling services for individuals and families who have a higher risk of developing cancer.
- Support recalls of specific groups of cancer patients, for example women who were treated for Hodgkin's disease with radiotherapy and may have an increased risk of developing breast cancer¹.

CASE STUDIES

LEVERAGING COLLABORATIONS TO ESTABLISH CANCER REGISTRIES IN LMICS: THE CANCER REGISTRY IN CALI, COLOMBIA

Some countries have successfully established cancer registries by collaborating directly with academic institutions. One such registry is the Cancer Registry in Cali, Colombia, the first and longest-running population-based cancer registry in Latin America, which covers a population of 1.8 million people. Dr. P. Correa started the registry in 1962, in the Department of Pathology of Del Valle University, and it has continued uninterrupted operations ever since.

The National Cancer Institute in the U.S. provided training and guidance, and assisted with securing the initial funding for the registry⁴. Since its inception, the registry has been financed and maintained primarily by an academic institution, the Del Valle University, with a small budgetary allocation⁵.

Data from the Cali Cancer Registry have been published in seven volumes of CI5, a tribute to the data's quality and completeness⁶. Data from the Cali Cancer Registry have guided targeted interventions that have led to improved outcomes. For example, high incidence rates of cervical cancer prompted national screening programmes. Screening successfully resulted in a shift in stage at diagnosis, with lower rates of invasive cervical cancers and more identification of in situ cancers⁷. In 1998, the Cali Cancer Registry participated in the creation of a new population-based cancer registry in the southern city of Pasto. The Pasto Cancer Registry covers a population of 350,000 and is the second population-based registry in Colombia.

THE GAMBIA NATIONAL CANCER REGISTRY (GNCR)⁸

The Gambia National Cancer Registry (GNCR) is one of the very few national, population-based cancer registries in the whole of Africa. It was established in 1986 to record data on the pattern of cancer occurrence in The Gambia, and in particular to support the long-term follow-up of the Gambia Hepatitis Intervention Study (GHIS), coordinated by IARC to evaluate the efficacy of the hepatitis B vaccination in childhood for the prevention of chronic liver disease and hepatocellular carcinoma.

The GNCR is remarkable amongst cancer registries in Africa in achieving a broad coverage, including a substantial proportion of the rural population. It provides an unbiased description of the cancer profile in the population and an unparalleled opportunity to study cancer occurrence and outcome in a low-income country in sub-Saharan-Africa.

The data generated by the GNCR demonstrated just how prevalent liver cancer is in this region and stimulated a substantial number of additional research collaborations on liver and other cancers of importance in the population. These included extensive investigations of the role of aflatoxin and its interaction with HBV infection in the etiology of liver cancer and, more recently, studies on breast cancer. The high coverage and quality of the data from the GNCR also permitted one of the rare studies of cancer survival in an African population, showing just how poor the outcomes were compared to high-resource countries.

The GNCR is a model of how investment in the cancer registry infrastructure, aimed at collecting quality data on cancer in low- and middle- income countries, provides not only vital information on the cancer burden but also stimulates fresh ideas to investigate the causes and prevention of the common cancers in a region.

"IMPROVING THE QUALITY OF CANCER REGISTRIES AND MORTALITY DATA SHOULD BE CONSIDERED A HIGH PRIORITY PUBLIC GOOD"

Global Task Force on Expanded Access to Cancer Care and Control in Developing Countries²

MEETING THE CHALLENGE

One of the greatest challenges associated with collecting and analysing cancer registry data in many low- and middle-income countries is the lack of basic health services, particularly in rural areas, which results in many cancer cases going un-diagnosed, un-treated, and therefore un-recorded. Even in areas serviced by hospitals and clinics, patients with advanced tumours, or those for whom treatment is not available may not be admitted to hospital at all. Other challenges include: lack of stability of the population which can complicate the definition of residents for population-based registries, lack of trained personnel and follow-up, and lack of data-processing facilities³.

Establishing and strengthening cancer registries requires not only financial resources but also recognition of the importance of these data, ongoing commitment to data collection, and trained personnel.

Capacity building opportunities for health practitioners (including in the areas of data management, privacy issues, analytic capability and metrics), as well as provision of the necessary hardware to support data collection and processing are therefore crucial to support the establishment of effective population-based registries in low- and middle- income countries.

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FOOD, NUTRITION, PHYSICAL ACTIVITY AND CANCER PREVENTION

IMPLEMENTING POLICIES ON GLOBAL, NATIONAL AND LOCAL LEVELS TO ENABLE PEOPLE TO MAKE HEALTHIER CHOICES TO REDUCE THEIR RISK OF CANCER AND OTHER NON-COMMUNICABLE DISEASES



THE FACTS

Cancer is a largely preventable disease. Global recommendations exist for reducing cancer risk through food, nutrition and physical activity, developed by an expert panel and derived from a robust evidence base¹.

Together with not smoking, eating a healthy diet, being physically active and maintaining a healthy weight, are the most important ways of reducing cancer risk. Now is the time for action to address food, nutrition and physical activity risk factors for cancer and other non-communicable diseases (NCDs). The implementation of evidence-based policies on a global, national and local level is vital in combating the growing burden of cancer and premature death worldwide.

The costs of inaction are enormous: cancer rates and health care costs will soar, economic and social development will stall, and millions of people worldwide will continue to suffer the devastating – yet, in many cases, avoidable – impact of cancer.

A GLOBAL SOLUTION

The most comprehensive report ever published on food, nutrition, physical activity and cancer risk¹ found several factors that modify the risk of cancer. Based on this robust evidence, global experts developed personal recommendations and public health goals for cancer prevention in ten key areas, including: body fatness (Box 1), physical activity and alcoholic drinks. Body fatness was shown to be one of the most important preventable risk factors, with convincing evidence that it increases the risk of six types of cancer.

Rates of overweight and obesity are rising globally, including in lower-income countries, which face a dual burden of over- and under-nutrition. Diet and activity patterns play a critical role in determining people's cancer risk both in relation to, and independently of, their association with body fatness. There are a number of actions that can be taken by global, national and local policy-makers in low-, middle- and high-income countries. Ensuring global and national structures and systems that enable people to make healthy choices is central to prevention. Governments have a chief and central responsibility for protecting public health and should work with other key societal actors to help people reduce their risk of cancer. Concerted action in all sections of society and at all levels is needed.



The Political Declaration of the United Nations High-Level Meeting on the Prevention and Control of NCDs adopted unanimously in September 2011 by 193 Member States, contains commitments that are aligned with the targets of the World Cancer Declaration.

The Political Declaration promotes the implementation of measures to reduce the impact of common non-communicable disease risk factors including tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol.



BOX 1: PERSONAL RECOMMENDATIONS AND PUBLIC HEALTH GOALS FOR BODY FATNESS AND CANCER PREVENTION

(Full list of Recommendations available at www.wcrf.org)

RECOMMENDATION 1
BODY FATNESS Be as lean as possible within the normal range ¹ of body weight
PUBLIC HEALTH GOALS Median adult body mass index (BMI) to be between 21 and 23, depending on the normal range for different populations ² The proportion of the population that is overweight or obese to be no more than the current level, or preferably lower, in 10 years
PERSONAL RECOMMENDATIONS Ensure that body weight through childhood and adolescent growth projects ³ towards the lower end of the normal BMI range at age 21 Maintain body weight within the normal range from age 21 Avoid weight gain and increases in waist circumference throughout adulthood
<small>¹ "Normal range" refers to appropriate ranges issued by national governments or the World Health Organization ² To minimize the proportion of the population outside the normal range ³ "Projects" in this context means following a pattern of growth (weight and height) throughout childhood that leads to adult BMI at the lower end of the normal range. Such patterns of growth are specified in International Obesity Task Force and WHO growth reference charts</small>

IN HIGH-INCOME COUNTRIES, ABOUT A THIRD OF THE MOST COMMON CANCERS COULD BE PREVENTED THROUGH HEALTHIER PATTERNS OF DIET AND PHYSICAL ACTIVITY. IN LOW- AND MIDDLE-INCOME COUNTRIES ABOUT A QUARTER COULD BE PREVENTED IN THIS WAY². RISING RATES OF OBESITY WILL LEAD TO INCREASED CANCER RATES UNLESS POLICIES AND ACTIONS ARE TAKEN TO IMPROVE PEOPLE'S DIETS AND PHYSICAL ACTIVITY LEVELS.

SUPPORTING EVIDENCE

This table¹ provides an overview of an independent international expert panel's judgements of the evidence for food, nutrition, physical activity and cancer prevention. The Continuous Update Project³ is an ongoing review of the evidence in this area, which will ensure this comprehensive scientific base remains current in the future.

	Mouth, pharynx, larynx	Nasopharynx	Oesophagus	Lung	Stomach	Pancreas	Gallbladder	Liver	Colorectum	Breast premenopausal	Breast postmenopausal	Ovary	Endometrium	Prostate	Kidney	Skin	Weight gain, overweight and obesity
Foods containing dietary fibre																	
Aflatoxins																	
Non-starchy vegetables ¹																	
Allium vegetables																	
Garlic																	
Fruits ²																	
Foods containing folate																	
Foods containing lycopene																	
Foods containing selenium ³																	
Red meat																	
Processed meat																	
Cantonese-style salted fish																	
Diets high in calcium ⁴																	
Energy-dense foods ⁵																	
Low energy-dense foods																	
Salt, salted and salty foods																	
Arsenic in drinking water																	
Maté																	
Sugary drinks																	
Alcoholic drinks ⁶																	
Beta-carotene ⁷																	
Physical activity																	
Sedentary living ⁸																	
Body fatness																	
Abdominal fatness																	
Adult weight gain																	
Adult attained height																	
Greater birth weight																	
Lactation																	
Being breastfed																	

KEY



Convincing decreased risk



Probable decreased risk



Probable increased risk



Convincing increased risk

¹ Includes evidence on foods containing carotenoids for mouth, pharynx, larynx; foods containing beta-carotene for oesophagus; foods containing vitamin C for oesophagus

² Includes evidence on foods containing carotenoids for mouth, pharynx, larynx and lung; foods containing beta-carotene for oesophagus; foods containing vitamin C for oesophagus

³ Includes evidence from supplements for prostate

⁴ Evidence is from milk and studies using supplements for colorectum

⁵ Includes 'fast foods'

⁶ Convincing harm for men and probable harm for women for colorectum

⁷ The evidence is derived from studies using supplements for lung

⁸ Includes evidence on television viewing

⁹ Judgement for physical activity applies to colon and not rectum



MEETING THE CHALLENGE

In addition to body fatness, other key factors that increase cancer risk include red and processed meats, alcohol and salt. In contrast, physical activity, plant foods and breastfeeding can decrease risk. In 2009, an evidence-based cancer prevention policy report² made 48 recommendations aimed at 9 actor groups, including Governments and Industry, who have decision-making responsibility for public health. These recommendations address the social, economic and environmental influences on people's ability to make healthy choices. Download the full policy report at: www.dietandcancerreport.org

CASE STUDY: SCHOOL MEALS IN BRAZIL

A HEALTHY START^{4,5}

A life course approach to the prevention of cancer and other NCDs has the greatest potential for impact. Brazil has what may be the most comprehensive government programme designed to improve and sustain the quality of food consumed by primary schoolchildren. In the 1990s, food supplied to government schools by the federal authorities was routed through Brasília. School meals tended to be monotonous and unpalatable, high in refined starches and sugars and in salt, and included little fresh food.

New laws passed by the federal government decentralised the system. This was to prevent misappropriation, and also for reasons of public health. The laws stipulate that 70 per cent of the budget for school meals (amounting in 2009 to an annual \$US 1 billion a year for 35 million children) be spent on fresh vegetables and fruits, and other minimally processed foods, and of this, 30 per cent should be locally sourced from cooperatives and family farms. In some cities children are also taught about the sources of food, and how to prepare meals. Networks of public health professionals have been set up to advise municipal authorities. This collaboration between national, state and municipal governments, local food producers, and school managers and staff, supports local and rural economies. It encourages parents to improve the quality of the food prepared and consumed at home, and supplies healthy meals to younger children throughout the country.

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HBV (HEPATITIS B VIRUS) AND LIVER CANCER

IMPLEMENTATION OF HBV VACCINATION PROGRAMMES TO REDUCE THE RISK AND INCIDENCE OF LIVER CANCER



THE FACTS

Liver cancer (also known as hepatocellular carcinoma) takes the lives of almost 700,000 people each year, making it the third most common cause of death from cancer worldwide¹.

Most of the burden is in developing countries where almost 85% of cases occur, with the regions of highest incidence and mortality in Eastern and South Eastern Asia and Middle and Western Africa¹.

Chronic infection with Hepatitis B Virus is a major cause of liver cancer accounting for approximately 50-55% of cases, with 72% of liver cancer deaths worldwide due to hepatitis viruses². HBV infection acquired in infancy and childhood particularly increases the risk of developing cancer later in life. In highly endemic areas, the most common routes are perinatal transmission (from mother to baby) or in early childhood (e.g. sibling-to-sibling transmission). This is in contrast to low endemic areas where HBV is more often contracted later in life either through sexual contact or the use of contaminated needles. The endemicity of Hepatitis B is described by the prevalence of the surface antigen of HBV (HBsAg) in the general population of a defined geographical region: HBsAg prevalences of $\geq 8\%$ are typical of highly endemic regions.

HBV infection is preventable through implementation of a safe, affordable and effective vaccine³. However, inequities still exist in vaccine coverage and a greater knowledge on the region-specific prevalence of HBV infection as well as new estimates on the global HBV-related disease burden are needed.

A GLOBAL SOLUTION

Universal infant immunisation with HBV vaccine is now recognised as the most effective prevention strategy for reducing the burden of liver cancer. As of 2009, 176 countries had incorporated HBV vaccines as part of their national immunisation programmes, and an estimated 70% of the 2009 birth cohort received 3 doses of hepatitis B vaccine^{4,5}.

The routine vaccination of all infants as an integral part of national immunisation schedules is recommended in all countries, and particularly in areas of high incidence. In order to prevent HBV transmission from mother to baby, and also from child-to-child in the first year of life, the first dose of hepatitis B vaccine should be given as soon as possible after birth, preferably within 24 hours. To complete the primary series, the birth dose should be followed by two doses as part of existing routine immunisation schedules⁶.

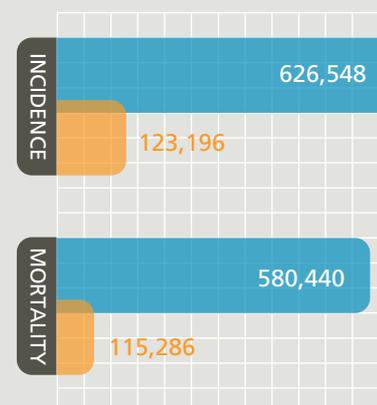


The Political Declaration of the United Nations High-Level Meeting on the Prevention and Control of NCDs adopted unanimously in September 2011 by 193 Member States, contains commitments that are aligned with the targets of the World Cancer Declaration.

The Political Declaration promotes increased access to cost-effective vaccinations to prevent infections associated with cancers as part of national immunisation schedules.



LIVER CANCER INCIDENCE AND MORTALITY IN 2008¹



■ LESS DEVELOPED
■ MORE DEVELOPED

IN 2008, THERE WERE 695,000 DEATHS FROM LIVER CANCER WITH ALMOST 85% OF CASES OCCURRING IN DEVELOPING COUNTRIES

SUPPORTING EVIDENCE

Universal HBV immunisation has been proven to be effective in reducing HBsAg prevalence to almost one-tenth of the rate before the vaccination programme in highly endemic areas⁷. Prevention of chronic HBV infection and subsequent HBV-related mortality by implementation of hepatitis B immunisation is confirmed in a number of studies from several countries world-wide^{7,9}.

Vaccine coverage has been shown to be high in most areas with a universal vaccination programme. However, a number of factors contribute to poor compliance that affect the success of these programmes. Cost of the vaccine is one of these⁶. The importance of offering the vaccine free of charge to all infants has been shown to be critical to uptake. This is particularly true in rural areas.

Education and public awareness also play a role in increasing compliance. Issues surrounding perceived side effects of the vaccine; awareness and knowledge about the transmission routes and risks associated with HBV; and the importance of administering HBV vaccine within 24 hours of birth; all contribute to the success of programmes⁶.

Vaccination against HBV is also cost-effective¹⁰. A global review of economic analyses of HBV immunisation spanning from 1994 to 2000 found HBV-vaccination strategies to be cost-saving in countries of intermediate to high endemicity¹⁰.



MEETING THE CHALLENGE

Despite the successes of HBV immunisation programmes in many countries, further education and a greater understanding of the global HBV prevalence and attributable disease burden are necessary. Given the current estimates, HBV infection must be promoted as a global health problem.

The poorest countries of the world are still tackling the problem of inadequate support to implement safe and efficient vaccination programmes. Even in areas where vaccination programmes exist, improvements in vaccine coverage and hepatitis birth dose implementation can still be achieved.

Despite the challenges, concerted action to tackle the global HBV burden was recognised with a resolution passed in May 2010 at the 63rd World Health Assembly WHA63.18 for a coordinated response covering vaccination, testing and treatment for patients, education and advocacy for those living with the disease, and research and support for countries to mount national responses.

CASE STUDY: REDUCING THE BURDEN OF HBV INFECTION

THE TAIWANESE EXPERIENCE⁷

The first population-based hepatitis B vaccination programme in the world was launched in Taiwan in July 1984. During the first 2 years of the programme, coverage was provided mainly for infants whose mothers were positive for the Hepatitis B surface antigen (HBsAg). Vaccination was subsequently extended to all newborns and then to unvaccinated preschool-age and elementary school-age children, and then subsequently extended to all children and adolescents in 1989-1991, and to adults in 1990-1993.

In a recent 20-year follow-up study, comparison of the incidence of hepatocellular carcinoma (HCC) among HBV-vaccinated and -unvaccinated cohorts was performed. The results show that this programme reduced the overall HBsAg prevalence rate from 9.8% in 1984 to 1.3% in 1994 among children less than 15 years of age. Comparison of the incidence of HCC in the vaccinated group (64 out of 37,709, 304 person-years) with the incidence in the unvaccinated group (444 HCC among 78,496,406 person-years) showed that HCC was significantly lower among vaccinated children aged 6-19 years.

The data from the Taiwanese study show that the universal vaccination programme against HBV initiated in 1984 was able to reduce HCC prevalence as demonstrated by following vaccinated children over 20 years.

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HPV (HUMAN PAPILLOMAVIRUS) AND CERVICAL CANCER

IMPLEMENTATION OF HPV VACCINATION PROGRAMMES TO REDUCE THE RISK AND INCIDENCE OF CERVICAL CANCER



THE FACTS

Cervical cancer is the third most common cancer in women, with an estimated 530,000 new cases in 2008¹.

About 88% of the global cervical cancer mortality occurs in developing countries, with the regions of highest incidence and mortality in sub-Saharan Africa, Latin America and the Caribbean, Melanesia and South-Central and South-East Asia¹. It is projected that without action, the global number of deaths from cervical cancer will increase by nearly 80% over the next decades, mainly in low- and middle-income countries.

Practically all deaths from cervical cancer are caused by infection with human papillomavirus (HPV)². Currently, two HPV vaccines are available, both of which protect against HPV types 16 and 18, the cause of approximately 70% of cervical cancer cases. These two vaccines have been shown to be at least 90% effective in preventing persistent HPV 16 and 18 infections.

HPV vaccines should be introduced as part of a comprehensive strategy to prevent cervical cancer. Pre-cancerous lesions of the cervix caused by persistent HPV infection are detectable prior to progression to invasive cancer, and are treatable. This means that early detection and screening are integral to prevention programmes. However, in developing countries most cases are detected at an advanced stage when treatment options are limited or not available and when treatment success rates are low.

A GLOBAL SOLUTION

Immunisation with HPV vaccine is now recognised as an effective way to significantly reduce the burden of cervical cancer. At the end of 2010, 33 countries had included HPV vaccinations in the national immunisation schedule with 20 additional countries undertaking pilot programmes³.

As HPV vaccines are most effective prior to HPV 16 and 18 infection, immunisation should occur prior to becoming sexually active. The World Health Organization recommends immunisation targeted at young adolescent girls aged 9 to 13 years in countries where cervical cancer constitutes a public health priority and where vaccine introduction is feasible, where sustainable financing can be secured and when cost-effectiveness is considered. Three doses of the vaccine are required within six months⁴.



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The Political Declaration promotes increased access to cost-effective vaccinations to prevent infections associated with cancers as part of national immunisation schedules.



AGE SPECIFIC CERVICAL CANCER MORTALITY RATES IN 2008

ASR (PER 100,000)



IN 2008, CERVICAL CANCER CLAIMED THE LIVES OF 275,000 WOMEN OF WHICH 88% WERE IN DEVELOPING COUNTRIES.

SUPPORTING EVIDENCE

A solid evidence base for the universal uptake of HPV vaccine programmes is building - not only showing the effectiveness of the vaccine to reduce persistent HPV infection but also stimulating public awareness of cervical cancer and vaccination.

In clinical trials, HPV vaccines are at least 90% effective in preventing persistent HPV infection caused by types 16 and 18, and 93% effective in preventing type-specific cervical lesions when given to girls prior to HPV infection^{5, 6}. It is estimated that at coverage rates of 70% in all 57 GAVI-eligible countries vaccination of young adolescent girls could avert close to 3 million deaths from cervical cancer over 10 consecutive years⁷.

The findings of pilot projects have shown encouraging results in targeting young adolescent girls in developing countries. The feasibility of reaching girls 9 to 13 years of age through schools, health care facilities and community-based settings has been demonstrated in a number of countries, although more evidence is needed to help guide programme planning and integration of these strategies with other health interventions⁸. Increased effort is needed to inform all communities about options for preventing cervical cancer; to give understandable information on the safety of the two vaccines; and to respond to community questions and concerns⁹.



MEETING THE CHALLENGE

One of the greatest barriers to universal introduction of HPV immunisation programmes is affordable pricing of the vaccine. While there has been a recent reduction in vaccine prices, it remains unaffordable for many low- and middle- income countries, so that large-scale programmes will require significant financial support. The provision of subsidies or cost-saving measures to facilitate the purchase of HPV vaccine for the poorest countries would likely increase vaccine uptake substantially. An important milestone to providing greater accessibility to HPV vaccines was achieved recently by the announcement by the GAVI Alliance Board of its decision to take the first steps to introduce HPV vaccines for eligible countries¹⁰. GAVI will invite countries to apply for funding for HPV vaccines provided a sustainable price from manufacturers can be secured.

Gaps in our understanding of the effectiveness of HPV vaccines remain. We do not yet know the long-term duration of HPV vaccine protection or whether boosters will be necessary; efficacy of HPV vaccines in HIV-infected individuals; or the degree of protection against other cancer-causing HPV types. Research is continuing into these questions.

The challenges associated with implementation of HPV vaccination programmes are significant but lessons learned from early demonstration projects support the implementation of HPV vaccines, even in low resource settings¹¹.

CASE STUDY: REDUCING THE BURDEN OF HPV INFECTION

THE RESULTS OF A PILOT PROGRAMME IN UGANDA⁸

In 2006, PATH initiated the "HPV Vaccines: Evidence for Impact project". Uganda was one of four countries chosen by PATH as a site for this project. Two districts participated in the project involving two different vaccine delivery strategies – a school-based strategy that identified girls in primary grade 5 in Ibanda district; and an integrated Child Days Plus or community-outreach strategy delivered at schools for girls aged 10 years old in Nakasongola district. Over 2 years, almost 10,000 young adolescent girls in Uganda were fully vaccinated (three doses of the HPV vaccine). Vaccine coverage rates were above 85% in Ibanda and above 50% in Nakasongola. In fact, even in Nakasongola acceptability of the vaccine was high, but there were challenges determining the correct ages of girls in Nakasongola due to cultural issues. For such situations, it was concluded that a grade-based strategy might achieve higher documentable coverage. It should be noted that this high acceptability and coverage was achieved in the context of careful evidence-based education and outreach at least one month before immunisation began. In particular, parental and community leader awareness was a key factor in the decision to be vaccinated.

Overall, the project demonstrated that it was feasible to deliver the vaccine using existing health and education infrastructure and that schools were an appropriate venue for HPV vaccinations. The lessons learned from this project will greatly benefit the further delivery of HPV immunisation programmes throughout Uganda and also other parts of Africa. For a full report on the project, see www.rho.org/files/PATH_Uganda_HPVP_demo_OR_summary_2010.pdf.

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EARLY DETECTION AND SCREENING FOR COLORECTAL CANCER

DEVELOP AND IMPLEMENT ORGANISED SCREENING AND EARLY DETECTION PROGRAMMES FOR COLORECTAL CANCER FOR DIFFERENT RESOURCE SETTINGS AND INCREASE PUBLIC AWARENESS



THE FACTS

As the second most common cancer in women, the third most common cancer in men, and the fourth most common cause of death from cancer worldwide, systematic approaches to early detection and care must be implemented to improve colorectal cancer outcomes¹.

Colorectal cancer rates are projected to increase in the next two decades by nearly 80% to 2.2 million new cases each year, with most of this global increase occurring in low- to middle-income countries^{2,3}.

Unhealthy lifestyles including poor diets are a significant contributing factor to the rising incidence of colorectal cancer. Targeted prevention and early detection programmes could help to reverse the international trends in incidence rates. Screening for colorectal cancer has the potential to both prevent the disease and/or detect it early. However, in most settings where screening is justified it is underused or nonexistent.

Lack of public awareness of colorectal cancer remains an important obstacle to disease control in all countries, but lack of adequate infrastructure for screening, diagnosis, and treatment are major challenges in many countries.

A GLOBAL SOLUTION

The colorectal cancer burden in countries at all resource levels can be significantly reduced through practical interventions that are feasible and cost-effective^{4,5}. Effective and efficient colorectal cancer screening methods including faecal occult blood tests, flexible sigmoidoscopy (a procedure to look inside the rectum and lower colon), and colonoscopy can be tailored to the resource setting and population-based need.

Of equal importance is increasing awareness of the value of regular screening and early diagnosis and the importance of seeking care when symptoms are present. This not only requires increasing knowledge, but often overcoming misconceptions and myths⁶.



MEETING THE CHALLENGE

Despite the significant challenges of establishing screening programmes for colorectal cancer, all resource settings that are able to meet well established WHO criteria for the introduction of screening should implement increased public awareness and early detection strategies that are integrated into existing health services.

The approach and scope of an effective colorectal cancer screening programme takes into account not only economic factors but also social and cultural factors. Ultimately, success of early detection programmes for colorectal cancer can be measured by a reduction in incidence, and the stage of the cancer at diagnosis, with earlier diagnosis being associated with a reduction in the risk of dying from colorectal cancer.



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The Political Declaration promotes increased access to cost-effective cancer screening programmes.



IN 2008, THERE WERE MORE THAN 600,000 COLORECTAL CANCER DEATHS, WITH NEARLY HALF OF THESE OCCURRING IN LOW- AND MIDDLE- INCOME COUNTRIES.

SUPPORTING EVIDENCE

The large majority of colorectal cancers arise as a result of a multi-step process from precancerous lesions (polyps) to invasive cancer⁷. Advanced precancerous lesions and colorectal cancers tend to bleed, which is the basis of the diagnostic faecal occult blood tests that can detect microscopic amounts of blood in the stool. The detection and removal of these lesions underpins effective colorectal cancer early detection and screening programmes, with annual or biennial faecal occult blood tests demonstrated to reduce colorectal cancer incidence and mortality^{8,9}. Direct examination of the bowel with sigmoidoscopy and colonoscopy also contribute to reduced colorectal cancer incidence and mortality^{10,11}, a benefit observed with both one-time and wider screening intervals. This strong evidence base and the wide and growing range of testing options mean that there are numerous options for programme design that can be tailored to a country's resources and burden of disease.

Public Education and Awareness: Increasing awareness of colorectal cancer and the value of screening among the public and health professionals are key components of successful prevention and early detection strategies in all resource settings. Increased awareness should focus not only on individual risk, but also the importance of prompt diagnostic evaluation of rectal bleeding accompanied by changes in bowel habits and abdominal pain. Delay in diagnosis is a problem at all resource levels, and prompt evaluation of rectal bleeding is associated with earlier stage at diagnosis and more favourable outcomes^{12,13}.

Training of Health Personnel: Appropriate training of health personnel, especially the frontline health staff, is critical in all settings. All health staff must be able to recognize the signs and symptoms of colorectal cancer, and be able to refer patients for further diagnosis and treatment. Health staff should also be attentive to family history, since overall risk and risk of developing cancer at a younger age is higher in families with multiple affected relatives¹⁴. Where there are limitations in the number of health professionals trained to perform diagnostic evaluations, studies have shown that nurses and non-medical endoscopists can satisfactorily perform these services^{15,16}. In some settings, screening uptake, as well as assessing symptoms, may be improved with same-gender health care professionals¹⁷.

Optimal Target Population: When defining a target group for colorectal cancer health programmes at any resource level, local planners should prioritize segments of the population according to the number of cases of colorectal cancer likely to be detected per number of men and women screened. Assessment of the underlying burden of disease in geographic and age-subgroups is important to ensure that programmes are cost-effective. In identifying a target population, consideration should also be given to longevity, local resources and other local considerations. These factors should be considered to determine both an age to begin offering screening and an upper age at which screening would no longer be offered. The ability to provide population-based colorectal cancer screening programmes with adequate coverage must be considered.

CASE STUDY: ADVOCATING FOR SCREENING:

GET BEHIND BOWEL SCREENING CAMPAIGN

Cancer Council Australia launched its Get Behind Bowel Screening campaign in June 2009. Bowel cancer is Australia's second most lethal cancer after lung cancer yet nearly all cases can be cured if found early. Fully implemented, the National Bowel Cancer Screening Programme is the most effective measure for immediately reducing cancer death in Australia, with the potential to save more than 30 lives per week.

Despite both sides of politics giving in-principle support to a comprehensive screening programme, the current National Bowel Cancer Screening Programme in Australia remains available as a one-off test only, restricted to individuals turning 50, 55 and 65 years.

Since the launch of the campaign, more than 22,000 messages of support have been sent by individuals to Federal Members of Parliament, asking them to put bowel cancer screening on the health agenda. As a result, in 2011 the Australian Government reinstated the National Bowel Cancer Screening Programme with a commitment to permanent funding. Advocacy efforts are now focused on obtaining a further commitment to expand the programme to free, regular screening for all Australians 50 and over.

For more information on the campaign, go to <http://www.getbehindbowelscreening.com.au/>

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EARLY DETECTION AND SCREENING FOR CERVICAL CANCER

DEVELOP AND IMPLEMENT ORGANISED SCREENING AND EARLY DETECTION PROGRAMMES FOR CERVICAL CANCER FOR DIFFERENT RESOURCE SETTINGS AND INCREASE PUBLIC AWARENESS



FACTS

Cervical cancer kills approximately 275,000 women each year, about 88% of whom live in developing countries with 53,000 deaths in Africa, 31,700 in Latin America and the Caribbean and 159,800 in Asia¹.

Virtually all deaths from cervical cancer are caused by infection with human papillomavirus (HPV). Transmitted through skin-to-skin contact, it is a common infection and most adults are exposed to the virus within a few years of becoming sexually active. A percentage of women develop persistent infections that progress to pre-cancer and, if not treated, invasive cancer.

Effective early screening and treatment, mainly using cytology-based (Pap) testing, has resulted in a steady drop in cervical cancer incidence and mortality in high-resource settings like the US and Europe. However, quality cytology has proven to be difficult to establish or sustain in lower-resource settings². Fortunately, new options are now proving effective for cervical cancer screening and treatment in those areas.

A GLOBAL SOLUTION

The cervical cancer burden in low- and middle-income countries can be significantly reduced through practical interventions that can be tailored to the resource setting and population-based need. These include new alternatives to Pap screening such as visual inspection strategies and HPV DNA testing, along with cryotherapy for treatment of precancer.

Of equal importance is increasing awareness among policy makers, the public, and health professionals that solutions to cervical cancer prevention are at hand in all resource settings.



AGE SPECIFIC CERVICAL CANCER MORTALITY RATES IN 2008

ASR (PER 100,000)



LESS DEVELOPED MORE DEVELOPED

EACH YEAR THERE ARE ABOUT 275,000 CERVICAL CANCER DEATHS WORLDWIDE, WITH 88% IN LOW- AND MIDDLE- INCOME COUNTRIES. THESE DEATHS ARE AVOIDABLE AND REPRESENT A FAILURE TO PROVIDE BASIC PREVENTIVE CARE TO WOMEN.

MEETING THE CHALLENGE

Achieving equity in cervical cancer early detection and treatment is a priority. Cervical cancer rates in wealthier nations plummeted once Pap testing was introduced broadly - and rates continue to be low. With the strong evidence base for use of VIA and cryotherapy, the tools are at hand to reduce cervical precancer and cancer. What is needed is the political will and resources to expand use of these tools in lower-resourced communities. Creating service models that can function in rural areas and be scaled up nationally will ensure that all eligible women have equitable access.



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SUPPORTING EVIDENCE

The critical issue for screening programmes is to select the test that is most appropriate for the context in order to achieve high screening coverage, high quality testing and reliable follow-up care for women.

Raising awareness: Recent experience with screening and vaccination programmes in low resource settings suggests that once people understand basic information about cervical cancer and know how to access services they tend to come for the services³⁻⁷. Although awareness in lower resource settings remains low, even among health professionals, levels of concern about cancer are high, and the public pays attention to messaging about cancer. Comprehensive prevention programmes that include strategies to improve knowledge of cervical cancer among communities, health professionals and policy makers and that expand access to services have the greatest chance of success.

Tailoring screening and treatment services: Evidence over the past decade has shown that alternatives to Pap, such as visual inspection with acetic acid (VIA), can make screening available to many more women. Building VIA capability can serve the needs of women now, while creating a service platform ready to take advantage of more sensitive HPV DNA (or other biochemical tests) in the future. Cryotherapy, or freezing cervical tissue that is likely to develop into cancer, can be used to treat precancer among women who have been screened using VIA or HPV DNA testing. The procedure is both cheaper and technically simpler than other treatment options, making it more accessible and field-friendly. A screen and treat approach that combines VIA or HPV DNA testing with cryotherapy is a low-cost strategy that can be established relatively close to populations in need.

Unlike in higher-resource settings, some of these programmes have determined that including a diagnostic step prior to treatment creates barriers to programme success. They have found that many women “drop out” of the system when asked to return again and again. Making it easier for women to access screening and treatment, and reducing visits by adopting a screen-and-treat approach for the majority of straightforward cases will improve outcomes and reduce cost and infrastructure demands^{2, 8, 9}. For example, in a ‘screen and treat’ project in Peru, only 9% of women who screened positive failed to receive treatment in the single visit approach, compared with 44% of women who were lost to treatment using a multi-visit model^{10, 11}.

In some cases, women are reluctant to come for screening because they do not want to undergo a pelvic exam, especially if conducted by a male provider¹²⁻¹⁵. In such a case, a test that allows women to gather a vaginal (not cervical) sample themselves, without a pelvic examination and in a private space using a small brush and storage tube provided by the clinic, could overcome this concern. Early results comparing clinician-gathered versus self-collected specimens for HPV testing showed only a slight decrease in sensitivity for the latter approach. While not yet proven effective, this option could remove another serious barrier to widespread screening¹⁶⁻¹⁹. Where high-quality cytology-based programmes work, with or without HPV DNA testing, they should be continued.

Optimal Target Population: In a resource-constrained setting, the optimal target population for cervical cancer screening is women above the age of 30²⁰. Younger women often present with HPV infection or low-grade cervical lesions, but the vast majority of these cases clear spontaneously within a few months or years, and do not progress to cancer. When HPV infection is found in women over 30, there is a greater chance that the infection is persistent (and therefore at higher risk of progressing to cancer). Studies have shown that even a single screening between the ages of 30 and 40 can reduce a woman’s lifetime risk of cervical cancer by 25-36%^{2, 21}.

CASE STUDY

THAILAND: SHOWING LEADERSHIP IN THE PROVISION OF CERVICAL CANCER SCREENING⁸

Thailand has implemented Pap testing for many years, with success in cities like Bangkok. Over the past decade, the country also became well-known as a proving ground for VIA, especially in the relatively poor region of “Isaan” (in the north-east, near Lao PDR). Successful demonstration projects there resulted in health policy change and in an expanded, VIA-based screening and treatment (or referral) programme reaching 17 of the 75 provinces in the country. Ministry of Health policy now states that all eligible women should be screened with either a Pap smear or VIA and the National Health Insurance system has approved VIA screening as an allowable/reimbursable health care cost. Local health officials see screening, with treatment soon thereafter in a convenient location, (the “screen-and-treat” approach) as a desired, cost-effective alternative to the long-term costs associated with undiagnosed and untreated cervical cancer (for which they now are financially responsible). In addition to country expansion, Thailand has been an active regional advocate, providing both leadership and a model programme for neighbouring countries to adapt to local circumstances.

For further information, go to

http://www.alliance-cxca.org/files/Jhpiego_Thailand_outcomes_2008.pdf

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EARLY DETECTION AND SCREENING FOR BREAST CANCER

DEVELOP AND IMPLEMENT ORGANISED SCREENING AND EARLY DETECTION PROGRAMMES FOR BREAST CANCER FOR DIFFERENT RESOURCE SETTINGS AND INCREASE PUBLIC AWARENESS



THE FACTS

As the most common cancer among women around the world and the most frequent global cause of female cancer mortality, systematic approaches to early detection and care must be implemented to improve breast cancer outcomes¹.

With breast cancer rates in developing countries projected to reach a 55% increased incidence and 58% increased mortality in fewer than 20 years, now is the time to act².

Lack of public awareness of breast cancer remains a critical obstacle in low-income countries where breast cancer is commonly diagnosed at an advanced stage, when treatment options are less effective or are simply unavailable³. In addition, misconceptions about breast cancer diagnosis and treatment can lead women to seek alternative care in place of standard treatment⁴.

A GLOBAL SOLUTION

The breast cancer burden in low- and middle- income countries can be significantly reduced through practical interventions that are feasible and cost-effective⁵. Effective and efficient breast cancer screening methods including screening mammography, clinical breast examination (CBE) and breast self-examination (BSE) can be tailored to the resource setting and population-based need.

Of equal importance is making the public aware that breast cancer outcomes are improved through early detection regardless of the breast cancer screening technique and the resource setting.

SUPPORTING EVIDENCE

A robust evidence base exists from diverse countries to support integrated approaches to early detection of breast cancer that are appropriate for different resource settings:

Public Education and Awareness: The major goal of earlier detection in low resource settings is to diagnose disease at an earlier stage. This can be achieved by teaching women the importance of seeking timely evaluation of breast symptoms and dispelling misconceptions about diagnosis and care. In a study assessing health system barriers to down-staging (detecting breast cancer at an earlier stage) in Mexico, breast cancer patients reported barriers to seeking care including: perceptions that breast symptoms like lumps are not serious; competing pressures at home and work; a desire to keep one's body intact; and the fear of possible mastectomy⁶.

CONTINUED OVERLEAF

MEETING THE CHALLENGE

Despite the significant challenges of establishing screening programmes in low- and middle- income countries, increased public awareness and early detection strategies should be implemented in all resource settings and integrated into existing health services.

The approach and scope of an effective breast cancer screening programme takes into account not only economic factors but also social and cultural factors. Ultimately, success of early detection programmes for breast cancer can be measured by a reduction in the stage of the cancer at diagnosis, with earlier diagnosis associated with improved outcomes for women.



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The Political Declaration of the United Nations High-Level Meeting on the Prevention and Control of NCDs adopted unanimously in September 2011 by 193 Member States, contains commitments that are aligned with the targets of the World Cancer Declaration.

The Political Declaration promotes increased access to cost-effective cancer screening programmes.

IN 2008, THERE WERE ALMOST 500,000 MILLION BREAST CANCER DEATHS WITH 60% OF THESE OCCURRING IN LOW- AND MIDDLE- INCOME COUNTRIES

SUPPORTING EVIDENCE CONTINUED

In lower-middle income countries, targeted outreach education programmes stressing increased awareness of breast symptoms and encouraging CBE for age groups at high risk can be implemented at the district or provincial level.

In middle-income countries, breast health education programmes can be organised at a regional level, and can be linked to general health and women's health programmes. Building on these initiatives, national breast awareness campaigns using national media can be implemented as economies strengthen.

Training of Health Personnel: Appropriate training of health personnel is critical in all settings but particularly in low-income countries where education of the frontline health staff is a key component to any early detection strategy. All health staff, and especially female staff whom women may approach first, must be able to recognize the signs and symptoms of early as well as advanced breast cancer, and be able to refer patients for further diagnosis and treatment. CBE by non-physicians as a screening method in low- and middle- income countries has the potential to detect cancers earlier, particularly in areas where the majority of breast cancers are diagnosed at an advanced stage. In lower-middle income countries where advanced breast cancers are particularly common, CBE performed annually from ages 40 to 60 years is predicted to be nearly as effective as biennial mammographic screening for reducing breast cancer mortality but at significantly lower cost⁷.

Optimal Target Population: When defining a target group for breast health programmes at any resource level, local planners should prioritize segments of the population according to the number of cases of breast cancer likely to be detected per woman screened. In most countries, targeting younger women for screening, who have an overall lower risk of breast cancer than older women, will detect fewer cases of breast cancer per woman screened than targeting older women, and will also lead to more unnecessary evaluations for benign breast conditions in already overloaded clinics.

Determining the target population for screening mammography should consider age-specific incidence rates, longevity, available resources, current evidence on the efficacy of screening at different ages, and other relevant local considerations. These factors should be considered to determine both an age to begin offering mammographic screening and an upper age at which screening would no longer be offered. The ability to provide population-based mammographic screening programmes with adequate coverage must be considered. Multiple studies in the Philippines⁸, China⁹ and Colombia¹⁰, have shown that without consideration of these important issues, the effectiveness of screening mammography will be limited.

CASE STUDY

BREAST CANCER SCREENING IN URUGUAY SUPPORTS DIAGNOSIS AT AN EARLIER STAGE¹¹

Background: In an effort to support coordinated cancer control activities in both public and private sectors, a National Integrated Health System was implemented to cover 100% of the population, in both public and private institutions. A national oncologic network was implemented, linking oncology and pathology units while mammography units were distributed all across the country.

Study: Health care workers were trained in CBE and how to use a national data collection form. A public education effort was launched to increase women's awareness of BSE and CBE using illustrated materials at the same time that they were informed of easy and rapid access to mammography units. A 6-month pilot study found that 74% of women presented at earlier disease stages (stages 0-II), both in the public and private sectors.

Outcomes: Expansion of the pilot programme will include quality control of mammographic units, targeted population screening, and redistribution of mammography units to improve accessibility. In addition, the need for standardized team assessments, reliable pathology reporting, and referral and follow-up procedures are being considered for further study.

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This fact sheet was prepared by Benjamin Anderson, University of Washington, Seattle.

HELICOBACTER PYLORI AND STOMACH CANCER

REDUCING THE RISK AND INCIDENCE OF STOMACH CANCER



THE FACTS

About one million new cases of stomach cancer (also known as gastric cancer) were estimated to have occurred in 2008, making it the fourth most common cancer in the world. Stomach cancer is the second leading cause of cancer-related mortality worldwide in both sexes¹.

More than 70% of cases occur in developing countries, with a higher incidence in men than women (467 000 in men, 246 000 in women). Almost half of the global burden occurs in Eastern Asia, with areas of high-risk including China, Japan and Korea. High mortality rates also occur in Central and Eastern Europe and in Central and South America.

Worldwide, 63% of stomach cancer cases are caused by infection with the bacterium *Helicobacter pylori* (*H. pylori*)². Transmission is from person-to-person, oral-to-oral and/or faecal-to-oral. In developing countries, most infections are acquired early in life³. It is estimated that approximately 15 - 20% of patients with persistent *H. pylori* infection develop peptic ulcers and ~3% progress to stomach cancer.

A lack of proper sanitation, safe drinking water, and basic hygiene as well as poor diets, all play a role in determining the overall prevalence of infection.

A GLOBAL SOLUTION

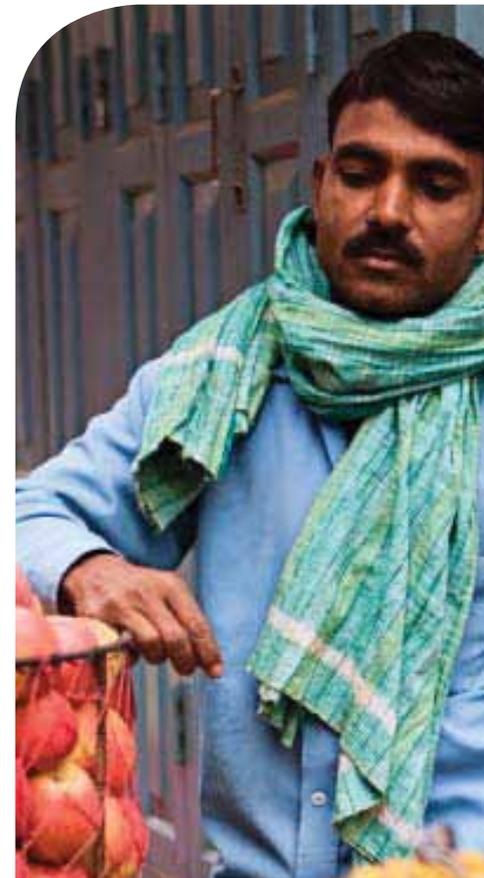
In areas of high incidence, a 'screen and treat' approach to eradicate *H. pylori* infection in those that are at risk for peptic ulcer disease or gastric cancer is an effective prevention strategy^{4, 5}.

Diagnosis of infection can be made using both endoscopic and non-invasive tests (stool antigen test, serology test and carbon urea breath test), and can be tailored to the resource setting and population of need^{5, 6}.

H. pylori eradication treatment is supported by many consensus groups worldwide⁵. Treatment involves triple drug therapy, a treatment consisting of two antibiotics to eradicate the bacterium and a standard proton pump inhibitor (PPI) to reduce the acid level in the stomach and help the ulcer to heal. This approach has been shown to result in eradication rates of *H. pylori* infection of ~90%⁴.

The specific choice of eradication regimen can be adapted to the population at need and should take into account such factors as the cost and efficacy of different medicines as well as antibiotic resistance which varies geographically and is higher in developing countries⁵.

Of equal importance is improving public health and education as part of effective strategies for reducing *H. pylori* infection rates⁴.



STOMACH CANCER INCIDENCE AND MORTALITY IN 2008



■ LESS DEVELOPED
■ MORE DEVELOPED

IN 2008, STOMACH CANCER CLAIMED THE LIVES OF 736,000 PEOPLE OF WHICH 75% WERE IN DEVELOPING COUNTRIES.



The Political Declaration of the United Nations High-Level Meeting on the Prevention and Control of NCDs adopted unanimously in September 2011 by 193 Member States, contains commitments that are aligned with the targets of the World Cancer Declaration.

The Political Declaration promotes increased access to cost-effective cancer screening programmes.

SUPPORTING EVIDENCE

Studies that have assessed the reduction of the occurrence of stomach cancer following eradication treatment for *H. pylori* infection in areas of high incidence support the implementation of a 'screen and treat' approach as an effective prevention strategy.

In China, in a study to determine whether treatment of *H. pylori* infection reduces the incidence of stomach cancer, 1630 healthy carriers of *H. pylori* were randomized to receive eradication drug therapy or placebo⁷. No patient developed stomach cancer during a follow-up of 7.5 years after *H. pylori* eradication treatment compared with six patients who received placebo. Consistent with these conclusions, a meta-analysis of six randomised trials that compared eradication treatment with no treatment in *H. pylori*-positive patients and that assessed stomach cancer or progression of precancerous lesions during follow-up, concluded that *H. pylori* eradication treatment reduces stomach cancer risk⁸.

The point in time at which eradication of *H. pylori* infection in a patient can prevent stomach cancer remains unclear. Since most infections in developing countries occur in childhood, the development of precancer may occur early in life, and more data are needed to inform the optimal timing of interventions.



MEETING THE CHALLENGE

The evidence-base for efficacy and cost-effectiveness for large-scale screening in all countries requires further attention. The worldwide *H. pylori* infection rates are declining, particularly in high-income countries, most likely due to improvements in overall living standards, including increased use of refrigeration as well as increasing use of antibiotics⁹. However, despite this decline, stomach cancer remains a major cause of mortality in developing countries, and the reduction of rates of *H. pylori* infection must be promoted as a global health problem.

Improvements in public health and education are important contributors to lowering the infection rates and will have a significant impact in reducing the burden of stomach cancer, as will encouraging the adoption of lifestyle choices which can help prevent stomach cancer such as a diet containing fruit and vegetables, physical activity, maintaining an appropriate body weight and avoiding risk-associated behaviour such as use of tobacco and smoked foods or those with excess salt^{10, 11}.

Even in areas of high incidence, the 'screen and treat' approach to eradicate *H. pylori* infection and prevent cancer is not applied consistently despite expert recommendations⁴. Screening and early detection programmes for stomach cancer that rely on radiological screening programmes to find early cancers are effective at improving rates of survival for gastric cancer but are not applicable to low resource areas⁴.

Further education of the importance of implementing effective eradication strategies are required to guide *H. pylori* management at the population level and reduce the global burden of stomach cancer.

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PROVIDING A CONTINUUM OF CANCER CONTROL AND CARE

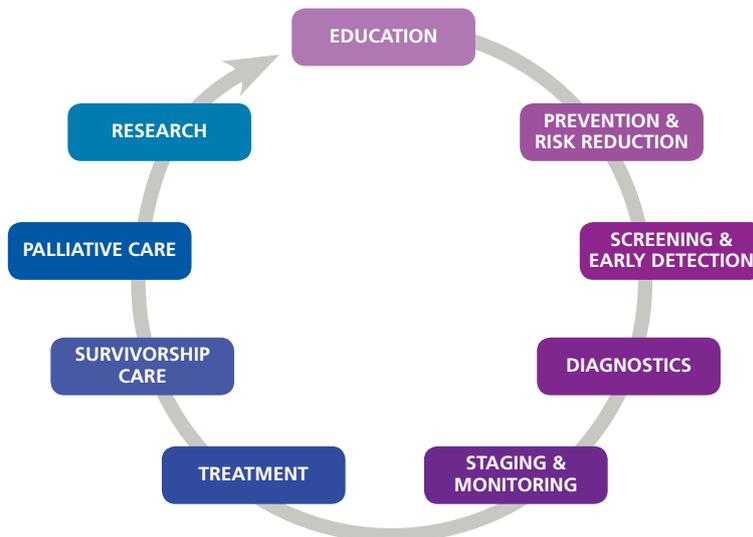


THE FACTS

Cancer is a complex disease with the appropriate treatment of most cancers requiring a multi-faceted approach that spans the entire cancer continuum, from prevention to long-term care (Figure 1).

Currently, cancer patients in many countries do not have access to some or all of these essential cancer services. Patients whose diseases are curable in the developed world unnecessarily suffer and die due to a lack of resources that enable early diagnosis and appropriate treatment. National Cancer Control Plans must be developed to meet the needs in all of these areas, and to ensure that cancer is diagnosed early when the chance of cure is greatest.

FIGURE 1: THE CORE ELEMENTS OF A COMPREHENSIVE CANCER CONTROL AND CARE CONTINUUM



A GLOBAL SOLUTION

The core elements of a cancer control and care continuum must be decided within each country based on existing health resources and infrastructure, the burden of cancer, country-specific cancer risks, political and social conditions, and cultural beliefs and practices. National Cancer Control Plans should consider the full spectrum of multidisciplinary cancer services and infrastructure across the continuum of cancer control and care, including capability and capacity to deliver:

- Education and public awareness programmes on cancer prevention, early detection and treatment
- Primary prevention programmes to address modifiable risk factors
- National immunisation programmes for HPV and HBV
- Early detection programmes
- Diagnostic technologies for accurate diagnosis and treatment
- Pathology services to process and interpret biological specimens
- Safe and effective cancer surgery
- Safe administration of effective, quality and affordable medicines
- Radiation therapy for treatment and symptom control
- Palliative care and relief of symptoms and suffering
- Survivorship support for cancer patients and their families
- Quality research and development
- Adequate and sustainable financing for primary and hospital care
- Skilled workforce



The Political Declaration of the United Nations High-Level Meeting on the Prevention and Control of NCDs adopted unanimously in September 2011 by 193 Member States, contains commitments that are aligned with the targets of the World Cancer Declaration.

The Political Declaration promotes:

- Improved access to services for prevention, treatment, palliation and rehabilitation particularly at the community level
- Increased access to affordable, safe, effective and quality medicines
- The production, training and retention of health workers with a view to facilitating adequate deployment of a skilled health workforce



SUPPORTING EVIDENCE

A robust evidence base exists from diverse countries to support the core elements of the cancer control and care continuum for different resource settings:

- The ability to conduct high quality research is crucial for the development and monitoring of successful National Cancer Control Plans as well as potential differences in the presentation of disease across populations and of response to specific treatments that may differ from those of high-income populations.
- Lack of information and education about cancer is a major barrier to effective cancer control and care in developing countries, especially for the detection of cancers at earlier and more treatable stages. Individuals, policy makers and health care professionals need to understand that many cancers can be prevented through appropriate behavioural change, that cancer can often be cured, and that effective treatments are available.
- Many cancers are preventable through infection control and lifestyle modifications. Prevention, through national immunisation programmes for HPV and HBV, promoting lifestyle change, reducing tobacco use and reducing exposure to environmental risk are of the highest priority.
- The most effective and efficient treatment programmes are those that are linked to early detection, with the infrastructure in place for accurate diagnosis that in turn underpins an appropriate and successful treatment plan. Without early diagnosis, the ability to successfully cure patients of their disease is diminished.
- Team-based, multidisciplinary treatment programmes that include access to quality, affordable and effective cancer medicines, surgery and radiotherapy are critical to the delivery of high-quality cancer care.
- In many cases the largest and most unacceptable gap in cancer care is the lack of adequate palliative care for much of the world's population. A small number of medications, none of which are limited by patent, can control pain for almost 90% of all people with cancer pain² including children³.
- For patients cured of their cancer, or living with their cancer, the provision of cancer survivorship care is critical for patients to return to a good quality of life. Mitigation of the effects of the cancer and treatment on the patient, establishment of a healthy lifestyle, and screening for new cancers becomes a key focus.

CASE STUDY: BURKITT'S LYMPHOMA

SUCCESS OF CHEMOTHERAPY IN IMPROVING SURVIVAL IN THE POOREST NATIONS

One of the most spectacular examples of how chemotherapy can be successfully delivered in low resource settings is for the treatment of Burkitt's lymphoma - a rapidly growing tumour that results in disfigurement. Although rare in high-income countries, it is the most common childhood cancer in the malaria belt of Africa, causing 3,000 deaths every year. Chemotherapy using inexpensive, readily available drugs is highly effective and can be delivered safely in low-resource settings. In India and Egypt, adoption of standard protocols has transformed the outlook for patients, increasing survival rates from 45% to 70-80%.

REPLICATING THIS MODEL IN OTHER SETTINGS

Founded in 1998, the International Network for Cancer Treatment and Research (INCTR) aims to promote evidence-based practice through long-term research projects investigating the most effective approaches to cancer care in specific settings, and supporting the growth of centres of excellence and training networks. Currently, the African Burkitt Lymphoma Strategy Group comprised of investigators from Cameroon, Kenya, Nigeria, Tanzania and Uganda has implemented a study protocol entitled, "The Treatment and Characterization of Burkitt's Lymphoma in Africa".

- Over 400 patients have been enrolled on the protocol with preliminary data showing it is possible to cure a significant fraction of patients, even those who relapse or partially respond to initial treatment.
- The preliminary reports indicate a significant improvement in managing patients with Burkitt's Lymphoma.
- The team approach to patient care is now well established in these centres.
- Supportive care and patient follow-up has improved.
- Accurate and complete data for all study patients are being collected, and data monitoring is performed.

MEETING THE CHALLENGE

Successful cancer control and care programmes in many low resource settings around the world provide effective cancer services across the continuum of care dispelling the myth that this approach is only feasible in high resource settings. Locally appropriate solutions that provide sustainable and equitable services and encompass the core elements are possible even with scarce resources and policy makers must understand that without each of the critical components of a multidisciplinary approach, high quality cancer care is not possible.

WITH FEW EXCEPTIONS, EARLY STAGE CANCERS ARE LESS LETHAL AND MORE TREATABLE THAN LATE STAGE CANCERS

Global Task Force on Expanded Access to Cancer Care and Control in Developing Countries¹

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PRIMARY HEALTH CARE AS PART OF THE CANCER CONTROL AND CARE CONTINUUM



THE FACTS

The concept of providing person-centred care to improve patient outcomes has been applied to many areas of health but is often not seen as central to cancer planning due to the misconception that cancer is a disease that can only be diagnosed and treated in specialist care facilities.

Primary care has a role in all stages of the cancer control and care continuum. Early detection of cancer, preventive care to reduce the incidence of poor health, health promotion to reduce exposure to cancer risk factors and provision of survivorship and palliative care can be delivered in an efficient, sustainable and equitable manner as part of primary health care services¹.

A GLOBAL SOLUTION

The development and implementation of an essential primary care benefits package for cancer as part of comprehensive National Cancer Control Plans is critical to providing an effective, sustainable and equitable response to national cancer burdens.

Practical evidence-based interventions can be delivered by primary care professionals and community health workers that are feasible and cost-effective for prevention, early detection of cancer signs and symptoms and delivery of survivorship and palliative care services. This core set of interventions can be expanded over time based on local requirements and the level of available resources².

Of equal importance is the development of a skilled primary care workforce and making the public, policy makers and health professionals aware of the benefits for both the health system and patients when cancer services are fully integrated into primary care.

SUPPORTING EVIDENCE

There is a considerable evidence base showing that strong primary care contributes to overall health system performance (quality, efficiency and equity) and to improved health outcomes⁴. A person-centred, comprehensive and integrated approach to cancer that provides continuity of care with a regular point of entry into the health system - some of the key aspects that differentiate conventional health care from primary care⁴ - is cost-effective and feasible for cancer prevention, early detection and management of care in all settings.

CONTINUED OVERLEAF



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The Political Declaration of the United Nations High-Level Meeting on the Prevention and Control of NCDs adopted unanimously in September 2011 by 193 Member States, contains commitments that are aligned with the targets of the World Cancer Declaration.

The Political Declaration promotes the inclusion of NCD prevention and control within sexual and reproductive health and maternal and child health programmes especially at the primary health-care level, and urges governments to pursue comprehensive strengthening of health systems that support primary health care.

“NON-SPECIALIZED HUMAN RESOURCES AND PRIMARY AND SECONDARY LEVELS OF CARE CAN BE USED TO DELIVER SEVERAL COMPONENTS OF CANCER CARE AND CONTROL AND THIS CAN HELP TO PARTIALLY OVERCOME THE SHORTAGE OF SPECIALTY SERVICES.”

Global Task Force on Expanded Access to Cancer Care and Control in Developing Countries³

SUPPORTING EVIDENCE CONTINUED

Education and awareness: Although awareness in developing countries remains low, even among health professionals, levels of concern about cancer are high, and the public pays attention to messaging about cancer. Awareness and education programmes targeted at communities, health professionals and policy makers can improve knowledge of cancer and cancer prevention and early detection strategies; dispel common misconceptions about cancer; and prevent stigma by the community, especially for women. Cancer outcomes cannot improve unless patients and the health care community understand the benefits of early detection and are willing to support timely diagnosis and treatment.

Prevention: Primary care professionals and community health workers should be a major source of health and lifestyle advice for primary prevention focused on reducing exposure to the major modifiable causes of cancer, including tobacco, harmful alcohol use, inactivity and unhealthy eating. Due to the large burden of cancer from infectious agents, cancer prevention through vaccination should be delivered in the primary care setting including the provision of HPV and HBV vaccines through national immunisation programmes to address cancer-related infections to reduce the future burden of cervical and liver cancers.

Early Detection and Treatment: Early detection accessed through primary care can improve uptake and public awareness of cancer screening programmes. Raising awareness about early cancer diagnosis to health professionals in primary care is a critical component to achieving reductions in cancer mortality⁵. Early recognition is particularly relevant in the context of primary care in low resource settings – it is cost-effective and in some cases does not require any specialist diagnostic technologies as is the case with clinical breast examination and inspection for oral cancers. For cervical cancer, the screen and treat approach that combines VIA or HPV DNA testing with cryotherapy for early detection for women 35 to 42 years is currently recommended as part of the WHO package of essential core noncommunicable (PEN) disease interventions for primary health care in low-resource settings².

Survivorship Care: Greater access to cancer control and care in low- and middle- income countries, and consequently reduced mortality and morbidity from cancer, will make it increasingly important to incorporate survivorship as part of care. There are currently more than 28 million cancer survivors worldwide, and people now diagnosed with cancer are increasingly likely to survive at least five years. The most effective way to expand survivorship care in low resource settings is through a diagonal approach that involves the primary care network as well as community-based programmes. This approach will also help to reduce stigma and discrimination.

Palliative Care: Countries must invest in the policies and procedures that enable access, effective and safe prescribing, dispensing and administering of key medications, especially opioids including morphine which is included on the WHO core list of medicines required for implementing essential NCD interventions in primary care². For a terminally ill patient, the ability to meet their specific needs including enabling a patient to die in the place of their choice, which for some will mean at home, is an important part of quality palliative care⁶.



MEETING THE CHALLENGE

Addressing the funding and policy gap: The evidence that primary care can deliver better health outcomes at lower cost is strong. Despite this, investment in per capita health expenditure in many countries is low, making it difficult to integrate cancer interventions into primary care in a comprehensive manner². The trend for donor funding in the last decade to focus on vertical, disease-specific outcomes has resulted in an under-investment in health systems further exacerbating the ability to provide comprehensive coverage at the primary care level and failing to address inequities in access to care. Investment in a diagonal approach that focuses on the integration of health services, including integrating cancer prevention and management into primary health care will tackle cancer-specific priorities while addressing the gaps within the health system, optimising the use of resources and improving coverage for many diseases and population groups.

Adoption of a national policy framework across all sectors of government that includes investment in education, training, health service provision, and research as well as comprehensive tobacco control measures, approaches and strategies to support individuals to lead healthy lifestyles and reduce consumption of salt and alcohol, and communities to engage in managing their health, must work in parallel to ensure that primary care interventions have the greatest impact on disability, morbidity and mortality from cancer².

Addressing the skills gap: A significant challenge is providing the workforce required to manage cancer with most developing countries facing a severe shortage of oncologists, and other specialists including pathologists and personnel to operate radiotherapy services. While access to some specialty care is essential, this can be complemented in many ways to build capacity in a skilled workforce at the primary care level. Optimal tasking whereby tasks are both shared among health workers with differing levels of training combined with the shifting of some tasks from specialist health workers to newly trained or less qualified health workers, has proven an effective way to engage expert patients, community health workers, clinical health assistants, nurses and physicians working in primary care level facilities to provide more and better access to cancer control and care services.

Addressing the infrastructure gap: The provision of care closer to patients and removing geographical barriers to access can be assisted through greater use of telecommunications to better connect patients, care givers and health providers through technology⁷. At the primary level, training for a range of staff can be enhanced by distance learning through structured courses. This is being undertaken in Mexico, for example, for health promoters, nurses, physicians, and outreach workers around breast cancer early detection through the National Institute of Public Health. In addition, telecommunications can be used to provide access to diagnosis and specialised care in remote primary care facilities through partnerships and linkages with distant oncology specialists, as well as to facilitate exchange of information for decision-making and awareness-building.

Summary: Greater emphasis on primary care not only has cost benefits but increases access, improves continuity of care and brings care closer to the home and community. Existing programmes are most often small-scale and under-resourced so that programmes now require evaluation, and lessons learned adapted and incorporated into large-scale programmes.

FOR BREAST CANCER CONTROL AND CARE

Using breast cancer as an example, many opportunities exist for optimal tasking and infrastructure shifting to expand access at each stage of the cancer control and care (CCC) continuum. In terms of health promotion and primary prevention, all players at the primary care level, including community members and community health workers (CHWs), should be trained and engaged in promoting healthy lifestyles and physical activity, and in preventing obesity. This should be part of any anti-poverty, empowerment of women, maternal and child health, or sexual and reproductive health initiatives.

In early detection, CHWs should be trained to identify risk factors related to family history, teach women about breast health and assist them in recognizing warning signs, and help women seek a diagnosis. CHWs can also be trained to perform effective breast clinical exams, especially where the objective is to reduce the number of very late cases that are easily detected with visual inspection. This does not require sophisticated technology such as mammography. During treatment, the CHW can play an active role by supporting the patient, and, in survivorship, by educating the community to prevent stigma.

Well-trained technicians and radiologists at the primary or secondary level of care can undertake mammography, ultrasound, and biopsy, if appropriate medical devices are available. Images and samples can be shared with experts in the remote, specialty facility, via either electronic or physical transfer of files. This can facilitate the diagnosis that must take place at the specialty level.

Much of the adjunct therapy for breast cancer is repetitive (multiple doses of the same agent over weeks, months, or years) and can be provided at the secondary or primary care level, or even at home, if support staff are trained (nurses), basic laboratory facilities are in place, hygiene is good, and effective communication is available to link-up to a specialist in case of a reaction or a needed adjustment in the treatment protocol. If initial doses are managed at a specialty centre, the risk of later reactions is minimized.

Ongoing survivorship care, such as therapy for lymphodema, can also be undertaken locally with proper training. Opioid-based pain control can be managed at the primary or secondary level, if drugs are available in appropriate packaging, and if there is guidance and communication with a remote specialist.

Thus, while diagnosis, treatment management, surgery, radiation, and some adjunct treatment should take place in tertiary-level facilities, many components of CCC for breast cancer can be handled in primary- and secondary- level care facilities. All of these activities can be assisted by telemedicine and applications of ICT that increase access to knowledge and awareness.

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ACCESS TO RADIOTHERAPY



THE FACTS

Radiotherapy (RT) is a critical component of high-quality cancer care. It can cure cancers alone, or in combination with surgery or chemotherapy.

It also plays an integral role in symptom control (palliative care) in cancer patients suffering from life-threatening diseases. More than 50% of cancer patients should receive radiotherapy at least once in the course of their care¹.

Limited access to radiotherapy for cancer control and treatment particularly in low- and middle- income countries, is a significant contributing factor to high morbidity and mortality. The International Atomic Energy Agency (IAEA) estimates that worldwide, an additional 7000 radiotherapy units are needed to adequately care for the current needs of cancer patients. This figure is predicted to rise due to the increasing global burden of cancer.

A vital investment for all countries is the development and implementation of a comprehensive National Cancer Control Plan that includes national policies and strategies to increase the use of radiotherapy as part of a sustainable multidisciplinary approach to cancer prevention, detection and treatment.

A GLOBAL SOLUTION

Increasing the use of radiotherapy as part of essential multidisciplinary cancer services will reduce morbidity and mortality for cancer patients in all settings.

The provision of increased capacity for radiotherapy should be delivered as part of a comprehensive National Cancer Control Plan to ensure long-term and sustainable action to address a country's cancer burden.

To translate this ambition into reality, political will and resources must be mobilised and focused around several inter-related activities. First, additional radiotherapy equipment is necessary to address overall capacity constraints and to begin to replace outdated, less effective, machines. Second, healthcare worker training is required to optimise care for cancer patients and maximise the application of RT technology. Third, a more concerted effort is required to develop and disseminate evidenced-based information - for patients, healthcare providers, government decision-makers, and international donors.

SUPPORTING EVIDENCE

Demand for Radiotherapy: The clinical need for radiotherapy for cancer treatment is expanding as a result of the growing global cancer burden and as RT, alone or in combination with surgery or chemotherapy, is increasingly seen as an effective way to control or cure certain types of cancer.

CONTINUED OVERLEAF



The Political Declaration of the United Nations High-Level Meeting on the Prevention and Control of NCDs adopted unanimously in September 2011 by 193 Member States, contains commitments that are aligned with the targets of the World Cancer Declaration.

The Political Declaration calls for the improvement of access to safe, affordable, effective and quality medicines and technologies to diagnose and treat cancer.

IN THE DEVELOPED WORLD, THERE IS ONE UNIT PER ~165,000 PEOPLE; IN LOW- TO MIDDLE- INCOME COUNTRIES, THE RATIO IS ONE UNIT PER ~3.5 MILLION PEOPLE².

SUPPORTING EVIDENCE CONTINUED

In Europe, an estimated 52% of patients are expected to benefit from radiotherapy alone or in combination with surgery and chemotherapy at least once in the course of treatment¹. This figure, while significant, greatly understates the demand over the next few years as policy-makers, health professionals, and patients come to understand how advances in radiotherapy technology over the past decade offer new hope for cancer treatment.

There is even greater need for RT in the developing world due to higher rates of late-stage cancer diagnosis that preclude adequate treatment by surgery alone³.

Demand for radiotherapy is also increasing for cancers that formerly were not treatable. For example, liver cancer that kills almost 700,000 people each year, making it the third most common cause of death from cancer worldwide⁴. Radiotherapy can now be precisely delivered to many liver cancers, thus permitting higher doses to the cancer and reduced doses to surrounding normal tissues⁵. Administered as the definitive therapy, radiotherapy has been successful in treating early stage cancers, and is key to improved outcomes when used in combination with other treatments for intermediate stage and locally advanced cancers^{6,7}.

For other advanced stage cancers, radiotherapy can also offer the best hope of successful treatment. For the thousands of women diagnosed each year in low- and middle- income countries with advanced stage cervical cancer, the ability to deliver a radiation source close to the surface of the cancer (brachytherapy) results in the best outcome for patients. Radiotherapy is also integral to the relief of pain and symptoms experienced by millions of terminal cancer patients.

Unmet Demand: Currently, the supply of radiotherapy services falls short of demand, most notably in developing countries where the need for radiotherapy vastly outstrips access to facilities^{8,9}. In many regions, the minimum goal set by IAEA of one therapy unit for every 1 million population is not being met. In Indonesia, available radiotherapy services represent less than 10% of national need. In Africa, it is estimated that only 18% of the need is met, with 22 countries without services and many others greatly under-resourced. In Nigeria, which is home to almost one-quarter the population of Africa, there are less than 15 operational radiotherapy units servicing 155 million people (IAEA, personal communication).

Large gaps in the number of radiotherapy services are evident in high-income countries as well, accounting for ~5 to 10% of total cancer care costs¹⁰⁻¹². This gap exists despite the cost-effectiveness of radiotherapy resulting from patients receiving radiotherapy in outpatient settings and the long life span of equipment and facilities once established⁸.

CASE STUDY: INTERNATIONAL ATOMIC ENERGY AGENCY

DELIVERING RADIOTHERAPY TO DEVELOPING COUNTRIES

Since 1980, the IAEA has delivered over \$US250 million worth of cancer-related assistance to developing countries, expert advice, essential equipment and training. In addition to fellowship training opportunities, the IAEA is now providing learning resources through a portal for health professionals engaged in delivering radiation medicine in developing countries (<http://nucleus.iaea.org/HHW/Home/index.html>).

However, the IAEA recognises that strategic planning and capacity building for cancer therapy cannot occur without extensive collaboration with other international key players. In 2004, IAEA launched a Programme of Action for Cancer Therapy (PACT) whose mission is to contribute to the improvement of cancer survival in developing countries by integrating radiotherapy investments into public health systems. PACT works to maximise the impact and effectiveness of radiotherapy by integrating it with comprehensive cancer strategies within the framework of a National Cancer Control Plan to ensure that all relevant cancer services are delivered via timely, planned and balanced investments across the health system. Working with the World Health Organization, and other leading international and national organisations in cancer prevention and control including UICC, PACT core activities include:

- Conducting multidisciplinary assessments of national cancer control capacity (imPACT)
- Developing and initiating sustainable, integrated cancer control programmes in PACT Model Demonstration Site (PMDS) countries
- Developing regional cancer training and mentoring networks through a Virtual University for Cancer Control, collectively called VUCCnet
- Working with the manufacturers of diagnostic and therapy equipment to deliver integrated solutions for radiotherapy that are affordable, safe, reliable, effective and suitable for low-resource settings (AGaRT)

For more information on PACT go to <http://cancer.iaea.org/>

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MEETING THE CHALLENGE

For the millions of patients suffering from cancer, access to quality radiotherapy services as part of multidisciplinary cancer care is critical¹³.

Addressing the radiotherapy services gap

Investment in new and additional radiotherapy units should be seen as an essential component of every country's national cancer control plan. The number and type of facilities is dependent upon the setting and should be determined to ensure that the investment in radiotherapy results in the greatest impact for cancer patients.

The type of facility should meet the country priorities for reducing the national cancer burden. The linear accelerator (linac) machine requires a reliable source of electricity and climate control to generate the source of radiation; however, advances in technology have provided more robust and more affordable alternatives to the extent that the linac is now the widely accepted standard in all regions around the world today for delivery of external beam radiation.

Cobalt-60 machines are often found in low-income settings as they are less expensive and are simpler to operate and maintain¹⁴. However, Cobalt-60 machines rely on a radioactive source. Sources must be replaced every 5-6 years, requiring safe disposal of the old radiation sources and this expense must be weighed against cost, commissioning, training, and maintenance of a linac which has a useful lifespan of 10-12 years².

The cost for establishing a basic radiotherapy clinic is one of the hurdles in providing quality radiotherapy services for cancer patients. The current price tag for establishing a basic radiotherapy clinic, in the range of \$3-5M, includes not only the price of the radiotherapy unit but also the ancillary costs of infrastructure, provision of skilled staff and operation of the facility which make up a significant component of the price tag. These factors should be considered versus the increasing benefits of using modern radiotherapy: more than half of all cancer patients benefit from a therapy that is targeted more accurately than ever before, treatment times are shorter (for example, due to more efficient use of the linac), cure rates are increased, and side effects are reduced.

Addressing the skills gap

The provision of equipment and maintenance while key to success is not sufficient. A significant challenge for most developing countries is the lack of qualified staff and radiotherapy experience. Ongoing education of radiation oncologists, radiation therapists, nurses and technicians and medical physicists are all needed for the successful operation of a high quality service for patients, irrespective of the type of facility. National policies and approaches that support appropriate legislation to ensure safe practices are also essential.

Addressing the information gap

Enhancing the information flow around radiotherapy is an integral part of the access challenge. Greater awareness is needed amongst policy makers, health professionals, patients and caregivers of the importance of early diagnosis and the possibilities for curative treatment, including radiotherapy. Comparative international studies indicate that late diagnosis accounts for a substantial share of sub-optimal cancer outcomes in developing countries¹⁵.

Perceptions around the cost of establishing a basic radiotherapy clinic are changing as the case for radiotherapy as a worthwhile investment is strengthening. Radiotherapy has been shown to be a cost-effective approach to cancer treatment in high-income countries. Indeed, "findings of published studies of costs consistently show that radiotherapy is one of the most cost-effective forms of cancer treatment because most people are treated as outpatients, equipment and buildings have a long life, and [patient] throughput on equipment is high⁸."

Evidence to further support cost-effectiveness is also emerging from developing countries. For example, the Breast Health Global Initiative (BGHI) produced regional estimates on the cost-effectiveness of treatment for breast cancer in Africa, Asia, and North America, and concluded that radiotherapy is generally cost-effective⁹. Additional analysis on the cost-effectiveness in low- and middle- income countries of newer technologies should be supported⁹.

New partnerships are being formed, such as the Advisory Group on Increasing Access to Radiotherapy Technologies in developing countries (AGaRT), which bring together manufacturers, radiotherapy manufacturers and providers, international organisations, representatives from developing nations, and IAEA-based experts to increase the ability to provide radiation technology affordably and safely in low- and middle-income countries.

Summary

Effective treatment for cancer exists and comprehensive cancer control programmes have proven successful in understanding and responding to the national cancer burden in all settings. New resources, in the form of radiotherapy machines, medical equipment, medicine and health workers, can have an immediate, positive effect. But achieving positive results requires coordinated action, based on a strategic and systematic approach. We must work through partnerships and bring the resources of the global health community together to transfer this success to fight cancer in the developing world.

PROVIDING SUSTAINABLE ACCESS TO ESSENTIAL CANCER MEDICINES



THE FACTS

The capacity to safely administer chemotherapy and other systemic therapies - often in conjunction with surgery and radiotherapy - is a critical component of high-quality cancer care.

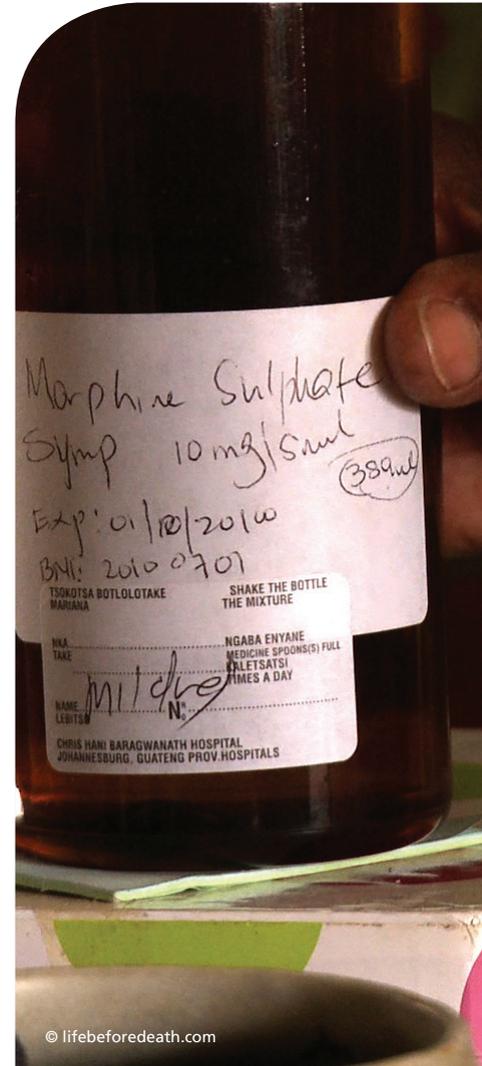
Significant inequities in access to cancer medicines exist both between and within countries, particularly in low- and middle- income countries, resulting in unnecessary deaths from cancers that are curable in high resource settings. All people should have access to proven effective cancer treatment and services on equal terms, and without suffering economic hardship as a consequence.

A vital investment for all countries is the development and implementation of a National Cancer Control Plan to ensure the efficient use of resources to implement comprehensive approaches to cancer prevention, diagnosis and care. This includes adopting national policies and strategies to promote sustainable access to affordable, safe, effective and quality-assured medicines.

A GLOBAL SOLUTION

The majority of critical anti-cancer drugs are off-patent and can be manufactured generically at relatively low prices. As the available resources in a country increase, so should the number and variety of cancer medicines available for treatment.

With proper training, cancer medicines can be safely prepared and administered at national and district hospitals even in very low-resource countries. This should be in accordance with resource-appropriate evidence-based guidelines, with appropriate support from oncology specialists, as well as psychosocial support.



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The Political Declaration of the United Nations High-Level Meeting on the Prevention and Control of NCDs adopted unanimously in September 2011 by 193 Member States, contains commitments that are aligned with the targets of the World Cancer Declaration.

The Political Declaration promotes increased access to affordable, safe, effective and quality medicines including generics and sustainable access to medicines through the efficient procurement and distribution of medicines in countries.

“ESSENTIAL MEDICINES ARE INTENDED TO BE AVAILABLE WITHIN THE CONTEXT OF FUNCTIONING HEALTH SYSTEMS AT ALL TIMES IN ADEQUATE AMOUNTS, IN THE APPROPRIATE DOSAGE FORMS, WITH ASSURED QUALITY AND ADEQUATE INFORMATION, AND AT A PRICE THE INDIVIDUAL AND THE COMMUNITY CAN AFFORD.”

World Health Organization

SUPPORTING EVIDENCE

Expanding sustainable access to inexpensive, effective quality, off-patent medicines is one of the keys to achieving improved outcomes for people with cancer in all countries. A number of cancer medicines can substantially reduce the mortality rate for some cancer patients, and greatly extend the life of others (Table 1). A recent report estimates that most of the off-patent generic cancer medicines required for low- and middle- income countries are available for less than \$US100 per course of treatment, and nearly all for under \$US1,000¹.

The delivery of these medicines, as part of a team-based approach to cancer care, is achievable in both high- and low- income settings if delivered according to guidelines that are appropriate for the level of resources. The resource-sensitive treatment guidelines for breast cancer developed by the Breast Health Global Initiative (BHGI) are one example, and include recommendations for use of inexpensive off-patent systemic drugs such as Tamoxifen (WHO Essential Medicines list) that provides contemporary breast cancer treatment with outcomes comparable to those seen today in high-resource settings^{2,3}. As the level of resources increases, additional drugs can be made available. For breast cancer, this includes aromatase inhibitors including anastrozole and letrozole, and taxanes (paclitaxel), which are off-patent but not on the WHO Essential Medicines list (Table 1).

The evaluation of newer, more costly, targeted therapies (drugs that interfere with specific molecules involved in cancer growth and progression) should be done on an individual basis within the national cancer control planning process to make the best possible use of resources. Although many of these newer agents only impact on a specific cancer type or provide incremental improvements, others have dramatic life-saving or life-extending results. In the case of HER2-positive breast cancer, access to on-patent medicines including trastuzumab (Table 1) as part of treatment given after surgery has been shown to dramatically reduce the risk of disease recurrence and death by nearly 50%^{2,5}. For chronic myelogenous leukaemia (CML), a rarer type of cancer, cancer drugs such as imatinib (Glivec) can be highly effective, greatly extending high-quality life for these patients. The Glivec International Patient Assistance Program (GIPAP), an initiative of the Max Foundation, aims to facilitate access to imatinib which would otherwise be unaffordable for many people⁶ and demonstrates that innovative approaches to facilitating expanded access to on-patent drugs are possible. Thus, governments and policy-makers in low- and middle- income countries should allow for the flexibility to include these emerging medicines into national cancer control plans understanding that different approaches may be appropriate in different settings and that additional, more costly drugs and technologies can be incorporated into cancer plans as the level of available resources increases.

Essential medicines for pain relief and symptom control should be included in national cancer control planning. A small number of medications, none of which are on patent, can control pain for almost 90% of all people with cancer pain⁷ including children⁸. These medications, when used alone or in combination, can significantly reduce pain, and directly improve the quality of care, level of function and level of comfort for millions of people around the world. Opioids such as morphine, are off-patent and inexpensive, and can be tailored to the needs of the individual⁹. For more information, please refer to: UICC's fact sheets on palliative care and access to pain relief, and; Global Access to Pain Relief Initiative (www.treatthepain.com).



MEETING THE CHALLENGE

The affordability of quality cancer medicines is a key determinant of access in many countries. As a first step cancer drugs on the WHO list of essential drugs, which are low cost and effective cancer drugs, should be made available in developing countries based on priorities set as part of national cancer control planning⁴. As the available resources increase so should the number and variety of cancer medicines available for cancer treatment.

Building a country's cancer care infrastructure is also critical to deliver chemotherapy and other systemic therapies safely and effectively. Priorities for action should include:

- Building expertise and capacity amongst health professionals to ensure the safe and proper administration of chemotherapy and other systemic therapies, including follow-up care
- Developing and promoting evidence-based, resource-appropriate cancer treatment guidelines
- Tailoring cancer treatment protocols so that individuals and populations receive the specific cancer medicines from which they are most likely to benefit
- Developing laboratory, pathology, and clinical services for cancer diagnosis, staging, and monitoring of effectiveness and safety of therapy

Governments and decision-makers need to give higher priority to providing sustainable access to affordable, safe, effective and quality-assured cancer medicines. A set of recommendations for activity at national and global level on access to medicines and technologies for non-communicable diseases (NCDs) including cancer, has been proposed by the NCD Alliance, including:

- Strengthening the capacity of national medicines regulatory authorities to promote the quality, safety and efficacy of cancer medicines
- Enabling efficient procurement and distribution systems
- Promoting the use of quality generic medicines
- Supporting innovative sustainable approaches to financing essential medicines

For the full NCD Alliance briefing paper on Essential Medicines and NCDs, please visit the NCD Alliance website: www.ncdalliance.org

TABLE 1: PROPOSED LIST OF ESSENTIAL CANCER MEDICINES¹

AGENT	ROUTE OF ADMINISTRATION	PATENT STATUS	WHO ESSENTIAL DRUG LIST 2010*
ANASTROZOLE, LETROZOLE	Oral	Off	No
ASPARAGINASE	Parenteral	Off	Yes
BLEOMYCIN	Parenteral	Off	Yes
CARBOPLATIN	Parenteral	Off	Yes
CISPLATIN	Parenteral	Off	No
CYCLOPHOSPHAMIDE	Parenteral and oral	Off	Yes
CYTARABINE	Parenteral	Off	Yes
DACARBAZINE	Parenteral	Off	Yes
DACTINOMYCIN	Parenteral	Off	Yes
DAUNORUBICIN	Parenteral	Off	Yes
DEXAMETHASONE	Oral	Off	Yes
DOXORUBICIN	Parenteral	Off	Yes
ETOPOSIDE	Parenteral and Oral	Off	Yes
FLUOROURACIL (5-FU)	Parenteral	Off	Yes
HYDROXYUREA	Oral	Off	Yes
IFOSFAMIDE	Parenteral	Off	Yes
IMATINIB	Oral	On	No
LEUCOVORIN	Parenteral and Oral	Off	Yes
MELPHALAN	Oral	Off	No
MERCAPTOPYRINE	Oral	Off	Yes
MESNA	Parenteral and Oral	Off	Yes
METHOTREXATE	Parenteral and Oral	Off	Yes
PACLITAXEL	Parenteral	Off	No
PREDNISONE	Oral	Off	Yes
RITUXIMAB	Parenteral	On	No
TAMOXIFEN	Oral	Off	Yes
TRASTUZUMAB	Parenteral	On	No
VINBLASTINE	Parenteral	Off	Yes
VINCRISTINE	Parenteral	Off	Yes

* The WHO Essential Medicines list:
<http://www.who.int/medicines/publications/essentialmedicines/en/>

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PALLIATIVE CARE

PALLIATIVE CARE AS PART OF NATIONAL AND JURISDICTIONAL HEALTH AND SOCIAL POLICIES



THE FACTS

Each year more than 7.6 million people with cancer will die worldwide¹. Of these, 64% of cancer deaths occur in developing countries.

For most cancer patients with advanced life-limiting illness, the prelude to death from cancer is a period of functional decline associated with progressive symptoms and an increasing burden of care. For most patients, day-to-day care is based in the community and provided by family and friends. Optimising symptom control and psychosocial support services benefits the patient and the caregiver.

A GLOBAL SOLUTION

The health of the population requires good palliative care, not simply for the benefit of the person dying, but also for caregivers while in the role and after the death, as well as providing substantial benefits for the health system.

For all populations and resource settings, palliative care should be part of national and jurisdictional health and social policies for all non-communicable diseases, including care delivery, education for the community and clinical staff, optimising models of service delivery, and research.

SUPPORTING EVIDENCE

At all levels of the health system, there are demonstrable benefits from very modest investments in palliative care that improve the health outcomes of the community².

For patients: Symptom control reduces suffering and the horrendous impacts of incurable illness^{3,4}. For a terminally ill patient, access to specialised palliative care services means that their specific needs can be better met, for example, enabling a patient to die in the place of their choice, which for some will mean at home⁶. Other demonstrable benefits for patients include improved satisfaction of care⁵ and comfort in the last weeks of life⁷.

For caregivers: How well people make the transition from caring for a terminally ill patient back to other roles varies widely and often has long-term consequences. For caregivers, the benefits of palliative care services can include better adjustment after the death, and potentially greater ability to reintegrate back into society after the role of caregiver ends. Access to specialised palliative care services has numerous other benefits for the caregiver, including reducing anxiety⁵, meaningful improvements in addressing the needs of caregivers, both in the short-term (“unmet needs”) and long-term (“moving on”)⁸, as well as affording a longer life for the caregiver having relinquished the role⁹.

For the health system and health funders: The involvement of specialised palliative care services has a number of significant benefits including reducing the inpatient bed days^{10,11} as well as the number of hospital admissions¹². The involvement of palliative care is also associated with decreased costs when compared to conventional care¹³.

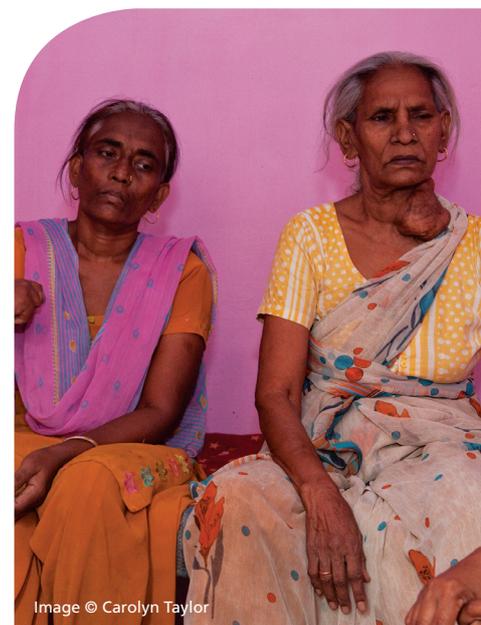


Image © Carolyn Taylor

The World Health Organization defines palliative care as **“AN APPROACH THAT IMPROVES THE QUALITY OF LIFE OF PATIENTS AND THEIR FAMILIES FACING THE PROBLEMS ASSOCIATED WITH LIFE-THREATENING ILLNESS, THROUGH THE PREVENTION AND RELIEF OF SUFFERING BY MEANS OF EARLY IDENTIFICATION AND IMPECCABLE ASSESSMENT AND TREATMENT OF PAIN AND OTHER PROBLEMS, PHYSICAL, PSYCHOSOCIAL AND SPIRITUAL.”**



The Political Declaration of the United Nations High-Level Meeting on the Prevention and Control of NCDs adopted unanimously in September 2011 by 193 Member States, contains commitments that are aligned with the targets of the World Cancer Declaration.

The Political Declaration promotes improved access to services for prevention, treatment, palliation and rehabilitation particularly at the community level.



MEETING THE CHALLENGE

Communities around the world value supportive and palliative care^{14, 15}. Despite this, there is consistently poor investment in palliative care compared to other areas¹⁶. Part of the challenge of attracting funding is that no single measure reflects the complexity of net benefit derived from specialised palliative care services¹⁷.

An absolute commitment is required from every government worldwide to see the care of the dying as an explicit investment in the health of the community. Specific policies in education, training, health service provision, and research need to be in place that actively promote best-practice palliative care through national strategies.

CASE STUDY: KERALA

DEMONSTRATING LEADERSHIP IN THE DELIVERY OF PAIN RELIEF AND PALLIATIVE CARE IN INDIA

Kerala, a small state on the southwest coast of India, has taken the lead role in the delivery of pain relief and palliative care in a resource-constrained setting. The state has a network of about 140 palliative care centres – more than all the centres in the rest of the country put together. This network first came to life in 1993 with the establishment of the Pain and Palliative Care Society (PPCS), a non-governmental organisation (NGO) based in Calicut, Kerala¹⁸. PPCS succeeded in developing a model of care adapted to the Indian situation, empowering care at home mostly delivered by relatives who are supported by an outpatient clinic. Home visits are offered to the bed-bound, and low cost oral morphine is made available for use by patients at home¹⁹. A study of 1723 patients over a 2-year period showed safe and effective use of oral morphine in the home setting without misuse²⁰.

Collaborative efforts of the Pain and Policy Studies Group (PPSG) at Madison-Wisconsin with Indian palliative care workers resulted in the simplification of narcotic regulations in Kerala in 1999, with trained volunteers forming a major part of the workforce. The support spread with Neighbourhood Networks in Palliative Care (NNPC) facilitating increased active involvement of the community in the care process²¹. In 2008, acting on a proposal submitted by the NGO Pallium India (www.palliumindia.org), the Government of Kerala introduced a palliative care policy, integrating palliative care into general health care.

Many barriers still remain: Quality of services in some centres; lack of education of clinical staff; and capacity to deliver care in the absence of adequate medical and nursing support. Despite this, the achievement in Kerala is remarkable and can be viewed in the context of Kerala State which demonstrates an outstanding performance in most health and health care indicators. This is in part due to the outstanding role of women and civil society²². This issue should be considered in any attempt to fully or partially replicate the model.

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PALLIATIVE CARE AND PAIN RELIEF

ACCESS TO KEY MEDICATIONS TO SUPPORT SYMPTOM CONTROL FOR PEOPLE WITH ADVANCED LIFE-LIMITING ILLNESS



THE FACTS

The major symptoms of advanced cancer and other life-limiting non-communicable diseases include fatigue, anorexia, pain and breathlessness; symptoms increase in prevalence and severity as death approaches.

Pain can be well controlled for more than 90% of people with advanced cancer, with a combination of inexpensive opioids together with simple analgesics. These are safe medications that can be adjusted carefully to the person's needs and for which addiction has not been a documented problem.

Each year more than 7.6 million people with cancer will die worldwide. Most people with advancing cancer will have pain that may be severe and totally disabling. Many people will also have pain from the cancer leading to the diagnosis, and during, or as a result of treatment. However, in a number of countries, people in severe pain have little or no access to opioid medications.

This is because many countries (at all resource levels) have no predictable access to opioid medications and many more countries have restrictions that render the use of opioids for chronic and worsening cancer pain almost impossible to access.

A GLOBAL SOLUTION

A small number of medications, none of which are limited by patent, can control pain for almost 90% of all people with cancer pain¹ including children². This short list of medications when used alone or in combination will significantly reduce pain, and directly improve the quality of care, level of function and level of comfort for millions of people around the world.

Without pain, people are better able to care for themselves without help from health or social services. Without pain, people can continue to actively contribute to their communities.

The Global Access to Pain Relief Initiative (GAPRI) is a joint project of UICC and the American Cancer Society (ACS) to make essential pain medicines universally available by 2020. Activities are focused in four areas:

1. **Providing** technical assistance to governments;
2. **Improving** the market for essential pain medicines;
3. **Advocating** at the international, national, and local levels;
4. **Empowering** a network of clinicians interested in pain relief.



Image © Carolyn Taylor



The Political Declaration of the United Nations High-Level Meeting on the Prevention and Control of NCDs adopted unanimously in September 2011 by 193 Member States, contains commitments that are aligned with the targets of the World Cancer Declaration.

The Political Declaration promotes access to affordable, safe, effective and quality medicines including generics and sustainable access to medicines through the efficient procurement and distribution of medicines in countries.

1 IN 10 PEOPLE WILL DIE IN SEVERE PAIN DUE TO A LACK OF ACCESS TO OPIUM-BASED MEDICINES.

World Health Organization, March 2009

SUPPORTING EVIDENCE

Most people with cancer will have clinically significant pain as a result of the cancer or treatment³. People with advanced cancer have increasing prevalence and severity of pain as death approaches. The medications that are required for good pain relief are some of the most inexpensive medications available⁴. Medications, especially opioids such as morphine, can be tailored to the needs of the individual⁵.

The World Health Organization analgesic ladder⁶ (guidelines on cancer pain relief), when used systematically can improve pain control for almost every person with cancer-related pain.

Organisationally, processes can be put in place for safe distribution, dispensing and administration of opioids even in low resource countries.



MEETING THE CHALLENGE

Cost, safety and efficacy are not the major drivers impairing access – policy restrictions are. Limitations on formulations; number of doses in a dispensed prescription; locations of opioid administration; and the authority to prescribe, dispense or administer opioids; are all major barriers to the adequate use of this important class of medications for the majority of people in the world. Countries must invest in the policies and procedures that enable access, effective and safe prescribing, dispensing and administering of key medications, especially opioids.

It is going to take an active process of government commitment to ensure mechanisms are enacted for the manufacture, distribution, prescription, dispensing and use of these essential medications. It will also require active support at a global level from the International Narcotic Control Board.

CASE STUDY: UGANDA

BUILDING EFFECTIVE PARTNERSHIPS TO DELIVER PAIN RELIEF

In Uganda in 2008, studies suggest that 66,000 deaths were in severe pain. Although opioid analgesics are on the essential medicines list, just 29.6 kg of morphine-equivalent opioids were consumed in Uganda, enough to provide adequate treatment for approximately 4,877 people. In 2010, Uganda experienced a nationwide stock-out of opioids for six months, leaving thousands to die untreated and in pain.

In October 2010, the Global Access for Pain Relief Initiative (GAPRI) programme team worked with the government of Uganda to create an innovative public-private partnership to ensure uninterrupted access to affordable and effective pain relief. The National Medical Stores, the government's drug procurement authority, with the support of the National Drug Authority, partnered with a local private hospice programme, Hospice Africa Uganda (HAU)*, to undertake local production of oral morphine. HAU had been manufacturing oral morphine for their patients since 1995 without any stock-out.

Local production allows the government to access lower prices by procuring morphine powder from suppliers, which is less expensive than formulated product and can be purchased from reputable suppliers without the need for product registration. Costs are lowered further through local production, thus reducing transport and storage costs by bringing in raw powder instead of finished product. Additional advantages of this approach include the ability to create different strengths of liquid morphine with a short lead-time and longer shelf life. This approach reduced the cost to the government by 75% and allowed them to double the number of patients who received pain relief for free, with plans to scale-up coverage in the coming years. Costing models were created to identify the most cost-effective supply plan. GAPRI then worked with the government and Hospice Africa Uganda to implement it, creating financial models, drafting procurement bids, and assisting with production planning and the creation of legal agreements. In the coming year, GAPRI will continue to support Hospice Africa Uganda as they scale-up production and will be seeking funding to expand clinical training and awareness about the availability of high-quality treatment for pain in Uganda and to replicate this innovative programme in other countries. With technical assistance from GAPRI, the government of Uganda and Hospice Africa Uganda have created an innovative public-private partnership to reduce cost and improve access to oral morphine, creating a replicable model for other countries.

For more information on GAPRI, go to <http://www.treatthepain.com>

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*Hospice Africa Uganda (HAU) was established in 1993 to look after cancer and HIV/AIDS patients by bringing modern methods of pain and symptom control, counselling and spiritual support to patients and their families, mainly in their own homes and hospitals. For more information, go to <http://www.hospiceafrica.or.ug>

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USEFUL LINKS

FRAMEWORK CONVENTION ALLIANCE

<http://www.fctc.org/>

GLOBAL TASK FORCE ON EXPANDED ACCESS TO CANCER CARE AND CONTROL IN DEVELOPING COUNTRIES (GTF.CCC)

<http://gtfccc.harvard.edu/icb/icb.do>

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

<http://gicr.iarc.fr/>

INTERNATIONAL ATOMIC ENERGY AGENCY (IAEA)

<http://www.iaea.org/>

INTERNATIONAL AGENCY FOR RESEARCH ON CANCER (IARC)

<http://www.iarc.fr/>

NCD ALLIANCE

<http://www.ncdalliance.org/>

RHO CERVICAL CANCER

<http://www.rho.org/index.htm>

TREAT THE PAIN, GLOBAL ACCESS TO PAIN RELIEF

<http://www.treatthepain.com/>

WORLD CANCER RESEARCH FUND (WCRF)

<http://www.wcrf.org/>

<http://www.dietandcancerreport.org/>

WORLD CANCER DAY

<http://www.worldcancerday.org/>