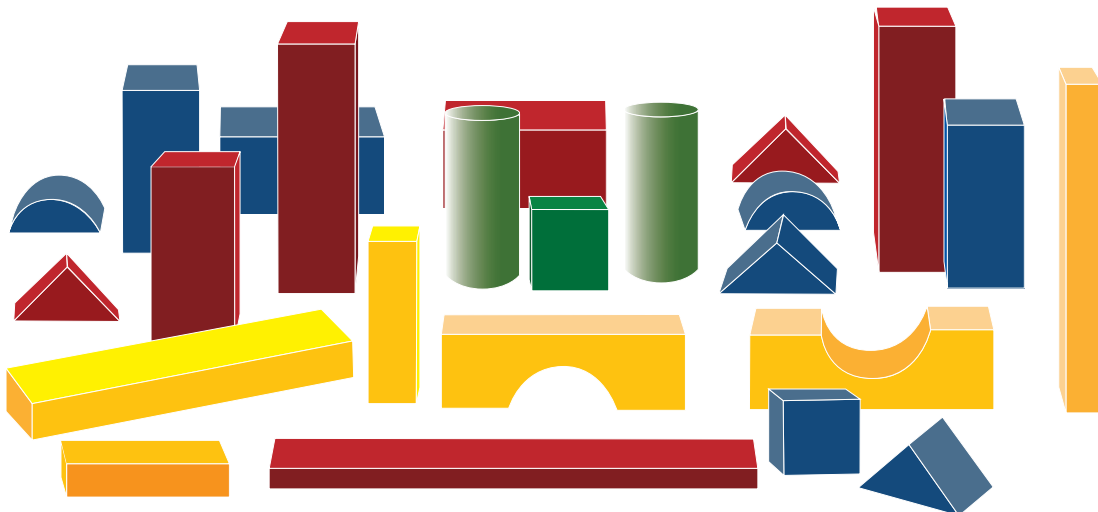




National Cancer Control Planning Resources for Non-Governmental Organizations



National Cancer Control Planning Resources for Non-Governmental Organizations



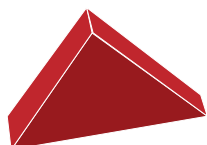
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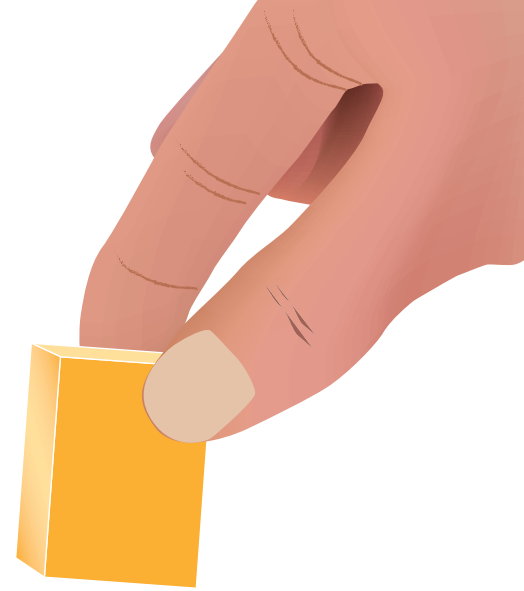
UICC would like, first and foremost, to thank the participants in the expert meeting in Geneva in July 2005 who contributed to the first draft of *National Cancer Planning Resources for Non-Governmental Organizations*: Ana Jovicevic Bekic, Vikram Bhadrasain, Bruce Black, Linda Blount, Robert Burton, Mark Clanton, Maria Stella de Sabata, Kéla Djoufelkit, Hellen Gelband, Leslie Given, Joe Harford, Tom Kean, Roberto Lillini, Nancy Lins, Mark Lodge, Ian Magrath, Isabel Mortara, Renée Otter, You-Lin Qiao, Eliezer Robinson, Graciela Sabini, Hélène Sancho-Garnier, Cecilia Sepúlveda, Edward Trimble, Andreas Ullrich, Marina Vercelli.

Many other experts have subsequently been involved as reviewers, and many more will contribute to the continuous development and translation of these resources. UICC extends its thanks to all those who gave thoughtful insights and constructive criticism and provided material that appears here.

UICC gratefully acknowledges the Centres for Disease Control and Prevention for its support of this project, both through the Cooperative Agreement Number U58/CCU923976 and technical guidance from Ms Leslie Given and Ms Jamila Fonseca.

A special word of thanks to UICC Strategic Leaders Dr Hélène Sancho-Garnier and Dr Robert Burton, who spearheaded the effort; UICC Staff Maria Stella de Sabata and ACS-UICC Liaison Nancy Lins, who coordinated the project from its inception; and Tom Kean, expert consultant, who drafted the *Resources*.





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Executive summary

Planning for cancer control

A national cancer control programme is the total of all cancer control activities taken by a whole country to address the cancer issue in that country. It should result from a national cancer control plan (NCCP) that is developed as an achievable strategic plan to control cancer, based on the country's cancer risk factor burden, cancer burden and the resources available to implement the plan in the context of the culture and health-care system in that country. In order to develop a NCCP the following information should be collected:

- ▶ **The cancer burden** – The minimum data needed is a realistic estimate of the number of new cases each year, and a reliable estimate of the proportion that is curable, as opposed to incurable at diagnosis. These data should provide a rank order of the common cancers, which will indicate those cancers for which effective prevention is possible, and those for which early diagnosis and screening are important. Cancer mortality, prevalence and five-year survival from diagnosis are helpful additional datasets, but most countries do not have them.
- ▶ **The cancer risk factor burden** – Some countries will not have a significant cancer burden but will have a significant prevalence of cancer risk factors. The common cancers can give clues to the risks, e.g., lung cancer and smoking. However, a population-based random survey will be necessary to measure these and indicate priorities for action.



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

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

UICC's *National Cancer Control Planning Resources* takes you step by step through the different phases needed to achieve a national cancer control programme:

the basics:	What's in our country's cancer picture?
collaboration:	Who can help us develop and implement a cancer plan?
content:	What will be in our plan?
action:	How do we communicate and implement our plan?
evaluation:	How will we know if we are successful?

A checklist covering the whole content of this material precedes the five sections and is intended to help you decide which parts of this material will be most useful to you.

All sections contain:

- an introduction
- guiding principles (e.g., lessons learned and considerations based on the experiences of other countries)
- critical questions to be addressed as the planning process evolves
- practical tools (e.g., diagrams, checklists, worksheets)
- samples and examples from other countries
- a list of references for additional details

As you embark on the formidable task of national cancer control planning or implementing your national cancer control plan, UICC hopes that this material will be a helpful tool in your work.

We welcome your comments and suggestions to improve these resources for the benefit of all who will use them after you (please write to nccp@uicc.org).

Introduction

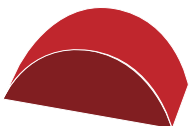
National cancer control planning: responding to the challenge of cancer burden

Current cancer patterns reflect the way we live, and global trends for cancer burden are on the rise, in both developed and developing countries.

Today, cancer causes 7 million deaths every year, corresponding to 12.5% of deaths worldwide. Over 11 million people are diagnosed with cancer every year, a figure estimated to rise to a staggering 16 million by 2020.

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

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



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

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

National Cancer Control Planning Resources: a contribution to civil society

UICC is committed to support civil society worldwide in its efforts towards cancer control, including its participation in planning the most effective cancer control activities for their country. To this end, UICC has developed practical guidance material aimed at non-governmental bodies and other civil society organizations, and showing how to prioritize and implement cancer planning actions for maximum impact.

National Cancer Control Planning Resources draws on existing literature and on feedback both from countries that developed and implemented population cancer control plans and from countries that are developing them. It provides practical suggestions that can be applied in a country, whatever the cancer and risk factor burdens, health system and care infrastructure, access to care, culture, political support and level of monetary and human resources available. The material is organized by key planning steps with guiding principles, questions to consider and tools to help cancer agencies work towards a cancer plan. It is published initially in English and Spanish and is intended as an evolving tool: as new material becomes available, it will complement the core material posted on the UICC website (www.uicc.org).

The main message in cancer control is that it is always possible to take population-based cancer control actions that will reduce the burden of cancer or cancer risk factors, no matter what the situation in the country. Every action, however limited, is a piece of a bigger picture that should at least be mapped out, so actions planned can be considered in the overall country approach to cancer control.

Planning frameworks that take account of all strategies to reverse the burden of cancer (prevention, early detection and screening, diagnosis and treatment, and palliative care) can help with this. This applies even when the country's resources may limit the population-based cancer control actions that can be taken.

Collaboration with government and other bodies

UICC operates in a spirit of transparency and collaboration, and believes that NGOs should do the same. NGOs should cooperate to the greatest extent possible with provincial, state or national authorities, even when cancer is not a priority for governments and people with cancer are best – or only – served by civil society.

The World Health Organization (WHO) is a natural partner of UICC; the adoption in 2005 by the World Health Assembly of the resolution on cancer prevention control shows the commitment of this international body, and its member states, to the issue.

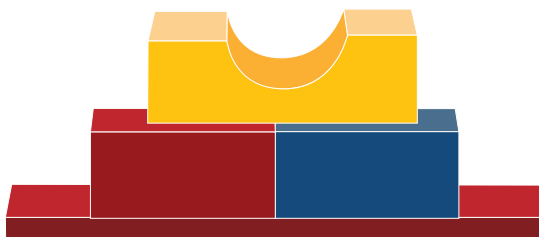
Other national or international bodies are also undertaking international activities contributing to cancer control, e.g., the US Centres for Diseases Control and Prevention (CDC), the US National Cancer Institute (NCI), and the International Atomic Energy Agency (IAEA).

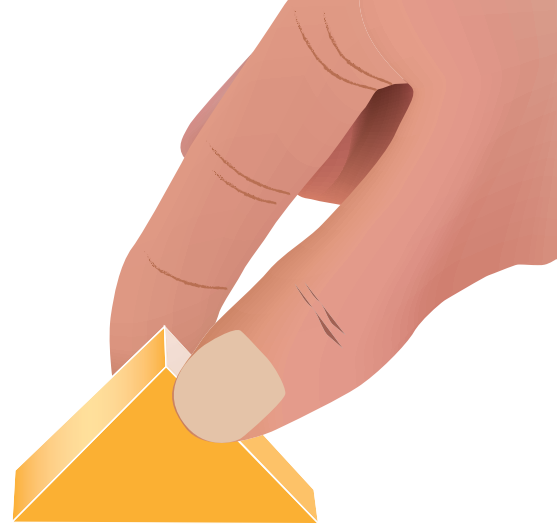
UICC is a partner in a number of the activities carried out by them.

There are also natural alliances with bodies tackling other diseases: lifestyle risks that are common to cancer, cardiovascular disease (stroke, heart attack etc.), chronic lung disease and diabetes are involved in causing more than half of all cancers. As at least 20% of all cancer is attributable to infection, appropriate alliances with organizations working on chronic communicable diseases such as HIV/AIDS, as well as advocacy and support of immunization programmes against infectious cancer (e.g., HBV for liver cancer, HPV for cervical cancer) are important strategies for cancer NGOs.

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

UICC is determined to contribute to real progress in international cancer control through coordinated and synergistic actions undertaken with its members, WHO and its member states, and other partners by planning together, defining common goals and pooling skills and resources. The challenge is a global one, as is the ultimate goal: reducing suffering for cancer patients and their families worldwide.





How to use this guide

This guide has been put together to help NGOs that are considering or developing a national cancer control plan. The ideas and tools it contains are based on the experiences of those who have already developed cancer plans and are now implementing them.

It was developed to provide you with an overview of cancer planning, some points to consider and tools to help you get started or enhance your existing efforts, and selected references, should you want to find more detailed information.

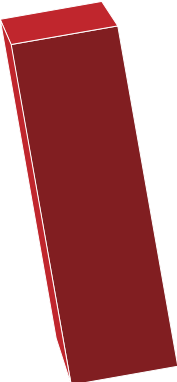
The guide is designed around five key questions that cover all of the major elements of a good cancer plan. It includes a separate section on each of these questions:

1. What is our country's cancer picture?
2. Who can help us develop and implement a cancer plan?
3. What will be in our plan?
4. How do we communicate and implement our plan?
5. How will we know if we are successful?

After you complete the Before You Begin checklist, there is a separate section of the guide for each of the key questions above.

These sections have a common format:

- ▶ *Introduction:* A brief overview of the section and its content.
- ▶ *Guiding principles:* Major lessons learned and considerations based on the experiences of countries that have developed cancer plans. As you read through these you will find that you begin asking yourself how these principles apply to your country. Some may apply directly, some might be adaptable to your country, and some may not apply at all. You will need to decide which ones are important for you and your cancer control colleagues to follow up on. Guiding principles are numbered for easy reference.
- ▶ *Critical questions* that you should answer after reading through the section. These questions will help you focus your attention on things you will want to consider as your cancer planning moves forward. We suggest you answer these questions with a group of your cancer control colleagues, if possible, so as to benefit from the different ideas that are offered.
- ▶ *Practical tools* are included to help you get started working on specific things related to your cancer plan. These tools are generally simple and include outlines, checklists, and worksheets, tipsheets with more detailed information on points in the basic guide, and diagrams to illustrate important ideas. These tools may be used as they are, or you may adapt them to reflect your local circumstances.
- ▶ *Samples and examples:* Ideas and materials contributed by other countries during their cancer control planning that show how they approached issues you may be tackling.
- ▶ *References* where you can find additional details on the major ideas covered in this guide in case you and your colleagues want to follow up on a particular topic.



This guide provides an overview of real-world issues, ideas and tools that are important for developing a good national cancer control plan. Every country will develop its own unique plan because the cancer problems and the systems to deal with these problems are different in each country. You may find that some of the ideas and tools in this guide can be used exactly as they are, but you may also change any ideas, tools, or words to reflect the needs and circumstances of your country. We hope you will also come up with new tools, samples and examples that you can then share with other countries.

We hope you will find this guide useful and we wish you every success in completing and implementing a national cancer control plan for your country! For questions and feedback about this guide, as well as questions on national cancer control planning, please contact UICC's Cancer Prevention and Control department (nccp@uicc.org).

We strongly urge you, before you begin using the guide, to take a few moments to fill out the checklist in the section below (Before you begin). This checklist provides a quick overview of the entire content of the guide and your answers will help you decide which parts of the guide will be most useful to you.

Before you begin – a checklist

You will find below a simple checklist that contains statements about your cancer planning process or the plan itself. Before you move to the individual sections of this guide take a few moments to go through this list and place a checkmark (✓) beside all the statements that you agree with. Then go back and look at the statements for which you did not place a checkmark. These statements will point out areas where you may need to focus your attention as you work through this guide.

In countries that are just getting started with their cancer planning effort, you may find that most of the statements below are not checked. You should not be discouraged if that happens. It shows merely that you are just getting started and may need to use the entire guide

1. What is our country's cancer picture?

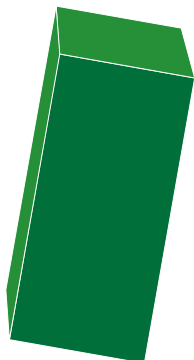
- We already know what cancer data are available in the country and how good they are.
- The major cancer data experts in the country are involved in our planning group.
- We have decided on additional data we will need to collect for our cancer plan and how to get them.
- Our whole cancer control planning group has reviewed the cancer data together.
- Using the data, we have already decided what the major cancer control needs or gaps are in our country.
- We know how we want to assemble the cancer data and report them to the public and decision-makers.

2. Who can help us develop and implement a cancer plan?

- We have already invited the major cancer experts in our country to be involved in our planning process.
- We have a strategy for engaging cancer control and other experts who have not yet committed to participating.
- We know what commitments we are asking from participants while working on the plan and we have communicated this to them.
- We have clear decision-making rules to guide our planning process.
- We have identified leaders for the planning process or we know how we are going to select them.
- We have identified people to speak on behalf of the cancer plan.
- We have a process to recognize the contributions of the cancer control group members to the planning effort.
- We know how we are going to divide the cancer control planning group into workgroups and what we expect these workgroups to bring back to the whole group.
- We have administrative personnel to maintain mailing lists, organize meetings, record minutes, keep planning group files up to date, etc.

3. What will be in our plan?

- We know which cancer issues will be a part of our plan and which will not.
- We know who the plan is intended for – that is, who we expect to implement it or support it.
- We have a mission and vision statement for the plan or know how we will develop one.
- We have defined the broad goals of the cancer plan.
- We have clear instructions on how to make our objectives specific, measurable, and linked to the goals of the plan.
- We have defined the process for identifying cancer control strategies that have a high likelihood of being successful.
- We know how we will set priorities for the plan and what criteria we will use to select them.
- We have an approach for identifying resource needs to implement the plan.
- We know who will write the plan.

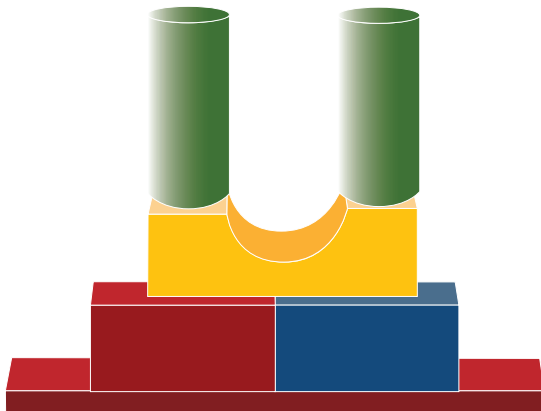


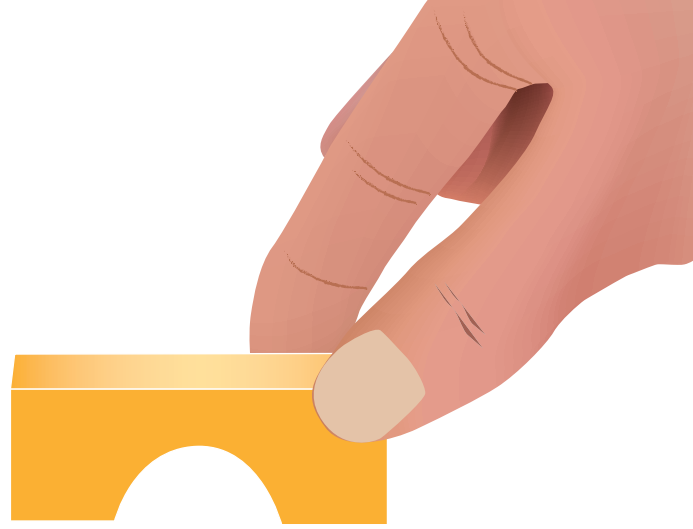
4. How do we communicate and implement our plan?

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

5. How will we know if we are successful?

- We have skilled evaluators who committed to helping design and carry out an evaluation.
- We have defined a process to determine the questions that will be included in the evaluation.
- We have defined the resources needed for the evaluation and know where we will find them.
- We have a strategy to summarize the results of the evaluation and report them to decision-makers and the public.





Section 1

What is our country's cancer picture?

Review the Before you begin checklist before starting this section!

Content

- Introduction
- Guiding principles
- Critical questions
- Practical tools
- Samples and examples
- References

Introduction

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

Some countries have cancer-related data that are readily available. Others may need to get data from a credible source outside the country to use in their country cancer picture. The International Agency for Research on Cancer's GLOBOCAN database has data online on every country, and UICC may also have a profile for your country.

Two types of data may be useful for building a picture of cancer in your country: quantitative data and qualitative data.

- ▶ Quantitative data consists of specific numbers that have been obtained through some method of counting (e.g., registry data, survey results, census records, or laboratory test results). Quantitative data assist in making decisions that are often precise and reliable. However, some quantitative data are estimated. Existing data may not include reliable community or regional information.

On the other hand, new data collection can be expensive and time consuming. You should find out how the data were derived to determine their accuracy.

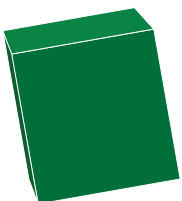
- ▶ Qualitative data are more subjective sources of information based on obtaining ideas and opinions in a less precise and reliable manner than quantitative methods. Qualitative methods include focus group interviews and interviews with key experts or decision-makers.

Qualitative data can be less expensive and quicker to gather than quantitative data. Qualitative methods provide insights into issues – not definitive results about specific questions. They rely on fewer individuals who are not usually selected randomly, thus the results are not considered representative of views on the needs of populations.

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

Guiding principles

- 1.1** The cancer burden should be described in the context of the chronic disease burden of the country and its overall disease burden.
- 1.2** It is a good idea to have one or more people who are knowledgeable about data and understand the available data.
- 1.3** The cancer burden assessment should include:
 - a.** Demographic information on the population
 - b.** Data on cancer incidence and mortality in the population
 - c.** Behavioural data related to cancer risks
 - d.** Health and social system data
 - e.** Existing cancer resources, including major cancer facilities, cancer workforce information, professional education, and current funding resources allocated to cancer control
 - f.** Political and cancer control leadership
 - g.** Capacity to support enhanced cancer control efforts



- 1.4** The availability of cancer data varies from country to country. At the start of the assessment, countries should identify:
 - a.** Cancer-related data that are readily available
 - b.** Cancer-related data that could be reliably obtained during the cancer control planning
 - c.** Cancer-related data that are needed but will not be available during the cancer control planning
- 1.5** Data used in developing the cancer picture should be for the most recent years available.
- 1.6** Where historical data are available, trends in data should be described in the cancer picture, especially trends that illustrate whether the cancer burden is rising or the prevalence of risk factors (such as tobacco use) is changing.
- 1.7** Some countries have a national cancer registry, which is very important in gathering the data on cancer incidence that are needed
- 1.8** Where possible, variations in the data should be noted. Important variations may include:
 - a.** Age differences
 - b.** Gender differences
 - c.** Geographic variations (e.g., by province)
 - d.** Rural/urban differences
 - e.** Ethnic variations
- 1.9** If you do not have a cancer picture already, look at examples of what other countries have done before you start developing your own picture.
- 1.10** It is best to assemble the cancer burden information before beginning the planning process. Where that is not possible, data should be assembled during the early stages of planning. Examples from some countries that have completed burden assessments indicate that it generally takes about nine months to complete a good assessment.
- 1.11** The quality of cancer data varies widely, even within a country. For example, some countries may have mortality data but no incidence data or vice versa. Others may have good data about cancer, but no data on the prevalence of risk factors, e.g., tobacco use, human papilloma virus (HPV) infection rates, or health services data, e.g., cancer screening rates. In some cases the reliability of the data may be good. Whatever the data available, a decision will need to be made about whether they can be used for planning purposes. In general, using what data you have is better than using no data; but you should be aware of how reliable the data are, as well as their limitations.
- 1.12** Needs for new or improved cancer-related data should be included in the cancer control plan.
- 1.13** To be most useful, the analysis of the country cancer data should include:
 - a.** Cancer and risk factor trend information
 - i.** things that are getting worse
 - ii.** things that are getting better
 - iii.** things that are not changing
 - b.** Gaps in cancer service delivery
 - c.** Population and health disparities
 - d.** Identification of specific targeted needs and population groups to be addressed by the plan

- 1.14** If possible, the cancer picture should depict the economic impact of cancer on the country as well as its burden in terms of human suffering.
- 1.15** The cancer picture should also tell the story of what will happen to the cancer burden if nothing new is done to tackle it – that is, what is the cost of doing nothing.
- 1.16** The cancer picture should note which major cancer control problems or needs can be addressed by existing cancer control interventions and which cannot. You must also decide which interventions are feasible in your country. For example, tobacco-caused cancers can be addressed through known smoking cessation or tobacco control policy interventions; at the same time, there are no effective mass screening interventions for detecting pancreatic cancer early. Pap tests may be feasible in some countries while in others, visual inspection of the cervix may be more feasible.
- 1.17** Data should be collected during the burden assessment only if they are useful to the planning process. Data that are interesting but do not help make decisions about what to include in the plan should not be collected immediately.
- 1.18** The cancer assessment should also include an assessment of the readiness for the country to undertake national cancer control planning.

Critical questions for planning

The following questions should help identify things that need to be done to complete a cancer burden assessment and a picture of cancer in your country.

- ✓ What existing documents and data sources do we already have that should be included in the assessment? Who has them? What do we need to do to access them?
- ✓ Who are the major experts on cancer data in our country? Are they involved in assembling our cancer picture? If not, how can we invite them to become involved?
- ✓ What other data do we need in order to have a complete picture of the cancer burden in our country? Do we have the capacity and resources to collect that information before or during the cancer planning process?
- ✓ Have all of our cancer control partners reviewed the cancer data together? If not, how will we get our partners' input on interpreting the data?
- ✓ What conclusions should be made about the major cancer needs in our country based on the picture we have created?
- ✓ How should we report the cancer burden data to our national decision-makers? To the public?
- ✓ What are our needs for new or better cancer-related data in future years?
- ✓ Have we completed an assessment that indicates we are ready to develop a national cancer control plan? If not, what else do we need to do to get ready?

Planning tools for creating a country cancer picture

Checklist	Key steps in conducting a cancer burden assessment
Outline	Sample cancer burden assessment report
Tipsheet	Potential data elements for inclusion in a cancer burden assessment
Worksheet	Assembling and assessing cancer-related data

NCCP tools can be accessed through www.uicc.org

Samples and examples

References

Australia: Priorities for Action in Cancer Control 2001-2003

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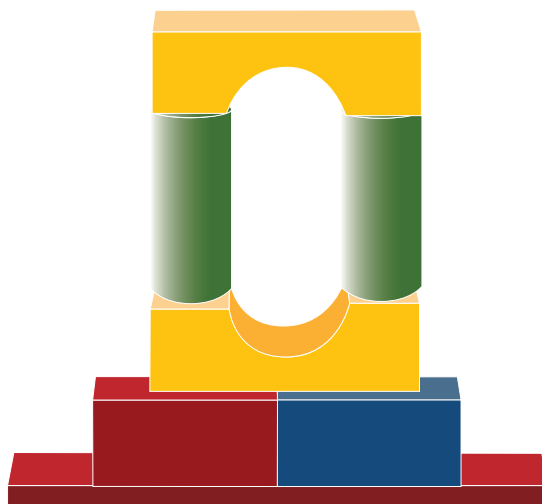
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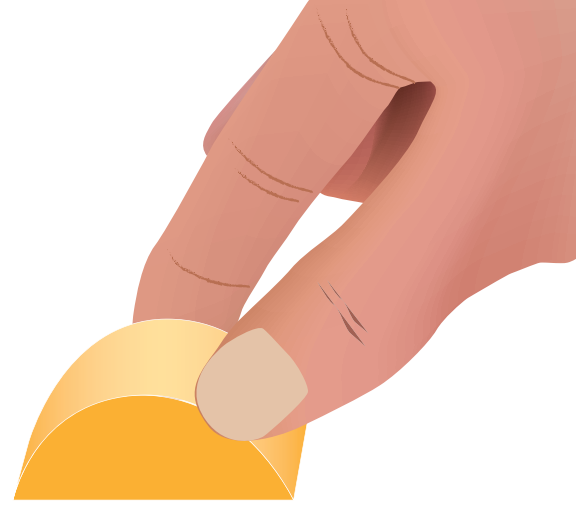
State Cancer Profiles. See Step 1 of the Cancer Control PLANET

<http://cancercontrolplanet/cancer.gov>

WHO Self-Assessment Tool for National Cancer Planning, to be released on www.who.int

Samples and examples can be accessed through www.uicc.org





Section 2

Who can help us develop and implement a cancer plan?

Review the Before you begin checklist before starting this section!

Content

- Introduction
- Guiding principles
- Critical questions
- Practical tools
- Samples and examples
- References

Introduction

A good comprehensive cancer plan will include a group of knowledgeable, interested people in its development. The reasons for this are simple;

- ▶ The more people who are involved in writing a plan, the more likely they are to be engaged in implementing it.
- ▶ With different stakeholders involved, a country has multiple perspectives about the cancer problems it faces, and multiple ideas about how best to tackle them that should be sorted through.
- ▶ Having a group involved in planning helps share the work so that no one person or organization is overwhelmed while contributing to the effort.

This group should represent different parts of society – NGOs, government, and the private sector (e.g., business leaders). The number of people involved may depend to some extent on the population of the country.

Recruiting people to participate in cancer planning can be challenging. The process needs to keep people interested and involved so they complete the plan. Once a plan is finished, it will be necessary to recruit other people to help with implementing it.

You may also wish to consider interacting with experts and organizations outside your country that have had experiences similar to yours.

Guiding principles

Who to involve

- 2.1** The number of people developing a cancer plan will vary from place to place. In Israel, approximately 35 people were involved, in the Netherlands, some 150-180, and in France, nearly 200. The key question to ask is not “How many people should be included?” but rather “Do we have all the right people here, so when the plan is done no one can criticize or dismiss it because the ‘right’ people weren’t involved?”
- 2.2** You may also involve experts or representatives of organizations outside the country. These may be may be experts in planning or in cancer or individuals who have been directly involved in developing their own country plans.
- 2.3** Determine early in the process what is the right mix of people for developing your cancer plan. In most cases, there is a mix of government and NGO involvement. In some cases, the government may develop the cancer plan and then promote it in the population. In other cases, NGOs may develop the cancer plan and try to “sell” it to government. The key is to involve people who will take on the responsibility for developing the plan.
- 2.4** Cancer patients, survivors and their families should be included in the cancer planning process. Their experiences are important benchmarks of what is and what is not working in the country’s cancer programme.
- 2.5** The cancer planning group should include the major cancer experts in the country. It should also include other key figures who may be helpful in implementing the plan and who represent important stakeholder groups (e.g., the mass media, major employers, elected officials, educators, and religious leaders).
- 2.6** In deciding who to invite to participate, consider people with the following characteristics:
 - a.** They care very much about the cancer problem
 - b.** They are capable of contributing to the planning process
 - c.** They want to participate and can work well with others
 - d.** They can influence others to participate
 - e.** They may be able to access resources to help with the plan
 - f.** They are persistent and work hard for what they believe in
 - g.** They can advocate with others to gain support for the plan
 - h.** They are realistic
 - i.** They communicate clearly

Leadership

- 2.7** A cancer planning effort must have champions and leaders. Champions are often well-known people who can speak on behalf of the cancer plan and inspire others to participate. Leaders are those who will take on extra work to help organize the planning effort and make sure it is moving forward; they are often more recognized inside the planning group than outside. In some cases, champions and leaders can be the same people.
- 2.8** Leaders are often chosen by the planning group or the organization leading the planning effort. Leaders need to be seen by others as expert in some area of cancer. More importantly, they must be able to think more broadly than their own area of expertise and help manage the planning discussion across all the major goals for the programme. For example, well-known clinical experts (physicians) are often asked to lead the planning. These clinicians need also to be able to lead discussions of non-clinical cancer needs in the country (e.g., prevention programmes).
- 2.9** Many cancer planning groups choose to have two or three co-leaders to ensure a wide range of expertise in leadership and help retain continuity in case a leader has to leave the process before it is complete.

Structure, involvement and support for participation

- 2.10** Some countries set up steering committees to help plan the process for completing a cancer plan and to make sure the process is working. For example, Australia, France and Serbia had such committees. China did not. People who are on a steering committee make a special commitment to meet more often than other participants.
- 2.11** Cancer planning groups often divide into smaller groups to discuss specific cancer topics and bring recommendations back to the full group. For example, there might be smaller groups on prevention strategies, early detection strategies, or treatment strategies. Or there might be smaller groups on specific cancers, such as cervical cancer, breast cancer, or colorectal cancer. When smaller groups are formed they must be given clear instructions on what is expected of them, when their work will be completed, and what support they will have to get it done.
- 2.12** When recruiting people to participate in a cancer planning process, it is important to share with them the following:
- a.** Why a cancer plan is important to the country.
 - b.** Why they specifically are being invited (e.g., because of special expertise, or because they represent an important group of people in the fight against cancer).
 - c.** How much time they are expected to contribute until the plan is done (e.g., over the next year they will attend five one-day meetings, participate in six one-hour conference calls, and spend approximately 20 hours reviewing and commenting on drafts of the plan).
 - d.** What benefits they will get from participating (e.g., public visibility for themselves or their organizations, new working relationships with cancer experts, ideas to help them manage their own cancer programmes better)

- 2.13** It is important for the planning group to know who will decide on the final content of the plan. In some cases, the key health leaders in the country decide what the final plan will include. In others, everyone who participates in the planning effort has a vote on whether to accept the plan or not. In general, the more people who have a say in decision-making, the more likely they will be to help implement the plan when it is done. Whatever approach you choose, participants in the planning process need to know at the beginning how decisions will be made.
- 2.14** It is important to publicly recognize and honour those who take time to help develop a cancer plan. This can be accomplished in a number of ways (e.g., giving “awards” for participating, or putting the names of all the participants at the front of the plan).
- 2.15** Some countries have resources for completing the planning process and are able to devote staff to help get the work done. Others rely solely on volunteer resources to get the plan done. In either case, it is important that someone be designated to coordinate the overall process and to be the person to whom all questions about the cancer plan and the planning process should be directed.

Timeframe

- 2.16** Developing a cancer plan is a long process, taking an average of one to two years. It is important during that period to have established lines of communication with all the participants about the progress being made and the issues that arise so that people stay well informed and feel engaged in the process.
- 2.17** It is very useful to ask participants regularly (e.g., every six months) how well they feel the cancer planning effort is working and whether they think their ideas are being heard.

Critical questions for planning

The following questions should help identify factors that need to be considered in assembling a group of people and keeping them engaged and committed to the cancer plan's development and implementation.

- ✓ Who are the cancer experts in our country? Are they already committed to working on our cancer plan, or do we need to recruit them?
- ✓ For our cancer plan to be seen as credible, who else needs to be involved in the cancer planning process?
- ✓ Who is responsible for recruiting people to participate in the planning process?
- ✓ Have we defined what we expect of each person in the planning process? Have we communicated that to them?
- ✓ What are the decision-making rules and structure for our planning group?
- ✓ How, and how often, will we ask our partners if they think the planning process is working well?
- ✓ How will we choose leaders for the planning effort?
- ✓ Who are our champions that will speak for us in public? What are we doing to prepare them for this role?
- ✓ How will we publicly recognize and thank the people who helped develop our cancer plan?
- ✓ Will we have smaller strategy groups working on parts of the plan? How will they be supported? Have we clearly defined what is expected of them and when their work is to be completed?

<i>Tools for recruiting a cancer planning group</i>	
Diagram	Levels of involvement of government and NGOs in the cancer planning process
Tipsheet	Advantages and disadvantages of government-led, NGO-led, and jointly led cancer planning efforts
Worksheet	Build and enhance the comprehensive cancer control partnership
Checklist	Desirable leadership characteristics for cancer planning
Diagram	Sample organizational charts for cancer planning
Tipsheet	Sample charge to a small work group
Tipsheet	List of resources needed for a cancer planning effort
Tipsheet	Tips for starting a cancer planning group

NCCP tools can be accessed through www.uicc.org

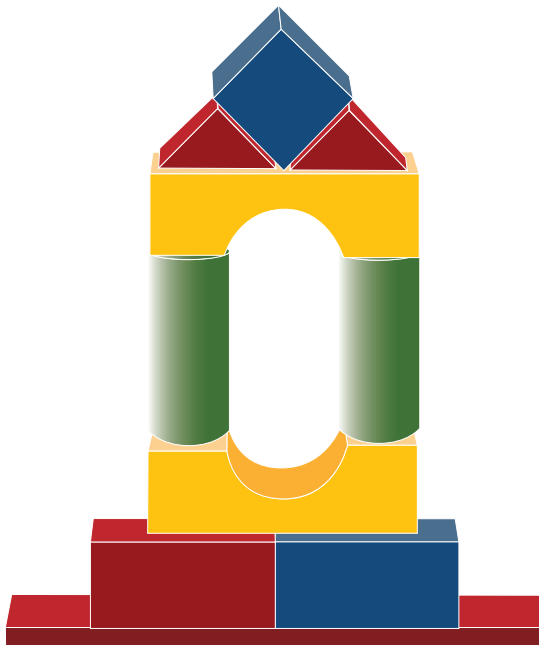
Samples and examples

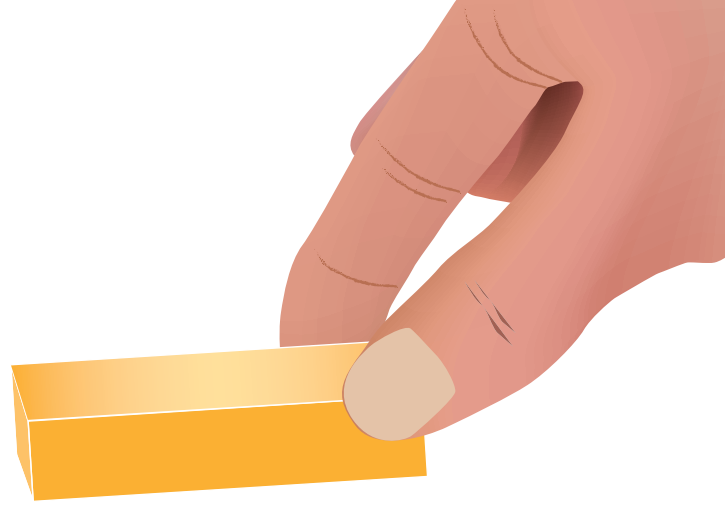
Samples and examples can be accessed through www.uicc.org

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<http://www.cdc.gov/CANCER/ncccp/guidelines/index.htm>

Find Programme Partners in Cancer Control and **Find Research Partners in Cancer Control**. See Step 2 of the Cancer Control PLANET.
<http://cancercontrolplanet.cancer.gov>





Section 3

What will be in our plan?

Review the Before you begin checklist before starting this section!

Content

- Introduction
- Guiding principles
- Critical questions
- Practical tools
- Samples and examples
- References

Introduction

The cancer picture in your country (see Section 1) is the foundation for building your plan. The cancer planning group you have recruited (see Section 2) will use the burden statement to begin identifying which cancer problems should be dealt with in the plan and what should be done about them. It is useful to think through how to organize the discussion of these topics and then how to assemble the ideas generated into a proper plan that will get a high level of attention from the country's decision-makers and the public.

Every cancer plan looks different from others, and yours will too. Your plan must reflect the needs of your people, their culture, and the resources of your nation. It is useful, however, to look at examples of cancer plans that have been developed elsewhere to get ideas about ways to organize your plan.

There are several early decisions your group will have to make:

▶ *What will be the scope of the plan?*

Some plans are truly comprehensive – they cover many cancers and deal with everything from prevention to early detection, diagnosis and treatment, and also issues facing people who survive cancer. Other plans start with a more limited scope. They may deal with only a few cancers or focus on a particular aspect of cancer control, such as prevention or treatment. In either case, it is important that the framework of the plan include the whole country.

▶ *Who is the plan for?*

The primary audience for the plan must be clear. Plans are usually made public (that is, everyone can see them), but sometimes the audience for the strategies is more limited. Some plans are intended for all cancer-focused organizations in a country; some may be for only one or a few NGOs; some may be only for government. The question to ask is, “Who do we expect to act on this plan when it is done?”

▶ *Will the plan be implemented around the country?*

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

Guiding principles

Components of a plan

- 3.1** Cancer plans often have a vision statement that describes very briefly the intent of the plan. For example, a vision statement might be, “No more cancer.” Another example is, “To eliminate cancer as a major public health problem.” Vision statements describe what the world would look like if you were to be successful.
- 3.2** Some cancer plans also have a mission statement that describes very briefly what your planning group is going to do, and how. For example, a mission statement might read, “Working together to develop and implement a national cancer plan.”
- 3.3** Most plans include a brief summary of the cancer picture that is developed for the country.
- 3.4** Some cancer plans include a listing of cancer control assets and liabilities. Assets are things that can help us achieve a cancer control outcome (e.g., strong public support for a cancer programme, or a great cancer hospital). Liabilities are things that may keep us from achieving a cancer control goal (e.g., no national budget for cancer programmes, or political opposition to a particular cancer control strategy, such as banning tobacco use in public places). As the plan develops, the group should be sure that it takes advantage of the assets and considers how to overcome or lessen the impact of the liabilities that it lists. Through a SWOT analysis, you can also assess the strengths, weaknesses, opportunities and threats of your plan.



- 3.5** Good cancer plans most often include:
- a. Goals
 - b. Objectives that help achieve the goals
 - c. Strategies that impact on the objective
 - i. A rationale for the strategy
 - ii. Outcomes that are expected if the strategy is implemented
 - iii. Action steps to implement the strategy
- 3.6** Most cancer plans have broad goals. Examples include:
- a. To prevent cancer whenever we can
 - b. To find cancer as early as possible when it does occur
 - c. To treat any cancer found with the highest quality cancer treatment available at the time
 - d. To assure the best quality of life possible for a cancer patient
- 3.7** For each goal, a plan may have multiple objectives for achieving it. Objectives differ from goals in that they define what should be done to reach the goal. Good objectives are specific, measurable, attainable, reasonable, and time-phased (SMART). An example of a good objective might be, “To increase the percentage of women screened for cervical cancer from 40% to 75% within three years.”
- 3.8** There may be several strategies for achieving a particular objective. Take the cervical cancer objective used above. Here are several strategies that may help achieve that objective:
- a. Every woman who enters a hospital is informed of the importance of having a Pap test
 - b. The government pays for all VIA (visual inspection after the application of acetic acid) for women who cannot afford them
 - c. Every primary care doctor in the country is trained in the latest techniques for doing VILI (visual inspection after the application of Lugol’s iodine).
 - d. Religious leaders educate their followers on the need to obtain cervical cancer screening tests

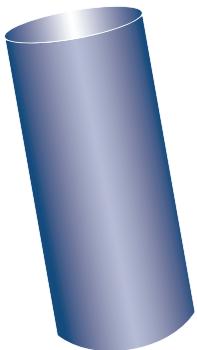
Cancer control strategies

- 3.9** Many strategies may be included in a national cancer plan. Usually there is a need to establish priorities among these many strategies because no nation can usually do everything that is needed. Instead, the cancer planning group decides which strategies are most important to start with. Some cancer plans set priorities among objectives as well as strategies.
- 3.10** Strategies for intervening on cancer problems fall into three broad categories for action. A good cancer plan will likely have a mix of these:
- a. Strategies that focus on individual behaviour change (e.g., strategies that change smoking behaviour)
 - b. Strategies to enhance the practices of health professionals (e.g., strategies that educate clinical staff in new or better cancer detection techniques)
 - c. Strategies that involve changing the policies and actions of systems that impact on cancer control (e.g., mandating that hospitals provide certain cancer care services for all patients who require them)

- 3.11** Whenever possible, strategies suggested in the plan should be based on some evidence, usually derived from scientific studies, that they are effective. UICC and others have put together summaries of the evidence that exists for many cancer control strategies (e.g., Matrix of Evidence Reviews across the Cancer Control Continuum, http://dccps.nci.nih.gov/d4d/info_er.html)
- 3.12** Sometimes there is no evidence about what strategies may work best, or strategies that have worked elsewhere aren't working in your country. When that happens, plans need to allow for creativity and innovation in developing new approaches relevant to your country's context.
- 3.13** Be aware of other chronic disease efforts or plans in your country. Some cancer strategies connect very well to programmes for other chronic diseases that are already working. For example, you may want to reach women of a certain age group for cancer testing. It may be that a national diabetes programme is already reaching the same women. Your cancer plan may then have a strategy to join forces with the diabetes programme, in order to reach these women with both tests.

Setting priorities

- 3.14** Before you start, it is important for the cancer planning group to agree on what the criteria for setting priorities will be. For example, in France the criteria included which cancer problems caused the greatest burden and which strategies dealt with issues raised and considered most important by cancer patients and survivors. In Australia, emphasis was placed on strategies that tackled cancer disparities as well as those with the most population impact. Other countries have chosen to emphasize those cancer problems where no new resources are needed, because there is an existing capacity to cope with them.
- 3.15** Once criteria have been agreed on, there are several methods for setting priorities. Your cancer planning group should decide on the method it will use well in advance.
 - a.** Consensus – everyone on the planning group comes to agreement about what the priorities should be. This is ideal but rarely occurs.
 - b.** Vote – everyone has the opportunity to vote on which strategies should be priorities. Those strategies with the most votes become priorities.
 - c.** Commitment – members of the planning group are asked to commit themselves to working on one or more strategies. Those strategies that have several people or organizations willing to work on them become priorities.
- 3.16** For each priority strategy, an action plan should be developed, with the major action steps that are required. The action plan should include the expected outcomes of implementing a strategy. To illustrate, using the cervical test example above, if every woman who came into a hospital were informed of the importance of getting a Pap test, how far could we move from the current 40% of women screened for cervical cancer to the 75% we would like to see? By identifying the expected outcomes, the planning group may decide that a strategy really won't impact on the problem and choose other strategies instead. The action plan also needs to identify additional resources needed to fully implement the strategy and the action steps to obtain them. Finally, the action plan needs to identify who has the responsibility to carry it out and establish a timeline for taking the action.



Finding resources

- 3.17** A discussion of what resources are needed to implement the plan and how to obtain them should be included in the plan. This means developing an overall budget for the plan, including the resources needed for the priority strategies. Approaches to finding resources include:
- a.** Reallocating or optimizing existing resources
 - b.** Obtaining grants to implement specific strategies in the plan
 - c.** Creative means of financing the whole plan (e.g., increasing taxes on the sale of tobacco products and dedicating all or some of the revenue to implementing the cancer control plan)
- 3.18** The plan should include a section on how the plan will be implemented (see Section 4).
- 3.19** There is a need early in the planning process to identify responsibilities for actually writing the plan. Some plans have been written by a single author, others by a special writing committee. In other cases, individuals have written sections of the plan and an editor has finalized the whole plan.

Critical questions for developing the plan

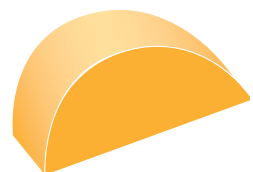
The following questions should help identify the major topics that should be included in a country cancer plan and how to address and organize them.

- ✓ What will be the scope of our plan?
What parts of the cancer problem will we address in it?
What parts will be left for future plans?
- ✓ Who is the plan for?
Who will implement it?
- ✓ Do we have a vision statement and mission statement?
Do all the members of the planning group know what these are?
- ✓ Should we develop a list of cancer assets and liabilities for our country?
- ✓ Do we have goals?
- ✓ How will we assure that our objectives are specific, measurable, and tied to the goals?
- ✓ What is our process for identifying strategies to achieve our objectives and goals and assuring they will really impact on the cancer problem?
- ✓ What criteria will we use to establish priorities?
What method will we use for setting priorities?
- ✓ How will we identify the resources needed to implement the plan and strategies for getting those resources?
- ✓ Who is going to write our plan?
How will they be involved from the beginning of the planning process?

Tools for organizing the plan and defining its content

Tipsheet	Selecting an organizing framework for the plan
Tipsheet	Sample timeline for developing a cancer plan
Tipsheet	Sample outline of a national cancer plan
Tipsheet	Selecting goals, objectives, strategies and outcomes
Tipsheet	Sample methods for setting priorities
Tipsheet	Developing action plans for our priorities
Worksheet	Action plan template
Worksheet	Resource assessment form

NCCP tools can be accessed through www.uicc.org



Samples and examples

Samples and examples can be accessed through www.uicc.org

References

Comprehensive Cancer Control Jurisdiction Guidebook for United States Associated Pacific Island Nations, National Partners for Comprehensive Cancer Control, 2005

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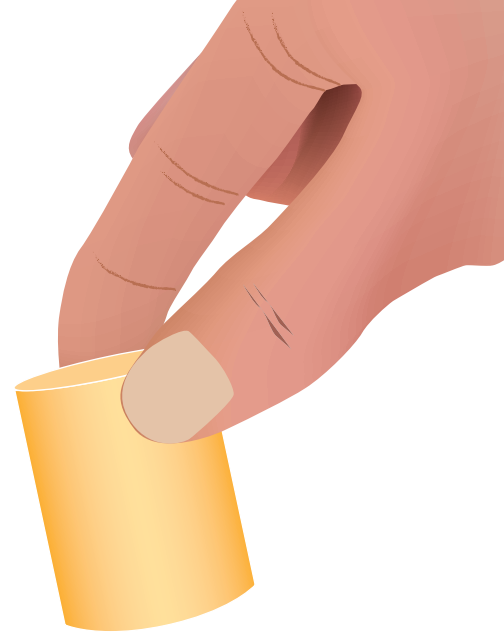
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The Cancer Control PLANET. <http://www.cancercontrolplanet.gov>

The Cancer Plan. <http://www.cancerplan.org>





Section 4

How do we communicate and implement our plan?

Review the Before you begin checklist before starting this section!

Content

- Introduction
- Guiding principles
- Critical questions
- Practical tools
- Samples and examples
- References

Introduction

Cancer plans are excellent guides for what a country should do to reduce the burden of cancer. Having a plan implies that you intend to take action – to implement the priority strategies in the plan. Sadly, there are cases when a lot of effort is put into making a plan but the plan is never implemented. Even as your cancer group is planning, therefore, it needs to be thinking about how the plan will be implemented. Discussing implementation in the plan itself is an important first step.

Implementing a cancer plan requires two types of action. The first is to communicate the plan to cancer-interested organizations, decision-makers and the public. The second is to reorganize the planning group into an action group.

Guiding principles

Communicating the plan

- 4.1** Even before the plan is finished there may be an opportunity to share a draft of it with people outside the cancer planning group and invite them to comment. This begins a process of engaging others who may be important to the implementation process. For example, there may be some cancer experts or leaders who were unable to participate in the planning process – inviting their comments on a draft of the plan may keep them interested in what you are doing. Similarly, asking key leaders in the country (e.g., the Minister of Health) to comment on the plan begins to get them interested in the plan. With modern technology such as the internet, some cancer planners are posting their draft cancer plans online and inviting comments from the broader public.
- 4.2** Once the plan is finished, it is important to communicate that the plan exists and your planning group intends to see it implemented. Here are some ways to communicate about your cancer plan:
- a.** Hold a major public event to announce the plan to the public. Invite national leaders and the mass media. Plan an event that is exciting, reminds people of the major burden that cancer places on the citizens, and invites people to get involved in implementing the plan.
 - b.** Deliver copies of the plan to the major political leaders in the country.
 - c.** Ask the national legislature to hold a special hearing on cancer in your country and to discuss the strategies you are recommending.
 - d.** Ask each member of your cancer planning group to communicate the plan to the members of their own organizations.
 - e.** Hold community meetings around the country to present the cancer plan and discuss how communities can implement parts of it.
 - f.** Post the cancer plan on a website and ask the media to make its availability known.
 - g.** Send copies of the plan to libraries and ask them to let the public know about it.
 - h.** Arrange for the leaders of your cancer planning group to give interviews to key mass media.
- 4.3** The leaders of your cancer planning effort need to be well prepared to speak about the plan. They should know the contents of the plan thoroughly, particularly the facts about the cancer burden in the country and the priority strategies you want the country to adopt. Anticipate the difficult questions that might be asked, prepare short, effective answers, and practice them with your leaders.
- 4.4** Every opportunity your group gets to present the plan should end with a call to action. A call to action asks the audience to do something to support the plan and may be different depending on the audience. If your audience is the public, for example, you may ask them to adopt certain kinds of behaviour (“eat more vegetables”, or “get a breast cancer test”, or “take your parents to get a cancer check-up”). If the audience is members of the health



professions, you may ask them to work with your cancer group on a particular strategy. If the audience is national political leaders, you may ask them to support a specific policy. The key point is asking people at every opportunity to do something that supports one or more of the strategies in your plan.

- 4.5** Prepare some specific stories about people with cancer in your country. Some of these stories should speak to the challenge that a cancer diagnosis presents. Others should speak to the good things that can happen as a result of cancer control. The stories should be real, not made up. The stories should relate to the priority strategies in your plan. For example, if one strategy is to increase the percentage of eligible women getting cervical cancer tests, a story of a woman who got such a test and what happened to her could be a powerful statement. Some cancer plans include such stories as part of the plan. Organizations that work directly with cancer patients can often help you find people who have good stories to tell.
- 4.6** Implementation creates an ongoing need to communicate with the cancer group members to keep them informed on progress and issues that arise. The group should decide how often they want communicate with each other, about what and how, and who will be responsible for initiating the communication.
- 4.7** Leaders come and go as professional lives change or new politicians come into power. Often, especially where government plays an active role, there is a need to brief new leaders who should be involved in implementing the plan. As soon as possible after a new leader takes office, the cancer control group should request an opportunity to briefly present the plan and its significance for the cancer problem in the country. As with all communications, the presentation should end with a call to action, usually asking for the support of the new leader. In preparing for this briefing, it is important to gather information about the new leader, including any known previous experience with cancer or in cancer control efforts.

Preparing for implementation

- 4.8** The group that worked on the cancer plan will often need to expand and reorganize itself to implement the plan.
- 4.9** Some people who worked on the cancer plan may also work on implementing it. Others may delegate someone else from their organization to work on implementation. For example, the president of an NGO may have participated in the planning, but once the plan is done, he or she may ask others in the NGO to work on specific strategies. Keep in mind that some people and organizations that were not involved in developing the plan may want to be active in implementing it and should be given the opportunity to do so.
- 4.10** The individuals who were leaders of the cancer planning group may wish to step aside once the plan is done and let others lead the implementation effort. There should be clearly defined rules for how long leaders serve and how new ones are chosen.
- 4.11** A most effective strategy for implementation is to form a team of volunteers to oversee the implementation of each strategy. If your cancer plan has six priority strategies, then your

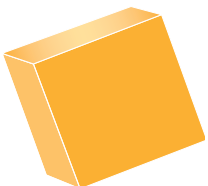
group forms six action teams to work on implementation. Each action team is asked to work on the specific action steps identified in the plan and report back from time to time to the full cancer group on progress and problems with the implementation. These action teams will need leaders, either chosen or assigned to them. They will also need logistical support for their work (e.g., conference calls, or grant writing).

4.12 A major part of implementation has to do with resource needs and acquisition. The individual action teams will identify their own resource needs. It is good also to look at the resource needs of all the priority strategies and make a coordinated effort to obtain them. For example, it is better to make one request to a foundation, for funds for several strategies, than to have a different and competing funding request for each strategy.

4.13 Accountability is an essential part of implementing the cancer plan. Some cancer groups respond to this need by conducting an annual review of progress in the plan. A progress report is prepared for the members of the group and often made available to the public as well.

4.14 Progress reviews typically cover a number of questions, including:

- a. What progress has been made in implementing the key strategies over the past year?
- b. What is working well in implementation?
- c. What is not working well in implementation? What can be done to make it work better?
- d. What will the priority strategies be for the coming year? What strategies will we continue with? What new ones will be added, if any?



Critical questions for implementing the plan

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

- ✓ Will we ask for comments on our draft plan from people outside the cancer planning group? Who will we ask?
How will they make their comments?
- ✓ How will we tell the country about our plan?
Who is responsible for leading this communications effort?
- ✓ Who are the people and organizations we most want to tell about our plan?
What is our call to action for each one of them?
- ✓ How will we prepare our leaders to talk publicly about the plan?
- ✓ What changes do we need to make in the way we are organized for planning to become implementation?
- ✓ Who outside the cancer planning group needs to be involved in implementation?
How will we recruit them?
- ✓ How will we select leaders for the implementation phase?
How long will we ask people to serve as leaders?
- ✓ How can we increase active support for the plan from our national and community leaders?
- ✓ How will we coordinate the effort to obtain the resources needed to implement our plan?
- ✓ How often will we formally review progress and what will the review include?

Tools for communicating and implementing the plan

Worksheet	Communicating the cancer plan
Worksheet	Expanding the group for implementation
Diagram	Sample organization chart for implementation
Worksheet	Identifying resources for implementation
Tipsheet	Sample outline for a progress review

NCCP tools can be accessed through www.uicc.org

Samples and Examples

Samples and examples can be accessed through www.uicc.org

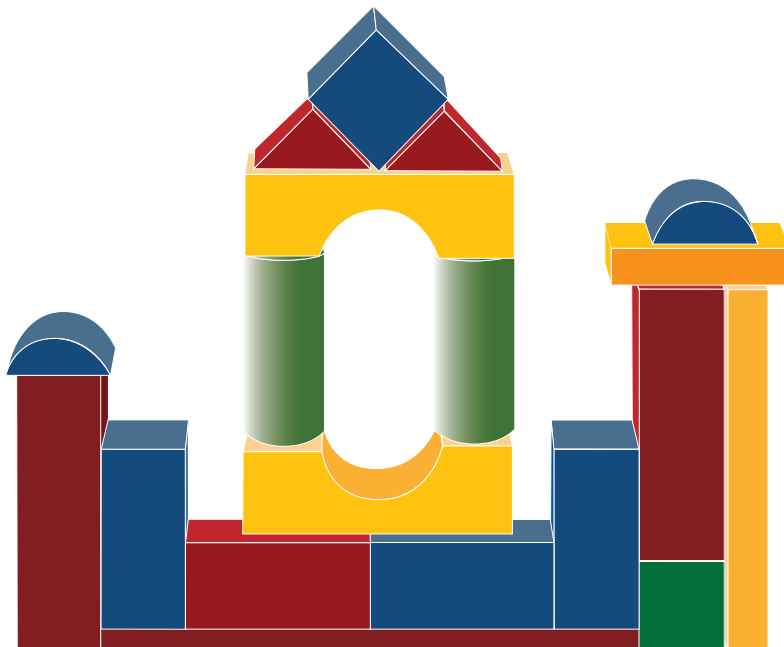
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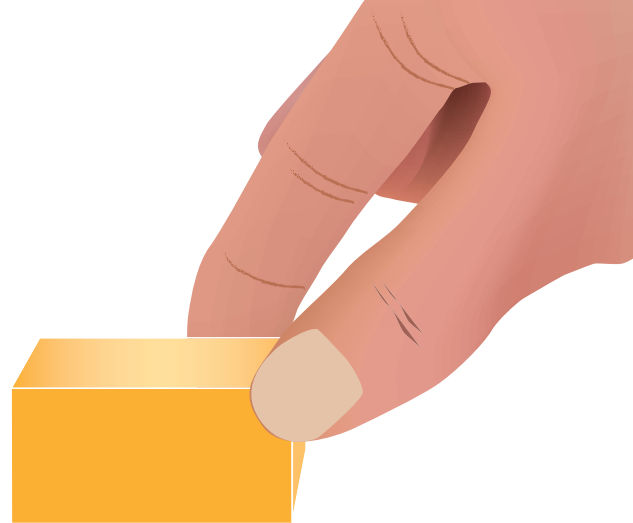
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<http://www.cdc.gov/CANCER/ncccp/guidelines/index.htm>

Steps 3 and 4 of *The Cancer Control PLANET*. <http://cancercontrolplanet.cancer.gov>



Section 5



How will we know if we are successful?

Review the Before you begin checklist before starting this section!

Content

- Introduction
- Guiding principles
- Critical questions
- Practical tools
- Samples and examples
- References

Introduction

To know if the plan is achieving what it was intended to do, an evaluation must be carried out. Evaluation uses many of the same methods as research (e.g., surveys, or cancer registries) but has a simpler purpose. Where research is designed to provide new information about cancer control or replicate previous research results, evaluation tells us how well we are doing in reaching the goals and objectives we have set. Using our previous cervical cancer example, if our goal is to increase the percentage of women getting a test from 40% to 75%, the evaluation should be designed to let us know how far that objective has been achieved since we began implementing the plan.

Evaluation is more a management tool than a scientific tool. Using the same example, let us say after two years of implementation, cervical cancer testing has risen from 40% to 55%. Clearly, implementing the strategy is having an effect, but we are still well short of the 75% objective that has been set.

Cancer control programme leaders must now look at the evaluation results and determine what they mean for the programme. Here are some possible conclusions they may reach:

- ▶ The programme is going well and achieving good results. We need to continue using the strategy and see whether the use of the cancer test continues to rise over the next year.
- ▶ The programme is going well and achieving good results. To meet our objective over the next two years, we need to double the resources we are spending on the strategy.
- ▶ The programme is going well and achieving good results, but the strategy we have been using has achieved all it can. We need to shift to another strategy to meet the objective.
- ▶ The programme is going well and achieving good results, but it may be that our original objective was too ambitious. We may need to scale back our expectation.

In evaluation, programme leaders, with the input of scientists and evaluators, make a judgment about how the results of the evaluation affect the direction of the programme. They make a management decision about what direction the programme will take in the future and how much resources should be allocated to it. The evaluation provides the data on which to make the most informed decision possible.

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

Guiding principles

Deciding who will do the evaluation

- 5.1** Good evaluation begins with good objectives that specific, measurable, attainable, reasonable, and time-phased (SMART). That is why it is so important when developing the plan to write objectives that are SMART and aligned with strategies that have well-defined outcomes.
- 5.2** Evaluation should be designed and carried out by professionals with the appropriate knowledge, training and experience.
- 5.3** Engage key stakeholders (e.g., programme staff, administrators, leaders, programme recipients) in developing the evaluation. In this way evaluators get a better understanding of the programme and buy-in and participation by stakeholders. There is an opportunity to resolve any issues at the outset.
- 5.4** Evaluators should be involved in planning as early as possible. If they are involved from the very beginning, evaluators can often help the cancer planning group to write more specific objectives into the plan.
- 5.5** Evaluation requires resources. These need to be identified and budgeted as part of the planning process.



Types of evaluation

- 5.6** A decision should be made about what type of evaluation will be done. There are three general approaches: process, impact, and outcome.
- a.** Process evaluation measures whether the programme is operating as expected. For example, if the plan calls for 100 women a day to be given a cervical cancer test the evaluation would determine whether the facility doing the tests is capable of handling that many tests. Or it might measure the number of women who are reached with information about the cancer test. Process evaluation can also measure how well the cancer group is functioning as a team and the extent to which members of the group are actively involved in implementing the plan.
 - b.** Impact evaluation measures the extent to which expected outcomes are being met over time and measures changes in knowledge, attitude and behaviours (KAB). For example:
 - i.** A short-term outcome would be the proportion of women who believe they need to have the cancer test and know where to get it
 - ii.** A mid-term outcome might be the number of women who actually get the test
 - c.** Outcome evaluation measures more long-term effects such as changes in morbidity and mortality. For example, a long-term outcome would be a decrease in the number of women diagnosed with late-stage cervical cancer.

Deciding what to evaluate

- 5.7** Early in designing an evaluation, evaluators will develop questions that will guide the selection of data collection techniques to answer them. For example, an evaluation question might be, “What proportion of women getting a cervical cancer test have never had one before?” The answer to this question will tell managers and health educators whether the women being tested are those who already know about the importance of testing and are getting repeat tests, or whether women who have never been tested before are being reached by the programme. If the objective is to increase the percentage of women getting a test, then the programme must reach not only the women who have had previous tests but also those who have never had them.
- 5.8** Evaluators and stakeholders must agree on which questions are to be included in the evaluation. Therefore, while evaluators must safeguard their independence and objectivity, and be free from the influence of programme leaders in reporting their results, they need to work together to determine the focus of the evaluation.
- 5.9** Past cancer plan evaluations have included questions for:
- a.** Evaluating the cancer group
 - b.** Evaluating the planning process
 - c.** Evaluating the cancer plan itself
 - d.** Evaluating the implementation process
 - e.** Evaluating shorter-term outcomes

- 5.10** The evaluation should ask questions not because people may find them interesting, but because they can be used to monitor progress. A good rule is to ask, “If I have the answer to this question, how will I use it to change the programme?” If there is no clear idea of how to use the data, don’t ask the question.
- 5.10** Once the evaluation questions are agreed on, we can determine the data we need, collection methods, analysis, and reporting. Using the familiar example, if we need to know whether women being tested for cervical cancer have had the test before, we will need to:
- a.** Develop a simple survey with a standard set of questions to ask the women if they have ever had this test before.
 - b.** Create a database with the answers we get. For that we will need to assign someone to enter the results into a computer programme or a spreadsheet.
 - c.** Analyse the results. To do that we will need to display the data in a way that helps decision-makers understand them. For example, we might display the results by day so that we can see if the proportion of previously untested women is going up or down over time. This requires expertise in data analysis and reporting.
 - d.** Report the results. This means we need expertise in writing reports that are understandable and presenting results in a clear manner.

Using evaluation results

- 5.11** Reports of evaluation results need to be complete and objective. They should note the things that are going well, the things that are not going well, what we know about why things are going well or not (if the data can tell us that), and conclusions the evaluators suggest the decision-makers consider when reviewing the results.

Resources

- 5.12** Evaluation requires resources. These need to be identified and budgeted as part of the cancer planning process.



Critical questions for evaluating success

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

- ✓ Are our cancer plan objectives and strategies stated in such a way that they can be evaluated? Are they SMART?
- ✓ Do we have people involved in the cancer planning process who have the skills needed to design and carry out an evaluation?
- ✓ Are we going to evaluate the cancer planning process as we go through it?
- ✓ Have we set up a process for the cancer group leaders and evaluators to agree on the evaluation questions that will be included in the plan?
- ✓ Will we include a budget for doing the evaluation as part of the resource needs for cancer control?
- ✓ Who will be responsible for reviewing the evaluation results?
How often will they be reviewed?
- ✓ How will we communicate the evaluation results to our cancer group and to the public?

<i>Tools for evaluating the plan</i>	
Diagram	An overview of evaluation steps
Worksheet	Evaluation skill sets
Worksheet	Checklist for choosing evaluators
Tipsheet	Sample evaluation questions

NCCP tools can be accessed through www.uicc.org

Samples and Examples

Samples and examples can be accessed through www.uicc.org

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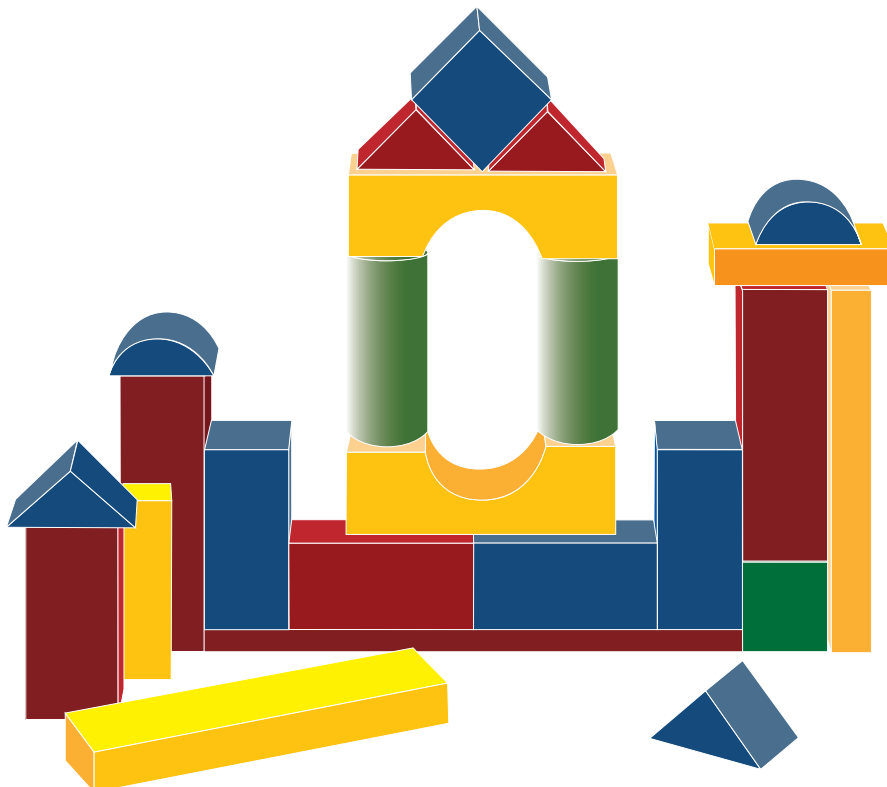
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About UICC

The International Union Against Cancer (UICC) is devoted exclusively to all aspects of the worldwide fight against cancer. Its objectives are to advance scientific and medical knowledge in research, diagnosis, treatment and prevention of cancer, and to promote all other aspects of the campaign against cancer throughout the world. Particular emphasis is placed on professional and public education.

Founded in 1933, UICC is a non-governmental, independent association of more than 270 member organizations in over 80 countries. Members are voluntary cancer leagues and societies, cancer research and treatment centres and, in some countries, Ministries of Health. UICC is non-profit, non-political and non-sectarian. It creates and carries out programmes around the world in collaboration with hundreds of volunteer experts. It works in four strategic directions: prevention and early detection, tobacco control, knowledge transfer, and capacity building.

UICC is governed by its members through a General Assembly, which meets every two years. Responsibility for programme structure and implementation rests with an elected Board of Directors. UICC organizes a World Cancer Congress every two years, as well as annual symposia, workshops and training courses. It publishes the *International Journal of Cancer* (30 issues per year), *UICC eNews* (every second month), *bloom*, the newsletter of Reach to Recovery International (twice yearly), a *Calendar of International Cancer Conferences* (twice yearly), and technical reports, textbooks, and manuals.

Its headquarters are in Geneva, Switzerland.

For detailed information please visit www.uicc.org

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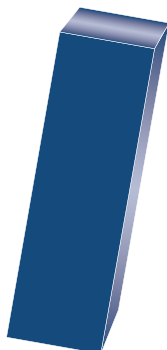
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Cancer control is a public health approach aimed at reducing the burden of cancer in a population. Planning integrated, evidence-based and cost-effective interventions across the cancer continuum (research, prevention, early detection, treatment, and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

Most countries have yet to begin a systematic national cancer planning effort. Where governments are concentrating on other immediate health priorities, non-governmental organizations (NGOs) can play a critically important role in increasing public and leadership awareness of the cancer problem and in developing effective partnerships to take on the responsibility of cancer planning.

UICC's National Cancer Control Planning Resources shows how to prioritise cancer planning actions and implement them for maximum impact when working towards a national cancer control programme. It is designed around five key questions:

- ▶ What is our country's cancer picture?
- ▶ Who can help us develop and implement a cancer plan?
- ▶ What will be in our plan?
- ▶ How do we communicate and implement our plan?
- ▶ How will we know if we are successful?



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This publication was supported by Cooperative Agreement Number U58/CCU923976) from the Centres for Disease Control and Prevention