

Cancer Control

Knowledge into Action

WHO Guide for Effective Programmes



Planning



World Health
Organization

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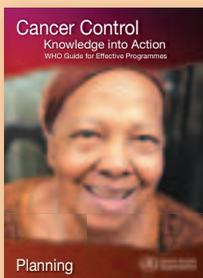
Introduction to the Cancer Control Series

Cancer is to a large extent avoidable. Many cancers can be prevented. Others can be detected early in their development, treated and cured. Even with late stage cancer, the pain can be reduced, the progression of the cancer slowed, and patients and their families helped to cope.

Cancer is a leading cause of death globally. The World Health Organization estimates that 7.6 million people died of cancer in 2005 and 84 million people will die in the next 10 years if action is not taken. More than 70% of all cancer deaths occur in low- and middle-income countries, where resources available for prevention, diagnosis and treatment of cancer are limited or nonexistent.

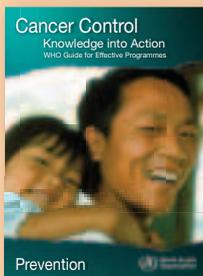
But because of the wealth of available knowledge, all countries can, at some useful level, implement the four basic components of cancer control – *prevention, early detection, diagnosis and treatment, and palliative care* – and thus avoid and cure many cancers, as well as palliating the suffering.

Cancer control: knowledge into action, WHO guide for effective programmes is a series of six modules that provides practical advice for programme managers and policy-makers on how to advocate, plan and implement effective cancer control programmes, particularly in low- and middle-income countries.



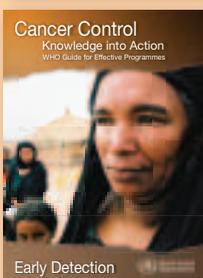
PLANNING

A practical guide for programme managers on how to plan overall cancer control effectively, according to available resources and integrating cancer control with programmes for other chronic diseases and related problems.



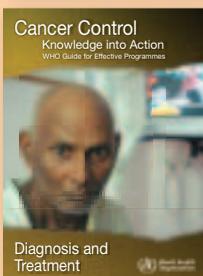
PREVENTION

A practical guide for programme managers on how to implement effective cancer prevention by controlling major avoidable cancer risk factors.



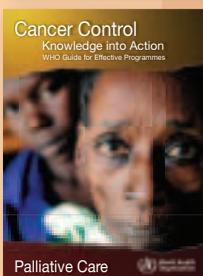
EARLY DETECTION

A practical guide for programme managers on how to implement effective early detection of major types of cancer that are amenable to early diagnosis and screening.



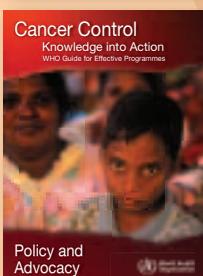
DIAGNOSIS AND TREATMENT

A practical guide for programme managers on how to implement effective cancer diagnosis and treatment, particularly linked to early detection programmes or curable cancers.



PALLIATIVE CARE

A practical guide for programme managers on how to implement effective palliative care for cancer, with a particular focus on community-based care.



POLICY AND ADVOCACY

A practical guide for medium level decision-makers and programme managers on how to advocate for policy development and effective programme implementation for cancer control.

The WHO guide is a response to the World Health Assembly resolution on cancer prevention and control (WHA58.22), adopted in May 2005, which calls on Member States to intensify action against cancer by developing and reinforcing cancer control programmes. It builds on *National cancer control programmes: policies and managerial guidelines* and *Preventing chronic diseases: a vital investment*, as well as on the various WHO policies that have influenced efforts to control cancer.

Cancer control aims to reduce the incidence, morbidity and mortality of cancer and to improve the quality of life of cancer patients in a defined population, through the systematic implementation of evidence-based interventions for prevention, early detection, diagnosis, treatment, and palliative care. Comprehensive cancer control addresses the whole population, while seeking to respond to the needs of the different subgroups at risk.

COMPONENTS OF CANCER CONTROL

Prevention of cancer, especially when integrated with the prevention of chronic diseases and other related issues (such as reproductive health, hepatitis B immunization, HIV/AIDS, occupational and environmental health), offers the greatest public health potential and the most cost-effective long-term method of cancer control. We now have sufficient knowledge to prevent around 40% of all cancers. Most cancers are linked to tobacco use, unhealthy diet, or infectious agents (see Prevention module).

Early detection detects (or diagnoses) the disease at an early stage, when it has a high potential for cure (e.g. cervical or breast cancer). Interventions are available which permit the early detection and effective treatment of around one third of cases (see Early Detection module).

There are two strategies for early detection:

- *early diagnosis*, often involving the patient's awareness of early signs and symptoms, leading to a consultation with a health provider – who then promptly refers the patient for confirmation of diagnosis and treatment;
- *national or regional screening* of asymptomatic and apparently healthy individuals to detect pre-cancerous lesions or an early stage of cancer, and to arrange referral for diagnosis and treatment.

Treatment aims to cure disease, prolong life, and improve the quality of remaining life after the diagnosis of cancer is confirmed by the appropriate available procedures. The most effective and efficient treatment is linked to early detection programmes and follows evidence-based standards of care. Patients can benefit either by cure or by prolonged life, in cases of cancers that although disseminated are highly responsive to treatment, including acute leukaemia and lymphoma. This component also addresses rehabilitation aimed at improving the quality of life of patients with impairments due to cancer (see Diagnosis and Treatment module).

Palliative care meets the needs of all patients requiring relief from symptoms and of psychosocial and supportive care, particularly those with advanced stages who have a very low chance of being cured or who are facing the terminal phase of the disease. Cancer and its management have emotional, spiritual, social and economic consequences for patients and their family members. For them, palliative care services addressing their needs from the time of diagnosis can influence their quality of life and their ability to cope effectively (see Palliative Care module).

Despite cancer being a global public health problem, many governments have not yet included cancer control in their health agendas. There are competing health problems, and interventions may be chosen in response to the demands of interest groups, rather than in response to population needs or on the basis of cost-effectiveness and affordability.

Low-income and disadvantaged groups are generally more exposed to avoidable cancer risk factors, such as environmental carcinogens, tobacco use, alcohol abuse and infectious agents. These groups have less political influence, less access to health services, and lack education that can empower them to make decisions to protect and improve their own health.

BASIC PRINCIPLES OF CANCER CONTROL

- **Leadership** to create clarity and unity of purpose, and to encourage team building, broad participation, ownership of the process, continuous learning and mutual recognition of efforts made.
- **Involvement of stakeholders** of all related sectors, and at all levels of the decision-making process, to enable active participation and commitment of key players for the benefit of the programme.
- **Creation of partnerships** to enhance effectiveness through mutually beneficial relationships, and build upon trust and complementary capacities of partners from different disciplines and sectors.
- **Responding to the needs of people** at risk of developing cancer or already presenting with the disease, in order to meet their physical, psychosocial and spiritual needs across the full continuum of care.
- **Decision-making** based on evidence, social values and efficient and cost-effective use of resources that benefit the target population in a sustainable and equitable way.
- **Application of a systemic approach** by implementing a comprehensive programme with interrelated key components sharing the same goals and integrated with other related programmes and to the health system.
- **Seeking continuous improvement**, innovation and creativity to maximize performance and to address social and cultural diversity, as well as the needs and challenges presented by a changing environment.
- **Adoption of a stepwise approach** to planning and implementing interventions, based on local considerations and needs. (see next page for WHO stepwise framework for chronic diseases prevention and control, as applied to cancer control).

WHO stepwise framework

1 PLANNING STEP 1 Where are we now?

Investigate the present state of the cancer problem, and cancer control services or programmes.

2 PLANNING STEP 2 Where do we want to be?

Formulate and adopt policy. This includes defining the target population, setting goals and objectives, and deciding on priority interventions across the cancer continuum.

3 PLANNING STEP 3 How do we get there?

Identify the steps needed to implement the policy.

The planning phase is followed by the policy implementation phase.

Implementation step 1 CORE

Implement interventions in the policy that are feasible now, with existing resources.

Implementation step 2 EXPANDED

Implement interventions in the policy that are feasible in the medium term, with a realistically projected increase in, or reallocation of, resources.

Implementation step 3 DESIRABLE

Implement interventions in the policy that are beyond the reach of current resources, if and when such resources become available.

PLANNING MODULE CONTENTS

KEY MESSAGES	2
PRE-PLANNING	4
Is a new cancer control plan needed?	4
If a plan is needed, who can advocate for it?	6
How to draw up a strategic plan	6
PLANNING STEP 1: WHERE ARE WE NOW?	12
Assess the cancer problem	13
Assess the existing cancer control plan and ongoing activities	16
Self-assessment by countries	21
PLANNING STEP 2: WHERE DO WE WANT TO BE?	23
Define the target population	23
Identify gaps	24
Set objectives	24
Assess feasibility of interventions	25
Set priorities	25
PLANNING STEP 3: HOW DO WE GET THERE?	29
Raise the necessary resources	33
Work with multidisciplinary and multisectoral teams	33
Build in monitoring and evaluation	33
Launch and disseminate the cancer control plan	34
Move from policy to implementation	35
CONCLUSION	37
REFERENCES	38
ACKNOWLEDGEMENTS	39

KEY MESSAGES

Planning involves:

“ An honest understanding of an organization’s history. A systematic examination of an organization’s environment. The rigorous assessment of an organization’s mission. Clear vision of organizational goals. A mapping process presenting ways of reaching those goals. An inclusive, collaborative process for gathering information, ideas, opinions and intuitions on which goals and decisions are based. A realization that planning never stops. ”

Source: Taylor E. *Trick or treat (or why plan?)*
(<http://www.nea.gov/resources/Lessons/TAYLOR.HTML>, accessed 18 May 2006).

Cancer control planning is necessary in any resource setting in order to respond to the cancer needs in populations by preventing cancer, detecting it early, curing it and caring for people affected by it. This module addresses some basic aspects of planning, and discusses how to determine whether a plan is needed and, if so, how to draw up a strategic plan.

key definitions

What is a plan?

- ▣ A plan is a set of intended actions that are expected to achieve a specified goal within a certain time frame.
- ▣ “A good plan is like a road map: it shows the final destination and usually the best way to get there.”

Judd HS. H. Stanley Judd Quotes (http://en.thinkexist.com/quotes/h._stanley_judd/ accessed 18 May 2006).

The key messages for people involved in cancer control planning and implementation are as follows:

- An integrated, comprehensive cancer control strategy allows for a more balanced, efficient and equitable use of limited resources.
- In order to plan cancer control wisely, it is necessary to understand the context, appreciate past experiences, and be ready to learn continuously.
- A cancer control plan that is goal-oriented, people-centred, realistic and carefully prepared through a participatory process is more likely to move into effective implementation.
- In lower-resource settings, a plan that considers the gradual implementation of a few, affordable, cost-effective and priority interventions will have a better chance of moving into effective action.

This module is complemented by various practical tools accessible through the WHO cancer web site
<http://www.who.int/cancer>



What is a programme?

A programme is the organized and systematic implementation of the actions described in the plan, according to a defined time frame and using defined resources (human, physical and financial).

What is a planning process?

Planning is a formalized procedure, in the form of an integrated system of decisions, to produce an articulated result. Thinking about, and attempting to control, the future are important components of planning (Mintzberg, 1994).

PRE-PLANNING

With careful planning, a substantial degree of cancer control can be achieved, even where resources are limited. Without careful planning, there is a risk that the resources available for cancer control will be used inefficiently, and that the benefits to the population that should flow from these resources will not be realized.

Several countries have introduced national cancer plans that provide good models of how to proceed, see <http://www.who.int/cancer> for examples.



IS A NEW CANCER CONTROL PLAN NEEDED?

There is no country in the world where cancer does not occur. Even in low-resource countries, some level of cancer control activity is going on. Effective cancer control plans are thus needed everywhere. Reasons for initiating a cancer control planning process, or for updating an existing plan might be:

- there is no previously written cancer control plan in the country or region, and there is recognition that cancer cases or cancer risk factors are a major or increasing problem, and systematic organized action is required;
- the available cancer control plan is outdated in relation to the present evidence on cancer control (for example, the plan is 10 or more years old and has not been updated);
- the implemented plan is not achieving the expected outcomes, is unrealistic or limited in scope, is inefficient or inequitable, or unsatisfactory to different stakeholders;
- the available plan is reasonable, but an opportunity has arisen for a more comprehensive and effective plan – for example, there is a prospect of health sector reform in the country.



**Maria Saloniki,
United Republic
of Tanzania**

her story

**MORE THAN 3 YEARS
HAVE PASSED SINCE
MARIA, A 60-YEAR-OLD
TANZANIAN LIVESTOCK
KEEPER AND MOTHER OF
10 CHILDREN, WOKE UP
ONE MORNING WITH A
SWOLLEN ARMPIT.**

Maria can hardly remember how many times she went to the local traditional healer, how many doctors in clinics and dispensaries she consulted in between two hospitalizations, how many words she used to describe her pain, how many friends she turned to for advice. Maria waited more than 3 years to discover she had breast cancer – the disease was diagnosed at a very late stage with little chance of being cured.

Sadly, Maria's story is common in the understaffed and poorly equipped hospital ward she shares with 30 other cancer patients in Dar es Salaam Ocean Road Cancer Institute, the only cancer hospital in the country. Maria is one of around 24 000 cancer patients who are diagnosed with advanced cancer every year in the United Republic of Tanzania. She is also one of 2400 cancer patients who are fortunate enough ever to reach the Ocean Road Cancer Institute.

The government recognizes that cancer is a public health problem. A national cancer control plan was endorsed by the Ministry of Health in 1997 and many steps have since been taken to improve the situation. However, the late stage at presentation does not seem to have changed much over the past 25 years. This has led policy-makers to identify past mistakes and search for new approaches.

The United Republic of Tanzania now has a unique opportunity to build on past experience and reformulate its plan of action to make it more effective. As suggested in this WHO guide, the country can consider the gradual implementation of prevention of common avoidable risk factors, the early diagnosis and treatment of a few – but frequent – cancers, and the provision of palliative care.

Source: Ngoma TA. *Report on Cancer Control Programme in Tanzania*, WHO participative workshop, 4–8 December 2000, Geneva. Additional information provided by T. Ngoma, Executive Director, Ocean Road Cancer Institute.

IF A PLAN IS NEEDED, WHO CAN ADVOCATE FOR IT?

If a new or updated cancer control plan is needed, who can champion the need for change?

Change is unlikely to occur in the absence of external stimuli. National and international organizations can act as triggers for change by influencing decision-makers in countries. Credible international organizations, such as WHO and the International Union Against Cancer (UICC), have the potential to encourage decision-makers to recognize the need for a cancer control plan in their countries.

To trigger change in a country or region, leaders with decision-making authority need to be identified and urged to take action. In the case of Chile, for example, WHO's offer to support the development of a demonstration project prompted the Chilean Minister of Health to appoint a national cancer control coordinator and council, and to develop a plan to be implemented in a stepwise manner.

Decision-makers should be reassured that a cancer control plan will not create a costly vertical programme, but can be integrated with other related programmes, which will make better use of available resources.

HOW TO DRAW UP A STRATEGIC PLAN

If national leaders decide to create a new or updated cancer control plan and if this effort survives any opposition, then the cancer control planning process can start. The planning process can be schematized as a systemic model with input, process, output, feedback and outcome, embedded in an environment (Figure 1).

It is essential to gear the planning process towards producing a cancer control plan that can be successfully implemented. A plan that is produced but not implemented within a reasonable time is a failure.

The benefits of planning are twofold: firstly, a plan is produced, and secondly, the participants in the planning process acquire knowledge and collaborative experience that will support the successful implementation of the new plan.

The planning process comprises three basic steps, providing answers, based on best evidence, to key questions:

PLANNING STEP 1:

Where are we now?

PLANNING STEP 2:

Where do we want to be?

PLANNING STEP 3:

How will we get there?

Step 3 includes two further questions:

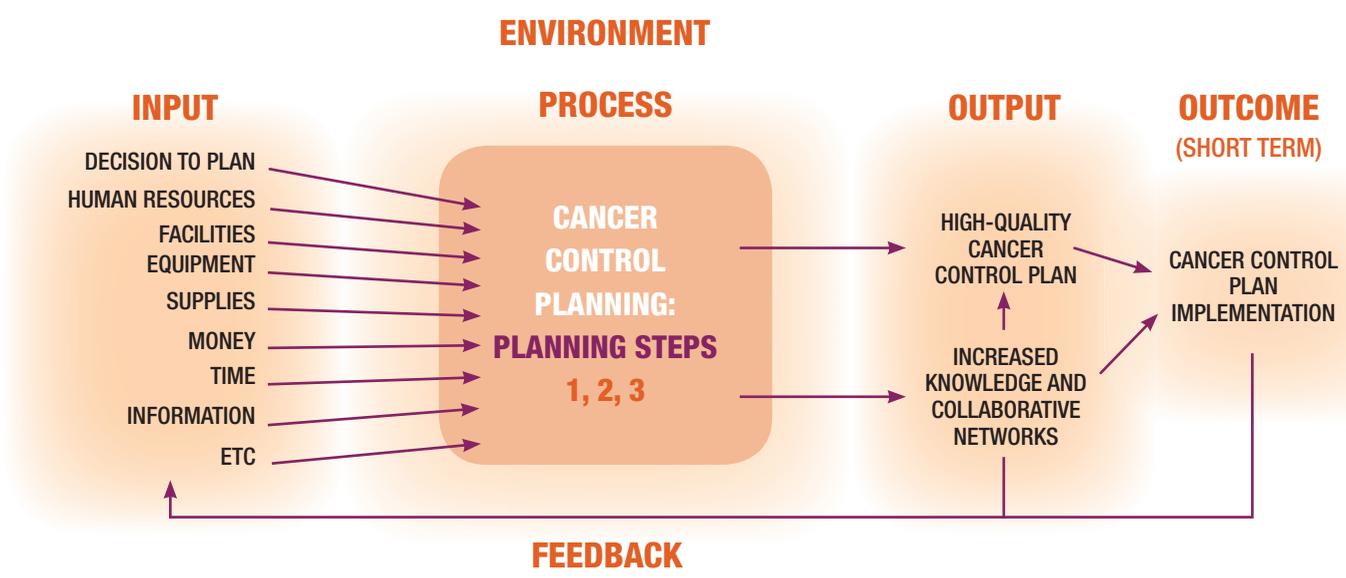
How will we know if we get there or not?

How will we track progress?

Planning is an iterative cyclical process; the plan is refined through each iterative cycle. Thus, the planning and implementation steps may overlap, and it may be necessary to repeat the sequence of planning steps. For example, the priorities identified in planning step 2 may include the reorganization of cervical cancer screening in a specific target area. It may then be necessary to return to planning step 1 and do a more in-depth assessment of the services in the selected area to be able to implement the best solutions.

In the current information society, where changes occur increasingly fast, it is impossible to anticipate all possible scenarios. The plan will need the flexibility to face the unexpected and react to unplanned contingencies. The plan should also be updated regularly to make adjustments for new knowledge, new technology and customer wishes.

Figure 1. Cancer control planning process



CANADA

Example of a “bottom-up” planning process

The Canadian Strategy for Cancer Control is an example of a “bottom-up” cancer control planning process with a high level of collaborative planning, within the context of a federal government.

Planning reports were produced during the course of a year of discussion, and involving consultation with over 250 cancer survivors, as well as medical and allied health professionals.

The planning process was guided by a steering committee consisting of senior executives of the Canadian Association of Provincial Cancer Agencies, the Canadian Cancer Society, the National Cancer Institute of Canada and Health Canada. It was characterized by consultation, multi-jurisdictional participation, survivor perspective and timeliness.

The process was driven by small and efficient working groups. These groups consulted broadly in developing their reports, which included as attachments written feedback submissions from stakeholders. An “integration group” consisting of representatives of national health organizations, oncology-related professional bodies, cancer survivors and the working group chairpersons, oversaw the working groups’ progress and scope, and assisted in identifying gaps, integrating areas of common concern and developing the overall strategic vision.

A consultation conference was held to obtain focused input, critical comment and consensus rankings of priority actions for implementation. Participation was sought from health ministries (federal, provincial and territorial), cancer treatment centres, community cancer providers, caregivers, patients and the public to ensure that the views of both policy-makers, implementers and clients/patients were taken into account.

Source: *Canadian Strategy for Cancer Control* (http://cancercontrol.org/home_csc.html, accessed 15 May 2006). Additional information provided by S. Sutcliffe, Chair of the Governing Council, Canadian Strategy for Cancer Control.

A good plan should be accessible and should include:

- involvement of all stakeholders,
- presentation of data on disease burden and existing control efforts,
- setting goals and objectives,
- selecting populations and strategies for intervention,
- integration of strategies with other programmes and in implementing the plan,
- resources for the implementation of the plan,
- monitoring and evaluation.

These are the components used by the State Plan Index to evaluate the quality of a written plan. The State Plan Index was developed by the United States Centers for Disease Control and Prevention (Butterfoss and Dunĕt, 2005; Dunĕt et al., 2005). It has been applied to obesity control.

Further information can be obtained at

http://www.cdc.gov/pcd/issues/2005/apr/04_0089.htm

http://www.cdc.gov/pcd/issues/2005/apr/04_0090.htm



WHO WILL DEVELOP THE CANCER CONTROL PLAN?

Who should participate in the cancer control planning process, in what ways, and during which phases?

The answer to this question will be related to a country’s particular context. Several aspects, such as human resources training, and social, cultural, political, economic and technological factors could influence the selection of participants and how they participate in the cancer control planning process.

In general, “bottom-up” planning processes are preferable, as they tend to ensure that those who will put the plan into effect are involved from the beginning (see example of Canada).

Bottom-up planning may not always be possible, especially if it is contrary to the existing culture of the government, or if the only way to ensure that new resources are available is to give the government ownership of the plan. However, even in a “top-down” process a broad participatory approach is possible (see example of China).

Developing the plan involves the following stages: preparation, drafting, refinement, review, communication and marketing, budgeting and activation. These stages are shown in Table 1, with their corresponding outcomes (products) and stakeholder involvement (who is going to participate).

Another useful planning model that could be adapted to different socioeconomic contexts is known as the Building Blocks of Comprehensive Cancer Control Planning, developed in the United States by the Centers for Disease Control and Prevention (CDC) and its partners primarily to help states develop comprehensive cancer control plans (CDC, 2002).

The CDC model (see Table 2) presents specific activities to be undertaken in a loosely defined order. The first four building blocks (*enhance infrastructure, mobilize support, use data and research, build partnerships*) lay the groundwork for planning and provide a strong foundation for the entire process. The activities for the sixth building block (*conduct evaluation*) may begin very early on the process and will certainly continue throughout the implementation phases of the plan.

The fifth building block (*assess and address the cancer burden*) describes what must be done to write a plan that can be implemented and evaluated. However, if conducted prematurely or without support from the other five building blocks, the activities of this building block may well result in a plan that is neither implemented nor evaluated.

CHINA

Example of a “top-down” planning process

An example of a “top-down” cancer control planning process is provided by the Programme of Cancer Prevention and Control in China (2004–2010) initiated in 2002 and launched in 2003. China is a lower middle-income country, with a centralized government structure. Cancer represents 20% of all deaths and is, at present, the leading cause of death in urban populations. Traditionally there has been excessive reliance on treatment-oriented approaches, neglecting prevention strategies.

Alarmed by rising cancer trends, the department for disease control of the Ministry of Health initiated the planning process. A core team was in charge of developing the plan in close coordination with the prevention and control of other diseases. The major difficulty during the planning phase was to agree on the objectives and priorities of the plan. Finally, the most relevant and feasible ones were selected. In June 2003, the plan was published on the web for comments from the public. Meanwhile suggestions were collected from more than 60 experts nationwide via mail. In August 2003, the final draft was approved at a symposium that brought together relevant leaders of the Ministry of Health and other experts.

The priorities of the plan include: prevention (e.g. tobacco control, hepatitis B vaccination, control of occupational risk factors); early detection and treatment of major cancer types (uterine, cervix, breast, stomach, liver, nasopharynx, colon and rectum); rehabilitation and palliative care; and expansion of cancer registries. The biggest problem encountered in implementation is insufficient funding to carry out the biennial action plan, which mainly focuses on early detection and a public education campaign. However, there are ongoing efforts to identify further funding to support the activities.

Source: Programme of cancer control and prevention in China, 2004–2010 (<http://www.chinacancernet.org.cn/links/english.html>, accessed 18 May 2006). Additional information provided by L. Kong, Deputy Director General, Disease Control Department, Ministry of Health.

Table 1. Stages in the development of a cancer control plan, their products, and potential participants

Stage	Product	Who is going to participate
Preparation	<ul style="list-style-type: none"> ○ Decide on organizational structure ○ Initial planning proposal ○ Mapping of available resources 	<ul style="list-style-type: none"> ○ Small action group
Drafting	<ul style="list-style-type: none"> ○ Draft of cancer control plan Planning step 1: Where are we now? i.e. assessment of: cancer burden, cancer control and context Planning step 2: Where do we want to be? i.e. identify: goals and objectives, target populations, priorities Planning step 3: How do we get there? Action plan How will we know if we get there? How will we track progress? 	<ul style="list-style-type: none"> ○ Executive group ○ Planning workgroup ○ Cancer council ○ Specific task groups ○ Facilitators ○ Consultants
Refinement	<ul style="list-style-type: none"> ○ Draft with incorporated feedback 	<ul style="list-style-type: none"> ○ Large reference group
Review	<ul style="list-style-type: none"> ○ Final cancer control plan 	<ul style="list-style-type: none"> ○ External expert group or consultants ○ Executive group ○ Planning workgroup
Communication and marketing	<ul style="list-style-type: none"> ○ Cancer control plan disseminated ○ Public opinion and governmental leaders awareness 	<ul style="list-style-type: none"> ○ Executive group ○ Specific task group
Budgeting	<ul style="list-style-type: none"> ○ Realistic pricing of the cost of initiating and maintaining the plan 	<ul style="list-style-type: none"> ○ Executive group ○ Financial advisors
Activation	<ul style="list-style-type: none"> ○ Adoption/endorsement by the relevant national authorities 	<ul style="list-style-type: none"> ○ Government (ministry of health)

Table 2. Contributions of the building blocks to the comprehensive cancer control process

Building block	Contributions
1. Enhance infrastructure	<ul style="list-style-type: none"> ○ Developing or enhancing infrastructure for planning helps initiate comprehensive cancer control, keeps it on track, and helps the process to progress.
2. Mobilize support	<ul style="list-style-type: none"> ○ Support must be mobilized both to permit initiation of the planning process and to sustain implementation and institutionalization.
3. Use data and research	<ul style="list-style-type: none"> ○ Data and research must be used to set priorities and to develop strategies to ensure that decisions are based on evidence and are defensible.
4. Build partnerships	<ul style="list-style-type: none"> ○ Partnerships must be built to ensure broad buy-in and support for both planning and implementation.
5. Assess and address the cancer burden	<ul style="list-style-type: none"> ○ This is the cornerstone of the comprehensive cancer control process supported by the other five building blocks. The cancer burden is assessed and then addressed through a broad-based partnership that enhances infrastructure, mobilizes support, uses data and research, and conducts evaluation.
6. Conduct evaluation	<ul style="list-style-type: none"> ○ Evaluation must be conducted both to monitor outcomes and to ensure continuous improvement of the process.

Source: CDC, 2002.

THE ROLE OF STAKEHOLDERS

A stakeholder is someone who has an interest in an organization or programme. Stakeholders either affect, or are affected by, the organization or programme. In the context of cancer control planning, a stakeholder has a potential to invest in the planning process.

Stakeholder analysis can be used to identify appropriate stakeholder participation. Examples of stakeholder analysis templates are:

UNICEF and Management Sciences for Health:
Guide to managing for quality stakeholder analysis
<http://www.erc.msh.org/quality/ittools/itstkan.cfm>



United Kingdom Overseas Development
 Administration:
*Guidance note on how to do stakeholder analysis of
 aid projects and programmes*
<http://www.euforic.org/gb/stake1.htm>



If a cancer control plan is comprehensive and assuming there is a real intention to implement it, all the key current and potential stakeholders should be invited, early on, to participate in the planning process. Early involvement increases the likelihood that stakeholders will develop a sense of ownership of the plan and a commitment to making it succeed. Each partner brings his or her knowledge assets, collaborative networks and possibly other resources to the cancer control plan.

INTERACTING AND COMMUNICATING

Participants in the planning process need to interact and communicate freely. Attributes essential for collaborative work include: flexibility, open-mindedness, tolerance, acceptance of changes in authority and status, and willingness to face a challenge.

BUDGETING

To complete the cancer control planning process, there has to be a budget costing out the resources needed to implement and maintain the plan. The budget should be realistic, i.e. compatible with the resources that are likely to be made available through both government action and nongovernmental support.

PLANNING STEP 1

Where are we now?

The first step in cancer control planning is to assess the present status of the cancer problem and the cancer control activities or programmes. Because assessment of the cancer problem and the cancer control plan and programme is a complex undertaking, it is important to determine what is relevant and feasible to assess, and how to assess it.

In any effective cancer control plan, cancer control priorities and programmes are driven by available data on the cancer needs in the general population and the groups particularly at risk. Such a plan makes it possible to direct available resources or new investments to respond to unmet needs in an effective and efficient way, reducing inequalities and improving well-being.