Meeting Report

Workshop on Leadership and Capacity-Building for Cancer Control

Seoul, Republic of Korea
17–21 June 2013
Participants of the Workshop on Leadership and Capacity-Building for Cancer Control, 17–21 June 2013, Seoul, Republic of Korea
REPORT

WORKSHOP ON LEADERSHIP AND CAPACITY-BUILDING FOR CANCER CONTROL

Convened by:

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR THE WESTERN PACIFIC

National Cancer Center, Seoul, Republic of Korea
17–21 June 2013

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NOTE

The views expressed in this report are those of the participants in the Workshop on Leadership and Capacity-Building for Cancer Control and do not necessarily reflect the policies of the Organization.

This report has been prepared for the World Health Organization Regional Office for the Western Pacific for governments of Member States in the Region and for those who participated in the Workshop on Leadership and Capacity-Building for Cancer Control held at the National Cancer Center, Seoul, Republic of Korea from 17 to 21 June 2013.
Noncommunicable diseases (NCDs) are the leading cause of death in the Western Pacific Region. Premature mortality (death before age 70) accounts for 50% of deaths due to NCD in low- and middle-income countries (LMICs) and demonstrates the impact of the NCD epidemic on productivity and development. Cancer is one of four leading NCDs in the Western Pacific Region. There were an estimated 4 million cases and 2.6 million deaths from cancer in the Region in 2008.

Cancer control capacity is limited in the Western Pacific Region, especially in LMICs. Constraints are noted in national cancer control planning, identification of cost-effective screening programmes, cancer registries and palliative care. Recognizing these issues, a Workshop on Leadership and Capacity-Building for Cancer Control (CanLEAD) was held at the National Cancer Center, Seoul, Republic of Korea from 17 to 21 June 2013, with the following objectives:

(1) to review the status of cancer control programmes in participating countries;
(2) to enhance leadership skills and share good practices in cancer control; and
(3) to identify country-specific steps on cancer control through strengthened capacity for national cancer control plans.

The five-day workshop comprised sessions on critical aspects of cancer control: current status and challenges, cancer registration, prevention and early detection, management and care, developing a national cancer control programme and a site visit. The workshop helped to build capacity for cancer control and to identify priority areas for action in the participating countries.
CONTENTS

1. INTRODUCTION .............................................................................................................
   1.1 Background ............................................................................................................... 1
   1.2 Objectives .................................................................................................................. 1
   1.3 Participants ............................................................................................................... 1
   1.4 Organization ............................................................................................................. 1
   1.5 Opening session ........................................................................................................ 2

2. PROCEEDINGS ................................................................................................................
   2.1 Session 1 – Cancer control: Current status and challenges ........................................ 2
   2.2 Session 2 – Cancer registration .................................................................................. 3
   2.3 Session 3 – Prevention and early detection .................................................................. 3
   2.4 Session 4 – Management and care ............................................................................ 4
   2.5 Session 5 – Developing a national cancer control programme (NCCP) ...................... 5
   2.6 Session 6 – Site visit ................................................................................................ 5
   2.7 Closing session .......................................................................................................... 6

3. CONCLUSIONS AND RECOMMENDATIONS ..............................................................
   3.1 Conclusions ............................................................................................................... 7
   3.2 Recommendations ................................................................................................... 7

ANNEXES:

ANNEX 1: List of participants, temporary advisers, observers and secretariat
ANNEX 2: Programme of activities
ANNEX 3: Draft national cancer control programmes
ANNEX 4: Evaluation of the workshop
ANNEX 5: Participant’s workbook

Keywords

Chronic diseases-prevention and control / Neoplasms – prevention and control / Leadership / Capacity-building
INTRODUCTION

1.1 Background

Premature mortality (death before age 70) accounts for 50% of deaths due to noncommunicable disease (NCD) in low- and middle-income countries (LMICs) in the Western Pacific Region and demonstrates the impact of the NCD epidemic on productivity and development. Cancer is one of four leading NCDs in the Western Pacific Region. There were an estimated 4 million cases and 2.6 million deaths from cancer in the Region in 2008. A well-conceived, well-managed national cancer control programme can reduce cancer incidence and improve the lives of patients.

Capacity for cancer control is limited in the Western Pacific Region, especially in LMICs. Challenges are noted in national cancer control planning, identification of cost-effective screening programmes, cancer registries and palliative care.

Recognizing these issues, a Workshop on Leadership and Capacity-Building for Cancer Control (CanLEAD) was held at the National Cancer Center, Seoul, Republic of Korea from 17 to 21 June 2013. The workshop aimed to enhance leadership and build capacity for national cancer control programme development in the Region. WHO has developed six modules—planning, prevention, early detection, diagnosis and treatment, palliative care and policy and advocacy—that provide practical advice for programme managers and policy-makers on how to advocate, plan and implement effective cancer control programmes.

1.2 Objectives

(1) To review the status of cancer control programmes in participating countries.

(2) To enhance leadership skills and share good practices in cancer control.

(3) To identify country-specific steps on cancer control through strengthened capacity for national cancer control plans.

1.3 Participants

The workshop was attended by 16 senior officers from ministries of health and national cancer centres in Brunei Darussalam, Cambodia, Fiji, the Lao People’s Democratic Republic, Mongolia, Papua New Guinea, the Philippines, Solomon Islands and Viet Nam. Staff members from the WHO Regional Office for the Western Pacific and WHO Headquarters in Geneva provided secretariat support for the consultation. A list of participants, temporary advisers, resource persons and secretariat members are given in Annex 1.

1.4 Organization

The workshop comprised six sessions in addition to the opening and closing sessions. Sessions were designed according to the critical aspects of cancer control: current status and challenges, cancer registration, prevention and early detection, management and care, developing a national cancer control programme and a site visit. A full outline of the programme is provided in Annex 2.
1.5 Opening session

Dr Jin Soo Lee, President of the National Cancer Center of the Republic of Korea, welcomed the participants to the workshop. Dr Shin Young-soo, WHO Regional Director for the Western Pacific, gave the opening address and highlighted the need to address cancer control. He called on the participants to consider pain relief and palliative care as entry points, even in resource-constrained settings. The National Cancer Center of the Republic of Korea was re-designated as a WHO Collaborating Centre for Cancer Control, and Dr Shin applauded the work of the centre.

2. PROCEEDINGS

2.1 Session 1 – Cancer control: current status and challenges

Dr Hai-Rim Shin, Team Leader, Noncommunicable Diseases and Health Promotion, WHO Regional Office for the Western Pacific, started her presentation with an overview of the global mandates for the prevention and control of NCDs with emphasis on the Global Monitoring Framework and a set of nine voluntary global NCD targets and indicators for 2025, which includes indicators for cancer incidence by type, cervical cancer screening, hepatitis B vaccine and human papillomavirus vaccine. Information on cancer burden can be obtained through reports of cancer deaths, cancer registries and global estimations of cancer such as the Cancer Incidence in Five Continents (CI5) and GLOBOCAN 2008 by the International Agency for Research on Cancer (IARC). Dr Shin highlighted the varying burden of cancer in the Region according to types of cancer in men and women, as well as premature deaths due to cancer in some countries and cancer risk factor associations.

Dr Cherian Varghese, Senior Medical Officer, Noncommunicable Diseases, WHO Regional Office for the Western Pacific, followed with a presentation on national cancer control programmes, their importance and the critical components. Dr Varghese noted the current scenario on cancer control with issues on sporadic primary prevention, opportunistic early detection, treatment centres burdened with palliative care, insufficient human resources, lack of treatment guidelines and limitations on financial protection. Challenges also include the public perception on cancer, high cost of treatment in private health care facilities, lack of therapeutic infrastructure and absence of information on the burden of cancer. He also presented ways to address the issues in prevention, screening, early detection, treatment, pain relief, palliative care, rehabilitation and some cross-cutting issues.

Dr Cecilia Sepulveda, Senior Adviser, Cancer Control, Management of Noncommunicable Diseases, WHO Headquarters, presented on capacity-building for cancer control and its significance to national cancer control programmes. There are four steps to building capacity: (1) capacity assessment, (2) identification of gaps in capacity, (3) development/formulation of a national cancer control programme and defining priorities, and (4) development of capacity-building plan with focus on implementation of priority areas. She also presented the WHO framework on strengthening management capacity in health systems and further elaborated on the responsibilities and qualities of the national cancer control programme manager and team.
Participants presented the challenges, opportunities and requirements to improve national cancer control programmes in their countries. A summary is presented in Table 1.

Table 1. Opportunities, challenges and requirements to improve national cancer control programmes in countries

<table>
<thead>
<tr>
<th>Opportunities</th>
<th>Challenges</th>
<th>What is needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Recognition of cancer as a priority</td>
<td>• Pathology/cytology services</td>
<td>• Governance system for cancer control</td>
</tr>
<tr>
<td>• Early detection programmes</td>
<td>• Screening facilities</td>
<td>• Technical capacity</td>
</tr>
<tr>
<td>• Initiatives for cancer registration</td>
<td>• Radiation oncology services</td>
<td>• Health promotion campaigns</td>
</tr>
<tr>
<td>• Recognition of pain relief and palliative care</td>
<td>• Follow-up of treated patients</td>
<td>• Infrastructure and clinical services</td>
</tr>
<tr>
<td>• Inclusion of cancer in insurance benefit packages</td>
<td></td>
<td>• Clinical guidelines</td>
</tr>
<tr>
<td>• Cancer within NCD programmes</td>
<td></td>
<td>• Cancer registries</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Human resources</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Financial resources</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Research on cancer</td>
</tr>
</tbody>
</table>

A market place activity followed in which participants chose an exciting and relevant aspect of cancer control in their country and marketed it to the other participants who acted as policy-makers. This activity also helped countries participants to enhance their skills for advocacy.

2.2 Session 2 – Cancer registration

Dr Hai-Rim Shin presented the concept, methods and uses of cancer registration. There are three types of cancer registries: population based, hospital based, and pathology registry. Dr Shin emphasized that countries can conservatively start with a hospital-based cancer registry and then slowly expand to a population-based cancer registry. Information obtained from cancer registries is important for health care planning and monitoring and in conducting further epidemiologic research on cancer. In developing countries, various problems arise in cancer registration such as identity of individuals, confidentiality, stability of the population, unavailability of census data, lack of follow-up and lack of basic health services, trained personnel and data processing facilities. The quality of data obtained is also of utmost concern in terms of completeness, comparability, validity of accuracy and timeliness.

Following this presentation, a group exercise helped participants to identify the current status and needs for cancer risk assessment and risk reduction programmes in their countries.

2.3 Session 3 – Prevention and early detection

Dr Sepulveda presented the concept of early detection of cancer. This key strategy in cancer control aims to detect cancer early in order to increase cure rates, improve survival and reduce mortality in the population. There are two approaches to early detection, diagnosis and screening. One targets the symptomatic population, while the other targets the asymptomatic population. It is crucial, however, to set up an adequate referral system to ensure that suspected cases get prompt diagnosis and treatment if cancer is confirmed.
Dr Kui-Son Choi from the Cancer Early Detection Branch of the National Cancer Center in the Republic of Korea presented the National Cancer Screening Programme (NCSP). The NCSP provides free screening services for cancers of the stomach, breast, cervix uteri, liver and colorectal for National Health Insurance beneficiaries who are in the lower 50% (based on income). Dr Choi noted the challenges that the programme faced, including increasing the participation rate, improving the quality of NCSP, assessing the effectiveness of NCSP and developing cost-effective and evidence-based cancer screening guidelines. Through the years, NCSP has been successful in covering the entire population with minimal personal expenses, increasing screening rate and awareness about early detection of cancer and contributing to cancer survival and mortality reduction. The notable factors for achieving successful implementation of the screening programme are the increased investments in health, the National Health Insurance programme, cancer control and related policies (e.g. Cancer Control Act, Health Promotion Act, Medical Screening Act) and existence of the National Cancer Registry, National Cancer Screening Information System and National Cancer Center.

Dr Varghese talked further about the concept of cancer screening and elaborated on the considerations when establishing a screening programme in terms of what kind of cancer to screen, what test to utilize, and its process which includes the frequency of screening, quality control systems, mechanisms for referral and treatment and the information system. He highlighted some elements of a successful screening programme such as wide coverage of the population at risk, appropriate follow-up and management, effective links between programme components (e.g. from screening to diagnosis and treatment) and adequate resources.

A group exercise taught participants how to design an organized cancer screening programme in the context of a local setting in a country.

2.4 Session 4 – Management and care

Dr Sepulveda presented the principles of cancer management from a public health perspective. The main goals of cancer management are to cure or considerably prolong the life of cancer patients and to ensure the best possible quality of life for cancer survivors. It involves cancer staging, treatment and follow-up. She highlighted that treatment is not limited to managing the disease. Other physical, psychosocial and rehabilitation needs of the patients and their families need to be addressed, and when curative intent is no longer possible, treatment gives way to palliative care. A sequence of main actions to develop a good quality cancer management are as follows: (1) developing referral and clinical guidelines; (2) estimating demand for services of priority cancers and assessing the capacity of services; (3) allocating resources (competent staff, essential list of medicines and technologies); (4) establishing a well-functioning information system; (5) ensuring diagnosis, treatment and follow-up services are organized and managed across all levels of care; and (6) ensuring access, quality, safety and continuity of care.

Dr Varghese presented the principles of organizing cancer care services. He initially discussed the current challenges associated with diagnosis and treatment, palliative care and human resources and alluded to the basic requirements in providing cancer care services such as advanced infrastructure, maintenance and calibration of equipment, trained personnel, appropriate referral systems and adequate resources. He also presented the early detection and treatment services across the levels of care.
Dr Yeol Kim, Head of the Division of Cancer Management and Policy, National Cancer Center, Republic of Korea, chronicled cancer management in the Republic of Korea, starting with the launch of national actions against cancer in 1989 when the National Cancer Center Plan was formulated and ending with the development of the Second 10-year plan for cancer control (2006–2015). Considering the high burden of cancer in the Republic of Korea, 12 regional cancer centres have been set up since 2004 to manage cancer effectively. The centres were established with financial and technical support from the central and local governments of the Republic of Korea. Dr Yoon-Jung Chang, National Cancer Center, Republic of Korea, then presented hospice and palliative care in the country, focusing on policy and quality management. Palliative care in the Republic of Korea is available in four forms (mobile team, hospital inpatient unit, hospice and home care). Currently, there are 55 hospices and palliative care units in the Republic of Korea.

Participants worked in country-specific groups to identify a core problem in cancer management, to determine its direct and indirect causes and to find possible solutions. An activity on prioritization and action planning followed.

2.5 Session 5 – Developing a national cancer control programme

Dr Sepulveda presented the modules for cancer control planning, which is a practical guide on how to plan overall cancer control effectively, according to available resources. Effective cancer control planning requires the leadership of the ministry of health and the involvement of all stakeholders; realistic goals and objectives that respond to the people’s needs; priority interventions based on evidence, resources and values and tailored to the context; gradual implementation of affordable interventions, focusing initially on what can be done with better organization of available resources; allocation of resources for the implementation of the plan; and monitoring and evaluation.

Dr Varghese then presented the various opportunities in strengthening and/or developing national cancer control programmes in terms of governance and financing, early detection and treatment services, human resources, surveillance and awareness and education. He noted, however, that in order to move forward, it is important to prioritize, contextualize and sustain the interventions in a phased manner. The use of “best buys” for cancer control may also be a good approach.

The presentations were followed by group work on leadership and stakeholder analysis. Outputs of this last group exercise on designing a national cancer control programme are presented in Annex 3.

2.6 Session 6 – Site visit

Participants visited the Korea Centers for Disease Control and Prevention (KCDC). Dr Park Hyekeyeong, Director, Chronic Disease Control Division, KCDC, presented the history of the centre and its organization, its main work, disease control efforts and surveillance schemes. Dr Park also talked about the prevention and management of NCDs in the Republic of Korea.

Dr Oh Kyungwon, Director, Health and Nutrition Survey Division, introduced the Korea National Health and Nutrition Examination Survey and Korea Youth Risk Behavior Web-based Survey and discussed how the information from these surveys were instrumental in monitoring progress toward national health plans and in evaluating public health policies and programmes.
2.6.1 Evaluation

An evaluation of the workshop was conducted using a structured questionnaire and a scale of 1–10 (with 10 being the highest score) to indicate participants’ impression and success of the workshop (Annex 4). The overall impression of the workshop was high (44% of participants rated the workshop as 10, while 44% rated it as 9). Participants also valued the information learnt in the sessions and the experiences from other countries.

2.7 Closing session

Dr Hai-Rim Shin closed the workshop by thanking participants for their active involvement. She acknowledged not only that more work has to be done in developing national cancer control programmes, but also that the workshop had equipped the participants with knowledge and skills needed to improve cancer control in their countries.
3. CONCLUSIONS AND RECOMMENDATIONS

3.1 Conclusion

The objectives of the Workshop on Leadership and Capacity-Building for Cancer Control (CanLEAD) were met, and the participants obtained the necessary information and skills to further enhance cancer control in their countries.

The workshop participants acknowledged the critical areas in national cancer control programmes.

3.2 Recommendations

1. Member States can strengthen cancer prevention and control as part of an overall NCD prevention and control programme.

2. Cancer control has to be addressed through planning, prevention, early detection, diagnosis and treatment, palliative care and should be supported by policy, advocacy and research.

3. Building capacity for cancer control requires the following steps: (a) assessment of capacity for cancer control, (b) identification of gaps in capacity, (c) development/formulation of a national cancer control programme and definition of priorities and (d) development of a capacity-building plan with focus on implementation of priority areas.

4. Effective cancer control planning requires the leadership of the ministry of health with the involvement of all stakeholders and should have realistic goals and objectives that respond to the people's needs.

5. The national cancer control programme can start with a set of priority interventions based on evidence, resources and values tailored to the context with incremental expansion.

6. Pain relief and palliative care are good entry points to start a national cancer control programme and should be prioritized.

7. Monitoring and evaluation are critical components. Cancer registration is an essential component of the national cancer control programme.

8. Countries that do not have cancer registries can start with hospital-based cancer registries and those with hospital-based registries can consider expanding to population-based registries.

9. Capacity-building is a critical component. The CanLEAD workshop programme can be considered for adaptation and implementation in the national context.

10. WHO can support Member States in building capacity for national cancer control programmes and cancer registration.
ANNEX 1

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PROGRAMME OF ACTIVITIES

Monday, 17 June 2013

08:30-09:00 Registration

09:00-09:15 Self-introduction of participants

(2) Cancer control: Current status and challenges

09:15-09:35 Cancer burden in the Western Pacific Region Dr Hai-Rim Shin
Team Leader (NHP)
WHO Regional Office for the Western Pacific

09:35-10:00 National cancer control programmes: Structures, challenges and opportunities Dr Cherian Varghese
Senior Medical Officer (NCD), NHP
WHO Regional Office for the Western Pacific

10:00-10:30 Coffee break

10:30-11:00 Cancer control: Building capacity Dr Cecilia Sepulveda
Senior Adviser Cancer Control Chronic Diseases Prevention and Management
WHO headquarters, Geneva

11:00-11:30 Discussion

11:30-12:15 (1) Opening ceremony

Welcome address Dr Jin Soo Lee
President, National Cancer Center (NCC) Republic of Korea

Opening address Dr Shin Young-soo
Regional Director WHO Western Pacific Region

Group photo

12:15-13:30 Lunch

13:30-15:30 Country presentations
(Each group of presentation will be followed by a discussion)
Group 1: Brunei Darussalam, Mongolia, Philippines
Group 2: Cambodia, the Lao People's Democratic Republic, Viet Nam
Group 3: Fiji, Papua New Guinea, Solomon Islands

15:30-16:00 Mobility break

16:00-17:30 Marketplace (good practice/programme of cancer control in countries)

17:30-19:00 Reception
Tuesday, 18 June 2013

09:00-09:10 Recap of Day 1

(3) Cancer registration

09:10-09:40 Cancer registration methods and uses Dr Hai-Rim Shin
09:40-10:00 Discussion
10:00-10:30 Mobility break

(4) Prevention and early detection

10:30-11:30 Group work: Assessment and reduction of risk factors
11:30-12:00 Early detection of cancer Dr Cecilia Sepulveda
12:00-12:30 Cancer screening in the Republic of Korea Dr Kui-Son Choi
NCC, Republic of Korea
12:30-13:30 Lunch break
13:30-14:00 Organizing a cancer screening programme Dr Cherian Varghese
14:00-15:30 Group work: Designing a population-based cancer screening programme
15:30-16:00 Mobility break
16:00-17:00 Group presentation and discussion

Wednesday, 19 June 2013

09:00-09:10 Recap of Day 2

(5) Management and care

09:10-09:30 Principles of cancer management Dr Cecilia Sepulveda
09:30-10:00 Cancer care services Dr Cherian Varghese
10:00-10:30 Mobility break
10:30-11:15 Cancer management in the Republic of Korea Dr Hong-Gwan Seo/Dr Yeol Kim
NCC, Republic of Korea
11:15-12:00 Discussion

Lunch break

13:00-15:30 Group work: Organizing cancer management services
15:30-16:00 Mobility break
16:00-17:00 Group presentation and discussion
Thursday, 20 June 2013

09:00-09:10 Recap of Day 3

(6) Developing a national cancer control programme (NCCP)

09:10-09:30 Planning national cancer control programmes Dr Cecilia Sepulveda

09:30-10:00 NCCP: Challenges and opportunities Dr Cherian Varghese

10:00-10:30 Mobility break

10:30-10:50 Group work: Leadership

10:50-12:00 Group work: Stakeholder analysis

12:00-13:00 Lunch break

13:00-15:30 Group work: Designing a national cancer control programme

15:30-16:00 Mobility break

16:00-17:00 Group presentation and discussion

Friday, 21 June 2013

(7) Site visit

09:30-09:40 Welcome remarks Dr Lee Duk Hyoung
Director, Disease Preventive Center

09:40-10:00 Introduction of Korea Centers for Disease Control and Prevention Dr Park Hyekyeong
Director, Chronic Disease Control Division

10:00-10:50 NCD prevention and management in the Republic of Korea Dr Park Hyekyeong

10:50-11:10 Coffee break

11:10-12:00 Korea National Health and Nutrition Examination Survey and Korea Youth Risk Behavior Web-based Survey Dr Oh Kyungwon
Director, Health and Nutrition Survey Division

12:00-13:00 Lunch break

13:00-13:30 KCDC tour by bus and move to field visit

16:00-17:00 Field visit (community health centre: Dong-gu, Ilsan)

17:00-17:15 (8) Closing session
NATIONAL CANCER CONTROL PROGRAMME

- Positioning of the plan - within the national health plan/linkages
- At present, No plan. Proposed plan would be part of Brunei NCD plan (2013-2018)

- Who is responsible?
  - Ministry of Health, Proposed steering committee of NCD and head of NCD unit
- Cancer control committee
- NCD unit, cancer support group, National Cancer centre
- Duration of the plan
  - 5 years
- Goal
  - "TO IMPROVE CANCER CONTROL IN BRUNEI"

Objectives (max 3 or 4)
1. To improve the quality of Brunei National Cancer registries
2. To improve early detection of breast cancer
3. To improve palliative care services
4. Activities under each objective (for two objectives)

Brunei National Cancer Registries (BNCR)
1. "Review and revamp" - technical assistance (WHO, IACR)
2. Capacity building - designated person, HR - recruitment and training (registrars - scheme of services), designated office space
3. Quality indicators and monitoring

Palliative care services (PCS)
1. Formation of steering committee with stakeholders
2. Formation of national palliative care guidelines
3. Training modules - UBD and international institutes
4. Recruitment of nurses
5. Training of PHC and secondary hospitals (3)

Resources needed
BNCR
- Human (registrars, epidemiologist), Computers with software and storage hardware, designated office space

PCS
- Human (Nurses), Guidelines

Who will do what?
BNCR
- Deputy Permanent secretary (Professional & technical) - designate person in charge and propose review & revamp to Minister of Health
- Director of Administration and Finance - HR and office
- UBD - to evaluate and perform research

Measures to monitor the plan?
BNCR - report accepted by IACR and CI5
PCS - 50% coverage of all eligible patients and increased morphine consumption by 30%

- How will resources be raised?
  - Annual MOH Budget

- Objectives (max 3 or 4)
  1. To improve the quality of Brunei National Cancer registries
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PCS - 50% coverage of all eligible patients and increased morphine consumption by 30%

- How will resources be raised?
  - Annual MOH Budget
CAMBODIA

NATIONAL CANCER CONTROL PROGRAMME

- Goal: reduce mortality/morbidity and improve quality of life of Cancer patients
  - Duration: 2014-2020
  - Objective:
    - Establish national cancer center
    - Set up palliative care at cancer center
  - Responsibility: National cancer prevention and control program/MOH
  - Activities:
    - Logistic: Building, lab, equipment and supply
    - Human resource: staff selection, train specialized staff (oncology, pathologist, Radiation therapy, oncology surgeon ...)
    - Train palliative staff
    - Demonstration of community palliative care at one selected province
    - Raising awareness on palliative care

Ministry of Health

Steering committee for Cancer Control

National Cancer Prevention and Control

National Cancer Center

Cancer registry

Early Detection

Treatment

Palliative care

Health Promotion

Raising awareness

Screening
**FIJI**

Within the Strategic Plan and is administered under the leadership of the National Advisor-KO

Northern  Central/ Eastern  Western

Subdivisions  Health centers  Nursing stations

**Cancer control committee**

Pediatric cancer committee: monthly meetings
- Chair: Consultant Paeds
- Nurses
- Doctors, Paeds, Pathology
- Pharmacy
- Dietitians

**GOAL:**

Reduce the prevalence of cancers in Fiji by 5% in 2014

Objectives:
- Improve early detection and management of common risk factors at nursing stations and health center levels
- Improve early detection of abnormal pap smears/VIA at nursing stations and health centers
- Improve early referrals from these primary centers to the divisional hospitals
- Establish ‘one stop concept’ for cancer management in the clinics

**Establish ‘one stop concept’ for cancer management in the clinics**

Resources needed:
Designated area for oncology-
larger room for:
- Manpower
- Consumables
- Equipment

**OUTPUTS**

Hospital Cancer Committee

Improved services to patients

Staff are happy to work there and get satisfaction from it

Monitoring:

Questionnaires
Interviews with families and patients’ views on services
Audit of return visits and services required
LAO PEOPLE’S DEMOCRATIC REPUBLIC

NATIONAL CANCER CONTROL PROGRAMME

- Positioning of the plan –within the national health plan/linkages
- 5 years plan of MOH--NCD Policy--Cancer Control Program
- Who is responsible?
- MOH--NCD Committee--Mittaphab Hospital--Cancer Center
- Duration of the plan: 3 years
- Goal:
- Establish Hospital based Cancer Registry in Vientiane Capital
- Objectives
  1. To have some data about the cancer status in Vientiane Capital
- Activities under each objective
  - Set a software programme for Registration
  - Set-up registration team in each hospital
- Resources needed: -HR
  - Office hardware including computers.....

- Who will do what?
- MOH, NCD Committee, Mittaphab Hospital: support
- Cancer Center: Software
- 06 hospitals: implementing institutions
- What are the expected outputs?
- Some Statistics of Cancer in Vientiane will be known
- Data for conducting prevention
- Measures to monitor the plan?
  - Regular report and evaluation each 03 months (in the first year)
- How will resources be raised?
  - National budget/funding?
NATIONAL CANCER CONTROL PROGRAMME - MONGOLIA

- Positioning of the plan – within the national health plan/linkages
- Who is responsible?
- Cancer control committee
- Duration of the plan
- Goal
- Objectives (max 3 or 4)
- Activities under each objective (for two objectives)
- Resources needed
- Who will do what?
- What are the expected outputs?
- Measures to monitor the plan?
- How will resources be raised?

**GOAL:** To provide palliative care for at least 2/3 of late stage cancer patients

**OBJECTIVE 1:** Increase access to palliative care

**ACTIVITY 1:** Establish oncology units at provincial and district general hospitals with beds for palliative care and palliative care staff

**Resources:** Funds for salaries, equipment, drugs and commodities

- MOH: Changes into Health and Health Insurance Laws
- NCC: Building capacity of local palliative care staff
- NHIF: reimbursement of services

**Output:** Increased access to palliative care services at local level

- Number of province and district hospitals that established and operate oncology units with palliative care
- Number of cancer patients served

---

**MONGOLIA**

NCCP

Steering committee for NCCP

MOH

NICH and other national hospitals and centers

Health department of the capital city (1)

Aimag (province) health departments (21)

District health alliances (9)

Regional diagnostic and treatment Centers (4)

Aimag general hospitals (17)

Soum (sub province) health centers and FGPs
PNG Cancer Control Plan

Ca Ca Early Detection by VIA

Governance Structure

- DOH
- NGOs
- Other Public Health and General Health Service
- Finance, Advice and Policy

Objectives

1. To prevent cancer through specific and sustainable cancer prevention programs for all age groups, with an emphasis on risk factor reduction, including promoting healthy lifestyles, preventing exposure to carcinogens and vaccination for hepatitis B virus (HBV) and human papillomavirus (HPV).
2. Establish cost-effective, locally appropriate screening programs for the early detection and treatment of priority cancers in women and men.
3. Establish a robust National Cancer Registry and cancer surveillance system to enable the burden and trends in diagnosis to be estimated and monitored in order to inform evidence-based interventions for cancer prevention and care.

Activities/Strategies

Governance/Operational

- Develop guidelines for VIA and cryotherapy
- Develop training modules and guidelines for TOT
- Identify population catchment area
- Project location and acceptance
- Resources:
  - Human: nurses, gynaecologists, cytologists, histopathologist
  - Materials: laboratory facilities, cryotherapy equipment, gas cylinder, VIA instrument tray
- Target Population: Between 35 and 45 years, voluntary attendance through awareness and education
- Raising Funding: Annual government budget, Private sector funding, development partner support.

Diagnosis and treatment/follow up

Positive: if aceto-white cervix and bleeds on touch
If suspicious, collect smear and send to lab to cytology
Treatment done for other inflammatory lesions;
- Patient will be contacted for follow-up
- Promote program through volunteers from cancer societies, church organisations, women’s groups, etc to talk and convince women to be tested.
- Cancer survivors

Expected outcome

- Awareness of early detection service for Cx ca available at no cost
- More women attending clinic for screening
- Early detection and treatment of Cx ca
- Reduction in advance Ca Cx
- Reduction in prevalence and mortality

Monitoring

- Number of women attending screening
- No of examinations done that are positive
- Referral and follow up system working
- No of early Ca Cx treatment done with complete cure
National Cancer Control Program

Department of Health
PHILIPPINES

- **Cancer control committee**
  - Creation of an Advisory Committee on NCCP composed of the following:
    - Chair: DOH
    - Members: professional cancer societies, academe, PhilHealth Insurance, other DOH offices (NCHP, NEC, IMS, HPPDB, HHRDB, NCHFD, BLHD, etc.), Rep. of patient advocacy groups, Rep. of League of Cities/Municipalities

- **Duration of the plan – 5 years (2013-2017)**

- **Positioning of the plan – within the national health plan/linkages**
  - Component of the NCDPC Strategic Plan (2013-2017)
  - Integrated into the National Health Objectives (2013-2017)

- **Who is responsible?**
  - Specifically the DDO-NCDPC of the DOH

- **Goal**: Reduction of morbidity and mortality due to cancer

- **Objectives**:  
  1. Strengthen health promotion on risk factors/healthy lifestyle  
  2. Improve early detection of the following: breast, cervical, colorectal cancers  
  3. Integrate palliative care into the management of cancer patients

- **Activities under objective #2**:  
  1. Training needs assessment (TNA)  
  2. Capacity building

- **Resources needed**:  
  1. TNA tool  
  2. Training modules and materials  
  3. Resource persons  
  4. Logistic requirements (i.e. Accommodation, transportation, honoraria, etc.)

- **Who will do what?**  
  - DOH – conduct TNA, develop training modules, identify participants, conduct TOT, funding  
  - Professional societies – technical assistance (i.e. module dev’t, trainers/resource persons/facilitators, follow-up and monitoring of trainees)  
  - CHDs (regional health offices) - cascade training to lower levels, monitoring  
  - LGUs - send participants for training, cost sharing (ex. transportation)
• What are the expected outputs?
  1. Enhance KAS of trainees
  2. Improved access and utilization of quality services
  3. Increase in the diagnosis of cancer in the early stages

• Measures to monitor the plan?
  ➢ Develop monitoring plan, develop monitoring tool, designate monitoring teams, regular monitoring, regular meetings

• How will resources be raised?
  ➢ Regular DOH budget
  ➢ PhilHealth benefit packages
  ➢ Dev’t partners- technical assistance, logistics
  ➢ LGUs – cost sharing (inclusion in their IRA and investment plans)

What are the expected outputs?
Solomon Islands

- **Who Responsible?**
  Ministry of Health
- **Committee:** DNCD, MS, Pathologist, NCCC, 1InterestGp
- **Duration of Plan:** one year
- **Goal:** To get early histopathological diagnosis at the National Referral Hospital
- **Objective:** Get histopath. Service locally so results are available early
- **Resources needed:** Funds for equipment and consumables
- **Source funding:** Government, Donors, NGO

- **MS and Pathologist submit report to Government and Donors**
- **NGO/Medical Association lobby government**
- **Outcome:** Equipment available, specimen processed early, early diagnosis patient treated timely.
- **Cost reduction**
- **Monitor:** Result turn around time, physician and patient satisfaction. CR information
VIETNAM NATIONAL CANCER CONTROL PROGRAMME

- Positioning of the plan -within the national health plan/linkages
  - One objective in the national health plan, as it is of one national objective program
  - Developing a separated cancer prevention and control program, ratified by Health minister.

- Who is responsible?
  - The Medical Service Administration in cooperation with health preventive administration and other functional dept of MOH
  - R hospital and oncology hospitals

- Cancer control committee
  - Set up by MOH
  - Participants are representative of relevant functional dept of MOH
  - Specialized hospitals (Public and Private hospitals)

NATIONAL CANCER CONTROL PROGRAMME

- Duration of the plan
  - 4 years: 2014 - 2017

- Goal
  - To reduce the burden of cancer diseases for Vietnam population by 5% in the next 10 years

- Objectives (max 3 or 4)
  - Improving early detection of breast, cervical, oral/ thyroid, colon/ rectum cancer to cover 20% of targeted population
  - Establishing palliative care service to cover 5% of population

NATIONAL CANCER CONTROL PROGRAMME

Activities under each objective

- 1st objective: Early detection
  - Pilot area selection
  - Team building
  - Training provision
  - Equipment and Logistic provision
  - Health education
  - Implementation
  - Continuous detection and treatment
  - Monitoring and case management

- 2nd objective: Palliative care
  - Identifying the focus point (H hospital taking leadership)
  - Selecting the pilot district and province
  - Training provision
  - Health education
  - Involvement of diff stakeholders
  - Establishing networks
  - Implementation
  - Monitoring

NATIONAL CANCER CONTROL PROGRAMME

- Resources needed
  - Human resource:
    - Health sector,
    - Other GO sectors: Education, Social Welfare, MOF, MPL...
    - Local authorities and associations
  - Fund raising
    - Government funding
    - NGO funding
    - WHO support

NATIONAL CANCER CONTROL PROGRAMME

- What are the expected outputs?
  - The pilot areas will be implemented and experienced
  - Expanding to larger area
  - Achieving:
    - 25% of selected population be early detected within 3 certain cancer diseases
  - 3% of population to be provided palliative care when needed

- Measures to monitor the plan?
  - Quality indicators will be developed
  - Regularly supervise following the quality indicators

- How will resources be raised?
  - Be well statement in the policy document to make sure this is highly prioritized
  - Involving charity institutions/ enterprises/ NGO, UN
  - Tobacco tax
  - Healthy campaign to raise fund

NATIONAL CANCER CONTROL PROGRAMME

- Who will do what?
  - 1st objective: Early detection
    - MOH: policy making
    - Specialized hospitals: Technical works
    - Health Prevention: Health education, identifying population, ...

  - 2nd objective: Palliative care
    - MOH: policy making, setting the network, integrating stakeholders
    - Specialized hospitals: Technical support, training provision,
    - Health Prevention: Health education, maintaining service in the community...
National cancer control programmes:
Cancer early detection objective

Interventions
- Technical support
- Training provision
- Monitor

Early detection
Follow-up patients

National Hospital
Provincial Hospital
District Hospital
Commune Health Stations
Villages / Home care

Decentralized

Centralized

Specialized
Non-specialized

National cancer control programmes:
Palliative care service provision

Interventions
- Technical support
- Training provision
- Palliative care
- Monitor
- Palliative care, home care
- Hospice service
- Community participation

National Hospital
Provincial Hospital
District Hospital
Commune Health Stations
Villages / Home care

Decentralized

Centralized

Specialized
Non-specialized
A. Questionnaire

Workshop on Leadership and Capacity-Building for Cancer Control
Seoul, Republic of Korea, 17-21 June 2013

EVALUATION FORM

Questionnaire 1 – Overall impression

Please rate your experience of the meeting by giving your score on a scale of 1-10 (1 being the lowest and 10 the highest in terms of success).

A. The participation in this meeting was
   Comments, if any.

B. The facilitation in this meeting was
   Comments, if any.

C. The leadership in this meeting was
   Comments, if any.

D. Travel arrangement for the meeting was
   Comments, if any.

E. Facilities of this meeting was
   Comments, if any.

F. Accommodation for this meeting was
   Comments, if any.

G. Meals of this meeting were
   Comments, if any.

H. The overall impression of this meeting was
   Comments, if any.
Questionnaire 2 – What have you achieved?

Rate the workshop by giving your score on a scale of 1-10 (1 being the lowest and 10 the highest in terms of success).

**Session 2: Cancer control- current status and challenges**

- a. to understand the objectives of the session
- b. to exchange views and information in discussion
- c. to learn from the experience of other countries
- d. Please indicate a specific learning that you gained

**Session 3: Cancer registration**

- a. to understand the objectives of the session
- b. to exchange views and information in discussion
- c. Please indicate a specific learning that you gained

**Session 4: Prevention and early detection**

- a. to understand the objectives of the session
- b. to exchange views and information in discussion
- c. Please indicate a specific learning that you gained

**Session 5: Management and care**

- a. to understand the objectives of the session
- b. to learn from the experience of other countries
- c. to identify common challenges and solutions
- d. Please indicate a specific learning that you gained

**Sessions 6: Developing a national cancer control programme**

- a. to exchange information and views in developing NCCP
- b. to learn from the experience of other countries
- c. Please indicate a specific learning that you gained

**Sessions 7: Surveillance and monitoring for NCD prevention and control (Site visit-KCDC)**

- a. to learn from the experience of Republic of Korea
- b. Please indicate a specific learning that you gained

**Questionnaire 3 – Comments and suggestions**

Please let us know your comments and suggestions. Please provide a maximum of 3 comments per question.

A. How can you further strengthen the leadership and capacity towards cancer control in your country?
B. What are the additional support/information that will help you to do this work?
B. Results

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Contents

SCOPE ..................................................................................................................................... 2

1 – CANCER CONTROL-CURRENT STATUS AND CHALLENGES ................................. 3
   Activity 1. MARKETPLACE .......................................................................................... 3

2 – CANCER REGISTRATION ............................................................................................ 4
   Activity 2. REVIEW OF DATA SOURCES OF CASE NOTIFICATION AND REPORT .... 4

3 – PREVENTION AND EARLY DETECTION .................................................................... 5
   Activity 3.1 REDUCING RISK FACTORS FOR CANCER ............................................ 5
   Activity 3.2 DESIGN AN ORGANISED SCREENING PROGRAMME ............................. 6

4 – MANAGEMENT AND CARE ......................................................................................... 7
   Activity 4.1 PROBLEM-SOLUTION TREE ................................................................. 7
   Activity 4.2 PRIORITIZATION AND ACTION PLANNING .......................................... 9

5 – DRAFTING A NATIONAL CANCER CONTROL PROGRAMME (NCCP) ............ 11
   Activity 5.1 THE AFFINITY DIAGRAM ........................................................................ 11
   Activity 5.1 STAKEHOLDER ANALYSIS: THE CHAPATI DIAGRAM ....................... 13
   Activity 5.2 DESIGNING A NATIONAL CANCER CONTROL PROGRAMME ........ 15

ANNEX

1 - CANCER REGISTRATION
2 - CHECKLIST FOR COMPREHENSIVE CERVICAL CANCER CONTROL
SCOPE

CanLEAD (Leadership and Advocacy for Cancer Control) was developed to assist cancer control programme managers to systematically assess and analyse the country situation of cancer prevention, early detection and management as well as identify stakeholders that have vital roles for cancer control. It also aims to provide a head start for developing a new or strengthening an existing cancer control programme in the country.

Participant’s workbook

This workbook is designed to guide the participants from the first to the fourth day of the programme in a structured manner. Day 1 focuses on identifying the milestones and achievements in cancer prevention and control in your country and coming up with effective approaches and strategies of lobbying to policy makers. Day 2 covers cancer registration, prevention and will help to identify components of an organized screening programme. Day 3 will focus on identifying problems and solutions to strengthen cancer management and care. Day 4 will focus on drafting a national cancer control programme. Day 5 will be a site visit to observe NCD surveillance activities. An outline of the schedule is presented below.

Outline of activities

<table>
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<th>Day</th>
<th>Agenda</th>
<th>Activity</th>
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<td>1</td>
<td>1. Cancer control- current status and challenges</td>
<td>1. Marketplace</td>
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<td>2. Cancer registration</td>
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<td>3. Prevention and early detection</td>
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<td>4. Management and care</td>
<td>4.1 Problem analysis (Problem-solution tree)</td>
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<td>4.2 Prioritization and action planning</td>
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<td>6. Surveillance and monitoring for NCD prevention and control</td>
<td>6. Site visit</td>
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1 CANCER CONTROL- CURRENT STATUS AND CHALLENGES

ACTIVITY 1 MARKETPLACE

SCOPE In a dynamic marketplace, sellers skilfully persuade buyers to buy their goods. Lobbying cancer prevention and control to policy makers is like selling a good product to tough consumers, where creativity and persuasion is important.

OBJECTIVE To identify effective approaches for cancer control in your countries and to learn the art of lobbying for cancer prevention and control to policy makers.

INSTRUCTION Pick an exciting/interesting/relevant information about cancer from your country data. Using a PowerPoint slide, create a catchy poster (in 30 minutes) to let the policy makers know about this information.

Each group will have a “stall” and will be given 5 minutes to “market” their poster to the audience. Use your creativity so that your audience will be persuaded to buy your poster.

After all the groups have finished “advertising,” take the role of a “buyer.” Look around the stalls and decide how much you are willing to “pay” for each poster. You will be given a fixed amount of currency for “buying” the posters. Please do not buy your own poster.

After all of the participants have finished buying, count the earnings of your poster. Determine who among the groups have the highest earnings.

"Best-selling" plans / programmes
## CANCER REGISTRATION

### ACTIVITY 2 REVIEW OF DATA SOURCES OF CASE NOTIFICATION AND REPORT

**SCOPE**

Learn about cancer registries, types, methods and uses. Supplementary materials which include the flowchart of case finding in hospital and a sample of notification form for case finding used for data collection illustrating the various items that are to be collected along with the instruction sheet are in Annex 1.

**OBJECTIVE**

To assess the current situation of cancer registration, key challenges and to identify options to address the challenges.

**INSTRUCTION**

Please complete the table below for the guide questions.

<table>
<thead>
<tr>
<th>Guide questions</th>
<th>Current situation</th>
<th>Key challenges</th>
<th>What can be done to address challenges?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your country have a system for cancer registration?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is it population-based or hospital-based?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Please describe the vital registration system (birth and death certificate)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Please describe the process of cancer registration and who is involved in the process.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How has data from cancer registration been used in your country and by whom?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How many specialized centres/hospitals for cancer are there in the country?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What is the technical capacity (manpower such as pathologists, etc.) and how are they distributed in the country (per region/state/province)?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## PREVENTION AND EARLY DETECTION

### ACTIVITY 3.1 REDUCING RISK FACTORS FOR CANCER

**SCOPE**

Describing the country situation on how to monitor and reduce the exposures to known risk factors to cancer is crucial in cancer prevention and control. Identifying the gaps will help us in prioritizing the activities and resources for cancer prevention programmes.

**OBJECTIVE**

To review the current status of the country in terms of monitoring and evaluation of risk factors for cancer as well as the programmes for risk reduction.

**INSTRUCTION**

For each risk factor, briefly describe the risk assessment and reduction programmes that are in your country.

<table>
<thead>
<tr>
<th>Risk factor</th>
<th>What mechanisms are present to monitor this risk factor?</th>
<th>What programs/activities exist to prevent/reduce exposures to this risk factor?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco smoking / Exposure to environmental tobacco smoke</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unhealthy diet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical inactivity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol drinking</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infections related with cancer (Hepatitis B Virus, Human Papilloma Virus, Human Immunodeficiency Virus, Helicobacter Pylori)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Environmental/occupational carcinogens</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Research</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
ACTIVITY 3.2  DESIGN AN ORGANISED SCREENING PROGRAMME

SCOPE  Early detection of cancer includes early diagnosis (by creating awareness in the public and among healthcare professionals) and screening. Organized screening is the systematic application of a screening test in a presumably asymptomatic population. Opportunistic screening is the unsystematic application of screening tests in routine health services.

OBJECTIVE  To learn the components of an organised cancer screening program keeping in view the national situation and context.

INSTRUCTION  You are to implement an organised cervical cancer screening programme in an area with a population of 100,000. You may infer to a specific local setting in your country to depict the available resources to tap and stakeholders to engage. Complete the checklist in Annex 2. Based on the checklist, fill the following table with input required and the key persons/entities responsible to conduct the cancer screening programme.

<table>
<thead>
<tr>
<th>Input</th>
<th>Responsible agencies/institutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governance/ Organization Responsible unit, structure, resources, operational mechanism</td>
<td></td>
</tr>
<tr>
<td>Technical capacity (Diagnosis, referral, treatment, monitoring)</td>
<td></td>
</tr>
<tr>
<td>Enhancing community participation (Information dissemination, education)</td>
<td></td>
</tr>
<tr>
<td>Research</td>
<td></td>
</tr>
</tbody>
</table>
4 MANAGEMENT AND CARE

ACTIVITY 4.1 PROBLEM-SOLUTION TREE

SCOPE The problem solution tree helps to identify barriers and actions to counter them. Using this approach, you can analyse a program.

OBJECTIVE To identify the causes of causes and feasible interventions to address them.

INSTRUCTION To use the problem-solution tree, identify a core problem in cancer management in your country. Write this in the box provided. Identify the direct and indirect causes of the core problem. This can be achieved by asking the question “why?” several times until all possible causes/roots of the problem are exhausted. Draw arrows to show the relationships of the causes among one another and their pathways toward the problem. Once all possible causes are considered, identify possible solutions to address these causes. Below is a simplified example, with late cancer detection as the core problem.
Develop a problem-solution tree stating the problem, its causes, and possible solutions. Note that the more detailed the analysis is, the greater is the probability of identifying effective solutions.
**ACTIVITY 4.2 PRIORITIZATION AND ACTION PLANNING**

**SCOPE**
Cancer treatment, management and palliative care need to be strengthened to improve the quality of life of cancer patients. The effective solutions identified in addressing the problem have to be prioritized taking into account the importance and feasibility.

**OBJECTIVE**
To prioritize solutions and design an action plan to strengthen cancer management and care

**INSTRUCTION**
List down the solutions that you identified in Activity 4.1 on the first column of the table provided (Table 4.2.1). Discuss with your country team members how important (I) and how feasible (F) the solutions are. For each solution, put a score of 1 to 5 on (I) and (F), with 1 being the lowest and 5 being the highest. Multiply the scores for (I) and (F). The solution with the highest score product (I x F) will be chosen for constructing an Action Plan. Table 4.2.2 shows an approach to develop the key components of Action Plan.

**Table 4.2.1**

<table>
<thead>
<tr>
<th>Solution</th>
<th>Important (I)</th>
<th>Feasible (F)</th>
<th>I x F</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Action Plan for ________________________________

**Table 4.2.2**

<table>
<thead>
<tr>
<th>Description</th>
<th>Health</th>
<th>Other Sectors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who is responsible?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Actions needed?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Research?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resources needed?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monitoring?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time frame?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# DEVELOPING A NATIONAL CANCER CONTROL PROGRAMME (NCCP)

## ACTIVITY 5.1 THE AFFINITY DIAGRAM

### SCOPE

Cancer control programmes and activities can only be effectively implemented with good leadership. The affinity diagram can help you identify the specific qualities or actions of a leader.

### OBJECTIVE

To identify the qualities of a good leader

### INSTRUCTION

Using metacards, each member of the group will list down qualities that a good leader should possess. The qualities/characteristics identified may be written on individual metacards and posted on a board that can be viewed by everyone. Group the qualities identified according to which are most related to one another. Assign a main heading to the issues grouped together. The main headings will be the general qualities identified. An example of qualities of a teacher is provided below. Share and discuss your affinity diagram for qualities of a good leader with the other groups.

### CONTENT

- Clear objectives
- Prepared lesson plans
- Good knowledge of subject matter

### MANAGEMENT AND ORGANIZATION

- Engaging personality
- Manages student's behaviour
- Encourages interactions

### PROFESSIONALISM

- Sets house rules
- Can promote positive behaviours and change

### PERSONALITY

- Having patience and good sense of humour
- People person and enjoys working with wide range of people
Develop an affinity diagram on leadership.
ACTIVITY 5.2  STAKEHOLDER ANALYSIS: THE CHAPATI DIAGRAM

SCOPE  A chapati or Venn diagram is a tool used to identify the different stakeholders and analyse their relationships using circles. The size of the circles indicates their perceived importance, while the positioning – whether overlapping, touching or separate – indicates their degree of interactions. This can illustrate the relationships among different stakeholders in cancer control and provide entry points for discussing ways of improving relationships between such institutions.

OBJECTIVE  To identify the different stakeholders in cancer control and their relationships using the chapati diagram

INSTRUCTION  Write the stakeholders that directly implement the cancer control activities inside the orange circle. Write the organizations, institutions and communities that are also involved in cancer control activities outside the orange circle and strategically locate their names depending on the degree of their involvement.

Draw a big or small circle around each entity depending on its magnitude of influence or function in cancer control. The circles can overlap or connecting lines can be drawn to show cooperation between or among institutions. An example for the stakeholder analysis for NCD prevention and control is given below.
Draw your chapati diagram below.

<table>
<thead>
<tr>
<th>Which stakeholders have a significant role in cancer control and are near the orange circle?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there a need to strengthen their interactions for an effective cancer control? What could be done?</td>
</tr>
<tr>
<td>Which stakeholders have a significant role in cancer control but are far from the orange circle?</td>
</tr>
<tr>
<td>What needs to be done to engage these stakeholders for an effective cancer control?</td>
</tr>
</tbody>
</table>
**ACTIVITY 5.3 DESIGNING A NATIONAL CANCER CONTROL PROGRAMME**

**SCOPE**

To identify the various aspects to be considered, resources needed and operational aspects of a comprehensive national cancer control programme.

**OBJECTIVE**

To learn the components of a national cancer control programme and to apply them in your local context.

**INSTRUCTION**

Based on the work of the previous sessions and using the planning module (from the WHO series) develop a draft NCCP for your country.
STRUCTURE OF A NATIONAL CANCER CONTROL PROGRAMME
ANNEX
**ANNEX 1**

**FLOW CHART FOR CASE FINDING IN HOSPITAL**

- Medical Records
- In-Patient Services
- Pathology
- Radiotherapy
- OPD/specialty Clinics
- Radiology/Imaging
- Tumor Board

Other sources

List all cases with Reportable Diagnosis

**MEDICAL RECORDS**
- ADMISSION / DISCHARGE BOOKS
- DISEASE INDEX
- RECORDS / CHARTS

Check Diagnosis / Incidence Date

- NOT ELIGIBLE
- UNCERTAIN
- ELIGIBLE

- SUSPENSE FILE
- HOSPITAL CASEFINDING LIST

ABSTRACT
DATA SOURCES AND IMPORTANCE OF CANCER DEATH INFORMATION

Death Certificate Only (DCO) means those cancers for which no other information than a death certificate mentioning cancer could be obtained. This must not be confused with the cases first notified by a death certificate (death certificate notification - DCN).
### HOSPITAL TUMOUR REGISTRY

#### A. FOR REGISTRY USE
1. **REGISTRY NUMBER**
   - [ ]
   - [ ]
   - [ ]

2. **PATIENT REGISTRATION NO.**
   - [ ]
   - [ ]
   - [ ]

#### B. PATIENT INFORMATION
3. **NAME**
   - ____________________________

4. **NAME OF SPOUSE**
   - __________________________________________________________

5. **GENDER**
   - [ ] Male
   - [ ] Female
   - [ ] Unknown

6. **BIRTHDATE**
   - Day [ ]
   - Month [ ]
   - Year [ ]

7. **AGE**

8. **BIRTHPLACE**

#### 9. **MARITAL STATUS**
   - [ ] Never Married
   - [ ] Married
   - [ ] Widowed
   - [ ] Div/Sep
   - [ ] Other
   - [ ] Unknown

#### 10. **PERMANENT ADDRESS**

   - TEL NO. ______________________

   - No. of years lived ________

11. **NAME & ADDRESS OF NEAREST RELATIVE**

   - (Name) ____________________________
   - (Relationship) ____________________________
   - TEL. NO. ______________________

12. **NATIONALITY**

13. **ETHNIC GROUP**
   - [ ] Khmer
   - [ ] Chinese
   - [ ] Vietnamese
   - [ ] Cham
   - [ ] Other
   - [ ] Unknown

14. **RELIGION**
   - [ ] Buddhist
   - [ ] Catholic
   - [ ] Muslim
   - [ ] Other
   - [ ] Unknown

15. **OCCUPATION**
   - [ ] Government officer / Employee
   - [ ] Agriculture
   - [ ] Businessman
   - [ ] Housewife
   - [ ] Student
   - [ ] Unknown

#### HOSPITAL IDENTIFICATION
16. **NAME OF HOSPITAL**

   - ____________________________

17. **DEPT. OF HOSPITAL**

18. **HOSP. RECORD NUMBER**

#### DIAGNOSIS

19. **DATE OF 1ST CLINIC DIAGNOSIS**
   - Day [ ]
   - Month [ ]
   - Year [ ]

20. **DATE OF 1ST CONSULT AT OR ADMISSION TO REPORT INST.**
   - Day [ ]
   - Month [ ]
   - Year [ ]

#### 21. INVESTIGATIONS RELEVANT TO DIAGNOSIS OF CANCER
   - [ ] Purely Clinical
   - [ ] Laboratory methods
   - [ ] Isotopes/x-ray
   - [ ] 1 + 2
   - [ ] 1 + 4
   - [ ] 6 + 2 + 4
   - [ ] 7 + 1 + 2 + 4
   - [ ] Unknown

   - [ ] Endoscopy
   - [ ] Explore Surgery
   - [ ] Cytology/Haematology
   - [ ] 1 + 4
   - [ ] 2 + 4
   - [ ] 1 + 2 + 4
   - [ ] Unknown

   - [ ] Histology, metastasis
   - [ ] Histology, primary
   - [ ] 1 + 2
   - [ ] 1 + 4
   - [ ] 2 + 4
   - [ ] 1 + 2 + 4

   - [ ] 9 None of these

#### 22. MOST VALID BASIS OF DIAGNOSIS
   - [ ] NON-MICROSCOPIC
     - [ ] Death certificate only
     - [ ] Clinical Only
     - [ ] Clinical Investigation

   - [ ] MICROSCOPIC
     - [ ] Exploratory Surgery/Autopsy
     - [ ] Specific biochemical and/or Immunological test

   - [ ] 5 Cytology or Haematology
   - [ ] 6 Histology of Metastasis
   - [ ] 7 Histology of Primary

   - [ ] 8 Autopsy with concurrent or Previous Histology
   - [ ] 9 Unknown
### 23. PRIMARY SITE (TOPOGRAPHY)

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
</table>

(use ICD-03)

### 24. HISTOLOGICAL TYPE

(Morphology/Grade) (use ICD-03)

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
</table>

Behaviour
GRADE:
1 Grade I Well differentiated
2 Grade II Moderately differentiated
3 Grade III Poorly differentiated
4 Grade IV Undifferentiated
5 T-cell
6 B-cell Pre-B
7 Null cell Non T- non B
8 Cell type not determined
9 Not stated or not applicable

### 25. LATERALITY

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
</table>

1 Right
2 Left
3 Central
4 Bilateral
5 Multiple
6 Not Applicable
9 Unknown

### 26. MULTIPLE PRIMARIES (organ/system)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
</table>

1 No
2 Yes, specify
3 Doubtful
4 Other
9 Unknown

### 27. CLINICAL EXTENT BEFORE TREATMENT

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
</table>

1 In Situ
2 Localized
3 Direct Extension
4 Reg’l Lymph Node Involvement
5 3 + 4
6 Distant Metastasis
7 Not Applicable (Lymphoma)
8 Other
9 Unknown

### 28. REASON FOR PRESENTATION

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
</table>

1 Advice
2 Screening
3 Diagnosis
4 Initial Treatment
5 Complementary Treatment
6 Secondary Treatment
7 Other
9 Unknown

### 29. TNM SYSTEM (CLINICAL)

(Tumor, Node, Metastasis)

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
</table>

### 30. STAGING SYSTEM

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
</table>

1 Summary Stage
2 TNM
3 FIGO

Stage I carcinoma strictly confined to the cervix, extension to the uterine corpus should be based on microscopic examination of remove tissue, preferably a cone, which must include the entire lesion.

Stage 1A invasive cancer identified only microscopically. Invasion is limited to measure stromal invasion with a maximum depth of 5 mm and no wider than 7 mm.

Stage 1A1 measured invasion of the stroma no greater than 3 mm in depth and no wider than 7 mm diameter.

Stage 1A2 measured invasion of stroma greater than 3 mm but no greater than 55 mm in depth and no wider than 7 mm in diameter.

Stage 1B clinical lesions confined to the cervix or preclinical lesions greater than Stage 1A. All gross lesions even with superficial invasion are Stage 1B cancer.

Stage 1B1 clinical lesions no greater than 4 cm in size.

Stage 1B2 clinical lesions greater than 4 cm in size.

Stage II carcinoma that extends beyond the cervix, but does not extend into the pelvic wall. The carcinoma involves the vagina, but not as far as the lower third.

Stage II A no obvious parametrial involvement. Involvement of up to the upper two-thirds of the vagina.

Stage II A B obvious parametrial involvement, but not into the pelvic sidewall.

Stage III carcinoma that has extended into the pelvic sidewall. On rectal examination there is no cancer free space between the tumour and the pelvic sidewall. The tumour involves the lower third of the vagina. All cases with hydrenephrosis or a non-functioning kidney are St. III cancers.

Stage III A no extension into the pelvic sidewall but involvement of the lower third of the vagina.

Stage III B extension into the pelvic sidewall or hydrenephrosis or non-functioning kidney.

Stage IV carcinoma that has extended beyond the true pelvis or has clinically involved the mucosa of the bladder and or rectum.

Stage IV A spread of the tumour into adjacent pelvic organs.

Stage IV B spread to distant organs.

4 Ann Arbor
5 Others (specify)
8 Not applicable
9 Unknown

### 31. LYMPHOMAS (INCL. HODGKIN’S DISEASE LEUKEMIAS)

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
</table>

Lymphomas: Leukemias For Lymphomas/Leukemias
1 Stage I
2 Stage II
3 Stage III
4 Stage IV
5 Active
6 In Remission
7 No Data on Extent
8 Not Applicable
9 Unknown
32. SITES OF DISTANT METASTASIS

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>None</td>
<td>5 Brain</td>
</tr>
<tr>
<td>1</td>
<td>Distant Lymph Nodes</td>
<td>6 Ovary</td>
</tr>
<tr>
<td>2</td>
<td>Bone</td>
<td>7 Skin</td>
</tr>
<tr>
<td>3</td>
<td>Liver</td>
<td>8 Other</td>
</tr>
<tr>
<td>4</td>
<td>Lung/Pleura</td>
<td>9 Unknown</td>
</tr>
</tbody>
</table>

33. CO-MORBIDITY (Associated Disease/s)

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
</tbody>
</table>

If yes, please specify disease

34. PREVIOUS DIAGNOSIS AND TREATMENT ELSEWHERE

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>No</td>
<td>5</td>
</tr>
<tr>
<td>2</td>
<td>Diagnosed by physician only but not treated</td>
<td>8</td>
</tr>
<tr>
<td>4</td>
<td>Diagnosed in other inst. and treated</td>
<td></td>
</tr>
</tbody>
</table>

35. TREATMENT AT REPORTING INSTITUTE

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>None</td>
<td>5</td>
</tr>
<tr>
<td>1</td>
<td>Surgery</td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td>Radiotherapy</td>
<td>5</td>
</tr>
</tbody>
</table>

36. OTHER THERAPY

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>No</td>
<td>5</td>
</tr>
<tr>
<td>2</td>
<td>Yes, specify</td>
<td>8</td>
</tr>
</tbody>
</table>

37. SUMMARY OF TREATMENT

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Symptomatic</td>
<td>5</td>
</tr>
<tr>
<td>2</td>
<td>Palliative</td>
<td>7</td>
</tr>
<tr>
<td>3</td>
<td>Curative Incomplete</td>
<td>8</td>
</tr>
<tr>
<td>4</td>
<td>Curative Complete.</td>
<td>9</td>
</tr>
</tbody>
</table>

38. CHRONOLOGY OF TREATMENT

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Surgery</td>
<td>8</td>
</tr>
<tr>
<td>2</td>
<td>Radiotherapy</td>
<td>9</td>
</tr>
<tr>
<td>3</td>
<td>Chemotherapy</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Hormonal Tx</td>
<td></td>
</tr>
</tbody>
</table>

39. FINAL DESCRIPTION OF EXTENT OF DISEASE (AFTER SURGERY/AUTOPSY)

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>In Situ</td>
<td>5</td>
</tr>
<tr>
<td>2</td>
<td>Localized</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>Unchanged</td>
<td>7</td>
</tr>
<tr>
<td>4</td>
<td>In Progression</td>
<td>9</td>
</tr>
</tbody>
</table>

40. CONDITIONS AFFECTING TREATMENT

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>0</td>
<td>None</td>
<td>4</td>
</tr>
<tr>
<td>1</td>
<td>Precancerous</td>
<td>5</td>
</tr>
<tr>
<td>2</td>
<td>Other Diseases</td>
<td>6</td>
</tr>
<tr>
<td>3</td>
<td>1 + 2</td>
<td>7</td>
</tr>
</tbody>
</table>

41. REASONS FOR NON-CURATIVE TREATMENT

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Treatment elsewhere</td>
<td>5</td>
</tr>
<tr>
<td>2</td>
<td>Refused Treatment</td>
<td>6</td>
</tr>
<tr>
<td>3</td>
<td>To Advanced</td>
<td>7</td>
</tr>
<tr>
<td>4</td>
<td>Poor Condition</td>
<td>8</td>
</tr>
<tr>
<td>9</td>
<td>Unknown</td>
<td></td>
</tr>
</tbody>
</table>

42. DISEASE STATUS AT DISCHARGE

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<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>No Cancer</td>
<td>5</td>
</tr>
<tr>
<td>2</td>
<td>In Regression</td>
<td>8</td>
</tr>
<tr>
<td>3</td>
<td>Unchanged</td>
<td>9</td>
</tr>
</tbody>
</table>

43. DURATION OF HOSPITALIZATION IN DAYS

44. PERFORMANCE STATUS (WHO) BEFORE & AFTER TREATMENT

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>0</td>
<td>Able to carry out all normal activity without restriction.</td>
<td>6</td>
</tr>
<tr>
<td>1</td>
<td>Restricted in strenuous activity but ambulatory and able to carry out light work.</td>
<td>7</td>
</tr>
<tr>
<td>2</td>
<td>Ambulatory and capable of all self-care but unable to carry out any work activities; up and about more than 50% of waking hours.</td>
<td>8</td>
</tr>
<tr>
<td>3</td>
<td>Symptomatic and in a chair or in bed for greater than 50% of the day but not bedridden.</td>
<td>9</td>
</tr>
<tr>
<td>4</td>
<td>Completely disabled; cannot carry out any self-care; totally confined to bed or chair.</td>
<td></td>
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45. PRESENT STATUS

<p>| | | |</p>
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<thead>
<tr>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Alive and well</td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td>Alive with cancer</td>
<td>5</td>
</tr>
<tr>
<td>3</td>
<td>Dead</td>
<td></td>
</tr>
</tbody>
</table>

46. DATE OF DEATH

Day Month Year

47. PLACE OF DEATH

1 Hospital
2 Home

48. CAUSE OF DEATH

49. ADDITIONAL CAUSES OF DEATH

50. RESULT OF AUTOPSY

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>No Autopsy</td>
<td>6</td>
</tr>
<tr>
<td>2</td>
<td>No Residual Tumor</td>
<td>7</td>
</tr>
<tr>
<td>3</td>
<td>Primary Site Revised</td>
<td>8</td>
</tr>
<tr>
<td>4</td>
<td>Morphology Revised</td>
<td>9</td>
</tr>
<tr>
<td>5</td>
<td>Diagnosis Confirmed</td>
<td></td>
</tr>
</tbody>
</table>

51. CANCER ENTERED ON DEATH CERTIFICATE

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<table>
<thead>
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<tbody>
<tr>
<td>1</td>
<td>No</td>
<td>2</td>
</tr>
<tr>
<td>9</td>
<td>Unknown</td>
<td></td>
</tr>
<tr>
<td>52. CLASS OF CASE</td>
<td>53. SURVIVAL IN MONTHS</td>
<td></td>
</tr>
<tr>
<td>-------------------</td>
<td>------------------------</td>
<td></td>
</tr>
<tr>
<td>Analytical case</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Diagnose this hospital since reference date and all of the 1st course of the therapy.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Diagnose and treated in this hospital.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Diagnose elsewhere but receive all or part of the first course of therapy at this hospital.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Analytical case</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Diagnose and all of the first course of therapy received elsewhere.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Diagnose and treated at this hospital before the reference date.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Diagnose only at autopsy.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

REMARKS: HISTOPATH NUMBER AND DIAGNOSIS/OPERATION DONE & DATE:

REPORTED BY: ________________________________
(Print Name & Signature)

DATE OF REPORTING: ________________________________
INSTRUCTIONS ON FILLING-UP THE HOSPITAL TUMOUR REGISTRY FORM

FOR REGISTRY USE

1. REGISTRY NUMBER. Code number assigned to the reporting institute/hospital. This is used if other hospitals/institutions are participating in cancer registration.

2. PATIENT REGISTRATION NUMBER OR THE HOSPITAL TUMOR REGISTRY (HTR) NUMBER. The number assigned by the registry. (Ex., the first patient registered in 2002, the HTR No. should be: 020001. 02 is the year of registration.) This HTR No. is also stamped at the left hand margin, topmost part of the patient’s case record for easy identification.

PATIENT INFORMATION

3. NAME OF PATIENT. Write down last name, first name.

4. NAME OF SPOUSE. Write down the Last name and First Name of the patient’s spouse.

5. GENDER. Indicate whether the patient is a male or female or otherwise not stated.

6. BIRTHDATE. List down in the box provided for. (Ex. Patient was born on 1 March 1950. The answer should be written down in the box provided for as 01 for the day, 03 for the month, and 50 for the year.

7. AGE. Give the age of patient at the incidence date. Record the patient’s age on his/her last birthday; do not round off to the next birthday. If the date of birth is known, one can check whether the age is correct. If information is not known, write down as unknown.

8. BIRTHPLACE. Write the town and province.

9. MARITAL STATUS. Encircle appropriate number. 1) Never married 2) Married 3) Widowed 4) Divorced or separated 8) Others 9) Unknown

10. PERMANENT ADDRESS Write down the patient's permanent address. State number of years of stay at permanent address.

   TELEPHONE NUMBER. Telephone number of patient

11. NAME AND ADDRESS OF NEAREST RELATIVE. List down the name of the patient's nearest relative, relationship and address of the relative.

   TELEPHONE NUMBER. Telephone number of the patient’s nearest relative, or any telephone number where the patient can be contacted by phone.

12. NATIONALITY. Write the answer before the box

13. ETHNIC GROUP. For race, encircle subnumber 1 if the patient is Cambodian, subnumber 2 if patient is Chinese, subnumber 3 if the patient is neither Cambodian nor Chinese.

   Specify race group in the blank provided for. For Dialect group, write down the dialect.

14. RELIGION. Write down your answer before the box.

15. OCCUPATION. Write the answer in the space provided for.

16. NAME OF HOSPITAL. Write the complete name of the Hospital.

17. DEPARTMENT OF HOSPITAL. Write down the department of the hospital wherein the patient is being treated/seen/followed-up.

18. HOSPITAL RECORD NUMBER OR HOSPITAL CASE NUMBER. Number assigned to the patient by the hospital. (Ex. In UP-PGH, the Hosp. Case Number (7 digit) is the number given to a patient when he is issued a case record for the first time. All subsequent records issued to this same patient will bear
the same Hospital Case Number in a unit numbering system. If the hospital uses a serial numbering system, a different hospital case number is given every time patient is admitted.

**DIAGNOSIS**

19. **1st CLINICAL DIAGNOSIS.** Date of first diagnosis of cancer by a physician even if histologic confirmation is made only later or never. List down the month and year in the box provided for. (Ex. Diagnosis was made on March 03, 2002. Therefore, answer should be: 03 for the day 03 for the month and 2002 for the year).

20. **1st CONSULT AT OR ADMISSION TO THE REPORTING INSTITUTE (INCIDENCE DATE).** Date patient first consulted or was admitted to reporting institute for the cancer in question.

21. **INVESTIGATIONS RELEVANT TO DIAGNOSIS OF CANCER.** 1st column refers to clinical Diagnosis. 2nd column refers to diagnosis by endoscopy, and 3rd column refers to diagnosis by histology. Please encircle your answer(s).

22. **MOST VALID BASIS OF DIAGNOSIS.** State means by which the diagnosis of cancer was established. The degree of validity is enumerated from the least valid (1) to the most valid (8). This item of information is very important in assessing the reliability of the data. The most conclusive method is microscopic examination of the tissues, also known as histological confirmation, which may be the initial histology of the primary site or histological examination of a metastatic site, or post-mortem examination with concurrent or previous histology. The next most conclusive method of diagnosis is the microscopic examination of cells, also known as cytological examination.

The basis of diagnosis distinguishes tumors which are examined microscopically from those which were not; cytological diagnoses are also distinguished from histological diagnoses, just as histology of the primary tumor is distinguished from histology of a metastatic lesion.

Example:

- A biopsy of the lung on bronchoscopy is distinguished from a biopsy of a lymph node metastasis

1. Clinical only: the only basis of malignancy is from the history and physical examination findings' Example: Breast cancer Stage IV based on the history of a progressively enlarging breast mass and bone pains (Breast Carcinoma with probable bone metastasis)

2. Clinical investigation: the basis of diagnosis of malignancy is through the use of x-rays, ultrasound, CT scan, MRI or other imaging techniques Example: Diagnosis of lung cancer based on an x-ray finding of an enlarged mass at the upper lobe and physical finding of supravaculicular lymph nodes on the ipsilateral side.

3. Exploratory Surgery/ Autopsy: basis of malignancy is an operative finding of malignancy but no histopathological examination was done. Example: Diagnosis of Gastric Malignancy but no histopathologic examination was done or biopsy result was not conclusive of malignancy.

4. Specific biochemical and/or immunological test – basis of diagnosis is a tumor marker Example: Prostatic malignancy based on elevated PSA (Prostatic specific antigen) or Primary liver cancer based on markedly elevated alpha feto protein levels.

5. Cytology or Hematology

Cytology - basis of malignancy is the examination of exfoliated cells
Example: Cervical cancer based on a positive Papanicolaou smear
Hematology – basis of diagnosis of Leukemia is the examination of the peripheral smear or the abnormally elevated immature cells in the hematologic examination like CBC.

6. Histology of Metastasis – with histologic confirmation of malignancy based on specimen taken from a metastatic site.
   Example: Diagnosis of nasopharyngeal carcinoma, based on a biopsy of the cervical lymph node. Autopsy

7. Histology of Primary: basis is histologic confirmation of malignancy in the origin of the tumor.
   Example: Diagnosis of Inv duct carcinoma breast, based on core needle biopsy or based on pathologic examination of operative specimen (modified radical mastectomy)

8. Autopsy with concurrent or previous histology:
   Example: Patient with an autopsy finding of malignant lymphoma, with a previous histopathologic result of malignant lymphoma, lymph nodes

9. Unknown: basis of diagnosis of malignancy is unknown.
   Example: Cases referred to the radiotherapy department for radiation with only a short history on the referral slip and no other documentation of work-up done.

10. Death certificate: The only basis for a diagnosis of malignancy is a death certificate where cancer is mentioned as an immediate, antecedent, or underlying cause of death. If the follow-back of this case is not successful, this will fall under the category of “death certificate only”.

23. PRIMARY SITE OF TUMOR (TOPOGRAPHY). Indicate anatomical location on where the tumor originated. Copy completely final diagnosis and/or pathologic diagnosis.
   The origin of the tumor. Be as specific as possible. Code using ICD-O 3
   
   EXAMPLE: BREAST, NOS C50.9
   BREAST, UPPER OUTER QUADRANT: C50.4

24. HISTOLOGY (MORPHOLOGY). Copy completely the histopathologic diagnosis, the result of which should be recorded in the Pathology report-cytology, surgical or autopsy. Record pathology number.

   Grade. Encircle appropriate subnumber

25. LATERALITY. State the appropriate subnumber.

26. MULTIPLE PRIMARIES. State appropriate subnumber. If answer is yes, please specify organ and/or system.

27. CLINICAL EXTENT OF DISEASE. State the extent of the patient’s disease. Record whether:

   (1) IN SITU: Presence of malignant cells within the cell group from which they arose. There is no penetration of the basement membrane. An insitu cancer fulfils all pathologic criteria for malignancy except that it has not invaded the supporting structure of the organ on which it arose.

   (2) LOCALIZED: The malignancy is limited to the organ of origin. There is infiltration past the basement membrane into the functional part of the organ but there is no spread beyond the boundaries of the organ.

   (3) DIRECT EXTENSION: The malignancy has extended beyond the organ of origin into neighbouring tissues by infiltration or direct extension.
(4) REGIONAL LYMPH NODE INVOLVEMENT: Tumor invasion of walls of lymphatics where cells can travel through lymphatic vessels to nearby lymph nodes where they are “filtered” out and begin to grow in the nodes.

(5) Regional by both direct extension and by lymph node involvement.

(6) DISTANT METASTASIS: Malignant cells have broken away from the primary tumor and spread to distant organs of the body by way of the blood stream or through the lymphatics.

(8) Not Applicable

(9) Unknown

29. TNM. Clinical staging of cancer by TNM System. The TNM Staging System is a classification scheme used frequently for clinical staging. It attempts to define the primary site by extent (T), degree of nodal disease (N) and presence or absence of distant metastases (M).

EXAMPLE: INV DUCT CARCINOMA, BREAST ST I (T1N0M0)

30. STAGING. The most basic way of categorizing how far a cancer has spread from its point of origin. There are several staging systems. Some apply to all types of tumours (general) and some are specific to certain types of tumours. Some of the staging systems are as follows:

(1) Seer Summary Staging: Developed by the Surveillance, Epidemiology and End Results Reporting (SEER program of the National Cancer Institute of the USA). Summary staging has also been called General Staging, California Staging and SEER Staging. The 2000 version of Summary Stage applies to every anatomic site, including the lymphomas and leukemia. Summary Staging uses all information available in the medical record; in other words, it is a combination of the most precise clinical and pathological documentation of the extent of disease.

(2) TNM Staging System: This was introduced by the International Union Against Cancer (UICC) and the American Joint Committee on Cancer (AJCC),

(3) FIGO Staging System: Developed by the International Federation of Gynecology and Obstetrics for staging of female reproductive site cancers.

Stage 1: carcinoma strictly confined to the cervix, extension to the uterine corpus should be based on microscopic examination of remove tissue, preferably a cone, which must include the entire lesion.

Stage 1A: invasive cancer identified only microscopically. Invasion is limited to measure stromal invasion with a maximum depth of 5 mm and no wider than 7 mm.

Stage 1A1: measured invasion of the stroma no greater than 3 mm in depth and no wider than 7 mm diameter.

Stage 1A2: measured invasion of stroma greater than 3 mm but no greater than 55 mm in depth and no wider than 7 mm in diameter.

Stage 1B: clinical lesions confined to the cervix or preclinical lesions greater than Stage 1A. All gross lesions even with superficial invasion are Stage 1B cancer.
Stage 1B1: clinical lesions no greater than 4 cm in size.

Stage 1B2: clinical lesions greater than 4 cm in size.

Stage II: carcinoma that extends beyond the cervix, but does not extend into the pelvic wall. The carcinoma involves the vagina, but not as far as the lower third.

Stage IIA: no obvious parametrial involvement. Involvement of up to the upper two-thirds of the vagina.

Stage IIAB: obvious parametrial involvement, but not into the pelvic sidewall.

Stage II: carcinoma that has extended into the pelvic sidewall. On rectal examination there is no cancer free space between the tumor and the pelvic sidewall. The tumor involves the lower third of the vagina. All cases with hydronephrosis or a non-functioning kidney are St. III cancers.

Stage IIIB: extension into the pelvic sidewall or hydronephrosis or non-functioning kidney.

Stage IVA: spread of the tumor into adjacent pelvic organs.

Stage IVB: spread to distant organs.


(5) Others(specify):

(8) Not applicable

(9) Unknown

The staging system used may vary from registry to registry. It is important that the system used by a particular registry be specified and guidelines should be clearly written. A simple classification which may be used by population-based registries to describe the extent of spread of a particular cancer may be limited to: In-situ, Localized, Regional, Distant, and Unknown.

32. SITES OF DISTANT METASTASIS. State where the sites of the distant metastasis of the patient. Metastasis is the spread of tumor cells in a discontinuous fashion, from the primary site to other organs of the body, via the blood stream or through the lymphatic system. This item is a low-priority item for population-based registries. However, for those who want to collect information on the site(s) of metastasis, a simple one-digit code is suggested:

0) None  5) Brain
1) Distant lymph nodes  6) Ovary
2) Bone  7) Skin
3) Liver  8) Other
4) Lung/Pleura  9) Unknown
Several metastatic sites may be possible in one individual and one can assign three or more per patient in sequence, for example:

The first metastatic site was to a distant lymph node, the second was to the lung, the third metastatic site was to the liver and the fourth was to the brain.

This may be recorded as follows:

Site(s) of metastasis:  1 4 3 5

The Registry personnel may record information on metastasis at the back of the abstract or in space allocated for notes. This information may be gathered from the results of diagnostic procedures performed, from the operative record or from the pathological reports.

33. CO-MORBIDITY (ASSOCIATED DISEASES). Encircle subnumber 1 if there is no associated disease. Encircle subnumber 2 if there is/are associated disease(s). If yes, indicate the disease(s).

TREATMENT

34. PREVIOUS DIAGNOSIS AND TREATMENT ELSEWHERE. State the previous diagnosis and treatment elsewhere.

35. TREATMENT AT REPORTING INSTITUTE. Treatment done to the patient at reporting institution. Definitive treatment is the specific therapy which modifies, controls, removes or destroys cancer tissues, both at the primary and at any metastatic sites. It is classified as definitive therapy even if it cannot be considered curative for a particular patient due to the extent of the disease, incompleteness of treatment or lack of apparent response.

For population-based cancer registries, data on treatment can be collected in broad categories such as groupings of the nature of the therapy, if so desired.

Suggested codes for treatment based on groupings of the nature of therapy:

0) None 4) Chemotherapy 8) Other  
1) Surgery 5) Surgery and Chemotherapy 9) Unknown  
2) Radiotherapy 6) Radiotherapy and Chemotherapy  
3) Surgery and Radiotherapy 7) Surgery, Radiotherapy and Chemotherapy

There should be a provision for identification of patients who did not receive the initial treatment since these are Important in survival studies as well as in the studies of the natural history of the disease. Give the possible reasons why the patient did not receive the initial treatment.

Categories of treatment:

**Surgery** includes the surgical removal totally or partially (except incisional biopsy) of tumor tissue of the primary or metastatic site (including lymph nodes and endocrine glands).

*Radiation therapy:* external beam radiation directed to cancer tissue regardless of the source of radiation. This includes:

i. X-ray  vi. Neutron beam  
ii. Cobalt  vii. Helium ion  
iii. Linear accelerator  viii. Spray radiation  
iv. 3-D conformal  
v. Intensity Modulated Radiation Therapy
Internal radiation includes the interstitial use of radioactive isotopes whether given orally, intracavitarily, interstitially or intravenously. Radioactive material such as radium, radon, radioactive gold, etc. can be given via implants, moulds, seeds, needles or applicators.

**Chemotherapy:** administration of drugs or chemicals to attack or treat cancer tissue. The cytotoxic effect does not result from a change in the hormone balance or in the host’s immune response.

**Endocrine or hormone therapy:** use of any therapy which exercises effect on cancer tissue through a change in the hormonal balance. This may be achieved through the use of hormones and anti-hormones or through ablative surgery or radiotherapy (oophorectomy, orchiectomy, hypophysectomy, etc.)

**Biological Therapy:** a form of treatment which helps the immune system fight cancer or control side effects secondary to other treatment.

36. **MODE OF TREATMENT RECEIVED BY THE PATIENT.** Encircle appropriate subnumbers.

37. **SUMMARY OF TREATMENT.** Refers to the opinion of the doctor at the time of completion of definitive treatment. “Curative Complete” should be recorded if the doctor thinks the operation has completely removed all traces of tumor. “Curative Incomplete” refers to treatment undertaken with curative intent which was not completed because of operative complications or some other problems. “Palliative Treatment” is that given without expectation of cure but with expectation of prolonging or improving life. “Symptomatic Treatment” implies no expectation of prolonging life but just to relieve symptoms. Please encircle appropriate subnumber.

38. **CHRONOLOGY OF TREATMENT.** List down the corresponding treatment (identified by subnumber codes) in order of treatment done (starting from left) in the box provided for. (Ex. Patient has been treated first by Surgery, followed by chemotherapy and radiotherapy. Therefore the answer in the box should appear as follows: 1:3:3

39. **FINAL DESCRIPTION OF EXTENT OF DISEASE (AFTER SURGERY/AUTOPSY).** Refers to the extent of the disease based on findings at surgery (including histology) or autopsy, if the patient died before treatment could be given and autopsy was performed. Please encircle appropriate subnumber.

40. **CONDITIONS AFFECTING TREATMENT.** Please encircle subnumber.

41. **REASONS FOR NON-CURATIVE TREATMENT.** Please encircle subnumber.

42. **DISEASE STATUS AT DISCHARGE.** Refers to the opinion of the doctor-in-charge of the patient at the time of discharge or at the end of hospitalization.

43. **DURATION OF HOSPITALIZATION IN DAYS.** Refers to the initial course of treatment given in days. It should include time spent in hospital as a result of treatment or direct complications but should not include extension of hospital stay for social or other reasons. (Ex. No one came to fetch the patient.)

44. **PERFORMANCE STATUS (WHO) BEFORE & AFTER TREATMENT**
   0. Able to carry out all normal activity without restriction
   1. Restricted in strenuous activity but ambulatory and able to carry out light work.
   2. Ambulatory and capable of all self-care but unable to carry out any work activities; up and about more than 50% of waking hours.
   3. Symptomatic and in a chair or in bed for greater than 50% of the day but not bedridden.
   4. Completely disabled; cannot carry out any self-care; totally confined to bed or chair.

45. **PRESENT STATUS.** Encircle 1) if patient is alive and well, 2) if patient is alive with cancer; 3) if patient is dead; 4 if patient emigrated; and 5 if patient has loss of contact.
46. DATE OF DEATH. List down month and year in the box provided as follows: Patient died March 03, 2011. Therefore, the answer should be 03 for the day 03 for the month and 2011 for the year.

47. PLACE OF DEATH. Encircle subnumber 1 if patient died in the hospital, and subnumber 2 if the patient died at home.

48. CAUSE OF DEATH. List down answer in the space provided for before the box.

49. ADDITIONAL CAUSES OF DEATH. This item allows causes that may be mentioned on the death certificate to be recorded. Please list down answer in the space provided before the boxes.

50. RESULT OF AUTOPSY. Please encircle appropriate subnumber.

51. CANCER ENTERED ON THE DEATH CERTIFICATE. Encircle subnumber for answer.

52. CLASS OF CASE. Encircle the appropriate subnumber to determine if class of case is analytical or non-analytical.

   Analytical case
   1 Diagnose this hospital since reference date and all of the 1st course of the therapy.
   2 Diagnose and treated in this hospital.
   3 Diagnose elsewhere but receive all or part of the first course of therapy at this hospital.

   Non-Analytical case
   4 Diagnose and all of the first course of therapy received elsewhere.
   5 Diagnose and treated at this hospital before the reference date.
   6 Diagnose only at autopsy.

53. SURVIVAL IN MONTHS. Calculate from the date of first admission at or first consultation to the reporting institute (incidence date) to the month and year of death.

   *Aside from any additional remarks to be made, please list down complete histopathologic number and diagnosis. In the event that histopathologic diagnosis was made outside of the reporting institute, please indicate the hospital where histopathologic diagnosis was made.
ANNEX 2

COUNTRY CAPACITY AND PREPAREDNESS ASSESSMENT FOR INTRODUCING OR SCALING UP A COMPREHENSIVE CERVICAL CANCER PREVENTION AND CONTROL PROGRAMME

Country ________________________________

CONTACT DETAILS OF NATIONAL FOCAL PERSON FOR CERVICAL CANCER CONTROL

Name: ___________________________________________ __________________

Position: ________________________________________ __________________

Organization/Dept: ____________________________ __________________________

Address: _________________________________________ _____________________

E-mail: _________________________________________ _____________________

Phone number: _____________________________________ _____________________

Date Completed: ___________________________________ _______________________

INSTRUCTIONS:

This checklist can be used to assess country capacity and preparedness in introducing or scaling up a cervical cancer prevention and control program. This questionnaire is divided into six sections: (1) background; (2) cervical cancer control program; (3) laboratory; (4) HPV vaccination; (5) school health; and (6) adolescent health: out-of-school youth. Because sections might be answered by different persons, contact information for the person completing each section is requested. If the same person completes two or more sections, there is no need to repeat the contact information other than the name.

All attempts should be made to collate information from multiple sectors relevant for the programme. All questions may not be applicable to all Member States, but these items can be considered at appropriate stages of planning and implementation of cervical cancer prevention and control programmes.
I. Background: National Population and Cervical Cancer Statistics

CONTACT INFORMATION OF THE PERSON COMPLETING THIS SECTION
(If you provided contact information in another section, please put only your name here.)

Name: ____________________________________________
Position: _________________________________________
Organization: ______________________________________
Address: _________________________________________
E-mail: __________________________________________
Phone number: ________________________________
Date Completed: ________________________________
1. **Demographics**

1.1 Year of last census: 

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<tr>
<td>1.2. Total Population (Pop)</td>
<td>1.3. Total Male Pop</td>
<td>1.4. Total Female Pop</td>
<td>1.5. Total Urban Pop</td>
<td>1.6. Total Rural Pop</td>
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<tr>
<td>1.7. No. of women aged 30-59 years</td>
<td>1.8. No. of girls aged 9 years old</td>
<td>1.9. No. of girls aged 10 years old</td>
<td>1.10. No. of girls aged 11 years old</td>
<td>1.11. No. of girls aged 12 years old</td>
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2. **Burden of Disease**

2.1 Incidence rate of cervical cancer

2.2 Mortality rate of cervical cancer

2.3 Number of cervical cancer cases per year

2.4 Number of cervical cancer deaths per year

2.5 Year of reporting

2.6 Source of data
II. Cervical Cancer Control Program

CONTACT INFORMATION OF THE PERSON COMPLETING THIS SECTION
(If you provided contact information in another section, please put only your name here.)

Name: ________________________________________________________________

Position: ______________________________________________________________

Organization: __________________________________________________________

Address: ______________________________________________________________

E-mail: _________________________________________________________________

Phone number: _________________________________________________________

Date Completed: ________________________________________________________
3. Governance and Management

3.1. Policy

3.1.1. Is there a national cancer prevention and control policy? □ Yes □ No

3.1.2. Is there a national cervical cancer prevention and control policy (as part of a national cancer policy or separately)? □ Yes □ No

3.2. Management and Operational Mechanism

3.2.1. Is there a program for cervical cancer prevention and control? □ Yes □ No

3.2.1.1 If yes, year established? _________

3.2.2. Tick the appropriate description of the cervical cancer prevention program in your country
   (Note: You can tick more than one box)
   □ National □ Selected areas □ Opportunistic

3.2.3. Is there a responsible office or agency for leading and coordinating a cervical cancer prevention program? □ Yes □ No

3.2.3.1. Name of office or agency? _______________________________

3.2.4. Is there a technical steering or advisory group for this program? □ Yes □ No

3.2.5. Is a referral system available for women who need:
   a. Treatment for precancerous lesion □ Yes □ No
   b. Treatment of cervical cancer □ Yes □ No
   c. Palliative care □ Yes □ No

3.2.6. Are there practice guidelines for the following areas:
   a. Age to initiate screening □ Yes □ No
   b. Coverage goals □ Yes □ No
   c. Screening interval □ Yes □ No
   d. Screening tests to use □ Yes □ No
   e. Standard terminology for reporting screening results and or treatment for precancerous lesion □ Yes □ No
   f. Health professionals permitted to conduct the screening test □ Yes □ No
   g. Methods to manage women with precancerous lesion □ Yes □ No

3.2.7. What is the cervical cancer screening test(s) used?
   □ Cytology Proceed to 3.2.7.1.1 Answer Cytology Services Column
   □ VIA Proceed to 3.2.7.1.2 Answer VIA Services Column
   □ Combination (cytology+VIA) Proceed to 3.2.7.1 Answer both Columns
### 3.2.7.1 Screening Test

| a. What is the target age group? | | |
| b. What are coverage targets? | | |
| c. Are the screening services delivered at: | | |
| 1. Primary | | |
| 2. Secondary | | |
| 3. Tertiary | | |
| d. Are the treatment services delivered at: | | |
| 1. Primary | | |
| 2. Secondary | | |
| 3. Tertiary | | |
| e. Who provides the screening services? | | |
| 1. OB-Gyn Specialists | | |
| 2. General practitioner | | |
| 3. Nurses | | |
| 4. Midwives | | |
| 5. Others ________ | | |
| f. What is the total number of health professionals providing screening services? | | |
| 1. No of OB-Gyn | | |
| 2. No of General practitioner | | |
| 3. No of Nurses | | |
| 4. No of Midwives | | |
| 5. No. of community health workers | | |
| g. Is there a training program for cytotechnologists? | | |
| h. Are refresher training courses offered? | | |
| i. How often? | | |
3.2.7.2 Are there facilities for cryotherapy at:
   a. District / Provincial hospital □ Yes □ No
   b. Community health center □ Yes □ No
   c. Primary Health Care □ Yes □ No

3.2.7.3 Are the screening services delivered:
   a. as part of the routine preventive health services for women □ Yes □ No
   b. as part of maternal and child health services □ Yes □ No
   c. as a special campaign for cervical cancer prevention □ Yes □ No

4. Monitoring

4.1 Health Information Systems

4.1.1. Is there a national health information system? □ Yes □ No

4.1.2. Are national cervical cancer screening coverage surveys performed on a regular basis in a standard manner? □ Yes □ No

4.1.3. Are there cancer registries?
   If yes, how many are there? __________ □ Yes □ No

4.1.3.1. What proportion of the population is covered by cancer registration systems? __________

4.1.3.2. Year of last report? __________

4.2 Cervical Cancer Screening

4.2.1. Is there a public health professional e.g. epidemiologist, responsible for monitoring cervical cancer screening data? □ Yes □ No

4.2.2. Is it possible to enumerate the target population for cervical cancer screening? □ Yes □ No

4.2.3. Is there a unique identification number to trace or for call and recall of women who were screened? □ Yes □ No

4.2.4. Is a central list of women with abnormal screening results available? □ Yes □ No
   (Proceed to 4.1.5)

4.2.4.1. For what purpose is this list used?
   □ Tracking clients
   □ Follow up or subsequent management
   □ Others (Please specify: __________________)

4.2.5. Is it possible to access laboratory records for each woman so that data are available by women screened? □ Yes □ No

4.2.6. Is there a cervical cancer screening registry? □ Yes □ No
4.2.7. Are the cervical cancer screening registry and HPV vaccination registry linked, exchanged or jointly examined for program monitoring and evaluation purposes? □ Yes □ No □ Not applicable (no HPV vaccination program and/or no cervical cancer screening registry)

4.2.8. Are there measures in place to ensure confidentiality? □ Yes □ No

4.2.9. Is there a system that links the cervical smears to the biopsy slides? □ Yes □ No

4.2.10. Are statistical reports on the cervical screening program produced routinely? □ Yes □ No

4.2.11. Are these reports available to policy-makers? □ Yes □ No

5. Financing

5.1. Is there a specified budget for cancer prevention and control? □ Yes □ No (Proceed to 5.2)

5.1.1. How much is the annual appropriation specific for cervical cancer prevention and control program? __________

5.2. Are there any assistance supporting the cervical cancer control program in your country?

5.2.1. International □ Yes □ No

5.3. Are women required to pay for cervical screening test? □ Totally □ Partially □ Free

5.4. Does the national health insurance cover cervical cancer screening? □ Yes □ No □ Not applicable (no national insurance)

END OF SECTION
III. Laboratory

CONTACT INFORMATION OF THE PERSON COMPLETING THIS SECTION
(If you provided contact information in another section, please put only
your name here.)

Name: ________________________________________________________________

Position: ______________________________________________________________

Organization: __________________________________________________________

Address: ______________________________________________________________

E-mail: _________________________________________________________________

Phone number: _________________________________________________________

Date Completed: _________________________________________________________
6. **Laboratory services**

6.1. How many laboratories are offering cervical pathology/histopathology services? □ □ □

6.2. Number of laboratories offering cervical pathology/histopathology services:
   a. At national level □ □ □
   b. At sub-national level □ □ □
   c. At district level □ □ □

6.3. How many cervical cytology smears does each level of laboratory process on average each year?
   a. At national level □ □ □
   b. At sub-national level □ □ □
   c. At district level □ □ □

6.4. How many cervical biopsy tests are processed on an average per year? □ □ □ □

6.4. Do all labs report according to the standard international terminology/classification used (e.g. Bethesda)? □ Yes □ No

6.5. Is there a regular external quality assessment of cytology? □ Yes □ No

6.6. Is there a regular external quality assessment of the histopathology? □ Yes □ No

6.7. Are there cytopathologists in the country? □ Yes □ No

6.7.1. Number of cytopathologists in each level of laboratory
   a. At national level □ □ □
   b. At sub-national level □ □ □
   c. At district level □ □ □

6.8. Are there cytotechnicians in the country? □ Yes □ No

6.8.1. Number of cytotechnicians in each level of laboratory
   a. At national level
   b. At sub-national level
   c. At district level

6.8.2. Is there a program in place for training, continuous updates, re-training, supervision, monitoring performance and evaluation of cytotechnicians? □ Yes □ No

6.8.3. Are all smears reported as negative by the cytotechnician re-screened by the cytopathologist/pathologist? □ Yes □ No

END OF SECTION
IV. HPV Vaccination

CONTACT INFORMATION OF THE PERSON COMPLETING THIS SECTION
(If you provided contact information in another section, please put only your name here.)

Name: ____________________________________________________________

Position: __________________________________________________________

Organization: ______________________________________________________

Address: __________________________________________________________

E-mail: _____________________________________________________________

Phone number: ______________________________________________________

Date Completed: ____________________________________________________
7. Governance and Management

7.1. Policy
7.1.1. Is there a national HPV vaccination policy? □ Yes □ No (Proceed to 7.2.1)

7.1.1.1 Is there a national guideline on HPV immunization service delivery? □ Yes □ No

7.1.1.2 Is there a national guideline on health promotion/communication for HPV vaccination? □ Yes □ No

7.2. Management and Operational Mechanism

7.2.1. Is there a government-funded or government-managed (may be donor-funded) HPV vaccination program? □ Yes (Proceed to 7.2.3) □ No

7.2.2. If there is no national HPV program in the country, is there a plan to start an HPV vaccination program? □ Yes □ No

7.2.2.1 By what year? _____________________________

7.2.2.2 Is there sufficient cold chain capacity to add HPV vaccine at:
   a. National level □ Yes □ No
   b. Regional or provincial level □ Yes □ No
   c. District level □ Yes □ No
   d. Health centre level □ Yes □ No

(Countries with future plans for an HPV vaccination program but not yet started: Proceed to 9.1)

7.2.3. Is the HPV vaccination program delivered in:
   a. Schools □ Yes □ No
   b. Community health centers □ Yes □ No
   c. Other (Please specify: ____________________________) □ Yes □ No

7.2.4. Are there communication strategy packages for:
   a. Clinicians & service providers □ Yes □ No
   b. Community □ Yes □ No
   c. Target groups (adolescent girls) □ Yes □ No
   d. Parents □ Yes □ No
   e. Teachers □ Yes □ No
7.2.5. Is there a training structure/module for:

- a. Clinicians □ Yes □ No
- b. Vaccinators □ Yes □ No
- c. Communicators □ Yes □ No

7.2.6 Who performs the vaccination?

- a. General practitioner □ Yes □ No
- b. Nurse □ Yes □ No
- c. Community health worker □ Yes □ No
- d. Other (Please specify: _________________________) □ Yes □ No

8. Monitoring

8.1 Can you identify the size of the target population for an HPV vaccination program? □ Yes □ No (Proceed to 8.2)

8.1.1 What is the size of the target population for vaccination? __________________

8.2. Is there a standard vaccination record for use by all HPV vaccination providers? □ Yes □ No

8.3. Is there an HPV vaccination register? □ Yes □ No

8.3.1 At what level? (tick all that apply)

□ National
□ Provincial/state
□ District
□ Delivery facility (school, health centre, etc.)

8.4. Since there is a need to monitor vaccine coverage by age and by dose, are the following information recorded:

- a. Date of birth □ Yes □ No
- b. Date of vaccine administration □ Yes □ No
- c. Vaccine dose number (dose #1, #2, or #3) □ Yes □ No

8.5. Is there a system to identify subjects who missed a dose, in order to follow up? □ Yes □ No

8.6. Are the HPV vaccination registry and cervical cancer screening registry linked, exchanged or jointly examined for program monitoring and evaluation purposes? □ Yes □ No □ Not applicable (no HPV vaccination program and/or no cervical cancer screening registry)

8.7. Is there a system (passive or active) for reporting of adverse events following immunization (AEFI) by the public and health professionals to a national center? □ Yes □ No
9. Financing

9.1. Is there funding to procure HPV vaccination?
- Yes, government budget
- Yes, from donor (or donated vaccine)
- No

9.2. Is there funding for operational costs to deliver HPV vaccine?
- Yes, government budget
- Yes, from donor
- No

9.3. Does the national health insurance cover HPV vaccination?
- Yes
- No
- Not applicable (no national insurance)

END OF SECTION
V. School Health

CONTACT INFORMATION OF THE PERSON COMPLETING THIS SECTION
(If you provided contact information in another section, please put only your name here.)

Name: ____________________________________________________________

Position: __________________________________________________________

Organization: ______________________________________________________

Address: __________________________________________________________

E-mail: ____________________________________________________________

Phone number: ____________________________________________________

Date Completed: ____________________________________________________
10. Governance and Management

10.1. Policy

10.1.1 Is there a national policy on school-based health programs? □ Yes □ No

10.2. Management and Operational Mechanism

10.2.1 Are there any school-based health programs? □ Yes □ No (END OF SECTION)

10.2.1.1 The school-based health programs are:
□ National □ In selected areas

10.2.1.2 The school-based health programs include:

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<tr>
<th>Service</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>a. Basic clinical services for acute illness or injury</td>
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<tr>
<td>b. Immunization</td>
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(If yes, specify vaccine(s) and age(s) given: 1. __________________________ 2. __________________________)

c. Sexual and reproductive health services □ Yes □ No

d. Other preventive health services (e.g., blood pressure check, vision screening, dental services, nutrition) □ Yes □ No

e. Mental health, substance abuse, or counseling services □ Yes □ No

f. Others (Please specify: __________________________) □ Yes □ No

10.2.1.4 Who delivers the school-based health services?

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<tr>
<th>Delivery Method</th>
<th>Yes</th>
<th>No</th>
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<tr>
<td>a. School nurses</td>
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<td>b. Staff from health facilities who travel to schools</td>
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<tr>
<td>c. Others (Please specify: __________________________)</td>
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11. Financing

11.1 Are students required to pay for any school-based health services? □ Yes □ No

11.1.1 If yes, specify services requiring payment: __________________________

END OF SECTION
VI. Adolescent Health: Out of School Youth

CONTACT INFORMATION OF THE PERSON COMPLETING THIS SECTION
(If you provided contact information in another section, please put only your name here.)

Name: ___________________________________________ __________________
Position: ________________________________________ __________________
Organization: ____________________________________ ______________________
Address: _________________________________________ ____________________
E-mail: _________________________________________ ____________________
Phone number: _____________________________________ _______________________
Date Completed: ___________________________________ _______________________
12. Governance and Management

12.1. Policy

12.1.1 Is there a national policy on out-of-school youth, addressing health services for them?

☐ Yes  ☐ No

12.2. Management and Operational Mechanism

12.2.1 Are there any out-of-school youth health programs?

☐ Yes  ☐ No

12.2.1.1 The out-of-school youth health programs are:

☐ National  ☐ In selected areas

12.2.1.2 The out-of-school youth health programs include:

a. Basic clinical services for acute illness or injury  ☐ Yes  ☐ No

b. Immunization  ☐ Yes  ☐ No

(Specify vaccine(s) and age(s) given: 1. ____________________________

2. ____________________________

c. Sexual and reproductive health services  ☐ Yes  ☐ No

d. Other preventive health services (e.g., blood pressure check, vision screening, dental services, nutrition)  ☐ Yes  ☐ No

e. Mental health, substance abuse, or counseling services  ☐ Yes  ☐ No

f. Others, specify: ____________________________  ☐ Yes  ☐ No

12.2.1.3 The out-of-school youth health services are delivered in:

a. Community health centers  ☐ Yes  ☐ No

b. Others, specify: ____________________________  ☐ Yes  ☐ No

END OF SECTION