

# INDIA

## Overview: National Cancer Control Programme

Cancer has become one of the ten leading causes of death in India. At present there are 2.5 million cancer cases and nearly 0.8 million new cases occurring every year and 0.4 million deaths occurring every year. Data from National Cancer Registry Programme indicate that the leading sites of cancer are oral cavity, lungs, oesophagus and stomach amongst men and cervix, breast and oral cavity amongst women. Tobacco is the most important identified cause of cancer and is responsible for about 40 to 50% of cancers in men and about 20% of cancers in women. India has the added burden of tobacco chewing which is more prevalent than smoking in many areas.

India is one of the few developing countries that have a National Cancer Control Programme. It was launched in 1976 with the objectives of primary prevention of cancers, early detection and prompt treatment. The ministry of health decided to revise the programme because the activities were more focused on district plans rather on an overall national effort and the results were not what were expected. The difficulty was that the patients were coming in advanced stages and treatment was not uniformly available. In view of the magnitude of the problem and the requirement to bridge the geographical gaps in the availability of cancer treatment facilities in the country; the programme was revised in December 2004. The problems encountered in the planning process included inconsistent and inadequate involvement of stakeholders, slow and long process of approval of plan. The current programme has 5 schemes:

1. Recognition of new Regional Cancer Centres (RCCs)
2. Strengthening of existing RCCs
3. Development of oncology wings in medical colleges
4. District Cancer Control Programme
5. Decentralized NGO Scheme

A national Task Force for developing a “Strategy for Cancer Control in India during the 11<sup>th</sup> Five Year Plan” (2007-2011) has been constituted. The new components include information, education , communication (IEC) activities; research and monitoring and evaluation. Dissemination of information through media and NGOs is planned. India is the first member country from the developing world to become a member of IARC. This will ensure appropriate direction of the Agency’s research efforts in India to benefit its large population. India has ratified the framework convention on tobacco control by WHO. A proposal (Onconet) for linking up of Regional Cancer Centres amongst themselves and each with 5 peripheral centres has been prepared.

Additional information on National Cancer Control Programme can be accessed in English at: <http://mohfw.nic.in/healthprogmain.html>

**The following information was provided in a telephone interview (March 2006) by:**

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**1. Is it a new plan or an updated one, when was your previous plan published?**

India is one of the developing countries who have national cancer control programme (NCCP). We started way back in 1975 and the plan has been revised three times. The first revision was in 1984, second one in 1991 and third one 2004. Every time we have brought out a report. First one a small booklet in 1984, then in 1991 and the latest is 2003 publication “50 years of cancer control in India”.

**THE FOLLOWING QUESTIONS REFER TO THE PRESENT PLAN**

**2. The new plan -is it already official?**

It was revised in 2004 and is already under implementation.

**3. Do you have a copy of the 2004 plan?**

It is on the website of the Ministry. It is called National control programme guideline published in May 2005.

**4. When did you start the planning process? Who decided to do the plan and why?**

We evaluate the programme that we have implemented. Then a draft is planned. For evaluation and planning, working groups are constituted. These working groups consist of experts from finance, and policy makers and NGOs. After the draft is ready, this is approved by the Ministry of health and forwarded to the planning commission for approval. Then it goes to the Ministry of Finance for the financial concurrence after going through this process we raise the matter before the cabinet for their approval. We call it cabinet committee on economic affairs. When this committee accords the plan then we implement the components of the plan.

**5. It goes to the cabinet committee on economic affairs for funding or is it just for policy development or support**

As a policy cabinet approval is required. If cabinet committee on economic affairs does not approve and if it needs revisions or updating then after new changes it is sent again to the Ministry of Finance for financial concurrence.

## **6. The plan 2004 went through all these stages already?**

Yes. In fact the planning process for the latest document was started in 2001 and the plan was evaluated by the National Institute of Family Welfare. It took about 1 ½ years to evaluate. Then it is sent to the working groups who took about 1 year to work on the document, because there is a lot of consultative process that takes place. Then it was sent to the Planning Commission who recommended a lot of modifications. Thus the revised final plan came out after 2 years. We could get the approval in 2004, So it took about three years from 2001 to 2004 to go through this process.

## **7. Who were the persons involved in each of the above process?**

Exploiting cancer control, radiotherapies, medical oncology, surgical oncology, the directors of the regional cancer, NGOs for big institution, hospitals in the country, so people drawn from all these institutions who render cancer care services were all consulted, there were also finance people, policy makers and stakeholders.

## **8. How was the plan done? What resources did you use, and what were the results?**

As I told you evaluation took about a year's time. That cost us US\$20,000 and the working group meetings cost about US\$10,000. WHO Biennium funds were utilized. There are large number experts in the country. There are 25 regional cancer centres and many non governmental cancer care hospitals in the country which also has a large number of professionals so they are all consulted.

## **9. When was the plan officially launched? Who and how was the plan disseminated?**

The latest plan was approved in 2004 and first launched on 1 January 2005, guidelines were printed and circulated to all states and institutions prior in the last one year seeking proposals. We in the Ministry the country division played a very proactive role. We called all the people in the institutions talked to them, disseminated all the information about the existing programmes obtained proposals and then processed them and released money. There are also guidelines in the website of the Ministry.

## **10 What problems were encountered in the planning process? How were they dealt with?**

This planning process involves the consultative process of the planning commission and the finance ministry which takes a lot of our time. Once you do a professional job, and make a powerpoint presentation and explain to the approving authorities of the major components as to why these components are important and as to why I need this amount of money to run the programme. If it could be systematic then it should be able to cut short the process in time. At times they make certain observations, and we make corrections.

**11. May I ask you about this process, who was leading the whole process? Was there someone at the ministry of health coordinating the whole process?**

The process is led by the Cancer Division in the Ministry of Health and the joint secretary in charge of cancer control. As of now I am the joint secretary. My colleagues have contributed to my earlier programmes, now I am trying to make it much more flexible, much more accessible and it will cover a wider area of cancer control.

**12. What were the lessons learnt from the planning process?**

Actual implementation had some bottlenecks. We run into difficulties at the time of actual implementation. The problem is that once the plan is approved by the cabinet we have no area of flexibility to go out of the approved jacket. For example our district cancer control programme is under implementation now, which is to support the district cancer societies to go into national awareness campaigns, education, detection and screening. This can be done only up to 5 years. There would be very little work by the completion of the 5 year plan and then a next 5 year plan ie another document is required.

Then there is another problem. All along we have been supporting non government cancer hospitals, unfortunately in the 10<sup>th</sup> plan these are left out. So the non government hospitals are finding it difficult to carry out the programme without funding and they feel that we have been left out. The involvement of stakeholders is not 100% perfect. We have to ensure that all the stakeholders, the clinicians the hospitals, the trust paramedical government bodies from these institutions, the NGOs which normally carry out the payment of palliative care, all of them take part. We encourage the public private partnership in the next plan in a better way.

There is a lot of demand from many centres to accord regional cancer care centre status but we are not able to do that because we have a limit. Every year we will accord only 5 regional care centres status. So we are also trying to address these things in the next plan. But we also would like to change the current policy in the next programme. There are about 110 government medical colleges in the country, we should strengthen the medical oncology department of all these medical colleges. If only 45 could be covered in this plan. We will have to go in for upgrade of all these cancer care hospitals as the centres of excellence (subject to the approval of the policy makers and the finance ministry).

**13. These hospitals are cancer hospitals or general hospitals?**

Many of them are exclusively cancer care hospitals. Some of them are partly the general hospital and partly cancer care. Firstly to upgrade these hospitals into centres of excellence we need a lot of money. Secondly oncology departments in medical colleges to be upgraded and strengthen so that the students are taught and services are delivered. The district cancer control programme should be given a critical portion so that the awareness campaign, the detection of cancer and early detection of cancer happen. Then we also have some pockets in the country which do not have either the regional cancer centre or the medical college or any medical hospital due to difficult terrain, lack of man power and due to financial difficulties. So we need to tackle these problems also.

#### **14. What are the priorities main goals and objectives of the main plan?**

In the first plan in 1975, our focus mainly was on primary prevention, secondary prevention, tertiary care in addition to palliative care. This remains by and large the same, in addition to offering curative services we are offering IEC services to educate the people dissemination through the visual e.g. TV channels, the media, the postal campaigns by involving NGOs who are in cancer care, pain and palliative care. One our priorities in the next plan will be to get more allocation for the cancer care. We are also taking a look at the standards of international hospitals in the world. I got the materials down loaded from about 5-6 hospitals in USA and other places. We would like to take a look at their standards.

There are 4 components in these national cancer control plan:

1. Assistance to new regional cancer centres
2. Assistance to existing cancer regional centres.
3. Assistance to develop oncology departments in medical colleges.
4. Assistance to NGOs for cancer control programme

The new components are IEC and research.

#### **15. What are the resources allocated to carry out the implementation of the plan?**

For the current plan we offer US\$66million assistance for institutions. The institution should be a govt run medical college or hospital in the field of cancer care services so this money should be used for procurement of equipment, for buildings to be constructed to accommodate electronic equipment.

Human resources, unfortunately, we are not providing, lack of human resource is one of the main constraints in running this programme. That constraint will be addressed in the next plan. Here under this scheme we assist the already existing hospitals, who take US \$ 66million assistance every year from us to upgrade the facilities in the regional cancer centres. Then every year they are suppose to accord their contributions to 5 cancer care hospitals so they give US\$1.1million further to those institutions. So 5 hospitals or 5 para medical hospitals or 5 cancer care hospitals are being given hospices status this year and next year also we will do and of small numbers of institutions are coming forward.

Then district cancer control programme is basically on prevention, early detection and awareness campaign. We give about US\$50,000 in the first year so total it comes US\$.2million for district cancer control programme. They get about US \$ 200 per current awareness detection camp which are operated in regional centres. There are two new components in the plan - IEC and research.

#### **16. Who will carry out the monitoring and evaluation?**

There are experts in the country and external agencies but there is paucity of funds to carry out this activity.

**May I just point out that WHO encourages the quality management approach for developing cancer control programmes. And in that framework it is advisable to encourage monitoring and evaluation done internally by the people that are carrying out the services of course that does not exclude the external evaluation, the internal evaluation has a lot of benefits in itself especially the monitoring can help the providers to correct errors or mistakes or identify gaps quite easily and try to solve them. So do you have any thoughts about that?**

Actually what we normally do is we evaluate the performance of these programmes and correct the mistakes. The periodic meetings are taken at the ministry level. We call these people after a period of 6 months for getting all their problems and getting their inputs. Of course it is ideal to evaluate the programmes and evaluate every year but we can evaluate only in 5 years. So there are enough experts in the country. I am glad to mention that we have a number of international experts for research in cancer.

**17. What has been implemented so far, when and where?**

We have about 210 institutions in the country. There are 24 private hospices. So we will complement the cancer treatment facilities in these centres. Some are taking up research cancer due to tobacco. We have also launched programmes on cancer registry and we propose for the region specific cancer registry for tailoring the programme according to the regional specific requirements. The regional cancer centres also have medical equipment facilities for teleconsultation. They have set up a task force to network all the 25 hospices so that people will not have to travel all the way to a far off hospital. Indian Medical Council of Research, is collaborating the international research in the field of cancer.

**The following information was provided in a telephone interview (February 2006) by:**

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**1. Is it a new plan or is it an updated one? When was the previous plan published and who did it?**

It is a completely new plan and is a national plan. Earlier there was the regional plan from Kerala.

**2. And there was no other region in India having a regional plan?**

No. Not to my knowledge.

## **THE FOLLOWING QUESTIONS REFER TO THE PRESENT PLAN:**

### **3. When did you start the planning process? Who decided to do the plan and why?**

The National plan was started about 6 months ago. The health department of the National Government under the guidance of health minister initiated this plan. The activities that started ten years ago were more focused on district plans rather on an overall national effort. They were several initiatives. One was to provide treatment equipment mostly cobalt units all through the country. Then there was a district cancer control programme which was started in 29 districts out of 625 districts in the country. This was started about 10 years ago. And the third initiative was in connection with the maternal and child health programme which also started about 8-10 years ago. None of these plans could help to improve the cancer treatment results. Mostly because we are not able to catch the cancer patients in the earlier stage of disease. And even now with all these programmes the localized disease detection remains at 20%. About 80% are coming in very late stages. And with all the installation of equipment to the medical colleges and hospitals the treatment results have remained sadly worse. The difficulty was the patients were coming in advanced stages and treatment was not uniformly available in different parts of the country. So after the evaluation a decision was taken to start a national plan. India's all development programmes are coordinated with the 5 year plan. We are going to launch the 11<sup>th</sup> five year plan in another two years time. So this effort is being made to synchronize with that particular plan. There will be the overall health plan and there will be plans for individual diseases.

### **4. What steps did you take to do the plan and how long did each step take?**

Three committees have been formed. One is called the cancer control committee, which is responsible for early detection and prevention. This committee is also responsible for human resource development and financial resources.. Second committee is responsible for diagnosis and treatment. Third committee is responsible for palliative care. All of them were appointed by the ministry of health. I am entrusted with the responsibility of primary prevention as well as early detection. I am mandated to send a draft plan to the chairmen of the other committees so that they can coordinate the ideas in this plan.

### **5. Who were the persons involved in each step of the process?**

Each committee has a core which composes of 5-6 people. There are other members who the committee chairman could invite. These committees have independent experts and also government officials.

### **6. Is there a way where these committees meet together and discuss?**

Yes. The core group of the three committees will be meeting by 1<sup>st</sup> week of March. By this time we hope that all the three plans will be ready. The linking could be worked out.

**7. May I ask you whether in each committee you have some standard way of doing the plan or some steps to follow or each group is doing its own planning process without consulting?**

One of the coordinators in the Ministry has given us a outlines to work on that.

**8. Who did that evaluation?**

The evaluation was done by the organization called Controller and Auditor General of India who looks into the performance of a project and into the financial aspects. This is a totally independent organization. Their functions are totally independent and they do not come under the government. They are not influenced by the government at all. He has given a report that the previous efforts have not produced any worthwhile results as far as cancer control is concerned. It is an open document and it was widely discussed.

**9. When was the evaluation done?**

This evaluation was done about 1 ½ to two years ago.

**10. Were you part of this evaluation for the cancer control?**

No. I was not part of the evaluation committee. Because that is a totally independent organization.

**11. Who are the members of the committees? Are they all experts or representatives of different governmental organizations?**

Most of them are experts working in cancer centres. Both private and public. There are some people from institutions for example biotechnology institutions. There are some who work for national scientific institutions and universities. They all together would constitute more than 25% of the total body of all these committees.

**12. Do you have other private sectors representatives or they are all medical doctors?**

There are statisticians, epidemiologists and a few belong to NGOs. Majority are medical doctors.

**13. Do you have nurses also in the group?**

Yes nurses are also there are at least 4-5 nurses.

**14. How big are these committees?**

There are 10-15 people in each committee. Then we have core group in each group. Core group will have about 5-6 people. Total number will be about 15 people. The core group is decided by the chairman of each committee with whom he feels comfortable to work with. And the chairman is appointed by the government.

**15. Are the members of the committee getting a full time job or is it volunteer work? Do they get salary as well?**

No it is only a part time job. Everybody is a volunteer, even the chairman. They do not receive any salary except the travel expenditures and meeting expenditures. So the resources are available for transportation and workshops etc.

**16. What is the time limit for producing the plan? When do you expect to finalize the plan?**

We are supposed to finalize the plan before end of April 2006. It has to go to different deciding administrative levels for it to be included in the 11<sup>th</sup> five year plan. That is a big administrative channel for approval. So plans are prepared two years ahead of starting the activities in the plan. Because once it is included as part of the plan probably it may have to be linked with other disease plans. This should be done at the administrative level. There will be further discussions on the plan. It will not be modified. The possibilities would be that certain linkages would have to be established.

**17. When this plan will be implemented?**

The implementation will start only by April 1, 2008.

**18. What are the goals or objectives in this plan?**

The objectives are, we are planning to concentrate on three common forms of cancer, cancer of the mouth, cancer of the breast and cancer of uterine cervix. Cancer of the mouth is a very important problem in India. These are three cancers which could be easily detected and could have good results with treatment. It is very important for people to gain confidence by working on these three cancers and then move forward.

**19. What about primary prevention like chewing tobacco?**

The people who develop tobacco related cancer very often chew tobacco. So what we are planning to do is to somehow through our various programmes keep these women and children out of the tobacco habits and try to stop the tobacco habits in adults. I have suggested to set up the exclusive "quit tobacco" clinics in all public offices and in various institutions, to start a formal and non formal education for children as well as women and to pursue some of the legislative measures. So in the formal education, messages should be taught to them at the primary school level and high school level and at the college level.

India has already ratified the convention on tobacco control, but like in various other countries here also it is not very seriously implemented.

**20. What are the structures you are targeting apart from tobacco? Is there any other real structure you are targeting? for example do you have occupational factors that you need to deal with?**

I do not think there are many occupational factors. India is a vast country and some of the industries are in places which are densely populated. India has a very big coal industry. It is concerning only a small part of one state.

**21. So you have not reassessed the importance of occupational hazards?**

No in fact no major study has been done about the occupational hazards due to industry. There is an institution of occupational health.

**22. Is there any paper with the assessment of the cancer development in India?**

There are very many papers. We have started with current scenario of cancer in the country in the new plan.

**23. What are the resources allocated to carry out the implementation of the plan?**

I do not think we have been able to make very accurate figures concerning financial resources. But I am working on a model. There will be a resource centre in each state to provide cancer control advice. There will be a channel through which this will go to the grassroot level. The channel is the district cancer control programme.

**24. What were the lessons learned from the planning process?**

What we have to remember is noncommunicable diseases have never been part of our health programme so far. So there are two major changes which the government has to make. Firstly the government has to make the health service responsible for that through an order. And they have to bring certain health service system changes to ensure that their employees do this also. Secondly to make sure that this is done through private institutions as well.

**25. What about insurance is it private or public? Are those services covered by insurance.**

There is an organization called the Commission for National Macro Economics and Health. This is totally different organization which has been interested in all national health aspects. They will be submitting the plan. We will decide how we are going to implement insurance in cancer plan. They have already prepared some macro economic plan. And they have promised the government regarding the government's input also. But they will have to fashion according to the needs of individual group. The Commission of National Macro Economic in on the website.

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