Report of the
WHO South-East Asia Regional workshop on scaling up services for cancer and implementing South-East Asia Cancer Grid

14-17 May 2024
Kathmandu, Nepal
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Table of contents

a. Background and objectives ..........................07

b. Workshop proceedings .......................... 09

   Inaugural session ..................................10
   Where are we in cancer control? .....................12
   What is the strategy to accelerate towards 2030? .....................16
   Resourcing NCCP and ensuring quality of care .....................19
   To screen or not to screen? .....................21
   Observational visit to cancer centres in Kathmandu ....................23
   South-East Asia Cancer Grid (SEACanGrid) ....................25
   Liver cancer – an emerging problem .....................28
   Scaling up management of cancers .....................29
      Parallel Session: Childhood cancer – a low hanging fruit among cancers .....................29
      Parallel Session: Strengthening management services for cancer – breast, cervix, and oral cancer as tracers .....................30
   Strengthening cancer registries in South-East Asia Region ....................33
   Country plans to scale up services for cancer management ....................35
c. Core outcome themes and the next steps ....................41

Annexure ...............................................45

   Annex: 1 Address by the Regional Director ....................46
   Annex: 2 List of participants ..........................48
   Annex: 3 Programme ..................................53
   Annex: 4 Participants’ feedback ..........................59
   Annex: 5 Resource materials ..........................62
Background and objectives
In 2022, World Health Organization (WHO) South-East Asia Region reported 2.4 million new cases of cancer. This included 56,000 children. Cancers of breast, cervix and lung are the most common cancers. The region has the highest rate of incidence for cancer of lips and oral cavity. And recent reports also suggest rise in liver cancers related chronic Hepatitis B and C infection. The number of deaths due to cancer was 1.5 million in the region in 2022. This number is an increase by almost one third compared to ten years before. Moreover, the number of new cases and deaths due to cancer in the region are estimated to increase further by over 85% by the year 2050.

Effective cancer control require reducing risk factors, preventing infection related cancers, screening for cancers with precancerous stages, diagnosing cancer at early stages and prompt treatment and palliative care without financial burden to the patients In last few years, countries in the region have made notable progress in cancer control. Six countries in the region are implementing national cancer control plans or programs. Six countries have introduced nationwide HPV vaccination. Global initiative for childhood cancer is being implemented in ten countries through a regional network of institutions. Eight countries have operational population-based cancer registries. Tertiary level care for cancer is available in ten countries, nine countries have services for radiation therapy. WHO and partners including St. Jude Children’s Research Hospital, International Atomic Energy Agency (IAEA), International agency for research on cancer (IARC) and Institutions with capacity within the region such as Tata Memorial Hospital (TMH), India have been providing valuable support to the member states through various fronts in the combat against cancer.

There are, however, persistent challenges. Cancer services are included in health benefit packages in only four countries. Mortality to incidence ratio is almost double that for high income countries indicating poor capacity for management of cancers. Almost half of the childhood cancers are estimated to remain undiagnosed and the difference of the mortality to incidence ratio is more than three times compared to high income countries. Screening coverage for cervical cancer is less than fifty percent in four countries. Cancer diagnostic capacity is not suboptimal with the number of CT Scanners available ranging from 3.8 to 73.4 per 10,000 cancer patients and cancer treatment centres are mostly overburdened with patients.

Since cancers are disease entities that require complex multidisciplinary care and multisectoral involvement in strengthening care delivery, scaling up the services thus requires coordinated multiprong actions in defined order of priorities from government and partners. One crucial need in achieving the priorities is the collaboration among institutions within and across countries. To facilitate this, SEARO has established the WHO South-East Asia Cancer Grid (SEACanGrid), a network of tertiary care institutions, in collaboration with the WHO collaborating centre for cancers Tata Memorial Hospital Mumbai to foster collaboration in technical capacity building and catalyse the efforts of countries to improve cancer services to their populations.

In this backdrop, the WHO South-East Asia regional workshop on improving services for cancer and implementing the South-East Asia Cancer Grid was conducted with participation of key service provider institutions, country policy makers and programme managers, and global and regional leaders in cancer care along with partners with the following objectives.

**General objective:**
To support countries in scaling up services for cancer with optimal financing and to implement SEACanGrid.

**Specific objectives:**
1. To identify strengths, limitations, and opportunities in countries to scale up services for cancer
2. To implement SEACanGrid for technical collaboration among institutions to scale up and improve quality of services for cancer with a focus on childhood cancer.
3. To develop country specific pathways to improve services for cancer and to identify models for sustainable financing.
4. To support expanding the coverage of cancer registries.
The highlights of the proceedings of the four day WHO South-East Asia regional workshop on improving services for cancer and implementing the South-East Asia Cancer Grid are summarized in this report.

**Inaugural session**

The workshop was inaugurated by the Honourable Secretary of Ministry of Health and Population in Nepal, Dr Roshan Pokharel. The session was also attended by the Director General of Department of Drug Administration and the Director of Management Division of Department of Health Services, Ministry of Health and Population Nepal.

Opening address form the Regional Director, Dr Saima Wazed, was delivered by Dr Gampo Dorji, the acting WHO Representative for Nepal. In her address the regional director emphasized the progress and the gaps that exist in cancer management services. She highlighted the need to prioritize HPV vaccination, to strengthen services for early diagnosis, and to scale up capacity for evidence-based quality treatment as well as palliative care.

In his remarks Dr Roshan Pokharel also emphasized that while cancer prevention efforts have been effectively implemented, there is a prominent deficiency in the capacity in curative aspects of cancer. He firmly expressed that the efforts must be intensified. He expressed hope that implementation of the South-East Asia Cancer Grid (SEACanGrid) would be beneficial for countries in the region.

Dr Catherine Lam, Director of Health Systems Unit and Co-Director of WHO Collaborating Centre for Childhood Cancer at St. Jude Children’s Research Hospital (St. Jude) shared the efforts that WHO and
St. Jude have jointly put in scaling up services for childhood cancer. She expressed that hope is the factor that has led to discoveries and efforts that have improved survival of children with cancer across the world.

Dr Pramesh CS, Director of Tata Memorial Hospital, Mumbai and Convener of National Cancer Grid, India shared the innovative initiatives in India including the National Cancer Grid in India that have transformed various aspects of cancer control. He expressed commitment to collaborate and contribute to cancer control in the region.

Dr. Igor Veljkovikj, Program Officer at Cancer Control Review and Planning Section at the International Atomic Energy Agency (IAEA) shared the efforts from IAEA and its partnerships to member countries in areas of cancer control specifically on radiation medicine and expressed commitment to continue to collaborate in order to improve services for cancer.

Ms. Genessa Giorgi, Health Attaché at the US Embassy, New Delhi and South Asia Regional Representative from US Department of Health and Human Services shared about the cancer moonshot initiative from the US government and called on for collaboration with countries in South Asia.

Dr. Cherian Varghese, ag. Director, Healthier Populations and Noncommunicable Diseases Department, WHO Regional Office for South-East Asia provided an overview of situation of cancer burden in the region and briefed on the scope and objectives of the workshop. He emphasized that the bottleneck in reducing the mortality due to cancer lies in the cancer management capacity in the region. He shared evidence from high income countries that mortality reduction was achieved by improving early diagnosis, much before population-based screening was introduced. He shared that there are tools, resources, and expertise to support countries in scaling up services, and the four days of the workshop would delve deeper into them.
Where are we in cancer control?

The objective of the session was to present an overview of the global and regional situation of cancer burden and progress and to share the efforts and experiences of countries on improving services for cancer including the challenges and opportunities. Following a brief presentation on the regional situation of cancer burden and the trends country delegates presented on country situation and progress.

The number of cancer deaths has increased by almost one third in the past decade in the WHO South-East Asia Region. According to the estimates by the International Agency for Research on Cancer, the number of new cancer cases and cancer deaths are estimated to almost double by the year 2050. The leading cancers sites are breast, cervix uteri, trachea / bronchus / lungs, lip / oral cavity, and colorectum. For lips and oral cancer, the region ranks as the one with highest number and rates of incidence and mortality among WHO regions. The region also ranks as the one with highest number of cervical cancer cases and deaths, and second highest in terms of age standardized rate.

In 2015, the WHO regional committee adopted the resolution SEA/RC68/R5 – cancer prevention and control: the way forward – urging the member states to develop / strengthen National cancer control programs and strengthen all levels of healthcare to provide services for cancer. Currently six countries in the region are implementing national cancer control plans or programs, two countries are drafting national plans, and two countries have their national plan due for revision.

World Health Assembly Resolution (WHA 70.12) on Cancer prevention and control in the context of an integrated approach in 2017, urged member states to collaborate by strengthening, regional and subregional partnerships and networks to create centres of excellence for the management of cancers.
In the years that followed, WHO launched the Global initiative for childhood cancer (GICC) in 2018, adopted the Global strategy to accelerate cervical cancer elimination in 2020, and launched the Global breast cancer initiative in 2021. Apart from the initiatives from WHO, IAEA has recently launched the Rays of hope initiative to strengthen services on radiation medicine and IARC has been implementing the Global initiative for cancer registry development.

In the WHO South-East Asia Region efforts on prevention of cancer have had notable impacts including in the areas of HPV vaccination tobacco control. However, as mentioned earlier, there are gaps in the fronts of screening, diagnosis, and treatment. Palliative care is not uniformly available and only one country is in the stage of integrating palliative care into routine health services. Financial challenges render many patients unable to seek care or seek care late. Only six countries have included cancer in the country's largest public sector health benefit package.

Despite the challenges, some notable initiatives across the countries have facilitated delivery of quality cancer care and serve as model for replication elsewhere in the same or a different country.

**In Bangladesh**, Cancers is responsible for 14% of total deaths, ranking as the second most common cause of death. Common cancers are similar to the regional average. There are 19 cancer centres in government and 15 in private sector. There are 70 radiotherapy equipment in the country. There are challenges with policy guidance, resource mobilization, weak referral system among others. The opportunities include upcoming health infrastructure including cancer centres and piloting of population-based cancer registries (PBCR).

The health flagship program in **Bhutan** carried out a nationwide screening of cervical, stomach and breast cancer from 2020 to 2023. At present the programme components are being integrated into routine health care. The country faces the challenge of lack of expertise to treat cancers with most of the cancer cases being referred outside the country for treatment. National cancer control program is relatively new in the ministry and there is now an upcoming plan to introduce screening for head and neck cancers which offers good opportunity. Strong political commitment has greatly facilitated strengthening services for cancer.

In **India**, the National program for noncommunicable diseases (NP-NCD) is the overall guiding document for activities on cancer control. Cancers of cervix, breast and oral cavity are screened at primary healthcare level. Cancer services are provided through 29 state cancer institutes, national cancer institutes and eight cancer centres functioning as grant-in-aid under department of atomic energy agency. Radiotherapy equipment availability is 0.6 per million population. Challenges include non-uniform availability of services across the country and shortage of skilled health professionals in addition to financial constraints on treatment.

**Indonesia** has prioritized breast cancer, cervical cancer, lung cancer, colorectal cancer, and childhood cancer. HPV DNA based screening for cervical cancer has been introduced as pilot project in Jakarta. Cancer services are provided through the 13 national referral hospitals with comprehensive cancer services, 18 provincial hospitals with cancer centres, and 42 mid-level hospitals in districts. Absence of national cancer control plan and uneven distribution of facilities is a challenge. The health transformation plan is a comprehensive plan that offers good opportunities for expanding cancer services including UHC.

**Maldives** provides cancer services via two main cancer centres in public sector in capital city and some private sector facilities. Complete information on cancer is not available since population-based cancer registry is not well established. Unavailability of trained experts and equipment poses challenges. The government has plans for establishing a cancer hospital in the country in near future. In the current
situation, use of telemedicine technologies, and visiting specialists are considered to be important in availing services for cancer.

WHO country office staff shared the information that the Myanmar National Cancer Control Strategic Action Plan was revised in 2023. Cancer services are provided in the public sector in the country via four hospitals for adult patients and two hospitals for children. There are two centres under military administration. Some chemotherapy services are also provided in 17 sites in the states. Cancer screening is included as part of PEN package services covering cervical, breast, and oral cancers delivered through the primary health care. Childhood cancer satellite centre network provides opportunity for delivery of part of treatment at facilities close to patient’s home. The Nay Pyi Taw PBCR provides information on cancer burden in central Myanmar. Limitation with fund availability and human resources is the major challenges in scaling up services for cancer.

Nepal is in near final stage of formulating national strategy for cancer control and national palliative care strategy. Cancer ranks as the third leading cause of death in Nepal. Cervical cancer screening with HPV DNA based tests have been started in 14 municipalities. HPV vaccine roll out is being planned with support from GAVI. There are seven cancer treatment centres in public sector. There is need for revision in existing cancer treatment protocol and developing those for newer cancers. Resource constrains including skilled professionals and inadequate financial protection are posing significant challenges.

In Sri Lanka, incidence, and mortality due to cancer is increasing steadily. Screening programs implemented through routine health services include that for breast, cervical and oral cancers with services being provided through the Well Women Clinic Program, Cancer Early Detection Centres, Healthy Lifestyle Centres and Dental Clinics. In the public sector there is one national cancer treatment centre, eight provincial cancer treatment centres, and fifteen district cancer treatment centres. Colombo district PBCR provides data to CI5 database. Access to good quality radiation therapy services in a timely manner is a challenge. Relatively uniform distribution of public sector health facilities across the country provides good opportunity for scaling up services.
In **Thailand**, the incidence of cancer has not changed so much in last two decades, however the mortality rate is increasing. Liver and bile duct cancer remains a major cause of mortality. Cervical cancer screening program has screened over 21 million women since 2005. Screening is currently done with HPV DNA based test. Screening for colorectal cancer among general population and breast cancer among first degree relatives are also included in national screening program in the public sector. Comprehensive cancer services are provided via the national cancer institute and seven regional cancer centres. 'Cancer Anywhere' is an initiative started in 2021 which allows patients under universal health coverage to access treatment from any of the hospital providing cancer care, thus minimizing delay. Palliative care is provided in the community via village health volunteers and municipality medical centres. Advanced stage at diagnosis of some cancers poses challenges. There are opportunities in introducing genetic testing, AI assisted screening technologies, and extension of services included within universal coverage among others.

In **Timor-Leste** cervical cancer screening and treatment services are available in the national referral hospital and the five regional hospitals. PEN package for NCD is implemented in primary health care across the country that includes screening of Breast oral and cervical cancers. Histopathology service is currently limited to the national hospital and requires strengthening. Many of the cancer cases are referred outside the country on state expenditure for treatment. Cancer registry is being established with support from WHO and IARC regional hub. Lack of expertise on diagnostic and treatment is the most significant challenge.
The objectives of this session were to present the draft WHO South-East Asia Regional Strategy for Comprehensive Cancer Prevention and Management 2024-2030 and obtain inputs from country delegates as well as to discuss on the approach towards adaptation of the strategy into national plans.

The draft WHO South-East Asia Regional Strategy for Comprehensive Cancer Prevention and Management 2024-2030 was presented by Dr. Nalika Gunawardena, Regional Adviser for Noncommunicable Diseases as WHO SEARO. The strategy has proposed the following broad strategic priorities:

**Strategic priority 1:** Formulate national cancer control plans with strong governance and accountability

**Strategic priority 2:** Strengthen effective cancer prevention policies and programmes

**Strategic priority 3:** Prioritize, and implement early diagnosis and screening with appropriate resources

**Strategic priority 4:** Scale-up capacity to implement cancer management with quality improvement

**Strategic priority 5:** Improve access to supportive, survivorship and palliative care

**Strategic priority 6:** Assess the burden, monitor trends and outcomes of cancer

**Strategic priority 7:** Partner with communities, civil society, and other stakeholders

Following introduction of the strategy, various partners agencies and experts made the deliberations on the considerations and approach to adapt the strategy components into national context. This included Dr Pramesh CS from Tata Memorial Hospital, Mumbai, Dr. Igor Veljkovikj from IAEA, Dr Catherine Lam from St. Jude Children’s Research Hospital, Dr Roberta Ortiz from WHO headquarters, and Dr Soehartati Gondhowiardjo from Cipto Hospital, Jakarta.

Considering the need for high resources for comprehensive cancer prevention and management, countries need to prioritize and address the gaps in phases. The priorities need to be based on disease burden, the gaps on human resource and infrastructure, interventions at hand and their expected impact, cost effectiveness, equity and acceptability among others. Prioritization needs to happen at various levels from broader programs till disease specific interventions. Value for money is to be considered while choosing interventions, this takes into
consideration the diseases as well as the technologies. Engaging all stakeholders is important when priorities are defined.

National plans on cancer should be based on evidence relevant to the country context. The integrated mission of program of action for cancer therapy (imPACT) review is a unique assessment tool implemented jointly by the IAEA, WHO, IARC, and other relevant partners that support countries’ cancer control capacities and needs and identify priority interventions. Some other tools that are helpful guide in setting priorities include the WHO report on cancer (2020) and Disease control priorities (third edition).

Strong governance mechanism and accountability is important to coordinate the implementation of national cancer control plans. It has been seen that very small portion of national plans have an implementation plan and even lesser have monitored the plan. Good governance will ensure that the plans are implemented in a comprehensive manner relevant to local context and coherent to other national strategies and priorities. This will ensure that a systems level thinking is in effect instead of activities in isolation. A defined governance mechanism can also link cancer control or leverage on preexisting legislative and regulatory provisions. St. Jude Children’s Research Hospital has developed tools to support developing of national plans and offers support when requested.

Childhood cancer represents a great health inequity between the high- and low-income countries with the survival rates as much as four times higher in HIC than in LICs and LMICs thus it merits special consideration in national cancer control plans. More than 20 countries across the six WHO regions have included childhood cancer into their NCCPs. More than ten countries including Peru, Philippines, and Argentina have formulated legislations for ensuring equitable access to quality childhood cancer services while others have addressed childhood cancer into UHC. Through collaboration with St. Jude, countries engaged in GICC are receiving support for capacity building on integrating children, adolescent, and young adults into national cancer control plans. WHO has developed the CureAll Framework to provide technical support to countries in implementing childhood cancer interventions.
Radiation therapy is required in the treatment of approximately fifty percent of the patients with cancers. In the South-East Asia region, the number of radiation therapy equipment is much less than the estimated requirement. It has been well established that investment in radiation therapy provides significant economic gains including human capital and productivity. Radiotherapy has to be an essential component of national cancer control plans. A careful planning along with legal and regulatory framework is essential while establishing Radiation medicine facilities. Human resource training is a critical requirement and quality assurance measures have to be in place while delivering services on radiation medicine. Scaling up services short, medium and long-term strategies and there are tools in place to support this.

The session included a country group work where the teams discussed the strategy for any technical inputs or points relevant to the national context. Written submissions were provided from all country groups on the suggested edits to the strategy.
On second day (15th May) the sessions focused on ensuring sustainable resources and quality in cancer care and priorities on screening of cancers. The second half of the day involved visits to selected cancer centres within the Kathmandu valley.

**Resourcing NCCP and ensuring quality of care**

Dr. Ajay Aggarwal, Professor of cancer services and systems research at London school of hygiene and tropical medicine shared that in LMICs healthcare spending remains relatively steady at about 2 percent of GDP. A Lancet paper in 2016 (Mahiben Maruthappu et al) showed that countries without UHC coverage for cancer have had more cancer mortalities than countries without such provision at the times of economic recession. In a longitudinal study by the ACTION study group it was seen that in South-East Asia upto 48% people face catastrophic health expenditure following treatment for cancer only about 23% complete treatment without financial catastrophe. It is also seen that about 50% of the expenditure on cancer is going on technologies, and only 2% of developmental assistance is going into NCDs (Reddy et al 2020, BMJ Global health). Thus, there is need for determining new funding sources and evaluate strategies to increase health sector spending. Some approaches to increase fiscal space include taking advantage of increased GDP where it exists, reprioritization of government budget, health sector specific resources such as sugar tax, external resources etc. Voluntary solidarity levy, contributions on retail goods, advanced market commitment, private investment funding are some of the innovative financing instruments seen to work in specific scenarios.
To maximize the value of investments there should be development of evidence informed package of essential services of high value for cancer and reducing waste go a long way. Health technology assessment allows for evidence informed package of services considering the cost benefit. Pooled procurement has massively reduced the price of the pilot drugs for the institutes in the national cancer grid of India.

Setting the case for cancer care by investment case is important to show the economic benefit of investment. For eg. every dollar spent on radiotherapy for cervical cancer will have a return of fourteen dollars.

Investment on health and on UHC should go parallelly with improvement in quality. Quality management improves productivity within existing resources. Indicators need to be developed for measuring the quality that are measurable, actionable, and improvable. There are recommendations on set of indicators for different tiers of cancer centers available in the literature. These indicators need to be contextualized to individual countries.
The objective of this session was to share experiences of implementing population-based cancer screening as part of mainstream service delivery and implementing screening as a campaign approach, and to identify the priority diseases and the appropriate approaches for screening of common cancers. Experiences of implementing the health flagship program of Bhutan and that of screening through routine healthcare systems in Thailand was discussed. This was followed by a presentation on use of digital technologies in screening and on priorities on screening.

Ms. Yangdon from Ministry of Health Bhutan shared that the country conducted the health flagship project with aim of screening three of the high burden cancers for the country viz. gastric, cervical, and breast cancer in the years 2020 - 2023. A national guideline defined the target group, the screening technique, the management of screening positives, and roles of various levels of healthcare. The entire project was coordinated by a project steering committee led by the minister of health. There was introduction of newer technologies at various levels of health facilities as required by the guideline. The project was able to achieve the target in all the three cancers and the screen positives were managed appropriately. The country is now planning to integrate these services into routine health care through post flagship action plan.

Dr Danai Manorom from National Cancer Institute Thailand presented on the country’s cervical cancer screening program. Cervical cancer screening started in Thailand in 1999 and national program was established in 2005. HPV DNA based testing was introduced in 2020, self-sampling has been introduced in 2023. Women of age 30-60 years are screened either by pap smear or HPV DNA based tests. Samples are collected in the health promotion hospitals and community hospitals and sample is transported to a centralized facility for testing. The reports are shared back to the institute that collected the specimen. Those with positive tests are referred to provincial hospital for colposcopy. Unique identifiers are used to keep record of women taking screening services. In the first five years of the national screening program, Thailand has screened over 75% of targeted population in the last four years.
Dr Cherian Varghese highlighted that Implementing screening programs is resource intensive and may cause harm if not implemented with good quality. Selecting disease to screen is the most important aspect, very few cancers are fit for population-based screening, and in countries with resource limitations even lesser may merit inclusion. Maturity of health system is the important determinant of disease selection and the screening approach. Cervical cancer is the only disease that is recommended for population-based screening for countries at all stages of development. For other high burden cancers in resource limited settings, approaches to early diagnosis may be more appropriate than screening.

Dr. Karthik Adapa, Regional Adviser for Digital Health at WHO SEARO shared the experience of developing, implementing and evaluating digital tool augmented by Artificial intelligence to screen breast cancer in Punjab State in India. Evidence-based digital health technologies can greatly facilitate screening programs by eliminating some of the barriers, reducing potential adverse effects, improving efficiency in referral and data management as well as patient tracking among other things. Digital technologies including Artificial intelligence and Machine learning developed using rigorous methodologies should undergo evaluation using robust clinical trials as for any other health technology products. These upcoming technologies for screening various cancers have shown promising results that are comparable to conventional screening methods.
Observational visit to cancer centres in Kathmandu

Observational visits to cancer centres within Kathmandu valley was organized to provide the participants with an opportunity to observe the typical settings for delivery of cancer care services. The participants were divided into four groups that visited the following hospitals, respectively:

**Bhaktapur Cancer Hospital, Bhaktapur:** The participants observed the resource requirement and operation of typical dedicated cancer centre in LMIC setting. The hospital, started by a civil society organization, has recently been taken up by the government and demonstrates an example of optimal utilization of the available resources.

**Bir Hospital, Mahabouddha:** Participants observed organization of cancer services in a tertiary care general hospital in LMIC setting. The hospital, oldest in the country, serves to all strata of population, especially the ones in lower socio-economic status. The hospital provides services at very low-cost, and with further subsidies to those not capable of affording the services.
Kanti Children's Hospital: Participants observed delivery of childhood cancer services and coordination of shared care. This hospital was the first one to start childhood cancer services in the country and in the recent years, it has shown notable progress in terms of standardizing treatment, quality improvement, and implementing shared care.

Patan Academy of Health Sciences, Lalitpur: Participants observed the services on palliative care and childhood cancer. This hospital is unique in the sense that although it is a public institution, it isn’t managed directly by the government. The hospital is pioneer in the country in establishing palliative care services and the academic programs. Childhood cancer services was started three years ago, but the progress has been remarkable, with 64 new cases being treated every year and the institute leading some works on childhood cancer at national level.
The third day (16th May) was focused on the South-East Asia Cancer Grid established on the foundation of experiences from the National cancer grid of India and the South-East Asia Childhood Cancer Network. There was a brief session on Liver cancers. The second half of the day had parallel group sessions on management of cancers with two broader groups, the first one on childhood cancers and second broader group on management of cancers among adults with oral, breast and cervical cancer as tracers.

South-East Asia Cancer Grid (SEACanGrid)

South-East Asia Cancer Grid has been established based on the experiences from the National Cancer Grid (NCG) India and the South-East Asia Regional Childhood Cancer Network. These networks have emerged in the backdrop of service provider institutions with limitations yet with unique strengths. The challenges in the countries are unique and collaboration among institutes is a way to technical capacity building.

Dr Pramesh CS, the convener of the National Cancer Grid, India shared that currently includes close to 300 institutions including the prominent cancer hospitals with large patient load. Some the activities that have been very effectively established through the cancer grid include Uniform standards of cancer care that are resource stratified and contextualized has been one major achievement of the grid, that has been adopted by the national health benefit package for supporting cancer treatment. The grid has worked on a guide on adaptive health technology assessment to support the institutions in deciding priorities. Quality improvement programs across cancer care services are implemented across institutions. Virtual tumour board have been very effectively utilized in planning treatment of complex cases. Pooled procurement of medicines has demonstrated a massive reduction in the selected pilot medicines. The grid also coordinates multicentric collaborative research and promotes the research capacity building including the CReDO research methodology training. Lately the grid has been endowed with the responsibility of framing the national cancer policy. The South-East Asia
Childhood Cancer Network has shown the network approach works in cross country context as well. The virtual tumour board is being effectively utilized by institutions from all countries in the region. Virtual trainings and pathology external quality assurance systems have been implemented by the network. Horizional collaborations are emerging between member institutions.

Dr. Bishnu Rath Giri, Technical Officer (Cancer Control) at WHO SERAO shared that building on the experiences from National Cancer Grid, India and the South-East Asia Childhood Cancer Network, WHO has established the South-East Asia Cancer Grid (SEACanGrid) in 2023 as a platform to foster collaboration and catalyse the efforts of countries in providing good quality cancer care to their populations. SEACanGrid is constituted by key institutions providing cancer services in the countries as members upon nomination by the ministries of health. The WHO Collaborating Centre - Tata Memorial Hospital, Mumbai – and the National Cancer Grid, India remains the technical collaborator for SECanGrid. SEACanGrid aims to leverage the unique strengths of each of its individual member institution to support in building capacity of another fellow institution in the same or a different country. Each individual member is also expected to lead in scaling up cancer services in the geographic area that it represents. The areas of work will involve establishing uniform standards and resource adapted regimens for care, workforce capacity building, contributing to direct patient care, and driving policy changes among other things.

In the interactive discussion session that followed, the participants in the workshop have suggested the priorities that SEACanGrid should be focusing on in the initial years of operation. The most common suggestions include human capacity building, cancer registry strengthening, virtual tumour board, teleradiology and telepathology services for patient care, support national treatment guidelines, developing and availing more online resources, creating a portal of available resources, and supporting national strategy development.

Ms. Andini Handayani from St. Jude Children’s Research hospital emphasized that partnerships are crucial to establishing and expanding services for cancer. They can provide not only the financial means but also the technological means and expertise required. St Jude children’s research hospital provides immense number of resources and support for scaling up childhood cancer services. They include regional tumour boards, resource stratified guidelines, palliative care capacity building and research, national cancer control planning, childhood cancer registry and many more. Similarly, Dr. Igor Veljkovikj from the International Atomic energy agency shared that the agency supports member states in assessing the cancer situation and recommends priorities through the imPACT reviews. It also supports in strengthening radiation medicine infrastructure and developing expertise. The rays of hope initiative is initiated to support institutions through the anchor centres that are capable of leading radiation medicine in the country or region. Ms. Genessa Giorgi from the US Department of Health and Human Services shared that the United States government has started cancer moonshot initiative, that also provide ample opportunities for partnerships.
Liver cancer – an emerging problem

Dr Polin Chan, Regional Adviser for HIV, Hepatitis and STIs at WHO SEARO, and Dr Joanna Kasznia-Brown from University of Bristol, UK presented on the session on liver cancer. The objective of this session was to sensitize to the fact that Liver cancer burden is rising in the SE Asia Region. It is now one of the top five causes of cancer deaths overall, and the second most common among men. The vast majority of liver cancers are attributable to hepatitis B and Hepatitis C infections.

The mortality to incidence ratio for liver cancers stands at over 95% for the region thus prevention strategies are crucial. Effective HBV vaccination coverage and provision of treatment of chronic hepatitis need to be ensured in order to reduce the burden of liver cancer.

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[Image of Dr Polin Chan and Dr Joanna Kasznia-Brown presenting]
Scaling up management of cancers

Childhood cancer: a low hanging fruit among cancers

Childhood cancer represents one of the profound inequities in health care in which survival of more that eighty percent is being achieved in the high-income countries whereas it is less than thirty percent in the low- and middle-income countries. To address this, the WHO alongside partners including St. Jude Children’s Research Hospital have launched the Global Initiative for childhood cancer (GICC) with aim of achieving at least 60% survival and reduce suffering for all children with cancer by 2030.

GICC has developed the CureAll framework consisting of four pillars and three enablers to guide the implementation of priority childhood cancer interventions in the countries. The framework also has ten categories of core CureAll projects that would help the required increase of near doubling the survival for six common cancers in children by 2030. Childhood cancers are generally not preventable. However, in most cases, they are curable with inexpensive generic medicines, thus making childhood cancer a low hanging fruit in cancer control. The core CureAll projects are accordingly focused on ensuring early detection and quality treatment.

In the three focus countries in the region the factors that have enabled implementation of GICC include the existence of policy framework specific to childhood cancer, multisectoral involvement in decision making, resource mobilization and partnerships, and generation of political will. Quality improvement works, uniform treatment guidelines, shared care networks, support for continuation of treatment during crisis, and childhood cancer registration are some notable areas of progress. The South-East Asia Regional Childhood Cancer Network has demonstrated the feasibility and value of cross-country collaborations and has facilitated horizontal collaborations. Political and economic situations have
dampened the effective implementation of initiatives in some countries, and unavailability of adequate human resources has been a significant challenge.

The momentum gained in childhood cancer should be further accelerated by addressing the challenges coupled with efforts on early detection and financial protection. Some of the experiences and gains in childhood cancer can serve as pathfinders for general cancer control.

**Strengthening management services for cancer – breast, cervix, and oral cancer as tracers**

*Establishing mechanisms for early detection and referral*

Early detection can be achieved by screening or by early diagnosis among symptomatic populations. We need to take into consideration the level of awareness in the population, availability of health workforce, potential for community and stakeholders’ engagement, and most importantly the cascade of care and the mechanism to follow-up the individuals subjected to early detection efforts. Screening requires the reach to a large population for detection of the diseases. When resources are limited strengthening early diagnosis is the priority, since it results in more lives saved with less investment of resources. For most of the cancers other than cervical cancers, an opportunistic screening or early diagnosis would be the preferred approach in most of the countries.

Outcome of group discussion: Task shifting can be an effective way to ensure early diagnosis, but it has to be coupled with quality control measures. Community engagement, digital technologies for tracking of individuals, SOPs and phased expansion are other potential enablers. Information management has to be robust, and proper process and outcome indicators have to be implemented in programs for early detection of cancers. Well defined referral mechanism and facilities for treatment of the ones with diagnosis including financial protection must be ensured.
**Strengthening diagnostic capacity**

Availability of trained staff and equipment is the major challenge in scaling up diagnostic capacity. This holds true for diagnostic radiology, pathology and other diagnostic disciplines. Information management is another challenge. Access to diagnostic services is limited in LMICs and it is not uniform even within the same country.

Outcome of group discussion: Priority actions to ensure access to diagnostic services include trainings to develop expertise, availing adequate equipment and consumables based on needs, and maximizing the utilization of the available ones. Standardizing protocols for diagnosis is important to ensure quality and efficiency. Closer cooperation between centres within same country or city can facilitate effective utilization of resources. Establishing facilities for teleradiology and telepathology are options to improve access to expertise for diagnosis. SEACanGrid can play a role in strengthening diagnostic capacity in the countries.

**Strengthening Treatment services**

Treatment of cancers is complex and generally requires multiple specialties and sophisticated equipment. There is requirement of huge capital investment hence when scaling up treatment services for cancers the priority should be on those with high value for money. Investment in human resources can take up up to two-thirds of total investment in cancer control and a significant portion of this is for availing human resource for treatment.
Outcome of group discussion: Developing expertise is fundamental need for establishing and scaling up services for cancer. Equal attention needs to be given in developing skilled human resource in oncology nursing, Radiotherapy technicians and other midlevel expertise. Standardizing treatment regimens and having uniformity across centres within the country is critical to ensure quality of care and auditing. Having measure for financial protection for treatment is crucial to ensure access to treatment.
On the fourth day (17th May) there was a dedicated session on strengthening cancer registration which was followed by country exercise on developing pathway for scaling up services for cancer.

**Strengthening cancer registries in South-East Asia Region**

Dr Atul Budukh from IARC Regional Hub at Centre for Cancer Epidemiology, TMC Mumbai highlighted that cancer registry should be integral part of cancer control programmes. Nine of the countries in the South-East Asia Region have population-based cancer registries. Registries from Bhutan, India, Nepal, Sri Lanka, and Thailand are regularly publishing the reports, others are working on improving the quality of data. Bhutan registry covers the entire population of the country. In Sri Lanka, PBCR Colombo is preparing to submit its data to CI5. Twenty-four PBCRs from India and Five from Thailand regularly provide data to CI5.

Dr Catherine Lam shared that St. Jude Children’s Research Hospital and IARC have launched ChildGICR (targeting childhood cancer through the global initiative of cancer registry development). This initiative attempts to improve the quality and availability of data on cancer in children, particularly in countries with limited resources thus complement the WHO GICC.

Leadership from the ministry, appropriate efforts on resource mobilization, support from service provider institutions and other agencies with relevant data are important enablers for a successful registry operation. Standardizing data handling and implementing quality measures is paramount in ensuring usability of the registry data.

Through the collaboration between WHO SEARO and the IARC regional hub for cancer registries, Mumbai the countries are being supported in establishing and strengthening cancer registries by means of Training, monitoring, technical support in data analysis and report publication, and data submission to CI5 among other things.
Provision of relatively stable staff for cancer registries has been a challenge in most of the countries. Rapid turnover of staff results in need for capacity building from basics, and thus compromising the quality. The existing PBCRs should carry out quality control exercise through outside experts. Funding should be ensured through sustainable resource. Registry governance is best if led by the ministry whereas the operations is best when based in large cancer hospitals and led by clinicians. There is need for expanding the coverage of PBCRs in majority of the countries. And for countries that are implementing disease specific cancer control programs with priority, the outcome should be evaluated with registry data such as stage shift, treatment completion, survival and mortality.
Country plans to scale up services for cancer management

On the final session, the country teams worked on developing country plans scaling up services for cancer in the country, till the year 2025. The facilitators and experts supported the country teams in developing the plans. This was presented to the whole group in flip charts in an interesting interaction, as a marketplace.

Bangladesh:

Bangladesh plans to form a steering committee to look after administrative and technical aspects of cancer control. The priorities include need analysis, developing national strategy, establishing uniform standards of treatment, establishing PBCR, improving diagnostic capacity, and HPV vaccination. Financial protection measures will be established through health benefit packages.

For the next two years the activities on priority include gap analysis, establishing PBCR, and strengthening early detection. The country will seek technical support from WHO, IAEA, SEACanGrid and others.

The anticipated challenges include HR shortage, equipment, and funding gap. To mitigate these, strong advocacy efforts will be undertaken to influence policy for prioritizing cancer.
Bhutan:
Bhutan will prioritize PBCR strengthening, cancer screening, and shared care for childhood cancer for the next two years.

The country plans to have one dedicated personnel for cancer registry and improve infrastructure. The second report of cancer registry will be published in a few months. Bhutan plans to work on sustaining the gains of the health flagship program by integrating screening of common cancers into routine health care. Shared care for childhood cancer will be established through the South-East Asia Childhood Cancer Network and also develop in-country shared care network.

The country plans to benefit from partnerships with institutions in SEAR-CCN and SEACanGrid.

India:
India intends to have a holistic approach to addressing cancer through whole of government and whole of society approach. The three pillars will be Cancer information management, sustained budgetary support and affordable cancer care.

Interventions on prevention will include HPV vaccination and lifestyle modifications. Screening services will be promoted by introducing reward system for referrals among other things. Human resource capacity building will be one major focus, with increase in training capacity.

Mapping of existing cancer centres will be carried out and a Hub and spoke model will be established for management of cancers. Integration will be maintained with other programs such as those for HIV and Hepatitis B.
Equipment and supplies will be made available through centralized procurement. Financial protection will be ensured through the Aayushmaan Bharat Scheme. Unique ID is already in place, and this will be utilized for information management and longitudinal follow-up.

**Indonesia:**
Indonesia plans to develop a comprehensive national cancer control plan by 2025. The priorities in the plan will be on governance – with a defined entity ensuring implementation. Other areas of priority are tobacco free initiatives, cancer registry, and palliative care with focus in PHC. For Universal health coverage cancers among women and childhood cancer will be the priorities.

The country will mobilize multisectoral engagement including partners and beyond health collaboration including CSOs, communities and charities.

Ensuring sustained political will is going to be one major effort from various sectors.

**Maldives:**
Maldives plans to strengthen screening programs for cancer by developing national screening guidelines and integrating them into routine health systems. Referral pathways will be clearly identified.

Diagnostic services will be provided via public private partnership. Multidisciplinary tumour boards will be established, telemedicine services will be utilized, and all atoll hospitals will be enabled to provide select chemotherapy services. The guidelines for seven cancers being developed currently will be completed.

The PBCR being built on DHIS 2 platform will be completed. The policy intervention will include that for adequate resource allocation.

**Myanmar:**
For Myanmar, the priority for cancer control includes cervical cancer, breast cancer and childhood cancer. The NCCP is within period of validity and provides clear guidance on scaling up services.

Myanmar plans to implement screening for cervical and breast cancer and intends to obtain technical support in guidelines development. It also expects continuation of technical support in sustaining the PBCR.
The country intends to develop essential medicine list and guidelines for common cancers, and to build capacity of the workforce and expects support from SEACanGrid and IAEA among others.

**Nepal:**
Nepal plans to increase the coverage of PBCR to 35% in the next two years, from the current 20%. For these four major cancer centres in various provinces will be utilized to lead the initiative. MoHP will have the ownership, and partnerships will be utilized for capacity building and resource mobilization.

The country plans to achieve 30% vaccination among the target age group (9-14 years of age girls) by 2025. HPV vaccination would be included in the national immunization plan. Support would be sought from GAVI for funding the vaccine supply.

The country plans to increase the number of shared care centres to eight from the current five. The initiative would be led by one of the comprehensive cancer centres and the shared care center would be established in some of the provincial level hospitals. MoHP funds will be utilized, and the technical leadership is available within the country.

**Sri Lanka:**
Sri Lanka has a national strategic plan for cervical cancer elimination valid till 2030. The team developed the plan for implementing the interventions in the next two years. At the moment the country has already achieved the target of >90% coverage of HPV vaccination. The coverage of screening is at below 50% and treatment coverage hasn’t been estimated. The country plans to have a working group with representation from multiple sectors and expertise. Screening efforts will be maximized via well women clinics with focus on high-risk group and utilizing opportunistic screening from gynaecology clinics. Information management system will be strengthened parallely. This will help increase the screening coverage to about 60%.

Baseline treatment coverage will be assessed by situation assessment, linkage will be established with cancer registry. Capacity building efforts will be undertaken to increase the treatment of precancerous lesions. Maximum efficiency will be ensured in use of radiation therapy including brachytherapy for treatment. The target will be to increase treatment coverage by more than 50% of the baseline. Palliative care will be strengthened under coordination of a dedicated program within MoH.

The country will utilize SEACanGrid platform for supporting implementing its plan, and it will also contribute to SEACanGrid by sharing best practices, among other things.
**Thailand:**
Thailand is now drafting the next version of NCCP that will cover the spectrum of cancer care continuum from primary prevention to palliative care as well as cancer informatics and research. There will be multisectoral collaboration involving the government, civil society and the private sector. NCCP will be presented for endorsement by the cabinet, which makes it legally binding. National cancer committee will develop the service plan. Thailand has also established cancer warrior committee to focus the efforts on the six most common cancers in Thailand.

The cancer information system integrates all data from diagnosis till treatment completion. The data will be used to inform future policy decisions. Thailand plans to expand HPV DNA based screening of and self-sampling in the next year.

The required resources for implementing the NCCP will be utilized internally. Thailand is willing to contribute to SEACanGrid on relevant areas.

**Timor Leste:**
Timor Leste plans to strengthen the national cancer registry in the next two years. Coordination within the Hospital Nacional Guido Valadares and with other hospitals and stakeholders will be improved. Support will be sought from WHO and IARC.

Advocacy efforts will be intensified to prioritize cervical and breast cancer in policies. HPV vaccination has been launched; efforts will be made to increase coverage. Early detection programs for breast and cervical cancer will be extended to regional level hospitals and below.

One major area of focus will be on capacity building on pathology, medical oncology and Radiotherapy. The country plans to utilize SEACanGrid for this aspect.
Core outcome themes and the next steps
The number of cancer cases in all the countries in the WHO South-East Asia Region is expected to rise because of the change in population demographics. The efforts on prevention of risk factors including tobacco control and HPV immunization have been effectively implemented. However, there are gaps in the fronts of cancer management - from screening to early diagnosis, referral, comprehensive treatment, and palliative care.

When faced with resource constrains, prioritization must be done to address the diseases and interventions with high value for the investment. Prioritization should be based on the specific disease burden, the feasibility of availing resources for the intervention or management of the disease under consideration and the relative gain in terms of life years and disability adjusted life years are some of the factors to consider while prioritizing. Tools are available to help the prioritization exercise.

Cervical cancer screening is recommended to be implemented in population-based approach in all countries. Where screening coverage is low, it may be good to consider expanding opportunistic screening in health facilities or targeting specific group of populations and then gradually scaling up in phases. For other cancers, the decision to adopt a population-based approach should be based on country specific disease burden, availability of resources and the priority needs. If screening programs are not implemented with good quality, they could cause more harm.

Where resources are limited, investing in early diagnosis provides more gains compared to investing in screening. Strong referral networks and availability of treatment facility should be ensured when interventions for early detection are planned.

Significant gaps exist in access to comprehensive cancer management including tests for staging and risk stratification, chemotherapy, surgery, radiation, and newer therapeutic modalities. Priority should be given in strengthening treatment services for diseases with relatively good outcome with
low-cost generic medicines and interventions such as childhood cancer. Comprehensive cancer centres can initially be established in urban and high population density areas. When resources are adequate the number of cancer centres need to be increased to ensure equitable access. Tools and resources are available in choosing the high value interventions in diagnostics and treatment services.

Palliative care services have to be strengthened in all levels of health care facilities with focus on delivering palliative care through primary health care. Mental health care needs of the patient and families have to be part of scaling up treatment services.

Human resource development is the most vital area when considering establishing or scaling up services for cancer. This should include multidisciplinary expertise as well as nursing, radiation technologists, laboratory personnel among others. Major portion of the investment on cancer services may be used for availing human resources. Investing in state-of-the-art equipment with no or suboptimal investment in availing the required human resource is an improper use of resources.

Collaboration among service providers helps amplify the efforts on scaling up services for cancer. This has been demonstrated in some of the national and cross-country network of practices on cancer. Building on these, the South-East Asia Cancer Grid has been established, with aim of facilitating collaboration in technical capacity building. Governments and cancer service provider institutions need to utilize the platform and contribute to it as appropriate.

Cancer has to be prioritized in national policies and resources allocation within the health budget has to be increased. Innovative approaches can be introduced to increase the fiscal space for cancer include taking advantage of increasing GDP where such scenario exists, health sector specific taxes such as in sugary beverages, voluntary solidarity levy, advanced market commitment etc. Up to a half of all cancer patients face catastrophic health expenditure, hence cancer must be included in the countries’ UHC benefit packages.

There is a need to increase the coverage and quality of population-based cancer registries in the region. Issues with stability of the human resource in cancer registry has been seen as a challenge. Cancer registry development should be included as part of national cancer control plans and resources allocated.
Annexures
ANNEXURE: 1

**RD’s message for the WHO South-East Asia Regional Workshop on scaling up services for cancer and implementing South-East Asia Cancer Grid**

Dignitaries, officials from our Member States’ Ministries of Health, experts, partners, and colleagues Good morning and welcome to this Regional workshop on scaling up services for cancer and implementing the South-East Asia Cancer Grid.

We all know that cancer is a significant challenge to health, and to the overall development of countries. I am glad that today we stand committed to tackle this challenge through a united and collaborative approach.

In 2022, our South-East Asia Region reported 2.4 million new cases of cancer. This included 56,000 children. 1.5 million people died of cancer in the same year, an increase of almost 33% in the last ten years. Alarmingly, the number of new cases in our region is estimated to increase by over 70% by 2045.

Cancer control has to be addressed through a variety of means. These include reducing risk factors, preventing cancers attributable to infections, screening, early diagnosis, prompt treatment and palliative care without financial toxicity. I am very pleased that in last few years, our Member States have made notable progress in these areas.

Our region has seen the fastest decline in tobacco use, which is the risk factor responsible for a quarter of all cancers. Six countries have introduced nationwide vaccination against human papilloma virus (HPV) for the prevention of cervical cancer. Bhutan implemented the health flagship project in 2020 and screened all the target population for gastric, cervical, and breast cancer, with provision of appropriate care for those who tested positive on screening. The global initiative for childhood cancer is being implemented in ten of our countries, through a regional network of institutions. This provided improved care to over 7,500 children, last year.

Admittedly, challenges exist, particularly in the capacity to provide cancer management services. The mortality to incidence ratio for our region is almost double that of high-income countries. The ratio is more than three times when it comes to childhood cancer. Diagnostic capacities are uneven across, and within, our countries. Only nine countries have reported availability of Radiation therapy services. Cancer treatment centers are generally overburdened. Only four countries include cancer services in health benefit packages, the absence of which leads to high out of pocket expenditure.

As we can see, it is now high time to scale up services for cancer. Cancers require complex multidisciplinary care, and multisectoral involvement in strengthening care. This means scaling up services requires coordinated multi-pronged actions from government and partners.

Countries should implement national cancer control plans with strong governance and accountability. Effective prevention policies and programmes, such as tobacco control and vaccination against HPV and Hepatitis B, should be strengthened. Investment should be prioritized for strengthening early diagnosis and the timely referral of cancer patients to treatment centers.
To reduce the mortality from cancers, the capacity for management of cancers must be scaled up. This requires significant investment in human resource capacity building. The availability of medical devices, medicines and supplies should be ensured. Cancer care should be included in UHC benefit packages. Cancer information systems need to be strengthened, including establishing population-based cancer registries, as well as improving the quality and coverage of existing ones. This allows for informed policy decisions. Access to palliative care, and the care for the mental health of patients and families, should be expanded at all levels, with a focus on primary and community levels.

To effectively coordinate and guide the implementation of these priorities, there is a need for a regional strategy for comprehensive cancer prevention and management. A draft of this will be presented and discussed during the workshop. I am confident that the inputs from all of you will help improve the strategy.

One crucial need is collaboration among institutions, both within and across countries. To facilitate this, SEARO has established the WHO South-East Asia Cancer Grid (SEACanGrid), a network of tertiary care institutions. SEACanGrid will foster collaboration in technical capacity building and will be a catalyst for countries to improve their cancer services.

I am hopeful that this workshop will be instrumental in streamlining the priorities according to specific country contexts, and in developing the means to achieve them. I am also confident that this workshop will encourage countries and institutions to utilize the SEACanGrid and support fellow institutions in the grid.

On that note, I wish you all a very productive workshop and a good stay in Nepal.

Thank you

Ms. Saima Wazed
Regional Director
ANNEXURE: 2

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60. Ms Andini Handayani  
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WHO SEARO

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Healthier Populations and Noncommunicable Diseases  
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74. Dr Nalika Gunawardena  
Regional Adviser  
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75. Dr Bishnu Rath Giri  
Technical Officer- Cancer Control  
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76. Dr Polin Chan  
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77. Dr Karthik Adapa  
Regional Adviser, Digital Health  
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78. Ms. Sumedha Das  
Executive Assistant, HPN Department  
sudas@who.int
### Programme

#### Day 1: 14 May 2024, Tuesday

<table>
<thead>
<tr>
<th>Time</th>
<th>Session Details</th>
<th>Chairs/ Speakers/Moderators</th>
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<tbody>
<tr>
<td>09:00 – 10:00</td>
<td><strong>INAUGURAL SESSION:</strong> Setting the scene, scope, and purpose</td>
<td><strong>Inaugural Ceremony</strong></td>
</tr>
<tr>
<td></td>
<td>Opening remarks</td>
<td><strong>Ms. Saima Wazed</strong> Regional Director, WHO Regional office for South-East Asia</td>
</tr>
<tr>
<td></td>
<td>Ministry of Health, Nepal</td>
<td><strong>Dr. Roshan Pokhrel</strong> Secretary Ministry of Health and Population, Nepal</td>
</tr>
<tr>
<td></td>
<td>Address by collaborators</td>
<td><strong>Dr. Catherine Lam</strong> Director Health Systems Unit, St. Jude Children’s Research Hospital, USA</td>
</tr>
<tr>
<td></td>
<td>Scope and purpose of the workshop</td>
<td><strong>Dr. Pramesh CS</strong> Director, Tata Memorial Hospital, Mumbai; Convener, National Cancer Grid India</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Dr. Igor Veljkovikj</strong> Programme officer, Cancer control, International Atomic Energy Agency, Vienna</td>
</tr>
<tr>
<td></td>
<td><strong>Introduction of participants</strong></td>
<td><strong>Dr. Cherian Varghese</strong> Director a.i. Department of Healthier Populations and NCD, WHO SEARO</td>
</tr>
<tr>
<td>10:00 – 10:30</td>
<td>Group photo and tea break</td>
<td></td>
</tr>
<tr>
<td>10:30 – 12:30</td>
<td><strong>SESSION 1</strong> Where are we in cancer control?</td>
<td><strong>Chair: India and Nepal</strong></td>
</tr>
<tr>
<td>10:30-10:45</td>
<td>Current situation of cancer in the SE Asia Region: burden, trends, service availability, and regional Initiatives</td>
<td><strong>Dr. Bishnu Rath Giri</strong> Technical Officer (Cancer control), WHO SEARO</td>
</tr>
<tr>
<td>Time</td>
<td>Session Details</td>
<td>Chairs/ Speakers/Moderators</td>
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<tr>
<td>10:45-12:30</td>
<td>Country presentation on status of cancer management services, challenges, and opportunities.</td>
<td>Country teams- 5 minutes each</td>
</tr>
<tr>
<td><strong>12:30 – 13:30</strong></td>
<td>Lunch</td>
<td></td>
</tr>
<tr>
<td>13:30 – 16:30</td>
<td><strong>SESSION 2</strong>&lt;br&gt;What is the strategy to accelerate towards 2030?</td>
<td><strong>Chair:</strong> Bangladesh and Sri Lanka</td>
</tr>
<tr>
<td>13:30 – 13:45</td>
<td>DRAFT WHO South-East Asia Regional strategy for comprehensive cancer prevention and management 2024-2030</td>
<td><strong>Dr. Nalika Gunawardena</strong>&lt;br&gt;Regional Adviser, NCDs, WHO SEARO</td>
</tr>
<tr>
<td>13:45 – 14:00</td>
<td>Choosing wisely: defining priorities in cancer services</td>
<td><strong>Dr. Pramesh CS</strong></td>
</tr>
<tr>
<td>14:00 – 14:15</td>
<td>imPACT review to provide evidence to formulate National Cancer Control Plans</td>
<td><strong>Dr. Igor Veljkovikj</strong></td>
</tr>
<tr>
<td>14:00 – 14:15</td>
<td>imPACT review to provide evidence to formulate National Cancer Control Plans</td>
<td><strong>Dr. Igor Veljkovikj</strong></td>
</tr>
<tr>
<td>14:15 – 14:30</td>
<td>Formulating National Cancer Control Plans with strong governance and accountability</td>
<td><strong>Dr. Catherine Lam</strong></td>
</tr>
<tr>
<td>14:30 – 14:45</td>
<td>Prioritizing childhood cancer management services in national policies</td>
<td><strong>Dr. Roberta Ortiz</strong>&lt;br&gt;Childhood cancer focal point, WHO Headquarters</td>
</tr>
<tr>
<td>14:45 – 15:00</td>
<td>Strategizing Radiation medicine in national plans for scaling up cancer management services</td>
<td><strong>Dr. Soehartati Gondhowiardi</strong>&lt;br&gt;Head of Radiation Oncology, Cipto Mangunkusumo Hospital, Jakarta</td>
</tr>
<tr>
<td><strong>15:00 – 15:15</strong></td>
<td>Tea Break</td>
<td></td>
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<tr>
<td>15.15-16:30</td>
<td>Group work to review the draft strategy.</td>
<td>Country groups</td>
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### Day 2: 15 May 2024, Wednesday

<table>
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<tr>
<th>Time</th>
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<tbody>
<tr>
<td>09:00 – 09:15</td>
<td>Recap</td>
<td>Dr. Bishnu Rath Giri</td>
</tr>
<tr>
<td>09:15 – 10:00</td>
<td>SESSION 3 Resourcing NCCP and ensuring quality of care</td>
<td>Chair: Thailand</td>
</tr>
<tr>
<td></td>
<td>Models for sustainable financing for cancer control in LMICs</td>
<td>Prof. Ajay Aggarwal</td>
</tr>
<tr>
<td></td>
<td>Implementing a comprehensive cancer audit programme: lessons from the UK National Cancer Audit Collaborating Centre (NATCAN)</td>
<td>Consultant Clinical \ Oncologist and Professor of Cancer Services and Systems Research, London School of Hygiene and Tropical Medicine, UK</td>
</tr>
<tr>
<td>10:00 – 12:00</td>
<td>Session 4 To screen or not to screen?</td>
<td>Chair: Maldives and Indonesia</td>
</tr>
<tr>
<td>10:00 – 10:15</td>
<td>The health flagship project in Bhutan – Implementing nationwide screening of high burden cancers - it is possible.</td>
<td>Ms. Yangdon \ Sr. Programme Officer, NCCD, Ministry of Health, Bhutan</td>
</tr>
<tr>
<td>10:15 – 10:30</td>
<td>Scaling up population-based screening of cancers in mainstream health services: experience of cervical cancer screening in Thailand</td>
<td>Dr. Danai Manorom \ Deputy Director, Health System Development, National cancer Institute, Thailand</td>
</tr>
<tr>
<td>10:30 – 10:45</td>
<td>Use of digital tools to aid in screening of cancers</td>
<td>Dr. Karthik Adapa \ Regional Adviser \ Digital Health, WHO SEARO</td>
</tr>
<tr>
<td>10:45 – 11:00</td>
<td>Tea Break</td>
<td></td>
</tr>
<tr>
<td>11:00 – 12:00</td>
<td>Interactive discussion: Priorities in screening and the importance of Integrating screening services into mainstream health system: Ensuring end to end coverage.</td>
<td>Dr. Cherian Varghese</td>
</tr>
<tr>
<td>12:00 – 12:10</td>
<td>Briefing on visit to cancer centers in Kathmandu</td>
<td>Dr. Suman Panthi \ Medical Officer, WHO Nepal</td>
</tr>
<tr>
<td>12:10 – 13:00</td>
<td>Lunch Break</td>
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<tr>
<td>13.00 - 17.00</td>
<td>Session 5 Observational visit to cancer centers in Kathmandu</td>
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<td>Bhaktapur Cancer Hospital, Bhaktapur</td>
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<td>Bir Hospital, Mahabouddha</td>
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<td>Kanti children's hospital, Maharajgunj</td>
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<td></td>
<td>Patan Academy of Health Sciences, Lalitpur</td>
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### Day 3: 16 May 2024, Thursday

<table>
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<tr>
<th>Time</th>
<th>Session Details</th>
<th>Chairs/ Speakers/Moderators</th>
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</thead>
<tbody>
<tr>
<td>09:00 – 09:30</td>
<td>Recap</td>
<td>Hospital visits’ team representatives – 5 min each.</td>
</tr>
<tr>
<td>09:30 – 11:30</td>
<td>SESSION 6</td>
<td>Chair: Thailand</td>
</tr>
<tr>
<td>09:30 – 09:40</td>
<td>South-East Asia Cancer Grid – An overview</td>
<td>Dr. Bishnu Rath Giri</td>
</tr>
<tr>
<td>09:40 – 10:10</td>
<td>Learnings from implementing the National Cancer Grid of India</td>
<td>Dr. Pramesh CS Convener, National Cancer Grid, India</td>
</tr>
<tr>
<td>10:10 – 10:20</td>
<td>Learnings from implementing the South-East Asia Childhood Cancer network</td>
<td>Dr. Bishnu Rath Giri</td>
</tr>
<tr>
<td>10:20 – 11:30</td>
<td>Group work: South-East Asia Cancer Grid - a collaborative platform for capacity building to scale up cancer services</td>
<td>Dr. Pramesh CS</td>
</tr>
<tr>
<td>11:30 – 11:45</td>
<td>Tea Break</td>
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<tr>
<td>11:45 – 12:00</td>
<td>Partnerships for improving services for cancer</td>
<td>Ms. Andini Handayani Program Manager, Asia Pacific Regional Program, St. Jude Children’s Research Hospital, USA</td>
</tr>
<tr>
<td>12:00 – 12:10</td>
<td>IAEA support for cancer services in countries</td>
<td>Dr. Igor Veljkovikj</td>
</tr>
<tr>
<td>12:10 – 12:30</td>
<td>SESSION 7</td>
<td>Chair: Indonesia</td>
</tr>
<tr>
<td>12:10 – 12:30</td>
<td>Liver cancer: an emerging problem</td>
<td>Dr. Polin Chan Regional Adviser Hepatitis, HIV and STIs, WHO SEARO</td>
</tr>
<tr>
<td>12:30 – 13:30</td>
<td>Lunch Break</td>
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</table>
### Time: 13:30 – 15:30
#### Session Details: SESSION 8
Scaling up management of cancers

<table>
<thead>
<tr>
<th>Parallel session I</th>
<th>Chair: Bhutan and Thailand</th>
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<tbody>
<tr>
<td><strong>Childhood cancer – a low hanging fruit</strong></td>
<td><strong>Cure All Pillars and enablers:</strong> Dr. Catherine Lam</td>
</tr>
<tr>
<td>Setting the scene:</td>
<td>Country examples: Myanmar, Nepal, Sri Lanka</td>
</tr>
<tr>
<td>CureAll Pillars and Enablers – 9 min</td>
<td>Pathfinder: Dr. Sanjeeva Gunasekera</td>
</tr>
<tr>
<td>Country examples from focus countries – 21 min</td>
<td>Consultant Pediatric Oncologist</td>
</tr>
<tr>
<td>Childhood cancer as pathfinder: prep for group discussion – 5 min</td>
<td>National Cancer Institute, Sri Lanka</td>
</tr>
<tr>
<td>Strengthening cross country collaboration: SEAR-CCN – 10 min</td>
<td>Cross country collaboration: Dr. Bishnu Rath Giri</td>
</tr>
<tr>
<td>Group discussion: 60 min.</td>
<td></td>
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<tr>
<td><strong>Group 1:</strong> CureAll Pillars</td>
<td><strong>Group 2:</strong> CureAll Enabler</td>
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<tr>
<td><strong>Group 3:</strong> Childhood cancer as pathfinder</td>
<td><strong>Group 4:</strong> Strengthening Collaboration</td>
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### Time: 13:30 – 15:30
#### Session Details: Parallel session II
Strengthening management services for cancer: breast, cervix, and oral cancer as tracers

<table>
<thead>
<tr>
<th>Group work</th>
<th>Chair: Bangladesh and Timor Leste</th>
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<tr>
<td><strong>Group I:</strong></td>
<td><strong>Group leads:</strong></td>
</tr>
<tr>
<td>Establishing mechanisms for early detection and referral with oral cancer as tracer.</td>
<td><strong>Group I:</strong></td>
</tr>
<tr>
<td><strong>Group II:</strong></td>
<td><strong>Group II:</strong></td>
</tr>
<tr>
<td>Approach to strengthening diagnostic capacity with breast cancer as tracer.</td>
<td>Dr. Cherian Varghese</td>
</tr>
<tr>
<td><strong>Group III:</strong></td>
<td><strong>Group III:</strong></td>
</tr>
<tr>
<td>Strengthening treatment services with cervical cancer as tracer.</td>
<td>Dr. Joanna Kasznia-Brown</td>
</tr>
<tr>
<td>Group leads:</td>
<td>Sr. Consultant Radiologist, University of Bristol</td>
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<tr>
<td><strong>Group I:</strong></td>
<td><strong>Group III:</strong></td>
</tr>
<tr>
<td>Dr. Cherian Varghese</td>
<td>Dr. Soehartati Gondhowiardjo</td>
</tr>
<tr>
<td><strong>Group II:</strong></td>
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<tr>
<td>Dr. Joanna Kasznia-Brown</td>
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<tr>
<td><strong>Group III:</strong></td>
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<tr>
<td>Dr. Soehartati Gondhowiardjo</td>
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### Time: 15:30 – 15:45
#### Tea break

### Time: 15:45 – 16:30
#### Plenary session
Reporting from groups and discussion

<table>
<thead>
<tr>
<th>Plenary session</th>
<th>Chair: Maldives and India</th>
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</table>
## Day 4: 17 May 2024, Friday

<table>
<thead>
<tr>
<th>Time</th>
<th>Session Details</th>
<th>Chairs/ Speakers/Moderators</th>
</tr>
</thead>
</table>
| **Recap**     | **SESSION 9**  
Strengthening cancer registries in South-East Asia Region                         | **Mr. Pema Lethro**                                               |
| 08:30 – 09:30 | **8:30 – 8:45** Expanding population-based cancer registries in South-East Asia  | **Dr. Atul Budukh**  
Professor, Center for cancer epidemiology, TMC, Mumbai           |
|               | **8:45 – 9:00** Establishing cancer registration in Nepal: factors leading to success and the challenges ahead | **Dr. Sandhya Chapagain**  
Associate Professor, National Academy of Medical Sciences, Kathmandu |
|               | **9:00 - 9:15** Integrating cancer registry into DHIS, experience from Maldives    | **Ms. Aishath Lubana Labeeb**  
Assistant Public Health Officer, Health Protection Agency, Maldives |
|               | **9:15 – 9:30** Introducing Child GICR                                           | **Dr. Catherine Lam**                                             |
| **Session 10**| **Country plans to scale up services for cancer management**                      | **Dr. Cherian Varghese**                                          |
| 09:30 – 09:45 | **09:45- 10:00** Tea break                                                       |                                                                 |
| 10:00 – 12:00 | Developing country specific pathways to scale up services for cancer management and implement SEACanGrid | **Country groups**                                                |
| 12:00 -13 00  | **Lunch break**                                                                   |                                                                  |
| 13:00 – 14:30 | Marketplace                                                                       |                                                                  |
| **14:30 – 14:45** | **Tea break**                                                                      |                                                                  |
| 14:45 – 15:30 | Concluding remarks and next steps                                                 | **Dr. Cherian Varghese**                                          |
|               |                                                                                 | **Dr. Gampo Dorji**  
Acting WR, WHO Nepal                                                   |
ANNEXURE: 4

Participants’ Feedback

To what extent the objectives of the meeting were accomplished?

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Whether the agenda items were relevant to achieve objectives?

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Were the outcomes of the workshop relevant to the needs of your country?

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Were the working papers presented substantive to the needs of the workshop?

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Was the WHO/SEARO staff technical support adequate in achieving your expectation?

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Were the resource person’s technical support adequate in achieving the objectives?

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</thead>
</table>
Did you find an opportunity to exchange information with other participants?

Yes: 47
No: 2

Was the field trip relevant to achieve the objectives of the workshop?

Yes: 47
No: 2

Are you in a position to integrate the outcome of this workshop to the national workplan?

Yes: 33
Maybe: 15
No: 1

Conduct of the workshop

More than Satisfied: 18
Very Satisfied: 16
Satisfied: 13
Partly Satisfied: 2
Not Satisfied: 0

Workshop venue

More than Satisfied: 16
Very Satisfied: 16
Satisfied: 16
Partly Satisfied: 1
Not Satisfied: 0

Seating arrangement

More than Satisfied: 10
Very Satisfied: 12
Satisfied: 22
Partly Satisfied: 3
Not Satisfied: 2
ANNEXURE: 5

Resource Materials

2. CureAll framework: WHO global initiative for childhood cancer. World Health Organization 2021
6. Roadmap towards a National Cancer Control Programme. IAEA, WHO 2019
9. WHO position paper on mammography screening. WHO 2014
11. South-East Asia Cancer Grid (SEACanGrid). WHO Regional Office for South East Asia 2023
12. National Cancer Grid India
14. Planning and Developing Population-Based Cancer Registration in Low-and Middle-Income Settings. IARC 2014