# Equity Monitoring Tool D4.2

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Changes to this document are summarized in the following table in reverse chronological order (latest version first).

| Revision | Date | Created by | Short Description of Changes |
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| 1st revision | 03/06/2025 | Ana Molina | The number of the Equity and General Indicators of the EBCP Monitoring and Evaluation framework has been specified in page 10 following EC suggestion. |
| 2nd revision | 04/06/2024 | Ana Molina | The number of the Equity and General Indicators of the EBCP Monitoring and Evaluation framework has been corrected in page 4, 10, 12 and 14, according to the updated version of D4.1. |
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# 1 EXECUTIVE SUMMARY

Social inequalities in cancer are present both between and within countries across Europe and within the different social groups. The European governments have a vital role to play in addressing them by coordinating actions and implementing effective measures to minimize inequalities in cancer incidence, mortality and survival.

Some European Union (EU) initiatives to reduce cancer inequalities are the Policy Paper on Tackling Social Inequalities in Cancer Prevention and Control for the European Population; the Europe's Beating Cancer Plan (EBCP); and the Mission on Cancer.

To evaluate the inclusion of the equity perspective in the National Cancer Control Programmes (NCCPs) and actions of each of the European Member States, an Equity Monitoring Tool has been co-design and validated. It is made up of 2 instruments: Equity Indicators and Equity Questions.

On the one hand, a total of 5 Equity Indicators have been developed, organized into 4 themes: relevance (n=2); awareness (n=1); stakeholder engagement (n=1); and knowledge integration (n=1). These indicators have been integrated into the EBCP Monitoring and Evaluation Framework (task 4.1).

On the other hand, 25 Equity Questions have been designed and organized into 4 domains: capacity-building (n=12); primary and secondary cancer prevention (n=5); cancer treatment (n=4); and cancer survivorship, rehabilitation and palliative care (n=4). These questions have been integrated into the Survey on National Cancer Control Programmes in EU Member States (MSs) and designated countries with special focus in cancer inequalities (Task 5.1).

This Equity Monitoring Tool allows monitoring the uptake and implementation of the EBCP in EU MSs from an equity perspective and facilitates the mapping of the current state-of-play of NCCPs with a special focus on cancer inequalities.

# 2 INTRODUCTION

Europe is facing significant inequalities in access to cancer prevention and care, both within and between countries, which have a profound impact on cancer incidence, survival and mortality (1). Taking this into account, the European Union (EU) is carrying out multiple initiatives to fight cancer and reduce the current inequalities in cancer.

Social determinants of health are defined as "The social, cultural, political, economic and environmental conditions in which people are born, grow up, live, work and age, and their access to power, decision-making, money and resources" (2). These social determinants of health influence exposure to cancer risk factors, access to secondary prevention, timely diagnosis and treatment, as well as rehabilitation services, producing as a result inequalities in cancer incidence and mortality. Social inequalities in cancer refer to health inequalities spanning the full cancer continuum across the life course (3). Survival rates in Southern and Eastern European countries often fall below the European average. Moreover, geographic disparities in survival within Western and Northern European countries highlight uneven access to quality cancer care (4). Privileged groups tend to experience better outcomes due to factors such as lower exposure to risk factors, improved access to screening programmes and healthcare services, and having more resources to cope with the social and financial burdens of cancer. In contrast, disadvantaged groups across the EU face higher risks for most common cancers (5).

Given the existence of these inequalities across Europe and within the different social groups, the European governments have a vital role to play in addressing them by coordinating actions and implementing effective measures to minimize inequalities in cancer incidence, mortality and survival.

Some EU initiatives to reduce cancer inequalities are for example the *European Guide on Quality Improvement in Comprehensive Cancer Control* (6) developed in CanCon Joint Action aimed to contribute in different ways to reducing the cancer burden in the EU. One of the outcomes of CanCon Joint Action is the *Policy Paper on Tackling Social Inequalities in Cancer Prevention and Control for the European Population* (7). This policy paper is the result of a collaborative work lead by Fisabio, with the

participation of international cancer experts and patient organizations. It includes evidence-based recommendations to promote equity-oriented policies related to cancer prevention and control.

On the other hand, the EU launched the *Europe's Beating Cancer Plan* (EBCP) (8) which includes concrete and ambitious actions that will support, coordinate and complement the efforts of Member States to reduce the suffering caused by cancer, having the reduction of inequalities as a transversal pillar. Another initiative is the *Mission on Cancer* (9), which aims to prevent what is preventable, to optimise diagnosis and treatment, and to support quality of life by understanding health determinants and ensuring equitable access to cancer prevention and control programmes. Among its principles, is the commitment to ensuring equity and access to knowledge, research and care between and within countries, regions and among people of different socio-economic backgrounds, genders, and age groups.

To effectively reduce the cancer social inequalities, it is necessary to work with a proportionate universalism approach (10) which involves resourcing and delivering universal services at a scale and intensity proportionate to the degree of need. Moreover, including a Health in All Policies (HiAP) approach (11) can further contribute to reducing social inequalities in cancer. HiAP is a public policy approach that systematically takes into account the health implications of decisions, seeks synergies and avoids adverse health effects in order to improve population health and health equity. Many of the social, environmental and economic determinants of health have origins beyond the health sector and health policies. It is therefore important that the impact of inequalities on cancer is taken into account in all sectors and initiatives.

It is particularly important to transfer the efforts to reduce cancer inequalities in the EU to each Member State. In this context, to evaluate the inclusion of the equity perspective in the National Cancer Control Programmes (NCCPs) and actions of each of the EU Member States, an Equity Monitoring Tool has been co-design in the context of the Joint Action on "*Contribution to the Cancer Inequalities Registry to Monitor National Cancer Control Policies*" (OriON JA). This Equity Monitoring Tool has been

developed in the context of WP4 on "*Sustainability and implementation – support to the monitoring and analysis of the implementation of EBCP*".

# 3 OBJECTIVES

**General objective:** To develope an Equity Monitoring Tool to evaluate European MSs cancer prevention and control policies and actions from an equity approach.

**Specific objective 1:** To develop Equity Indicators to monitor EBCP uptake and implementation in EU MSs from an equity perspective.

**Specific objective 2:** To develop Equity Questions to evaluate National Cancer Control Programmes alignment with equity objectives.

# 4 METHODOLOGY

The Equity Monitoring Tool includes two instruments:

1. Equity Indicators that have been integrated into the EBCP Monitoring and Evaluation Framework developed in Task 4.1.
2. Equity Questions that have been integrated into the Survey on National Cancer Control Programmes in EU MSs and designated countries with special focus in cancer inequalities developed in Task 5.1.

The methodology used to develop both instruments is described below.

## 4.1 Equity Indicators

As part of the work developed in Task 4.1, an EBCP Monitoring and Evaluation Framework was developed (see Deliverable 4.1). The objective of this Framework is to monitor EBCP uptake and implementation in EU MSs for better identification of remaining actions and information gaps. The framework includes a set of process indicators organised into 4 themes:

- Relevance: overview on EBCP being aligned with priorities identified at the national level.
- Awareness: evaluate the degree of awareness among key actors, and capture dissemination levels of the EBCP in the MSs.
- Stakeholder engagement: assess the extent of MSs participation in various EBCP initiatives/projects.
- Knowledge integration: evaluate how deliverables and recommendations from EBCP projects are integrated into MSs health systems and across sectors/policies.

A total of 41 initial process indicators were developed (30 general and 11 equity-related), reviewed by external experts, and prioritized by a Delphi exercise (see Deliverable 4.1).

The Equity Indicators were based on the equity recommendations included in the CanCon Policy Paper on Tackling Social Inequalities in Cancer Prevention and Control (7), the EBCP (8) and the Mission on Cancer (9).

The initial Equity Indicators (n=11), together with the General Indicators (n=30), were prioritized through a Delphi process. The Delphi was conducted with stakeholders from to the JA OriON consortium. It consisted of a total of three rounds, where the importance was evaluated first, followed by feasibility, and finally a final round was held to confirm the definitive list of indicators. At the end of the process, the EBCP monitoring and evaluation framework included 5 Equity Indicators and 17 General Indicators (n=22). Details of the methodology used in this Delphi are provided in Deliverable 4.1.

### 4.2 Equity Questions

Equity Questions were developed in the context of the Task 5.1 Survey on National Cancer Control Programmes in EU MSs and designated countries with special focus in cancer inequalities. This survey has the aim of mapping the current state-of-play of NCCPs with a special focus in cancer inequalities.

The Survey was structured into three parts:

1. General information.
2. Specific information regarding the quality of NCCPs.
3. Specific information regarding the inequalities.

The Equity Questions were developed to be integrated into the Part 3 of the survey. The Equity Questions were based on the CanCon Policy Paper on Tackling Social Inequalities in Cancer Prevention and Control (7), the EBCP (8) and the Mission on Cancer (9).

A total of 25 Equity Questions were developed and organized into 4 domains:

- Capacity building: recommendations aimed at enhancing the ability of institutions, organizations, and health systems to address health equity in cancer prevention and control.
- Primary and secondary prevention: recommendations to reduce inequalities in cancer risk factors exposition and cancer screening programmes access.

- Cancer treatment: recommendations for equitable access to innovative cancer treatments, personalised medicine and telemedicine.
- Cancer survivorship, rehabilitation and palliative care: recommendations to ensure equity during the survivorship process, return to work or palliative and end-of-life care.

The Equity Questions, along with the questions included in Part 1 and Part 2 of the survey, underwent an external review process for validation in a two steps process:

- First step validation – internal (methodological) validation
- Second step validation – external validation.

For more details about the validation process please see Deliverable 5.1.

# 5 RESULTS

## 5.1 Equity Indicators

The initial Equity Indicators (n=11) organised per themes are presented below **(Table 1):**

**Table 1. Initial Equity Indicators per theme**

| | |
|---|---|
| **Relevance (n=2)** | R7. Cancer inequalities are addressed during parliamentary debates or interministerial discussions at the national or federal level (e.g., as an agenda item or parliamentary question).<br>Scale: Categorical (Yes/No); time period to be specified by EU-MS |
| | R8. Specific EBCP actions targeting cancer inequalities are included in NCCP or other strategic health documents.<br>Scale: Categorical (Yes/No) response for each sub-indicator<br>Sub-indicators:<br>a. Contribution to the Cancer Inequalities Registry<br>b. Implementation of telemedicine and remote monitoring systems<br>c. Equitable access to screening and high-quality cancer care |
| **Awareness (n=3)** | A6. Number of national or regional stakeholders mentioning the Cancer Inequalities Registry in newsletters.<br>Scale: Numerical; time period specified by EU-MS |
| | A7. Number of meetings or conferences held by stakeholders to promote the Cancer Inequalities Registry.<br>Scale: Numerical; time period specified by EU-MS |
| | A8. Number of meetings or conferences organised by stakeholders to promote the EBCP's equity objectives.<br>Scale: Numerical; time period specified by EU-MS |
| **Stakeholder engagement (n=4)** | SE9. Presence of national experts in advisory groups for the Cancer Inequalities Registry.<br>Scale: Categorical (Yes/No) |
| | SE9. Presence of national experts in advisory groups for the Cancer Inequalities Registry.<br>Scale: Categorical (Yes/No) |
| | SE10. Country participates in one or more EBCP projects related to tackling cancer inequalities, funded through action grants and operating grants (selected through open calls for proposals).<br>Scale: Numerical response for each sub-indicator; time period specified by EU-MS<br>Sub-indicators: |

| | |
|---|---|
| | a. Number of projects where the country is the coordinator<br>b. Number of projects where the country is a work package lead<br>c. Number of projects where the country participates as a pilot site<br>d. Number of projects with multidisciplinary team (including experts on social sciences, health promotion, statistics, public health, and other disciplines) |
| | SE11. Country participates in one or more EBCP projects tackling cancer inequalities, funded through direct grants to identified beneficiaries (e.g. Joint Actions).<br>Scale: Numerical for each sub-indicator; time period specified by EU-MS<br>Sub-indicators:<br>a. Number of projects where the country is the coordinator<br>b. Number of projects where the country is a work package lead<br>c. Number of projects where the country participates as a pilot site<br>d. Number of projects with multidisciplinary team (including experts on social sciences, health promotion, statistics, public health, oncologists, and other disciplines) |
| | SE12. Number of training activities organized by national or regional stakeholders focused on cancer inequalities.<br>Scale: Numerical; time period specified by EU-MS |
| **Knowledge integration (n=2)** | KI12. National or regional initiatives are in place to facilitate the exchange of good or best practices aimed at addressing social inequalities in cancer care.<br>Scale: Categorical (Yes/No) |
| | KI13. National cancer prevention and control policies, programs, or actions incorporate recommendations from EBCP projects, specifically focused on tackling cancer inequalities.<br>Scale: Categorical (Yes/No) |

As a result of the Delphi process 5 Equity Indicators were selected **(Table 2).**

**Table 2. Final Equity Indicators**

| | |
|---|---|
| **Relevance (n=2)** | R7. Cancer inequalities are addressed during parliamentary debates or interministerial discussions at the national or federal level (e.g., as an agenda item or parliamentary question).<br>R8. Specific EBCP actions targeting cancer inequalities are included in NCCP or other strategic health documents. |
| **Awareness (n=1)** | A7. Number of meetings or conferences held by stakeholders to promote the Cancer Inequalities Registry. |
| **Stakeholder engagement (n=1)** | SE10. Country participates in one or more EBCP projects related to tackling cancer inequalities, funded through action grants and operating grants (selected through open calls for proposals). |
| **Knowledge integration (n=1)** | KI13. National cancer prevention and control policies, programs, or actions incorporate recommendations from EBCP projects, specifically focused on tackling cancer inequalities. |

These Equity Indicators were integrated into the EBCP Monitoring and Evaluation Framework developed in task 4.1. These indicators evaluate whether NCCPs incorporate specific equity-related EBCP activities and objectives. They also assess whether the country addresses the topic of equity through conferences and other awareness initiatives, actively participates in EBCP projects focused on equity in cancer care and control and integrates recommendations on addressing cancer inequalities into national health strategies. The Framework is being piloted in three countries: Belgium, Italy, and Slovenia. Pilot results are under development (Task 4.3).

### 5.2 Equity Questions

A total of 25 Equity Questions **(Appendix 1)** were validated and organised into the 4 domains:

- Capacity-building (n=12)

- Primary and secondary cancer prevention (n=5)
- Cancer treatment (n=4)
- Cancer survivorship, rehabilitation and palliative care (n=4).

For each question, there are two answer options: Yes or No, but with different levels of detail. On the one hand, there are questions where professionals should specify the equity approach of the NCCP, including as an option “proportionate universalism approach”, “universal approach”, or “targeted approach”. On the other hand, they should specify the social determinants of health their NCCP are addressing (e.g. age, sex/gender, educational level, territory, disability, etc.). Finally, some questions will ask for details regarding other specific equity approaches, such as, social participation or health in all policies approach.

In each of the questions policy experts should justify their answers copying and pasting the NCCP Excerpts that support their response.

To facilitate the comprehension of each question, equity concepts have been defined in a Glossary of Terms (**Appendix 2**).

The Equity Questions were integrated into the Task 5.1 Survey on National Cancer Control Programmes in EU MSs and designated countries with special focus in cancer inequalities. The results of the survey are presented in Deliverable D5.1 Analysis of NCCPs.

# 6 CONCLUSIONS

An Equity Monitoring Tool has been developed. It is made up of 2 instruments:

- Equity Indicators integrated into the EBCP Monitoring and Evaluation Framework (task 4.1)
- Equity Questions integrated into the Survey on National Cancer Control Programmes in EU MSs and designated countries with special focus in cancer inequalities (Task 5.1)

This Equity Monitoring Tool enables:

- Monitoring EBCP uptake and implementation in EU MSs from an equity perspective.
- Mapping the current state-of-play of NCCPs with a special focus in cancer inequalities.

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# 8 APPENDIX 1: EQUITY QUESTIONS

**CAPACITY-BUILDING**

Question (Q) 16. Does your NCCP contain objectives aimed tackling **social inequalities in cancer** from a **proportionate universalism approach,** which means favouring universal access (**universal approach**), but also targeting actions with an intensity proportionate to the degree of need of specific social groups (**targeted approach)**?

- □ Yes, from a proportionate universalism approach (universal + targeted approach). Please specify the **social determinant of health** it is addressed (Multiple response):
  - □ Territory (e.g. place of residence, rural/urban, deprived areas, etc.)
  - □ Age (e.g. childhood, elderly population, etc.)
  - □ Sex/Gender (e.g. male/women, transgender, non-binary, etc.)
  - □ Socioeconomic level (e.g. occupation, income, etc.)
  - □ Educational level (e.g. level of education, health literacy, etc.)
  - □ Ethnicity/Cultural background (e.g. migrants, country of origin, race, language, etc.)
  - □ Disability (e.g. physical, mental, sensory, intellectual, etc.)
  - □ Institutionalised population (e.g. inmate population, residents of healthcare institutions, etc.)
  - □ Other type of social determinant of health: _____
  - □ It is not specified
- □ Yes, from a universal approach
- □ Yes, from a targeted approach. Please specify the social determinant of health it is addressed (Multiple response):
  - □ Territory (e.g. place of residence, rural/urban, deprived areas, etc.)
  - □ Age (e.g. childhood, elderly population, etc.)
  - □ Sex/Gender (e.g. male/women, transgender, non-binary, etc.)
  - □ Socioeconomic level (e.g. occupation, income, etc.)
  - □ Educational level (e.g. level of education, health literacy, etc.)

- □ Ethnicity/Cultural background (e.g. migrants, country of origin, race, language, etc.)
- □ Disability (e.g. physical, mental, sensory, intellectual, etc.)
- □ Institutionalised population (e.g. inmate population, residents of healthcare institutions, etc.)
- □ Other type of social determinant of health: _____
- □ It is not specified

□ No

If **Yes**, please specify the reference of the NCCP document and copy and paste the particular content that supports your answer. (max 200 words)

_____

_____

Q17. Does your NCCP include the **Health in all Policies** approach, which means including objectives and actions that involve not only the health sector, but also environment, social, education, agriculture, finance, taxation and economic sectors?

□ Yes. Please specify the type of sector/s involved (Multiple response):

- □ Healthcare
- □ Public Health
- □ Social welfare
- □ Education
- □ Research and academia
- □ Environmental
- □ Agriculture
- □ Financial
- □ Taxation and economical
- □ Private
- □ Community and civil society
- □ Other sector: _____
- □ It is not specified

□ No

If **Yes**, please specify the reference of the NCCP document and copy and paste the particular content that supports your answer (max 200 words)

_____

_____

Q18. Does your NCCP promote the creation of multidisciplinary cancer workforce? (e.g. create a multidisciplinary group, including experts on social science, health promotion, statistics, public health, and other disciplines, to promote healthy behaviours for preventing cancer)

□ Yes. Please specify the type of discipline/s involved (Multiple response):

- □ Social science
- □ Health science
- □ Humanities
- □ Engineering
- □ Technology
- □ Natural science
- □ Arts
- □ Business and management
- □ Education
- □ Law
- □ Other discipline: _____
- □ It is not specified

□ No

If **Yes**, please specify the reference of the NCCP document and copy and paste the particular content that supports your answer (max 200 words)

_____

_____

Q19. Does your NCCP include indicators and/or quality criteria related to the **social determinants of health**? (e.g. indicator: colorectal cancer screening participation rate

by socioeconomic level, gender or age; quality criteria: reaching an equal colorectal cancer screening participation between men and women)

□ Yes. Please specify the **social determinant of health** it is included (Multiple response):

□ Territory (e.g. place of residence, rural/urban, deprived areas, etc.)

□ Age (e.g. childhood, elderly population, etc.)

□ Sex/Gender (e.g. male/women, transgender, non-binary, etc.)

□ Socioeconomic level (e.g. occupation, income, etc.)

□ Educational level (e.g. level of education, health literacy, etc.)

□ Ethnicity/Cultural background (e.g. migrants, country of origin, race, language, etc.)

□ Disability (e.g. physical, mental, sensory, intellectual, etc.)

□ Institutionalised population (e.g. inmate population, residents of healthcare institutions, etc.)

□ Other type of social determinant of health: _____

□ It is not specified

□ No

If **Yes**, please specify the reference of the NCCP document and copy and paste the indicators and/or quality criteria related to equity that supports your answer (max 200 words)

_____

_____

Q20. Does your NCCP plan to identify and analyse the existing **social inequalities in cancer** in your country? (e.g. monitoring and/or research activities on social inequalities in the cancer continuum)

□ Yes. Please specify the **social determinant of health** it is planned to be analysed (Multiple response):

□ Territory (e.g. place of residence, rural/urban, deprived areas, etc.)

□ Age (e.g. childhood, elderly population, etc.)

- □ Sex/Gender (e.g. male/women, transgender, non-binary, etc.)
- □ Socioeconomic level (e.g. occupation, income, etc.)
- □ Educational level (e.g. level of education, health literacy, etc.)
- □ Ethnicity/Cultural background (e.g. migrants, country of origin, race, language, etc.)
- □ Disability (e.g. physical, mental, sensory, intellectual, etc.)
- □ Institutionalised population (e.g. inmate population, residents of healthcare institutions, etc.)
- □ Other type of social determinant of health: _____
- □ It is not specified

□ No

If **Yes**, please specify the reference of the NCCP document and copy and paste the particular content that supports your answer (max 200 words)

_____

_____

Q21. Does your NCCP plan to assess its impact on the **social inequalities in cancer**? (e.g. use the Health Equity Impact Assessment tool for evaluating the impact of the population-based cervical cancer screening programme implementation in your country)

□ Yes. Please specify the **social determinant of health** it is planned to be assessed (Multiple response):

- □ Territory (e.g. place of residence, rural/urban, deprived areas, etc.)
- □ Age (e.g. childhood, elderly population, etc.)
- □ Sex/Gender (e.g. male/women, transgender, non-binary, etc.)
- □ Socioeconomic level (e.g. occupation, income, etc.)
- □ Educational level (e.g. level of education, health literacy, etc.)
- □ Ethnicity/Cultural background (e.g. migrants, country of origin, race, language, etc.)
- □ Disability (e.g. physical, mental, sensory, intellectual, etc.)

- □ Institutionalised population (e.g. inmate population, residents of healthcare institutions, etc.)
- □ Other type of social determinant of health: _____
- □ It is not specified

□ No

If **Yes**, please specify the reference of the NCCP document and copy and paste the particular content that supports your answer (max 200 words)

_____

_____

Q22. Does your NCCP promote the inclusion of **social determinants of health** variables in your national/regional cancer information systems? (e.g. including information regarding country of origin and/or socioeconomic status in the cancer registries)

□ Yes. Please specify the social determinant of health variable (Multiple response):

- □ Territory (e.g. place of residence, rural/urban, deprived areas, etc.)
- □ Age (e.g. childhood, elderly population, etc.)
- □ Sex/Gender (e.g. male/women, transgender, non-binary, etc.)
- □ Socioeconomic level (e.g. occupation, income, etc.)
- □ Educational level (e.g. level of education, health literacy, etc.)
- □ Ethnicity/Cultural background (e.g. migrants, country of origin, race, language, etc.)
- □ Disability (e.g. physical, mental, sensory, intellectual, etc.)
- □ Institutionalised population (e.g. inmate population, residents of healthcare institutions, etc.)
- □ Other type of social determinant of health: _____
- □ It is not specified

□ No

If **Yes**, please specify the reference of the NCCP document and copy and paste the particular content that supports your answer (max 200 words)

_____

_____

Q23. Does your NCCP promote the collection of information on patient reported outcome and experience measures (PROMs and PREMs)? (e.g use of PROMS and PREMS for analysing the patient's quality of life receiving radiotherapy)

- □ Yes
- □ No

If **Yes**, please specify the reference of the NCCP document and copy and paste the particular content that supports your answer (max 200 words)

_____

_____

Q24. Does your NCCP promote the **social participation** of citizens and patients in the design, implementation and evaluation of your cancer policies/programmes? (e.g. patient association to be part of the NCCP evaluation committees)

- □ Yes. Please specify the social agent involved (Multiple response):
  - □ Civil society organizations (e.g. neighbourhood association, environmental and humanitarian organizations, etc.)
  - □ Patient associations (e.g. cancer patient associations, other patient associations, etc.)
  - □ Community representatives (e.g. representatives of marginalised communities, etc.)
  - □ Religious and faith-based organizations
  - □ Youth and student organizations
  - □ Other type of social agent: _____
  - □ It is not specified
- □ No

If **Yes**, please specify the reference of the NCCP document and copy and paste the particular content that supports your answer (max 200 words)

_____

_____

Q25. Does your NCCP promote informed decision making for citizens and patients from a **proportionate universalism approach**? (e.g. use of Patient Navigation to assist patients in overcoming barriers to care, understanding their diagnoses and treatment options, and accessing necessary resources and support services)

- □ Yes, from a proportionate universalism approach (universal + targeted approach)
- □ Yes, from a universal approach
- □ Yes, from a targeted approach
- □ No

If **Yes**, please specify the reference of the NCCP document and copy and paste the particular content that supports your answer (max 200 words)

_____

_____

Q26. Does your NCCP foster exchanges of good practices in tackling **social inequalities in cancer** in your country? (e.g. create a national best practice repository for reducing social inequalities in cancer in your country)

- □ Yes
- □ No

If **Yes**, please specify the reference of the NCCP document and copy and paste the particular content that supports your answer (max 200 words)

_____

_____

Q27. Does your NCCP promote training for cancer professionals in the cancer **equity** perspective? (e.g. include the equity perspective in the training programmes directed to health professionals to enhance communication skills with patients)

- □ Yes

□ No

If **Yes**, please specify the reference of the NCCP document and copy and paste the particular content that supports your answer (max 200 words)

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**PRIMARY AND SECONDARY CANCER PREVENTION**

Q28. Does your NCCP promote the development of **healthy living environments** favouring compliance with the European Code Against Cancer? (e.g. to develop programmes in public schools aimed at reducing the consumption of unhealthy foods, such as salt and red meat, while increasing the proportion of healthy foods, such as vegetables and fruits)

□ Yes. Please specify which living environment it is promoted (Multiple response)

- □ Transport and walkability
- □ Green spaces
- □ Healthy schools and kindergartens
- □ Municipal planning and control (e.g. investment in active traffic, environmental and regulatory controls and taxes)
- □ Urban planning measures (e.g. redesign of infrastructure to meet the needs of the elderly)
- □ Other living environment:_____
- □ It is not specified

□ No

□ Not Applicable: Primary cancer prevention is not covered in the NCCP

If **Yes**, please specify the reference of the NCCP document and copy and paste the particular content that supports your answer (max 200 words)

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Q29. Does your NCCP promote the improvement of **health literacy** on cancer risks and determinants from a **proportionate universalism approach**? (e.g. develop informative material regarding cancer risk factors directed to the whole population but tailored to different population groups according to their health literacy levels)

- □ Yes, from a proportionate universalism approach (universal + targeted approach)
- □ Yes, from a universal approach
- □ Yes, from a targeted approach
- □ No
- □ Not Applicable: Primary cancer prevention is not covered in the NCCP

If **Yes**, please specify the reference of the NCCP document and copy and paste the particular content that supports your answer (max 200 words)

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Q30. Does your NCCP promote healthy behaviours for preventing cancer, based on the European Code Against Cancer, **from a proportionate universalism approach**? (e.g. design programmes to promote physical activity through the free use of sports facilities among **socially vulnerable groups**)

- □ Yes, from a proportionate universalism approach (universal + targeted approach)
- □ Yes, from a universal approach
- □ Yes, from a targeted approach
- □ No
- □ Not Applicable: Primary cancer prevention is not covered in the NCCP

If **Yes**, please specify the reference of the NCCP document and copy and paste the particular content that supports your answer (max 200 words)

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Q31. Does your NCCP promote equitable access and compliance with population-based cancer screening programmes taking into account the **proportionate universalism approach**? (e.g. provision of free transportation for breast cancer screening units to women facing mobility barriers)

- □ Yes, from a proportionate universalism approach (universal + targeted approach)
- □ Yes, from a universal approach
- □ Yes, from a targeted approach
- □ No
- □ Not Applicable: Secondary cancer prevention is not covered in the NCCP

If **Yes**, please specify the reference of the NCCP document and copy and paste the particular content that supports your answer (max 200 words)

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Q32. Does your NCCP consider personalised risk assessment taking into account the **social determinants of health** in order to promote targeted cancer prevention? (e.g. include various thresholds for faecal occult blood testing between men and women)

- □ Yes
- □ No
- □ Not Applicable: Primary and Secondary cancer prevention are not covered in the NCCP

If **Yes**, please specify the reference of the NCCP document and copy and paste the particular content that supports your answer (max 200 words)

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**CANCER TREATMENT**

Q33. Does your NCCP promote the creation of National Comprehensive Cancer Centers? (e.g. integrate clinical care, research and education in the cancer centers)

- □ Yes
- □ No
- □ Not Applicable

If **Yes**, please specify the reference of the NCCP document and copy and paste the particular content that supports your answer (max 200 words)

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Q34. Does your NCCP ensure equitable access to personalised medicine taking into account the **proportionate universalism approach**? (e.g. promote the education of healthcare providers and the public about personalised medicine, its benefits, and its potential to improve health outcomes)

- □ Yes, from a proportionate universalism approach (universal + targeted approach)
- □ Yes, from a universal approach
- □ Yes, from a targeted approach
- □ No
- □ Not Applicable

If **Yes**, please specify the reference of the NCCP document and copy and paste the particular content that supports your answer (max 200 words)

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Q35. Does your NCCP ensure equitable access to timely and high-quality treatments, including surgical care, radiotherapy and systemic therapy taking into account the **proportionate universalism approach**? (e.g. to ensure equitable access to innovative radiotherapy irrespective of individuals' geographical locations)

- □ Yes, from a proportionate universalism approach (universal + targeted approach)
- □ Yes, from a universal approach

- □ Yes, from a targeted approach
- □ No
- □ Not Applicable: Cancer treatment is not covered in the NCCP

If **Yes**, please specify the reference of the NCCP document and copy and paste the particular content that supports your answer (max 200 words)

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Q36. Does your NCCP encourage equitable access to telemedicine and remote monitoring throughout the entire cancer pathway taking into account the **proportionate universalism approach**? (e.g. establish a telemedicine hub at the local health center in rural areas)

- □ Yes, from a proportionate universalism approach (universal + targeted approach)
- □ Yes, from a universal approach
- □ Yes, from a targeted approach
- □ No
- □ Not Applicable

If **Yes**, please specify the reference of the NCCP document and copy and paste the particular content that supports your answer (max 200 words)

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**CANCER SURVIVORSHIP, REHABILITATION AND PALLIATIVE CARE**

Q37. Does your NCCP support the creation of personalised survivorship care plans, taking into account the **proportionate universalism approach**? (e.g. design cancer rehabilitation plans tailored for the prison population)

- □ Yes, from a proportionate universalism approach (universal + targeted approach)
- □ Yes, from a universal approach
- □ Yes, from a targeted approach

□ No

□ Not Applicable: Survivorship is not covered in the NCCP

If **Yes**, please specify the reference of the NCCP document and copy and paste the particular content that supports your answer (max 200 words)

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Q38. Does your NCCP support the survivors´ return to work, from a **proportionate universalism approach**? (e.g. promote the development of employment programmes focusing on older population)

□ Yes, from a proportionate universalism approach (universal + targeted approach)

□ Yes, from a universal approach

□ Yes, from a targeted approach

□ No

□ Not Applicable: Survivorship is not covered in the NCCP

If **Yes**, please specify the reference of the NCCP document and copy and paste the particular content that supports your answer (max 200 words)

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Q39. Does your NCCP support the promotion of work-life balance for informal carers from a **proportionate universalism approach**? (e.g. promote the collaboration with social welfare and economy sectors to implement economic incentives for informal carers)

□ Yes, from a proportionate universalism approach (universal + targeted approach)

□ Yes, from a universal approach

□ Yes, from a targeted approach

□ No

□ Not Applicable

If **Yes**, please specify the reference of the NCCP document and copy and paste the particular content that supports your answer (max 200 words)

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Q40. Does your NCCP support equitable access for palliative and end-of-life care services from a proportionate universalism approach? (e.g. access to psychosocial support regardless their geographic location)

□ Yes, from a proportionate universalism approach (universal + targeted approach)

□ Yes, from a universal approach

□ Yes, from a targeted approach

□ No

□ Not Applicable: Palliative and end-of-life care are not covered in the NCCP

If **Yes**, please specify the reference of the NCCP document and copy and paste the particular content that supports your answer (max 200 words)

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# 9 APPENDIX 2: GLOSSARY OF TERMS

**Health equity**: absence of unfair, avoidable or remediable differences in health status among population groups defined socially, economically, demographically or geographically.

**Health literacy**: the personal knowledge, competencies, and motivation that enable people to access, understand, appraise, and use information and services to form judgments and take decisions in terms of healthcare, disease prevention, and health promotion.

**Health in all Policies:** approach that recognizes that population health is not merely a product of health sector programmes but largely determined by policies that guide actions beyond the health sector, such as those influencing transport, housing and urban planning, the environment, education, agriculture, finance, taxation and economic development so that they promote overall health and health equity.

**Healthy living environments:** environments that offer the necessary conditions for individuals to lead healthy lifestyles and reduce health risks.

**Proportionate universalism approach:** resourcing and delivering universal services at a scale and intensity proportionate to the degree of need.

**Social inequalities in cancer**: health inequalities that span the full cancer continuum and involve social inequalities in the prevention, incidence, prevalence, detection and treatment, survival, mortality, and burden of cancer and other cancer-related health conditions and behaviours.

**Socially vulnerable groups**: subgroups of the population who are at higher risk of multiple exposures to cancer risk factors due to geographic location, sex, age, ethnicity, socioeconomic level, disability, etc.

**Social determinants of health:** the social, cultural, political, economic, and environmental conditions in which people are born, grow up, live, work, and age, and their access to power, decision-making, money, and resources.

**Social participation:** implies that social actors group their collective potential to achieve a collective good, to bridge the gap between policymakers´ perspectives and the experiences and needs of communities.

**Targeted approach:** actions favouring access to specific social groups (e.g. developing specific strategies to ensure access to cancer screening programmes for the inmate population).

**Universal approach:** actions favouring universal access (e.g. population-based cancer screening programmes).