Analysis of data from the Survey on National Cancer Control Programmes in EU Member States and designated countries with a special focus on cancer inequalities

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1. ACKNOWLEDGEMENTS

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2. EXECUTIVE SUMMARY

In accordance with the 9th flagship initiative of the Europe's Beating Cancer Plan, the main objective of OriON JA WP 5 – Analysis of the Survey on National Cancer Control Programmes is to pave the way for the improvement of the quality of National Cancer Control Programmes (NCCPs) with a special focus on cancer inequalities on the basis of the analysis of the developments in NCCPs in European Union (EU) Member States (MSs) and designated countries.

The main purpose of this report is to present the latest status of NCCPs, which are key documents in the field of cancer control in every country. The report arises from the Survey on NCCPs in 27 EU MSs and other 7 European designated countries with a special focus on cancer inequalities (hereafter: the Survey) carried out within the framework of the OriON Joint Action (JA) in the second half of 2024.

This is the fourth report of its kind arising from the JAs in the field of cancer. The first extensive Survey on NCCPs took place in 2011 as part of the European Partnership for Action Against Cancer Joint Action (EPAAC JA). The second Survey on NCCPs was conducted in the frame of the Cancer Control Joint Action (CanCon JA) in 2015, and the results were published in 2016. The third Survey took place in 2018 in the frame of the Innovative Partnership for Action Against Cancer JA (iPAAC JA).

With regard to the present Survey, we received a very good response from participating countries. All EU MSs and designated countries were invited to participate, and all 34 responded, giving a response rate of 100%. Most of the participating countries, 31 out of 34 (91.2%), had an operational NCCP and/or plan, strategy, policy or other related documents in 2024. Only three out of the 34 participating countries (8.8%) did not have an operational NCCP in 2024, and all others had some form of formalized cancer document. We analysed the responses to the Survey from 31 (91.2%) participating countries that confirmed the existence of an NCCP in their country. The analysis in this report is focused exclusively on these 31 countries with an NCCP in their country. The majority of countries, 22 out of 31 (71.0%), prepared a single document addressing cancer control. Additionally, nine out of 31 participating countries (29.0%) prepared several documents addressing cancer control. Just over half of the these (16 countries out of 31, or 51.6%) classified their NCCPs as programmes, 16 (51.6%) countries prepared a strategy, 13 (41.9%) prepared

a plan, and eight out of 31 participating countries (25.1%) classified their cancer document as a policy.

More than half of the countries (17 out of 31 countries, or 54.8%) reported having additional policy documents addressing cancer control. In contrast, 14 countries (45.2%) reported not having such documents at present. The expiry date of the NCCPs of the largest group of countries (11 countries, 35.5%) is 2030. Regarding the duration of the cancer documents, most countries favour medium- to long-term planning. A duration of from 3 – 5 years was reported in 10 countries, while from 7 – 13 years was reported in 14. However, some countries favour a flexible duration. The majority of countries (20 out of 31 countries, or 64.5%) intend to update their NCCPs when the current one expires, and three countries (9.7%) are uncertain about this. Only one (3.2%) of the 31 countries explicitly stated that it has no intention of preparing a new NCCP. Most countries (19 out of the 31 countries, or 61.3%) participating in the Survey use indicators to assess their NCCPs, which is a positive indicator of a systematic approach to monitoring cancer control practices. The results of the Survey show that the evaluation and reporting processes for NCCPs in 24 of the 31 participating countries (77.6%) involve a range of institutions, including health authorities, ministries of health, or specialized advisory bodies. Regarding the use of the indicators in the process of evaluating their NCCPs, most countries (13 out of 31 countries, or 41.9%), reported using a combination of structure, process, and outcome indicators. Four countries reported using a combination of process and outcome indicators (12.9%), while three countries (9.7%) focused only on outcome indicators. Four countries reported using other combinations and seven did not respond.

The Survey aimed to assess the status of stable funding for the coordination of the implementation of NCCPs. The results show that less than half (45.2%) of the countries that participated in the Survey are able to secure funding for the implementation of their NCCPs, while just over half (51.6%) still face challenges in this area.

Regarding the quality of NCCPs, the most fulfilled areas recommended by the European Guide for Quality National Cancer Control Programmes are primary prevention, cancer screening, early detection, diagnosis, treatment, cancer data and information, psychosocial oncology care, education and training. Over 80% of the countries with an operational NCCP reported including these areas in their NCCPs/cancer documents. In contrast, areas that are not covered adequately in NCCPs

are financing, cancer resources, monitoring of cancer burden, governance, rehabilitation, patient empowerment and survivorship, meaning that there it is still room for the improvement of NCCPs or the relevant cancer documents.

In order to analyse how countries are integrating the equity perspective in their NCCPs, equity questions were analysed into four domains: capacity-building, primary and secondary prevention, treatment and survivorship, rehabilitation and palliative care.

Regarding the capacity-building domain, it is notable that most NCCPs/cancer documents have objectives aimed tackling social inequalities in cancer (24/30; 80%), with the most common being age, territory, and the social determinants of health. Moreover, 70% (21/30) of the NCCPs/cancer documents promote the social participation of citizens and patients in the design, implementation and evaluation of cancer policies and programmes, and 60% (18/30) promote informed decision-making for citizens and patients. Additionally, 56.7% (17/30) include the Health in All Policies approach, and 53.3% (16/30) mention fostering a multidisciplinary cancer workforce. On the other hand, 46.7% (14/30) of the NCCPs/cancer documents encourage the collection of information on patient-reported outcomes and experience measures. Both supporting for training on the equity perspective for cancer professionals and planning to analyse the existing social inequalities in cancer in the focal countries appear in 43.3% (13/30) of the NCCPs/cancer documents. Moreover, 40% (12/30) support the inclusion of equity variables in cancer information systems, while 36.7% (11/30) include indicators related to the social determinants of health. Finally, 33.3% (10/30) of the NCCPs/cancer documents consider performing an equity impact assessment and 23.3% (7/30) encourage fostering the exchange of good practices in tackling social inequalities in cancer.

With regard to the primary and secondary prevention domain, for those NCCPs/cancer documents that cover this 80% (24/30) promote the development of healthy living environments favouring compliance with the European Code Against Cancer. Moreover, almost the same number call for the improvement of health literacy with regard to cancer risk factors and determinants (23/29; 79.3%) and promoting healthy behaviours for preventing cancer (22/30; 73.3%), while over half (17/30; 56.7%) call for ensuring equitable access and compliance with population-based cancer screening programmes. In contrast, only 31% (9/30) of them mention personalized risk

assessments, taking into account the social determinants of health, in order to promote targeted cancer prevention.

Turning to the treatment domain, for those NCCPs/cancer documents that include this it is remarkable that 78.6% (22/28) call for ensuring equal access to high-quality treatments and 76.7% (23/30) endorse the creation of National Comprehensive Cancer Centres. Moreover, more than half of the NCCPs/cancer documents (15/28; 57.7%) encourage ensuring equitable access to personalized medicine, while only 35.7% (10/28) call for more equitable access to telemedicine and remote monitoring.

In terms of the survivorship, rehabilitation and palliative care domain, the results show that less than half of the NCCPs/cancer documents addressing this topic support survivors' return to work (13/28; 46.4%). Moreover, only 39.3% (11/28) support the creation of personalized survivorship care plans, and just 29.6% (8/27) promote a better work-life balance for informal carers. In contrast, the vast majority, 85.7% (24/28), support equitable access to palliative and end-of-life care services.

Finally, when considering all four domains, the equity perspective (mean) in NCCPs in Europe is 54.3%, with significant differences among countries. When analysing the various equity approaches, the most common one is the universal approach (29.7%), followed by the proportionate universalism approach (25.1%). When observing the results country by country, those that do most to incorporate the equity perspective in their NCCPs/cancer documents are Croatia, Malta, Sweden, Slovenia, Ireland and Italy.

Based on the results of the Survey on NCCPs and related cancer documents in EU MSs and designated countries, it is possible to conclude that the situation regarding the development and quality of these programmes and documents is improving, thanks in part to the constant efforts of the European Commission in this regard. However, in the field of quality there is still a lot of room for improvement in terms of respecting the recommendations of the European Guide for Quality NCCPs. From the equity results it can be concluded that we still need to make special efforts to mainstream equity in cancer prevention and control policies in order to prevent the existing inequalities in cancer incidence and mortality from worsening, following the recommendations of the CanCon JA Policy Paper, the EBCP, and the Mission on Cancer.

3. INTRODUCTION

A National Cancer Control Programme (NCCP) is a public health programme designed to reduce the number of cancer cases and deaths and improve quality of life of cancer patients, through the systematic and equitable implementation of evidence-based strategies for the prevention, early detection, diagnosis, treatment, rehabilitation, and palliative care of cancer, as well as research to find innovative solutions and evaluate outcomes (1). Such programmes are designed with the aim of making the best use of available resources. During the design of a comprehensive NCCP an evaluation of the various ways to control cancer is undertaken, and the programme then incorporates and promotes the implementation of those measures that are considered to be the most cost-effective and beneficial for the maximum number of people in the population and according to the specific situation of the nation and the resources (present and planned) at its disposal. An effective NCCP promotes the development of care management guidelines, places emphasis on the prevention of cancers or early detection of cancer cases so as to increase the possibility of curing patients, offering better control of symptoms and a faster return to pre-diagnosis life, as well as planning for the provision of services that will seek to offer as much comfort as possible to patients (and their carers) with advanced or incurable forms of cancer. A well-conceived and well-managed NCCP lowers cancer incidence and mortality, improves the life of cancer patients, no matter what resource constraints a country faces. NCCPs are also an effective tool for the communication of the related decisions and plans identified and chosen by a Member State (MS) and the evidence supporting and influencing these in a transparent fashion, both to public within the MS and also among other members of the European Union (EU) (1, 2).

Controlling cancer in Europe requires the investment of substantial resources and the effective coordination of national policies. Since the beginning of the 21st century a number of EU MSs have started to develop, publish and implement their NCCPs or similar cancer documents. However, in a study published by the World Health Organization (WHO) in 2004 it was shown that there were notable “performance gaps” in the cancer control programmes operating in different countries in Europe, as characterized by unacceptable inequalities in cancer control both between and within MSs.

Therefore, the European Commission decided to support EU MSs by co-financing an important European project – the European Partnership for the Action Against Cancer Join Action (EPAAC JA). The Communication from the Commission of 2009 on EPAAC JA pledged that by the end of the partnership, i.e. by 2013 all MSs would have adopted integrated cancer plans (3). The EPAAC JA was followed by two more Joint Actions (JAs) in the field of cancer: CanCon JA and iPAAC JA, which both included an analysis of the situation regarding the development of NCCPs in the EU (4).

In 2011 the first survey on the situation regarding NCCPs in Europe was performed under the EPAAC JA (2011-2013). A separate working group on cancer programmes was established and co-chaired by the European Commission and Slovenia. All EU MSs, plus Iceland and Norway, were invited to actively participate and contribute to its work. The responses to this survey provided an input for the comprehensive overview and assessment of the situation in the EU, Iceland and Norway regarding the availability of cancer programmes and other similar documents. The results of the survey were published in the report entitled National Cancer Control Programmes: Analysis of Primary Data from Questionnaires which is available online: http://www.epaac.eu/images/END/Final_Deliverables/WP_10_Annex_7_Final_Report_on_National_Cancer_Control_Programmes.pdf. The European Guide for Quality NCCPs was developed in the frame of EPAAC JA (6).

In 2013 in the frame of the European Guide on Quality Improvement in Comprehensive Cancer Control Joint Action – CanCon JA (2013-2017), a working group called the Expert Group on NCCPs was established. Members of the group from different countries prepared a survey, which was used to overview the situation in 2016 regarding cancer programmes in the EU countries, along with Iceland, Norway, Turkey and Montenegro. On the basis of the answers to the survey a report was prepared, and this was the baseline document for the position papers regarding the overview of the situation on NCCPs in the EU and other participating countries, and regarding inequalities in this context, with the results were published in a scientific article (2).

As part of the Innovative Partnership for Action Against Cancer Joint Cancer – iPAAC JA (2017-2021) the survey on NCCPs provided valuable information regarding the situation in the field of NCCPs in Europe and the presence or absence of some key elements (quality indicators, patient-reported outcome measures-PROMs, patient pathways, implementation of Comprehensive Cancer Care Networks-CCCNs). The survey on NCCPs in EU MSs, some EEA countries and EU candidate countries was carried out in 2018, and the response rate was 100%. Thirty-two out of the 34 countries which completed the Survey reported having an NCCP/cancer document. Two countries (Belgium and the Netherlands) did not have an NCCP/cancer document, while Croatia had prepared a draft version which was being revised at the time of the survey was conducted. In 16 of the countries the related cancer documents were single documents, while the other 16 had several documents addressing cancer. Eleven countries defined their cancer documents as programmes, seven as plans, and five as strategies, while nine countries used other or mixed terminology. In only 16 countries were the cancer documents supported by a legal act, and in one country this legal support was partial. Twenty-two countries reported that their NCCPs/cancer documents had been implemented, and one country (Finland) that theirs was partially implemented. Belgium, which did not have an NCCP at the time of the survey, reported that they had evaluated the implementation of their previous plan in 2012. The survey did not focus on cancer inequalities (4).

The main objective of OriON JA WP 5 is to pave the way for the improvement of the quality of NCCPs, with a special focus on cancer inequalities (7), and based on the analysis of the developments in such programmes, all in accordance with the 9th flagship initiative of Europe's Beating Cancer Plan (EBCP). In fact, in the EBCP it is stated that cancer inequalities are unacceptable in a European Health Union that seeks to protect everyone (5).

At the beginning of 2024, the fourth analysis of NCCPs/cancer documents was performed in the frame of OriON JA. The analysis of the Survey on NCCPs in European MSs and designated countries is presented in this report. In line with the 9th flagship initiative of the EBCP, special attention was given to cancer inequalities (5). NCCPs are key documents in the field of cancer control, and health systems can only respond

to population needs regarding cancer in an effective manner with adequate planning. In this context it is thus vital for the European Commission to gain insights into the situation regarding the development and quality of NCCPs in Europe, as well as to address cancer inequalities. In fact, a number of indicators show major differences in cancer prevention and care between and within MSs. These inequalities can be seen in access to prevention programmes, in rates of early cancer detection, diagnosis, treatment, and survival, and measures to improve the quality of life of cancer patients and survivors. For instance, mortality rates from colorectal cancer are substantially higher among men than women. Differences in survivorship and access to care can be explained by gender differences, a combination of lower exposure to risk factors, better access to screening programmes and health services, and better capacity to absorb the social and financial consequences of cancer. Furthermore, persistent inequalities can also be observed for women, older people, persons with disabilities, and disadvantaged and marginalized groups, like people with a minority racial or ethnic backgrounds and people living in poverty. These inequalities are unacceptable in a European Health Union that aims to protect everyone (5).

This Survey was conducted with the aim of reviewing the state of play and level of quality in the field of NCCPs in EU MSs and designated countries, and in particular with regard to cancer inequalities.

4. METHODS

The report on the basis of the analysis of data from the Survey on NCCPs in EU MSs and designated countries, with a special focus on cancer inequalities, was prepared in the frame of the work in the first (Mapping of the current state-of-play of NCCPs with a special focus on cancer inequalities – T5.1) and second (Identifying how the topic of cancer inequalities is addressed within NCCPs – T5.2) tasks of WP5 of OriON JA. The document will serve for the preparation of actions for the improvement of the quality of NCCPs, and especially in terms of cancer inequalities.

4.1. Preparation of the Survey

The Survey on NCCPs in EU MSs and designated countries with a special focus on cancer inequalities (Survey) was prepared by National Institute of Public Health of the

Republic of Slovenia (leaders of OriON JA WP 5) and Fisabio from Spain. The Survey was structured in three parts:

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

The first and second parts of the Survey were prepared by NIJZ, which has previous experience with regard to conducting surveys on NCCPs. The third part was prepared by Fisabio, an institution with experience of research on cancer inequalities, and the main author of the policy paper regarding cancer inequalities that was prepared in the frame of the CanCon JA. Fisabio prepared the equity monitoring tool and integrated it into the Survey. The draft of the first version of the Survey was sent to the partners of OriON JA WP5 and the European Observatory on Health Systems and Policies (leaders of OBS Learning from Progress Addressing Cancer in Europe – OBS PACE). Their comments and suggestions were evaluated, and the Survey was changed as needed based on them.

4.2. Validation of the Survey

The Survey was than validated using a two-step process:

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

First step validation

The methodologist Tomaž Burnik from the NIJZ validated the Survey prepared by NIJZ and Fisabio and approved by the partners of OriON JA WP5 and EU OBS from the methodological point of view, which was then updated according to his suggestions.

Second step validation

After the first step validation the updated Survey was sent to three renowned international experts in the field of cancer:

- Michele Cecchini, MD, PhD, Lead, Public Health at the Organisation for Economic Co-operation and Development (OECD), Paris, France.

- Yannick Romero, PhD, Senior Knowledge & Advocacy Manager, Union for International Cancer Control (UICC), Geneva, Switzerland. Ms Zuzanna Tittenbrun from the same institution collaborated with Y. Romero.
- André Ilbawi, MD, Lead, Cancer Control, Department of Noncommunicable Diseases, Rehabilitation and Disability, World Health Organization (WHO), Geneva, Switzerland.

All their comments and suggestions were studied carefully and the Survey was then adapted based on these. The final version of the Survey was produced by NIJZ and Fisabio, and this, as well as all the comments and suggestions of the evaluators, was presented to the partners at the fourth OriON JA WP 5 meeting.

4.3. Identification of the experts in NCCPs

In parallel, the process of identifying experts responsible for NCCPs in the MSs and designated countries was going on. The mailing list of the recipients of the Survey was finalized at the end of April 2024.

Different steps were used in the identification of experts:

1. OriON JA partners were kindly asked to provide the emails of the experts on NCCPs in their countries.
2. The experts identified in iPAAC JA were contacted.
3. Collaboration with the Department of Foreign Affairs at the Ministry of Health of the Republic of Slovenia was established.
4. Collaboration with EU OBS, coordinators of the ECHoS project and secretariat of CraNE JA was established.
5. Personal connections were of key importance in the cases of North Macedonia and Ukraine.

Experts from the United Kingdom and Bosnia (the Federation of Bosnia and Herzegovina and Republika Srpska) were not identified, while the experts identified from Serbia did not confirm the participation.

4.4. Distribution of the Survey and collection of data

The Survey that was validated and coordinated with all partners of OriON JA WP 5 was transferred to the 1KA platform/tool, that was chosen for the distribution of the Survey. Individual cover letters for countries were prepared. At the end of April 2024, the Survey was distributed using the 1KA platform/tool for the conducting of surveys at the NIJZ. The Survey was sent to the experts in the field of NCCPs in the following EU MSs and designated countries: *Austria, Belgium, Bulgaria, Croatia, Cyprus, the Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Moldova, Montenegro, the Netherlands, North Macedonia, Norway, Poland, Portugal, Romania, the Slovak Republic, Slovenia, Spain, Sweden, Turkey and Ukraine* (see Figure 1).
The data were collected and validated, including through additional interactions with the Survey respondents when needed.

4.5. Definitions of the cancer documents

In order to avoid misunderstandings and contribute to a more harmonized use of the terms, the following definitions of *policy, strategy, plan* and *programme* were given in the Survey:

- A ***policy*** reflects a vision (and thus usually contains a vision statement, explaining the way a government, institution or organization will look in the future), with inspirational dimensions related to what it is that the government wants to achieve for its population – in this case regarding cancer prevention and control, both in terms of public health and healthcare systems. Such statements are often tied, even if only indirectly, to other national goals.
- A ***strategy*** spells out the mission to be accomplished and the generic roadmap to achieve this, which is articulated through a mission statement (in essence, outlining the *raison d'etre* or fundamental purpose of the initiative), succinctly describing why it exists and what it does to achieve its vision. The strategy also includes the layout, design, or concept used to accomplish the vision and mission. A strategy is usually understood with underlying flexibility, being open to adaptation and change when needed in order to fulfil the mission and its ultimate goals.
- A ***plan*** is a precise arrangement of steps, following a defined pattern, for a definite purpose according to a value chain coherent with the policy and strategy. It is

concrete in nature, although it does not necessarily contain all the details, which in fact are further developed and explained through more specific programmes and projects.

- A ***programme*** implies the arranged selection of systematic steps, activities and tasks and deliverables coherently within the plan. The programme addresses the entire set of changes that are desired in the field. A programme can be monitored or evaluated with regard to the achievement of the goals and deliverables set, or the process followed in order to achieve these operational goals, and the resources allocated to facilitate the process. As these activities are often based on arbitrary definitions, it is possible that there are also different combinations of goals and deliverables.
- According to the WHO definition used in this study, a **National Cancer Control Programme** (NCCP) is interpreted as "a public health programme designed to reduce cancer incidence and mortality and improve quality of life of cancer patients, through the systematic and equitable implementation of evidence-based strategies for the prevention, early detection, diagnosis, treatment and palliative care, making the best use of available resources".

4.6. Definitions of approaches in cancer inequalities

- *A **proportionate universalism approach*** – This approach combines universal policies with targeted interventions. It ensures that resources and services are available to all, but are distributed in proportion to the level of need. Those with greater disadvantage receive more support, while everyone benefits from a universal framework.
- *A **universal approach*** – This approach provides services or policies to the entire population equally, regardless of need or socioeconomic status. While it promotes inclusivity and fairness, it may not adequately address disparities because it does not account for differences in individual or community needs.
- *A **targeted approach*** – This approach focuses resources and interventions on specific groups that are considered to be at higher risk or greater need.

4.7. Statistical methods used in the analysis

4.7.1. Data source

The data source for this retrospective observational analysis was the completed Survey on NCCPs in EU MSs and designated countries, with a special focus on cancer inequalities.

4.7.2. Statistical analysis

Descriptive analysis of the responses was performed by NIJZ *(Parts 1 and 2)* and Fisabio *(Part 3).* Data was presented in tabular form and using bar charts and graphs. Belgium, Montenegro and Finland were excluded from the analysis, as they did not have an operational NCCP/cancer document in place in 2024.

5. RESULTS OF THE ANALYSIS - PART 1 OF THE SURVEY

5.1. Participating countries

Thirty-four EU MSs and designated countries participated in the Survey, and all their responses were analysed (Appendix 1). The participating countries are shown in Figure 1.

Figure 1. Participating countries (n=34)

5.2. Status of operational NCCPs/cancer documents in 2024

Most of the participating countries (91.2%, or 31 of the 34) – namely *Austria, Bulgaria, Croatia, Cyprus, the Czech Republic, Denmark, Estonia, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Moldova, the Netherlands, North Macedonia, Norway, Poland, Portugal, Romania, the Slovak Republic, Slovenia, Spain, Sweden, Turkey and Ukraine* – had operational NCCPs and/or plans, strategies, policies or other related documents (Appendix 2) in 2024, as seen in the results for Q1 of the Survey (Table 1). Only 8.8% of the participating countries (three of the 34 countries) did not have an NCCP, namely *Belgium, Finland and Montenegro* cancer document.

Table 1. Countries with and without NCCPs or other cancer documents (Q1: n=34)

Category responses	Number of countries (in percent)	Countries	
Countries with NCCPs or other CC documents [Yes]	31 (91.2%)	Austria, Bulgaria, Croatia, Cyprus, the Czech Republic, Denmark, Estonia, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Moldova, the Netherlands, North Macedonia*, Norway, Poland, Portugal, Romania, the Slovak Republic, Slovenia, Spain, Sweden, Turkey and Ukraine	
Countries without NCCPs or other CC documents [No]	3 (8.8%)	Belgium, Finland and Montenegro	
The number of participating countries	**34 (100%)**		

Notes: CC – cancer document(s); *for North Macedonia_1 and _2 both answers are the same [Yes].

In the continuation of this study, we present the analysis of the responses to the Survey (Appendix 1) from the 31 (91.2%) participating countries that confirmed they had NCCPs.

5.3. Number of cancer documents

An analysis of the documents on cancer control in the participating countries, based on Q2, reveals two basic approaches regarding the number of NCCPs/cancer documents (Appendix 3).

5.3.1. Countries with a single document addressing cancer

A majority of the participating countries (70.9%, or 22 out of 31) approach cancer control with a single, comprehensive document (Table 2), namely *Austria, Bulgaria, Cyprus, Estonia, France, Hungary, Iceland, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Moldova, the Netherlands, North Macedonia, Norway, Poland, Portugal, Romania, Slovenia and Turkey.*

5.3.2. Countries with several documents addressing cancer

Conversely, 29.0% of the participating countries, or nine out of 31, address cancer control in several documents (Table 2), namely *Croatia, the Czech Republic, Denmark, Germany, Greece, the Slovak Republic, Spain, Sweden and Ukraine.*

Table 2. Countries' cancer documents by approach (single vs. several documents) (Q2: n=31)

Category responses	Number of countries (in percent)	Countries	
Countries with a single CC document	22 (71.0%)	Austria, Bulgaria, Cyprus, Estonia, France, Hungary, Iceland, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Moldova, the Netherlands, North Macedonia*, Norway, Poland, Portugal, Romania, Slovenia and Turkey	
Countries with several CC documents	9 (29.0%)	Croatia, the Czech Republic, Denmark, Germany, Greece, the Slovak Republic, Spain, Sweden and Ukraine	
The number of participating countries	**31 (100%)**		

Notes: CC – cancer document(s); *for North Macedonia_1 and _2 both answers are the same [Yes].

In general, the analysis of the results of the Survey on cancer documents in the 31 participating countries which such documents reveals that the majority, 22 (71.0%), prefer a consolidated framework with *a single comprehensive document*. In contrast, a notable minority of nine countries (29.0%), adopt a multi-document approach to address varying or evolving priorities.

5.4. Classification of NCCPs/cancer documents

Analysing the responses to the third question (Q3) of the Survey (presented in Appendix 4, an overview of NCCPs), it is possible to conclude that the countries examined prepared programmes, plans, strategies, policies, and/or other cancer documents (Table 3).

Table 3. Classification of NCCPs/cancer documents in the participating countries (Q3: n=31)

Category responses	Number of countries (in percent)	Countries	
Countries with a programme	16 (51.6%)	Austria, Bulgaria, the Czech Republic, Denmark, Greece, Hungary, Iceland, Ireland, Lithuania, Moldova, the Netherlands, North Macedonia*, Poland, Slovenia, Sweden and Turkey	
Countries with strategy	16 (51.6%)	Croatia, Cyprus, the Czech Republic, Denmark, Estonia, France, Greece, Iceland, Moldova, the Netherlands, Norway, Portugal, Spain, Sweden, Turkey and Ukraine	
Countries with plan	13 (41.9%)	Bulgaria, the Czech Republic, Denmark, Germany, Greece, Italy, Latvia, Luxembourg, Malta, the Netherlands, the Slovak Republic, Turkey and Ukraine	
Countries with policy	8 (25.8%)	Denmark, France, Greece, Iceland, Moldova, the Slovak Republic, Sweden and Ukraine	
Countries with other type of document**	1 (3.2%)	Romania	

Notes: *For North Macedonia_1 and _2 the answers are the same. **Countries with other types of document. For Romania the law on cancer prevention and control does not fit any of the above definitions, but could maybe be classified as a policy.

This categorization underscores the varied approaches countries use to design and implement their cancer control strategies:

- ***Countries with a programme:*** Sixteen (51.6%) of the 31 participating countries *(Austria, Bulgaria, the Czech Republic, Denmark, Greece, Hungary, Iceland, Ireland, Lithuania, Moldova, the Netherlands, North Macedonia, Poland, Slovenia, Sweden and Turkey)* classify their NCCPs as programmes (short definition: a structured set of systematic steps, activities and results to achieve specific objectives). These can be monitored and evaluated based on the objectives achieved, the processes carried out and the resources deployed. Programmes often contain a combination of objectives and results. This shows that half of the countries have a more structured, programmatic approach to cancer control. These programmes may include specific initiatives and measures tailored to the prevention, diagnosis and treatment of cancer.
- ***Countries with a strategy:*** Sixteen (51.6%) of the 31 participating countries *(Croatia, Cyprus, the Czech Republic, Denmark, Estonia, France, Greece, Iceland, Moldova, the Netherlands, Norway, Portugal, Spain, Sweden, Turkey and Ukraine)* categorize their NCCPs as a strategy, i.e. they focus on the mission and roadmap to

achieve specific goals. This includes a mission statement (outlining the purpose of the initiative) and a flexible design or concept that guides implementation and can be adapted if necessary. This suggests that a significant number of countries are focussing on a strategic framework that outlines the long-term goals of cancer control, such as reducing cancer incidence or improving early detection and treatment outcomes.

- ***Countries with a plan:*** Thirteen (41.9%) of the 31 participating countries *(Bulgaria, the Czech Republic, Denmark, Germany, Greece, Italy, Latvia, Luxembourg, Malta, the Netherlands, the Slovak Republic, Turkey and Ukraine)* classify their NCCPs as plans, i.e. a concrete and organized arrangement that outlines steps to achieve a specific goal and is guided by policy and strategy. While they provide a defined framework, detailed activities are usually developed through programmes and projects. These are usually more detailed, actionable steps or a tactical roadmap to achieve cancer control goals, which may be tied to specific timeframes or funding allocations.
- ***Countries with a policy:*** Eight (25.8%) of the 31 participating countries *(Denmark, France, Greece, Iceland, Moldova, the Slovak Republic, Sweden and Ukraine)* categorize their NCCPs as a policy, i.e. it reflects a long-term vision and high-level objectives that are often linked to broader national objectives. The policy defines the government's aspirations for cancer prevention and control in the context of public health and healthcare systems. It may be a legislative or regulatory approach aimed at influencing broader health system frameworks, regulations or reforms related to cancer control.
- ***Countries with other types of documents:*** One (3.2%) of the 31 participating countries *(Romania)* uses other types of documents, such as specific guidelines, frameworks or protocols that do not strictly fall under the usual programme, plan, strategy or policy categories.

The analysis of NCCPs and other related cancer documents summarized above reveals significant variations among the participating countries, highlighting diverse policy approaches and administrative frameworks (see Table 4 and Figure 2).

The results, presented in Table 4, reveal that 16 out of 31 participating countries (or 51.6%) classify their cancer documents under the term "programme". Seven (22.6%) of the countries – including *Austria, Hungary, Ireland, Lithuania, North Macedonia, Poland and Slovenia* – refer to this programme as the single framework for their national cancer control measures. This indicates a strong reliance on a single, comprehensive policy approach. In addition, nine (29.0%) of the 31 participating countries fit their programme into a broader policy framework by combining it with other policy classifications. For example, *Bulgaria* (3.2%) uses both "programme" and "plan", while *the Czech Republic, the Netherlands and Turkey* (9.7%) use a combination of "programme, plan and strategy". *Denmark and Greece* (6.5%) extend the term "programme" to "policy", demonstrating a multi-layered approach to policy formulation. Similarly, *Iceland, Moldova and Sweden* (9.7%) use a combination of "programme, strategy and policy", emphasizing the strategic orientation and integration of the latter. It is notable that 15 out of 31 of the participating countries (48.4%) do not use the term "programme" for their cancer documents, and opt for other administrative classifications.

Table 4. Combinations of cancer documents by participating countries (Q3: n=31)

National type of document	**Number of countries** *(in percent)*	**Countries**
Programme	**7 (22.6%)**	Austria, Hungary, Ireland, Lithuania, North Macedonia, Poland and Slovenia
Programme and plan	1 (3.2%)	Bulgaria
Programme, plan and strategy	3 (9.7%)	Czech Republic, the Netherlands and Turkey
Programme, plan, strategy and policy	2 (6.5%)	Denmark and Greece
Programme, strategy and policy	3 (9.7%)	Iceland, Moldova and Sweden
Plan	**5 (16.1%)**	Germany, Latvia, Luxembourg, Malta and Italy
Plan and policy	1 (3.2%)	*Slovak Republic*
Strategy	**6 (19.4%)**	Croatia, Cyprus, Estonia, Norway, Portugal and Spain
Strategy, plan and policy	1 (3.2%)	*Ukraine*
Strategy and policy	1 (3.2%)	*France*
Other	1 (3.2%)	Romania
The number of participating countries	**31 (100%)**	

Five (16.1%) of the 31 participating countries *(Germany, Latvia, Luxembourg, Malta and Italy)* use "plan" as their primary framework and one (3.2%) *(the Slovak Republic)* uses "plan" and "policy", while six (19.4%) of the 31 countries rely solely on "strategy" (*Croatia, Cyprus, Estonia, Norway, Portugal and Spain). France* (3.2%) developed a "strategy and policy", while *Ukraine* (3.2%) prepared a "plan, strategy and policy". In addition, *Romania* (3.2%) used unique classifications, labelled as "other" in the responses, indicating country-specific adaptations (for Romania, the law on cancer prevention and control does not meet any of the above definitions, and perhaps it could be categorized as a "policy"). The results, presented in Figure 2, reveal notable differences in how participating countries structure and categorize their NCCP documents.

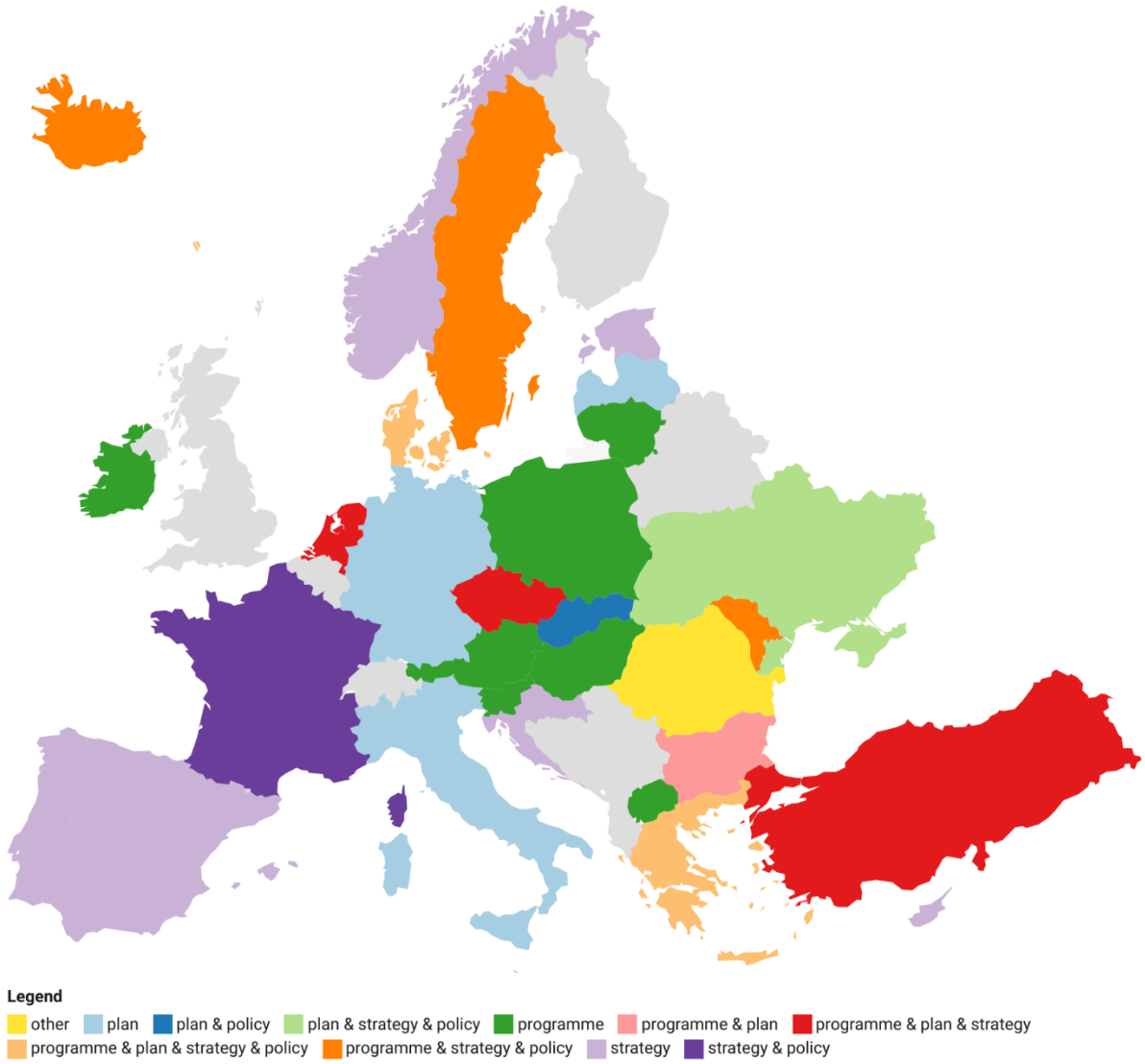


Figure 2. Combinations of cancer control documents by participating countries (Q3: n=31)

5.5. Presence of additional cancer documents

Based on the responses to Q4 of the Survey (Appendix 5), it is possible to observe the existence of other policy documents relevant to cancer control in the participating countries, as summarized in Table 5. More than half of the countries – 17 out of 31 (52.9%) – reported having additional policy documents addressing cancer control, namely *Austria, Croatia, Estonia, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Luxembourg, Malta, the Netherlands, Norway, Poland, Romania, and Sweden*. In contrast, 14 countries (45.2%) – *Bulgaria, Cyprus, the Czech Republic, Denmark, Iceland, Lithuania, Moldova, North Macedonia, Portugal, the Slovak Republic, Slovenia, Spain, Turkey, and Ukraine* – reported not having such documents at present.

Table 5. Other policy documents relevant for action on cancer control in the participating countries (Q4: n=31)

Category responses	Number of countries (in percent)	Countries	
Countries with other policy relevant documents [Yes]	17 (54.8%)	Austria, Croatia, Estonia, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Luxembourg, Malta, the Netherlands, Norway, Poland, Romania and Sweden	
Countries without other policy relevant documents [No]	14 (45.2%)	Bulgaria, Cyprus, the Czech Republic, Denmark, Iceland, Lithuania, Moldova, North Macedonia*, Portugal, the Slovak Republic, Slovenia, Spain, Turkey and Ukraine	
The number of participating countries	**31 (100.0%)**		

Note: * For North Macedonia_1 and _2 both answers are the same [No].

5.6. Expiration years of NCCPs/cancer documents

The results presented in Table 6, based on Q5 of the Survey (Appendix 6), show the expiration years of the various NCCPs, and they highlight the varying timetables and approaches to cancer policy planning and implementation among the participating countries. In 2024, the NCCPs expired in three countries *(Cyprus, Latvia and Norway)*, representing 9.7% of the 31 participating countries. These countries will likely need to renew their programmes or introduce new ones in the near future to maintain the continuity of their cancer control strategies. Looking ahead, five countries (16.1%) – *Greece, Lithuania, Moldova, the Slovak Republic and Turkey* – will phase out their NCCPs in 2025. These plans, which often extend over several years, reflect medium-term strategies that require careful renewal planning. Three other countries *(Ireland,*

Luxembourg and Slovenia), which account for 9.7% of the total, have NCCPs that will expire in 2026. Only one country, *Italy* (3.2%), has an NCCP that will expire in 2027. Overall, the results indicate that most of the countries are either aiming for longer-term plans or, as seen in some cases, have plans with no defined expiry dates.

Table 6. Year of expiry of NCCPs/cancer documents in the participating countries (Q5: n=31)

Year of expiry	Number of countries (in percent)	Countries
2024	3 (9.7%)	Cyprus, Latvia and Norway
2025	5 (16.1%)	Greece, Lithuania, Moldova, the Slovak Republic and Turkey
2026	3 (9.7%)	Ireland, Luxembourg and Slovenia
2027	1 (3.2%)	Italy
2030	11 (35.5%)	Bulgaria, Croatia, the Czech Republic, Estonia, France, Hungary, Iceland, Poland, Portugal, Romania and Ukraine
2032	1 (3.2%)	Netherlands
Other* response	7 (22.6%)	Austria, Denmark, Germany, Malta, North Macedonia, Spain, Sweden
The number of participating countries	**31 (100.0%)**	

*Austria: no expiry year (currently preparing a new NCCP); Denmark: 2020; Germany: ongoing; Malta: 2021 (has not been replaced yet); North Macedonia (with two responses: 1: one year; 2: the NCCP is an annual programme); Spain: the expiry year is not established; Sweden: the present strategy is valid until further notice, while work with on updated strategy was ongoing at the time of the Survey and expected to be presented during late 2024.

The largest group of countries (11, or 35.5%) have NCCPs/cancer documents that expire in 2030, *namely Bulgaria, Croatia, the Czech Republic, Estonia, France, Hungary, Iceland, Poland, Portugal, Romania and Ukraine. The Netherlands* has the most long-term NCCP, which is valid until 2032, making it one of the most far-sighted plans in the group of 31 countries. Interestingly, seven (22.6%) of the 31 participating countries gave answers that were not a simple year of expiry. *Austria*, for example, did not define an expiry year as it is currently preparing a new NCCP. *Denmark's* NCCP expired in 2020, while *Germany's* plan continues without a defined end date. *Malta's* NCCP expired in 2021 and has not yet been replaced. *Spain* did not report a defined expiry year for its NCCP, and *Sweden's* current strategy was valid until further notice at the time of the Survey, with a new plan not expected before late 2024. *North Macedonia* gave a unique response, and reported that its NCCP operates either as an annual programme or with a one-year duration.

5.7. Duration of NCCPs/cancer documents

The data presented in Appendix 7, and based on Q6 of the Survey, shows that the timeframes for the implementation and evaluation of cancer control measures vary depending on the duration of the NCCPs/cancer documents in the 31 participating countries. The results, as shown in Table 7, show that most countries favour medium- to long-term planning.

Table 7. Duration of the NCCPs in the participating countries (Q6: n=31)

Duration of the NCCPs documents	**Number of countries (in percent)**	**Countries**
3 years	1 (3.2%)	Latvia
4 years	2 (6.5%)	Denmark and Greece
5 years	7 (22.6%)	Cyprus, Italy, Malta, the Slovak Republic, Slovenia, Turkey and Ukraine
7 years [other]	3 (9.7%)	Bulgaria, Luxembourg and Romania
9 years [other]	1 (3.2%)	Czech Republic
10-years	8 (25.8%)	Croatia, Estonia, France, Ireland, Lithuania, Moldova, the Netherlands and Poland
12 years [other]	1 (3.2%)	Hungary
13 years [other]	1 (3.2%)	Iceland
Other duration of the NCCPs documents*	7 (22.6%)	Austria, Germany, North Macedonia, Norway, Portugal, Spain and Sweden
The number of participating countries	**31 (100.0%)**	

*Austria: no fixed timeline; Germany: ongoing; Montenegro: N/A; North Macedonia (including two responses: 1: one year; 2: the NCCP is an annual programme); Norway: it varies; Portugal: published to be implemented until a fixed date for further review; Spain: the duration is not established; Sweden: the present strategy is valid until further notice.

The most common duration is 10 years. Eight countries (25.8%) – *Croatia, Estonia, France, Ireland, Lithuania, Moldova, the Netherlands and Poland* – have a long-term approach to their NCCPs. Seven countries (22.6%) – *Cyprus, Italy, Malta, the Slovak Republic, Slovenia, Turkey and Ukraine* – have five-year plans, which strikes a balance between achieving realistic targets and the need for regular reviews. Short-term planning is relatively rare, as only *Latvia* (3.2%) uses a three-year plan, and two countries (6.5%) have four-year plans *(Denmark and Greece).* This indicates that

cancer control generally requires longer-term planning and sustained efforts to have a significant impact.

The second common category is “other duration”, which includes seven (22.6%) of the 31 participating countries. These NCCPs have a non-standardized or indefinite timeframe, allowing for flexibility or adaptation to specific national priorities. Countries such as *Austria, Germany, North Macedonia, Norway, Portugal, Spain and Sweden* have adopted flexible timelines for their NCCPs. Three countries (9.7%) have opted for a seven-year term *(Bulgaria, Luxembourg and Romania)*, while others have opted for nine years *(the Czech Republic)*, 12 years *(Hungary)* or 13 years *(Iceland).* This reflects the different approaches to the strategic planning of cancer control in the individual countries.

No country sets a duration of just two years for its NCCP, emphasizing that longer periods are needed to achieve measurable results in cancer incidence, mortality and survival rates. A significant proportion of the 31 participating countries (41.9%) fall into the “other duration” category, suggesting that flexible planning cycles may coincide with funding cycles, political mandates or changes in the health system. This emphasizes the diversity with which countries design their NCCPs.

5.8. Intention to prepare a new NCCP/cancer document upon expiry of the existing one

Q7 of the Survey gathered information on the intentions and willingness of the participating countries to renew their NCCPs/cancer documents upon expiry of the existing ones. The data analysis, presented in Table 8 and Appendix 8, shows the intention to prepare a new edition of the NCCP when the current one expires.

Table 8. Intention to develop a new NCCP/cancer document upon expiry of the existing one (Q7: n=31)

Intention to develop a new NCCP document	**Number of countries (in percent)**	**Countries**
Intend to renew the NCCP [Yes]*	20 (64.5%)	Austria, Bulgaria, Croatia, Cyprus, Denmark, Estonia, France, Germany, Hungary, Iceland, Ireland, Norway, Poland, Portugal, the Slovak Republic, Slovenia, Spain, Sweden, Turkey and Ukraine
Uncertain [Do not know]	3 (9.7%)	Czech Republic, Greece and Italy
No plans to renew [No]	1 (3.2%)	Romania
Lack of response [No answer]	7 (22.6%)	Latvia, Lithuania, Luxembourg, Malta, Moldova, the Netherlands and North Macedonia
The number of participating countries	**31 (100.0%)**	

* Austria: currently preparing a new NCCP; Germany: there is no expiry date for the National Cancer Plan, which is currently being revised/updated; Ireland: Yes, it intends to prepare a new cancer strategy, and has already updated its national cancer strategy three times – in 1996, 2006 and 2017.

- ***The majority intend to update the NCCP:*** Twenty (64.5%) of the 31 participating countries *(Austria, Bulgaria, Croatia, Cyprus, Denmark, Estonia, France, Germany, Hungary, Iceland, Ireland, Norway, Poland, Portugal, the Slovak Republic, Slovenia, Spain, Sweden, Turkey and Ukraine)* expressed a clear intention to produce a new edition of their NCCPs when the current one expires. Examples include *Austria*, which is currently preparing a new NCCP, and *Ireland*, which has already updated its cancer strategy three times – in 1996, 2006 and 2017. *Germany* clarified that its current plan has no expiry date and will be continuously revised or updated, reflecting an alternative approach to renewing its cancer control policy.
- ***Uncertain:*** Three (11.8%) of the 31 participating countries indicated that they are uncertain ("Do not know") about their plans to update their NCCPs. These include *the Czech Republic, Greece and Italy*, and this is either due to a lack of immediate planning or ongoing discussions on this issue.

- ***No plans to update:*** One (3.2%) of the 31 participating countries – *Romania* – has explicitly stated that it does not intend to produce a new edition of its NCCP.
- ***Missing response:*** Seven (22.6%) of the 31 participating countries – *Latvia, Lithuania, Luxembourg, Malta, Moldova, the Netherlands and North Macedonia* – did not provide a response, indicating gaps in the available data or possibly reflecting a lower prioritization of NCCP renewal in these countries.

5.9. Countries with NCCPs/cancer documents in the preparation phase and reasons why not, if this is the case

The results for Q8, presented in Table 9 (see Appendix 9), provide insights into the status of NCCPs/cancer documents in the 31 participating countries, focusing on whether these documents are in preparation and outlining the reasons why not, if this is the case. This data reflects a spectrum of readiness, policy priorities and structural challenges in cancer control.

The results show that just over half (16, or 51.6%) of the 31 participating countries *(Austria, Bulgaria, Croatia, the Czech Republic, Estonia, Germany, Hungary, Ireland, Luxembourg, Moldova, Poland, Portugal, Romania, Slovenia, Sweden and Turkey)* reported reasons for the lack of such documents, while 15 (48.4%) of the countries *(Cyprus, Denmark, France, Greece, Iceland, Italy, Latvia, Lithuania, Malta, the Netherlands, North Macedonia, Norway, the Slovak Republic, Spain and Ukraine)* reported having NCCPs/cancer documents in the preparatory phase.

Table 9. Countries with/without NCCPs in preparation (Q8: n=31)

Countries answer	Number of countries (in percent)	Countries	
Countries with NCCPs in preparation [Yes]	15 (48.4%)	Cyprus, Denmark, France, Greece, Iceland, Italy, Latvia, Lithuania, Malta, the Netherlands, North Macedonia, Norway, the Slovak Republic, Spain and Ukraine	
Countries without NCCPs in preparation [No] and reasons w**hy not** *	16 (51.6%)	Austria, Bulgaria, Croatia, the Czech Republic, Estonia, Germany, Hungary, Ireland, Luxembourg, Moldova, Poland, Portugal, Romania, Slovenia, Sweden and Turkey	
The number of participating countries	**31 (100.0%)**		

* The comments from Germany and Ireland were categorized as NCCPs are not in preparation. The comments from Croatia and Turkey have been translated into English.

5.9.1. *Countries without an NCCP/cancer document in the preparation phase, and the reasons why*

As noted above, the responses to Q8 regarding the preparation of new cancer documents (see Table 9 and Appendix 9) show that 16 (51.6%) of the 31 participating countries indicated that they do not have an NCCP/cancer document in preparation, and the reasons for this are as follows.

- ***Countries with an existing NCCP or other type of national cancer document (e.g. plan, strategy or policy, etc):*** Most (11, or 68.8%) of the 16 selected countries which are not preparing new documents stated that they already have an NCCP document. These countries include *Austria, Croatia, Estonia, Germany, Hungary, Luxembourg, Poland, Portugal, Romania, Slovenia and Turkey*. In three cases *(Poland, Croatia, Portugal)*, the existing long-term plans are valid until 2030. Other countries noted that their national cancer documents *(e.g. Turkey,* with a programme*)* or plans *(e.g. Germany)* are actively updated to maintain their relevance. These responses emphasize the structured and strategic nature of cancer control efforts. *Slovenia*, for example, emphasizes the iterative nature of its NCCP, which is now in its third version (2022–2026), while *Turkey* emphasizes accessibility by publishing its NCCP online and updating it as needed. The findings show that the countries reporting on existing NCCPs have robust institutional frameworks and a clear prioritization of cancer control.
- ***Countries with alternative strategies:*** Three (18.8%) of the 16 selected countries without such documents in preparation stated that they use more comprehensive health strategies or alternative frameworks instead of specific NCCPs. Examples include *the Czech Republic, Ireland and Sweden. Ireland*, for example, reported that the topic is irrelevant as it already has a more comprehensive strategy, and *the Czech Republic* stated that it has a strategy, but did not provide any details on its alignment with the NCCP principles. A comparison shows that these countries are flexible in their approaches to cancer control, but these may not have the specificity and focus of specialized NCCPs.
- ***Countries reporting obstacles to the development of NCCP:*** A smaller group of countries in this group, two (12.5%) of the 16, reported obstacles to developing or implementing an NCCP. Examples include *Bulgaria and Moldova. Bulgaria*, for example, stated that updates are needed to align its NCCP with current priorities

but cites the lack of a National Cancer Mission Hub (NCMH) as a structural challenge. *Moldova*, on the other hand, stated that an NCCP exists but there are limited opportunities for its further development or improvement.

5.9.2. Countries with NCCPs/cancer documents in the preparation phase

In contrast, the results for Q8, as presented in Appendix 10, revealed that 15 (48.4%) of the 31 participating countries (excluding Ireland), do not have a current NCCP/cancer document, suggesting that they have an NCCP/cancer document in the preparation phase, and in some cases the expected year of adoption was also given. The results are summarized in Table 10.

Table 10. The expected year of adoption of NCCPs by country (Q8: n=15)

Response from the selected countries	**Number of countries (in percent)**	**Countries**
Expected year of adoption of the NCCP Document [Yes]	11 (73.3%)	Cyprus, Denmark, Greece, Iceland, Latvia, Lithuania, Malta, North Macedonia, Norway, the Slovak Republic and Spain
Expected year of adoption of the NCCP document [do not know/other]	4 (26.7%)	France, Italy, the Netherlands and Ukraine
The number of countries selected	**15 (100.0%)**	

Notes: The comments from Germany and Ireland were categorized as NCCPs are not in preparation [No]. The comments from Croatia and Turkey have been translated into English. The responses of North Macedonia_2, are included in the analysis [expected year: 2025, while the responses of North Macedonia_1 are excluded [do not know].

According to the timeline for the adoption of the NCCPs/cancer documents by the various ministries of health, as shown in Table 10, most of the selected participating countries with their NCCPs/cancer documents in the preparatory phase (11 countries, 73.3%) expect to adopt them between 2024 and 2026 *(2024: Denmark, Iceland, Lithuania and Malta; 2025: Cyprus, Finland, Greece, Latvia, North Macedonia and the Slovak Republic; 2026: Spain).* On the other hand, four (26.7%) of the 15 selected participating countries are still unsure about their timetable for introduction. These include *France, the Netherlands and Ukraine,* which have expressed uncertainty, as well as *Italy*, where procedural inconsistencies indicate a need for clarification and improvement in this context.

5.10. Financing of the coordination of the implementation of the NCCPs/cancer documents

According to the results to Q9 of the Survey (Appendix 11), less than half (45.2%) of the countries (14 out of 31) were able to secure funding for the implementation of their NCCPs, while a significant proportion (16, or 51.6%) still face challenges in this area. An overview of the status of funding for the coordination of the implementation of NCCPs in the participating countries is provided in Table 11.

Table 11. Assessment of financing of the coordination of the implementation of NCCPs (Q9: n=31)

Category responses	Number of countries (in percent)	Countries
Financing secured [Yes]	14 (45.2%)	Croatia, Cyprus, the Czech Republic, Denmark, France, Germany, Greece, Latvia, Luxembourg, Poland, Portugal, Slovenia, Sweden and Ukraine
Financing not secured [No]	16 (51.6%)	Austria, Bulgaria, Estonia, Hungary, Iceland, Ireland, Italy, Lithuania, Malta, Moldova, the Netherlands, Norway, Romania, the Slovak Republic, Spain and Turkey
Partial financing secured [Yes/No]	1 (3.2%)	North Macedonia*
The number of participating countries	**31 (100.0%)**	

*Including North Macedonia_1 and _2 (both responses).

North Macedonia has not secured the necessary funding to coordinate the implementation of its NCCP, although it reported that partial funding has been secured.

- Of the 31 countries surveyed, 14 (45.2%) indicated that they have secured funding for the coordination and implementation of their NCCPs. These countries are confident in their financial arrangements, ensuring that their NCCPs (including strategies, plans, policies or other documents) are implemented effectively. Countries such as *France, Germany, Greece, Latvia and Slovenia*, among others, belong to this group, and are signalling a strong commitment to cancer control through sustainable funding mechanisms. This funding probably covers various aspects of NCCP implementation, including administrative coordination, and programme implementation, and monitoring and evaluation processes.
- However, the results also showed that 16 countries (51.6%) have not yet secured adequate funding for the implementation of their NCCPs. This group includes countries such as *Estonia, Hungary and Norway*, among others, and the lack of

secured funding raises concerns about the feasibility of cancer control measures in these. Without adequate funding, the implementation of NCCPs could be delayed or jeopardized, which could compromise the effectiveness of cancer prevention, treatment and care programmes. For one country (3.2%), namely *North Macedonia*, the results show that funding is partially secured but a full commitment is still pending.

5.11. Monitoring and evaluation of the NCCPs/cancer documents

The results of the Survey on the evaluation and monitoring of NCCPs/cancer documents provide crucial insights into how the 31 participating countries assess and refine their cancer control measures (Survey Q10, see Appendix 12 and Table 12).

Table 12. Evaluation and monitoring of NCCPs/cancer documents in the participating countries (Q10: n=31)

Country response	Number of countries (in percent)	Countries
Mid-term and final NCCP evaluation and monitoring [Yes, mid-term and final] **	8 (25.8%)	Croatia, Denmark, France, Iceland, Ireland**, Lithuania, Luxembourg and Poland
Only final NCCP evaluation and monitoring [Yes, only final] *	4 (12.9%)	Latvia, North Macedonia*, Spain and Turkey
Other NCCP evaluation and monitoring [Yes, other]	12 (38.7%)	Austria, the Czech Republic, Estonia, Germany, Greece, Hungary, Italy, Malta, the Netherlands, Portugal, Slovenia and Sweden
Without NCCP evaluation and monitoring [No]	7 (22.6%)	Bulgaria, Cyprus, Moldova, Norway, Romania, the Slovak Republic and Ukraine
The number of participating countries	**31 (100.0%)**	

* The responses of North Macedonia_1 are included in the analysis [Yes, final only], while the responses of North Macedonia_2 are excluded [No answer]. **Ireland: The Department of Health in Ireland regularly reviews the progress of the implementation of the national strategy; specifically, implementation reports for the National Cancer Strategy are prepared and published on the Department of Health's website annually [available at: https://www.gov.ie/en/publication/a89819-national-cancer-strategy-2017-2026/].

This reveals a complex landscape of practices characterized by different resources, priorities and institutional capacities.

- A significant proportion of countries, namely 12 (38.7%) of the 31 participating ones, reported using "other" types of evaluation methods, reflecting the flexibility and diversity of their approaches. Countries such as *Austria, the Czech Republic, Estonia, Germany, Greece, Hungary, Italy, Malta, the Netherlands, Portugal, Slovenia and Sweden* are likely to use context-specific strategies tailored to their respective health systems and policy frameworks. However, the lack of

standardization in this regard makes comparisons difficult, and can lead to best practices remaining unclear. An in-depth analysis of the context-specific, different approaches to monitoring and evaluation of NCCPs reported by 12 (38.7%) of the 31 participating countries (Table 12) is summarized below (Box 1).

- Notably, eight (25.8%) of the 31 participating countries, *Croatia, Denmark, France, Iceland, Ireland, Lithuania, Luxembourg and Poland*, have implemented comprehensive frameworks that include both mid-term and final evaluations and monitoring activities. They are examples of systematic approaches that not only ensure accountability but also provide the opportunity to adjust strategies during implementation. Such two-stage assessments allow policymakers to respond to new challenges and ensure that long-term goals are met.
- In contrast, four (12.9%) of the 31 participating countries, such as *Latvia, North Macedonia, Spain and Turkey*, limit their efforts to final evaluations and monitoring. While this approach allows for a final assessment of the results, it risks overlooking the iterative improvements that mid-term evaluations can offer. This singular focus may be due to resource constraints or a preference for summative over formative evaluation methods.
- On the other hand, seven (22.6%) of the 31 participating countries, namely *Bulgaria, Cyprus, Moldova, Norway, Romania, the Slovak Republic and Ukraine*, reported having no formal evaluation or monitoring procedures, which raises concerns about the effectiveness and sustainability of their NCCPs/cancer documents. Without systematic evaluation, these countries could run the risk of not adapting their measures to changing needs or not achieving the desired results.

Box 1. Context-specific strategies for monitoring and evaluating the NCCPs in 12 participating countries

Countries such as ***Austria*** and ***Estonia*** emphasize regular monitoring and focus on narrowly defined targets. ***Austria's*** approach is to assess the "status of targets", which is a simple and practical evaluation mechanism. ***Estonia*** also favours annual evaluations, which allow for frequent reviews and adjustments. These methods allow countries to respond quickly to deviations from planned outcomes and ensure continuous alignment with NCCP targets. Regular monitoring can offer significant benefits in terms of adaptability and responsiveness. However, these narrowly focused approaches may lack the depth required for a comprehensive understanding of systemic challenges. While annual evaluations provide current insights, they may overlook long-term patterns or disregard the impact on the health system.

Germany provides a robust example of comprehensive monitoring and evaluation. The Federal Ministry of Health and a designated Steering Committee oversee close monitoring of NCCP implementation. This is complemented by scientifically rigorous evaluations, including research projects and quality-assured screening programmes. Furthermore, the German National Cancer Plan was subjects to an in-depth analysis of its implementation and milestones achieved between 2011 and 2023. This comprehensive review forms the foundation for ongoing revisions, demonstrating a commitment to continuous improvement. Similarly, ***Sweden*** employs a multi-faceted evaluation process, involving diverse entities responsible for specific aspects of its NCCP. These evaluations include assessments tied to agreements between government bodies and stakeholders, such as the Board of Social Affairs and Health. Additionally, Sweden's Agency for Health and Care Services Analysis provides a holistic view of the strategy, as evidenced by its 2024 publication mapping the national cancer strategy. This comprehensive approach ensures that evaluations capture both detailed metrics and overarching policy impacts. These examples show how comprehensive evaluation frameworks can provide deeper insights into the effectiveness of NCCPs. By combining scientific rigour and stakeholder engagement, ***Germany*** and ***Sweden*** demonstrate the potential of robust monitoring to drive meaningful policy change and improve outcomes.

The ***Slovenian*** approach emphasizes the importance of stakeholder involvement in monitoring and evaluation. The country's NCCP is based on a supervisory board composed of decision-makers, policymakers and representatives of cancer patients. This inclusive governance model ensures that different perspectives inform the strategic direction of the programme. The board's role in monitoring and ensuring effective implementation demonstrates the value of participatory approaches in promoting transparency and accountability. The involvement of stakeholders not only enriches the evaluation process, but also strengthens public trust and acceptance. By involving patient representatives, Slovenia ensures that the policy reflects real needs and challenges, making the NCCP more responsive and equitable.

Despite notable successes, several countries face challenges in establishing consistent monitoring and evaluation practices. ***Malta***, for example, incorporates indicators for implementation monitoring but acknowledges that this is not done regularly. Similarly, ***Greece*** has yet to specify its targets and indicators. The ***Netherlands***, though having launched its agenda in November 2023, is still in the process of developing frameworks for yearly monitoring and adjustment. These cases underscore the difficulties some nations encounter in institutionalizing structured evaluation systems. Irregular monitoring can undermine the effectiveness of NCCPs by creating gaps in data and limiting the ability to track progress over time. For countries like ***Malta*** *and* ***Greece***, developing consistent and reliable evaluation mechanisms will be crucial for addressing these shortcomings and ensuring sustainable improvements.

The ***Czech Republic's*** focus on harmonizing its NCCP evaluation with national initiatives shows a holistic approach. In contrast, ***Hungary*** and ***Italy*** emphasize cancer-specific targets, with *Hungary* uses predefined indicators and *Italy* embeds the evaluation in the NCCP itself. Both the ***Czech Republic*** and ***Portugal*** carry out annual evaluations or reports, ensuring regular updates. While the processes in Hungary and Italy are also periodic, they emphasize specific targets or detailed monitoring frameworks. *Hungary's* approach, with targeted indicators, provides clear benchmarks but may not be flexible enough. Italy's comprehensive integration provides coherence but could be resource intensive. *Portugal's* simpler model could be more flexible, but possibly less detailed. Each country's approach to evaluating its NCCP reflects its unique public health context, policy priorities and resources.

5.12. Institutions undertaking the evaluation of NCCPs/cancer documents and preparing reports

According to the results for Q11 of the Survey (see Appendix 13 and Table 13), the evaluation and reporting processes for NCCPs/cancer documents in 23 of the 31 participating countries (74.2%) involve a range of institutions, including health authorities, ministries of health, or specialized advisory bodies. A country-specific summary of these results is provided in Box 2.

Box 2. Institutions responsible for monitoring and evaluating the NCCPs/cancer documents and the preparation of the reports in 23 participating countries

The institutions named below from 23 participating countries ensure compliance, assess progress and adapt strategies to achieve the set targets through regular reviews, external consultations and structured evaluations.

Austria: Austrian National Public Health Institute (Gesundheit Österreich GmbH, GÖG).

Croatia: Ministry of Health and Croatian Institute of Public Health.

Czech Republic: Ministry of Health evaluates NOPL, the Ministry of Industry and Trade oversees the National Recovery Plan.

Denmark: Ministry of Health evaluated Cancer Plan 4; the evaluation of Cancer Plan 5 is pending.

Estonia: National Cancer Control Steering Committee with data from multiple institutions.

Germany: The Federal Ministry of Health and Steering Committee evaluate milestones and implementation, alongside scientific project evaluations.

Greece: Expert Committee of Public Health under the General Secretariat of Public Health.

Hungary: National Institute of Oncology and the NCCP Governing Board, supported by an international advisory board.

Iceland: Ministry of Health collects data from service providers.

Ireland: Department of Health leads, while the NCCP is responsible for implementing recommendations and annual reporting.

Italy: A coordination committee assesses regional implementation.

Latvia: Ministry of Health consolidates reports from institutions implementing the plan.

Lithuania: Ministry of Health Programme Implementation and Monitoring Board.

Luxembourg: Independent experts conduct mid-term and final evaluations.

Malta: Dr Miriam Dalmas, the main author of the plan.

Netherlands: The Netherlands Cancer Collective and partners carry out the evaluation through acceleration teams.

North Macedonia: Institute of Epidemiology and Biostatistics with Medical Informatics at the Faculty of Medicine.

Poland: National Institute of Oncology Maria Skłodowska-Curie – National Research Institute.

Portugal: Executive Committee with the National Institute of Health.

Slovenia: Supervisory Board with policymakers, decision-makers, and patient representatives.

Spain: Technical coordinators of the Cancer Strategy at the Subdirectorate of Quality of Care.

Sweden: Various actors, including the Board of Social Affairs and Health, and the Swedish Agency for Health and Care Services Analysis.

Turkey: Public Health Directorate General (Halk Sağlığı Genel Müdürlüğü)

Table 13. Countries that provided names of the institutions that assess NCCPs/cancer documents and produce reports as part of the monitoring and evaluation process (Q11: n=31)

Category responses	Number of countries (in percent)	Countries
Description of the institutions [provided]	23 (74.2%)	Austria, Croatia, the Czech Republic, Denmark, Estonia, Germany, Greece, Hungary, Iceland, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, the Netherlands, North Macedonia, Poland, Portugal, Slovenia, Spain, Sweden and Turkey
Description of the institutions [missing]	8 (25.8%)	Bulgaria, Cyprus, France, Moldova, Norway, Romania, the Slovak Republic and Ukraine
The number of participating countries	**31 (100.0%)**	

Note: The answer of North Macedonia_1 is included in the analysis [described institutions]. France: The National Cancer Institute (with input from an International Scientific Advisory Board) leads the mid-term and final evaluations.

5.13. Indicators for the evaluation of NCCPs/cancer documents

Q12 asked about the use of evaluation indicators for the NCCPs/ cancer documents in the 31 participating countries (Appendix 14), with the results summarized in Table 14.

Table 14. The utilization of indicators in the evaluation of NCCPs/cancer documents in the participating countries (Q12: n=31)

Category answers	Number of countries (in percent)	Countries
Countries that do use indicators*	19 (61.3%)	Austria, Croatia, the Czech Republic, Estonia, France, Germany, Greece, Hungary, Ireland, Lithuania, Luxembourg, Malta, the Netherlands, North Macedonia, Poland, Portugal, Spain, Sweden and Turkey
Countries that do not use indicators	5 (16.1%)	Denmark, Iceland, Italy, Latvia and Slovenia
Countries that did not respond	7 (22.6%)	Bulgaria, Cyprus, Moldova, Norway, Romania, the Slovak Republic and Ukraine
The number of participating countries	**31 (100.0%)**	

Including North Macedonia_1 (answer) and excluding North Macedonia_2 (no answer); Germany: partially (e.g. for evaluation of population-based quality-assured screening programmes).

The majority of the countries, namely 19 (61.3%) out of 31, stated that they use indicators to assess their NCCPs/cancer documents, namely *Austria, Croatia, the Czech Republic, Estonia, France, Germany, Greece, Hungary, Ireland, Lithuania, Luxembourg, Malta, the Netherlands, North Macedonia, Poland, Portugal, Spain, Sweden and Turkey*. One of the countries – *Germany* – clarified that indicators are used in certain areas (e.g. quality-assured screening programmes), but not consistently for all aspects of its NCCP/cancer documents. Five (16.1%) of the 31 participating countries – *Denmark, Iceland, Italy, Latvia and Slovenia* – do not use indicators. Meanwhile, seven (22.6%) of the 31 countries – *Bulgaria, Cyprus, Moldova, Norway, Romania, the Slovak Republic and Ukraine* – did not answer the question.

The analysis of the responses of the 19 (61.3%) countries that reported using indicators in the evaluation process reveals a diverse range of methodologies, including varying methods and practices for selecting indicators for evaluating their NCCPs/cancer documents, as summarized below (see Box 3).

Box 3. Comparative overview of evaluation criteria for NCCPs/cancer documents and selection of indicators in 19 selected countries

Many of the 19 countries emphasized the importance of involving experts in the definition and selection of indicators. In **Austria**, for example, the indicators used are discussed in expert groups. In **France**, expert groups from the National Cancer Institute work with partners to select relevant indicators, while in the **Czech Republic** experts in cancer prevention, oncological care and systems play a key role in the process, and in **Germany** the selection is based on the EU guidelines for screening. **Malta** uses the "Donabedian framework", which focuses on structure, process and outcome indicators, while the **Netherlands** uses the "theory of change" approach, which ensures that indicators are aligned with the outcomes and societal impact of cancer control interventions. **Portugal** and **Poland** rely on nationally defined strategies. **Poland**'s National Oncology Strategy, for example, defines epidemiological indicators for mortality from the main types of cancer (e.g. colorectal cancer, breast cancer, lung cancer, cervical cancer). **Hungary** uses data on cancer incidence, mortality rates and information on patient care from several national healthcare institutions.

Several countries, such as **North Macedonia** and **Sweden**, include detailed indicators on screening programmes, including participation rates, time between diagnoses and outcomes for specific cancer types. Countries such as **Estonia** and **Spain** define outcome and performance indicators based on feasibility and the ability to collect data through existing systems (e.g. questionnaires and databases). **Croatia** uses a simple framework in which the main evaluation criteria are relevance, utility, efficiency and effectiveness, providing a broad but focused lens for evaluating policy outcomes. In **Greece**, the process is more institutionalized. The Expert Committee for Public Health (ECPH), which reports to the General Secretariat for Public Health of the Ministry of Health, oversees the selection of indicators. This centralized approach ensures that the indicators selected are in line with national public health objectives. **Ireland** has a structured and transparent monitoring system. For example, an annual report assesses progress against the 52 recommendations of the National Cancer Strategy and analyses 23 key performance indicators. This detailed reporting framework improves accountability and provides clear measures of success.[1] **Luxembourg** follows a collaborative approach, in which indicators are first selected by the committee that developed the plan. These are then revised or expanded by working groups based on specific projects or actions, reflecting a flexible, adaptable strategy. **Turkey** defines its progress indicators within the NCCP, and ensures that the sub-activities under each strategic heading are focused on measurable outcomes. For **Lithuania**, no information is available on the evaluation criteria or the selection of indicators, either due to a gap in the documentation or possible differences in the programme structure.

[1] See section 1.2 of the National Cancer Strategy for information on how the strategy was developed. https://assets.gov.ie/9315/6f1592a09583421baa87de3a7e9cb619.pdf

Table 15. Categorized methodology used for indicators to evaluate NCCPs in the participating countries (Q12: n=19)

Methodologies used for indicators	Number of countries (in percent)	Countries
Expert consultations	5 (26.3%)	Austria, the Czech Republic, France, Greece and Luxembourg
Screening-focused	4 (21.1%)	Germany, North Macedonia, Hungary and Sweden
Outcome-oriented indicators	4 (21.1%)	Malta, the Netherlands, Poland and Turkey
Mixed methods	5 (26.3%)	Croatia, Estonia, Ireland, Portugal and Spain
Insufficient information	1 (5.3%)	Lithuania
The number of selected countries	**19 (100.0%)**	

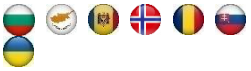
Nineteen (61.3%) of the 31 participating countries where information on the methodology used for the indicators was provided as part of the evaluation of the NCCP process (Table 14) – including *Lithuania* (which answered "do not know") – are categorized according to the methodology applied[2] (see Appendix 15). The analysis of the results shows (Table 15) that five (26.3%) of the 19 selected countries *(Austria, the Czech Republic, France, Greece, and Luxembourg)* worked with expert groups to select indicators. Four (21.1%) of the selected countries *(Germany, North Macedonia, Hungary, and Sweden)* favoured a screening-focused methodology for the indicators, while four (21.1%) *(Malta, the Netherlands, Poland and Turkey)* preferred measurable outcome-oriented indicators such as mortality, incidence, or quality of life. Finally, five (26.3%) of the 19 *(Croatia, Estonia, Ireland, Portugal, and Spain)* opted for a combination or mixed-methods approach, and one (5.3%) *(Lithuania)* did not report a methodology.

5.14. Inclusion of indicators in the NCCPs/cancer documents

The data analysed from 31 participating countries, as presented in Appendix 16 on Q13 of the Survey, reveals notable trends in the inclusion of indicators in the NCCPs/cancer documents (Figure 3 and Table 16).

[2] **Expert consultation:** countries relying primarily on expert group collaboration or committees to determine which indicators to include. **Screening-focused:** countries emphasizing cancer screening programmes or using indicators based on screening participation, timeliness, or retention. **Outcome-oriented indicators:** countries focusing on outcome-oriented measures, such as mortality, quality of life, patient-centredness, epidemiological impacts and so on. **Mixed methods:** countries using two or more methods (e.g. expert consultation, screening-focused, and outcome-oriented measures).

Table 16. Inclusion of indicators in NCCPs/cancer documents in the participating countries (Q13: n=31)

Country response	Number of countries (in percent)	Countries
Indicators included [Yes]*	18 (58.1%)	Austria, the Czech Republic, Estonia, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, the Netherlands, North Macedonia, Poland, Portugal, Spain, Sweden and Turkey 
Indicators not included [No]	6 (19.4%)	Croatia, Denmark, France, Germany, Iceland and Slovenia 
No answer**	7 (22.6%)	Bulgaria, Cyprus, Moldova, Norway, Romania, the Slovak Republic and Ukraine 
The number of participating countries	**31 (100.0%)**	

* Including North Macedonia_1 (response); ** excluding North Macedonia_2 (no response).

- Eighteen (58.1%) of 31 participating countries *(Austria, the Czech Republic, Estonia, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, the Netherlands, North Macedonia, Poland, Portugal, Spain, Sweden and Turkey)* include indicators in their NCCPs/cancer documents.
- Six (19.4%) of 31 participating countries *(Croatia, Denmark, France, Germany, Iceland and Slovenia)* explicitly reported that indicators are not included in their NCCPs/cancer documents.
- Seven (22.6%) of 31 participating countries *(Bulgaria, Cyprus, Moldova, Norway, Romania, the Slovak Republic and Ukraine)* did not provide any information on whether or not indicators are included.

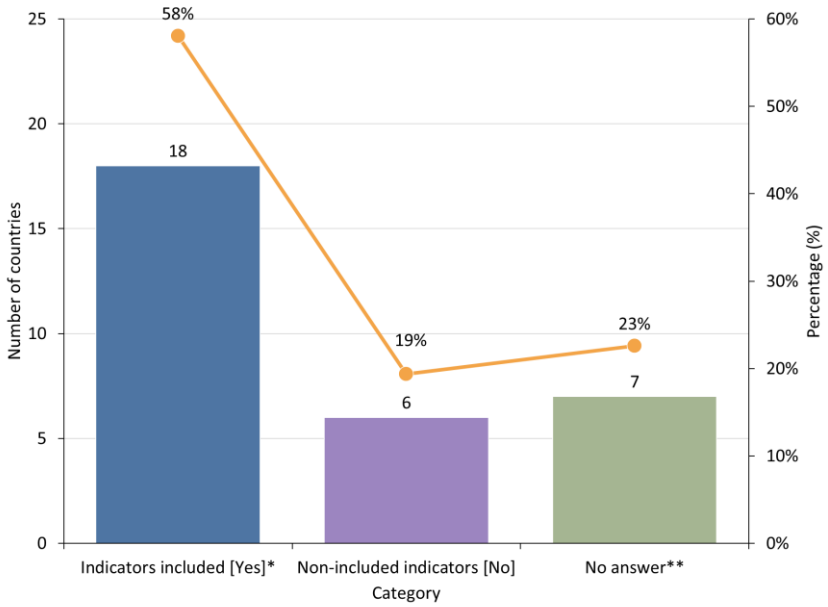


Figure 3. Inclusion of indicators in NCCPs/cancer documents (Q13: n=31)

5.15. Methods used in the evaluation of NCCPs/cancer documents

Table 17 presents the data based on the responses of the participating countries regarding the methods used in the evaluation of their NCCPs/cancer documents. The key types of evaluation, according to the European Guide for Quality NCCPs,[3] are evaluation by structure, process, and outcomes.[4] Of the 31 participating countries, 24 (77.4%) responded to Q14 by noting various types of evaluation methods, with the results presented in Appendix 17 and Figure 4. The largest share of these used a combination of structure, process, and outcome indicators (13 countries, accounting for 41.9% of the full 31 responses – *Croatia, Denmark, France, Germany, Greece, Italy, Latvia, Luxembourg, Malta, the Netherlands, North Macedonia, Spain and Sweden).* This was followed by countries that used a combination of process and outcome indicators (four countries, 12.9% of 31 – *Czech Republic, Estonia, Iceland, and Portugal)*, and those that focused solely on outcomes (three countries, 9.7% of 31 countries – *Austria, Poland, and Turkey).*

[3] Albreht T, Martin Moreno JM, Jelenc M, Gorgojo L, Harris M. European Guide for Quality National Cancer Control Programmes. Ljubljana: National Institute of Public Health, 2015.
[4] Summary of definitions: **Structure** refers to the setup of a system, including resources, organization, and infrastructure. **Process** relates to the actions taken to deliver services, including procedures and strategies. **Outcomes** are the results of the processes, such as health improvements, patient satisfaction, or system efficiency.

One country each (3.2% of 31 responses) used only process indicators (*Lithuania)*, a combination of structure and process indicators *(Slovenia)*, or structure and outcome indicators (*Hungary).*

Table 17. Evaluation methods for NCCPs by type (structure, process, outcomes) in the participating countries (Q14: n=31)

Country response	Number of countries (in percent)	Countries
Response of evaluation methods by *type* [Yes]*	24 (77.4%)	
Structure, process, and outcomes	*13 (41.9%)*	*Croatia, Denmark, France, Germany, Greece, Italy, Latvia, Luxembourg, Malta, the Netherlands, North Macedonia, Spain and Sweden*
Process and outcomes	*4 (12.9%)*	*Czech Republic, Estonia, Iceland and Portugal*
Outcomes	*3 (9.7%)*	*Austria, Poland and Turkey*
Structure and process	*1 (3.2%)*	*Slovenia*
Structure and outcomes	*1 (3.2%)*	*Hungary*
Process	*1 (3.2%)*	*Lithuania*
Other**	*1 (3.2%)*	*Ireland*
No answer	7 (22.6%)	Bulgaria, Cyprus, Moldova, Norway, Romania, the Slovak Republic and Ukraine
The number of participating countries	**31 (100.0%)**	

* Including North Macedonia_1 and _2 (responses). ** Ireland publishes an annual implementation report which sets out the progress achieved on the implementation of the 52 recommendations of the National Cancer Strategy and the degree to which the 23 associated key performance indicators are being met; recommendations and KPIs of the Strategy include structures, processes and outcomes.

In addition, one country (3.2%), *Ireland*, gave "other" as its response, indicating a different approach to evaluation. Ireland follows a unique evaluation method, where an annual implementation report is published. This report outlines the progress made in implementing the 52 recommendations of the National Cancer Strategy and the extent to which the 23 associated key performance indicators (KPIs) are being met. The recommendations and KPIs of the strategy cover a comprehensive range of areas, including structures, processes, and outcomes. This approach reflects Ireland's focus on assessing the effectiveness of its healthcare strategy through a detailed, performance-driven framework that incorporates multiple evaluation dimensions. The remaining seven countries, accounting for 22.6% of 31 responses – namely *Bulgaria, Cyprus, Moldova, Norway, Romania, the Slovak Republic, and Ukraine* – did not provide an answer for this question.

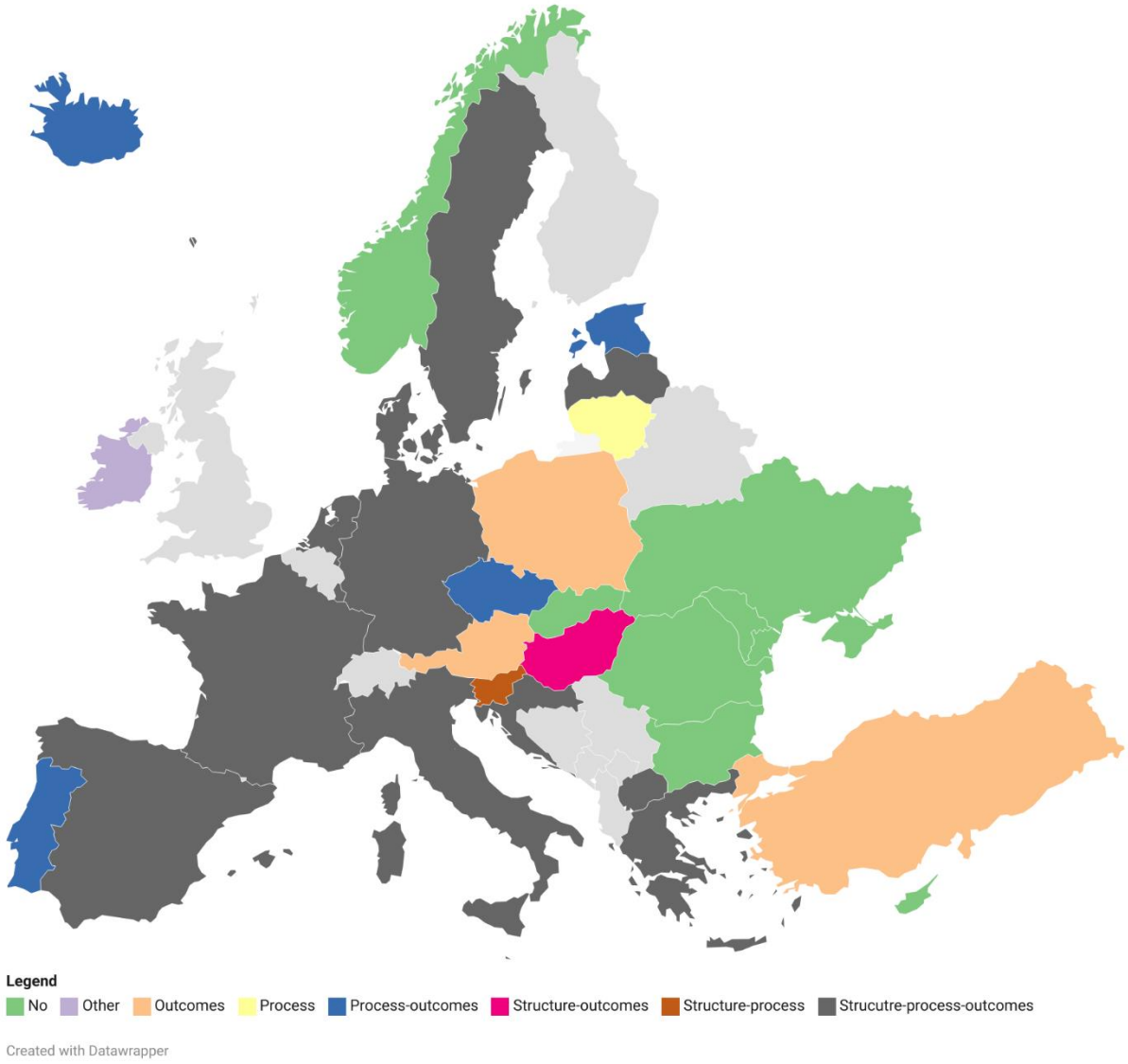


Figure 4. Evaluation methods for NCCPs by structure, process, and outcomes in the participating countries (Q15: n=31)

6. RESULTS OF THE ANALYSIS – PART 2 OF THE SURVEY

6.1. Alignment of NCCPs with areas recommended by the European Guide for Quality NCCPs/cancer documents

According to the results for Q15 of the Survey, presented in Appendix 18, key areas of the European Guide for Quality NPPCs have been widely adopted and implemented by the participating countries.

Table 18. Inclusion of the areas recommended by the European Guide for Quality NCCPs in the NCCPs/cancer documents in the participating countries (Q15: n=31)

Recommendation area***	Number of responding countries (in percent)			
	Yes	No	NA	Total
Primary prevention	30 (96.8%)	0 (0.0%)	1 (3.2%)	31 (100.0%)
Cancer screening	30 (96.8%)	0 (0.0%)	1 (3.2%)	31 (100.0%)
Early detection	29 (93.5%)	1 (3.2%)	1 (3.2%)	31 (100.0%)
Diagnosis	29 (93.5%)	1 (3.2%)	1 (3.2%)	31 (100.0%)
Treatment	29 (93.5%)	1 (3.2%)	1 (3.2%)	31 (100.0%)
Cancer data and information	29 (93.5%)	1 (3.2%)	1 (3.2%)	31 (100.0%)
Psychosocial oncology care	27 (87.1%)	3 (9.7%)	1 (3.2%)	31 (100.0%)
Research	27 (87.1%)	3 (9.7%)	1 (3.2%)	31 (100.0%)
Health promotion	26 (83.9%)	4 (12.9%)	1 (3.2%)	31 (100.0%)
Palliative and end-of-life care	26 (83.9%)	4 (12.9%)	1 (3.2%)	31 (100.0%)
Access to innovative cancer treatments	25 (80.6%)	5 (16.1%)	1 (3.2%)	31 (100.0%)
Education and training	25 (80.6%)	5 (16.1%)	1 (3.2%)	31 (100.0%)
Survivorship	24 (77.4%)	6 (19.4%)	1 (3.2%)	31 (100.0%)
Rehabilitation	22 (71.0%)	7 (22.6%)	2 (6.5%)	31 (100.0%)
Patient empowerment	22 (71.0%)	8 (25.8%)	1 (3.2%)	31 (100.0%)
Governance*	21 (67.7%)	9 (29.0%)	1 (3.2%)	31 (100.0%)
Cancer resources**	20 (64.5%)	10 (32.3%)	1 (3.2%)	31 (100.0%)
Monitoring of cancer burden	19 (61.3%)	7 (22.6%)	5 (16.1%)	31 (100.0%)
Financing	16 (51.6%)	14 (45.2%)	1 (3.2%)	31 (100.0%)
Other	2 (6.5%)	0 (0.0%)	29 (93.5%)	31 (100.0%)

* Management and planning of cancer services. ** Human resources, infrastructure, health technology, cancer specific expenditure. ***Albreht T, Martin Moreno JM, Jelenc M, Gorgojo L, Harris M. European Guide for Quality National Cancer Control Programmes. Ljubljana: National Institute of Public Health, 2015.

The Survey results, as presented in Table 18 and Figure 5, illustrate the adoption rates of the European Guide for Quality NCCPs[5] across 19 recommendation areas in the participating countries. The data highlights the degree to which these countries have implemented the guide's recommendations.

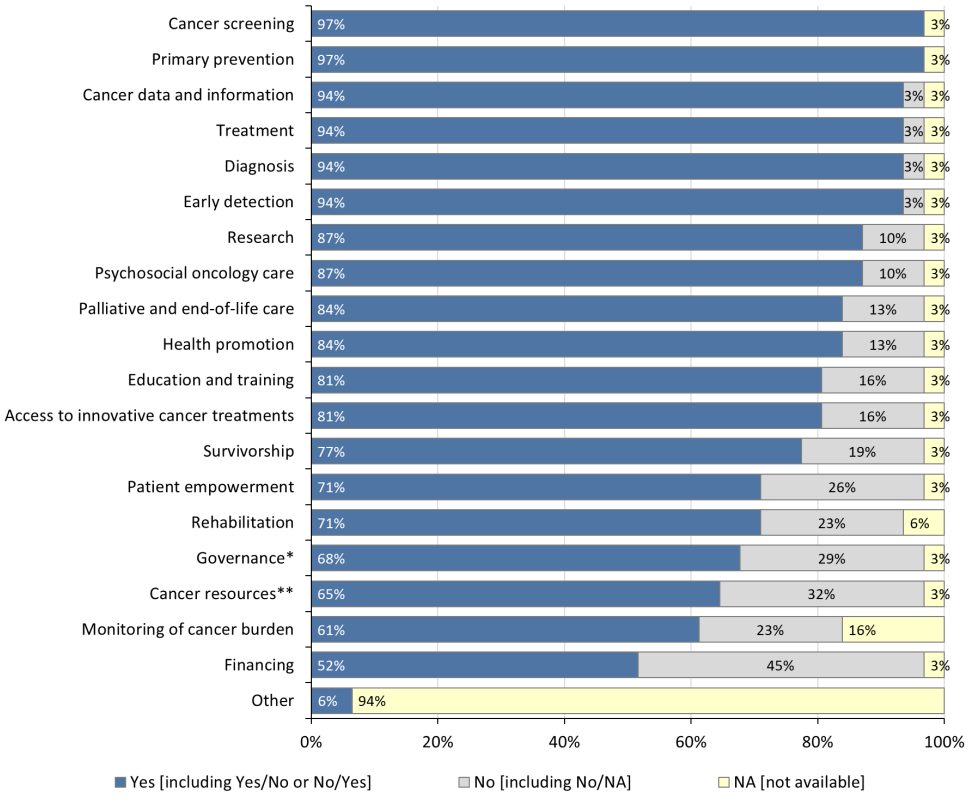
The highest adoption rates are observed in the areas of primary prevention and cancer screening, with 96.8% (30 out of 31) of the participating countries reporting implementation. Similarly, early detection, diagnosis, treatment, and cancer-related data and information exhibit high adoption rates, with 93.5% (29 out of 31) of the participating countries incorporating these areas into their programmes. Psychosocial oncology care and research are also widely implemented, with 87.1% (27 out of 31) of the participating countries integrating these components. Additional areas, such as health promotion, and palliative and end-of-life care show substantial adoption levels, with 83.9% (26 out of 31) of the participating countries including them in their strategies.

However, adoption rates vary significantly across other areas. For example, access to innovative cancer treatments, and education and training have a lower adoption rate, with 80.6% (25 out of 31) of the participating countries implementing this area. Similarly, the survivorship area is adopted by 77.4% (24 out of 31) of the participating countries, meaning that seven (19.4%) do not address this. The rehabilitation and patient empowerment areas have even lower adoption rates, with 71.0% (22 out of 31) of the participating countries implementing these. However, the rates differ with regard to the lack of adoption, which stands at 22.6% (seven out of 31) for rehabilitation and 25.8% (eight out of 31) for patient empowerment.

Governance – the management and planning of cancer services – shows a notable gap in adoption, with only 67.7% (21 out of 31) of the participating countries implementing the related recommendations, while 29.0% (nine out of 31) have not. Cancer resources – which include human resources, infrastructure, health technology, and cancer-specific

[5] Albreht T, Martin Moreno JM, Jelenc M, Gorgojo L, Harris M. European Guide for Quality National Cancer Control Programmes. Ljubljana: National Institute of Public Health, 2015. https://cancercontrol.eu/archived/uploads/images/European_Guide_for_Quality_National_Cancer_Control_Programmes_web.pdf

expenditure – are adopted by 64.5% of the participating countries (20 out of 31). However, there is still a significant number of countries that have not implemented these recommendations, accounting for 32.3% of the total (10 out of 31). Monitoring the cancer burden shows a mixed response: 61.3% (19 out of 31) of the participating countries have adopted this area, while 22.6% (seven out of 31) have not, and 16.1% (five out of 31) marked it as "not applicable". Financing has the lowest adoption rate, with just 51.6% (16 out of 31) of the participating countries implementing the recommendations, and 45.2% (14 out of 31) not adopting this area. Finally, the "other" category, which includes additional areas specified by only two of the 31 participating countries, has minimal adoption, at just 6.5%, with the remaining 93.5% (29 countries) marking it as not applicable. Specifically, Estonia highlighted a separate section on cancer in childhood and among AYA (adolescents and young adults), and Slovenia emphasized the quality of cancer care. The coverage of the areas suggested by the European Guide for Quality NPPCs among the participating countries is presented in Figure 5.



Notes: *management and planning of cancer services.
** human resources, infrastructure, health technology, cancer specific expenditure.

Figure 5. Percentage of adoption of the European Guide for Quality NCCPs by recommendation area in the participating countries, in 2024 (Q15: n=31)

7. RESULTS OF THE ANALYSIS – PART 3 OF THE SURVEY

In order to analyse how countries are integrating the equity perspective in their NCCPs, equity questions were analysed into four domains: capacity-building, primary and secondary prevention, treatment and survivorship, and rehabilitation and palliative care. Belgium, Montenegro and Finland were excluded from the analysis as they do not have an NCCP in place. Moreover, Germany was excluded as it did not answer Part 3 of the Survey.

7.1. Capacity-building

The capacity-building questions aimed at analysing the impact of NCCPs on skills development, process improvement, and the quality of healthcare institutions' own resources and their professionals, as well as how these relate to patients. In total, 12 different topics were addressed in this part of the Survey.

7.1.1. Equity objectives

One of the first questions addressed in the capacity-building domain is whether each country has equity objectives in their NCCPs. The results (Figure 6) show that the vast majority of NCCPs (24/30; 80%) have objectives aimed at tackling social inequalities in cancer, with of these 43.3% (13/30) having a proportionate universalism approach, and 36.7% (11/30) with a universal approach.

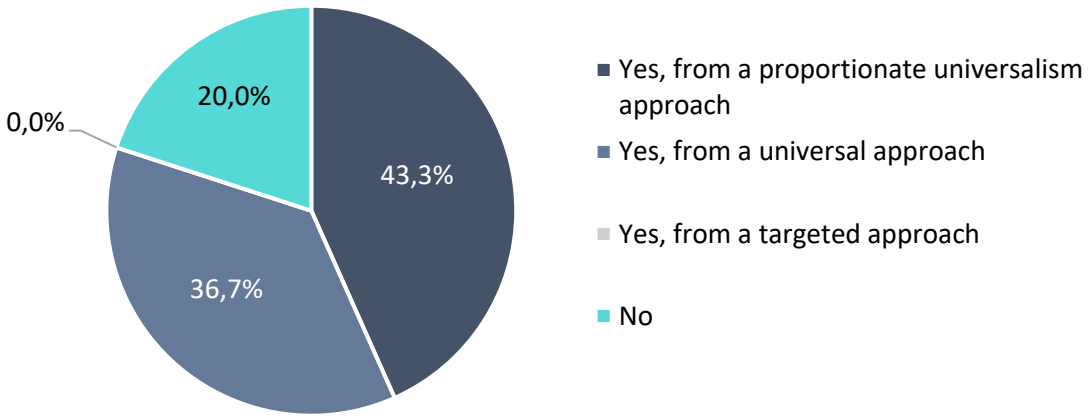


Figure 6. Content of objectives aimed at tackling social inequalities in cancer in NCCPs (Q16: n=30)

Table 19 shows the distribution of responses by country for each option.

Table 19. Objectives aimed at tackling social inequalities in cancer in NCCPs by country (Q16: n=30)

Country response	Number of countries (in percent)	Countries
Yes, from a proportionate universalism approach (universal + targeted approach)	13 (43.3%)	Austria, Croatia, Estonia, France, Iceland, Luxembourg, Malta, North Macedonia, the Slovak Republic, Slovenia, Sweden, the Netherlands, Turkey
Yes, from a universal approach	11 (36.7%)	Cyprus, the Czech Republic, Denmark, Greece, Hungary, Ireland, Italy, Poland, Portugal, Romania, Spain
Yes, from a targeted approach	0 (0%)	/
No	6 (20%)	Bulgaria, Latvia, Lithuania, Moldova, Norway, Ukraine
Total number of participating countries	**30 (100%)**	

For those NCCPs that include equity objectives, the social determinants of health that are most commonly mentioned (Figure 7) are age (11/13; 84.6%) and territory (10/13; 76.9%), while ethnicity and cultural background (7/13; 53.9%) and the institutionalized population (5/13; 38.5%) are the least common.

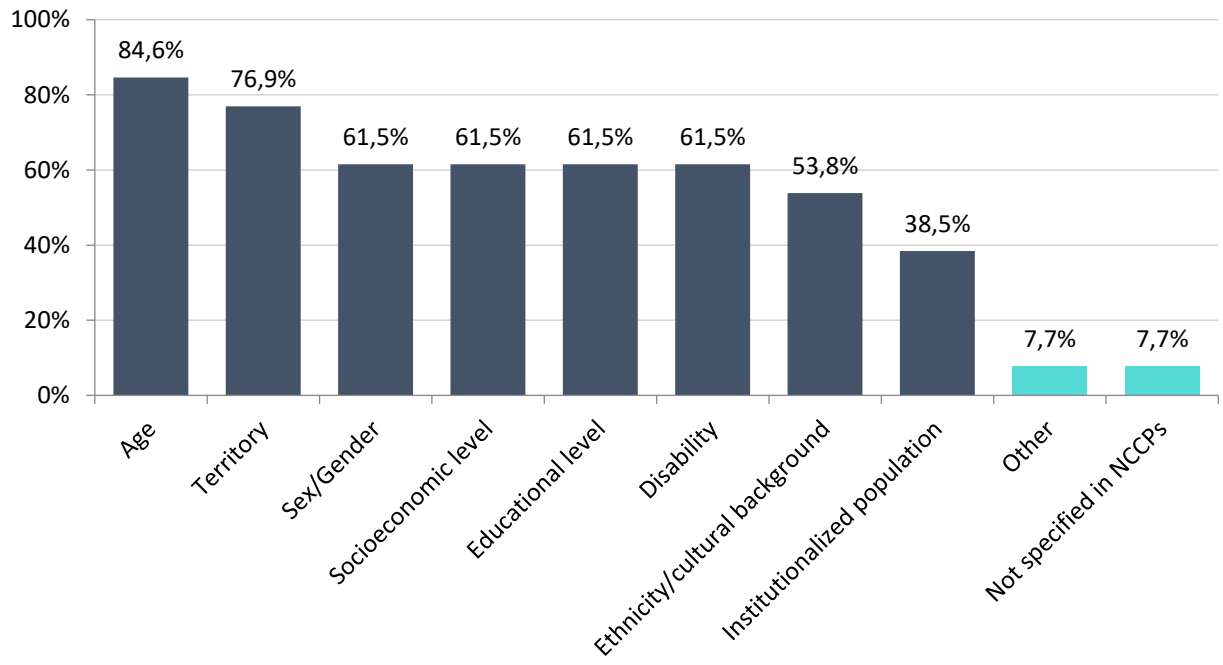


Figure 7. Social determinants of health considered by countries with equity objectives (Q16: n=30)

7.1.2. Health in All Policies

Regarding the inclusion of the Health in All Policies approach in their NCCPs, 56.7% (17/30) of countries include it in their cancer documents (Figure 8).

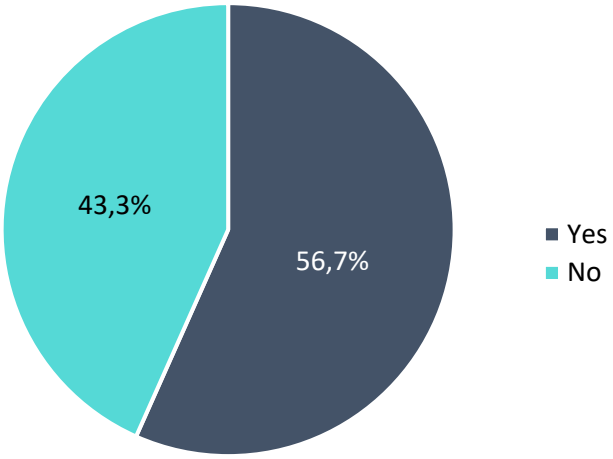


Figure 8. Inclusion of the Health in All Policies approach in NCCPs (Q17: n=30)

Table 20 shows the distribution of responses by country for each option.

Table 20. Inclusion of the Health in All Policies approach in NCCPs by country (Q17: n=30)

Country response	Number of countries (in percent)	Countries
Yes	17 (56.7%)	Austria, Croatia, Cyprus, France, Hungary, Italy, Latvia, Luxembourg, Malta, the Netherlands, Poland, Portugal, the Slovak Republic, Slovenia, Spain, Sweden, Turkey
No	13 (43.3%)	Bulgaria, the Czech Republic, Denmark, Estonia, Greece, Iceland, Ireland, Lithuania, Moldova, North Macedonia, Norway, Romania, Ukraine
Total number of participating countries	**30 (100%)**	

Out of those which include the Health in All Policies approach (Figure 9), the sectors most considered are public health (16/17; 94.1%), healthcare (15/17; 88.2%), education (14/17; 82.4%) and research sectors (14/17; 82.4%), while the least considered are agriculture and the private sector (5/17; 29.4% each).

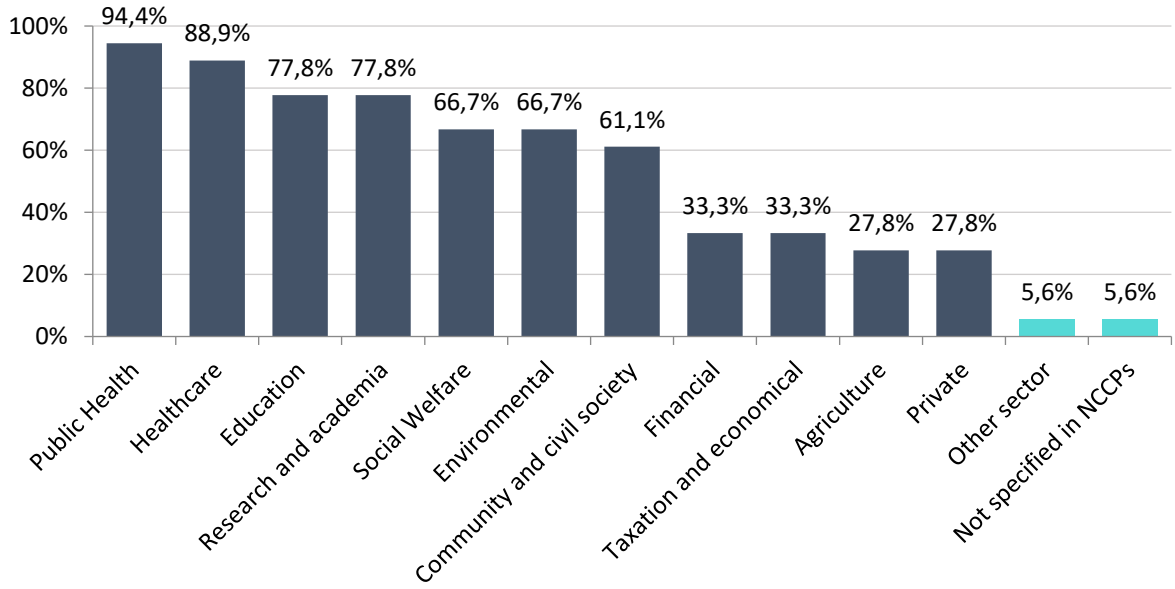


Figure 9. Sectors involved by countries with the Health in All Policies approach (Q17: n=30)

7.1.3. Multidisciplinary workforce

Slightly more than half of the countries (16/30; 53.3%) include the promotion of a multidisciplinary cancer workforce in their NCCPs (Figure 10).

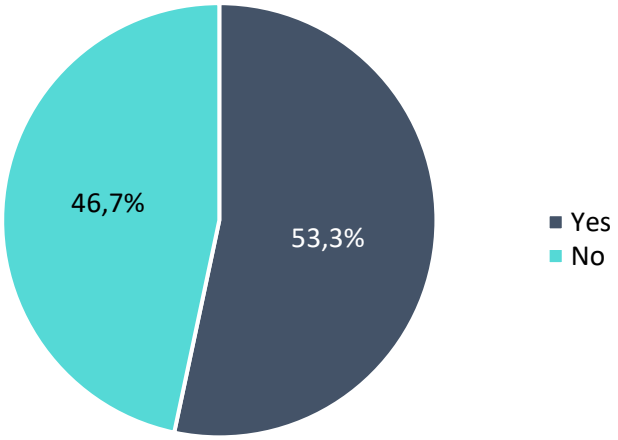


Figure 10. Promotion of the creation of a multidisciplinary cancer workforce in NCCPs (Q18: n=30)

Table 21 shows the distribution of responses by country for each option.

Table 21. Promotion of the creation of a multidisciplinary cancer workforce in NCCPs by country (Q18: n=30)

Country response	Number of countries (in percent)	Countries
Yes	16 (53.3%)	Croatia, Cyprus, the Czech Republic, Hungary, Ireland, Italy, Latvia, Luxembourg, Malta, the Netherlands, North Macedonia, the Slovak Republic, Slovenia, Spain, Turkey, Ukraine
No	14 (46.7%)	Austria, Bulgaria, Denmark, Estonia, France, Greece, Iceland, Lithuania, Moldova, Norway, Poland, Portugal, Romania, Sweden
Total number of participating countries	**30 (100%)**	

The most commonly involved disciplines (Figure 11) are health and social science (present in 81.3% [13/16] and 68.6% [11/16] of countries, respectively), while the least promoted ones are engineering (3/16; 18.8%), business and management (3/16; 18.8%), and the arts, which is not present in any NCCP.

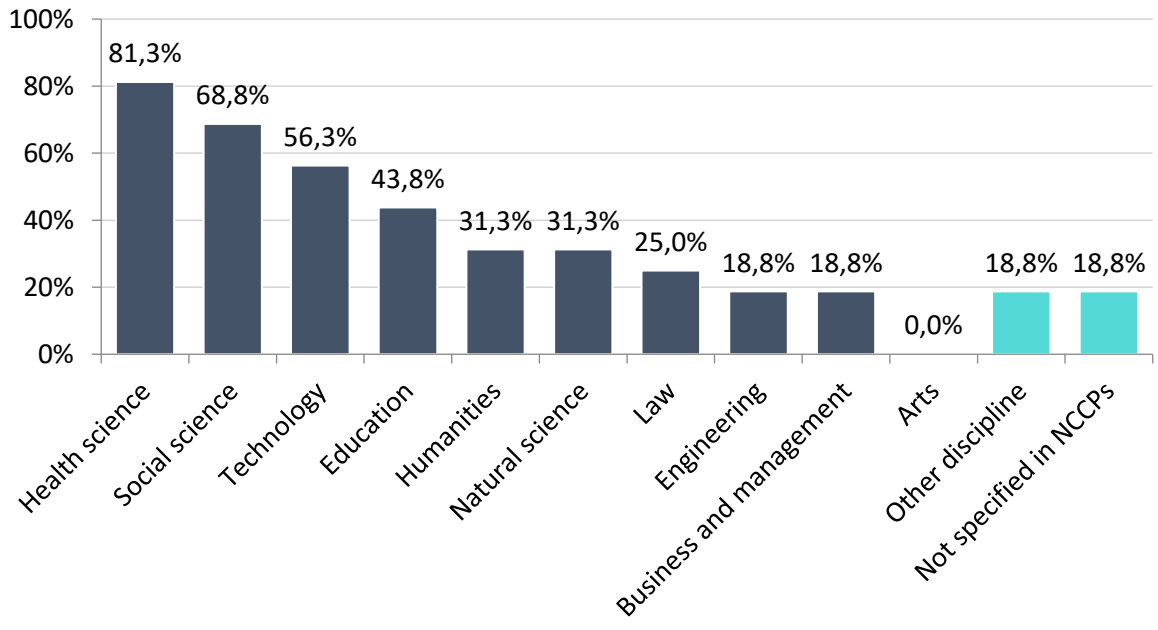


Figure 11. Disciplines involved by countries with a multidisciplinary workforce (Q18: n=30)

7.1.4. Equity indicators

Less present in NCCPs are equity indicators, with only 36.7% (11/30) of cancer documents including indicators related to the social determinants of health (Figure 12).

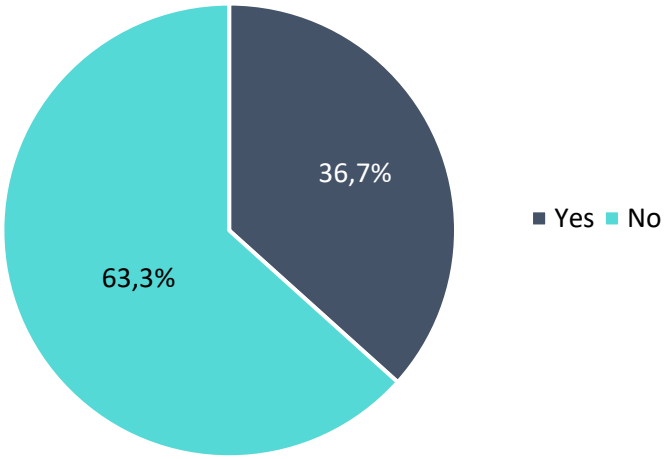


Figure 12. Inclusion of indicators and/or quality criteria related to the social determinants of health in NCCPs (Q19: n=30)

Table 22 shows the distribution of responses by country for each option.

Table 22. Inclusion of indicators and/or quality criteria related to the social determinants of health in NCCPs by country (Q19: n=30)

Country response	Number of countries (in percent)	Countries
Yes	11 (36.7%)	Bulgaria, Croatia, Estonia, France, Ireland, Malta, the Netherlands, North Macedonia, Slovenia, Sweden, Turkey
No	19 (63.3%)	Austria, Cyprus, the Czech Republic, Denmark, Greece, Hungary, Iceland, Italy, Latvia, Lithuania, Luxembourg, Moldova, Norway, Poland, Portugal, Romania, the Slovak Republic, Spain, Ukraine
Total number of participating countries	**30 (100%)**	

For those that include this type of indicators (Figure 13), age and sex are the most common (9/11; 81.8% of countries include them), while disability (3/11; 27.3%) and the institutionalized population (1/11; 9.1%) is the least common.

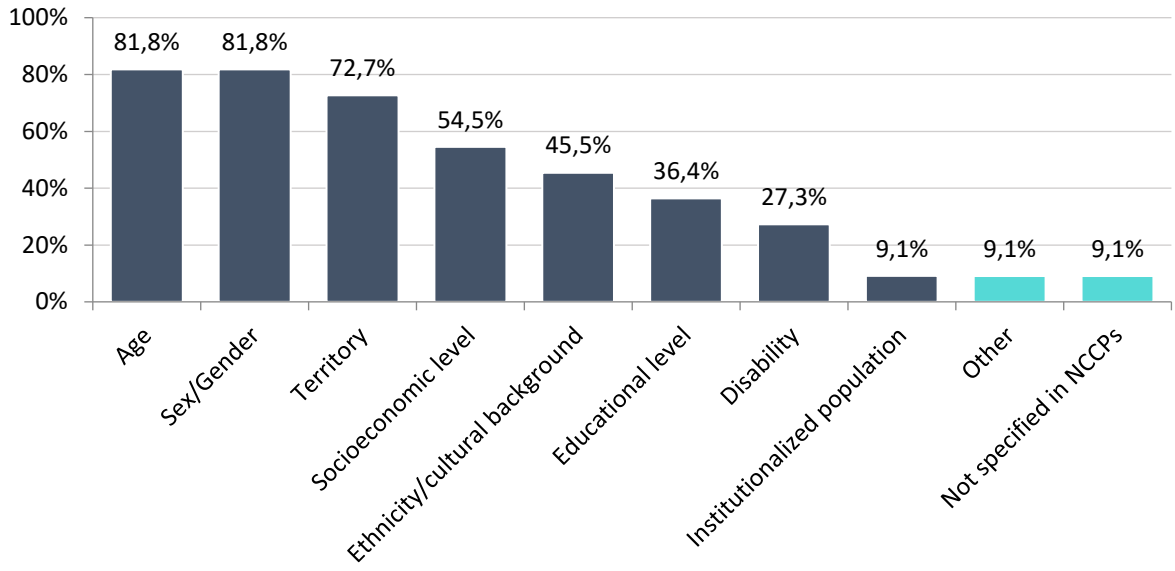


Figure 13. Social determinants of health considered by countries in their indicators and quality criteria (Q19: n=30)

7.1.5. Analysis of inequalities

Fewer than half of the countries (13/30; 43.3%) are planning to analyse the existing social inequalities in cancer in their NCCPs (Figure 14).

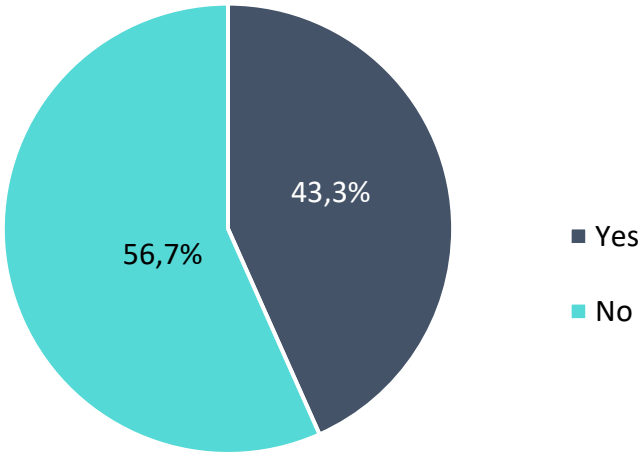


Figure 14. Planning of the identification and analysis of the existing social inequalities in cancer in NCCPs (Q20: n=30)

Table 23 shows the distribution of responses by country for each option.

Table 23. Planning of the identification and analysis of the existing social inequalities in cancer in NCCPs by country (Q20: n=30)

Country response	Number of countries (in percent)	Countries
Yes	13 (43.3%)	Austria, Croatia, France, Hungary, Ireland, Italy, Luxembourg, Malta, the Netherlands, North Macedonia, Slovenia, Sweden, Turkey
No	17 (56.7%)	Bulgaria, Cyprus, the Czech Republic, Denmark, Estonia, Greece, Iceland, Latvia, Lithuania, Moldova, Norway, Poland, Portugal, Romania, the Slovak Republic, Spain, Ukraine
Total number of participating countries	**30 (100%)**	

For those planning to analyse existing social inequalities (Figure 15), socioeconomic level (9/13; 69.2%) and territory inequalities (8/13; 61.5%) are the most considered social determinants of health, while disability (3/13; 23.1%) and the institutionalized population (1/13; 7.7%) are once again the least considered.

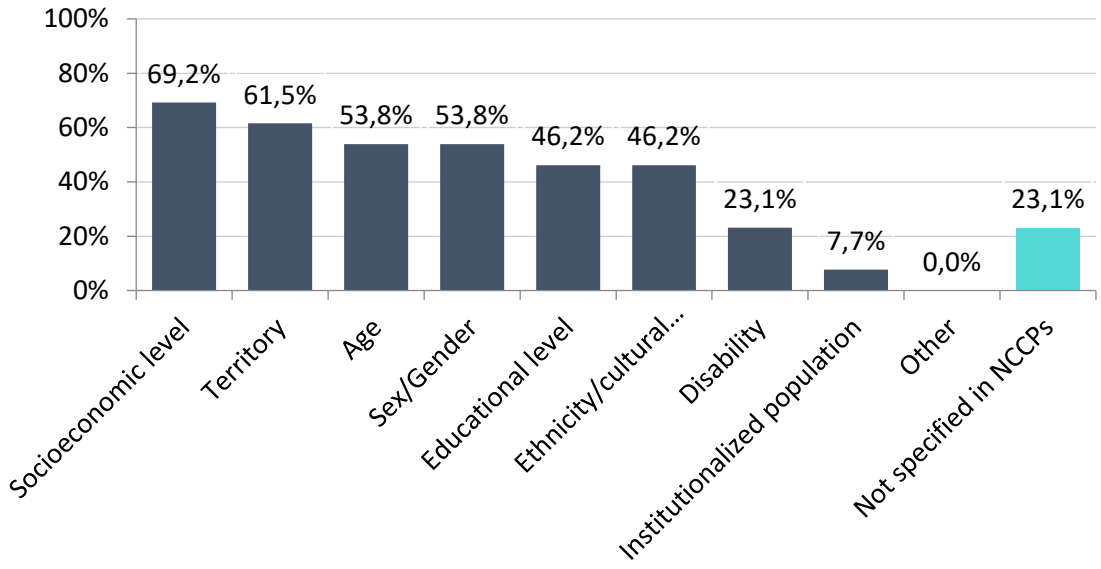


Figure 15. Social determinants of health considered by countries planning to identify and analyse existing social inequalities in cancer (Q20: n=30)

7.1.6. Equity impact assessment

As found with regard to equity impact assessments (Figure 16), only one third (10/30; 33.3%) of countries are planning to perform one in their NCCPs.

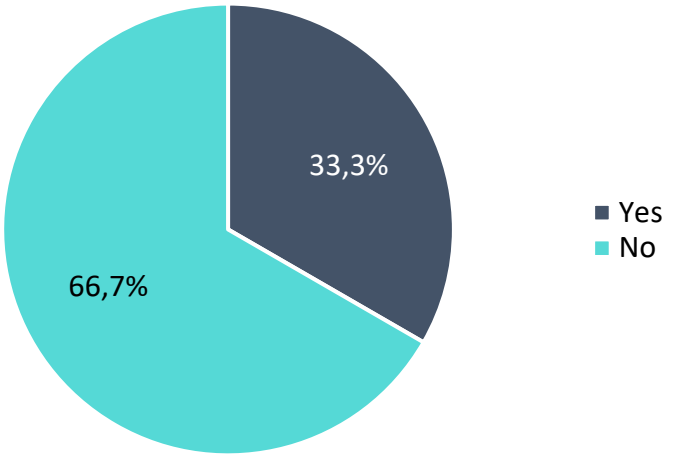


Figure 16. Planning of assessment of the impact of NCCPs on the social inequalities in cancer (Q21: n=30)

Table 24 shows the distribution of responses by country for each option.

Table 24. Planning of the assessment of the impact of NCCPs on the social inequalities in cancer by country (Q21: n=30)

Country response	Number of countries (in percent)	Countries
Yes	10 (33.3%)	Croatia, France, Greece, Ireland, Italy, Malta, North Macedonia, Slovenia, Sweden, Turkey
No	20 (66.7%)	Austria, Bulgaria, Cyprus, the Czech Republic, Denmark, Estonia, Hungary, Iceland, Latvia, Lithuania, Luxembourg, Moldova, the Netherlands, Norway, Poland, Portugal, Romania, the Slovak Republic, Spain, Ukraine
Total number of participating countries	**30 (100%)**	

Out of those planning to perform an equity impact assessment, the potential inequalities most frequently taken into account (Figure 17) are age (8/10; 80.0%), followed by territory, sex and socioeconomic level (7/10; 70.0% each). Once again, inequalities in the disabled (3/10; 30.0%) and institutionalized populations (1/10; 10.0%) are ranked in last position.

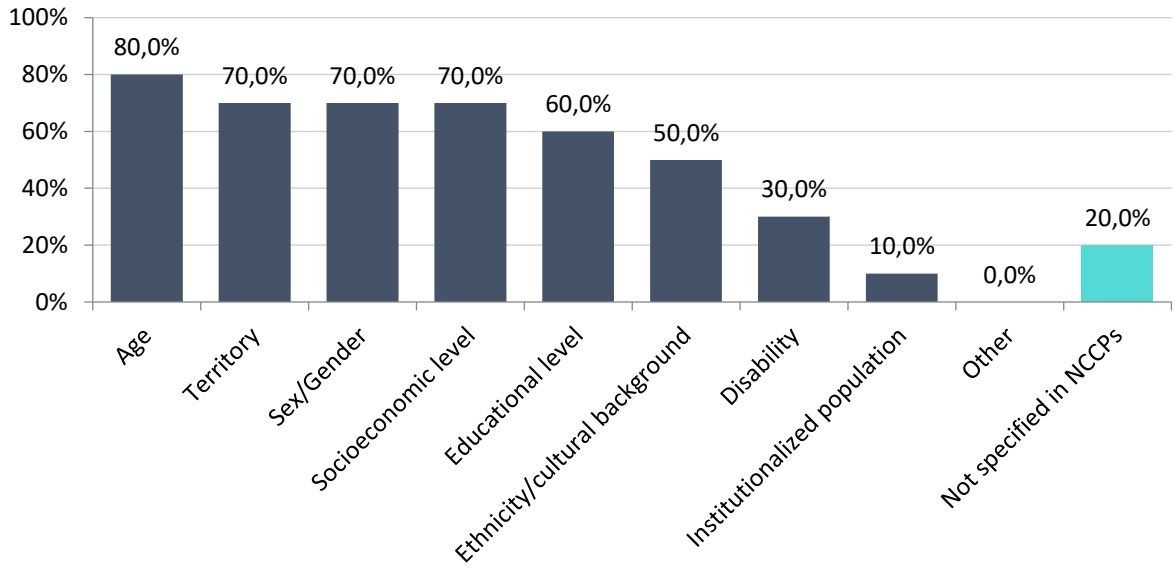


Figure 17. Social determinants of health considered by countries planning to assess their impact on the social inequalities in cancer (Q21: n=30)

7.1.7. Equity variables

Regarding the inclusion of equity variables in their cancer information systems (Figure 18), only 40.0% (12/30) of NCCPs promote this.

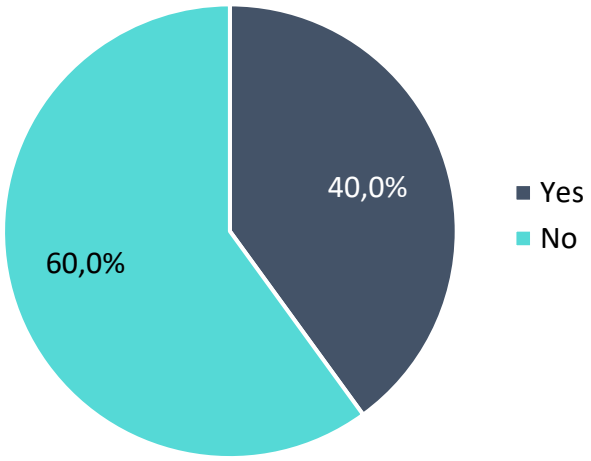


Figure 18. Promotion of the inclusion of the social determinants of health variables in the national/regional cancer information systems (Q22: n=30)

Table 25 shows the distribution of responses by country for each option.

Table 25. Promotion of the inclusion of the social determinants of health variables in the national/regional cancer information systems in NCCPs by country (Q22: n=30)

Country response	Number of countries (in percent)	Countries
Yes	12 (40%)	Croatia, Cyprus, Greece, Hungary, Ireland, Malta, the Netherlands, North Macedonia, Slovenia, Spain, Sweden, Turkey
No	18 (60%)	Austria, Bulgaria, the Czech Republic, Denmark, Estonia, France, Iceland, Italy, Latvia, Lithuania, Luxembourg, Moldova, Norway, Poland, Portugal, Romania, the Slovak Republic, Ukraine
Total number of participating countries	**30 (100%)**	

Out of all social determinants of health used considered in their regional cancer information systems (Figure 19), age, sex and territory are the most common ones (present in 75.0% [9/12] of NCCPs). In this case, disability (2/12; 16.7%) and the institutionalized population (0%) are, again, the least mentioned.

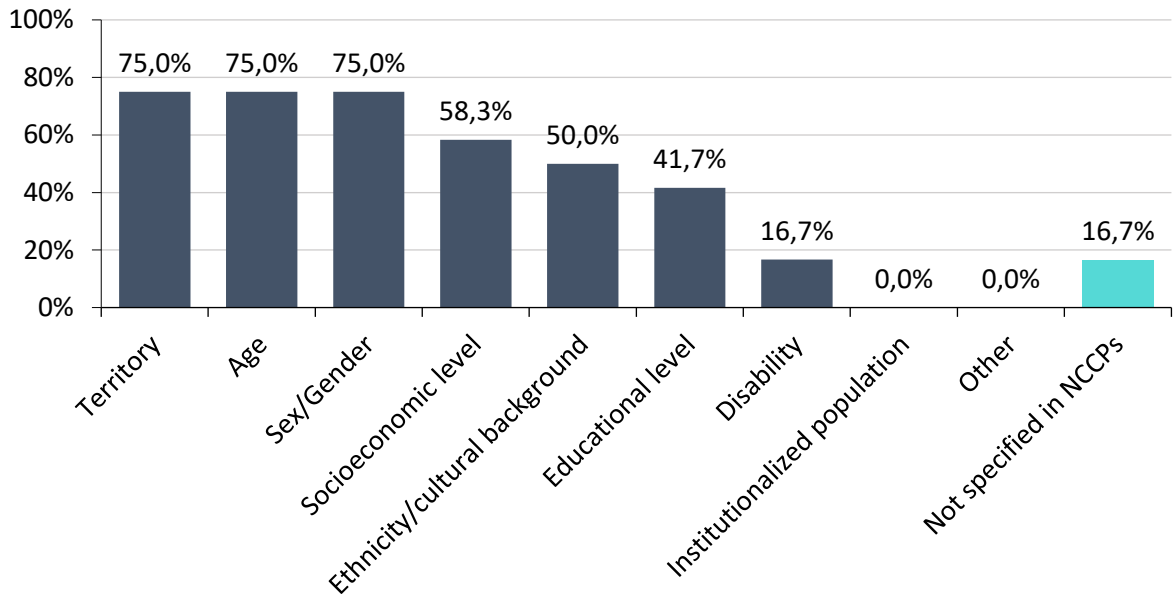


Figure 19. Social determinants of health considered by countries in the variables in their cancer information systems (Q22: n=30)

7.1.8. Information on patient-reported outcomes and experience measures

Slightly less than half of the countries (14/30; 46.7%) actually promote the collection of information on patient-reported outcomes and experience measures (Figure 20).

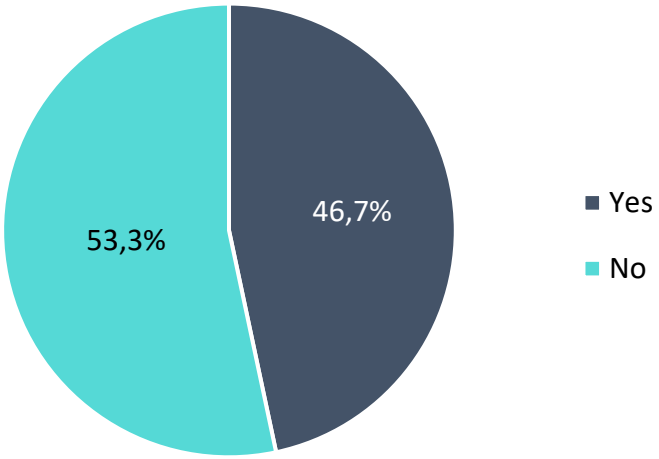


Figure 20. Promotion of the collection of information on patient-reported outcome and experience measures (PROMs and PREMs) in NCCPs (Q23: n=30)

Table 26 shows the distribution of responses by country for each option.

Table 26. Promotion of the collection of information on patient-reported outcome and experience measures (PROMs and PREMs) in NCCPs by country (Q23: n=30)

Country response	Number of countries (in percent)	Countries
Yes	14 (46.7%)	Croatia, the Czech Republic, Denmark, Estonia, Ireland, Italy, Latvia, Luxembourg, Malta, the Netherlands, Norway, Portugal, Slovenia, Sweden
No	16 (53.3%)	Austria, Bulgaria, Cyprus, France, Greece, Hungary, Iceland, Lithuania, Moldova, North Macedonia, Poland, Romania, the Slovak Republic, Spain, Turkey, Ukraine
Total number of participating countries	**30 (100%)**	

7.1.9. Social participation

Many NCCPs, 70% (21/30) of all included in the study, actually are promoting the social participation of citizens and patients in the design, implementation and evaluation of their cancer policies and programmes (Figure 21).

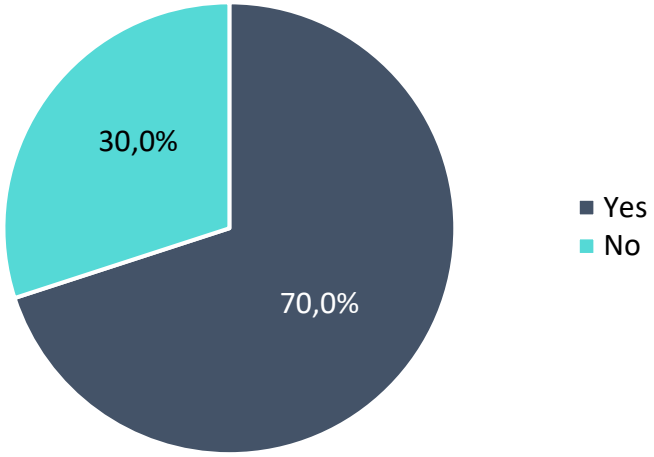


Figure 21. Promotion of the social participation of citizens and patients in the design, implementation, and evaluation of cancer policies/programmes in NCCPs (Q24: n=30)

Table 27 shows the distribution of responses by country for each option.

Table 27. Promotion of the social participation of citizens and patients in the design, implementation, and evaluation of NCCPs by country (Q24: n=30)

Country response	Number of countries (in percent)	Countries
Yes	21 (70%)	Bulgaria, Croatia, Cyprus, the Czech Republic, Denmark, Estonia, France, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, the Netherlands, Norway, Portugal, Slovenia, Spain, Sweden
No	9 (30%)	Austria, Iceland, Moldova, North Macedonia, Poland, Romania, the Slovak Republic, Turkey, Ukraine
Total number of participating countries	**30 (100%)**	

Out of countries promoting social participation (Figure 22), all of them include patient associations, while other organizations are mentioned in less than 30% of the NCCPs. The least present youth and student organizations (3/21; 14.3%), followed by religious and faith-based organizations (1/21; 4.8%).

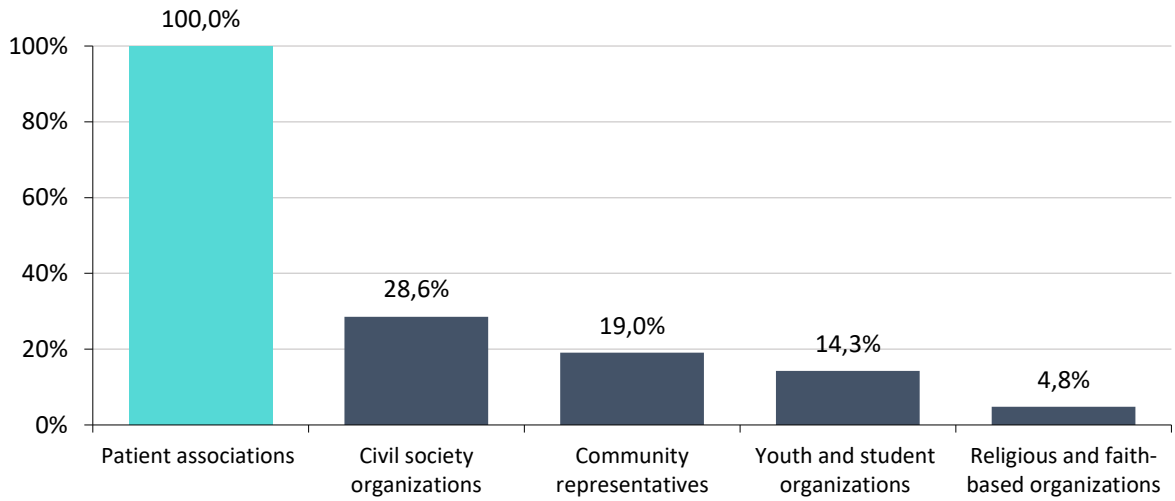


Figure 22. Social agents involved by countries promoting the social participation of citizen and patients (Q24: n=30)

7.1.10. Informed decision-making

As for the promotion of informed decision-making for citizens and patients (Figure 23), most countries (18/30; 60%) include this action in their NCCPs. The most common approach used is the proportionate universalism approach, present in 33% (10/30) of NCCPs, followed by 20% (6/30) of countries with a universal approach and a 7% (2/30) with a targeted approach.

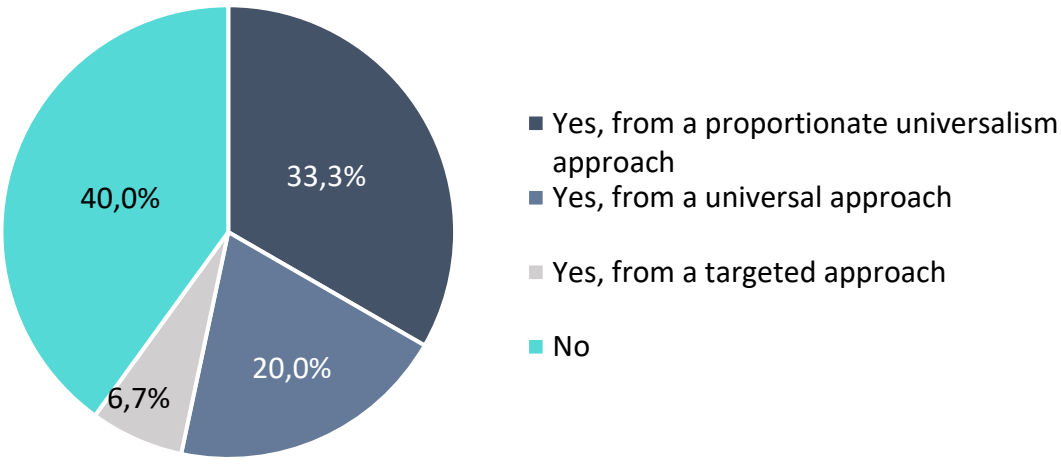


Figure 23. Promotion of informed decision-making for citizens and patients from an equity perspective in NCCPs (Q25: n=30)

Table 28 shows the distribution of responses by country for each option.

Table 28. Promotion of informed decision-making for citizens and patients from an equity perspective in NCCPs by country (Q25: n=30)

Country response	Number of countries (in percent)	Countries
Yes, from a proportionate universalism approach (universal + targeted approach)	10 (33.3%)	Croatia, the Czech Republic, France, Hungary, Italy, Malta, the Netherlands, Slovenia, Sweden, Turkey
Yes, from a universal approach	6 (20%)	Denmark, Ireland, Luxembourg, Poland, the Slovak Republic, Spain
Yes, from a targeted approach	2 (6.7%)	Iceland, North Macedonia
No	12 (40%)	Austria, Bulgaria, Cyprus, Estonia, Greece, Latvia, Lithuania, Moldova, Norway, Portugal, Romania, Ukraine
Total number of participating countries	**30 (100%)**	

7.1.11. Good practices

Regarding the exchange of good practices in tackling social inequalities in cancer (Figure 24), only 23.3% (7/30) of countries are making efforts to encourage this, making it the least common approach in all NCCPs with regard to the capacity-building domain.

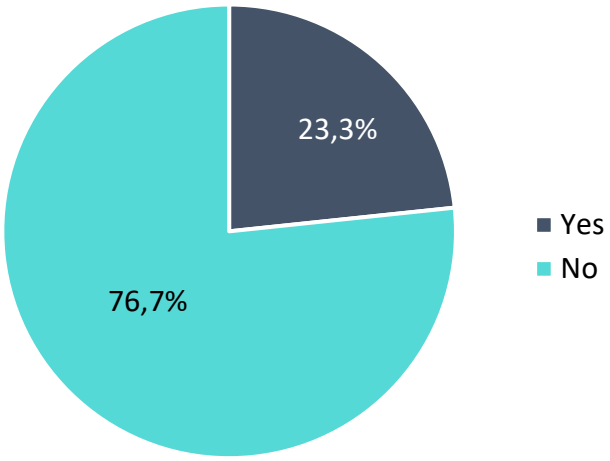


Figure 24. Fostering exchanges of good practices in tackling social inequalities in cancer in NCCPs (Q26: n=30)

Table 29 shows the distribution of responses by country for each option.

Table 29. Fostering exchanges of good practices in tackling social inequalities in cancer in NCCPs by country (Q26: n=30)

Country response	Number of countries (in percent)	Countries
Yes	7 (23.3%)	Croatia, France, Hungary, Ireland, Malta, Slovenia, Sweden
No	23 (76.7%)	Austria, Bulgaria, Cyprus, the Czech Republic, Denmark, Estonia, Greece, Iceland, Italy, Latvia, Lithuania, Luxembourg, Moldova, the Netherlands, North Macedonia, Norway, Poland, Portugal, Romania, the Slovak Republic, Spain, Turkey, Ukraine
Total number of participating countries	**30 (100%)**	

7.1.12. Equity training

The last question related to the capacity-building domain (Figure 25) shows that 43.3% (13/30) of all NCCPs promote training on the equity perspective for cancer professionals.

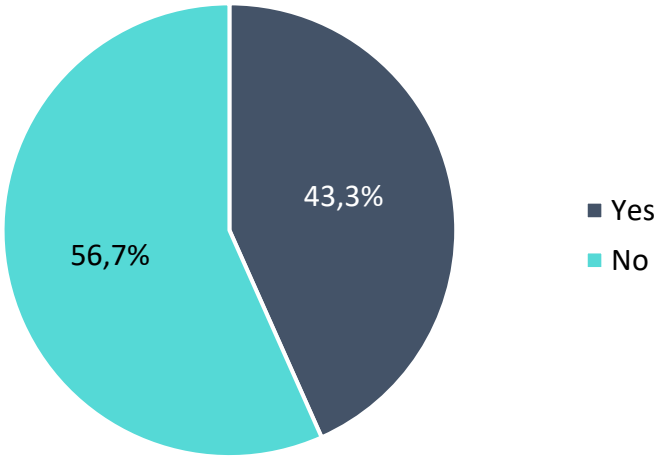


Figure 25. Promotion of training for cancer professionals in the cancer equity perspective in NCCPs (Q27: n=30)

Table 30 shows the distribution of responses by country for each option.

Table 30. Promotion of training for cancer professionals in the cancer equity perspective in NCCPs by country (Q27: n=30)

Country response	Number of countries (in percent)	Countries
Yes	13 (43.3%)	Bulgaria, Croatia, Denmark, Hungary, Ireland, Italy, Malta, the Netherlands, North Macedonia, Poland, Slovenia, Spain, Turkey
No	17 (56.7%)	Austria, Cyprus, the Czech Republic, Estonia, France, Greece, Iceland, Latvia, Lithuania, Luxembourg, Moldova, Norway, Portugal, Romania, the Slovak Republic, Sweden, Ukraine
Total number of participating countries	**30 (100%)**	

7.1.13. Capacity-building general overview

Figure 26 provides an overview of the equity perspective with regard to positive responses to each of the capacity-building questions. Notably, the items with the strongest equity perspective are the inclusion of equity objectives (24/30; 80%) and the promotion of social participation (21/30; 70%), while the ones with the weakest equity perspective are the equity impact assessment (10/30; 33%) and the exchange of good practices in reducing cancer inequalities (7/30; 23%).

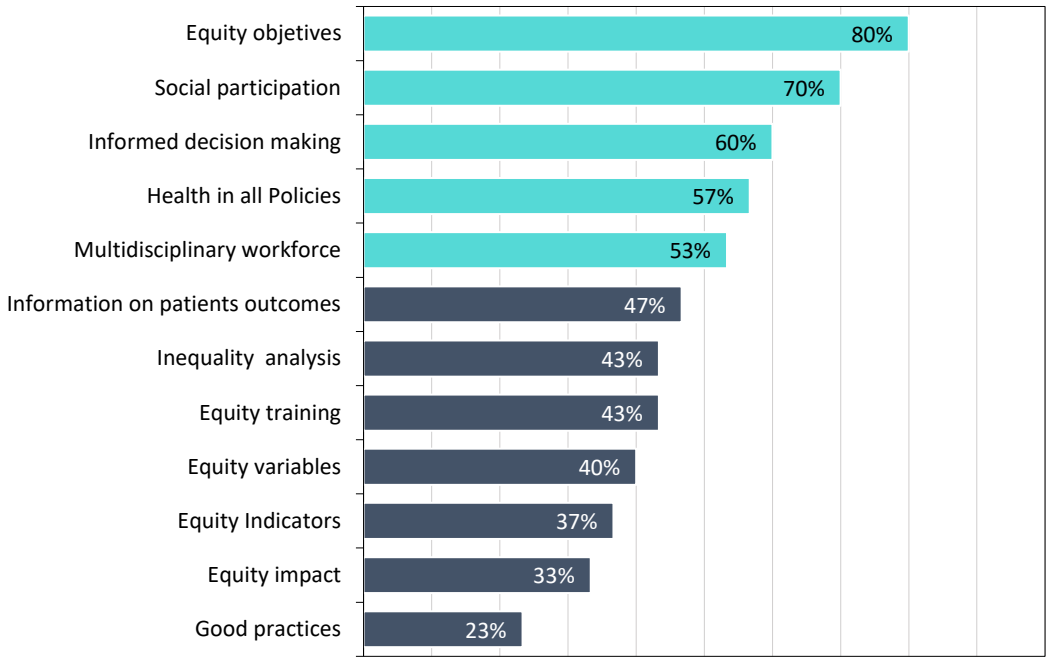


Figure 26. Percentage of countries that answered positively for each capacity-building question (Q26: n=30)

The results by country (Figure 27) show that higher rate of positive answers is found in Croatia, Malta and Slovenia, with all 12 questions answered positively. Ireland, with 11, and Netherlands and Sweden, with 10 each, also have many positive responses. In the group with the fewest positive answers are Lithuania, Romania and Ukraine, with only one each, and finally Moldova, with no positive responses.

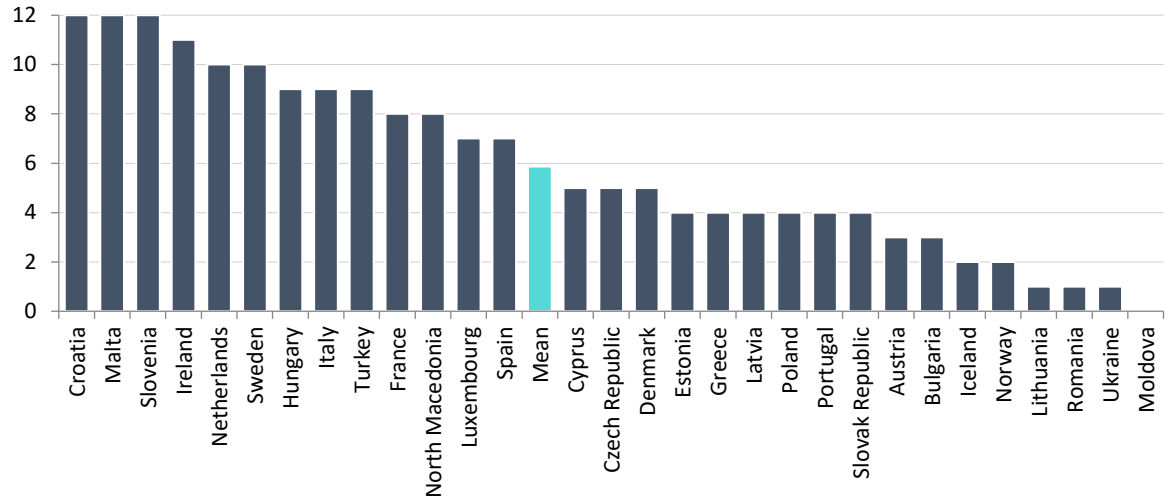


Figure 27. Number of capacity-building questions answered positively by country (Q26: n=30)

To finish this analysis of the capacity-building domain, two excerpts from policy documents are presented to highlight some good practices and high-quality policymaking in this context.

Regarding equity objectives, Sweden states that it aims to "reduce differences between different population groups in incidence and survival time after a cancer diagnosis. It is well documented that people living in poorer socio-economic conditions are at greater risk of developing and dying from cancer."

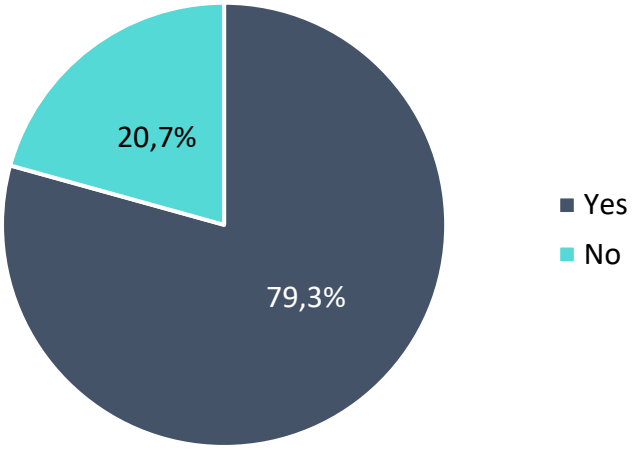
On the topic of the Health in All Policies approach, France mentions that "health becomes the concern of a set of stakeholders […] This intersectional approach to public policies (including transport, agriculture, social or education sector) is in keeping with the Health in All Policies concept promoted by the WHO."

7.2. Primary and secondary prevention

The primary and secondary prevention domain refers to questions focusing on ways to prevent cancer from developing and improve early detection, and it was assessed using five questions.

7.2.1. Healthy living environments

The first prevention question focuses on the development of healthy living environments, favouring compliance with the European Code Against Cancer. Out of all the NCCPs, only 20.7% (6/29) do not promote it (Figure 28).



Note: n=29, as for one country this was not applicable (North Macedonia).

Figure 28. Promotion of the development of healthy living environments in NCCPs (Q28: n=29)

Table 31 shows the distribution of responses by country for each option.

Table 31. Promotion of development of healthy living environments in NCCPs by country (Q28: n=29)

Country response	Number of countries (in percent)	Countries
Yes	23 (79.3%)	Austria, Bulgaria, Croatia, Cyprus, Estonia, France, Greece, Hungary, Iceland, Ireland, Italy, Lithuania, Luxembourg, Malta, the Netherlands, Norway, Poland, Portugal, the Slovak Republic, Slovenia, Spain, Sweden, Turkey
No	6 (20.7%)	Czech Republic, Denmark, Latvia, Moldova, Romania, Ukraine
Total number of participating countries	**29 (100%)**	

Note: n=29, as for one country this was not applicable (North Macedonia).

Meanwhile, almost 60% (13/23) of countries which do promote healthy living environments, do so by promoting healthy schools and kindergartens. The rest of the options fall between a 23% and a 33% with regard to their presence in NCCPs. It is also worth noticing that a third (33.3%) (8/23) of NCCPs promoting healthy living environments do not actually specify what kind of living environment is being promoted in this regard (Figure 29).

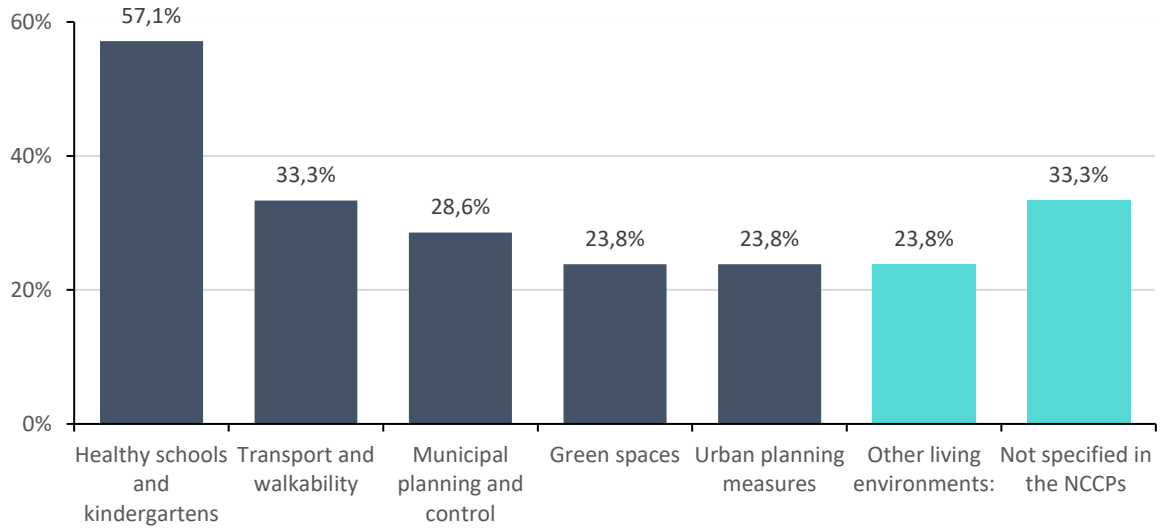


Figure 29. Type of living environments promoted by countries which had that perspective in their NCCPs (Q28: n=29)

7.2.2. Health literacy

The vast majority of the NCCPs (24/30; 80%) promote the improvement of health literacy with regard to cancer risks and determinants (Figure 30). The most common approach used is the universal approach (12/30; 40%), followed closely by proportionate universalism (10/30; 33.3%). On the other hand, only 6.7% (2/30) of NCCPs use the targeted approach.

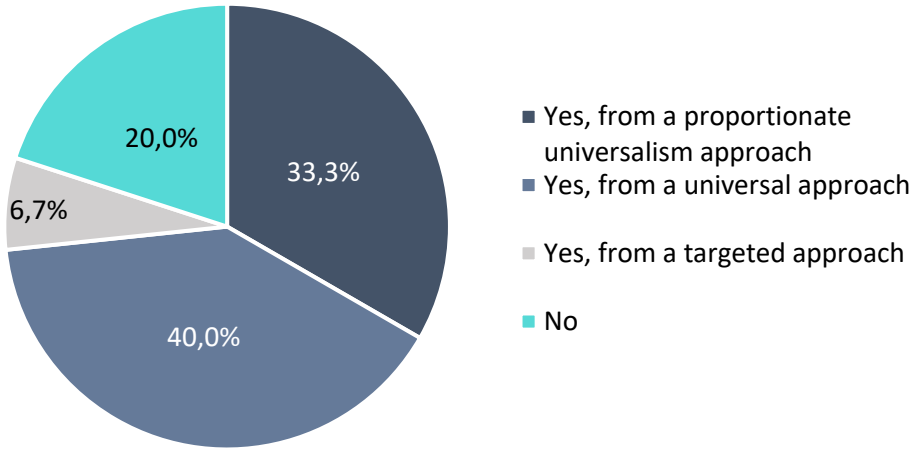


Figure 30. Promotion of the improvement of health literacy with regard to cancer risk and determinants from an equity perspective in NCCPs (Q29: n=30)

Table 32 shows the distribution of responses by country for each option.

Table 32. Promotion of improvement of health literacy on cancer risk and determinants from an equity perspective in NCCPs by country (Q29: n=30)

Country response	Number of countries (in percent)	Countries
Yes, from a proportionate universalism approach (universal + targeted approach)	10 (33.3%)	Croatia, Cyprus, Estonia, France, Ireland, Malta, Poland, Slovenia, Sweden, Turkey
Yes, from a universal approach	12 (40%)	Austria, Greece, Hungary, Italy, Latvia, Lithuania, Luxembourg, Moldova, Portugal, the Slovak Republic, Spain, Ukraine
Yes, from a targeted approach	2 (6.7%)	North Macedonia, Norway
No	6 (20%)	Bulgaria, the Czech Republic, Denmark, Iceland, the Netherlands, Romania
Total number of participating countries	**30 (100%)**	

7.2.3. Healthy behaviours

Almost three quarters of the NCCPs promote healthy behaviours for preventing cancer (Figure 31), with both the proportionate universalism approach and universal approach being used in 26.7% (8/30) of cases. The targeted approach follows closely, with a 20% (6/30) of NCCPs using this.

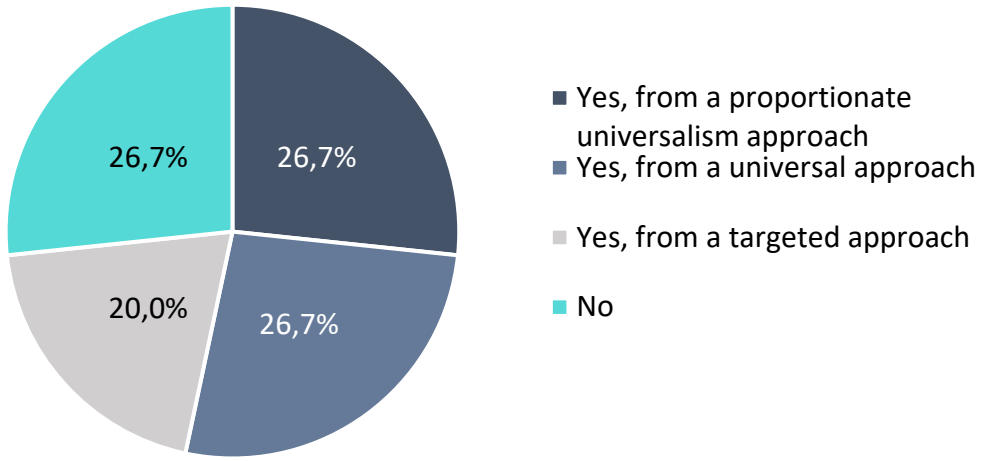


Figure 31. Promotion of healthy behaviours for preventing cancer with an equity perspective in NCCPs (Q30: n=30)

Table 33 shows the distribution of responses by country for each option.

Table 33. Promotion of healthy behaviours for preventing cancer with an equity perspective in NCCPs by country (Q30: n=30)

Country response	Number of countries (in percent)	Countries
Yes, from a proportionate universalism approach (universal + targeted approach)	8 (26.7%)	Croatia, the Czech Republic, Estonia, Hungary, Ireland, Malta, Slovenia, Sweden
Yes, from a universal approach	8 (26.7%)	Italy, Lithuania, Luxembourg, Moldova, Poland, Portugal, the Slovak Republic, Spain
Yes, from a targeted approach	6 (20%)	Austria, Greece, Iceland, North Macedonia, Norway, Turkey
No	8 (26.7%)	Bulgaria, Cyprus, Denmark, France, Latvia, the Netherlands, Romania, Ukraine
Total number of participating countries	**30 (100%)**	

7.2.4. Equal screening access

With a lower positive response rate than the last three topics, 56.7% (17/30) of the NCCPs promote equitable access and compliance with population-based cancer screening programmes (Figure 32). The proportionate universalism approach is, again, the most common one used (8/30; 26.7%), followed by the universal (6/30; 20%) and targeted (3/30; 10%) approaches.

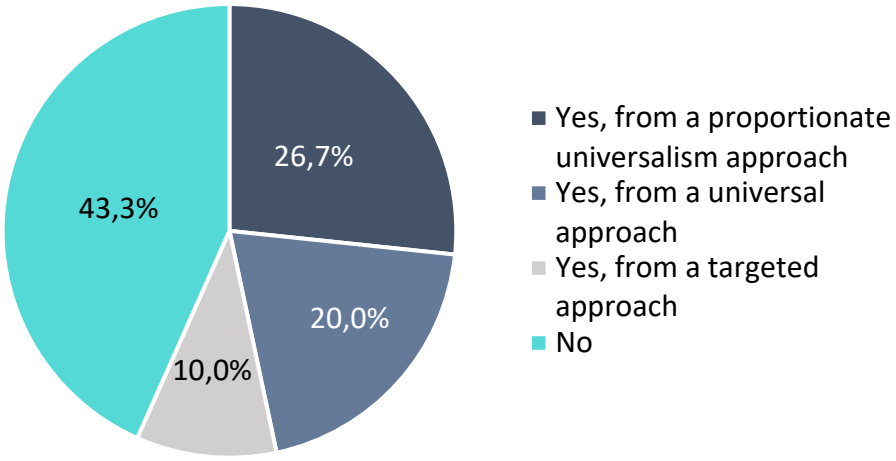


Figure 32. Promotion of equitable access and compliance with population-based cancer screening programmes from an equity perspective in NCCPs (Q31: n=30)

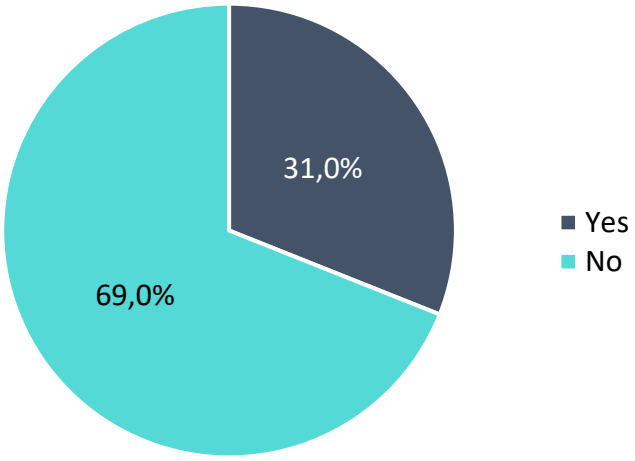
Table 34 shows the distribution of responses by country for each option.

Table 34. Promotion of equitable access and compliance with population-based cancer screening programmes from an equity perspective in NCCPs by country (Q31: n=30)

Country response	Number of countries (in percent)	Countries
Yes, from a proportionate universalism approach (universal + targeted approach)	8 (26.7%)	Croatia, Denmark, France, Ireland, Malta, Slovenia, Sweden, Turkey
Yes, from a universal approach	6 (20%)	Greece, Hungary, Italy, Portugal, the Slovak Republic, Spain
Yes, from a targeted approach	3 (10%)	Cyprus, Luxembourg, North Macedonia
No	13 (43.3%)	Austria, Bulgaria, the Czech Republic, Estonia, Iceland, Latvia, Lithuania, Moldova, the Netherlands, Norway, Poland, Romania, Ukraine
Total number of participating countries	**30 (100%)**	

7.2.5. Personalized risk assessment

While more than half of the countries were taking into account the prior prevention items, only 31% (9/29) of NCCPs are promoting personalized risk assessment, taking into account social determinants of health, in order to promote targeted cancer prevention (Figure 33).



Note: n=29, Ireland did not respond to this question.

Figure 33. Consideration of personalized risk assessment taking into account the social determinants of health in order to promote targeted cancer prevention in NCCPs (Q32: n=29)

Table 35 shows the distribution of responses by country for each option.

Table 35. Consideration of personalized risk assessment taking into account the social determinants of health in order to promote targeted cancer prevention in NCCPs by country (Q32: n=29)

Country response	Number of countries (in percent)	Countries
Yes	9 (31%)	Croatia, the Czech Republic, Denmark, Italy, Malta, Moldova, North Macedonia, Sweden, Turkey
No	20 (69%)	Austria, Bulgaria, Cyprus, Estonia, France, Greece, Hungary, Iceland, Latvia, Lithuania, Luxembourg, the Netherlands, Norway, Poland, Portugal, Romania, the Slovak Republic, Slovenia, Spain, Ukraine
Total number of participating countries	**29 (100%)**	

Note: n=29, Ireland did not respond to this question.

7.2.6. Primary and secondary prevention general overview

Figure 34 provides an overview of the equity perspective across each of the prevention questions. Notably, the items with the strongest presence of an equity perspective are those related to the promotion of health literacy (24/30; 80%) and healthy living environments (23/29; 79%), while that with the least emphasis on equity is for personalized risk assessment (9/29; 31%).

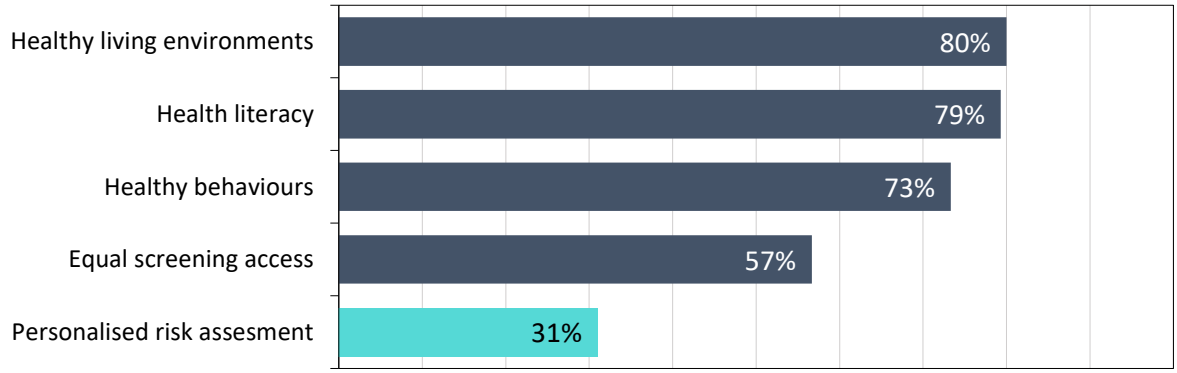


Figure 34. Percentage of countries that answered positively for each primary and secondary prevention question

The results by country, as seen in Figure 35, show that those with more positive answers for the prevention questions are Croatia, Italy, Malta, Sweden and Turkey, each with all five areas taken into account. On the other hand, Bulgaria, Latvia, the Netherlands

and Ukraine only have one of the prevention perspectives taken into account in their NCCPs, while Romania does not have any.

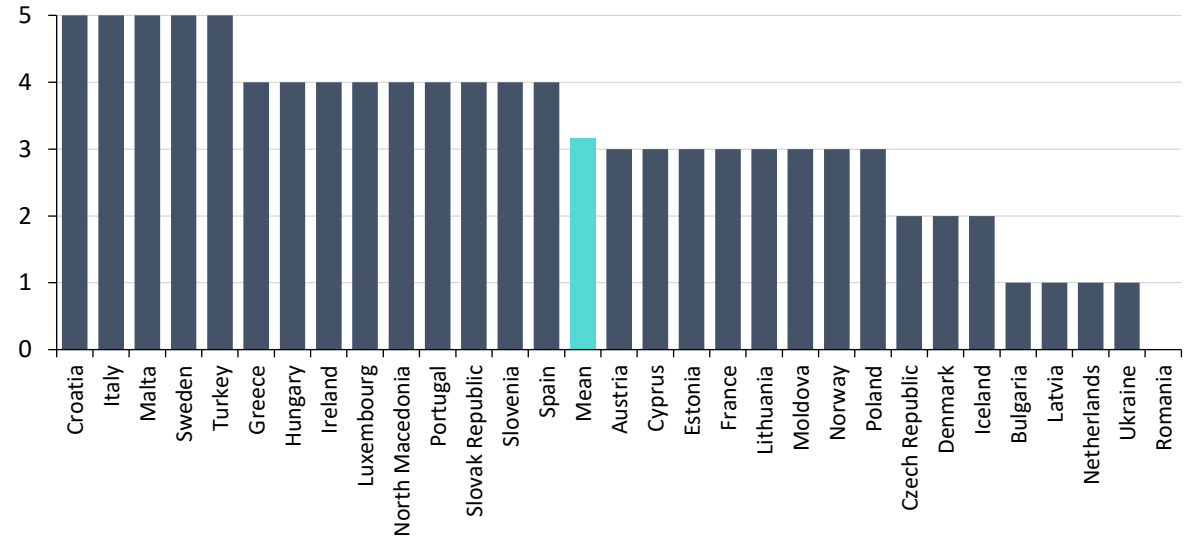


Figure 35. Number of capacity-building questions answered positively by country

This section concludes with, two excerpts from policy documents in the prevention domain are presented. Regarding healthy behaviours, Malta is committed to "reducing growth in the number of cancer cases by reducing tobacco use. The plan also mentions that smoking behaviour is the single most important driver of health inequalities […] And that special populations need augmented attention during the time span of this plan, such as persons with mental health problems and persons living in institutions, including correctional facilities."

Meanwhile, Slovenia has set a goal to "increase the participation of the target population in the Svit programme to 70% by the end of 2026, strengthening the cooperation of primary healthcare stakeholders to actively encourage non-respondents to participate and to reduce socio-economic inequalities in access to the programme."

7.3. Treatment

The treatment domain includes four questions that specifically address equity aspects related to disease management and patient interactions.

7.3.1. National Comprehensive Cancer Centres

The first treatment question refers to whether the NCCPs promote the creation of National Comprehensive Cancer Centres, and as can be seen in Figure 36, most countries (23/30; 76.7%) do promote them.

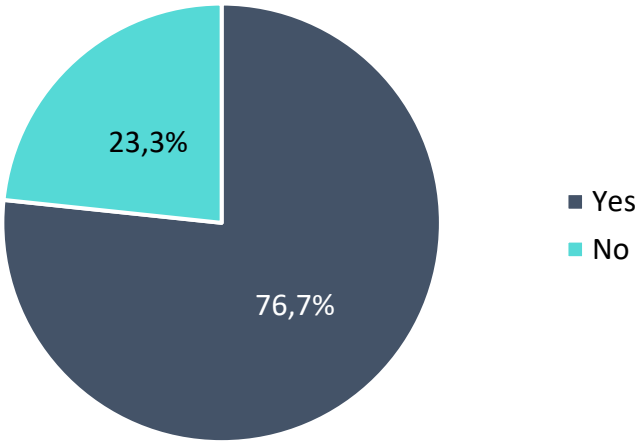


Figure 36. Promotion of the creation of National Comprehensive Cancer Centres in NCCPs (Q33; n=30)

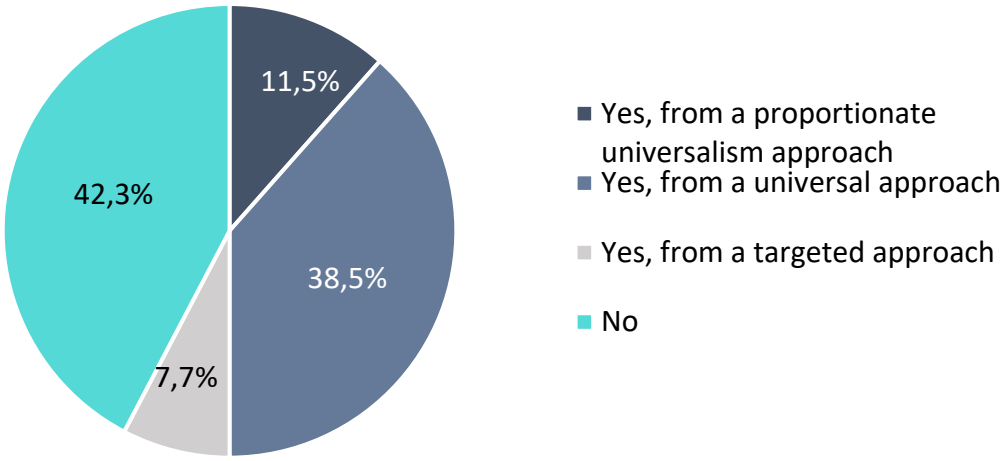
Table 36 shows the distribution of responses by country for each option.

Table 36. Promotion of the creation of National Comprehensive Cancer Centres in NCCPs by country (Q33: n=30)

Country response	Number of countries (in percent)	Countries
Yes	23 (76.7%)	Croatia, Cyprus, the Czech Republic, Denmark, Estonia, France, Greece, Hungary, Ireland, Italy, Latvia, Luxembourg, Moldova, the Netherlands, Poland, Portugal, Romania, the Slovak Republic, Slovenia, Spain, Sweden, Turkey, Ukraine
No	7 (23.3%)	Austria, Bulgaria, Iceland, Lithuania, Malta, North Macedonia, Norway
Total number of participating countries	**30 (100%)**	

7.3.2. Equal personalized medicine access

With regard to equitable access to personalized medicine, more than half (15/26; 57.7%) of the NCCPs ensure it (Figure 37). The main approach used is the universal one, at 38.5% (10/26), while the proportionate universalism and target approaches are at 11.5% (3/26) and 7.7% (2/26), respectively.



Note: n=26, four countries responded "not applicable" (Greece, Iceland, Luxembourg and Slovenia).

Figure 37. Provision of equitable access to personalized medicine from an equity perspective in NCCPs (Q34: n=26)

Table 37 shows the distribution of responses by country for each option.

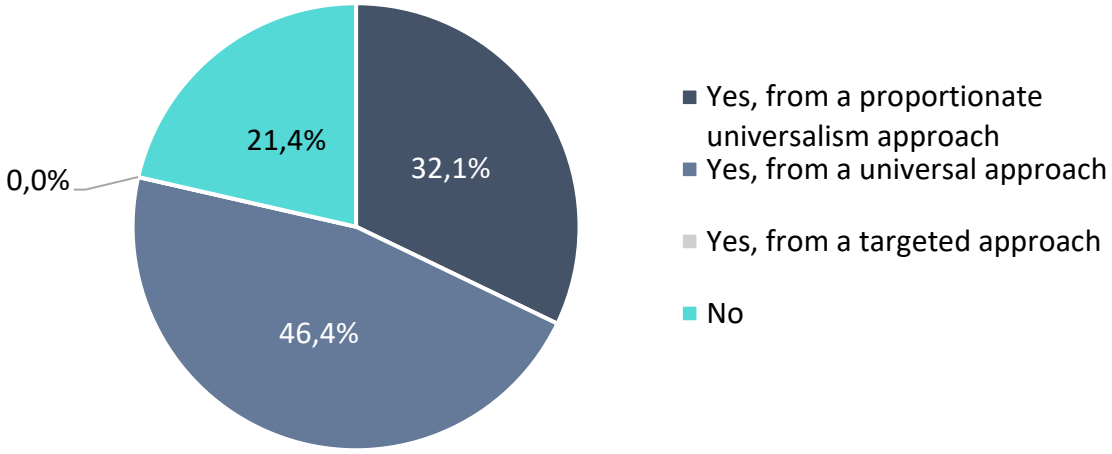
Table 37. Provision of equitable access to personalized medicine from an equity perspective in NCCPs by country (Q34: n=26)

Country response	Number of countries (in percent)	Countries
Yes, from a proportionate universalism approach (universal + targeted approach)	3 (11.5%)	Croatia, the Netherlands, Turkey
Yes, from a universal approach	10 (38.3%)	Czech Republic, Denmark, Hungary, Ireland, Italy, Latvia, the Slovak Republic, Spain, Sweden, Ukraine
Yes, from a targeted approach	2 (7.7%)	Malta, Norway
No	11 (42.3%)	Austria, Bulgaria, Cyprus, Estonia, France, Lithuania, Moldova, North Macedonia, Poland, Portugal, Romania
Total number of participating countries	**26 (100%)**	

Note: n=26, four countries responded "not applicable" (Greece, Iceland, Luxembourg and Slovenia).

7.3.3. Equal treatment access

Most NCCPs cover equal treatment access, with only 21.4% (6/28) not doing this (Figure 38). The most common approach is the universal one (13/28; 46.4%), followed by the proportionate universalism (9/28; 32.1%). No countries include the targeted approach in their NCCPs with regard to equal treatment access.



Note: n=28, two countries responded "not applicable" (Greece and Luxembourg).

Figure 38. Provision of equitable access to timely and high-quality treatments, including surgical care radiotherapy and systemic therapy, taking into account an equity perspective in NCCPs (Q35: n=28)

Table 38 shows the distribution of responses by country for each option.

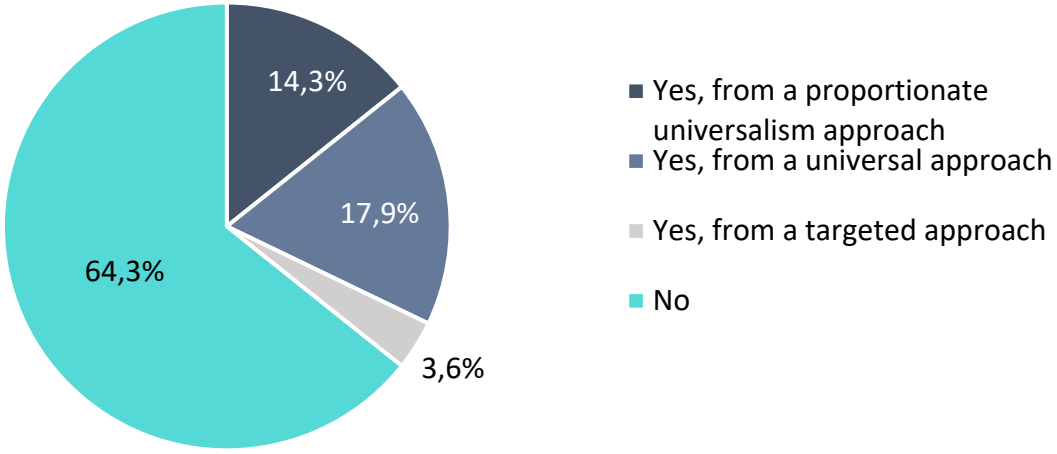
Table 38. Provision of equitable access to timely and high-quality treatments, including surgical care radiotherapy and systemic therapy, taking into account an equity perspective in NCCPs by country (Q35: n=28)

Country response	Number of countries (in percent)	Countries
Yes, from a proportionate universalism approach (universal + targeted approach)	9 (32.1%)	Croatia, France, Hungary, Ireland, Lithuania, Malta, the Netherlands, Slovenia, Turkey
Yes, from a universal approach	13 (46.4%)	Austria, Bulgaria, Cyprus, the Czech Republic, Denmark, Estonia, Italy, Latvia, Poland, Portugal, the Slovak Republic, Spain, Sweden
Yes, from a targeted approach	0 (0%)	/
No	6 (21.4%)	Iceland, Moldova, North Macedonia, Norway, Romania, Ukraine
Total number of participating countries	**28 (100%)**	

Note: n=28, two countries responded "not applicable" (Greece and Luxembourg).

7.3.4. Equal telemedicine access

Equal telemedicine access is the least common treatment topic, and out of all 28 applicable countries, only 35.7% (10/28) have an equity approach in their NCCPs (Figure 39). The most common approaches for this used are the universal approach (5/28; 17.9%) and the proportionate universalism approach (4/28; 14.3%). The targeted approach is only used by one (1/28; 3.6%) country.



Note: n=28, two countries responded "not applicable" (Greece and Luxembourg).

Figure 39. Encouragement of equitable access to telemedicine and remote monitoring throughout the entire cancer pathway from an equity perspective in NCCPs (Q36; n=28).

Table 39 shows the distribution of responses by country for each option.

Table 39. Encouragement of equitable access to telemedicine and remote monitoring throughout the entire cancer pathway from an equity perspective in NCCPs by country (Q36: n=28)

Country response	Number of countries (in percent)	Countries
Yes, from a proportionate universalism approach (universal + targeted approach)	4 (14.3%)	Croatia, France, Malta, Slovenia
Yes, from a universal approach	5 (17.9%)	Denmark, Hungary, Iceland, Italy, Sweden
Yes, from a targeted approach	1 (3.6%)	Ireland
No	18 (64.3%)	Austria, Bulgaria, Cyprus, the Czech Republic, Estonia, Latvia, Lithuania, Moldova, the Netherlands, North Macedonia, Norway, Poland, Portugal, Romania, the Slovak Republic, Spain, Turkey, Ukraine
Total number of participating countries	**28 (100%)**	

Note: n=28, two countries responded "not applicable" (Greece and Luxembourg).

7.3.5. Treatment general overview

Figure 40 provides an overview of the equity perspective across each of the treatment questions. The two recommendations with the strongest presence of an equity perspective are those related to equal treatment access (22/28; 79%) and the creation of National Comprehensive Cancer Centres (23/30; 77%). In a distant third place, but still included in more than half (15/28; 58%) of the NCCPs, there is equal personalized medicine access. Finally, equal telemedicine access is the recommendation that is least commonly included in the equity perspective (10/28; 36%).

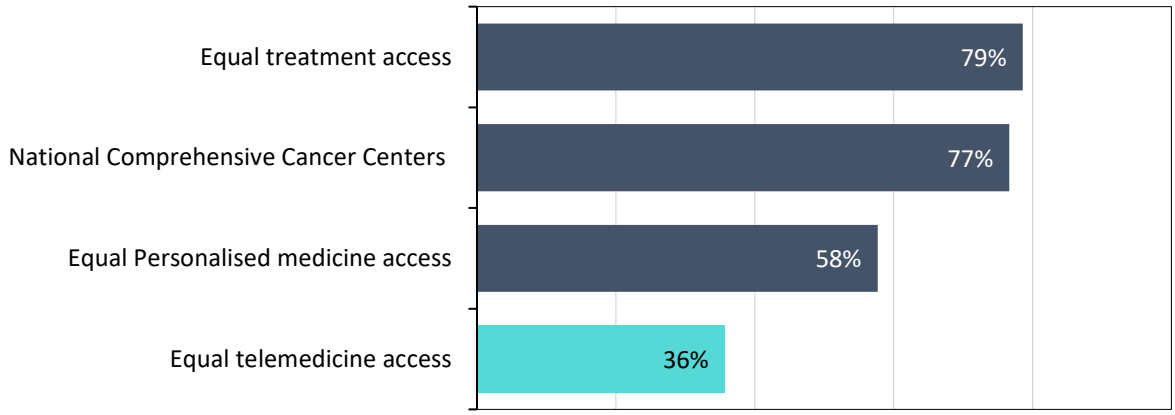


Figure 40. Percentage of countries that answered positively for each treatment question.

The results by country, as seen in Figure 41, show that the countries with more positive answers for the treatment questions, with all recommendations taken into account, are Croatia, Denmark, Hungary, Ireland, Italy and Sweden. In contrast, Austria, Bulgaria, Lithuania, Luxemburg, Moldova, Norway and Romania only have one recommendation in their NCCPs, while there are also two countries with no inclusion of treatment equity at all – Iceland and North Macedonia.

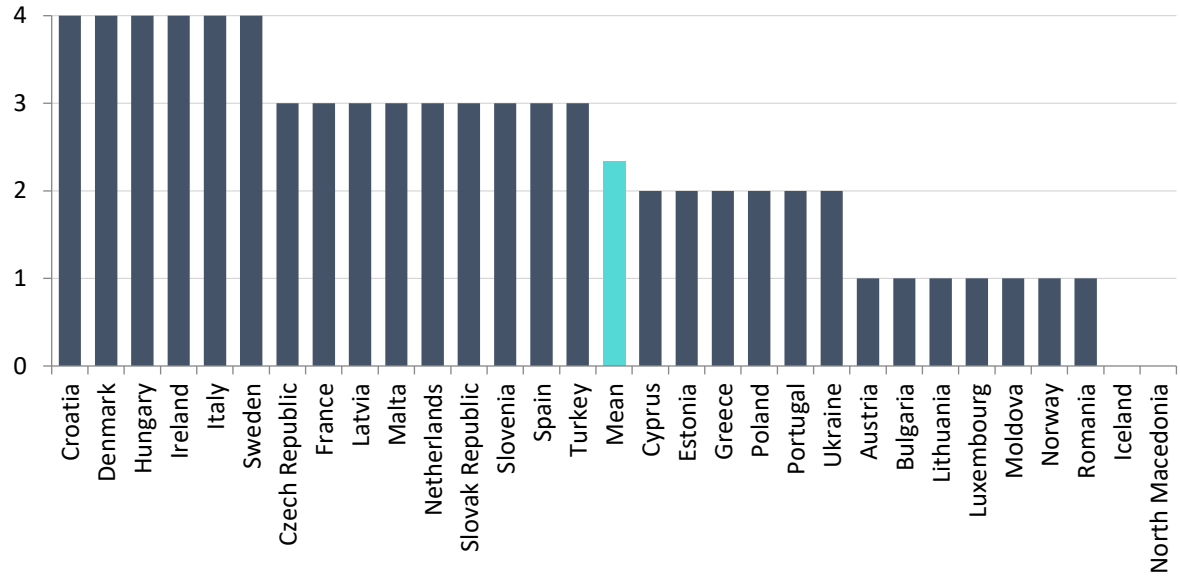


Figure 41. Number of treatment questions answered positively by country

To conclude this section, two excerpts from policy documents in the treatment domain are presented below.

Regarding the creation of National Cancer Centres, Estonia mentions in its cancer plan that "the key to the best possible outcomes is access to high-quality treatment for every patient, regardless of their education, livelihood, or place of residence. To ensure high-quality cancer diagnostics and treatment for all patients, cancer care will be centralized in cancer centres offering multimodal cancer treatment."

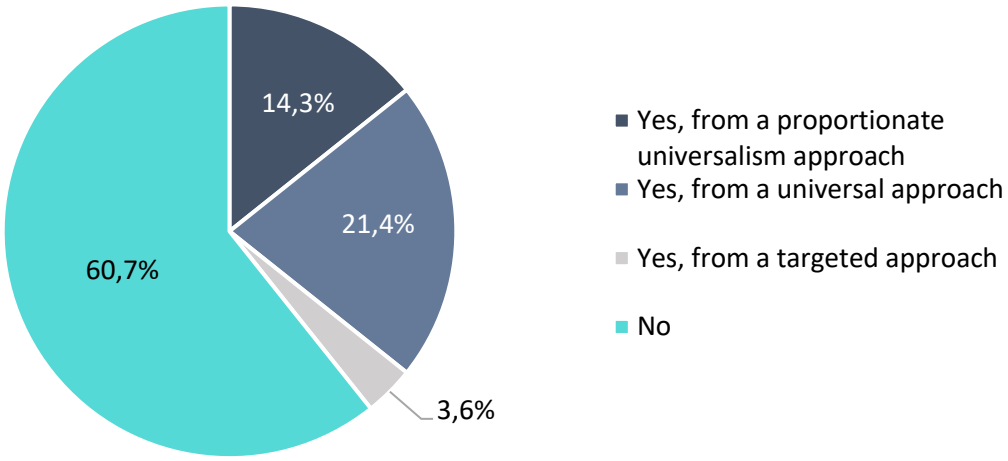
On the other hand, Croatia recommends "the use of telemedicine for analysis, decision-making, and arranging treatment for more complex cases, such as, for example, managing severe side effects of treatment in patients who have received different therapies in clinical hospital centres, and due to the severity of the side effects that are treated in regional centres without the possibility of transportation to clinical hospital centres."

7.4. Survivorship, rehabilitation and palliative care

The final domain – survivorship, rehabilitation and palliative care – comprises four questions that focus on equity considerations during the post-diagnosis phase and after the patient has successfully completed the medical treatment process.

7.4.1. Personalized survivorship care plans

The first recommendation is about support for the creation of personalized survivorship care plans, which is present only in 39.3% (11/28) of NCCPs (Figure 42). Of those NCCPs which address this topic, the majority use either a universal approach (6/28; 21.4%) or a proportionate universalism approach (4/28; 14.3%). Only one country (1/28; 3.6%) uses the targeted approach for this topic.



Note: n=28, two countries responded "not applicable" (Greece and Luxembourg).

Figure 42. Support for the creation of personalized survivorship care plans from an equity perspective in NCCPs (Q37: n=28)

Table 40 shows the distribution of responses by country for each option.

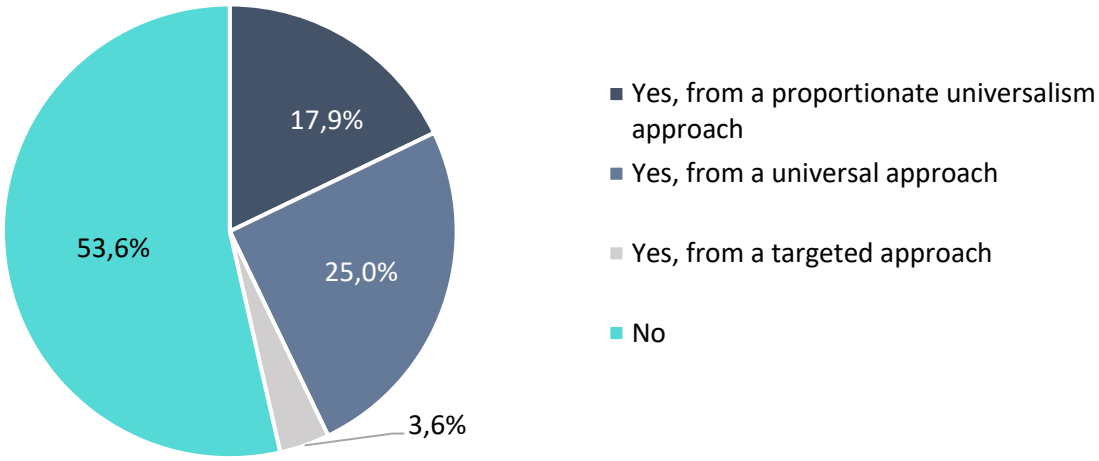
Table 40. Support for the creation of personalized survivorship care plans from an equity perspective in NCCPs by country (Q37: n=28)

Country response	Number of countries (in percent)	Countries
Yes, from a proportionate universalism approach (universal + targeted approach)	4 (14.3%)	Croatia, Estonia, the Netherlands, Sweden
Yes, from a universal approach	6 (21.4%)	Czech Republic, Denmark, Ireland, Malta, the Slovak Republic, Spain
Yes, from a targeted approach	1 (3.6%)	Austria
No	17 (60.7%)	Bulgaria, Cyprus, France, Hungary, Iceland, Italy, Latvia, Lithuania, Moldova, North Macedonia, Norway, Poland, Portugal, Romania, Slovenia, Turkey, Ukraine
Total number of participating countries	**28 (100%)**	

Note: n=28, two countries responded "not applicable" (Greece and Luxembourg).

7.4.2. Return to work

When talking about support for survivors' return to work, less than half of the countries actually address this in their NCCPs (Figure 43). The most common approach, once again, is the universal one, present in 25% (7/28) of countries, while the proportionate universalism approach is present in 17.9% (6/28). As per the targeted approach, it is present in only one country (1/28); 3.6%), Portugal.



Note: n=28, two countries responded "not applicable" (Greece and Luxembourg).

Figure 43. Support for the survivors' return to work from an equity perspective in NCCPs (Q38: n=28)

Table 41 shows the distribution of responses by country for each option.

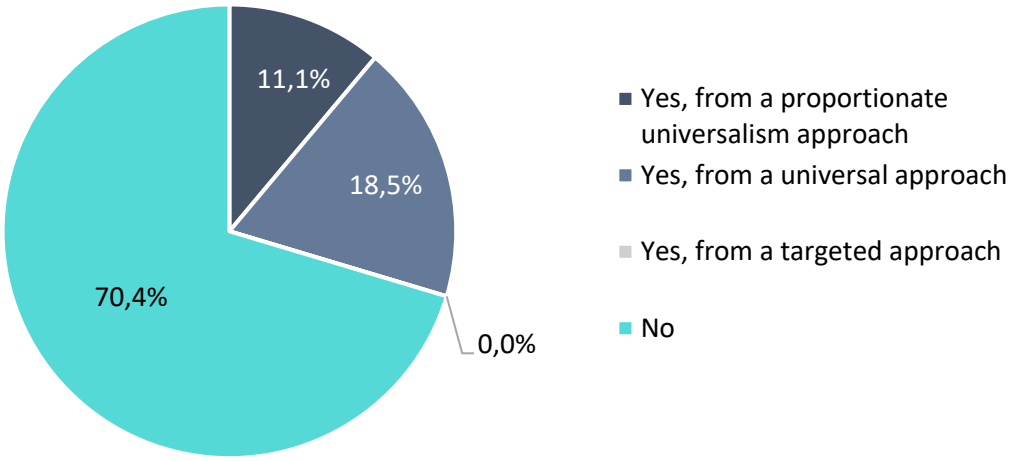
Table 41. Support for the survivors' return to work from an equity perspective in NCCPs by country (Q38: n=28)

Country response	Number of countries (in percent)	Countries
Yes, from a proportionate universalism approach (universal + targeted approach)	5 (17.9%)	Croatia, Estonia, Ireland, the Netherlands, Sweden
Yes, from a universal approach	7 (25%)	Cyprus, the Czech Republic, Denmark, Hungary, Italy, the Slovak Republic, Slovenia
Yes, from a targeted approach	1 (3.6%)	Portugal
No	15 (53.6%)	Austria, Bulgaria, France, Iceland, Latvia, Lithuania, Malta, Moldova, North Macedonia, Norway, Poland, Romania, Spain, Turkey, Ukraine
Total number of participating countries	**28 (100%)**	

Note: n=28, two countries responded "not applicable" (Greece and Luxembourg).

7.4.3. Work-life balance for informal carers

The promotion of a work-life balance for informal carers is one of the least present in all NCCPs, since it is considered in less than 30% of them (Figure 44). The most common approach is the universal one (5/27; 18.5%), followed by 11.1% (3/28) of countries that have a proportionate universalism approach. There are no countries using a targeted approach for this.



Note: n=27, three countries responded "not applicable" (Greece, Luxembourg and Ukraine).

Figure 44. Support for the promotion of work-life balance for informal carers from an equity perspective in NCCPs (Q39: n=27)

Table 42 shows the distribution of responses by country for each option.

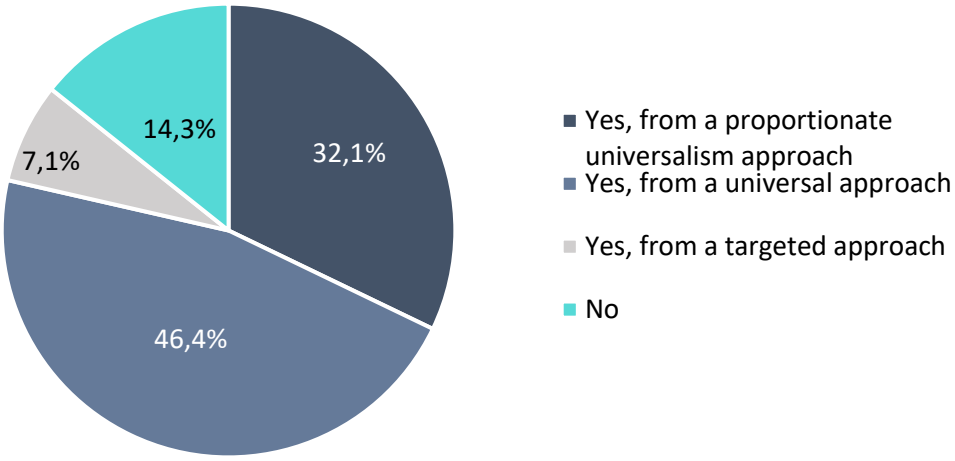
Table 42. Support for the promotion of work-life balance for informal carers from an equity perspective in NCCPs by country (Q39: n=27)

Country response	Number of countries (in percent)	Countries
Yes, from a proportionate universalism approach (universal + targeted approach)	3 (11.1%)	Croatia, the Netherlands, Slovenia
Yes, from a universal approach	5 (18.5%)	Estonia, Malta, Portugal, the Slovak Republic, Sweden
Yes, from a targeted approach	0 (0%)	/
No	19 (70.4%)	Austria, Bulgaria, Cyprus, the Czech Republic, Denmark, France, Hungary, Iceland, Ireland, Italy, Latvia, Lithuania, Moldova, North Macedonia, Norway, Poland, Romania, Spain, Turkey
Total number of participating countries	**27 (100%)**	

Note: n=27, three countries responded "not applicable" (Greece, Luxembourg and Ukraine).

7.4.4. Equal palliative care access

In the domain of survivorship, rehabilitation and palliative care, equal palliative care access is the most common factor in all NCCPs. Out of all applicable countries, 85.7% (24/28) support equitable access to palliative and end-of-life care services (Figure 45). The most common approach used, in almost half of the NCCPs, is the universal approach (13/28; 46.4%). The proportionate universalism approach is present in 32.1% (9/28) of NCCPs, while only the 7.1% (2/28) use the targeted approach.



Note: n=28, two countries responded "not applicable" (Ireland and Luxembourg).

Figure 45. Support for the equitable access to palliative and end-of-life care services from an equity perspective in NCCPs (Q40: n=28)

Table 43 shows the distribution of responses by country for each option.

Table 43. Support for the equitable access to palliative and end-of-life care services from an equity perspective in NCCPs by country (Q40: n=28)

Country response	Number of countries (in percent)	Countries
Yes, from a proportionate universalism approach (universal + targeted approach)	9 (32.1%)	Austria, Croatia, Iceland, Latvia, Lithuania, Malta, the Netherlands, Slovenia, Sweden
Yes, from a universal approach	13 (46.4%)	Cyprus, the Czech Republic, Denmark, Estonia, Greece, Hungary, Italy, Moldova, Portugal, Romania, the Slovak Republic, Spain, Ukraine
Yes, from a targeted approach	2 (7.1%)	Bulgaria, Norway
No	4 (14.3%)	France, North Macedonia, Poland, Turkey
Total number of participating countries	**28 (100%)**	

Note: n=28, two countries responded "not applicable" (Ireland and Luxembourg).

7.4.5. Survivorship, rehabilitation and palliative care general overview

Figure 46 provides an overview of the equity perspective across each of the survivorship, rehabilitation and palliative care questions. The most common recommendation, by far, is for equal palliative care access, present in 86% (24/28) of the NCCPs. Topics related to the return to work and personalized survivorship care plans are present in 46% (13/28) and 39% (11/28) of countries, respectively. In contrast, the equity approach with regard to a better work-life balance for informal carers only appears in 30% (8/27) of the NCCPs.

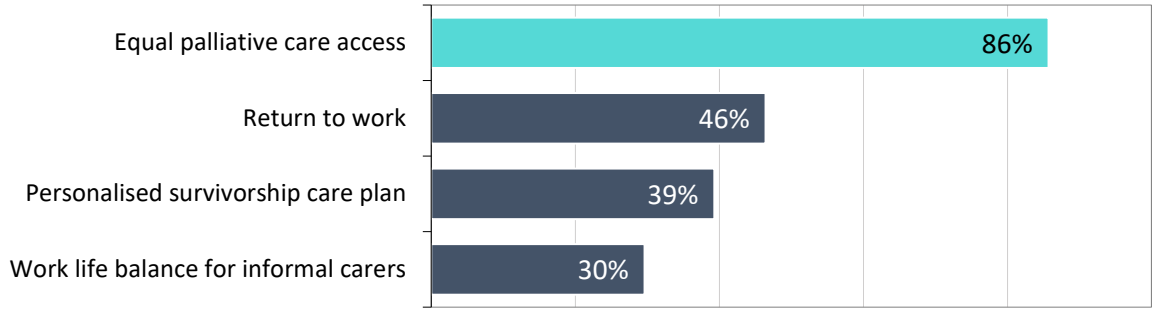


Figure 46. Percentage of countries that answered positively for each survivorship, rehabilitation and palliative care question

The results by country (Figure 47) show that the countries with the most positive answers for the survivorship, rehabilitation and palliative care domain are Croatia, Estonia, the Netherlands, the Slovak Republic and Sweden. While these countries' NCCPs include all the recommendations from this domain, there are five that do not include any of them, from France, Luxemburg, North Macedonia, Poland and Turkey.

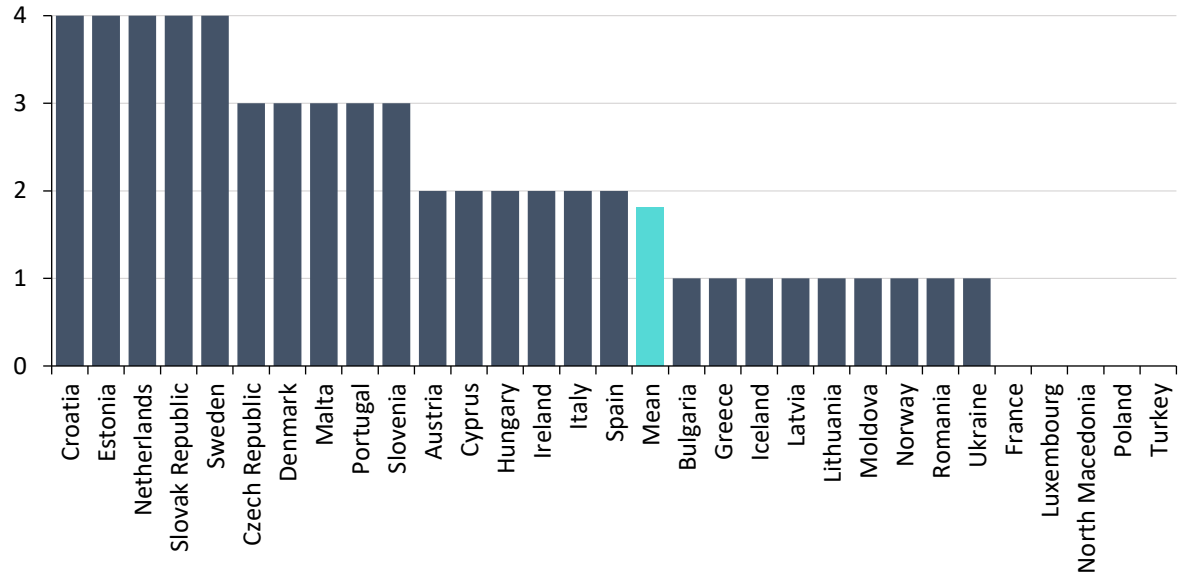


Figure 47. Number of survivorship, rehabilitation and palliative care questions answered positively by country

To conclude the final section on this domain, two excerpts from policy documents on survivorship, rehabilitation and palliative care are presented below.

Spain includes the following objective regarding personalized survivorship plans: "to establish and provide each patient with a written, individualized follow-up plan […] which includes, at least, the treatments received, possible medium- and long-term side effects, and toxicities that may have arisen during treatment, sequelae, care plan, and psychological care."

On the topic of work-life balance for informal carers, the Netherlands states that "professionals should co-operate better to provide good (work-related) care and support […] Activities include: – Connecting and expanding existing networks with the social domain and informal care – Increasing knowledge about laws and regulations surrounding illness and (long-term) absenteeism of people with or after cancer."

7.5. General overview

After reviewing each domain, it is evident that there is great variability both between countries and responses. Nevertheless, it is important to have an overview from the four domains in the NCCPs to have a clear view on how we stand with regard to the challenging aim of ensuring better and more equitable access to cancer prevention and treatment for all.

Table 44 presents the mean percentage of positive responses regarding equity approach in each domain, taking into account all of the questions. The overall mean is 54.3%, while the domain that is most commonly included in the NCCPs is primary and secondary prevention, with a mean of 64.2% positive answers, closely followed by the treatment domain, at 62.5%. This is then followed by the survivorship, rehabilitation and palliative care domain, at 50.5%, and the capacity-building domain, at 48.9%.

Table 44. Equity perspective mean percentage – total and by domain

Domain	**Equity perspective (mean)**
Capacity building	48.9%
Prevention	64.2%
Treatment	62.5%
Survivorship	50.5%
Total (%)	**54.3%** (weighted)

Part 3 of the Survey included 12 items addressing the equity approach (if any) used in the different processes of cancer prevention, care and treatment. The overall results for these items can be seen in Table 45, showing the response rates for the different approaches (proportionate universalism, universal and targeted) as well as the percentage when no equity approach was considered. The universal approach was mentioned in 29.7% of all responses, and the proportionate universalism approach in 25.1%, while the targeted approach was only stated in 5.8% of cases.

Table 45. Average answers for all 12 questions on equity perspective approaches

Equity approach	**Equity perspective (mean)**
Proportionate universalism	25.1%
Universal	29.7%
Targeted	5.8%
No equity perspective	39.4%

Another way of analysing the equity variability is looking at all the responses from each country. The individual reviews of the four domains presented above showed that some countries took the equity perspective into account more often than others. But since a country may do well in one cancer domain, and less well in another, it is important to analyse all of them together.

Figure 48 shows the number of questions for which each country responded positively with regard to having an equity perspective, and covers all the domains. The countries at the top, with an equity perspective in their answers to 20 or more questions, are Croatia, Malta, Sweden, Slovenia, Ireland and Italy. At the other end of the spectrum there are those countries with an equity perspective in their responses to five or less questions, namely Iceland, Moldova, Ukraine and Romania.

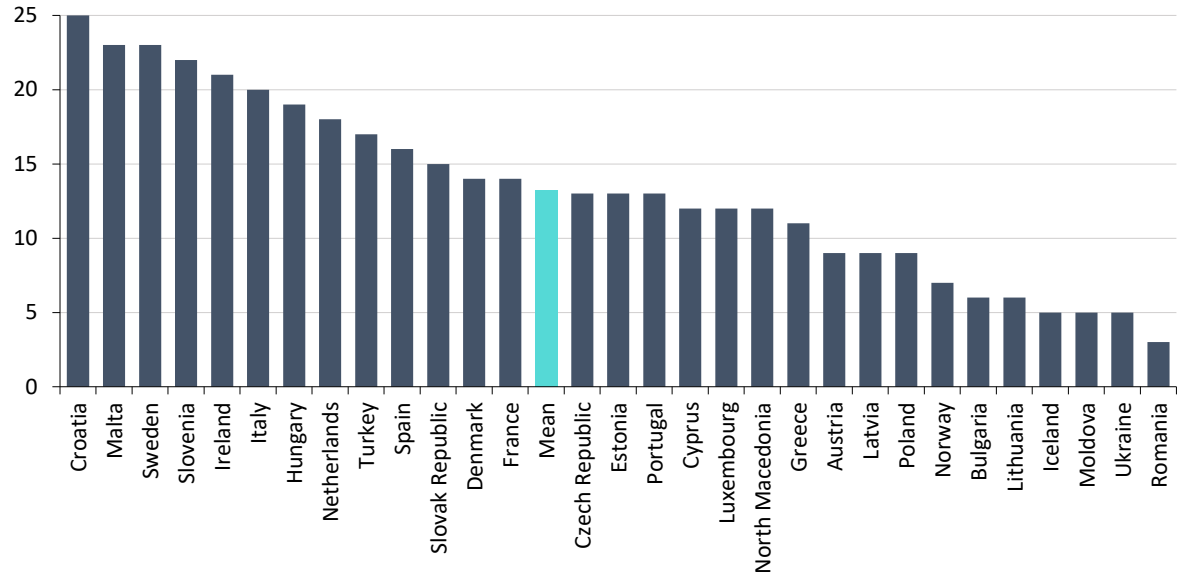


Figure 48. Total number of equity perspective questions answered positively by country

8. DISCUSSION AND CONCLUSION

On the basis of the results of the Survey on NCCPs in EU MSs and designated countries which was conducted in 2024 in the frame of OriON JA WP 5 – Analysis of the National Cancer Control Programmes, it is possible to observe that most of the participating countries, 31 out of 34 (91.2%), have an operational NCCP and/or plan, strategy, policy or other related documents. Only three of the 34 (8.8%) did not have an NCCP/cancer document in 2024, and all the other countries reported that they had or were preparing some form of formalized cancer document. This high adoption rate indicates a strong commitment to cancer control within Europe.

The majority of the participating countries – 71.0% (22 out of 31) – approach cancer control with a single, comprehensive document. This reflects a preference for centralizing strategies and initiatives into a single framework that ensures consistency and coherence in policy implementation. The use of a single document indicates a desire to summarize objectives, actions and evaluation measures in a single strategy, which may allow for easier monitoring and revision or implementation of the NCCPs/cancer documents. In contrast, 29.0% of the participating countries (nine out of 31) address cancer control in several documents, which suggests a more segmented or modular strategy, possibly tailored to specific aspects of cancer control, such as prevention, screening or treatment. These divergent strategies reflect differences in policy design and governance, shaped by the unique health needs and administrative structures of each country.

An analysis of the types of the documents that the countries prepared (programmes, strategies, plans, policies, and/or other cancer documents) shows a significant variation among participating countries, highlighting diverse policy approaches and administrative frameworks. However, half of the participating countries prepared a programme which is in line with the EU Guide for Quality NCCPs, and many combined different documents. The term “programme” typically indicates a comprehensive, centralized approach that integrates various policy elements into a unified framework. Its inclusion, especially alongside other terms, highlights strategic coordination and detailed planning, while its absence may reflect alternative governance models or policy preferences. Overall, terminological choices in policy documents shape national

health strategies, with “programme” reflecting both the ambition and approach to cancer control. More than half of the countries reported having additional policy documents addressing cancer control.

The largest group of countries has NCCPs/cancer documents that expire in 2030. These countries represent a forward-looking group with long-term planning horizons, potentially aiming to ensure stability and continuity in their cancer control efforts. This variability in expiry years and approaches to NCCPs reflects the different political, economic and health contexts of these countries. Some countries emphasize long-term planning with durations that extend a decade or more into the future, while others focus on short-term or ongoing strategies. In addition, some countries have no defined plans at all, indicating potential gaps in cancer action planning and the need for greater alignment with international best practices. Overall, these findings emphasize the importance of robust, adaptable and forward-looking cancer documents in addressing the evolving challenges of cancer control worldwide.

Regarding the duration of the NCCPs/cancer documents, it is possible to summarize that most countries favour medium- to long-term planning, reflecting the complexity of cancer control. While 10-year strategies are common, the popularity of the “other duration” category indicates that many countries favour adaptable or tailored frameworks. This variability emphasizes the importance of tailoring NCCPs to the country context, while also highlighting the need for regular evaluations to ensure effective implementation and progress tracking.

Most countries intend to develop a new NCCP/cancer document upon expiry of their existing one. In general, the data underlines the strong commitment of the majority of the participating countries (20 out of 31, or 64.5%) countries to maintain and update their cancer control frameworks to ensure their relevance and responsiveness to new challenges.

Over half of the participating countries indicated that they do not have an NCCP/cancer document in preparation, and they gave the reasons for this. There are three main patterns that can be discerned here: (1) countries with an existing NCCP and no need to prepare a new one; (2) countries with an alternative strategy or framework that fulfils

the function of an NCCP; and (3) countries that cite a lack of prioritization or structural barriers as reasons for not having an NCCP. Some countries reported obstacles to developing or implementing their NCCPs/cancer documents, and their explanations for this reflect systemic challenges, such as limited institutional support or competing health priorities.

Regarding financing, just over half of the countries (16, or 51.9%) have not yet secured adequate funding for the implementation of their NCCPs. It is thus possible to conclude that financial uncertainty is a critical problem in European cancer control efforts. Securing consistent and sustainable funding is crucial not only for the implementation of NCCPs/cancer documents, but also for their long-term success. This means that countries without secured funding may find it difficult to maintain the momentum needed to implement their cancer control strategies, and may need external support or further internal policy adjustments to fill these gaps. To summarize, while some of the participating countries have made progress in securing funding for the implementation of their NCCPs/cancer documents, in some other countries the issue of funding remains a significant obstacle. Addressing these funding gaps should be a priority as it has a direct impact on countries' ability to implement effective and sustainable cancer prevention and treatment programmes. Ensuring financial security for the implementation of NCCPs/cancer documents will ultimately determine the success of these important health strategies and contribute to the global fight against cancer.

Seven of the 31 participating countries (22.6%) still do not evaluate or monitor their NCCPs/cancer documents. As the evaluation and monitoring of these types of documents provide important insights into how countries assess and refine their cancer control measures, this issue needs more attention. Mid-term and final evaluations of NCCPs/cancer documents are performed in eight countries (25.8%), and final evaluations in only four participating countries (12.9%). Interestingly, other forms of evaluation were reported by more than one third (12) of the participating countries). The evaluation and reporting processes for NCCPs/cancer documents involve a range of institutions, including health authorities, ministries of health, or specialized advisory bodies.

The data regarding the use of indicators for the assessment of NCCPs/cancer documents reflects a strong trend towards the use of these in most countries, but it also highlights areas where further development or clarification may be needed, particularly in countries that did not provide a response for this. More than a half of the participating countries (19, or 61.3%) reported using indicators to assess their NCCPs/cancer documents, which is a positive indicator of a systematic approach to monitoring cancer control practices. These countries described a diverse range of methodologies, including varying methods and practices for selecting indicators to assess NCCPs/cancer documents. These differences reflect variations in health systems, cancer control priorities, and evaluation approaches. Most countries emphasized the importance of involving experts in the definition and selection of indicators. A small number reported not using indicators, which could indicate possible gaps in their evaluation processes. Almost one third of the countries did not provide any answer regarding the use of indicators, suggesting that these may still be developing or refining their assessment systems.

More than half of the participating countries included indicators in their NCCPs/cancer documents. These countries have prioritized structured monitoring and evaluation mechanisms to track progress and outcomes in their cancer control efforts. This majority emphasized the importance of measurable benchmarks in evaluating documents. Six countries did not include indicators in their NCCPs/cancer documents, which could reflect a lack of prioritization with regard to evaluative frameworks or limited resources for developing and tracking such metrics. Almost one third of the countries did not provide any information on this issue, which suggests gaps in reporting or insufficient engagement with the Survey, thus limiting comprehensive insights into global practices regarding cancer documents in Europe.

The majority of the participating countries (41.9%) have adopted a multi-level approach to evaluation of the NCCPs/cancer documents, considering structure, implementation methods, and results achieved, as suggested by the European Guide for Quality NCCPs. Seven countries did not answer this question, a significant proportion, suggesting that evaluation is still an area where many countries may lack a clear or documented methodology. Overall, the collected data illustrate diverse approaches to evaluation, which depend on the policies and priorities of individual countries, while also

highlighting the lack of clear guidelines or documented methods in some cases. Most countries use a holistic approach that incorporates structure, process, and outcomes into their evaluation frameworks, which reflects a focus on monitoring the implementation phase of NCCPs/cancer documents. The relatively low adoption of comprehensive evaluations (42%) indicates that just over a third of the countries – 11 (35.5%) – focus on one or two types of methods rather than all three (structure-process-outcomes).

Regarding the quality of the NCCPs/cancer documents, primary prevention and cancer screening are included in these in nearly all countries (30, or 96.8%), followed by early detection, diagnosis, treatment, and cancer-related data and information (29 countries, or 93.5%). Psychosocial oncology care and research are also widely covered in NCCPs/cancer documents (27 countries, 87.1%). Health promotion, palliative and end-of-life care, access to innovative cancer treatments, and education and training are covered in NCCPs/cancer documents in more than 80% of the countries. On the other hand, survivorship, rehabilitation, and patient empowerment are included in NCCPs/cancer documents in less than 80% of countries. Moreover, more complex and resource-demanding areas – like financing, monitoring of cancer burden, cancer resources, and governance – are not adequately covered in NCCPs/cancer documents. This variation highlights the significant challenges participating countries encounter in implementing a comprehensive NCCP/cancer document that addresses all the recommended areas.

Focusing on equity results, it is remarkable that the equity perspective (mean) in NCCPs in Europe is actually low (<60), with significant differences among countries. Equity is defined as the absence of unfair, avoidable, or remediable differences in health status among population groups defined socially, economically, demographically, or geographically (8). Evidence shows that inequalities in cancer incidence and mortality exist both between and within countries. Regarding inequalities between countries, Ferlay et al. (9) show that the incidence of cancer in both sexes is higher in Northern and Western European countries, while cancer mortality is higher in Eastern and Southern European countries. Moreover, the cancer mortality rate is higher among men than women (10) (11). Taking into account the results of this Survey, special efforts must be made to ensure the inclusion of the equity perspective in all European countries to prevent the existing inequalities in incidence and mortality from worsening.

Moreover, the universal approach is the most prevalent one in the NCCPs analysed, and this means that efforts are being made to ensure that all populations have access to cancer prevention and control policies. However, considering that, due to the inverse care law (12), people in the lowest positions on the social scale benefit less from universal approaches, proportional efforts must also be made according to the needs of each social group, following the proportionate universalism approach (13). Therefore, in addition to favouring universal access to cancer prevention and control services, these proportional efforts must be also implemented.

The Health in All Policies approach is present in only 57% of NCCPs. Taking into account the fact that health status is the result of a complex combination of factors, some of which are outside the health sector, reinforcing the Health in All Policies approach (14) is also necessary. Therefore, to reduce inequalities in cancer, NCCPs should encourage the collaboration of various sectors, such as education, transportation, economic development, and housing, among others.

The social determinants of health are the social, cultural, political, economic, and environmental conditions in which people are born, grow up, live, work, and age, and which affect their health (15). If we focus on the specific results regarding which social determinants of health are being considered in the objectives, indicators, and variables of NCCPs, it is noteworthy that age, gender, and territory are the most commonly considered. Reducing cancer inequalities by age, gender, and territory is crucial, but to achieve equity in cancer, attention must also be given to low socioeconomic groups, ethnic minorities, disabled individuals, and the institutionalized population.

Inequalities in cancer incidence and mortality are due to health inequalities across the entire cancer continuum across the life course (16). These inequalities result from disparities in exposure to risk factors, and access to secondary prevention, diagnosis, treatment, and rehabilitation services. Therefore, equity objectives and actions to reduce cancer inequalities should be developed at every stage of the cancer continuum.

Equity results by domain show that there are areas where special efforts should be made to improve the equity perspective in NCCPs. For example, in the capacity-building

domain, enhancing the performance of equity impact assessments and the exchange of good practices in reducing cancer inequalities are the least included equity recommendations in NCCPs. On the other hand, in the primary and secondary prevention domain, the promotion of personalized risk assessments, taking into account the social determinants of health, is only supported by 31% (9/29) of NCCPs. Moreover, encouraging equitable access to telemedicine and promoting a better work-life balance for informal carers are the least supported equity recommendations in the treatment and survivorship, rehabilitation and palliative care domains, respectively.

Based on the results of the present and previous surveys on NCCPs/cancer documents in European MSs and designated countries, it is possible to conclude that the situation regarding the development and quality of NCCPs/cancer documents is improving thanks also to the constant efforts of the European Commission in this field. From the equity results it can be concluded that we still need to make special efforts to mainstream equity in cancer prevention and control policies, following the recommendations of the CanCon JA Policy Paper (7), the EBCP (5), and the Mission on Cancer (17).

Limitations of the research

The results of this research refer solely and exclusively to the responses received from the participating countries. The results are based on the analysis of the answers to the questions from the Survey on NCCPs provided by the experts in the field in EU MSs and designated countries, as based on their own interpretations and not on actual implementation. This mean that the findings may reflect their professional judgement, which may be subjective.

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10. ANNEXES

Appendix 1. Survey

Q1. In your country do you have an operational National Cancer Control Programme/Plan/Strategy/Policy or other cancer document (NCCP)?

Q2. Is there a single document or several documents addressing cancer control in your country?

/ *Please report the name/s and the reference/s (web link) of the document/s in English or in your language in case the translation does not exist. Please list the main document in the first line. / If there is no official English translation of those documents available, please provide the name of those documents in their original language, followed with an unofficial translation into English.*

Q3. Would you categorize your NCCP as a programme/plan/strategy or policy?

[Multiple answers are possible]

Q4. In your country is there other policy document that is relevant for action on cancer?

Q5. What is the expiry year of your NCCP?

Q6. Is your NCCP a ___ -year document(s):

Q7. Do you intend to prepare a new edition of your NCCP when the current one expires?

Q8. If your country does not have an NCCP, is there one being prepared? Please give the reason why or why not.

Q9. Is the financing of the coordination of the implementation of your NCCP secured?

Q10. Do you have a monitoring and evaluation process for your NCCP in place? If so, please describe it.

/Max. 200 words/

Q11. Who is undertaking the evaluation(s) and preparing the report? Please describe this process.

/Max. 200 words/

Q12. Are indicators used for the evaluation process?

Q13. Are the indicators included in the NCCP?

Q14. How will the evaluation be carried out?

[Multiple answers are possible]

Q15. Which of the following areas recommended by the European Guide for Quality National Cancer Control Programmes* does your NCCP cover?

** Albreht T, Martin Moreno JM, Jelenc M, Gorgojo L, Harris M. European Guide for Quality National Cancer Control Programmes. Ljubljana: National Institute of Public Health, 2015.* *https://cancercontrol.eu/archived/uploads/images/European_Guide_for_Quality_National_Cancer_Control_Programmes_web.pdf*

Q16. 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 that is addressed (multiple answers are possible):

- □ Territory (e.g. place of residence, rural/urban, deprived areas, etc.)
- □ Age (e.g. children, the 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.)
- □ Institutionalized 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 answers are possible):

□ 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.)
- □ Institutionalized 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 answers are possible):

- □ Healthcare
- □ Public health
- □ Social welfare
- □ Education
- □ Research and academia
- □ Environmental
- □ Agriculture
- □ Financial
- □ Taxation and economic
- □ 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 answers are possible):

- □ 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. indicators: 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 answers are possible):

- □ 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.)
- □ Institutionalized 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 answers are possible):

- □ 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.)
- □ Institutionalized 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 answers are possible):

- □ 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.)
- □ Institutionalized 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 the 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 answers are possible):

- □ 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.)
- □ Institutionalized 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 answers are possible):

□ 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 marginalized 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).

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 answers are possible)

  □ 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).

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).

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).

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).

Q32. Does your NCCP consider personalized 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).

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

□ 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).

Q34. Does your NCCP ensure equitable access to personalized medicine, taking into account the proportionate universalism approach? (E.g. promote the education of healthcare providers and the public about personalized 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).

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).

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 centre 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).

Q37. Does your NCCP support the creation of personalized 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).

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).

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).

Q40. Does your NCCP support equitable access to 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).

Appendix 2. Operational NCCPs (plans/strategies/policies or other cancer documents) in the participating countries in 2024 (Q1: n=34)

Country		National Cancer Control Programmes (NCCP) [plans/strategies/policies or other cancer control documents]	
		Yes	No
1	Austria	X	
2	Belgium		X
3	Bulgaria	X	
4	Croatia	X	
5	Cyprus	X	
6	Czech Republic	X	
7	Denmark	X	
8	Estonia	X	
9	Finland		X
10	France	X	
11	Germany	X	
12	Greece	X	
13	Hungary	X	
14	Iceland	X	
15	Ireland	X	
16	Italy	X	
17	Latvia	X	
18	Lithuania	X	
19	Luxembourg	X	
20	Malta	X	
21	Moldova	X	
22	Montenegro		X
23	Netherlands	X	
24	North Macedonia*	X	
25	Norway	X	
26	Poland	X	
27	Portugal	X	
28	Romania	X	
29	Slovak Republic	X	
30	Slovenia	X	
31	Spain	X	
32	Sweden	X	
33	Turkey	X	
34	Ukraine	X	

Notes: CC – cancer document(s); *including North Macedonia_1 and _2, and both answers are the same [Yes].

Appendix 3. Title and number of documents addressing cancer control in the participating countries (one/several) with corresponding links to the documents (Q2: n=34)

Country		Title and number of documents		Name(s) and the reference(s) (weblink) of the document(s)
		A single	Several	
1	Austria	X		Krebsrahmenprogramm 2014 [https://www.sozialministerium.at/dam/jcr:b7b1d384-0906-4980-844e-bff365418d83/krebsrahmenprogramm.pdf] DE: Krebsrahmenprogramm (KRP); *(National Cancer Framework Programme).*
2	Belgium		X	Belgian Cancer Inventory (internal document under development, not publicly available): monitoring and evaluation framework for cancer care and control in Belgium – List of priority actions by the Federal Government for 2020-2024 related specifically to cancer (internal list, not publicly available)
3	Bulgaria	X		[https://www.mh.government.bg/media/filer_public/2022/07/08/bg_national_cancer_plan_2030_-_site.pdf; https://www.strategy.bg/StrategicDocuments/View.aspx?lang=bg-BG&Id=1589]
4	Croatia		X	Nacionalni strateški okvir protiv raka do 2030 *(National strategic framework against cancer until 2030).*
5	Cyprus	X		*National Cancer Strategy 2019* [https://www.gov.cy/moh/documents/ethniki-stratigiki-gia-ton-karkino-2019/]
6	Czech Republic		X	Národní onkologický plán ČR 2030 *(Czech National Cancer Control Plan 2030; NOPL)*: [https://mzd.gov.cz/narodni-onkologicky-plan-cr-2030/]; Implementační plán NOPL *(Implementation plan on NOPL)* - not on website; *National Recovery Plan – component 6.2 National plan on strengthen oncological prevention and care* [https://mzd.gov.cz/podpora-zdravotnictvi-z-narodniho-planu-obnovy/]
7	Denmark		X	Kræftplan 4 *(Cancer plan 4)* [https://www.regeringen.dk/aktuelt/tidligere-publikationer/patienternes-kraeftplan/] In Denmark, the government has issued four cancer plans so far. Cancer Plan 4 is the most recent one, but it technically expired in 2020. The Danish Health Authority will complete the national recommendations for Cancer Plan 5 in the autumn of 2024 as a presentation for the political action plan, which is prepared by the Ministry of Health and is expected to arrive at the end of the year 2024. The answers to this questionnaire are primarily based on Cancer Plan 4 but also partly on the planned content of Cancer Plan 5. This questionnaire is answered on behalf of the Danish Health Authority.[6]
8	Estonia	X		[https://tai.ee/et/valjaanded/vahitorje-tegevuskava-2021-2030]
9	Finland		X	Syövän hoidon kehittäminen vuosina 2010-2020 *(Development of cancer care 2010-2020)* [https://www.iccp-portal.org/plans/sy%C3%B6v%C3%A4n-hoidon-kehitt%C3%A4minen-vuosina-2010%E2%80%932020]; Syövän ehkäisyn, varhaisen toteamisen ja kuntoutumisen tuen kehittäminen vuosina 2014–2025 *(Development of cancer prevention, early detection and rehabilitation support 2014-2025)* [https://urn.fi/URN:ISBN:978-952-302-185-3]
10	France	X		*Cancer Control Strategy 2021-2030* [https://en.e-cancer.fr/]

[6] Further information and relevant documents can be found at: (1) https://www.sst.dk/-/media/Udgivelser/2016/Styrket-indsats-p%C3%A5-kr%C3%A6ftomr%C3%A5det-%E2%80%93-et-fagligt-opl%C3%A6g-til-Kr%C3%A6ftplan-IV/styrket-indsats-paa-kraeftomraadet-2016-fagligt-oplaegt-til-kraeftplan-IV-2016.ashx; (2) https://www.regeringen.dk/media/2146/sum_patienternes-kraeftplan_web.pdf; (3) https://www.sst.dk/-/media/Viden/Kraeft/Kr%C3%A6ftplaner/Kr%C3%A6ftplaner-IV/Udmntningsaftale-om-Krftplan-IV-20172020-mellem-SUM-Danske-Regione.ashx?sc_lang=da&hash=D80BBE3FCBC33DCBE6DF668CB3D6FA53; (4) https://www.ism.dk/Media/638355487363257287/Kommissorium%20for%20fagligt%20opl%C3%A6g%20til%20Kr%C3%A6ftplan%20V.pdf.

Continue Appendix 3.

Country		Title and number of documents		Name(s) and the reference(s) (weblink) of the document(s)
		A single	Several	
11	Germany		X	The priorities of the German National Cancer Plan (which was initiated in 2008) and areas for action are currently being revised and updated [https://www.bundesgesundheitsministerium.de/themen/praevention/nationaler-krebsplan].
12	Greece		X	ΝΟΜΟΣ 4675/2020: Πρόληψη, προστασία και προαγωγή της υγείας - ανάπτυξη των υπηρεσιών δημόσιας υγείας και άλλες διατάξεις. LAW 4675/2020: *(Prevention, protection and promotion of health – development of public health services and other provisions)* [http://www.publicrevenue.gr/elib/view?d=/gr/act/2020/4675/]; Εθνικό Σχέδιο Δράσης Δημόσιας Υγείας 2021 - 2025 *(National Public Health Action Plan 2021 – 2025)* [https://www.moh.gov.gr/articles/health/domes-kai-draseis-gia-thn-ygeia/ethnika-sxedia-drashs/8776-ethniko-sxedio-drashs-gia-th-dhmosia-ygeia-2021-2025?fdl=20523]; Υπουργείο Υγείας: Εθνικά Σχέδια Δράσης 2022-24 *(Ministry of Health: National Action Plans 2022-24; 2022)* [https://government.gov.gr/wp-content/uploads/2021/12/yp_ygeias_2022.pdf]; *2023:* [https://government.gov.gr/wp-content/uploads/2022/12/%CE%95%CE%A3%CE%94-2023_%CE%A5%CE%A0%CE%A5%CE%93.pdf]; *2024:* [https://www.moh.gov.gr/articles/newspaper/egkyklioi/12102-ethsio-sxedio-drashs-2024-ypoyrgeio-ygeias?fdl=26592]
13	Hungary	X		*2006 National Cancer Control Programme* [Hungarian: https://weborvos.hu/adat/tordelt1Kesz.pdf; English: http://epaac.eu/from_heidi_wiki/Hungary_National_Cancer_Control_Programme_English.pdf]; *2018, the most recent National Cancer Control Programme, is available at:* [Hungarian: https://hatter.hu/sites/default/files/dokumentum/konyvlap/nep-rakellenes.pd]; *National Cancer Control Programme* (original language: Hungarian) The unofficial English translation is attached as a separate document.
14	Iceland	X		Tillaga að íslenskri krabbameinsáætlun til ársins 2020 *(National Cancer Plan until 2020)* [https://www.stjornarradid.is/library/04-Raduneytin/Velferdarraduneytid/ymsar-skrar/Tillaga%20a%c3%b0%20%c3%adslenskri%20krabbameins%c3%a1%c3%a6tlun%20til%20%c3%a1rsins%202020%20-%20ma%c3%ad%202016.pdf]
15	Ireland	X		*National Cancer Strategy 2017-2026* [https://www.gov.ie/en/publication/a89819-national-cancer-strategy-2017-2026; https://www.hse.ie/eng/services/list/5/cancer/].This website hosts the NCCP lists of publications and other relevant information.
16	Italy	X		Piano Oncologico Nazionale – documento di pianificazione e indirizzo per la prevenzione e il contrasto del cancro 2023-2027 *(National Cancer Plan - planning and direction document for the prevention and fight against cancer 2023-2027)* [https://www.salute.gov.it/portale/tumori/dettaglioContenutiTumori.jsp?lingua=italiano&id=6012&area=tumori&menu=vuoto; https://www.salute.gov.it/imgs/C_17_pubblicazioni_3291_allegato.pdf]
17	Latvia	X		*Plan for Improving Health Care Services in Oncology for the years 2022-2024.* [https://likumi.lv/ta/id/333775-par-veselibas-aprupes-pakalpojumu-uzlabosanas-planu-onkologijas-joma-2022-2024-gadam] The plan is only available in Latvian.
18	Lithuania	X		NACIONALINĖ VĖŽIO PROFILAKTIKOS IR KONTROLĖS 2014–2025 METŲ PROGRAMA *(NATIONAL CANCER PREVENTION AND CONTROL PROGRAMME 2014-2025)* [https://e-seimas.lrs.lt/portal/legalAct/lt/TAD/297f53d00d2c11e48595a3375cdcc8a3?jfwid=-vaidol8b9]

Continue Appendix 3.

Country		Title and number of documents		Name(s) and the reference(s) (weblink) of the document(s)
		A single	Several	
19	Luxembourg	X		*Plan National Cancer 2020-2026 :* initialement 2020-2024, puis étendu à 2026 suite à l'interruption due à la pandémie *(National Cancer Plan 2020-2026: initially 2020-2024, extended to 2026 due to the interruption linked to the COVID-19 pandemic)* [https://sante.public.lu/fr/espace-professionnel/plans-nationaux/plan-national-cancer.html]
20	Malta	X		National Cancer Plan 2017-2021 [https://health.gov.mt/wp-content/uploads/2023/04/The_National_Cancer_Plan_for_the_Maltese_Islands_2017%E2%80%932021_EN.pdf]
22	Montenegro	X		N/A
23	Netherlands	X		https://nederlandskankercollectief.nl/agenda/
24	North Macedonia*	X (1,2)		**Ad 1:** Early detection programme for malignancies in the Republic of Northern Macedonia FOR 2024 *(Official Gazette of the Republic of Macedonia No. 13/2024 of 22 January 2024)*; **Ad 2:** Programme for early detection of malign diseases – annual programme budgeting from the Government. (This programme includes three kinds of screenings – for colorectal carcinoma, cervical screening and breast screening.) [https://zdravstvo.gov.mk/wp-content/uploads/2024/01/Tekst-maligni-2024-usoglaseno-so-sz-002-1.pdf]
25	Norway	X		*"Living with cancer - a national cancer strategy 2018-2022" (extended to 2024)* [https://www.regjeringen.no/contentassets/266bf1eec38940888a589ec86d79da20/regjeringens_kreftstrategi_180418.pdf]
26	Poland	X		(1) Ustawa z dnia 26 kwietnia 2019 r. o Narodowej Strategii Onkologicznej Dz. U. 2019 poz. 969r. *(Act of April 26, 2019 on the National Oncology Strategy, Journal of Laws, Laws of 2019, item 969)* [https://isap.sejm.gov.pl/isap.nsf/DocDetails.xsp?id=WDU20190000969 - no English version]; (2) Narodowa Strategia Onkologiczna na lata 2022-2023 – uchwała nr 10 Rady Ministrów z dnia 4 lutego 2020 r. w sprawie przyjęcia programu wieloletniego pn. Narodowa Strategia Onkologiczna na lata 2020-2030 M.P. 2020 poz. 189 *(the National Oncology Strategy for 2020-2030 implemented by resolution No. 10 of the Council of Ministers of February 4, 2020 on the adoption of the multiannual programme entitled the National Oncology Strategy for 2020-2030 M.P. 2020 item 189)* [https://www.gov.pl/web/zdrowie/narodowa-strategia-onkologiczna - no English version]
27	Portugal	X		[https://diariodarepublica.pt/dr/detalhe/despacho/13227-2023-835712442]
28	Romania	X		Law no.293/2022 on cancer prevention and control: [https://legislatie.just.ro/Public/DetaliiDocument/261246]
29	Slovak Republic		X	Action plans NOP 2021-2025 [https://rokovania.gov.sk/RVL/Material/26288/1]
30	Slovenia	X		Državni program obvladovanja raka 2022-2026 *(National Cancer Control Programme 2022-2026)*

Continue Appendix 3.

Country		Title and number of documents		Name(s) and the reference(s) (weblink) of the document(s)
		A single	Several	
31	Spain		X	ESTRATEGIA EN CÁNCER DEL SISTEMA NACIONAL DE SALUD 2021 *(Strategy for cancer control in the national health system 2021)* [https://www.sanidad.gob.es/areas/calidadAsistencial/estrategias/cancer/docs/ESTRATEGIA_EN_CANCER_DEL_SNS.pdf]; ESTRATEGIA DE PROMOCIÓN DE LA SALUD Y PREVENCIÓN EN EL SISTEMA NACIONAL DE SALUD 2013 *(Strategy for health promotion and prevention in the national health system 2013)* [https://www.sanidad.gob.es/areas/promocionPrevencion/estrategiaSNS/docs/EstrategiaPromocionSaludyPrevencionSNS.pdf]; ESTRATEGIA EN CUIDADOS PALIATIVOS DEL SISTEMA NACIONAL DE SALUD 2010-2014 *(Strategy for palliative care in the national health system 2010-2014)* [https://www.sanidad.gob.es/areas/calidadAsistencial/estrategias/cuidadosPaliativos/docs/cuidadospaliativos.pdf]; CUIDADOS PALIATIVOS PEDIÁTRICOS EN EL SISTEMA NACIONAL DE SALUD: CRITERIOS DE ATENCIÓN *(Paediatric palliative care in the national health system: care criteria)* [https://www.sanidad.gob.es/areas/calidadAsistencial/estrategias/cuidadosPaliativos/docs/01-Cuidados_Paliativos_Pediatricos_SNS.pdf]
32	Sweden		X	The Swedish national cancer strategy was launched in 2009, and in 2019 the strategy was complemented with a long-term plan. The strategy works as the framework for all national efforts to strengthen Swedish cancer care and is implemented through both government tasks to public authorities and through yearly agreements between the government and the Swedish Association of Local Authorities and Regions. In February 2024 the government appointed a commission of enquiry to propose an updated national strategy. En nationell cancerstrategi för framtiden, SOU 2009:11 [https://www.regeringen.se/rattsliga-dokument/statens-offentliga-utredningar/2009/02/sou-200911/]; English summary [https://www.regeringen.se/contentassets/e343b40615eb46b395e5c65ca38d1337/summary-sou-200911/]; Långsiktig inriktning för det nationella arbetet med cancervården [https://www.regeringen.se/informationsmaterial/2018/05/langsiktig-inriktning-for-det-nationella-arbetet-med-cancervarden/]; Examples of agreements between the government and SALAR relevant for the implementation of the cancer strategy: Överenskommelsen jämlik och effektiv cancervård med kortare väntetider 2024 [https://cancercentrum.se/samverkan/om-oss/mal-och-inriktning/overenskommelse/]; & God och nära vård 2024 - En personcentrerad och patientsäker hälso-och sjukvård med primärvården som nav: Överenskommelse om God och nära vård 2024 - En personcentrerad och patientsäker hälso-och sjukvård med primärvården som nav SKR
33	Turkey	X		Türkiye Ulusal Kanser Kontrol Programı *(Türkiye National Cancer Control Program)*
34	Ukraine		X	План дій щодо виконання Національної стратегії контролю злоякісних новоутворень на період до 2025 року [Action plan for national strategy on cancer control up to 2025]; Національна стратегія контролю злоякісних новоутворень на період до 2030 року; [National strategy for cancer control up to 2030]; Наказ МОЗ України від 06.01.2023 № 35 "Про внесення змін до складу робочої групи з питань удосконалення та розвитку онкологічної допомоги"; [On changes of members in the working group for improvement and development of cancer care].

*Including North Macedonia_1 and _2, and both answers are the same [Yes].

Appendix 4. NCCP documents by type (programme/plan/strategy/policy) and country (Q3: n=34)

Country		National type of documents				
		Programme	**Plan**	**Strategy**	**Policy**	**Other**
1	Austria	X				
2	Belgium					X (a)
3	Bulgaria	X	X			
4	Croatia			X		
5	Cyprus			X		
6	Czech Republic	X	X	X		
7	Denmark	X	X	X	X	
8	Estonia			X		
9	Finland	X				
10	France			X	X	
11	Germany		X			
12	Greece	X	X	X	X	
13	Hungary	X				
14	Iceland	X		X	X	
15	Ireland	X				
16	Italy		X			
17	Latvia		X			
18	Lithuania	X				
19	Luxembourg		X			
20	Malta		X			
21	Moldova	X		X	X	
22	Montenegro					X (b)
23	Netherlands	X	X	X		
24	North Macedonia*	X (1,2)				
25	Norway			X		
26	Poland	X				
27	Portugal			X		
28	Romania					X (c)
29	Slovak Republic		X		X	
30	Slovenia	X				
31	Spain			X		
32	Sweden	X		X	X	
33	Turkey	X	X	X		
34	Ukraine		X	X	X	

* Including North Macedonia_1 and _2 (both responses); (a) not applicable; (b) not available; (c) the law on cancer prevention and control does not fit any of the above definitions, and maybe it could be classified as a “policy”.

Appendix 5. Presence of other policy documents relevant to cancer control measures, including titles and links to the documents in the participating countries (Q4: n=34)

Country		Existence of other policy documents		Name(s) and reference(s) (weblink) of the document(s) in English or in your language if there is no translation
		Yes	No	
1	Austria	X		Nationales Screening-Komitee auf Krebserkrankungen (Recommendations on screening programmes of the national screening committee) [https://www.sozialministerium.at/Themen/Gesundheit/Nicht-uebertragbare-Krankheiten/Krebs/Nationales-Screening-Komitee-auf-Krebserkrankungen.html]
2	Belgium	X		There are plans for prevention, which are not cancer-specific and differ by region: • Walloon region: Plan de promotion et de prévention de la santé Horizon 2030 (Horizon 2030 health promotion and prevention plan) [https://www.aviq.be/fr/sensibilisation-et-promotion/promotion-de-la-sante/horizon-2030]; • German-speaking community: Gesundheitspräventions - und Gesundheitsförderungs-politik in der Deutschsprachigen Gemeinschaft heute und morgen (Health prevention and health promotion policy in the German-speaking Community today and tomorrow) [https://pdg.be/PortalData/34/Resources/dokumente/schriftenreihe/Schriftenreihe_PDG_Band_4.pdf];• Brussels region: Plan bruxellois de promotion de la santé (Brussels health promotion plan) [https://ccf.brussels/download/plan-promotion-sante-2023/?wpdmdl=24189&masterkey=62d678682c83d] and Plan social santé intégré (Integrated social health plan) [https://www.brusselstakescare.be/wp-content/uploads/2022/10/PSSI_2023_FR_FINAL.pdf#page=19]; • Flemish region: Globaal preventie plan (Global prevention plan) [https://publicaties.vlaanderen.be/view-file/65277#page=51; no full version of this document seems to be retrievable online at the moment, this is only an overview of the key points]
3	Bulgaria		X	/
4	Croatia	X		Akcijski plan za provedbu Nacionalnog strateškog okvira protiv raka za razdoblje do 2025 (Action plan for the implementation of the National Strategic Framework against Cancer for the period until 2025).
5	Cyprus		X	/
6	Czech Republic		X	/
7	Denmark		X	/
8	Estonia	X		NATIONAL HEALTH PLAN 2020–2030 [https://www.sm.ee/sites/default/files/documents/2023-03/National%20Health%20Plan%202020-2030.pdf]
9	Finland		X	/
10	France	X		Programme national de lutte contre le tabagisme (National Tobacco Control Programme 2023-2027) [https://sante.gouv.fr/actualites/actualites-du-ministere/article/un-nouveau-programme-national-de-lutte-contre-le-tabac-2023-2027]; Feuille de route priorité dépistages (Roadmap for screening priorities); [https://sante.gouv.fr/IMG/pdf/feuille_de_route_depistage_organise_des_cancers_2024_2028.pdf].
11	Germany	X		A research-oriented strategy was introduced in 2019 by the Ministry of Education and Research called the “National Decade Against Cancer Initiative”.* The mission of this initiative is to strengthen research in the areas of prevention, early detection, diagnostics and innovative therapies. The results of this research shall be made available to patients as soon as possible (speed up forward translation). *Federal Ministry of Education and Research (2019). National Decade Against Cancer Initiative [Link]

Continue Appendix 5.

Country		Existence of other policy documents		Name(s) and reference(s) (weblink) of the document(s) in English or in your language if there is no translation
		Yes	No	
12	Greece	X		Α. Κοινή Υπουργική Απόφαση 27866, 19/05/2022-2459: Ειδικότερα θέματα υλοποίησης της Δράσης για τη δημόσια υγεία «Προληπτικές διαγνωστικές εξετάσεις μαστογραφίας κατά του καρκίνου του μαστού *(Joint Ministerial Decision 27866, 19/05/2022-2459 Specific implementation issues of the Public Health Action "Preventive mammography diagnostic tests against breast cancer"* [https://istrikala.gr/wp-content/uploads/2022/05/2459b-22.pdf]; • Β. Κοινή Υπουργική Απόφαση 20/05/2023-3417 Όροι και διαδικασία υλοποίησης της δράσης για τη δημόσια υγεία «Αντιμετώπιση της Παιδικής Παχυσαρκίας» του Εθνικού Προγράμματος πρόληψης της Δημόσιας Υγείας «Σπύρος Δοξιάδης» Joint Ministerial Decision 20/05/2023-3417 *(Terms and procedure for the implementation of the public health action "Combating Childhood Obesity" of the "Spyros Doxiadis" National Public Health Prevention Program).* • C. Κοινή Υπουργική Απόφαση 16076, 15/03/2024-1724 Ειδικότερα θέματα υλοποίησης της Δράσης Δημόσιας Υγείας «Προληπτικές Διαγνωστικές Εξετάσεις για τον Καρκίνο του Τραχήλου της Μήτρας» *(Joint Ministerial Decision 16076, 15/03/2024-1724 Specific implementation Issues of the Public health Action "Preventive Diagnostic Examinations for Cervical Cancer")* [http://istrikala.gr/wp-content/uploads/2024/03/FEK-2024-Tefxos-B-01724-downloaded-28_03_2024-%CE%A6%CE%95%CE%9A.pdf]; • D. Κοινή Υπουργική Απόφαση 09/04/2024-2180 Όροι και διαδικασία υλοποίησης της δράσης για τη δημόσια υγεία «Πρωτογενής Πρόληψη» του Εθνικού Προγράμματος πρόληψης της Δημόσιας Υγείας «Σπύρος Δοξιάδης» ως προς τα έργα «Σύμβουλος Υγείας» και «Healthflix» *(Joint Ministerial Decision 09/04/2024-2180 Terms and procedure for the implementation of the "Primary Prevention" public health action of the "Spyros Doxiadis" National Public Health Prevention Programme regarding the "Health Advisor" and "Healthflix" projects).*
13	Hungary	X		Egészséges Magyarország 2021–2027 - Egészségügyi Ágazati Stratégia *(Healthy Hungary 2021-2027 – Health Sector Strategy)* [https://cdn.kormany.hu/uploads/document/d/dc/dc5/dc5e0cad5e44450024c624018aa351dfc0946e40.pdf]
14	Iceland		X	/
15	Ireland	X	~~X~~	Healthy Ireland Framework, which is an all of government, Health in All Policies approach to health and wellbeing for the population. While not targeted at cancer, many of these policies and recommendations are relevant to cancer prevention [https://www.gov.ie/en/publication/e8f9b1-healthy-ireland-framework-2019-2025/]
16	Italy	X		Piano Nazionale della Prevenzione 2020-2025 *(National Prevention Plan 2020-2025)* [https://www.salute.gov.it/portale/prevenzione/dettaglioContenutiPrevenzione.jsp?id=5772&area=prevenzione&menu=vuoto; https://www.salute.gov.it/imgs/C_17_notizie_5029_0_file.pdf]
17	Latvia	X		Public Health Guidelines 2021-2027. [https://likumi.lv/ta/id/332751-sabiedribas-veselibas-pamatnostadnes-2021-2027-gadam; available only in Latvian]
18	Lithuania		X	/
19	Luxembourg	X		Plateforme Nationale Cancer (Comité de Pilotage du plan) (National Cancer Platform (Steering Committee of the Plan)) [https://www.stradalex.lu/fr/slu_src_publ_leg_mema/toc/leg_lu_mema_202101_78/doc/mema_etat-leg-rgc-2021-01-22-a78-jo].
20	Malta	X		National Health Systems Strategy 2023-2030 [https://health.gov.mt/wp-content/uploads/2023/04/A_National_Health_Systems_Strategy_for_Malta_2023_-_2030_Investing_Successfully_for_a_Healthy_Future_EN.pdf]
21	Moldova		X	/
22	Montenegro		X	/

Continue Appendix 5.

Country		Existence of other policy documents		Name(s) and reference(s) (weblink) of the document(s) in English or in your language if there is no translation
		Yes	No	
23	Netherlands	X		There are many policy documents from various health organizations, social organizations, patient organizations and government regarding cancer. Within the Dutch Cancer Agenda, we try to connect the dots. Therefore, you will also find references to specific websites of partner organizations. This will not be a complete overview, but it is used to illustrate some of our answers.
24	North Macedonia*		X	/
25	Norway	X		National guidelines on cancer (25 different guidelines) [https://www.helsedirektoratet.no/tema/kreft]; National cancer patients pathways [https://www.helsenorge.no/en/sykdom/kreft/cancer-patient-pathways/]; Quality assurance manuals for national screening cancer programmes: Quality assurances manual - breast cancer [https://www.kreftregisteret.no/en/General/Publications/Mammografiprogrammet/quality-assurance-manual/]; Quality assurance manual - cervical cancer [https://www.kreftregisteret.no/screening/livmorhalsprogrammet/Helsepersonell/Faglig-Radgivningsgruppe/kvalitetsmanual2/]; Quality assurance colorectal cancer [https://www.kreftregisteret.no/screening/tarmscreening/for-helsepersonell/kvalitetsmanual/].
26	Poland	X		Ustawa z dnia 9 marca 2023 r. o Krajowej Sieci Onkologicznej *(Act of March 9, 2023, on the National Oncology Network)*; ensuring equal access to high-quality oncological care, through the implementation of integrated care in oncology, competence centres in oncology, medical guidelines, oncological quality indicators, and medical registers for the purposes of assessing quality and equality in access to care [https://isap.sejm.gov.pl/isap.nsf/DocDetails.xsp?id=WDU20230000650; no English version]
27	Portugal		X	/
28	Romania	X		Order of the Minister of Health no. 3303/2023 on psychology services provided to oncological patients [https://legislatie.just.ro/Public/DetaliiDocument/275110]; Order of the Minister of Health no. 3514/2023 on approval of the organization, functioning and authorization of palliative services (updating previous one): [https://legislatie.just.ro/Public/DetaliiDocument/275351]; Order of the Minister of Health no. 3787/2023 on the approval of the action plan for defining and organization of integrated network for diagnosis and treatment of paediatric cancers: [https://legislatie.just.ro/Public/DetaliiDocument/276201].
29	Slovak Republic		X	/
30	Slovenia		X	/
31	Spain		X	/
32	Sweden	X		Examples of ongoing government tasks contributing to the implementation of the strategy: Ändringsbeslut 2024-05-23 Myndighet Strålsäkerhetsmyndigheten (esv.se) Uppdrag att kartlägga cancerrehabiliteringen - Regeringen.se Uppdrag att utreda behov och kostnader i fråga om vaccination mot humant papillomvirus - Regeringen.se uppdrag-att-betala-ut-medel-till-genomic-medicine-sweden.pdf (regeringen.se)
33	Turkey		X	/
34	Ukraine		X	/

*Including North Macedonia_1 and _2 (both responses).

Appendix 6. Year of expiry of the NCCPs in the participating countries (Q5: n=34)

Country		2024	2025	2026	2027	2028	2029	2030	Other
1	Austria								[No expiry year (currently preparing a new NCCP)]
2	Belgium								[Not applicable]
3	Bulgaria							X	
4	Croatia							X	
5	Cyprus	X							
6	Czech Republic							X	
7	Denmark								[2020]
8	Estonia							X	
9	Finland								[None]
10	France							X	
11	Germany								[Ongoing]
12	Greece		X						
13	Hungary							X	
14	Iceland							X	
15	Ireland			X					
16	Italy				X				
17	Latvia	X							
18	Lithuania		X						
19	Luxembourg			X					
20	Malta								[2021 (has not been replaced as yet)]
21	Moldova		X						
22	Montenegro								[The previous NCCP expired on 2015]
23	Netherlands								[2032]
24	North Macedonia*								(1, 2) [1: one year; 2: the NCCP is an annual programme]
25	Norway	X							
26	Poland							X	
27	Portugal							X	
28	Romania							X	
29	Slovak Republic		X						
30	Slovenia			X					
31	Spain								[Expiry year is not established]
32	Sweden								[The present strategy is valid until further notice. Work with an updated strategy is ongoing and will be presented during the autumn of 2024]
33	Turkey		X						
34	Ukraine							X	

*Including North Macedonia_1 and _2 (both responses).

Appendix 7. Intention to develop a new NCCP after the end of the current one in the participating countries (Q7: n=34)

Country		Intention to develop a new NCCP document			
		Yes	No	Do not know	No answer
1	Austria	X (A)			
2	Belgium			X	
3	Bulgaria	X			
4	Croatia	X			
5	Cyprus	X			
6	Czech Republic			X	
7	Denmark	X			
8	Estonia	X			
9	Finland	X			
10	France	X			
11	Germany	X (B)			
12	Greece			X	
13	Hungary	X			
14	Iceland	X			
15	Ireland	X (C)			
16	Italy			X	
17	Latvia				X
18	Lithuania				X
19	Luxembourg				X
20	Malta				X
21	Moldova				X
22	Montenegro				X
23	Netherlands				X
24	North Macedonia				X
25	Norway	X			
26	Poland	X			
27	Portugal	X			
28	Romania		X		
29	Slovak Republic	X			
30	Slovenia	X			
31	Spain	X			
32	Sweden	X			
33	Turkey	X			
34	Ukraine	X			

Comments: **(A)** Austria is currently preparing a new NCCP; **(B)** Germany: There is no expiry date of the National Cancer Plan which is currently being revised/updated. **(C)** Ireland: The intention is to prepare a new cancer strategy; there have been three national cancer strategies in Ireland to date, in 1996, 2006 and 2017.

Appendix 8. NCCPs in preparation and reasons for the absence of an NCCP or other cancer document in the participating countries (Q8: n=34)

Country		NCCPs in preparation		Reasons for the absence of an NCCP or other cancer control document
		Yes	No	
1	Austria		X	Austria has an NCCP.
2	Belgium		X	Belgium is currently applying a cancer strategy focusing on four topics in cancer control and care: excellence in healthcare quality, accessibility and knowledge development and division, with specific attention to children and AYA with cancer.
3	Bulgaria		X	Bulgaria has an NCCP which should be adapted and updated with the relevant to the maturity level of the environment priorities, actions and roadmap. There is a lack of a structured National Cancer Mission Hub (NCMH).
4	Croatia		X	**The national strategic framework for cancer control until 2030 has been adopted and is currently in force (Nacionalni strateški okvir protiv raka do 2030. je donesen i na snazi je).
5	Cyprus	X		
6	Czech Republic		X	We have a strategy.
7	Denmark	X		
8	Estonia		X	We have an NCCP.
9	Finland	X		
10	France	X		
11	Germany		X	*Germany has had a National Cancer Plan since 2008.
12	Greece	X		
13	Hungary		X	Hungary has an NCPP in force. Please revise the wording of the questionnaire.
14	Iceland	X		
15	Ireland		X	*Not relevant, as a strategy is in place.
16	Italy	X		
17	Latvia	X		
18	Lithuania	X		
19	Luxembourg		X	We have an NCCP in Luxembourg – the question is not applicable.
20	Malta	X		
21	Moldova		X	In our country we have a National Cancer Control Programme endorsed by the government.
22	Montenegro		X	It is not our government's priority.
23	Netherlands	X		
24	North Macedonia	X		
25	Norway	X		
26	Poland		X	The current document "National Oncology Strategy for 2020-2030", which serves as the NCCP, was developed to last until 2030, and a new one is not planned at present. There seems to be a missing "N/A" checkbox, as Poland has an NCCP.
27	Portugal		X	Our country has an NCCP in place that is valid until 2030.

Continue Appendix 8.

Country		NCCPs in preparation		Reasons for the absence of an NCCP or other cancer control document
		Yes	No	
28	Romania		X	There is one in force.
29	Slovak Republic	X		
30	Slovenia		X	Slovenia has already established an NCCP. The current one for the period from 2022 until 2026 is the third one.
31	Spain	X		
32	Sweden		X	Not a relevant question.
33	Turkey		X	**The current NCCP VAR has been published on our website. It is updated as needed (Mevcut NCCP VAR, web sayfamızda yayımlandı. İhtiyaç halinde güncellenmektedir).
34	Ukraine	X		

* The comments from Germany and Ireland were categorized as an NCCPs are not in preparation [No]. **The comments from Croatia and Turkey have been translated into English.

Appendix 9. The expected year of adoption of NCCPs by the Ministry of Health in selected countries (Q8: n=16)

Country		NCCP document in preparation process [Yes]	The expected year of adoption of NCCPs by the MoH					
			Do not know	2024	2025	2026	2027	Other
5	Cyprus	X			X			
7	Denmark	X		X				
9	Finland	X			X			
10	France	X	X					
12	Greece	X			X			
14	Iceland	X		X				
15	Ireland	excluded						X (A)
16	Italy	X						X (B)
17	Latvia	X			X			
18	Lithuania	X		X				
20	Malta	X		X				
23	Netherlands	X	X					
24	North Macedonia	X (1,2)	X (1)		X (2)			
25	Norway	X		X				
29	Slovak Republic	X			X			
31	Spain	X				X		
34	Ukraine	X	X					

Legend: **(A)** Ireland: The lifetime of the current strategy is until the end of 2026. A new strategy may be developed for 2027+ (unconfirmed). **(B)** Italy: We have an NCCP (Q8 is not applicable for us).

Notes: Ireland is not included in the analysis (Q8 is not relevant). Italy is included in the analysis, as it is reported to have an NCCP (Q8 is relevant) included in the analysis [do not know]. The responses of North Macedonia_2 are included in the analysis [expected year: 2025, while the responses of North Macedonia_1 are excluded [do not know].

Appendix 10. Financing the coordination of the implementation of the NCCPs in the participating countries (Q9: n=34)

Country		Funding to ensure the implementation of the NCCPs	
		Yes	No
1	Austria		X
2	Belgium		X
3	Bulgaria		X
4	Croatia	X	
5	Cyprus	X	
6	Czech Republic	X	
7	Denmark	X	
8	Estonia		X
9	Finland		X
10	France	X	
11	Germany	X	
12	Greece	X	
13	Hungary		X
14	Iceland		X
15	Ireland		X
16	Italy		X
17	Latvia	X	
18	Lithuania		X
19	Luxembourg	X	
20	Malta		X
21	Moldova		X
22	Montenegro		X
23	Netherlands		X
24	North Macedonia*	X (1)	X (2)
25	Norway		X
26	Poland	X	
27	Portugal	X	
28	Romania		X
29	Slovak Republic		X
30	Slovenia	X	
31	Spain		X
32	Sweden	X	
33	Turkey		X
34	Ukraine	X	

*Including North Macedonia_1 and _2 (both responses).

Appendix 11. Existence of a monitoring and evaluation procedure for the NCCPs in the participating countries (Q10: n=34)

Country		NCCP evaluation and monitoring process				
		Yes, mid-term & final	**Yes, final only**	**Yes, other**	**Description of other options related to the monitoring and evaluation process of the NCCPs**	**No**
1	Austria			X	Monitoring of targets' status	
2	Belgium					X
3	Bulgaria					X
4	Croatia	X				
5	Cyprus					X
6	Czech Republic			X	We monitor the activities of NOPL, Implementation plan respectively every year. We (CR) monitor the results of National Recovery Plan support.	
7	Denmark	X				
8	Estonia			X	Yearly evaluation	
9	Finland					X
10	France	X				
11	Germany			X	In terms of meeting the defined objectives of the German National Cancer Plan there is close monitoring of the implementation process by the Federal Ministry of Health and the Steering Committee. Apart from that there is/will be evaluation of many activities, in a strictly scientific sense, e.g. through evaluation of research projects within the National Cancer Plan, or evaluation of population-based quality-assured screening programmes by the organizations responsible (e.g. Federal Joint Committee). As part of the evaluation and current revision process of the National Cancer Plan, an in-depth analysis of the implementation process and analysis of the achieved milestones between 2011 and 2023 have been completed by the Federal Ministry of Health and the Steering Committee of the German National Cancer Plan. The results will be the basis for the continuation and revision of the German National Cancer Plan.	
12	Greece			X	Not specified yet	
13	Hungary			X	The specific targets and indicators to be measured are set by the NCCP Governing Board. The development plan and progress in implementing the plan will be regularly evaluated by the Governing Board.	
14	Iceland	X				
15	Ireland	X			The Department of Health in Ireland regularly reviews progress of the implementation of the national strategy. Implementation reports for National Cancer Strategy prepared and published on the Department of Health website annually https://www.gov.ie/en/publication/a89819-national-cancer-strategy-2017-2026/	
16	Italy			X	Each Chapter of the national Cancer Plan has a section dedicated to the monitoring Indicators	
17	Latvia		X			
18	Lithuania	X				
19	Luxembourg	X				
20	Malta			X	The Plan incorporates a number of indicators for monitoring of implementation. However, monitoring is not done regularly	
21	Moldova					X

Continue Appendix 11.

Country		NCCP evaluation and monitoring process				
		Yes, mid-term & final	**Yes, final only**	**Yes, other**	**Description of other options related to the monitoring and evaluation process of the NCCP**	**No**
22	Montenegro					X
23	Netherlands			X	The agenda was launched in November 2023. The process for yearly monitoring, evaluation and adjustment is in development.	
24	North Macedonia*		X (1)			X (2)
25	Norway					X
26	Poland	X				
27	Portugal			X	Yearly reports to the Health Ministry.	
28	Romania					X
29	Slovak Republic					X
30	Slovenia			X	The Slovenian NCCP has an established Supervisory Board, which includes decision-makers, policymakers and cancer patient representatives. This board provides essential oversight, strategic direction, and ensures that the plan's objectives are met effectively and efficiently.	
31	Spain		X			
32	Sweden			X	Different parts of the strategy are evaluated regularly. Due to different entities being involved in the implementation of the strategy, there are also different both actors evaluating the strategy and ways in which the strategy is evaluated. For example: the implementation carried out in line with the yearly agreements between the government and SALAR is evaluated by the Board of Social Affairs and Health. The Boards of Social Affairs and Health are also due to report soon on the state of cancer rehabilitation in Sweden. Apart from these area specific evaluations, The Swedish Agency for Health and Care Services Analysis did a mapping of the strategy in its entirety, which was published in January 2024: Lägesbild av den nationella cancerstrategin Vårdoch omsorgsanalys (vardanalys.se)	
33	Turkey		X			
34	Ukraine					X

Notes: * The answers of North Macedonia_1 are included in the analysis [Yes, final evaluation only], while the answers of North Macedonia_2 [No] are excluded.

Appendix 12. Institutions undertaking the evaluation of NCCPs and preparation of reports in the participating countries with a monitoring and evaluation process in place (Q11: n=34)

Country		Answer		Disruption
		Yes	No	
1	Austria	X		Austrian National Public Health Institute (Gesundheit Österreich GmbH, GÖG)
2	Belgium		X	
3	Bulgaria		X	
4	Croatia	X		Ministarstvo zdravstva i Hrvatski zavod za javno zdravstvo (Ministry of Health and the Croatian Institute of Public Health)
5	Cyprus		X	
6	Czech Republic	X		For NOPL (and implementation) the Ministry of Health, for whole National Recovery Plan Ministry of Industry and Trade
7	Denmark	X		The evaluation refers to Cancer Plan 4 and was then carried out by the Ministry of Health. The specific evaluation for Cancer Plan 5 has not yet been determined.
8	Estonia	X		National Cancer Control Steering Committee is leading the process, several institutions provide data.
9	Finland	X		In February 2021, the French President unveiled the ten-year Cancer Control Strategy (2021-2030) built together by the Institute and the French cancer community and French citizens through a national consultation. This ambitious Strategy aims to significantly reduce the burden of cancer in the daily lives of French people. It follows on from the successive Cancer Plans and continues the collective mobilization established on the fight against cancer. This Strategy revolves around four priorities: to improve prevention; to limit the after-effects and enhance the quality of life; to fight against cancers with poor prognosis; to ensure that progress benefits everyone. The firm commitments made by the French President and government around these four ambitious objectives to serve the French society concretize themselves by the means allocated to this Strategy: global funding of nearly €1.74 billion (an increase of almost 20% compared to the previous Cancer Plan), including additional financing of €284 million for the next five years, supplemented by the ministry in charge of Research, the hospital "ONDAM" (a national health insurance spending objective) and part of the Institute's funds up to €57 million. The Institute is entrusted with ensuring the Strategy's implementation by the law of March 8, 2019. Moreover, the Strategy is part of a dynamic and scalable process: goals and priorities will be adapted based on results, via a midterm review envisaged by the law of 8 March 2019. To this end, roadmaps will be drawn up for the 2021-2025 period, and afterward for the 2026-2030 period. This national roadmap has been drawn up for the 2021-2025 period. It sets around 240 measures to be implemented in the next five years, including 70 by 2021. It specifies the parties responsible for the various measures, the partners, deliverables, and launch schedule. The mid-term evaluation will be conducted by the International Scientific Advisory Board of the Institute, which is composed of world-known cancer experts appointed by the Ministries for Health and for Research. It gives advice and recommendations and attends to the consistency of the medical and scientific strategy. The report will be drafted by the Institute.
10	France		X	
11	Germany	X		In terms of meeting the defined objectives of the German National Cancer Plan, there is close monitoring of the implementation process by the Federal Ministry of Health and the Steering Committee. Apart from that there is/will be evaluation of many activities, in a strictly scientific sense, e.g. through evaluation of research projects within the National Cancer Plan, or evaluation of population-based quality-assured screening programmes by the organizations responsible (e.g. Federal Joint Committee). As part of the evaluation and current revision process of the National Cancer Plan, an in-depth analysis of the implementation process and analysis of the achieved milestones between 2011 and 2023 has been completed by the Federal Ministry of Health and the Steering Committee of the German National Cancer Plan. The results will be the basis for the continuation and revision of the German National Cancer Plan.
12	Greece	X		The Expert Committee of Public Health (ECPH) which is under the supervision of the General Secretariat of Public Health, Ministry of Health.

Continue Appendix 12.

Country		Answer		Disruption
		Yes	No	
13	Hungary	X		Taking the WHO recommendations into account, the National Institute of Oncology drew up the National Cancer Control Programme for the prevention and treatment of cancer in 1993, which Hungary was the first Central European country to prepare. Revised in 2001 and 2005, the Hungarian National Cancer Control Programme (MNCCP) was upgraded to a government programme in 2006. The objectives of the then adopted Cancer Programme included the establishment of an oncology network. The oncology care centres are organized and operate in a hierarchical network, with 19 county oncology centres, four regional centres and one comprehensive cancer centre (National Institute of Oncology) providing cancer care. Different levels of progressivity have been defined according to the minimum requirements of clinical oncology, based on the tasks assigned to each level of care. Regarding the evaluation the NCCP states as follows: The specific targets and indicators to be measured are set by the NCCP Governing Board. The development plan and progress in implementing the plan will be regularly evaluated by the Governing Board. To further ensure quality, the implementation of the NCCP is also supported by an international advisory board, composed of internationally recognized experts in the field of the organization of oncology care and quality assurance of care, with expertise in cancer programmes.
14	Iceland	X		The Ministry of Health collects information from all service providers.
15	Ireland	X		Department of Health (DOH) in Ireland. (Lead agencies are defined for implementation of each of the 52 recommendations of the National Cancer Strategy. The NCCP is the lead agency with responsibility for delivering the majority of recommendations. The NCCP reports to DOH regarding progress in implementing recommendations, and DOH signs off on and publishes the annual implementation reports. For the previous two strategies (1996 and 2006), external reviews of their implementation have been commissioned towards the ends of their terms. This may be undertaken for the current strategy (to be confirmed).
16	Italy	X		There is a coordination committee that assesses the implementation of the plan by the Italian regions.
17	Latvia	X		Institutions involved in the implementation of the plan must prepare and submit to the Ministry of Health by July 1, 2023, 2024 and 2025 information on the progress and results of the tasks specified in the plan. The Ministry of Health shall prepare and submit to the Cabinet of Ministers by November 1, 2025, an informative report on the evaluation of the plan's impact and implementation.
18	Lithuania	X		Ministry of Health Programme Implementation and Monitoring Board.
19	Luxembourg	X		Two independent experts for the midterm evaluation and three independent experts for the final evaluation.
20	Malta	X		The main author of the plan is Dr Miriam Dalmas.
21	Moldova		X	
22	Montenegro		X	
23	Netherlands	X		The hub in cooperation with the acceleration teams of the five featured goals and all the partners of the Netherlands Cancer Collective.
24	North Macedonia*	X (1)		(ad 1) Institute of Epidemiology and Biostatistics with Medical Informatics at the Faculty of Medicine at the University of St Constantine and Helena. Cyril and Methodius – Skopje.
25	Norway		X	
26	Poland	X		The report is prepared by the competent entity acting as the coordinator of "Narodowa Strategia Onkologiczna 2020-2030", which is the National Institute of Oncology Maria Skłodowska-Curie – National Research Institute (Narodowy Instytut Onkologii im. Marii Skłodowskiej-Curie – Państwowy Instytut Badawczy). https://www.gov.pl/web/zdrowie/narodowa-strategia-onkologiczna-nso
27	Portugal	X		The executive committee in charge of overseeing the strategy in cooperation with the National Institute of Health.
28	Romania		X	
29	Slovak Republic		X	

Continue Appendix 12.

Country		Answer		Disruption
		Yes	No	
30	Slovenia	X		The Slovenian NCCP has an established Supervisory Board, which includes decision-makers, policymakers and cancer patient representatives. This provides essential oversight, strategic direction, and ensures that the plan's objectives are met effectively and efficiently.
31	Spain	X		The last update of the Spanish Cancer Strategy was launched in 2021. It is planned to evaluate it after approximately five years' time, that would be in 2026. The evaluation will be undertaken by the technical coordinators of the Cancer Strategy at the Subdirectorate of Quality of Care, which depends on the Directorate of Public Health.
32	Sweden	X		Different parts of the strategy are evaluated regularly. Due to different entities being involved in the implementation of the strategy, there are also different both actors evaluating the strategy and ways in which the strategy is evaluated. For example: the implementation carried out in line with the yearly agreements between the government and SALAR is evaluated by the Board of Social Affairs and Health. The Boards of Social Affairs and Health are also due to report soon on the state of cancer rehabilitation in Sweden. Apart from these area specific evaluations, The Swedish Agency for Health and Care Services Analysis did a mapping of the strategy in its entirety which was published in January 2024: Lägesbild av den nationella cancerstrategin Vårdoch omsorgsanalys (vardanalys.se)
33	Turkey	X		Halk Sağlığı Genel Müdürlüğü (General Directorate of Public Health)
34	Ukraine		X	

*The answers of North Macedonia_1 are included in the analysis [the institutions are described].

Appendix 13. Use of indicators in the evaluation process in the participating countries (Q12: n=34)

Country		Indicators used	Indicators not used	No answer
1	Austria	X		
2	Belgium			X
3	Bulgaria			X
4	Croatia	X		
5	Cyprus			X
6	Czech Republic	X		
7	Denmark		X	
8	Estonia	X		
9	Finland			X
10	France	X		
11	Germany	X (A)		
12	Greece	X		
13	Hungary	X		
14	Iceland		X	
15	Ireland	X		
16	Italy		X	
17	Latvia		X	
18	Lithuania	X		
19	Luxembourg	X		
20	Malta	X		
21	Moldova			X
22	Montenegro			X
23	Netherlands	X		
24	North Macedonia*	X		
25	Norway			X
26	Poland	X		
27	Portugal	X		
28	Romania			X
29	Slovak Republic			X
30	Slovenia		X	
31	Spain	X		
32	Sweden	X		
33	Turkey	X		
34	Ukraine			X

Notes: * Including North Macedonia_1 (answer); excluding North Macedonia_2 (no answer); **(A)** Germany: partially (e.g. for evaluation of population-based quality-assured screening programmes).

Appendix 14. Methodology behind the selection of the indicators for the evaluation of the NCCPs in the selected countries (Q12: n=19)

Country		Description of the methodology for the selection of indicators for the assessment of NCCPs
1	Austria	Discussed within expert groups.
4	Croatia	Glavni kriteriji evaluacije su relevantnost, korisnost, učinkovitost i djelotvornost. (The main evaluation criteria are relevance, usefulness, efficiency, and effectiveness.)
6	Czech Republic	NOPL – collaboration with experts on cancer prevention, oncological care and on systems; National Recovery Plan – do not know exactly, but suppose that it is also with collaboration with experts.
8	Estonia	Outcome and performance indicators have been defined in the NCCP.
10	France	Un groupe de travail d'experts de l'Institut et de ses partenaires est réuni pour sélectionner les indicateurs pertinents. (A working group of experts from the Institute and its partners was convened to select the relevant indicators.)
11	Germany	In line with the EU Screening Guidelines
12	Greece	The selection of indicators is a task of the Expert Committee of Public Health (ECPH) which is under the supervision of the General Secretariat of Public Health, MoH, or another respected Board relevant to different aspects of the program
13	Hungary	The indicators for evaluation of the NCCP were selected by the Governing Board based on the cancer incidence data from the National Cancer Registry, mortality data from the Central Statistical Office, cancer screening data from the National Centre for Public Health and patient care data from the National Health Insurance Fund Management.
15	Ireland	An annual report is published which sets out the progress achieved on the implementation of the 52 recommendations of the National Cancer Strategy and the degree to which the 23 associated key performance indicators are being met. (See section 1.2 of the National Cancer Strategy for information on how the strategy was developed. https://assets.gov.ie/9315/6f1592a09583421baa87de3a7e9cb619.pdf).
18	Lithuania	I do not know.
19	Luxembourg	Originally selected by the committee that wrote the Plan and modified or completed by the working groups depending on the selected projects or actions.
20	Malta	Indicators relevant to each chapter of the Plan were selected and included, mostly extracted from the literature. They follow the Donabedian framework: structure, process, outcome.
23	Netherlands	The acceleration teams for the featured goals work together on the action plans based on the Theory of Change approach. The impact evaluation will be done accordingly. Therefore, with every activity the foreseen output and outcome (leading to impact) are indicated. So, the key indicators are based on the output and outcome indicators These outcome indicators are steps in reducing the impact of cancer on Dutch society, the total impact will be measured by: incidence, mortality, quality of life, physical health, mental health, degree of independence, social relationships, environment, personal values and beliefs, quality of care, effectiveness, safety, patient-centredness, timeliness, efficiency and equality of treatment.
24	North Macedonia*	Institute of Epidemiology and Biostatistics with Medical Informatics, Faculty of Medicine, University of St Constantine and Helena. Cyril and Methodius – Skopje, is preparing an annual report on the success of the implementation of the cervical cancer screening programme and analysis of observations (findings) through monitoring of key indicators selected in accordance with EU regulations. The key indicators selected refer to: (1) screening scope; (2) screening participation rate; (3) screening retention rate; (4) rate of PAP tests performed and pap tests unsatisfactory for analysis; (5) rate of detected cellular abnormalities by categorizing the Bethesda system; (6) need rate and response for succession; (7) cervical cancer rate with additional categorization of the finding; 8) rate of interval finding of cervical cancer; (9) lymph node status and categorization; (10) participation of screening in the total finding of cervical cancer; (11) average screening time to: screening result, final diagnosis, first treatment; (12) average time from indications to biopsies/ colposcopy/ surgery; (13) screening complication rate; (14) complication rate related to additional/ instructive screening reviews; 15) rate of women with a positive PAP test (HSIL+/ASC-H) who had consecutive colposcopy within 3, 6, 9 and 12 months after the index PAP test Indicators for conducting screening activity and early detection of breast cancer. The key indicators selected refer to: (1) screening scope; (2) screening participation rate; (3) need rate and response for succession; (4) breast cancer rate with additional categorization of the finding; (5) lymph node status and categorization; (6) rate of interval breast cancer; (7) participation in breast cancer screening; (8) average time from screening to result, i.e. first treatment; (9) average time from indications for surgery and surgery; (10) rate of detection of benign change in open surgical biopsy; and (11) mastectomy rate. Indicators for conducting screening activity and early detection of colon cancer (1) screening scope; (2) participation rate; (3) retention rate; (4) rate of abnormalities detected by categorizing the find; (5) need rate and response for succession; (6) colon cancer rate with additional categorization of the finding; (7) rate of interval finding of colon cancer; (8) lymph node status and categorization; (9) participation of screening in total colon cancer; (10) average screening time to: screening result, final diagnosis, first treatment; (11) average time from screening indications to surgeries; (12) screening complication rate (perforation, bleeding, etc.); (13) indicated hospitalization days after screening; (14) complication rate related to additional/ instructive screening reviews; (15) rate of diagnosed with benign changes in colon and catheter.

Continue Appendix 14.

Country		Description of the methodology for the selection of indicators for the assessment of NCCPs
26	Poland	The National Oncology Strategy contains only the expected epidemiological indicators regarding mortality from malignant cancers: colorectal cancer, breast cancer in women, cervical cancer, skin melanoma, and lung cancer.
27	Portugal	All indicators are set forth in the Strategy.
31	Spain	The indicators are selected considering the impact of the objectives achieved and the feasibility for collecting the information through questionnaires and data bases.
32	Sweden	Which indicators are used varies dependent on what aspect of the strategy that is being evaluated. Indicators such incidents, mortality, cancer-survival and screening participation are however regularly evaluated.
33	Turkey	Her bir strateji başlığındaki alt faaliyetlere yönelik ilerleme göstergeleri NCCP de tanımlanmıştır. *(The progress indicators for the sub-activities under each strategic heading have been defined in the NCCP).*

Appendix 15. Inclusion of the indicators in the NCCPs in the participating countries (Q13: n=34)

Country		Indicators used	Indicators not used	No answer
1	Austria	X		
2	Belgium			X
3	Bulgaria			X
4	Croatia		X	
5	Cyprus			X
6	Czech Republic	X		
7	Denmark		X	
8	Estonia	X		
9	Finland			X
10	France		X	
11	Germany		X	
12	Greece	X		
13	Hungary	X		
14	Iceland		X	
15	Ireland	X		
16	Italy	X		
17	Latvia	X		
18	Lithuania	X		
19	Luxembourg	X		
20	Malta	X		
21	Moldova			X
22	Montenegro			X
23	Netherlands	X		
24	North Macedonia*	X		
25	Norway			X
26	Poland	X		
27	Portugal	X		
28	Romania			X
29	Slovak Republic			X
30	Slovenia		X	
31	Spain	X		
32	Sweden	X		
33	Turkey	X		
34	Ukraine			X

* Including North Macedonia_1 (answer); excluding North Macedonia_2 (no answer).

Appendix 16. Types of evaluation of NCCPs in the participating countries (Q14: n=34)

Country		Answer		Types of evaluation of NCCPs			
		Yes	No	Structure	Process	Outcome	Other
1	Austria	X				X	
2	Belgium		X				
3	Bulgaria		X				
4	Croatia	X		X	X	X	
5	Cyprus		X				
6	Czech Republic	X			X	X	
7	Denmark	X		X	X	X	
8	Estonia	X			X	X	
9	Finland		X				
10	France	X		X	X	X	
11	Germany	X		X	X	X	
12	Greece	X		X	X	X	
13	Hungary	X		X		X	
14	Iceland	X			X	X	
15	Ireland	X					X (A)
16	Italy	X		X	X	X	
17	Latvia	X		X	X	X	
18	Lithuania	X			X		
19	Luxembourg	X		X	X	X	
20	Malta	X		X	X	X	
21	Moldova		X				
22	Montenegro		X				
23	Netherlands	X		X	X	X	
24	North Macedonia*	X		X	X	X	
25	Norway		X				
26	Poland	X				X	
27	Portugal	X			X	X	
28	Romania		X				
29	Slovak Republic		X				
30	Slovenia	X		X	X		
31	Spain	X		X	X	X	
32	Sweden	X		X	X	X	
33	Turkey	X				X	
34	Ukraine		X				

Notes: **(A)** Ireland**:** An annual implementation report is published which sets out the progress achieved on the implementation of the 52 recommendations of the National Cancer Strategy and the degree to which the 23 associated key performance indicators are being met. Recommendations and KPIs of the Strategy include structures, processes and outcomes. ** Including North Macedonia_1 and _2 (responses).

Appendix 17. Coverage of the areas recommended by the European Guide for Quality NCCPs in the participating countries (Q15: n=34)

Country			Primary prevention	Health promotion	Cancer screening	Early detection	Diagnosis
1		Austria	Yes	Yes	Yes	Yes	Yes
2		Belgium	No	No	No	No	No
3		Bulgaria	Yes	No	Yes	Yes	Yes
4		Croatia	Yes	Yes	Yes	Yes	Yes
5		Cyprus	Yes	Yes	Yes	Yes	Yes
6		Czech Republic	Yes	Yes	Yes	Yes	Yes
7		Denmark	Yes	Yes	Yes	Yes	Yes
8		Estonia	Yes	No	Yes	Yes	Yes
9		Finland	Yes	Yes	Yes	Yes	Yes
10		France	Yes	Yes	Yes	Yes	Yes
11		Germany	NA	NA	NA	NA	NA
12		Greece	Yes	Yes	Yes	Yes	Yes
13		Hungary	Yes	Yes	Yes	Yes	Yes
14		Iceland	Yes	Yes	Yes	Yes	Yes
15		Ireland	Yes	Yes	Yes **(A)**	Yes	Yes
16		Italy	Yes	Yes	Yes	Yes	Yes
17		Latvia	Yes	Yes	Yes	Yes	Yes
18		Lithuania	Yes	Yes	Yes	Yes	Yes
19		Luxembourg	Yes	Yes	Yes	Yes	Yes
20		Malta	Yes	Yes	Yes	Yes	Yes
21		Moldova	Yes	Yes	Yes	Yes	Yes
22		Montenegro	No	No	No	No	No
23		Netherlands	Yes	Yes	Yes	Yes	Yes
24		North Macedonia (1/2) *	Yes	Yes/No*	Yes	Yes	Yes
25		Norway	Yes	Yes	Yes	Yes	Yes
26		Poland	Yes	Yes	Yes	Yes	Yes
27		Portugal	Yes	Yes	Yes	Yes	Yes
28		Romania	Yes	No	Yes	No	No
29		Slovak Republic	Yes	No	Yes	Yes	Yes
30		Slovenia	Yes	Yes	Yes	Yes	Yes
31		Spain	Yes	Yes	Yes	Yes	Yes
32		Sweden	Yes	Yes	Yes	Yes	Yes
33		Turkey	Yes	Yes	Yes	Yes	Yes
34		Ukraine	Yes	Yes	Yes	Yes	Yes

Note: **(A)** Ireland: National Screening Service.

Continue Appendix 17.

Country		Treatment	Psychosocial oncology care	Survivorship	Rehabilitation	Palliative and end-of-life care
1	Austria	Yes	Yes	Yes	Yes	Yes
2	Belgium	No	No	No	No	No
3	Bulgaria	Yes	No	No	No	No
4	Croatia	Yes	Yes	Yes	Yes	Yes
5	Cyprus	Yes	Yes	Yes	Yes	Yes
6	Czech Republic	Yes	Yes	Yes	Yes	Yes
7	Denmark	Yes	Yes	Yes	Yes	Yes
8	Estonia	Yes	Yes	Yes	Yes	Yes
9	Finland	Yes	Yes	No	Yes	Yes
10	France	Yes	Yes	Yes	Yes	Yes
11	Germany	NA	NA	NA	NA	NA
12	Greece	Yes	Yes	No	No	Yes
13	Hungary	Yes	Yes	Yes	Yes	Yes
14	Iceland	Yes	Yes	No	No	Yes
15	Ireland	Yes	Yes	Yes	NA	No (B)
16	Italy	Yes	Yes	Yes	Yes	Yes
17	Latvia	Yes	Yes	Yes	Yes	Yes
18	Lithuania	Yes	Yes	Yes	Yes	Yes
19	Luxembourg	Yes	Yes	Yes	Yes	Yes
20	Malta	Yes	Yes	Yes	Yes	Yes
21	Moldova	Yes	Yes	Yes	Yes	Yes
22	Montenegro	No	No	No	No	No
23	Netherlands	Yes	Yes	Yes	Yes	Yes
24	North Macedonia (1/2) *	No *	No *	No *	No *	No *
25	Norway	Yes	Yes	Yes	Yes	Yes
26	Poland	Yes	Yes	Yes	Yes	Yes
27	Portugal	Yes	Yes	Yes	Yes	Yes
28	Romania	Yes	Yes	Yes	No	No
29	Slovak Republic	Yes	No	Yes	No	Yes
30	Slovenia	Yes	Yes	Yes	Yes	Yes
31	Spain	Yes	Yes	Yes	No	Yes
32	Sweden	Yes	Yes	Yes	Yes	Yes
33	Turkey	Yes	Yes	No	Yes	Yes
34	Ukraine	Yes	Yes	No	Yes	Yes

Note: (B) Ireland: Palliative care is covered by the National Cancer Strategy but does not fall under the remit of the National Cancer Control Programme, which is a division of the National Health Service responsible for the implementation of the National Cancer Strategy. There is a separate programme for palliative care within the National Health Service, which covers palliative care for cancer and other areas. There is collaboration on relevant areas.

Continue Appendix 17.

Country			Governance (management and	Financing	Cancer resources (human	Cancer data and information	Research
1		Austria	No	No	No	Yes	Yes
2		Belgium	No	No	No	No	No
3		Bulgaria	No	No	No	No	No
4		Croatia	Yes	Yes	Yes	Yes	Yes
5		Cyprus	No	No	No	Yes	Yes
6		Czech Republic	Yes	Yes	Yes	Yes	Yes
7		Denmark	Yes	Yes	Yes	Yes	Yes
8		Estonia	No	No	Yes	Yes	No
9		Finland	Yes	No	No	Yes	No
10		France	Yes	Yes	Yes	Yes	Yes
11		Germany	NA	NA	NA	NA	NA
12		Greece	Yes	No	Yes	Yes	Yes
13		Hungary	Yes	Yes	Yes	Yes	Yes
14		Iceland	No	No	Yes	Yes	Yes
15		Ireland	Yes	Yes	Yes	Yes	Yes
16		Italy	Yes	No	Yes	Yes	Yes
17		Latvia	Yes	Yes	Yes	Yes	Yes
18		Lithuania	No	No	No	Yes	Yes
19		Luxembourg	Yes	Yes	Yes	Yes	Yes
20		Malta	Yes	Yes	Yes	Yes	Yes
21		Moldova	No	Yes	No	Yes	Yes
22		Montenegro	No	No	No	No	No
23		Netherlands	Yes	Yes	Yes	Yes	Yes
24		North Macedonia (1/2) *	Yes/No	Yes/No	Yes/No	Yes *	No/Yes
25		Norway	No	No	No	Yes	Yes
26		Poland	Yes	Yes	Yes	Yes	Yes
27		Portugal	Yes	No	Yes	Yes	Yes
28		Romania	Yes	No	No	Yes	No
29		Slovak Republic	No	No	No	Yes	Yes
30		Slovenia	Yes	No	No	Yes	Yes
31		Spain	Yes	No	No	Yes	Yes
32		Sweden	Yes	Yes	Yes	Yes	Yes
33		Turkey	Yes	Yes	Yes	Yes	Yes
34		Ukraine	Yes	Yes	Yes	Yes	Yes

Continue Appendix 17.

Country			Access to innovative cancer treatments	Patient empowerment	Monitoring of cancer burden	Education and training	Other (please list them)
1		Austria	Yes	No	Yes	Yes	NA
2		Belgium	No	No	No	No	Yes (C)
3		Bulgaria	Yes	No	No	Yes	NA
4		Croatia	Yes	Yes	Yes	Yes	NA
5		Cyprus	Yes	Yes	Yes	Yes	NA
6		Czech Republic	Yes	Yes	NA	Yes	NA
7		Denmark	Yes	Yes	Yes	Yes	NA
8		Estonia	Yes	Yes	Yes	Yes	Yes (D)
9		Finland	No	Yes	Yes	Yes	NA
10		France	Yes	Yes	Yes (E)	Yes	NA
11		Germany	NA	NA	NA	NA	NA
12		Greece	No	Yes	No	Yes	NA
13		Hungary	Yes	Yes	Yes	Yes	NA
14		Iceland	Yes	Yes	No	Yes	NA
15		Ireland	Yes	Yes	Yes (F)	Yes	NA
16		Italy	Yes	Yes	Yes	Yes	NA
17		Latvia	Yes	Yes	No	Yes	NA
18		Lithuania	Yes	Yes	Yes	Yes	NA
19		Luxembourg	Yes	Yes	No (G)	Yes	NA
20		Malta	Yes	No	Yes	Yes	NA
21		Moldova	Yes	No	Yes	Yes	NA
22		Montenegro	No	No	No	No	NA
23		Netherlands	Yes	Yes	Yes	Yes	NA
24		North Macedonia (1/2) *	No *	No *	No *	No/Yes	NA
25		Norway	Yes	Yes	Yes	No	NA
26		Poland	Yes	Yes	NA	Yes	NA
27		Portugal	Yes	Yes	Yes	No	NA
28		Romania	Yes	No	No	No	NA
29		Slovak Republic	No	No	Yes	Yes	NA
30		Slovenia	No	Yes	Yes	Yes	Yes (H)
31		Spain	No	No	Yes	Yes	NA
32		Sweden	Yes	Yes	Yes	Yes	NA
33		Turkey	Yes	Yes	NA	No	NA
34		Ukraine	Yes	Yes	NA	No	NA

Notes: **(C) Belgium:** If this question only refers to areas addressed in a single NCCP, then the answers are "no" to everything because Belgium does not currently have an NCCP. However, this does not mean that these areas are not covered by structural activities or individual actions or initiatives. **(D) Estonia:** Separate section on childhood and AYA cancer. **(E) France:** Response received on 4/12/2024: "The French NCCP does indeed cover monitoring of the cancer burden." **(F) Ireland:** NCRI. **(G)** In **Luxembourg**, cancer burden monitoring does not occur within our National Cancer Control Programme (currently, the 2nd National Cancer Plan 2020-26, https://sante.public.lu/fr/espace-professionnel/plans-nationaux/plan-national-cancer.html). It is performed based on the results provided by our National Cancer Registry (RNC, https://www.rnc.lu), and periodic evaluations are presented in the National Cancer Report https://gouvernement.lu/dam-assets/documents/actualites/2021/02-fevrier/04-journee-cancer/MSA-5632-20-rapport-cancer-2020-web-BAT-4-.pdf). The next report is in preparation, and its publication is scheduled for 2026. **(H) Slovenia:** Quality of cancer care.

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