

# A Global Community of Practice for Cancer Control Why? What? How? When?

**Simon B. Sutcliffe**

President, BC Cancer Agency

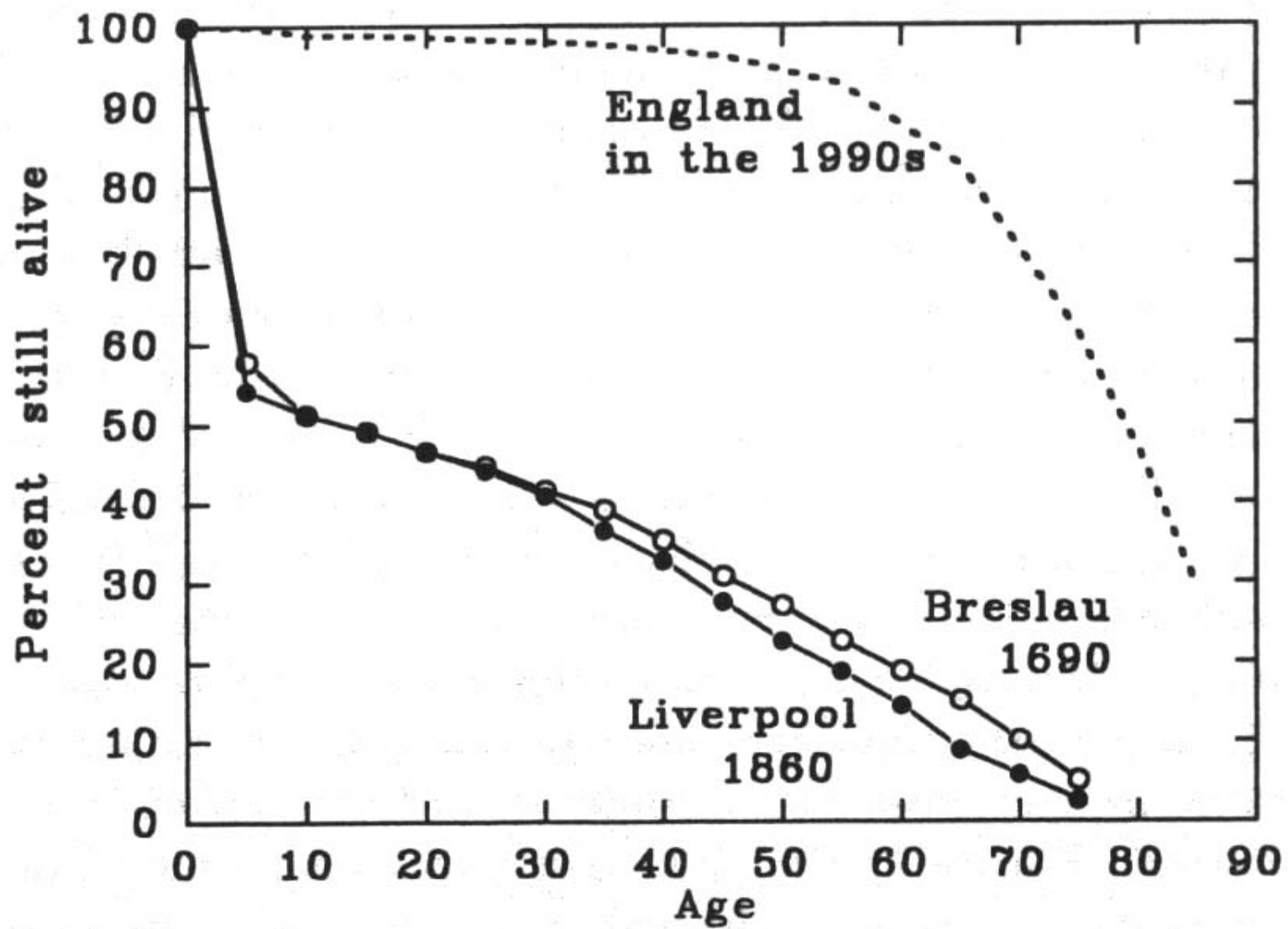
Vice Chair, Canadian Partnership Against Cancer

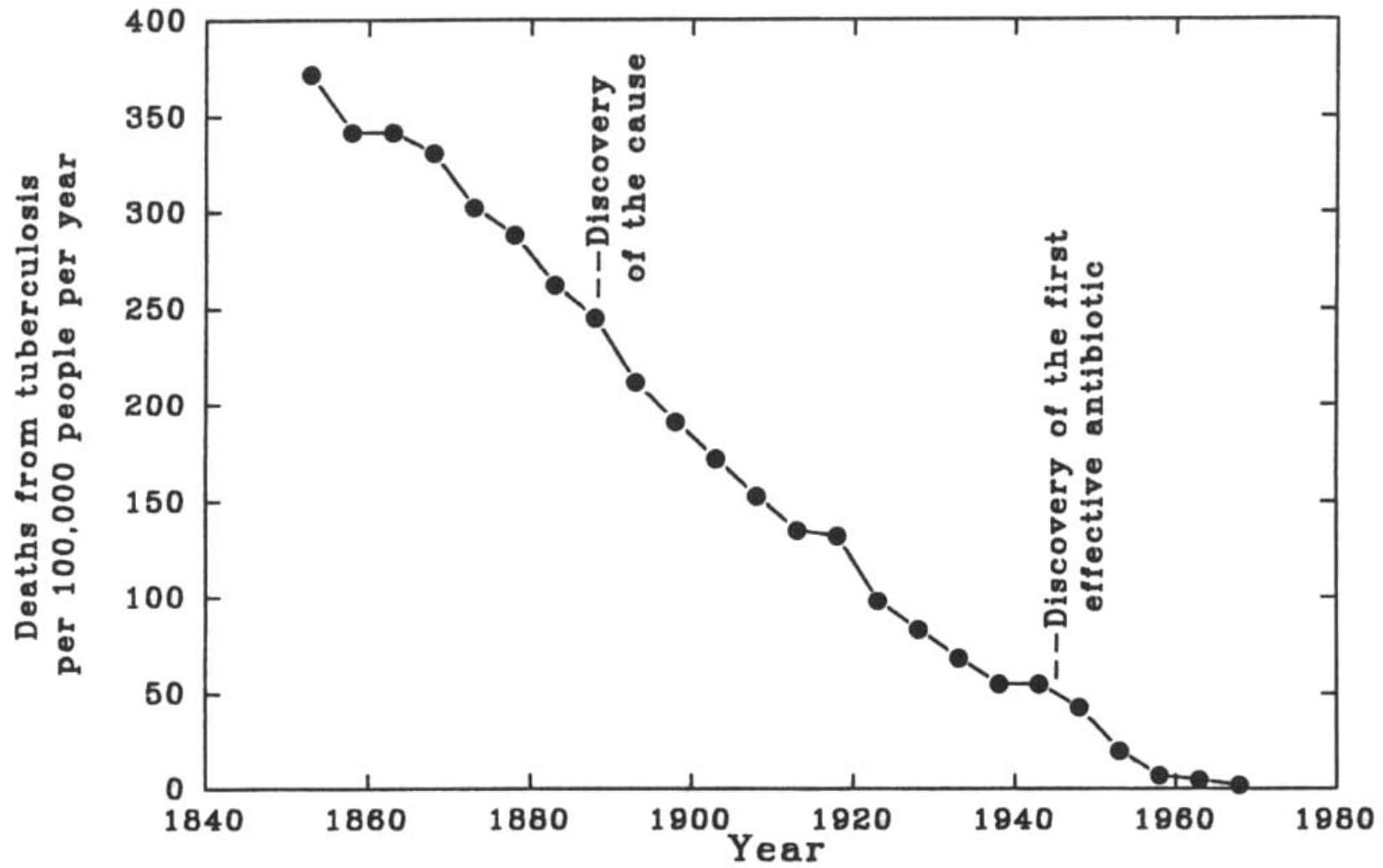
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# A Global Community of Practice for Cancer Control

## Why?

What we *achieve* in cancer control = What we *know* about cancer control x What we *apply* in cancer control







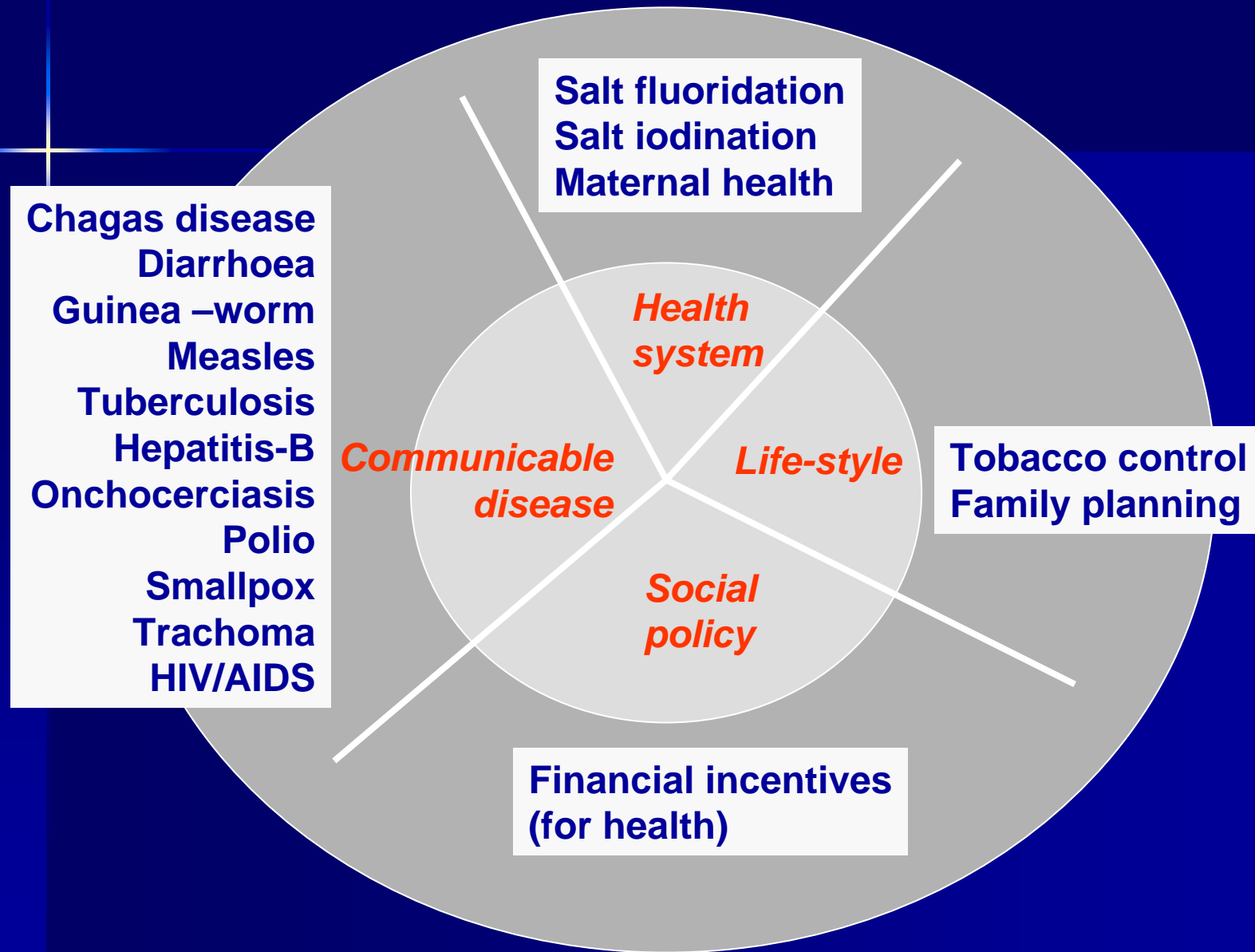
# The Example of "River Blindness" in West Africa

- 10 countries, often quarrelsome, collaborated
- donor initiated : health & economics factored in at start
- strategically driven ... target "eradication"; not "cure"
- no cost network of volunteers in "the front line"
- initiators "bowed out" over time with transfer to community for follow through
- program now expanding to
  - other countries; other health conditions
- model of how to make a small program big and stay focused until the job is done

# Criteria for Evaluating Success in Addressing Health Priorities

- Implementation on a significant scale
- Address a major public health problem (as in D.A.L.Y's)
- Lasted at least 5 consecutive years
- Cost-effective (less than \$100 per D.A.L.Y – averted)
- Clear and measurable effect on health outcomes (not coverage or process)
- Variable intervention methods:
  - Products, eg vaccines
  - Services, eg prenatal care; surgery
  - Promotion of behaviour change, eg condoms, hygiene
  - Reduced environmental risks, eg latrines; spraying

# Successful Population-Based Interventions (WHO 2006)



# Observations re Successful Population Health Interventions

1. Wide range of proven, cost-effective interventions applied at a population scale level do change outcomes despite:
  - Low income settings
  - Limited health infrastructure
  - Challenging macro policy environments
2. The importance of the public sector (policy; regulation; legislation)
3. Attention/focus on:
  - Strong leadership
  - Strong program management
  - Realistic financing
  - "Country" ownership
  - Technical innovation – build knowledge

## Same Knowledge Different Application : Different Outcome

|  | Global | Canada  | BC     |
|--|--------|---------|--------|
| Mortality <sup>1</sup>                 | 6.7M   | 70,400  | 8,800  |
| Incidence <sup>2</sup>                 | 10.9M  | 153,100 | 21,100 |
| Mortality : Incidence <sup>3</sup> (%) | 61.5%  | 46.0%   | 43.8%  |

*All invasive cancers – male & female*

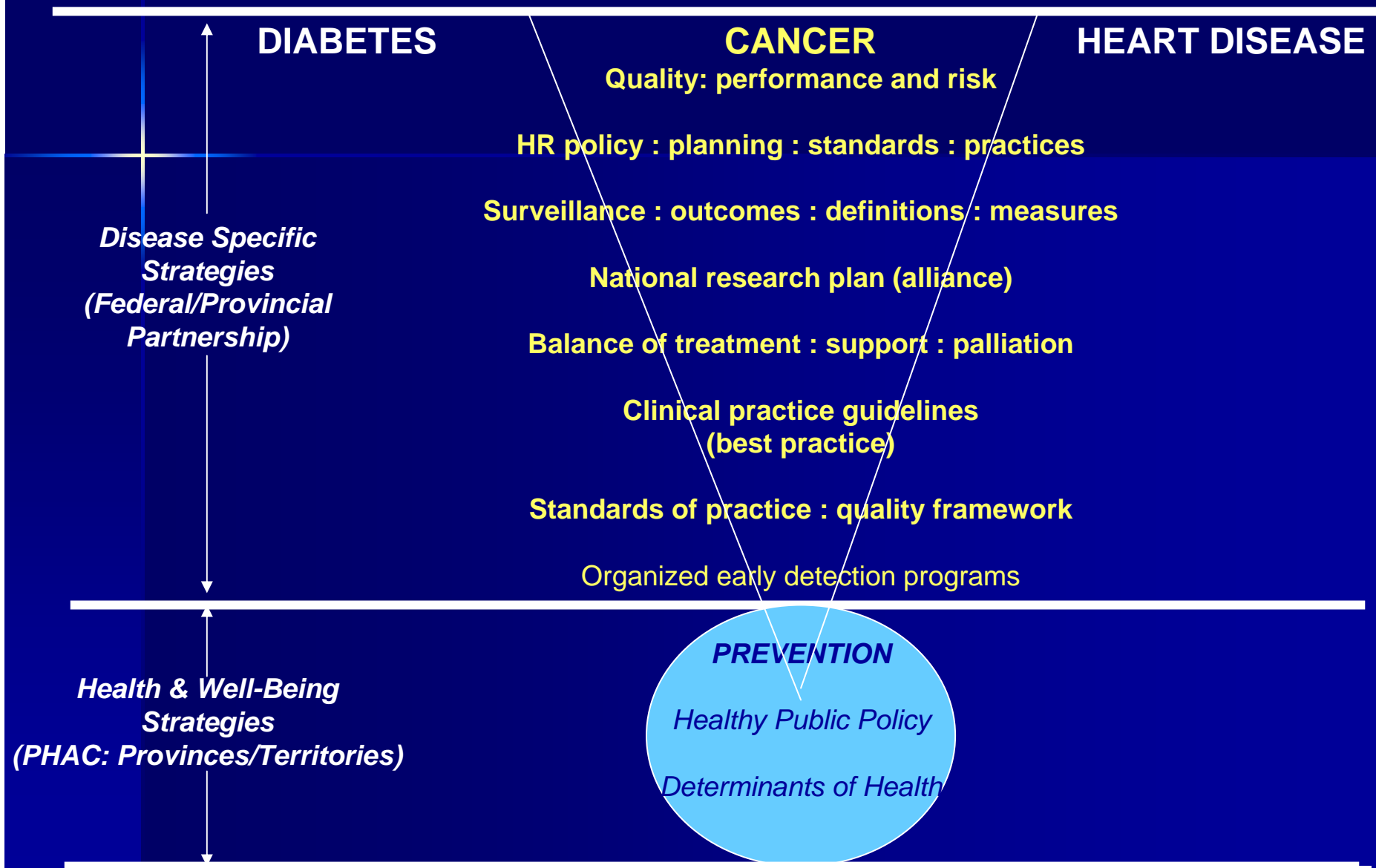
1. *Mortality – number of deaths due to cancer per annum*
2. *Incidence – number of new cases of cancer per annum*
3. *Mortality : incidence – proportion of cancer cases who die of cancer*

## Mortality changes in North Karelia in 1970-1995 (per 100,000 35-64 years, men, age adjusted)

|                        | Rate in 1970 | Change in 1970-1995 |
|------------------------|--------------|---------------------|
| All causes             | 1509         | -49%                |
| All cardiovascular     | 855          | -68%                |
| Coronary heart disease | 672          | -73%                |
| All cancers            | 271          | -44%                |
| Lung cancer            | 147          | -71%                |

# Canadian Strategy for Cancer Control

(also: Canadian Strategies for Chronic Disease Management)



# Community of Practice - What

Wenger (1997) defines this as:

- Groups of people who share a **concern or a passion for something they do and who interact regularly to learn how to do it better.**
- Are not generally computer-mediated although they can be.
- They are **very informal and pervasive.**
- Membership of multiple communities is the norm: some of which one is a core member, and some of which membership is more peripheral.

# Community of Practice: Why

- Benefits of Communities of Practice
  - Communities of practice are 'organizational techniques' that **speed up the application of innovative ideas for decision-making, learning, and partnering to achieve objectives and goals.**
  - Communities of practice facilitate **improved access to development and operational knowledge**; improved mentoring; improved knowledge sharing; more rapid problem resolution.

# Communities of Practice : Sharing Knowledge

**What is Being Shared:**

**The Role of what is being Shared**

**The Result of Knowledge Sharing through CoP**

**Short**

**Medium**

**Long Term**

**Information:**

Documents  
Projects, articles  
Links  
Re-use of Assets

Improved access to information

Better informed dialogue

Improved approaches programs projects

Improved development and outcomes

**Knowledge:**

Responses  
Access to expertise  
Definition of issues

Training  
Expertise  
Strategy

**Social:**

Personal contacts  
Increased collaboration

Sense of common purpose

Commitment  
Engagement

**Organizational Personnel**

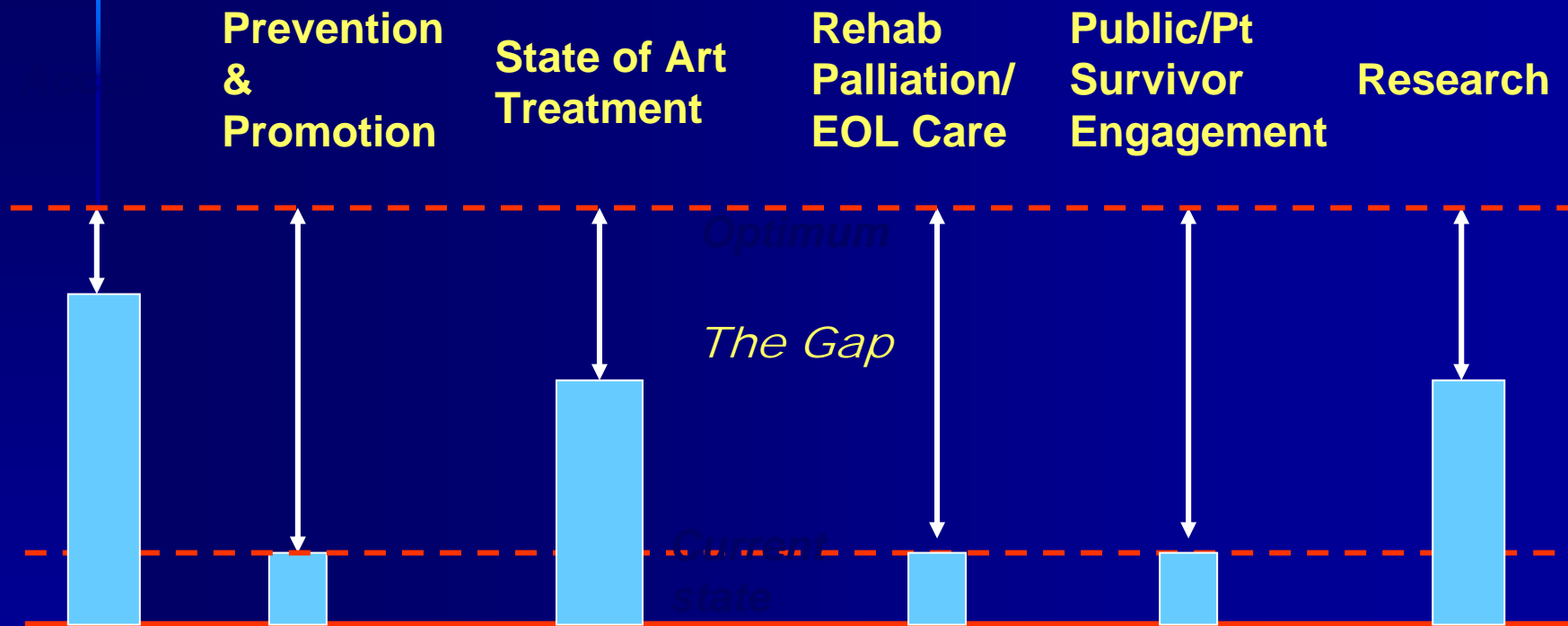
*Synergy Coordination*

# Common Characteristics of CoP's

|                 |  |
|-----------------|--|
| Domain          | shared domain of interest – cancer control   |
| Community       | relationship-based; sharing; informal  |
| Practice        | members are practitioners – a 'shared' practice  |
| Formality       | informal; no-one is 'in charge'  |
| Power structure | non-authoritarian; personal relations  |
| Attributes      | relevance; value-added; commitment; openness; capacity to contribute and share; clarity of purpose; flexibility (animation). |

# Reaching New Heights Together

## Cancer Control Continuum



**The Gap** - not transferring what we know to practice  
- not knowing enough to transfer to practice

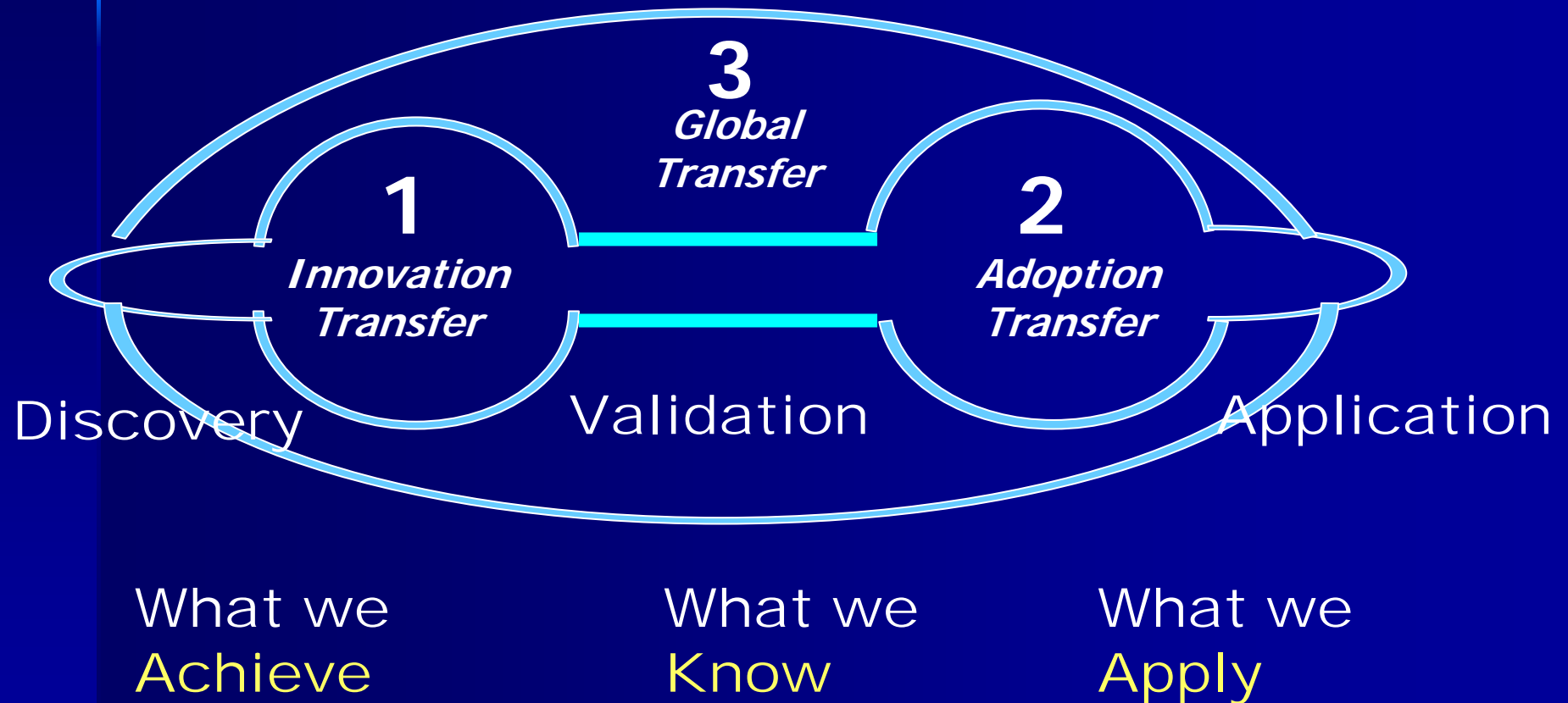
# Addressing the "Gaps"

- **Building capacity**
  - intellectual
  - technical
  - public/patient/survivor
  - functional networks:
    - within countries; across countries
- **Cultural, ethical and societal development:**
- **Structures, organizations & networks to effect action:**
  - social
  - professional
  - political
- **Addressing inequity:**
  - children; women; men
  - health care services
  - access to services
  - exposure to health risks
- **Priorities for research – 'what is meaningful?**
- **Mobilization of resources – access, assistance, efficacy**

# CoP Management

- Manage flow of information across the CoP
- Keep participants engaged
- Balance consultation with commitment to action
- Monitor financial health - sustainability

# A Global Community of Practice for Cancer Control



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## THE GAPS

**Building capacity**  
**Cross-sectoral engagement**  
**Inequities**  
**Priorities**  
**Mobilization of resources**

## THE ASSETS

**Population**  
**Personnel**  
**Platforms**  
**Profile**  
**Policy**  
**Developmental assistance/aid**

# A Global Community of Practice for Cancer Control When? The Imperative?



|  | <u>2002</u> | <u>2020</u> |
|--|-------------|-------------|
| Cancer Deaths                                    | 6.7         | 10.3        |
| New Cancer Cases                                 | 10.9        | 16.0        |
| People Living with Cancer<br>( <i>millions</i> ) | 24.6        | >35         |