



GUIDE ON HOW TO

IMPLEMENT THE GLOBAL BREAST CANCER INITIATIVE (GBCI) IN PRACTICE



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FOREWORD

Breast cancer is the most commonly diagnosed cancer among women worldwide and remains a major cause of premature mortality, particularly in settings where health systems face persistent barriers to early detection, timely diagnosis, and access to comprehensive treatment. The World Health Organization's Global Breast Cancer Initiative (GBCI) provides a clear and ambitious framework to address these challenges, with the goal of reducing breast cancer mortality through coordinated action across three pillars: health promotion for early detection, timely diagnosis, and comprehensive breast cancer management.

Translating this global framework into local impact requires more than consensus on priorities. It requires structured planning, local ownership, and the ability to adapt global guidance to the realities of countries, cities, health systems, institutions, professionals, and communities. Successful implementation further requires coherence with broader cancer-control and health-sector planning processes, including National Cancer Control Plans, so that breast cancer actions contribute to and are sustained within existing systems.

This guide has been developed to support that translation. Drawing on the experience of City Cancer Challenge (C/Can) and WHO in supporting GBCI implementation at city and subnational levels, it provides a practical approach to planning, prioritization, and action-plan development. The guide emphasizes that successful implementation depends on a sequence of interrelated steps: consultation, situation analysis, governance, structured workshops, action planning, implementation, scale-up, and monitoring. These are not isolated activities, but parts of a continuous planning and learning process. By bringing together evidence, stakeholder perspectives, institutional leadership, and structured discussion, the guide aims to support countries and cities in developing practical programmes of work that can improve early detection, reduce delays, strengthen treatment pathways, and promote more equitable outcomes for women with breast cancer.

This document is designed to serve as a useful resource for ministries of health, national cancer control programmes, city and subnational health authorities, clinical leaders, civil society organizations, technical partners, and all those working to advance breast cancer control. Most importantly, we hope it will contribute to turning the ambition of GBCI into locally owned action, sustained implementation, and measurable improvements in breast cancer care.

INTRODUCTION

Background

Cancer is a leading cause of morbidity and mortality worldwide. In 2020, an estimated 19.3 million new cancer cases and 10 million cancer deaths were recorded globally. Breast cancer is the most commonly diagnosed cancer worldwide, accounting for nearly 12% of all cancer cases and 31% of all cancer cases among women and is the most common cancer among women in 86% of countries and is the leading or second-leading cause of cancer death among women¹ in 95% of countries. Addressing breast cancer is therefore essential for countries seeking to reduce the overall cancer burden.

Despite improvements in mortality demonstrated in high-income settings due to improved prevention, diagnosis, and treatment, many low- and middle-income countries (LMICs) continue to face significant health system challenges that limit access to timely and effective breast cancer care. These challenges include limited diagnostic capacity, shortages of specialized workforce, financial barriers to treatment, and insufficient monitoring and evaluation systems.

Launched by the World Health Organization (WHO) in 2021, the Global Breast Cancer Initiative² (GBCI) is a global effort to reduce breast cancer mortality by 2.5% per year, potentially saving 2.5 million lives by 2040.

The initiative is structured around three strategic pillars that constitute the operational backbone of the WHO framework:

1. Health Promotion for Early Detection (pre-diagnostic interval): with the aim that more than 60% of invasive breast cancers are diagnosed at stage I or II.
2. Timely Breast Diagnosis (diagnostic interval): with the aim that diagnostic evaluation, imaging, tissue sampling and pathology are completed within 60 days.
3. Comprehensive Breast Cancer Management (treatment interval): with the aim that more than 80% of patients complete recommended multimodality treatment without abandonment.

Together, these pillars provide a health systems-based approach to improve breast cancer management.

¹ International Agency for Research on Cancer. Global Cancer Observatory (GLOBOCAN 2020). Available at: <https://gco.iarc.fr/>

² World Health Organization. Global Breast Cancer Initiative Framework. 2021. Available at: <https://www.who.int/initiatives/global-breast-cancer-initiative>

Purpose and Scope of the Document

The challenge is not to reframe the GBCI framework, but to translate it into a context-specific planning and implementation process that national and subnational stakeholders can adapt to their health system capacities, available resources and community needs. While the GBCI provides a strong strategic template, additional practical guidance is needed to make that translation, particularly where limited capacity, resource constraints and fragmentation across levels of care lead to delays, inefficiencies and missed opportunities for early detection, timely diagnosis and effective treatment.

This guide responds to that need with a clear, stepwise process for aligning stakeholders, assessing gaps, setting priorities and sequencing interventions. Its main focus is the development and operationalization of a city-specific Breast Cancer Action Plan (BCAP) following GBCI workshops. The BCAP is a practical planning tool that identifies service delivery gaps, defines priority actions, assigns responsibilities, and sets timelines and resource requirements for implementation.

GBCI implementation is not a standalone activity. The BCAP serves as an operational extension of the National Cancer Control Plan (NCCP) or national cancer strategy, aligning local priorities, resource allocations, and stakeholder responsibilities with national targets, tracking locally relevant indicators, and generating data and lessons that can inform the refinement of national health policy. The guide focuses on planning, coordination and implementation rather than detailed clinical guidelines. It provides a common basis for planning while preserving flexibility for local adaptation, and can improve coordination, support more efficient use of resources and strengthen accountability.

Methodological Approach

The guide is based on a practice-oriented planning methodology developed by City Cancer Challenge (C/Can) in collaboration with the World Health Organization. It draws on the WHO GBCI implementation framework and on WHO principles for participatory, evidence-informed and operationally grounded health planning, applied through a stepwise process that links consultation, situation analysis, governance, prioritization and implementation planning.

The approach was developed through implementation experience in four partner cities: Cali (Colombia), Kumasi (Ghana), Phnom Penh (Cambodia), and Tbilisi (Georgia), between 2023 and 2025. These settings were selected to reflect different regions and health-system contexts, allowing the approach to be applied, tested, and refined in diverse environments. Lessons learned were systematically reviewed and used to refine the methodology, so the guide should be understood as an evidence-informed, practice-based planning reference.

Target Audience and Levels of Application

This guide is intended for those involved in planning and coordinating breast cancer services at national, sub-national and city levels, primarily health planners and decision-makers responsible for the design, coordination, and implementation of cancer control programmes.

Primary users include:

- NCCP managers
- Ministry of Health officials responsible for cancer, NCDs, or health system planning
- Sub-national and city-level health authorities, including programme managers leading cancer initiatives

Other actors (clinicians, academia, professional societies, and development partners) play a critical role in implementation but are key contributors to the processes described here rather than primary users.

Although the GBCI framework is primarily expressed at national level, implementation takes place through health systems that are organized and delivered at sub-national and city levels. The guide therefore gives particular attention to localization: the adaptation of GBCI priorities to local contexts, capacities, and service-delivery realities, while keeping city and sub-national action aligned with national priorities.

STEP-BY-STEP GUIDANCE FOR GBCI IMPLEMENTATION

Implementing the GBCI effectively begins with a comprehensive understanding of the national and local context. This foundation enables tailored interventions, ensures alignment with existing plans, and fosters shared ownership across sectors. This section presents a phased approach to planning and implementing the GBCI. It begins with a preparatory phase to establish the planning foundation, moves into strategic planning through a workshop and BCAP development, and then addresses implementation, broader integration and scale-up, and monitoring.

Phase 1. Preparatory Phase

Effective planning for the implementation of the GBCI requires an initial preparatory phase that establishes the foundation for later prioritization, action-plan development, implementation, and monitoring. For practical purposes, this phase is presented in three steps: consultation with relevant actors, situation analysis, and governance. In practice, however, these steps should not be understood as fully separate or strictly linear blocks. They are closely interrelated functions of the same planning phase.

Some form of institutional leadership or convening authority is usually required from the outset to initiate the process. Stakeholder engagement begins early and continues throughout the preparatory phase and beyond. Similarly, the situation analysis is not only a technical exercise, but also a process informed by consultation and subject to validation through governance arrangements. The steps below are therefore presented sequentially for clarity, while recognizing that, in implementation, they often overlap and inform one another.

STEP 1 - CONSULTATION WITH RELEVANT ACTORS

Consultation with relevant actors is a foundational step in planning the implementation of the GBCI. It helps ensure that planning reflects system realities, service-delivery constraints, stakeholder priorities, and the perspectives of the populations affected. It also supports ownership, legitimacy, and accountability by creating a structured basis for dialogue among the institutions and groups that will shape, implement, finance, monitor, and use breast cancer services³.

³ World Health Organization. Strategizing national health in the 21st century: a handbook. Geneva: WHO; 2016. Available at: <file:///C:/Users/User/Downloads/9789241549745-eng.pdf>

Who Should Be Consulted

Consultation should include a wide, diverse and representative group of actors reflecting the multiple levels and functions involved in breast cancer control. These may include:

- Ministry of Health and government institutions.
- NCCP representatives.
- Sub-national and city-level health authorities.
- Healthcare providers (representing primary, secondary, tertiary levels of care).
- Private-sector providers and institutions, where relevant.
- Professional societies and academic institutions.
- Cancer registries, health information systems and Monitoring & Evaluation (M & E) representatives.
- Patient organizations and individuals with lived experience.
- Civil society and community-based organizations.
- Financing, purchasing, or insurance actors, where relevant.
- Development and technical partners.
- Private sector.

Ensuring representation of different population groups, including underserved and vulnerable communities, is essential to capture diverse perspectives, reflect barriers to access and continuity of care, and address inequities in breast cancer outcomes.

How to Conduct Consultations

The consultation process should be organized in a structured way. Depending on context, it may include:

- Workshops and structured dialogues with multi-sector participants.
- Focus group discussions with specific actor groups.
- Key informant interviews with experts and decision-makers.
- Surveys targeting providers, patients and those with lived experience.

National- or city-level authorities may use one or a combination of these approaches depending on planning objectives, the stakeholder landscape, and the level at which implementation is being considered to ensure comprehensive input.

A consultation process should include the following steps:

- Define objectives and scope of the consultation: clarify key questions and scope.
- Identify participants: ensure diverse and representative actors.
- Facilitate discussions: gather inputs on needs, barriers, and implementation opportunities.
- Synthesize findings: identify common priorities and themes.
- Validate results: confirm findings and conclusions and priorities with participants.
- Integrate into planning: use results to inform priority setting and the Breast Cancer Action Plan (BCAP).

What Are the Expected Results

A well-conducted consultation process results in:

- A high-level understanding of key challenges and priorities affecting breast cancer early detection, diagnosis, treatment, and continuity of care.
- Increased alignment between policy-makers, institutions, professionals, stakeholder groups and the target population including an improved understanding of roles and responsibilities.
- Strengthened ownership and legitimacy of subsequent planned interventions.
- A strong foundation for equitable and sustainable implementation of GBCI.
- Better identification of the issues, service gaps, and stakeholder perspectives that should be examined through the situation analysis.

STEP 2 - SITUATION ANALYSIS OF THE BREAST CANCER CONTEXT

The situation analysis provides the foundation for evidence-informed priority-setting, planning and implementation of breast cancer programs or interventions aligned with the GBCI framework. It facilitates the identification of key challenges, the leveraging of existing opportunities, and the design of context-specific interventions that are responsive to the broader health system landscape. It should combine quantitative evidence with qualitative insights and move beyond description to identify systemic bottlenecks, root causes, and opportunities for improvement.

Purpose of the Situation Analysis

The purpose of a situation analysis is to develop a comprehensive understanding of the breast cancer landscape, including the health system, policy and regulatory environment, workforce capacity, infrastructure, financing, research ecosystem, and the population needs. It also ensures that planning incorporates stakeholder perspectives, including underrepresented populations, to support equitable and sustainable interventions.

Scope of the Situation Analysis

A situation analysis should cover, at a minimum:

- Policy and governance landscape: existing national cancer control strategies, regulatory frameworks, coordination mechanisms, and policy alignment with the GBCI pillars.
- Health system performance: availability, quality, and accessibility of prevention, early detection, diagnostics, and treatment services.
- Workforce capacity: numbers, training, and competencies of healthcare professionals involved in breast cancer care.
- Infrastructure and technology: availability of diagnostic and treatment facilities, equipment, and supply chains.
- Financing and resources: public and private investment in cancer care, budget allocation, and sustainability of programs.
- Research and data systems: cancer registries, monitoring and evaluation mechanisms, and local evidence generation.
- Population context: demographics, sociocultural factors, patient behaviors, barriers to care, and the perspectives of underserved or vulnerable groups.

Methodology to conduct the Situation Analysis

A situation analysis should be:

- Participatory and inclusive – engage government representatives, program managers, clinical experts, academia, patient advocates, and civil society.
- Evidence-based – combine quantitative data (e.g., cancer incidence, mortality, service utilization) with qualitative insights (e.g., stakeholder interviews, focus groups).
- Analytical and root-cause oriented – go beyond description to understand systemic drivers of gaps and successes.
- Integrated and cross-sectoral – consider interactions across health services, policies, financing, workforce, and social determinants of health.

Steps to Conduct the Situation Analysis

- Identify and engage stakeholders to provide expertise, data, and perspectives, ensuring inclusion of underrepresented groups;
- Define key questions across all relevant domains: policy, system, workforce, infrastructure, population needs, and financing;
- Collect and synthesize data from multiple sources, including health facilities, government reports, surveys, and academic studies;
- Validate findings through workshops or consultations with stakeholders;
- Analyze root causes, system bottlenecks, and potential enablers of change;
- Consolidate insights to inform priority-setting, planning, and evidence-based interventions.

Expected Results

A comprehensive situation analysis should:

- Provide a shared understanding of the current breast cancer landscape, including systemic, policy, and population-level factors.
- Reflect consensus among stakeholders on key challenges and priorities.
- Serve as a foundation for planning and decision-making, guiding policy, programmatic, and system-level interventions.
- Identify opportunities for equitable, sustainable, and context-adapted solutions, aligned with GBCI strategic pillars.

STEP 3 – ESTABLISH BREAST CANCER GOVERNANCE

A planning process for GBCI implementation requires an institutional anchor from the beginning. In many settings, this will be led or convened by the Ministry of Health or another mandated authority, ideally linked to existing cancer-control or health-sector coordination mechanisms. The purpose of governance in this phase is to provide legitimacy, institutional ownership, coordination, and continuity across the planning process and later stages of implementation and monitoring.

For practical purposes, governance is presented here as the third step of the preparatory phase. However, some governance function usually exists from the outset in order to convene actors, define scope, and support the initiation of consultation and analysis. Step 3 should therefore be understood not as creating governance from nothing, but as formalizing or strengthening the governance arrangements needed to validate findings, guide prioritization, oversee BCAP development, and support implementation, monitoring, and policy dialogue.

Purpose

Strong governance ensures coordinated planning, implementation, and monitoring of GBCI activities, aligned with national health priorities.

Leadership and Structure

The governance body should be convened under the Ministry of Health and, where possible, embedded within existing cancer coordination mechanisms to ensure political legitimacy, institutional ownership, and sustainability.

Composition

A multisectoral team should include the following stakeholders with the key roles as defined:

- Ministry of Health: strategic leadership, policy alignment, inter-sectoral coordination.
- Cancer centers/referral hospitals: clinical expertise, training hubs, implementation support.
- Professional societies: clinical guidelines, continuing education.
- Universities/public health institutions: pre-service training, operational research.
- Civil society/patient groups: community perspectives, advocacy, accountability.
- International partners/technical agencies: technical guidance, global knowledge exchange.

Key Responsibilities

The governance body coordinates GBCI implementation and:

- Validates the situation analysis and identifies priority gaps for action;
- Provides guidance for stakeholder workshops;
- Develops and validates the BCAP;
- Coordinates implementation across institutions;
- Facilitates collaboration between national and sub-national authorities;
- Monitors progress through defined indicators;
- Supports policy dialogue and resource mobilization;
- Promotes continued coordination with relevant governance structures across the health sector to enable greater coordination and sustainability. Embedding governance within existing national cancer coordination frameworks ensures alignment with broader health policies, avoids duplication, and strengthens multi-stakeholder engagement and accountability.

With the situation analysis validated, stakeholder roles clarified, and a governance body in place, the foundational conditions for structured planning are established. The governance body should also ensure clear reporting and accountability mechanisms, including regular reporting to a senior representative within the Ministry of Health and/or a steering committee overseeing implementation activities. The process can now move into the strategic planning phase, where these inputs are translated into prioritized action.

Phase 2. Strategic Planning Phase

Building on the foundations established in Phase 1, the strategic planning phase translates preparatory work into participatory prioritization and action-oriented planning. For practical purposes, this phase is presented in two steps: **GBCI workshops for prioritization and planning and development of the BCAP**. These steps are closely linked. The workshop process serves as the main platform for collective review, validation, prioritization, and early planning discussions, while the BCAP translates those outputs into a structured and actionable planning instrument. In practice, these steps may overlap, particularly where post-workshop refinement, validation, and drafting continue over several weeks.

STEP 4 – GBCI WORKSHOPS FOR PRIORITIZATION AND PLANNING

Purpose

GBCI workshops are a central component of the strategic planning phase. The purpose is to introduce participants to the GBCI framework in greater detail, including its implementation logic, key performance indicators, and examples of how the framework can be translated into practice. The workshop also provides a guided space for reflection on the local breast cancer context. Through structured exercises and worksheets, participants examine barriers, opportunities, service gaps, and potential interventions across the GBCI pillars (see annex 1 for a sample workshop agenda and structure). These discussions complement the preparatory work adding the implementation layer discussion, by testing assumptions, surfacing implementation realities, and generating a more structured basis for prioritization.

Therefore, the GBCI workshop is not a standalone event, but a bridge between preparatory work and action planning, and the main forum through which the concepts of the GBCI are translated into locally relevant planning discussions.

Key Principles

A well-designed GBCI workshop should be:

- Evidence informed: grounded in the outputs of consultation, situation analysis, and governance discussions developed in the preparatory phase.
- Aligned with the GBCI framework: helping participants understand the practical implications of the GBCI pillars, key performance indicators, and implementation logic.
- Inclusive: all relevant stakeholders are represented in the workshop
 - › Ensure representation across sectors: policymakers, health professionals, patient groups, scientific societies, and data managers.
 - › Multi-stakeholder participation fosters ownership, accountability, and alignment with national priorities.
- Structured and participatory: using guided discussion, facilitation methods, and worksheets to support collective reflection and planning
 - › Workshops provide a forum to review local data, assess system gaps, and collectively identify solutions.
 - › Structured discussions guide participants to develop priorities that are practical, feasible, and strategically aligned with the GBCI pillars: early detection, timely diagnosis, and treatment completion.

■ Consensus building and prioritization

- › Facilitate dialogue to reach agreement on actionable priorities.
- › Focus on high-impact, feasible interventions that address both immediate needs and long-term system strengthening.

■ Operationalizing strategic goals and follow up

- › Synthesize all subgroup findings, priority-setting exercises, and gap analyses into a comprehensive GBCI Workshop Report (see annex 2 for a report template).
- › Map out concrete priority actions, target timelines, initial resource estimates, and responsible institutions identified during workshop discussions.
- › Conduct post-workshop consultations over a 2–4 week window to validate proposed priorities with key leadership and consensus bodies.
- › Use the validated workshop report as the direct foundational input for drafting the BCAP.

The worksheets included in Annex 3 are especially important, as they provide a guided and structured way to bring the main elements of the GBCI framework into discussion and translate them into context-specific planning considerations. Depending on context, the workshop process may also generate other deliverables including, for example, Mentimeter outputs, notes, transcripts, presentations, and others. These materials should be treated as inputs for the drafting of the BCAP.

Prioritization Approach

The workshop should use a transparent and structured approach to move from identified gaps and potential interventions to a manageable set of priorities for the BCAP. Structured prioritization supports consistency across stakeholder groups while preserving the role of deliberation and contextual judgment.

Potential interventions should be assessed against a small set of common criteria:

- Expected impact: potential contribution to addressing identified gaps and advancing GBCI objectives.
- Feasibility: technical, institutional, and operational feasibility in the local context.
- Equity: potential to reduce disparities in access, quality, or outcomes.
- Resource requirements: affordability and compatibility with available or realistically mobilizable resources.
- Implementation readiness: availability of the enabling conditions, institutional ownership, and capacity required to initiate implementation.

Each criterion may be scored using a simple common scale, such as 1–3 (low, moderate, high), or continuous (1–100). Scores should support facilitated discussion. The final selection of priorities should take into account the scoring results alongside stakeholder perspectives, dependencies between interventions, alignment with national priorities, and other relevant contextual considerations.

The workshop should document both the results of the prioritization exercise and the rationale for the final selection of interventions. These outputs should form part of the workshop record and provide a transparent basis for drafting the BCAP.

Expected Results

By implementing workshops according to these principles, countries can:

- Align GBCI initiatives with national cancer control objectives.
- Validate and refine the main findings emerging from the preparatory phase.
- Elaborate a documented and transparent set of prioritized interventions, with the rationale for their selection, to inform BCAP development.
- Foster collaboration and alignment across sectors and institutions.
- Produce actionable, evidence informed ideas that are feasible, strategically focused, and ready for incorporation in the BCAP.

STEP 5 - BREAST CANCER ACTION PLAN (BCAP) DEVELOPMENT

Purpose

BCAP is the main planning product of the strategic planning phase. Building on Steps 1–4, it translates the outputs of consultation, situation analysis, governance arrangements, and the workshop process into a structured, context-specific, and actionable plan aligned with the three pillars of the GBCI framework. Its purpose is to guide implementation by defining prioritized interventions, responsible institutions, indicative timelines, implementation considerations, and, where possible, resource implications. A generic BCAP template is provided in Annex 4 and can be adapted to the local context to support this process.

The BCAP is not a formal element of WHO GBCI framework, but a practical planning instrument for translating GBCI priorities into coordinated local action. Where relevant, it should remain aligned with broader cancer-control and health-system planning processes, including the NCCP, so that strategic goals are operationalized in a way that reflects local context while remaining connected to higher-level policy and planning frameworks. In practice this means checking that BCAP priority interventions do not duplicate or contradict existing NCCP commitments, that responsibilities and timelines are consistent with national planning cycles, and that data generated through BCAP implementation can feed into national monitoring frameworks.

Key Principles

- Grounded in the workshop outputs: translating the discussions, exercises, and planning artifacts generated during the workshops into an actionable roadmap.
- Participatory and prioritized: reflecting the collective prioritization process rather than a broad catalog of possible interventions.
- Aligned: consistent with the GBCI pillars and with broader national and sub-national cancer-control and health-sector planning instruments.
- Prioritized and operational: translate each priority into a sufficiently specified intervention, including the responsible institution(s), expected results, indicative timeline, resource or cost implications, implementation considerations, and the indicators, baselines and targets required to monitor progress, where applicable.
- Iterative and adaptive: refine the BCAP through reviews and stakeholder feedback, ensuring alignment with national strategies.
- Monitored and implementable: establish mechanisms for tracking progress, evaluating outcomes, and updating the plan as needed.

Results Logic

Each priority intervention should be linked to an explicit results logic that explains how the proposed action is expected to contribute to the intended change. At a minimum, the BCAP should connect the identified gap or problem to the intervention, its immediate outputs and expected results, and, where relevant, its contribution to the corresponding GBCI objective or KPI. This results chain provides the basis for defining appropriate indicators, baselines and targets and supports subsequent monitoring, evaluation and learning.

Example: Diagnostic delay → pathology workflow redesign and capacity strengthening → improved diagnostic workflow and capacity → reduced diagnostic turnaround time → contribution to timely diagnosis (GBCI KPI 2).

BCAP Development Process

Development of the BCAP should normally include the following steps:

- Structuring and contextualizing: draft the plan's content adapted to local conditions, integrating epidemiological data, policy frameworks, and workshop findings.
- Drafting priority actions: translate workshop outputs into prioritized interventions across the GBCI pillars. For each priority intervention, define the responsible institution(s), expected result, indicative timeline, resource or cost implications, implementation considerations, and appropriate indicators, baselines and targets, where applicable.
- Stakeholder review and validation: engage the governance body and relevant actors to confirm feasibility, coherence, and alignment with national priorities.
- Finalization and dissemination: finalize the BCAP, secure endorsement from national and sub-national authorities, and share through appropriate channels to facilitate implementation.

A generic BCAP template may be used as a practical guide, but the plan should be adapted to the local context rather than applied mechanically. The template should be understood as a supporting tool, not as a substitute for contextualized planning.

Expected Results

A well-developed BCAP should result in:

- A locally relevant, actionable plan that operationalizes GBCI priorities.
- Clear alignment between priority interventions and with national, sub-national or city-level cancer strategies.
- Explicit articulation of responsibilities and implementation considerations.
- Stronger coordination and accountability across administrations, institutions and stakeholders.
- A foundation for monitoring, iterative improvement, and potential scale-up of breast cancer services.

By the end of the strategic planning phase, countries or sub-national actors should have produced a prioritized and validated BCAP grounded in evidence, stakeholder dialogue, and institutional oversight. This provides the basis for the next phase, in which priority interventions are implemented, monitored, and, where appropriate, scaled up within broader cancer-control and health-system planning processes.

Phase 3. Implementation, Learning and Scale-Up

With a validated BCAP, the focus shifts from planning to action. This phase focuses on putting prioritized interventions into practice, monitoring progress, and, where appropriate, supporting broader scale-up and integration into national cancer-control and health-system planning processes. For practical purposes, this phase is presented in three steps: implementation of priority interventions across the GBCI pillars, integration and scale-up of BCAP interventions, and monitoring, evaluation and learning. These steps are closely connected. Implementation generates the experience and evidence needed for adaptation and scale-up, while monitoring provides the basis for accountability, course correction, and learning over time.

STEP 6 – IMPLEMENT PRIORITY INTERVENTIONS ACROSS THE GBCI PILLARS

Purpose

Following development of the BCAP, implementation should begin through a phased operationalization of selected priority interventions. The BCAP provides the strategic direction for implementation, but does not by itself constitute an operational implementation plan. This step therefore focuses on translating BCAP priorities into manageable workstreams, implementation packages, or sub-projects, with clear sequencing, responsibilities, coordination arrangements, and follow-up mechanisms.

A phased approach is important because not all interventions can or should be launched simultaneously. Some actions may be implemented directly through existing institutional structures and programmes, while others may require additional preparation, dedicated coordination, or more formal project-management arrangements.

Key Principles

- Prioritize and sequence implementation: select a feasible set of interventions for early implementation, taking into account urgency, feasibility, dependencies, available resources, and institutional readiness.
- Translate priorities into operational workstreams: define the activities, responsibilities, timelines, coordination arrangements, and implementation requirements needed to move each selected intervention into practice.
- Use proportionate implementation arrangements: some interventions may be implemented through existing institutional routines, while more complex interventions may need to be managed as dedicated workstreams or sub-projects.
- Clarify ownership and accountability: assign responsible institutions, technical leads, focal points, and coordination mechanisms for each intervention.
- Identify implementation requirements: consider the staffing, training, procurement, financing, workflow changes, infrastructure, technical support, and other enabling conditions required for implementation.
- Maintain alignment with the BCAP and broader planning processes: operationalization should remain consistent with the priorities established in the endorsed BCAP and, where relevant, with national cancer-control and health-system planning processes.
- Use implementation experience to adapt: implementation should be actively followed so that bottlenecks can be identified, corrective actions introduced, and lessons incorporated as implementation progresses.

Planning Approach

Implementation of the BCAP may be organized using different planning methodologies, depending on local practice and institutional preference. A results-based management approach, supported by a higher-level theory of change, can be particularly useful to clarify the ambition of the programme, define the results expected from prioritized interventions, and guide sequencing, responsibilities, and monitoring. This helps ensure that activities implemented under the GBCI pillars are not treated as isolated actions, but as part of a coherent pathway toward improved early detection, diagnosis, treatment completion, and equity. Other planning approaches may also be appropriate, provided they support clear prioritization, operational coherence, and alignment between implementation and intended results.

Illustrative Intervention Areas in Pillar 1 – Strengthening Early Detection

Objective:

Increase the proportion of breast cancers diagnosed at an early stage to improve survival and treatment outcomes.

Illustrative intervention areas:

1. Conduct awareness campaigns targeting the general public and high-risk populations.
2. Strengthen primary care capacity to identify early warning signs and symptoms, clinical breast examinations and early referral.
3. Establish standardized referral pathways from primary care to diagnostic services.

Note of caution: In settings where the required infrastructure and quality-control measures are not yet fully in place, organized population-based mammographic screening is not an appropriate starting point. Health systems must first ensure the capacity to identify and refer women presenting with symptomatic breast complaints before considering screening as a programmatic strategy.

Expected Results:

- Increased proportion of breast cancers diagnosis at stage I or II.
- Improved timely referral of suspected cases.
- Strengthened engagement of primary care and community-level services in breast cancer early detection.

Illustrative Intervention Areas in Pillar 2 – Improving Timely and Accurate Diagnosis

Objective:

Ensure women with suspected breast cancer receive prompt, reliable and high-quality diagnostic services.

Illustrative intervention areas:

1. Expand access to imaging (mammography, ultrasound), tissue sampling, pathology and other essential diagnostic services.
2. Implement standardized diagnostic protocols, including reporting systems and quality assurance systems in line with national clinical guidance.
3. Reduce diagnostic delays through patient navigation systems and tracking of waiting times.

Expected Results:

- Reduced time from presentation to diagnosis.
- Consistent, timely and accurate diagnostic reporting.
- Streamlined and coordinated patient pathways from suspicion to treatment initiation.

Illustrative Intervention Areas in Pillar 3 – Ensuring Comprehensive Breast Cancer Management

Objective:

Deliver evidence-based treatment and supportive care, and ensure patients initiate and complete recommended therapy.

Illustrative intervention areas:

1. Establish or strengthen multidisciplinary mechanisms, such as tumour boards to guide coordinated treatment planning.
2. Expand access to surgery, radiotherapy, and systemic therapies, and other essential treatment modalities.
3. Provide patient navigation, psychosocial support, and mechanisms to reduce organizational, financial and geographic barriers.

Expected Results:

- Increased initiation and treatment completion rates
- Coordinated, guideline-aligned care across specialties and levels of care
- Improved patient experience and equity of access to breast cancer treatment and support services

Illustrative Cross-cutting interventions

Beyond the pillar-specific intervention areas above, two enabling mechanisms cut across all three GBCI pillars and should be considered as priority interventions within the BCAP regardless of which pillar-specific actions are selected.

- Patient navigation is an evidence-informed mechanism that can significantly improve implementation outcomes across the three pillars. The BCAP should consider whether the establishment or strengthening of patient navigation services is a priority, and how such services can be integrated across levels of care⁴.
- Data systems and information infrastructure is a foundational condition for implementation, monitoring, and improvement across the three pillars. The BCAP should consider strengthening data systems, including cancer registries, patient tracking mechanisms, and reporting infrastructure aligned with national health information systems.

Expected Results

A well-managed process of phased operationalization should result in:

- A feasible set of BCAP interventions selected and sequenced for implementation.
- Clear operational workstreams or sub-projects for selected interventions.
- Explicit assignment of responsibilities, leadership, and coordination arrangements.
- Defined implementation requirements, timelines, and milestones.
- Initiation of concrete implementation activities under the endorsed BCAP.
- A practical basis for monitoring implementation progress, identifying bottlenecks, and supporting adaptive management.

These are the immediate outcomes of the operationalization process. Improvements in early detection, timely diagnosis, treatment completion, and other GBCI-related outcomes are expected to emerge progressively through implementation and should be assessed through the monitoring, evaluation, and learning processes that accompany this phase.

⁴ <https://iris.who.int/server/api/core/bitstreams/bbf6a18d-d58a-4d86-8790-7c0e80a2232a/content>

STEP 7 – INTEGRATION AND SCALE-UP OF BCAP INTERVENTIONS

Purpose

Scale-up should build on implementation experience and on the evidence generated through monitoring, evaluation, and learning. The purpose of this step is to determine which interventions, approaches, or delivery models emerging from BCAP implementation are sufficiently relevant, feasible, and effective to justify broader adoption.

Scale-up should therefore not be understood simply as expansion. It is a managed process through which selected interventions are assessed for broader application, adapted where necessary, and integrated into wider cancer-control and health-system planning processes. This is particularly relevant where initial implementation has taken place at city or sub-national level and lessons from implementation can inform broader adoption, including integration into the NCCP or other national planning mechanisms.

Key Principles

- Evidence-informed scale-up: decisions should draw on implementation experience, monitoring data, evaluation findings, and documented learning rather than on initial assumptions alone.
- Selective scale-up: not all interventions should be expanded. Priority should be given to interventions that demonstrate sufficient relevance, feasibility, implementation performance, and potential for broader application.
- Adaptive implementation: refine interventions during scale-up based on feedback and lessons learned.
- Assess transferability: consider whether the conditions that enabled implementation in one setting are present elsewhere, including institutional capacity, workforce, financing, infrastructure, governance, and data systems.
- Adapt rather than replicate mechanically: interventions may require modification to reflect differences in health-system organization, population needs, resources, and institutional arrangements.
- Integration with national systems: align with NCCP priorities, existing health policies, and resource allocation mechanisms.
- Inclusive governance: engage relevant ministries, health authorities, professional societies, civil society, and patient groups.
- Sustainability: embed responsibilities, timelines, and monitoring mechanisms to ensure long-term impact.
- Resource mobilization: develop an investment case for the breast cancer programme expansion.

High-Level Process

Scale-up should begin with a structured review of implementation experience. This should consider what was implemented, how implementation progressed, what bottlenecks were encountered, what adaptations were required, and what evidence has emerged regarding feasibility, effectiveness, acceptability, and sustainability.

The process should normally include:

- Review implementation experience: consolidate lessons, challenges, enabling factors, and successes from city or sub-national BCAPs.
- Identify scalable interventions: select priority actions that show relevance, feasibility, and potential for broader adoption.
- Align with national priorities: ensure interventions complement NCCP objectives and existing health system strategies.
- Develop the scale-up and integration approach: clarify how the interventions will be adapted, expanded, or incorporated into broader policy and service-delivery arrangements. Define roles, responsibilities, timelines, and required resources.
- Secure institutional endorsement: obtain political, technical and administrative support including government approvals where necessary.
- Coordinate multi-level implementation: engage local and regional authorities to adapt interventions contextually.
- Establish or strengthen M&E mechanisms: track progress, assess results, and integrate findings into ongoing policy and program improvements.

Expected Results

A well-managed scale-up process should result in:

- Identification of selected BCAP interventions suitable for broader rollout or integration.
- Clearer understanding of the conditions required for successful replication or adaptation.
- Evidence-informed decisions on whether, how, and where interventions should be scaled.
- Alignment of scale-up priorities with national cancer-control and health-system planning processes.
- Broader institutional ownership of interventions that have demonstrated operational value.
- A structured basis for sustainable expansion of selected breast cancer interventions beyond the initial implementation setting.

STEP 8 - MONITOR IMPLEMENTATION, EVALUATE PROGRESS AND SUPPORT LEARNING THROUGHOUT IMPLEMENTATION

Purpose

Monitoring, evaluation, and learning (MEL) should accompany implementation from the outset and continue throughout the implementation cycle. Although presented as Step 8 for practical purposes, MEL is a cross-cutting function that runs alongside the operationalization of BCAP interventions and informs adaptation, decision-making, and scale-up.

Its purpose is to systematically track implementation progress, assess whether interventions are producing their intended results, identify bottlenecks and underlying causes of underperformance, and generate evidence on what is working, what is not, and why. This evidence supports accountability and continuous programme improvement, enables timely corrective action, and provides the basis for deciding whether interventions should be adapted, sustained, discontinued, or considered for broader scale-up.

Key Principles

- Embed MEL from the outset: monitoring, evaluation, and learning should accompany implementation throughout the cycle.
- Track implementation and results: assess both delivery of planned interventions and progress toward GBCI objectives.
- Use GBCI KPIs as the main reference: complement them with implementation, service-delivery, and equity indicators where relevant.
- Use mixed methods where needed: combine quantitative and qualitative evidence to understand what works, what does not, and why.
- Build in periodic review: use mid-cycle and end-cycle assessments to support adaptation and learning.
- Use findings for decisions: MEL should inform course correction, accountability, sustainability, and scale-up.
- Use existing data systems where possible: build on registries, routine information systems, and national monitoring frameworks.

Key Responsibilities

- Breast Cancer Governance body: provide overall oversight, review progress, interpretation of findings, and coordination of corrective actions and adaptive planning.
- Program managers and health authorities: oversee routine data collection, reporting, ensuring timely follow-up on indicators, and use of findings for programme management.
- Clinical teams and implementing institutions: accurate recording of clinical, diagnostic, treatment and follow-up data.
- M&E, registry, and health information teams: support data quality, analysis, interpretation, and integration with existing monitoring systems.
- Stakeholders and partners: contribute qualitative evidence, validate findings, and support participatory evaluation and learning processes.

Key Indicators

Monitoring should combine high-level GBCI outcome indicators with operational and service-delivery indicators relevant to the BCAP and local implementation context.

GBCI-aligned indicators

- Proportion of invasive breast cancers diagnosed at Stage I or II
- Time from first presentation or symptom recognition to confirmed diagnosis
- Treatment initiation and completion rates for recommended therapy

Implementation and service-delivery indicators

- Reach and participation in awareness and early detection activities
- Referral completion rates across the diagnostic pathway
- Utilization and timeliness of imaging, pathology, and diagnostic services
- Coverage of multidisciplinary care and patient navigation mechanisms
- Adherence to relevant clinical guidelines and protocols

Equity indicators

- Access and outcomes across population subgroups, including underserved communities
- Geographic, socioeconomic, and demographic disparities

Broader outcome indicators, where feasible

- Overall survival trends
- Mortality trends at local and national levels
- Patient-reported outcomes and quality of life measures

Data Sources and Methods

Monitoring, evaluation, and learning should draw primarily on existing data systems, complemented by additional methods where needed. Relevant sources may include:

- Routine health information systems, hospital records, and population-based cancer registries.
- Facility-level electronic medical records and other monitoring and programme reporting systems.
- Patient follow-up, surveys, and key informant interviews.
- Workshops and review meeting documentation.
- Periodic audits and quality assessments of diagnostic and treatment services.
- Integration with existing national monitoring frameworks to ensure comparability and alignment with NCCP objectives.

Quantitative and qualitative methods should be combined where appropriate to assess implementation progress, service-level changes, barriers and enablers, and the experiences of implementers and affected populations. Additional data collection should be proportionate to the evaluation questions and used where routine systems do not provide sufficient information.

Monitoring, Evaluation and Learning Across the Implementation Cycle

Monitoring, evaluation, and learning should be organized across the full implementation cycle rather than concentrated at the end. Routine monitoring provides continuous information on progress, milestones, bottlenecks, and early service-level changes, while periodic assessments allow for deeper review of implementation performance and emerging results.

A mid-implementation-cycle assessment should review progress against planned activities, identify implementation barriers and adaptations, and support corrective action where needed. An end-of-implementation-cycle assessment should examine achievements, limitations, lessons learned, and the implications for future implementation, sustainability, and potential scale-up.

Where appropriate, evaluations should use mixed methods to assess not only whether interventions were implemented and produced intended results, but also how implementation occurred, what factors influenced performance, and how interventions were experienced by implementers, stakeholders, and affected populations.

Findings from monitoring and evaluation should be reviewed through the governance mechanism and used to support adaptive management, programme improvement, accountability, and decisions on continuation, modification, or scale-up of interventions.

Expected Results

A strong monitoring, evaluation, and learning function should result in:

- Timely information on implementation progress, bottlenecks, and emerging results.
- Clearer understanding of what is working, what is not, and why.
- Evidence to support corrective action and adaptive management during implementation.
- Documented learning from mid-cycle and end-of-cycle assessments.
- Stronger accountability between decision-makers, implementers, and stakeholders.
- Evidence to inform decisions on continuation, adaptation, sustainability, and scale-up.
- Lessons incorporated into future BCAP cycles and broader cancer-control planning processes.

CONCLUSION

Planning for breast cancer control is not a one-time event. The process described in this document (from consultation and situation analysis through governance, prioritization, action planning, implementation, and monitoring) is intended to be iterative. A completed BCAP cycle is not an endpoint. It is the foundation for the next one, informed by what has been learned, what has worked, and what has not.

For those using this guide in practice, the path forward will rarely follow the sequence described here exactly, requiring continuous adaptation. The structured approach presented here provides a common reference point for decision-making, a shared basis for accountability, and a framework for learning that persists beyond any single planning cycle.

The three GBCI pillars define what needs to be improved. The steps described in this guide define how to organize that effort. Between the two lies the work of implementation: local, specific, and owned by the institutions, professionals, and communities closest to the women (and men) it is intended to serve. The ultimate goal is not a well-written plan. It is measurable, sustained improvement in breast cancer outcomes for all who need it.

This document complements a growing body of WHO technical resources on GBCI implementation, including dedicated guidance on patient navigation, health system strengthening, and monitoring and evaluation. Users are encouraged to consult these documents alongside this guide.

ACKNOWLEDGMENT

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We are grateful to all stakeholders at city-level who contributed to the development, application, and refinement of the planning approach presented in this document. In particular, we acknowledge the partners and participants involved in GBCI implementation. Their engagement, insights, and practical experience were essential in shaping this booklet.

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Finally, we acknowledge the patients, survivors, families, and community representatives whose experiences and perspectives continue to remind us that effective breast cancer control is not only a technical priority, but also a matter of equity, dignity, and accountability. This guide is intended to support locally owned action that brings the goals of the GBCI closer to implementation and impact.

The views expressed in this report do not necessarily represent the decisions, policies, or views of the WHO. In any use of this publication, there should be no suggestion that WHO endorses any specific organization, products or services.

DISCLOSURE

The contributors involved in the development of this guide declared any relevant interests in accordance with applicable organizational policies. No conflicts of interest that could have influenced the content of this publication were identified.

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ANNEXES

ANNEX 1. GBCI WORKSHOP AGENDA

Global Breast Cancer Initiative (GBCI) Implementation Workshop

Time and length	DAY #1: Topic / Session / Programme	Facilitator/Presented by
8:30 - 9:00	Registration	
	SESSION #1: Strategic Planning, Review of Policy Documents, Opportunities for Quality Improvement	
9:00 - 9:15 (15 mins)	Opening remarks: Welcome participants, introduce facilitators	National MOH Lead City Policy Lead
9:15 - 9:25 (10 mins)	Implementation Workshop Overview: Context, Objectives, Participant Roles	Workshop facilitator
9:25 - 9:45 (20 mins)	Participant Introductions	Workshop facilitator
9:45 - 10:00 (15 mins)	National Cancer Control Plan: Breast Cancer Goals	Workshop facilitator
10:00 - 10:15 (15 mins)	City Situation Analysis - Summary	Workshop facilitator
10:15 - 10:20 (5 mins)	Agenda Review and Breakout Working Group Activities	Workshop facilitator
10:15 - 10:30	COFFEE BREAK	
	SESSION #2: GBCI, Breast Cancer Patient Pathway, Opportunities and Barriers	
10:30 - 10:45 (15 mins)	GBCI Overview, Context and Background	Workshop facilitator
10:45 - 11:10 (25 mins)	Breakout 1: Opportunities for improving breast care aligned to GBCI pillars	Table breakout session # with Mentimeter worksheet 1
11:10 - 11:30 (20 mins)	Rapporteur Summary and Group Dialogue	Moderated discussion
11:30 - 11:45 (15 mins)	GBCI Key Performance Indicators (KPIs) and Quality Improvement	Workshop facilitator
11:45 - 12:10 (25 mins)	Breakout 2: Barriers to implementing the GBCI	Table breakout session #2 with Mentimeter worksheet 2
12:10 - 12:30 (20 mins)	Facility Team Reports / Group Discussion	Moderated discussion

12:30 - 13:30		LUNCH
SESSION #3: Clinical Services and Quality Improvement		
13:30 – 13:45 (15 mins)	WHO Health System Building Blocks and Root-Cause Analysis (RCA) Process / Fish-bone method	Workshop facilitator
13:45 - 14:15 (30 mins)	Level Breakout 3: Service Delivery for early detection and diagnosis (Pillars 1 and 2): 1. Early detection and quality improvement (Worksheet 3) 2. Diagnostic services and quality improvement (Worksheet 4)	Table breakout session #3 with Mentimeter worksheets 3 and 4
14:15 – 14:35 (20 mins)	Rapporteur Summary and Group Dialogue	Moderated discussion
14:35 - 14:45	STRETCH BREAK	
14:45 – 15:00 (15 mins)	Essential services required for coordinated multidisciplinary care	Workshop facilitator
15:00 – 15:30 (30 mins)	Breakout 4: Service Delivery for cancer management, Pillar 3: Comprehensive treatment (MDC) (Worksheet 5) Supportive and Palliative care (Worksheet 6)	Table breakout session #4 with Mentimeter worksheets 5 and 6
15:30 - 15:50 (20 mins)	Facility Team Reports / Group Discussion	Moderated discussion
15:50 – 16:15 (15 mins)	Day #1 Summary/Plan for Day #2 Writing Group Planning	Workshop facilitator
16:15 - 17:00	Networking session	

Time and length	DAY #2: Topic / Session / Programme	Facilitator/Presented by
12:30 - 13:00	Registration	
	SESSION #4: Action Plan Development	
13:00 - 13:10 (10 mins)	Opening remarks: Overview of the session's objectives and agenda	Workshop facilitator
13:10 - 13:30 (20 mins)	Key Findings from Mentimeter Review	Workshop facilitator
13:30 - 14:00 (30 mins)	Priority Ranking of Implementation Priorities	Moderated discussion
14:00 - 14:15 (15 mins)	Quality assurance in designing an Action Plan: CFIR Framework	Workshop facilitator
14:15 - 14:40 (25 mins)	Breakout 5: Team Drafting of City-Level Action Plan – Key Points	Table breakout session #5 with Mentimeter worksheets 7
14:40 - 15:00 (20 mins)	Facility Team Reports / Group Discussion	Moderated discussion
15:00 - 15:15 (15 mins)	Implementation strategies, measurement of success and quality metrics	Workshop facilitator
15:15 - 15:40 (25 mins)	Breakout 6: Planning for facility-level implementation: What resources are needed?	Table breakout session #6 with electronic worksheet #8
15:40 - 16:00 (20 mins)	Discussion and Feedback	Moderated discussion
16:00 - 16:15 (15 mins)	Closing Remarks and Next Steps	Workshop facilitator
16:15	MEETING CLOSE	

ANNEX 2. WORKSHOP REPORT TEMPLATE

City, Country – [Date of Workshop]

1. Background and Context

- Overview of the city/country's cancer control landscape, with emphasis on breast cancer:
 - › Incidence and mortality rates (if available)
 - › Key challenges in early detection, diagnosis, or treatment
 - › Existing programs or national strategies relevant to breast cancer
- Rationale for selecting this city for a GBCI workshop
- Summary of the city's involvement in the Global Breast Cancer Initiative or related initiatives (e.g. C/Can, WHO, national cancer plans)

2. Executive Summary

- Brief overview of the workshop purpose, context, and key outcomes

3. Workshop Objectives

- Main objectives of the workshop
- Specific aims related to each GBCI pillar

4. Workshop Preparation

- Key preparatory steps:
 - › Stakeholder engagement
 - › Agenda adaptation
 - › Logistics and coordination

5. Participants and Stakeholders

- Summary of participating institutions and individuals
- Representation by sector (e.g., government, hospitals, NGOs, academia)
- Roles in cancer care pathway

6. Key Discussion Points and Outputs

Organized by GBCI Pillar:

6.1 Early Detection

- Key barriers identified
- Best practices shared
- Prioritized actions

6.2 Timely Diagnosis

- System gaps and challenges
- Diagnostic capacity
- Coordination and referral pathways

6.3 Comprehensive Breast Cancer Management

- Availability and access to treatment
- Multidisciplinary care capacity
- Patient support and follow-up services

7. Action Plan Summary

- Summary of proposed actions categorized by pillar
- Short-term vs. medium-term priorities
- Responsible entities and suggested timelines

8. Next Steps and Recommendations

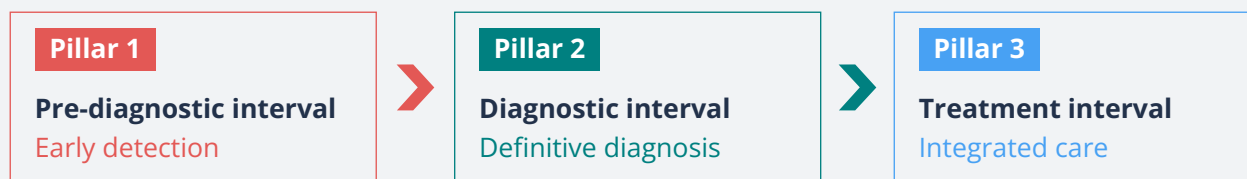
- Recommendations for city taskforce
- Follow-up mechanisms
- Upcoming milestones or check-ins

9. Annexes

- Workshop agenda
- List of participants
- Workshop presentations or handouts

ANNEX 3. GBCI WORKSHOP WORKSHEETS

Worksheet 1: Opportunities for improving breast care aligned to GBCI pillars



Q1. What are the opportunities to improve breast cancer early detection?

Public education

Professional education

Early diagnosis services

Screening programmes

Other

Q2. What are the opportunities to improve prompt diagnosis?

Clinical evaluation

Imaging

Tissue sampling

Pathology

Other

Pillar 3a. What are the opportunities to improve breast cancer-directed therapies?

Multidisciplinary treatment planning

Biomarker testing

Cancer staging

Breast/lymph node cancer surgery

Breast/lymph node radiotherapy

Chemotherapy

Endocrine therapy

Targeted (biological) therapy

Other

Pillar 3b. What are the opportunities to improve Supportive services?

Supportive-care medicines

Psycho-oncology services

Physiotherapy

Lymphedema management

Pain management

Other

Comments:

Worksheet 2: KPI and barriers to implementation

Pillar 1	Pillar 2	Pillar 3
Health promotion for early detection (pre-diagnostic interval)	Timely breast diagnostics (diagnostic interval)	Comprehensive breast cancer management (treatment interval)
KPI benchmark for Pillar 1: >60% of invasive cancers are stage I or II at diagnosis	KPI benchmark for Pillar 2: diagnostic evaluation, imaging, tissue sampling and pathology completed within 60 days	KPI benchmark for Pillar 3: >80% undergo multimodality treatment to completion without abandonment

Q1. What barriers in your setting cause patients to delay presentation/or delay referral for diagnostic workup until their cancers are advanced (Pillar 1)?

Patient knowledge

Patient Access

Primary Care Provider knowledge

Referral processes and navigation

Information systems

Other

Q2. What barriers in your setting delay diagnostic workups beyond 2 months from the first presentation (Pillar 2)?

Referral and/or navigation to a diagnostic facility

Access to diagnostic imaging

Availability of tissue sampling

Pathology services (availability /quality)

Information management

Other

Q3. What are the barriers in your setting that lead to patients beginning but not completing treatment (Pillar 3)?

Availability of treatment services

Patient access to treatment services

Multi-disciplinary cancer planning

Access to cancer treatment

Access to supportive care services

Information management

Medical products

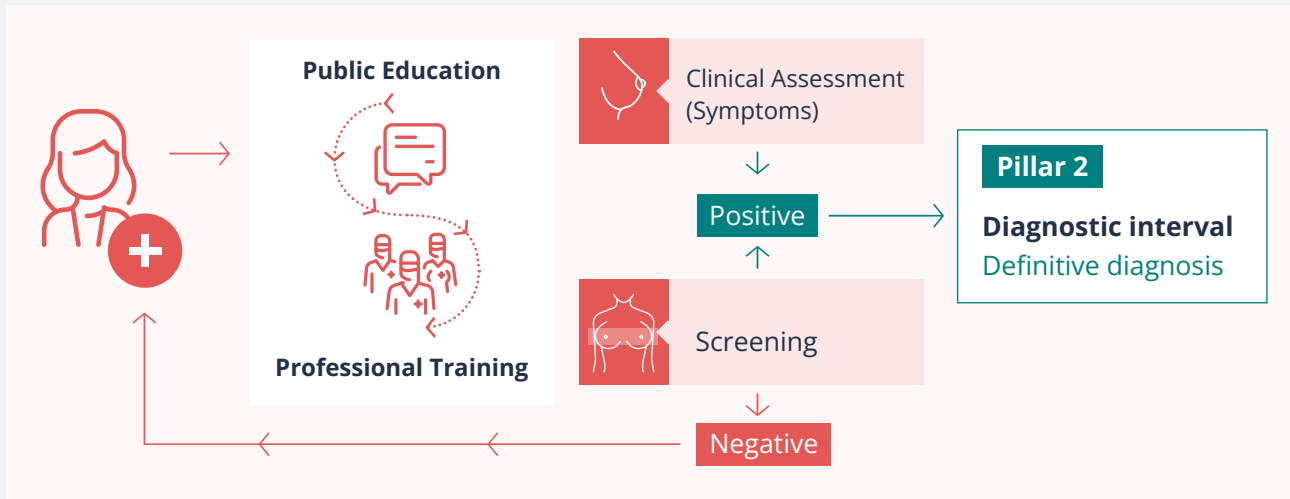
Medical technologies

Health workforce

Other

Comments

Worksheet 3: Pillar 1 – Early detection and quality improvement



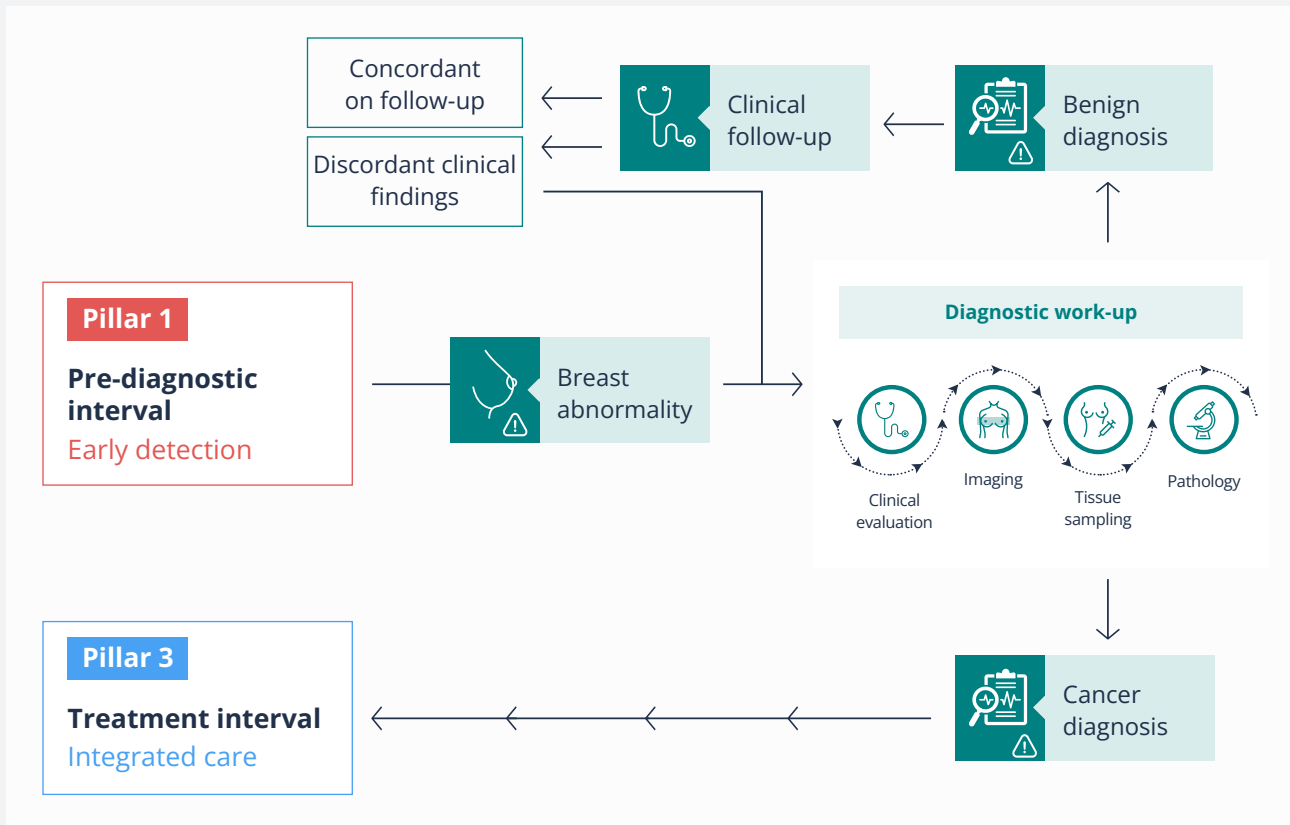
Q1. What activities or services can improve patient knowledge about breast cancer early detection?

Q2. What activities or services can support primary care clinicians to recognize signs and symptoms of possible breast cancers and refer for diagnostic workups?

Q3. What health system services can improve patient referral and navigation to facilities for diagnostic services?

Comments

Worksheet 4: Pillar 2 - Timely Diagnosis and quality improvement



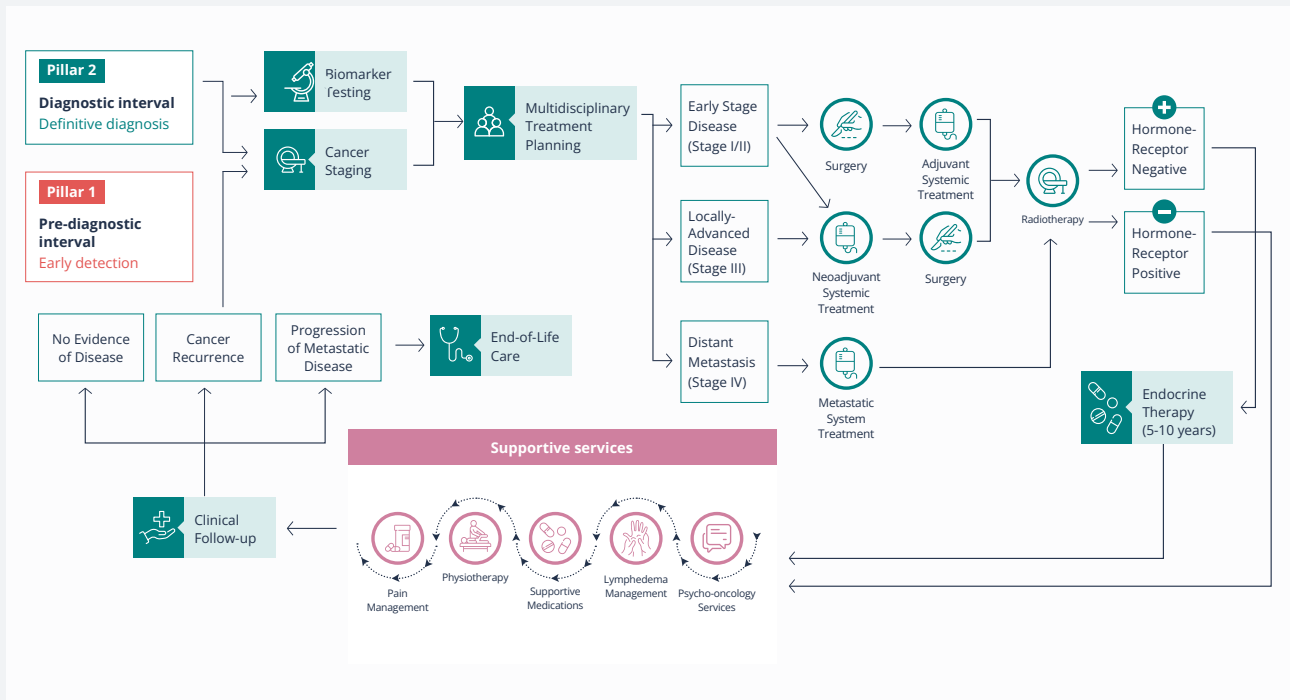
Q1. What activities or services could support the clinical evaluation of breast abnormalities in your setting?

Q2. What activities or services can support timely access and/or quality of diagnostic imaging services (ultrasound, mammography etc.) in your setting?

Q3. Which pathology services (tissue sampling, pathology interpretation, pathology reporting, etc.) are accessible in your setting?

Comments

Worksheet 5: Pillar 3 – Multimodality Treatment and Quality Improvement



Q1. What activities or services could improve access to surgical services in your setting?

Q2. What activities or services could improve access to radiotherapy services in your setting?

Q3. What activities or services could improve access to systemic treatment services in your setting?

Comments

Worksheet 6: Pillar 3 – Supportive and Palliative Care and Quality Improvement



Q1. What activities and/or services could improve access to supportive care medications to improve treatment compliance in your setting?

Q2. What activities or services could improve access to psycho-oncological interventions in your setting?

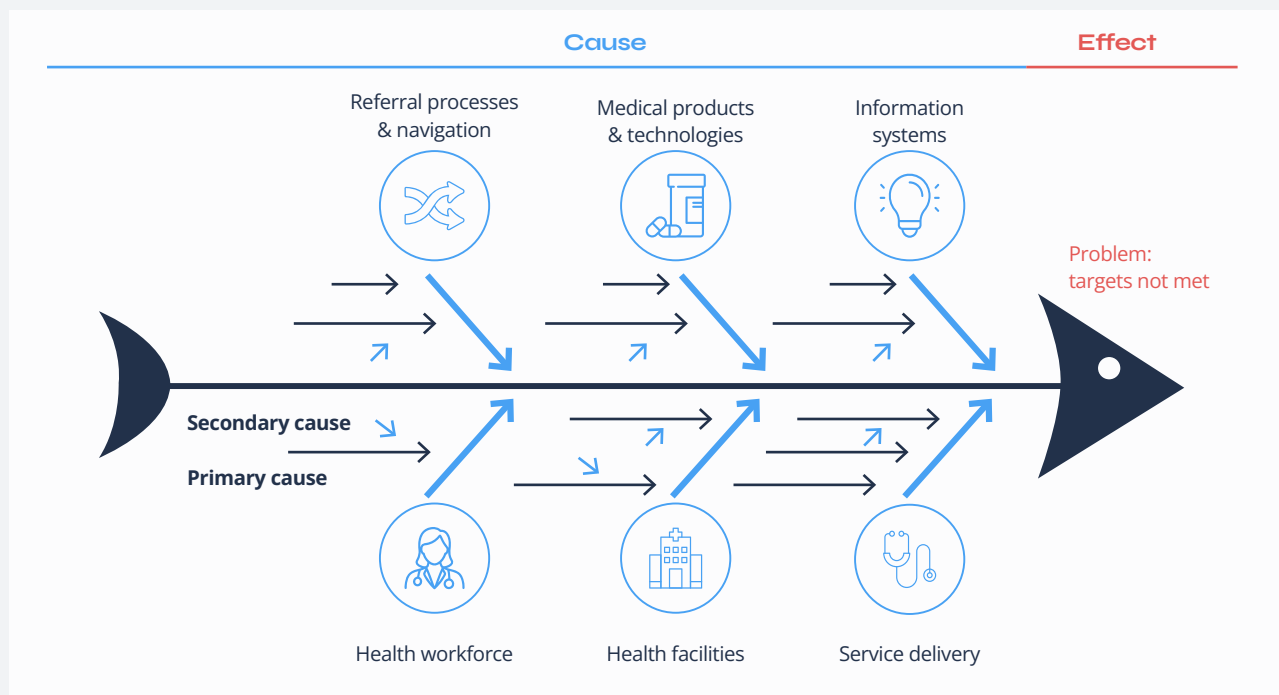
Q3. What activities or services could improve access to physiotherapy interventions in your setting?

Q4. What activities or services could improve access to lymphedema management interventions in your setting?

Q5. What activities or services could improve access to pain management in your setting?

Comments

Worksheet 7: Fishbone Analysis / Root Cause Analysis (RCA)



Q1. What changes are needed to improve early detection, prompt diagnosis and treatment to completion?

HEALTH SYSTEM BUILDING BLOCK

INTERVENTION or SERVICE

KPI INFLUENCED

Referral / Navigation

Medical Products

Technologies

Information Management

Health Workforce

Cancer Services

Comments

Worksheet 8: Comprehensive Framework for Implementation Research⁵



Q1. Intervention Characteristics: What is the degree to which the GBCI can be adapted to local needs regarding breast cancer care?

Q2. Characteristics of Individuals: Do the individuals believe in their own capabilities in implementing the GBCI?

Q3. Inner Setting: What is the capacity of your institution for change needed to implement the GBCI?

Q4. Outer Setting: What strategies do you think would facilitate the successful progression of the GBCI implementation?

Q5. Processes: Who do you think would be the main drivers in carrying out the implementation of GBCI in your facility?

⁵ Damschroder, L.J., Aron, D.C., Keith, R.E. et al. Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science. Implementation Sci 4, 50 (2009). <https://doi.org/10.1186/1748-5908-4-50>

ANNEX 4. GENERIC BREAST CANCER ACTION PLAN (BCAP)

PILLAR 1: Breast Cancer Action Plan Interventions – Breast Cancer Early Detection

GBCI Pillar	Intervention	Target Group(s)	Health Impact	Monitoring
GBCI PILLAR 1: Breast Cancer Early Detection and Stage Shifting KPI-1 Target: >60% of invasive breast cancers Stage I or II at diagnosis	1A. Public Education – Ministry of Health Leadership			
	Health education through media & workshops	General public	Improved breast cancer awareness improving early-stage diagnosis	Participation rates in breast cancer early detection programmes
	Engagement of community leaders and organizations (churches, social groups, etc.)	Organizations providing social support to women and families	Improved community support for women and families with breast cancer	Therapy completion rates among women undergoing breast cancer treatment
	1A. Public Education – Clinical Community / Facility-Level Support			
	■ Cancer experts participate in developing <i>context-appropriate educational materials</i> for education programmes led by MoH ■ Providers in primary care and cancer specialty facilities (secondary and tertiary) promote <i>public breast cancer awareness education workshops</i> organized by MoH			
	1B. Healthcare Professional Education & Training – Ministry of Health Leadership			
	In-service training for primary care providers (PCPs) on breast history taking, clinical breast examination (CBE) and indications for diagnostic referrals	PCPs who provide healthcare to women and/or families	Increased referrals for breast diagnostic workups; improved early breast cancer detection rates	Number of women referred for diagnostic workups (all ages) and/or participation in breast screening programs (target group)
	1B. Healthcare Professional Education & Training – Clinical Community / Facility-Level Support			
	■ Cancer experts participate in <i>Primary Care Provider (PCP) training courses</i> ■ PCPs facilitate patient registration and tracking processes to permit the monitoring of patient referral and navigation			

PILLAR 1: Breast Cancer Action Plan Interventions – Breast Cancer Early Detection

GBCI Pillar	Intervention	Target Group(s)	Health Impact	Monitoring
GBCI PILLAR 1: Breast Cancer Early Detection and Stage Shifting (Continued) KPI-1 Target: >60% of invasive breast cancers Stage I or II at diagnosis	1C. Navigation and Referral in Early Detection – Ministry of Health Leadership			
	Define facility maps within catchment area to define optimal referral pathways for breast diagnosis among participating facilities	Primary, secondary (district level) and tertiary care facilities with breast diagnostic services	Improved diagnostic referral pathways; standardization of diagnostic testing protocols	Patient referral tracking including loss-to-follow-up measurement
	Establish breast diagnosis navigation programmes among participating facilities	Primary, secondary (district level) and tertiary care facilities with breast diagnostic services	Optimal patient pathways throughput for breast diagnosis with minimal loss-to-follow-up	Patient tracking to assess time-to-diagnosis performance
1C. Navigation and Referral in Early Detection – Facility-Level Support				
■ Cancer experts collaborate with MoH and PC clinics to map referral programming among participating institutions and define optimal referral patterns for the catchment area ■ Clinical community facilitates data collection for patient tracking to measure diagnostic referral rates, loss-to-follow-up rates, time-to-diagnosis assessments, and cancer stage-at-diagnosis as recorded in the medical chart and patient registries				

PILLAR 2: Breast Cancer Action Plan Interventions – Prompt Diagnosis

GBCI Pillar	Intervention	Target Group(s)	Health Impact	Monitoring
GBCI PILLAR 2: Prompt Diagnosis KPI-2 Target: Cancer diagnosis made within 60 days (2 months) of initial presentation to health system	2A. Workforce Training in Clinical Breast Assessment (CBA) – Ministry of Health Leadership			
	Standardize diagnostic protocols (imaging, tissue sampling, pathology reporting) with international guidelines & the GBCI Patient Pathway	Secondary (district level) and tertiary care facilities with breast diagnostic services	Standardization of breast diagnostic protocols; improved quality and timeliness of breast diagnostic procedures	Compliance with standardized diagnostic utilization protocols
	Training of breast clinicians and nurses on clinical breast assessment (CBA) including history taking, clinical breast examination (CBE), and indications for diagnostic imaging and tissue sampling	Clinical teams (providers and technicians) who perform definitive breast diagnostic tests and procedures for breast early diagnosis and/or screening	Standardization of breast diagnostic protocols; improved quality and timeliness of breast diagnostic procedures	Number of women undergoing breast diagnostic workups in breast early diagnosis programs (all ages) and/or screening programs (target group) including timeliness of services
	Training of radiologists, sonographers, and radiographers in breast imaging and diagnosis	Radiology teams in facilities where breast diagnostics are performed	Standardization of breast imaging protocols; improved quality of breast diagnostic procedures	Number and quality of women undergoing breast diagnostic imaging studies
	Training of pathologists and pathology technicians in breast pathology services	Pathology teams in facilities where breast pathology services are available	Standardization and quality improvement of breast pathology protocols	Number and quality of women undergoing breast diagnostic imaging studies
	2A. Workforce Training in Clinical Breast Assessment (CBA) – Facility-Level Support			
	■ Cancer experts define a context appropriate standardized CBA approach for breast diagnosis for use in all centers certified to perform breast-specific diagnostic workups ■ Cancer experts collaborate with MoH to establish clinical workforce requirements for diagnostic services at secondary and tertiary care levels			

PILLAR 2: Breast Cancer Action Plan Interventions – Prompt Diagnosis

GBCI Pillar	Intervention	Target Group(s)	Health Impact	Monitoring
GBCI PILLAR 2: Prompt Diagnosis (Continued) KPI-2 Target: Cancer diagnosis made within 60 days (2 months) of initial presentation to health system	2B. Diagnostic Services (imaging, tissue sampling, pathology) – Ministry of Health Leadership			
	Ensure regular maintenance of installed equipment in diagnostic imaging and pathology	Secondary (district level) and tertiary care facilities with breast diagnostic services	Increase cancer diagnostic services for timely diagnostics linked to tissue sampling and histopathology	Monitoring of patient throughput in diagnostic; median time to diagnosis
	Expand image-guided biopsy capacity (ultrasound and mammography)	Secondary (district level) and tertiary care facilities with breast diagnostic services	Reduce demands for surgical services; Reduce time-to-diagnosis to 60 days or less	Monitoring of patient throughput in diagnostic; median time to diagnosis
	Improve needle biopsy & specimen management (guidelines, SOPs, specimen tracking, barcoding...)	Secondary (district level) and tertiary care facilities with breast diagnostic services	Improve access to diagnostic services for timely diagnosis within 60 days, set standards and perform QA/QC	Monitoring of patient throughput in diagnostic; median time to diagnosis
2B. Diagnostic Services (imaging, tissue sampling, pathology) – Facility-Level Support				
■ Facilities allocate space and resources for breast services under direction of MoH ■ Cancer experts collaborate to establish and apply algorithmic diagnostic protocols (imaging, tissue sampling, pathology reporting) developed in conjunction with MoH ■ Cancer experts support establishment and maintenance of diagnostic services in participating facilities				

PILLAR 2: Breast Cancer Action Plan Interventions – Prompt Diagnosis)

GBCI Pillar	Intervention	Target Group(s)	Health Impact	Monitoring
GBCI PILLAR 2: Prompt Diagnosis (Continued) KPI-2 Target: Cancer diagnosis made within 60 days (2 months) of initial presentation to health system)	2C. Navigation in Breast Diagnostic Services – Ministry of Health Leadership			
	Monitor compliance with diagnostic referral pathways and navigation protocols from PCP facilities to and within facilities providing breast diagnostic services	Secondary (district level) and tertiary care facilities with breast diagnostic services	Improve access to quality diagnostic services for timely diagnosis within 60 days	Monitoring of patient throughput in diagnostic; median time to diagnosis
	2C. Navigation in Breast Diagnostic Services – Facility-Level Support			
	■ Develop a diagnostic patient registry to permit the measurement of time to diagnosis (KPI-2) in each facility (KPI-2 target < 60 days for cancer) ■ Collaborate with MoH to establish a monitoring program for timely breast diagnostics.			

PILLAR 3: Breast Cancer Action Plan Interventions – Treatment to Completion

GBCI Pillar	Intervention	Target Group(s)	Health Impact	Monitoring
GBCI PILLAR 3: Breast Cancer Treatment to Completion KPI-3 Target: >80% of patients diagnosed with breast cancer undergo treatment to completion without excessive delay and avoiding unplanned or unintended treatment abandonment	3A. Quality Management in Cancer Directed Treatment			
	3A-i. Multidisciplinary Management and Navigation – Ministry of Health Leadership			
	Establish standards for delivering multidisciplinary treatment (MDT) following international guidelines & the GBCI Patient Pathway	Secondary (district level) and tertiary care facilities with breast cancer treatment services	Standardizes multimodality cancer treatment in alignment with international standards and norms	Episodic chart review to ascertain breast cancer management strategies in compliance with accepted treatment guidelines
	3A-i. Multidisciplinary Management and Navigation – Facility-Level Support			
	■ Cancer experts collaborate to develop facility-specific programming for multidisciplinary treatment (MDT) planning including guideline-based management protocols to be followed in all centres. ■ Establish and support a multistakeholder Community of Practice addressing supportive care needs for the community			
	3A-ii. Surgical Services – Ministry of Health Leadership			
	Training surgical teams (surgeons, anaesthesiologists, nurses, & support staff (BCS, mastectomy, SNB, chemo-port placement, etc.)	Surgeons and surgical staff in facilities providing surgical treatment for breast cancer patients	Improve availability of surgical services for cancer treatment; standardization of surgical services for breast cancer	Monitoring of patient throughput undergoing breast cancer surgical treatment

PILLAR 3: Breast Cancer Action Plan Interventions – Treatment to Completion

GBCI Pillar	Intervention	Target Group(s)	Health Impact	Monitoring
GBCI PILLAR 3: Breast Cancer Treatment to Completion KPI-3 Target: >80% of patients diagnosed with breast cancer undergo treatment to completion without excessive delay and avoiding unplanned or unintended treatment abandonment	3A-ii. Surgical Services – Facility-Level Support			
	- Develop surgical expansion plan (infrastructure, equipment, training priorities, and quality SOPs at participating facilities providing breast cancer surgical diagnostics and treatment. - Develop capacity to improve post-operative surgical care (including wound care, lymphedema, rehabilitation...)			
	3A-iii. Radiotherapy Services – Ministry of Health Leadership			
	Implement a maintenance strategy for radiation treatment (RT) equipment procurement and maintenance	Radiation oncologists, physicists and radiotherapy staff in facilities providing radiation treatment for breast cancer patients	Improve availability and quality of radiotherapy services for cancer treatment; standardization of radiotherapy services for breast cancer	Monitoring of patient throughput undergoing breast cancer radiation therapy
	3A-iii. Radiotherapy Services – Facility-Level Support			
	- Training engineers for preventive and first-line maintenance (including a retaining policy) - RT teams trained in breast RT (contouring, treatment plan, side-effects...)			
	3A-iv. Systemic Therapy Services – Ministry of Health Leadership			
	Training support for cancer teams (oncologists, nurses, pharmacists) on quality and safe administration of systemic therapy	Medical/clinical oncologists and staff in facilities providing systemic treatment for breast cancer patients	Improve availability of oncology services for breast cancer treatment; standardization of systemic therapy use; basis for assessing safe handling of cancer medicines	Monitoring of patient throughput undergoing breast cancer systemic therapy

PILLAR 3: Breast Cancer Action Plan Interventions – Treatment to Completion

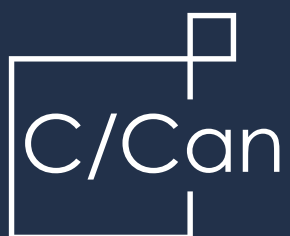
GBCI Pillar	Intervention	Target Group(s)	Health Impact	Monitoring
GBCI PILLAR 3: Breast Cancer Treatment to Completion (Continued) KPI-3 Target: >80% of patients diagnosed with breast cancer undergo treatment to completion without excessive delay and avoiding unplanned or unintended treatment abandonment	3A-iv. Systemic Therapy Services – Facility-Level Support			
	■ Develop a systemic therapy plan (infrastructure, pharmacy rooms, forecasting medicines & consumables, training gaps and quality SOPs) based on service-demand analysis ■ Improving hospital infrastructure for quality chemotherapy preparation and administration			
	3B. Quality Management in Supportive Services			
	3B-i. Supportive Medications and Related Services – Ministry of Health Leadership			
	Include essential palliative care medicines in the NEML to forecast palliative medicine utilization	Cancer care providers and staff in facilities providing treatment for breast cancer patients	Improved use of palliative medications; increased treatment completion rates	Monitoring of patient throughput undergoing breast cancer treatment
	3B-i. Supportive Medications and Related Services – Facility-Level Support			
	■ Training healthcare workers in the use of pain medications and supportive medicines ■ Develop protocols for use of supportive medicines for routine use.			
	3B-ii. Psycho-Oncologic Support – Ministry of Health Leadership			
	Training of psychologists, counsellors, and other support service personnel	Primary, secondary (district level) and tertiary care facilities where cancer patients are seen	Improved patient and family coping; improved patient compliance and treatment completion	Cancer patient and family surveys

PILLAR 3: Breast Cancer Action Plan Interventions – Treatment to Completion

GBCI Pillar	Intervention	Target Group(s)	Health Impact	Monitoring
GBCI PILLAR 3: Breast Cancer Treatment to Completion (Continued) KPI-3 Target: >80% of patients diagnosed with breast cancer undergo treatment to completion without excessive delay and avoiding unplanned or unintended treatment abandonment	3B-ii. Psycho-Oncologic Support – Facility-Level Support			
	- Active participation of psychologists in MDT meetings - Involve survivors in peer counselling			
	3B-iii. Physiotherapy Interventions – Ministry of Health Leadership			
	Training of physiotherapists and occupational therapists in cancer-specific rehabilitation	Primary, secondary (district level) and tertiary care facilities where cancer patients are seen	Improved patient and family coping; improved patient compliance and treatment completion	Monitoring of patient throughput undergoing breast cancer treatment and supportive therapy
	3B-iii. Physiotherapy Interventions – Facility-Level Support			
	- Involving physiotherapists in patient care - Training caregivers to provide basic physiotherapy care			

ALL PILLARS: Breast Cancer Action Plan Interventions – Health Systems Support

GBCI Pillar	Intervention	Target Group(s)	Health Impact	Monitoring
PROGRAMMATIC SUPPORT (ALL PILLARS 1 – 3): All 3 KPIs KPI-1 Target: >60% of invasive breast cancers Stage I or II at diagnosis) KPI-2 Target: Cancer diagnosis made within 60 days (2 months) of initial presentation to health system) KPI-3 Target: >80% of patients diagnosed with breast cancer undergo treatment to completion without excessive delay and avoiding unplanned or unintended treatment abandonment	4A. National Cancer Control Planning (NCCP) – Ministry of Health Leadership			
	Review and update National Cancer Control Plan (NCCP)	Ministries of health; ministries of finance; clinical cancer community	Coordinate and facilitate communication between clinical community & MoH	Cancer registry reporting
	Establish / confirm hospital-based cancer registries in all the cancer centres	Primary, secondary (district level) and tertiary care facilities	Improve cancer surveillance, enhanced administration of cancer centres	Cancer registry reporting
	4A. National Cancer Control Planning (NCCP) – Facility-Level Support			
	■ Cancer experts participate in the NCCP planning process led by MoH. ■ Cancer care facilities evaluate NCCP recommendations to guide MoH on facility-level costs and feasibility ■ Clinical community establishes multi stakeholder Communities of Practice forums for discussing quality standards aligned to NCCP.			
	4B. Patient Referral and Navigation – Ministry of Health Leadership			
	Navigation programmes for essential diagnostic and treatment services	Primary, secondary (district level) and tertiary care facilities	Reduce the current high loss to follow up; supports clinical outcomes research	Cancer registry reporting
	4B. Patient Referral and Navigation – Facility-Level Support			
	■ Cancer facilities work with MoH to define the preferred cancer referral network from Primary Care facilities to diagnostic facilities (secondary level) (Pillar 2) and from diagnostic facilities to treatment facilities (secondary and tertiary levels) to receive multidisciplinary care planning and subsequent treatment (Pillar 3). ■ Care facilities at all levels (primary, secondary, tertiary) to establish internal care maps to establish monitoring of patient flow in alignment with the GBCI Breast Cancer Patient Pathway.			



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