# Strengthening cancer control in the South Pacific through coalition-building: a co-design framework

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## Summary

**Background** Cancer is a significant problem for the South Pacific region due to a range of complex health challenges. Currently gaps in diagnosis, treatment and palliative care are significant, and while governmental commitment is strong, economic constrains limit health system strengthening. Alliances have been successful in strengthening non-communicable disease and cancer control policy and services in resource constrained settings. A regional coalition approach has therefore been recommended as an effective solution to addressing many of the challenges for cancer control in the South Pacific. However, evidence regarding the effective mechanisms for development of alliances or coalitions is scarce. This study aimed to 1) create a Coalition Development Framework; 2) assess the use of the Framework in practice to co-design a South Pacific Coalition.

**Methods** Creation of the Coalition Development Framework commenced with a scoping review and content analysis of existing literature. Synthesis of key elements formed an evidence-informed step-by-step guide for coalition-building. Application of the Framework comprised consultation and iterative discussions with key South Pacific cancer control stakeholders in Fiji, New Caledonia, Papua New Guinea, Samoa and Tonga. Concurrent evaluation of the Framework utilising Theory of Change (ToC) and qualitative analysis of stakeholder consultations was undertaken.

**Findings** The finalised Coalition Development Framework comprised four phases with associated actions and deliverables: engagement, discovery, unification, action and monitoring. Application of the Framework in the South Pacific identified overwhelming support for a Cancer Control Coalition through 35 stakeholder consultations. Framework phases enabled stakeholders to confirm coalition design and purpose, strategic imperatives, structure, local foundations, barriers and facilitators, and priorities for action. ToC and thematic consultation analysis confirmed the Framework to be an effective mechanism to drive engagement, unification and action in alliance-building.

**Interpretation** A Coalition to drive cancer control has significant support among key Pacific stakeholders, and establishment can now be commenced. Importantly results confirm the effective application of the Coalition Development Framework in an applied setting. If momentum is continued, and a regional South Pacific Coalition established, the benefits in reducing the burden of cancer within the region will be substantial.

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## Research in context

### Evidence before this study

We identified existing research documenting the current state of cancer prevalence and control in the Western Pacific region. We searched Google and Google Scholar on August 14 2019 for all published peer-reviewed and white paper literature using the terms: "cancer control" "alliance" "non-communicable disease" and "regionalism". Outputs of this search are documented in Table 1. Existing literature emphasised the significant challenges faced by Pacific island nations in achieving cancer control with small populations and scare resources. Many seminal works recommended the investigation and/or development of a cancer control alliance or coalition to strengthen cancer control in the region. Recent developments in utilisation of alliances and regional approaches to cancer control to overcome similar challenges in other resource constrained settings have proved effective. However, literature providing structured and effective approaches to achieve regionalism were lacking.

### Added value of this study

We synthesised literature detailing coalition and/or alliance building into a comprehensive Coalition Development Framework to facilitate development of an evidence-informed step-by-step guide to assist stakeholders design and develop a regional health coalition. We then applied this framework in practice in the South Pacific region. Between September and October 2019, 35 key cancer control stakeholders working within the five following Pacific island nations: Fiji, Samoa, Tonga, New Caledonia, and Papua New Guinea were engaged to test the framework and commence the development of the South Pacific Cancer Control Coalition.

### Implications of all the available evidence

The Coalition Development Framework conceived as part of this work was demonstrated to be an effective resource in practice. Regionalism in the form of a cancer control coalition is well-supported in the South Pacific, with appetite and motivation for the coalition now established. If momentum is continued, and a coalition established per design and scope outlined by stakeholders as part of this study, the benefits in reducing the burden of cancer within the region will be substantial.

## Introduction

Globally, cancer is one of the leading causes of morbidity and mortality, with rates set to continue to rise worldwide.[1] The Pacific is particularly impacted by non-communicable diseases (NCDs) such as cancer, due to a range of complex health challenges caused by shared social, environmental and economic factors.[2] The region comprises 22 Pacific island countries and territories (PICTs) which sit within the geographically and culturally distinct island groupings of Melanesia, Polynesia and Micronesia, with a combined population of approximately 10.5 million[2–5]; with the 'South Pacific' referring to the region and nations located south of the equator. However, the true scale of cancer burden in the South Pacific is difficult to ascertain due to significant challenges with obtaining, measuring and recording accurate diagnostic data.[2–8] The few national cancer registries in existence are cited as fragmented or dormant; with the notable exception of New Caledonia, which as a protectorate of France receives additional funding and support to undertake cancer control activity.[3–7]

Factors which drive high rates of cancer in the South Pacific include, but are not limited to: geographic remoteness both within and between PICTs; high rates of cancer risk factors such as obesity, and tobacco and alcohol consumption; strong influence from unhealthy commodity industries; food insecurity and lack of access to healthy produce; fragile developing economies; and impacts from climate change.[2–5,7–10] In addition, many PICTs are undergoing epidemiological transition, meaning communicable disease risk factors are prevalent[3,4,11]. Together, these factors create a challenging environment for governments in establishing effective cancer control policy, infrastructure, workforce and activity.[2,5,10]

The majority of South Pacific countries have inadequate histopathology services to diagnose and stage cancer, meaning that many cases are unable to be detected or correctly diagnosed.[3–5,8] Further many PICTs in the South Pacific are unable to provide treatment or palliative care services for people diagnosed with cancer.[3–5,12,13] While cancer surgery is often the first or only cancer treatment available in many LMICs, in many PICTs this is not available, particularly the highly specialised surgery required for some cancers.[14] Patients often cannot access chemotherapy or analgesics on the World Health Organization's (WHO) essential medicines list, and radiotherapy is unavailable in most South Pacific nations.[4,13,15] While strengthening cancer treatment as part of Universal Health Coverage (UHC) is on the policy agenda for the

majority of governments within the region, economic constraints are cited as the key barrier.[2,16] The impacts of COVID19 are likely to further exacerbate strained financial resources in resource constrained settings.[17] Small population sizes in many PICTs further limit the feasibility of implementation of specialist services at a national level.[2,4]

A regional, collaborative approach has been recommended as an effective solution to addressing many of the challenges for cancer control in the South Pacific and achieving UHC.[4,5] Collective approaches, such as coalitions or other voluntary multi-stakeholder agreements created to improve mutually agreed healthcare goals, have been demonstrated to be effective and feasible in many settings around the world.[13,18–20] In the Pacific there exists precedence for regional comprehensive cancer control planning. The United States of America (USA) Centre for Disease Control and Prevention (CDC) funded the establishment of the Cancer Council of the Pacific Islands (CCPI) to facilitate a regional multi-national coalition of all USA-affiliated Pacific island jurisdictions in the early 2000s.[21–24] Since its inception, the CCPI has successfully developed effective cancer control strategies for the USA-affiliated islands, including national and regional registry establishment, population cancer screening, and workforce capacity development.[21–24] However, despite the existence of successful regional health-focused alliances, comprehensive and appropriate information detailing how to effectively scope and establish a multi-national or regional coalition is scarce.

This project consisted of two parts: 1) the creation of the Coalition Development Framework (also referred to as the "Framework"), and 2) use of the Framework to co-design a South Pacific Cancer Control Coalition through consultation with key cancer control stakeholders working within Fiji, New Caledonia, Papua New Guinea, Samoa and Tonga.

## Methods

### Pacific leadership and oversight

Importantly, the drivers for this project were key civil society organisations (CSOs) based in Fiji and Samoa: the Fiji Cancer Society (FCS) and Samoa Cancer Society (SCS) who contacted SA as CEO of Cancer Council Australia (CCA) regarding support for investigation of a regional coalition for cancer control. CCA and FSC then supported AH to undertake this work as part of her Master of Public Health Studies with the University of Melbourne.

A Pacific project advisory committee was established prior to the commencement of this project. The committee comprised members from the FCS and the SCS, in conjuction with cancer control specialists with experience in regionalism and coalition-building based in Fiji, Samoa, New Zealand, Hawaii and Australia. This group was responsible for ensuring Pacific leadership, oversight, and input.

### Creation of the Coalition Development Framework

The first step comprised a literature review of published peer-reviewed and grey literature describing the elements, processes, and activities required for the establishment and ongoing success of operational health coalitions and multi-stakeholder partnerships. Papers were identified through searches on Pub Med, Ovid MEDLINE, CINAHL, PsychINFO and Google Scholar and Google Search, between 01 January 2009 to 15 August 2019. Search terms and variations were broad to capture all relevant publications, and included: “cancer”, “coalition”, “alliance”, “partnership” “NCD”, “non-communicable disease”, “framework”, “method”. Only papers which described multi-stakeholder coalitions at a national or multi-national level were retained. This review identified a small number of peer reviewed journal articles and one white paper publication. Content analysis of these documents identified a range of key elements and activities which informed the Coalition Development Framework (see Table 1.)

Identified elements and activities were synthesised into a Coalition Development Framework using Theory of Change (ToC).[26] The Coalition Development Framework is proposed as a comprehensive, evidence-informed step-by-step guide to assist leading stakeholders in the design and development of health coaltions (see Table 2). Four key phases evident across all resources and materials were identified as essential to guide development: Engagement; Discovery; Unification, and Action (see Fig. 1). Note: italicised text denotes additions made through the testing and evaluation of the Framework in practice.

Each phase includes a dedicated aim and associated deliverables in the form of discrete activities and outputs recommended for completion informed by the principles of co-design,[27] with dedicated stakeholder leadership and input from: project inception and conducting a situational analysis, to the proposed Coalition organisational design and model. Importantly, once commencing, each phase should continue until the Coalition is established, as activities and processes are non-linear, and involve iterative and continuous connection to facilitate development, information synthesis and consensus-building (described in Table 2).

### Stakeholder consultations

The Coalition Development Framework was then used to guide the establishment of a South Pacific Cancer Control Coalition. Evaluation of the Framework in this applied setting was documented using Interpretive

| Source/Author | Elements | Use |
|---|---|---|
| Toolkit: "Practical guide on how to build effective NCD alliances" NCD Alliance (NCDA)[25] | Define coalition need, scope the landscape, make the case for partnership, develop a shared agenda, determine design and governance | Useful in identifying key practical elements, activities and stages for the development of health alliances |
| Journal Article: A socio-ecological framework for cancer control in the Pacific: a community case study of the US affiliated Pacific Island jurisdictions Neal A Palafox et al.[23] | Determine organisational design, stakeholder inclusion, managing power-brokers and civil society engagement and leadership | Provided important learnings for operationalising key concepts in coalition establishment |
| Journal Article: Cancer control in small island nations: from local challenges to global action Diana Safarti et al.[2] | Political will, support from health leaders, individual country resources and needs are identified, mutually agreed governance structures are developed, ongoing review processes established, collaborative leadership and decision-making, priorities determined | Recommendations for essential elements associated with ongoing success of regional partnership and alliances, particularly at the country-level are important to consider and include in coalition building |
| Journal Article: Multi-stakeholder partnerships: breaking down barriers to effective cancer-control planning and implementation in low-and middle-income countries Paul Pearlman et al.[18] | Recommendations that interested stakeholders form teams to complete situational analyses and engage with international partners to provide technical support in developing action plans | Theoretical underpinnings guiding effective development of multi-stakeholder partnerships in cancer control planning and implementation are useful for informing and guiding the development of framework inputs, activities and outputs |
| Journal Article: Pacific island partnership: the Pacific Cancer Initiative Neal A Palafox et al.[24] | Identifies that a participatory development process is essential for success, needs assessments to determine contextual factors for consideration are important, diversity is an important strength of multi-stakeholder partnerships | Provided evidence that co-development and design of a coalition with input from all relevant and appropriate stakeholders is essential to ensure operational success |
| Journal Article: Cancer control in the Pacific: A South Pacific collaborative approach Sunia Foliaki et al.[5] | Proposes a model of regional cooperation in the South Pacific terms of functionality, key steps (e.g. establishing leadership, undertaking needs assessments), potential collaborators, and highlights cancer control strengthening opportunities | Provides support for a CSO-led coalition model, outlines ideas for steps and opportunities which triangulate and harmonise with other coalition-building sources |

*Table 1:* **Key sources informing coalition framework development.**

Description and health program evaluation research methods.[28]

Co-design was employed as the overarching methodology, as the principles and practical application of co-design require active and democratic involvement of a diverse range of participants from concept creation to implementation of solutions developed in response to shared challenges.[29] In particular, co-design has been recognised as a novel methodology increasing useful for engaging stakeholders to find solutions to complex problems, particularly in the policy context.[29]

Initial data collection occurred over six weeks from September 10th to October 29th, 2019. During this time, the research team were based in Fiji with the FCS, then travelled to Tonga and Samoa to meet with participants face-to-face for interviews. Participants located in New Caledonia and Papua New Guinea were contacted via videoconference. Further, participants who expressed interest in providing ongoing feedback and input into Coalition design were contacted throughout 30th Feb to 24th September 2020 to contribute iterative review of proposed Coalition model, development concepts, and plans per *Unification* and *Action* phases. Stakeholders involved in ongoing review were contacted individually via teleconferencing and emails instead of planned whole-of-stakeholder workshops due to COVID-related travel/resourcing/capacity disruptions.

### Participants

Potential stakeholder participants were identified by members of the advisory committee, and via a desktop audit conducted by the researcher. Specifically, stakeholders working in a role involving the development or delivery of cancer control care, research and/or policy at either a national or regional level in the following organisations were identified:

- CSOs or NGOs
- Ministry or Department of Health
- Health Services
- Regional Development Partners

Advisory committee members contacted potential participants directly via email or telephone to introduce the project and the researcher, as is culturally appropriate for the South Pacific. Given the breadth of individuals working in cancer control in the South Pacific, and that it is often difficult to identify potential stakeholders in this region except via verbal referral, snowball sampling techniques were concurrently employed.[30] Snowball sampling consisted of identified stakeholders and project participants referring colleagues and peers for inclusion, and then making the initial introduction. If the stakeholder was interested, an interview time was arranged.

| Phase | Aim | Category | Deliverables to complete | Elaboration |
|---|---|---|---|---|
| Engagement | Determine all relevant individual and organisational activity within the region | Activities: | ▫ Complete a comprehensive situational analysis to identify all individual and organisational activity within the area of interest<br>▫ Define key stakeholders and commence stakeholder engagement to determine preliminary Coalition interest<br>▫ Use stakeholder contacts to identify other potential actors for engagements | Once commenced, stakeholder engagement, should continue throughout all stages of Coalition development.<br>Likewise, the situational analysis should continue to be updated as new information is collected and synthesised. |
| | | Outputs: | ▫ A preliminary situational analysis: covering all key actors in all sectors (state, market, civil society)<br>▫ Stakeholder lists | |
| Discovery | Continue to build knowledge and momentum from the Engagement phase. | Activities: | ▫ Continued stakeholder engagement via more structured and purposeful consultation<br>▫ Confirmation of information identified in the situational analysis/updating of situational analysis as new information is gathered<br>▫ Verification of coalition interest, and level of commitment to involvement and ongoing action<br>▫ Initial identification of contextual information e.g. barriers and potential threats versus facilitators and existing strengths<br>▫ Preliminary suggestions for Coalition design, structure, purpose and goals are identified<br>▫ *Commence consideration of monitoring and evaluation systems and consideration of governance structures* | Formal or informal interviews or conversations can be employed to connect with key stakeholders. Ideally, as information in the Engagement and Discovery phase is collected and documented, regular, iterative review and synthesis should be undertaken. |
| | | Outputs: | ▫ Updated situational analysis<br>▫ Stakeholder analysis confirming interest and engagement in a Coalition<br>▫ Several draft/potential models for Coalition design, structure, purpose and goals<br>▫ *Monitoring and evaluation and governance* | |
| Unification | Achieve unity and consensus on key issues, such as context, proposed Coalition design and structure. | Activities: | ▫ Continued stakeholder engagement and consultation<br>▫ Updating of situational analysis as new information is gathered<br>▫ Synthesising of information to group key ideas and themes<br>▫ Building consensus on key issues and concepts | Discussion and testing of popular concepts and ideas with engaged stakeholders is important as key ideas begin to coalesce and form more concrete structures. At the end of this phase, a clear outline of the Coalition design, structure and purpose should be evident. |
| | | Outputs: | ▫ Updated situational analysis<br>▫ One or two possible plans for Coalition design, structure, purpose and goals<br>▫ *Monitoring and evaluation and governance systems drafted* | |
| Action | Finalise all essential Coalition conceptss | Activities: | ▫ Finalise Coalition design, strategy and structure<br>▫ Determine strategic imperatives, key milestones and priorities for action, *monitoring and evaluation frameworks and governance systems*<br>▫ Consolidate all findings into a report for stakeholder review and ratification | The Action phase should continue until shared vision is established, and all stakeholders agree on Coalition development concepts and future plans. |
| | | Outputs: | ▫ A proposed model for Coalition design, structure, purpose and goals, monitoring and evaluation and governance, including indicative funding sources and plans for financial sustainability, endorsed by the majority of engaged stakeholders | |

***Table 2:*** **Coalition development framework outline.**

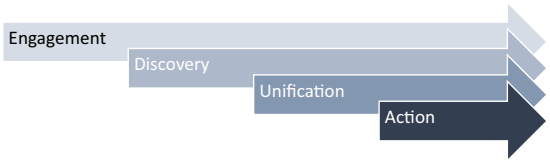


*Fig. 1:* Coalition development framework phases.

### Informed consent

As the project concurrently involved evaluation of the Coalition Development Framework, potential stakeholder participants were also emailed with a research participant information and consent form (PICF). At the time of the interview, if the participants agreed for their interview data to form part of the research study, they were asked to sign a copy of the consent form and were given a copy to keep.

### Data collection

A semi-structured interview schedule was developed to facilitate evaluation of the Framework, with 12 questions and associated prompts mapping to each of the four stages: Engagement, Discovery, Unification and Action (see supplementary materials). Participating stakeholders had their consultations audio-recorded and then transcribed to facilitate analysis. Three demographic questions were also included at the start of the interview comprising participant role, organisation type, and country of focus. Comprehensive notes were created to supplement interview data and to document information relevant to evaluation of the Framework.

### Data statement

A condition requested by participants at consent was that all potentially identifiable qualitative interview and demographic data collected as part of this study to be kept confidential and not made publicly available via data-sharing mechanisms.

### Data analysis

Demographic data were analysed descriptively, using frequencies and percentages. Consultation transcripts and other text documents (field notes etc.) were uploaded to NVIVO12 for analysis using interpretive description methods.[31] Consultations were analysed in alignment with the Coalition Development Framework phases to facilitate evaluation. Analysis was inductive, with data initially described in broad, generic codes, which were then iteratively and reflexively re-labelled and interpreted as categories and themes were developed.[16] Analysis was considered finalised once themes reached a balance of both meaningfully representing stakeholder perspectives, and addressing the research objectives.[32]

### Ethics approval and consent to participate

Ethics approval was sought and granted through Melbourne University School of Population and Global Health Human Ethics Advisory Group (ID: 1955207.1).

### Role of the funding source

The funder had no role in the study design, data collection, data analysis, interpretation or writing of the paper.

## Results

### Engagement

A total of 43 stakeholders working directly within cancer control, and other key leaders or actors ancillary or adjacent to cancer control within the health or government sector were identified and contacted. Of these, 35 were available and interested in taking part in a consultation to discuss a South Pacific Regional Cancer Control Coalition, and all agreed to participate in the research evaluation of the Framework. Table 3 summarises the key characteristics of stakeholders interviewed. Role title and organisation name are not reported to preserve participant confidentiality.

The majority of stakeholder consultations ($n$ = 29, 83%) were conducted face-to-face in country; the remainder were conducted via telephone or videoconference ($n$ = 6, 17%). Consultations ran for an average of 42 min (SD = 20 min), generating a total of 23 h of data.

| Stakeholder Demographic Category | *n* | % |
|---|---|---|
| **Role** | | |
| Public Health Professional | 11 | 31 |
| Clinician | 9 | 26 |
| Policymaker | 6 | 17 |
| Project/Technical Officer | 5 | 14 |
| Epidemiologist | 2 | 6 |
| Consumer Advocate | 1 | 3 |
| Academic | 1 | 3 |
| **Organisation type** | | |
| CSO/NGO | 11 | 31 |
| Ministry/Department of Health | 9 | 26 |
| Development Partner | 6 | 17 |
| Public Tertiary Health Service | 4 | 11 |
| Private Tertiary Health Service | 3 | 9 |
| Private Primary Care Health Service | 1 | 3 |
| Academic Organisation | 1 | 3 |
| **Country Focus** | | |
| Fiji | 15 | 43 |
| Regional | 8 | 23 |
| Tonga | 5 | 14 |
| Samoa | 4 | 11 |
| New Caledonia | 2 | 6 |
| Papua New Guinea | 1 | 3 |

*Table 3:* **Summary of stakeholder demographic characteristics.**

Of the eight stakeholders not consulted: three were on leave for the duration of the project, three did not respond to emails, one did not have time-capacity (though was supportive), and one cancelled due to illness. Importantly, Papua New Guinea and New Caledonia had only 1 and 2 stakeholders participate respectively, despite equal engagement attempts with potential cancer control actors in both nations by the project advisory committee and research team. While low response reasons are unknown, language barriers, short project timeframe, and lack of in-country visitation likely impacted participation.

### Discovery, unification and action

Analysis of stakeholder consultations, followed by ongoing iterative review of the draft Coalition model per all four Framework stages resulted in the following finalised description of Coalition design, strategy and structure strategic imperatives, key milestones and priorities for action:

1. Coalition design and purpose
2. Strategic imperatives
3. Structure and membership
4. South Pacific ownership and leadership
5. Barriers and facilitators to coalition establishment
6. Priorities for action

Brief summaries for each of the six outputs are presented below.

### Coalition design and purpose

All thirty-five stakeholders supported the development of a South Pacific Cancer Control Coalition. Stakeholders advised the first step in Coalition-building must be the establishment of a regional Cancer Agency, to function as the secretariat and to lead all next coalition-building activities. A regional agency would immediately harness Pacific leadership, and remove perceived 'ownership' from any one country.

Stakeholders preferred results-oriented and achievable purpose statements, such as: 'Effective Cancer Control', and values specified included: transparency, accountability, respect, and integrity. Stakeholders emphasised that the Coalition must be outcomes focused, and achieve tangible and measurable benefits.

### Strategic imperatives

A clear mandate and purpose, in conjunction measurable objectives was deemed essential by stakeholders to ensure that the Coalition activities are effective and not tokenistic. The following strategic imperatives articulate both key objectives, and what individuals and organisations would expect from membership.

1. Partnerships
   Facilitate community and regional networks, and foster partnerships between individuals and organisations.
2. Data-driven to respond to South Pacific needs
   Respond to issues identified through data collected by members in region-specific clinical settings and by cancer registries.
3. Advocacy and Empowerment
   Provide a powerful, unified, and respected voice to the political arena to bring cancer to the forefront of discussions; and empower national agencies in advocating in the international setting.
4. Strengthen, streamline, capacity-build
   Enable a strategic approach to all activities from education, awareness, and outreach, through to screening, treatment, and palliative care. All current activities would be strengthened and streamlined through partnerships and coordination. A regional approach to cancer control would increase regional capacity, knowledge, and resources.

### Structure and membership

Membership was proposed for all current interested South Pacific organisations working in cancer control; however, alignment of missions and values would be critical for acceptance.

**CSO-led:** Most stakeholders felt that the Coalition should be CSO-driven. It was recommended that the Coalition work in close partnership with governments and clinical services, but noted that, as a CSO, the Coalition would be able to act independently, call government actors to account, or surmount diplomatic issues between countries. The following points were outlined by stakeholders as essential:

**Representative of all working in cancer control**: the Coalition must be representative of each country and facet of cancer control undertaken within the region. The following groups were deemed important for inclusion:

- Ministries/departments of health
- CSOs and NGOs
- Clinical Services and Health Professionals
- Academics
- Consumer advocates
- Traditional medicine providers
- Church and other social groups

**Partner with Governments:** For the Coalition to be viable, it will need to work closely with governments. It was recommended that the Coalition, once establishment efforts begin, apply to receive endorsement from governments and Heads of Health at a national and regional level.

**Supported by Development Partners**: International development partners within the region (WHO, The Pacific Community (SPC) or UNICEF) must be engaged as essential partners for impact and regional cohesion. These organisations may be able to provide valuable Coalition establishment support in the form of technical and practical assistance.

### South Pacific leadership and governance

Stakeholders emphasised that Pacific ownership and leadership of the Coalition must be retained throughout the development process. South Pacific culture, cancer burden and politics are best understood and navigated by Pacific people, with technical support where needed. Further, given current capacity constraints faced by all individuals working in cancer in the South Pacific, stakeholders emphasised the need for full-time, paid local staff.

Stakeholders further agreed that the Coalition should sit outside governmental and clinical arenas to maintain independence. Impartiality and distance were seen as essential in order to effectively set policies, evaluate activities, and work in partnership with all stakeholders. A steering committee to drive leadership and governance was suggested, comprising representatives from cancer organisations and health services. A pre-defined time-period for serving on the committee would ensure that people were willing to take on this role, and to nurture innovation and change.

### Barriers and facilitators

Potential barriers and threats to Coalition development and activities were outlined by stakeholders to highlight the challenges which need to be thoughtfully considered, discussed, and addressed. Equally, existing and potential future facilitators were also described, so that development of the Coalition can leverage or harness these opportunities where possible and appropriate (see Table 4).

### Priorities for action

Stakeholders agreed that priority areas for the coalition must hit a balance between what is meaningful for patients and healthcare professionals, but achievable for NGOs/CSOs or health services and systems. The following priorities were identified by participants as being essential actions to improve cancer control across the continuum and strengthen health systems in the region.:

- Standardise Systems for Quality Data: establish high quality methods to facilitate data collection, monitoring and evaluation, storage, sharing and research at national and regional levels.
- Strengthen Cervical Cancer programs: capitalise on momentum present with the WHO Elimination Strategy, and build on current progress in implementation of evidence-based interventions in cervical cancer prevention, screening and treatment.
- Development of Cancer Control Plans and Policy: support creation or refresh of national and regional cancer control strategy; review and improve current cancer control laws and policies in member states.
- Implement Palliative Care Strategy: development of regional and national palliative care policies and implementation strategies.
- Improve Overseas Treatment Referral Pathways: facilitate equitable, affordable, sustainable and appropriate access to effective and high quality cancer treatment, where possible within the Pacific.

| Facilitators | Barriers |
|---|---|
| **Health system design and cancer burden**<br>Health systems, cancer burden, risk factors and technical capacity in the region are similar, forming strong facilitators for regional activity and transferrable learnings. | **Lack of adequate data**<br>Paucity of health and cancer-related data in all countries is a significant barrier to Coalition establishment and development of targeted cancer control activities. |
| **Established multi-national programs and goals**<br>Existing international indicators, goals and programs can be leveraged by the Coalition to facilitate governmental support, international funding, partnerships, and national accountability. | **Lack of dedicated CSOs or government teams**<br>No governments in the South Pacific have dedicated cancer teams. Many nations do not have dedicated cancer CSOs. This will be challenging for the Coalition to navigate relationships with governments, and maintain cancer-specific activity along with implications for the mandate remit and representation of the Coalition in these nations. |
| **Established relationships, interest and capacity**<br>Existing partnerships between CSOs, Ministries of Health and public and private healthcare services can be strengthened with the introduction of a Coalition. | **Politics**<br>Existing political alliances or issues between nations and regions require the coalition maintain neutrality. Concerns regarding inter-organisational politics and agendas are also present. |
| **Embracing technology**<br>Use of technology can be employed by the Coalition to overcome geographical and travel limitations, support health professional networks, telehealth, capacity development; and communication with international partner organisations. | **Sustainability, funding and travel**<br>Funding is scarce and existing CSOs and governments are wary of new competitors. Travel can be prohibitively expensive in the Pacific, and logistically difficult as many countries do not have direct transit routes. |

*Table 4:* **Comparison of barriers and facilitators.**

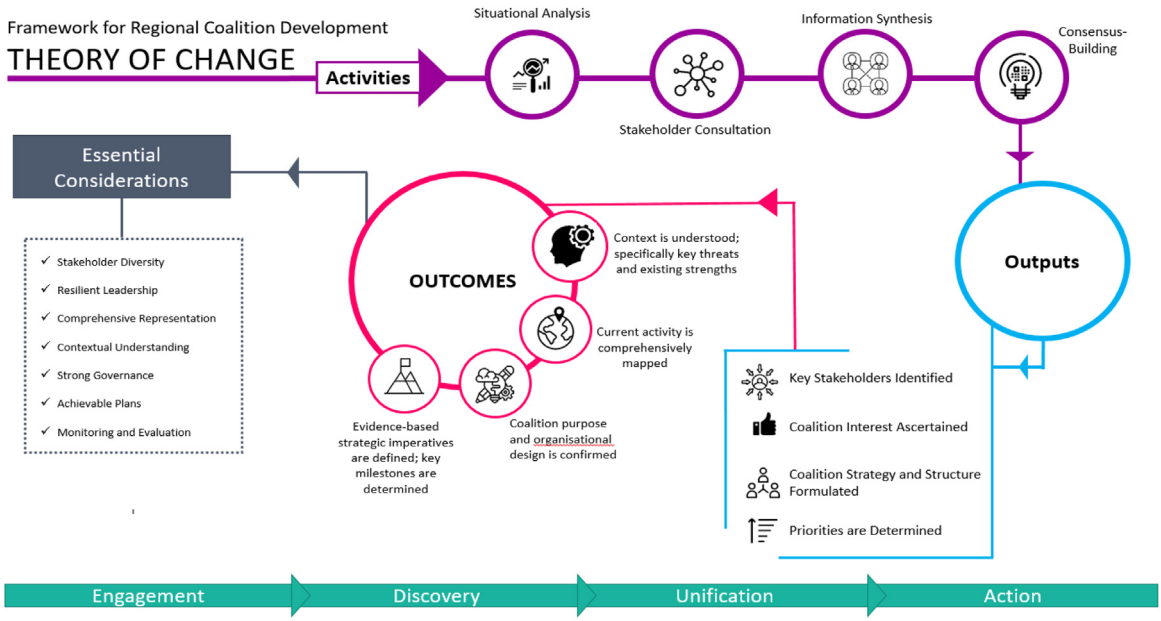


*Fig. 2:* Evaluation of the proposed Coalition Development Framework.

### Framework evaluation

ToC analysis determined that the proposed framework inputs and activities resulted in the anticipated outputs and outcomes (see Fig. 2). Further, essential considerations, amendments, and adjustments to strengthen the use of the framework were identified through this evaluation process. Specifically diversity of stakeholders and key actors within civil society, the private sector and the state was needed to optimise contextual understanding, and to determine priorities which ensure a whole-of-system approach. Unique perspectives and situational understanding would have been missed if diversity in stakeholders was not purposively sought.

Identification of key actors and power-brokers was vital to inform targeted engagement. In some nations, hierarchy and ceremony are necessary contextual elements to understand and adhere to. Identification and engagement with key actors ensured that the proposed governance and organisational design accounts for managing or leveraging commercial interest and/or competing priorities.

Early conversations with key stakeholders regarding leadership and ownership were important, and facilitated stakeholder engagement and support. Further, mechanisms for action were more easily articulated, as leadership and ownership had been to some degree decided upon. Other key findings highlighted that concurrent mapping of key barriers and facilitators ensured that Coalition goals were relevant, achievable and measurable.

Finally, additional areas which required inclusion were uncovered through use of the Framework in practice: specifically, development of effective monitoring and evaluation systems and strong governance. Stakeholders identified these requirements and recommended that the framework be updated to include activities, outputs and deliverables across all stages to achieve this (see Table 2 '*italicised*' items.

## Discussion

Stakeholder consultations and perspectives provided comprehensive information to support the feasibility of a South Pacific Cancer Control Coalition and confirmed the appropriateness and usefulness of the proposed Coalition Development Framework. Key barriers and facilitators were outlined, and stakeholders described in detail current cancer control activities, and their perceptions regarding priority actions for the Coalition in strengthening cancer control for the region.

### South Pacific and civil society leadership

Consensus between stakeholders was that this should be a CSO-led Coalition, was formalised as part of the operational design. Interestingly, research looking at regionalism in cancer control for the South Pacific has previously focused only on policy-makers as prime candidates for leadership, agenda setting and decision-making; with CSOs and NGOs included only in relation to their use in the delivery of priority actions.[2] While understandable as health activities are usually led by governments, this is not reflective of the situation in the Pacific, where a large proportion of cancer control activity is being undertaken by civil society, particularly in communities where treatment is not available.[5]

Established CCPI and NCDA Coalitions emphasise that civil society leadership has been crucial in their success, and that identification of regional priorities is best commenced where change is aimed to occur, at the community level.[13,23] Ensuring community is at the heart of all Coalition activities from identification of priorities to capacity building to advocacy, has been further cited by several other island nation health coalitions as a key factor behind their success.[20,22,23,33] Civil society can also be highly effective and influential at a policy level in cancer control advocacy and universal health system strengthening.[34] Linking back to the Coalition Development Framework, these findings emphasise the importance of stakeholder determination of leadership, organisational design, and governance in ensuring alignment with local context (Fig. 2).

Building local health capacity and allowing organisations and nations to remain autonomous was likewise emphasised by stakeholders; a message consistently reiterated by those working in health within the Pacific.[5,24,35] Underpinning these messages is an continuing issue unfortunately present in low and middle income countries (LMIC), where global health programs eschew local expertise due to issues such as long-standing colonialist attitudes or belief in the superiority of western knowledge and methods.[36] The CCPI highlights that the essential element behind their success was ensuring that dedicated Pacific staff were hired and appropriately paid to run the Coalition.[22] From these learnings it's clear that assistance provided by development partners in supporting the Coalition must acknowledge past issues of colonisation, respect Pacific local knowledge, leadership and decision-making, and ensure funding is directed to ensuring Pacific islanders are recruited to key Coalition roles. Dedicated and highly qualified Pacific personnel with strong knowledge of local culture and context will be needed to achieve robust scientific excellence in coalition activities. Importantly, use of the Framework facilitated stakeholders to underscore these issues and develop locally informed solutions and requirements to improve internal capacity-building and growth.

### Managing politics and power

Managing potential government desire to lead or override CSO agenda-setting, as documented in other health Coalitions, are important considerations when designing the Coalition organisational design and structure.[18,23] This was noted by stakeholders as a key potential barrier in Coalition establishment for the South Pacific. Harmonising national priorities with regional Pacific coalition priorities has proven difficult in other contexts such as the Alliance of Small Island States in advocating for climate change, where differences in country versus regional agendas limited action on key issues.[37]

Therefore Coalition goals must be broad enough to facilitate regional action, yet still be realistic and well-aligned with each PICT goals and strategies. Regionalism requires support from health leaders (both government and private sector) in all countries involved, as these leaders are skilled at identifying and advocating for what is needed in the Pacific context, and little momentum is likely to occur without their support.[2,5,18,35]

However, management of power imbalances, or existing political issues, particularly in terms of agenda-setting is an important consideration.[18,37] Levels of political influence and power can impact a nation or organisation's ability to effectively bargain or advocate for their needs, and poor political relationships can impact on successful collaborative decision-making.[18,37] Learnings from the CCPI highlighted that good leadership utilises a collaborative partnership structure, which will be important to consider when creating organisational design to ensure that stakeholder relationships remain cohesive and integrated across all hierarchies, systems and cultures, and to overcome potential power imbalances or political issues.[22,23]

### Overcoming barriers

Acquiring funding is challenging in a multi-national environment, and as identified, the Coalition is likely to be seen as a competitor for resources within an already scarce funding environment.[23] However, capitalising on identified facilitators, such as existing and diverse stakeholder relationships, can widen the range of funding opportunities outside of usual health avenues.[18] Likewise innovative use of technology can overcome multiple sustainability issues such as: travel, funding, and workforce capacity barriers endemic to the Pacific.[2] Health technologies such as telehealth provide evidence-based solutions to bridge the gap, by facilitating access for patients to healthcare irrespective of geographic location.[38] Further, development and/or utilisation and implementation of evidence-based consensus care guidelines, pathways and strategic frameworks for the delivery and strengthening of treatment and care services will be essential in overcoming existing barriers and gaps in cancer control.[39] Comprehensive scoping of necessary data and associated systems, such as cancer registries or mechanism, administrative, supply chain and workforce data, will be essential to ensure that Coalition activities are grounded in evidence and areas of unmet need. It is therefore recommended that future research focus on this issue as a priority.

### Framework application: global potential

Implementation and use of the Coalition Development Framework was successful in the Pacific Island context, with proposed activities resulting in anticipated outputs and deliverables. Evaluation of stakeholder use of the

framework in practice uncovered additional activities and outputs associated with developing robust monitoring and evaluation and strong governance systems. This resulted in amendments made to the Framework to further improve implementation in other settings, such as: ensuring diversity participation and perspective (particularly community and consumer involvement), and development of monitoring and evaluation and strong governance systems that will be essential to achieving success. Importantly, stakeholders in all nations found the Framework to be acceptable in assisting with building relationships and shared understandings across different political, geographical, social and cultural contexts. The Framework therefore has potential for application in facilitating cancer, and/or NCD Coalitions in other global contexts, particularly in small island states in other world regions. Future implementation and evaluation of the Framework in other contexts is therefore recommended.

## Limitations

It is important to note that some countries were represented by fewer than four stakeholders. While this is in part reflective of the low number of individuals working in cancer control in some areas (e.g. Tonga, Samoa); it is predominantly the result of the limited six-week data collection time-frame. Reduced engagement with and participation by stakeholders in Papua New Guinea and New Caledonia, in conjunction with project time and resourcing constraints which reduced capacity to engage with all other nations in the South Pacific must be noted as a key limitation of the study. It is recommended that next steps of Coalition development and implementation involve increased stakeholder engagement both within and across all nations within the South Pacific to review and confirm current findings.

## Conclusion

Our results describe the effective implementation and monitoring of a Coalition Development Framework in an applied setting. A regional cancer control Coalition for the South Pacific is wanted and, with appropriate funding, feasible. If momentum is continued, and a regional South Pacific Coalition established following the findings and recommendations from this project, the benefits in reducing the burden of cancer within the region will be substantial.

### Contributors

SA, AH, BC, CB, and SB conceived the study. Study design, methods and project planning was completed by all authors. AH and BC undertook data collection. AH analysed the data AH analysed the data, with this accessed and verified by SA and MV. AH drafted the publication RM and SA reviewed data analysis. All authors read and approved the final manuscript. AH, SA and MV were responsible for the decision to submit the manuscript.

### Data sharing statement

The datasets generated and/or analysed during the current study are not publicly available as maintaining privacy and confidentiality of both qualitative and quantitative data generated via coalition consultations was a condition of consent.

### Declaration of interests

The authors declare that they have no competing interests.

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### Appendix A. Supplementary data

Supplementary data related to this article can be found at https://doi.org/10.1016/j.lanwpc.2022.100681.

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