

FOCUSED ON THE FUTURE



ANNUAL REPORT 2021/22



CANADIAN
PARTNERSHIP
AGAINST CANCER



We have before us an unprecedented challenge and opportunity to transform health care, improve cancer outcomes for people living in Canada and achieve health equity.

Leadership message, page 3

CONTENTS

- 2 Leadership message
 - 4 Putting equity at the forefront of cancer care
 - 6 The Partnership's commitment to reconciliation
-

7 **2021/22 Year in review**

- 8 Accelerating innovation to support pandemic recovery
 - 10 Expanding access to palliative care
 - 12 Reducing barriers to colorectal cancer screening
 - 14 Eliminating cervical cancer
 - 16 Addressing the needs of cancer survivors
 - 18 Taking action to improve cancer care for First Nations, Inuit and Métis
 - 21 Other highlights
-

- 26 Pan-Canadian and international collaborations
- 29 Collaborating to advance cancer care
- 30 Board of Directors
- 32 Financial statements
- 43 Third parties
- 44 Materials published
- 46 Other reporting
- 47 References

ISSN 2369-3215 (Online)

Production of this report, and the programs described within it, has been made possible through a financial contribution from Health Canada. The views expressed herein represent the views of the Canadian Partnership Against Cancer.

LEADERSHIP **MESSAGE**

As successive waves of the COVID-19 pandemic continue to test cancer and health systems across Canada, the Canadian Partnership Against Cancer (the Partnership) has not wavered in its commitment to supporting partners and people with cancer.

We continue to build strong partnerships, create alignment on shared priorities and adopt fresh approaches with partners to achieve a more equitable and resilient cancer system.

In the Partnership's 15 years of experience as steward of the *Canadian Strategy for Cancer Control* (the Strategy) it continues to be clear that not all people in Canada are benefiting equally from advances in cancer control, and the COVID-19 pandemic has only deepened existing inequities.

This reality guides the Partnership's ongoing efforts to support partners as they respond to the pandemic, implement ongoing and new initiatives and plan for pandemic recovery.

In 2021/22, the Partnership continued to design, fund and implement initiatives to deliver on the priorities and actions of the Strategy. Despite delays caused by the pandemic, partners across Canada remained resolute in their efforts to eliminate cervical cancer, implement lung cancer screening programs, train paramedics to provide palliative care at home, provide smoking cessation supports to people with cancer and develop and implement cancer plans to improve the cancer journey and cancer outcomes for First Nations, Inuit and Métis. Work also began on the initiatives identified in the Partnership's new 2022-27 business plan.

Progress across these and other priority areas is the foundation on which we and our partners will build the next phase of our work together. The early days of the pandemic required real-time responsiveness and the years ahead will demand the same from us.

We continue important conversations with staff and our Board of Directors to sustain our commitment to reconciliation and continue our pursuit of diversity, equity and inclusion in all we do and how we do it.

We have before us an unprecedented challenge and opportunity to transform health care, improve cancer outcomes for people living in Canada and achieve health equity. The Partnership's 2022-27 business plan is a nimble and responsive framework that will help the Partnership support partners and the health system to tackle new and evolving challenges, while harnessing opportunities to innovate as we rebuild from the impact of the pandemic.

The priorities and actions set out in the Strategy are designed to align with the shared priorities of federal, provincial and territorial health systems and of people in Canada. Our business plan for the next five years is similarly grounded by the Strategy, and effective implementation will be reliant on four anchors: equity, pandemic recovery, stewardship and organizational excellence. Ongoing collaboration with federal, provincial and territorial governments and our pan-Canadian healthcare partners is essential to remaining aware of emerging challenges at this critical time, achieving our 2027 outcomes and supporting people in Canada at risk for cancer or who have been diagnosed with cancer.

Internally, we continue important conversations with staff and our Board of Directors to sustain our commitment to reconciliation and continue our pursuit of diversity, equity and inclusion in all we do and how we do it. We were saddened by news of children's remains found at former residential schools this past year and continue to ensure staff and board members receive cultural awareness training to support the journey of reconciliation. We created a multi-year diversity, equity and inclusion roadmap to ensure a diversity, equity and inclusion lens underpins all of our work at the Partnership and with partners. The Board of Directors also approved a Diversity, Equity and Inclusion and Reconciliation Action Plan, including actionable practices, to embed these principles and accountabilities in all aspects of their work.

Strong leadership from hundreds of partners and advisors, our Board of Directors and Partnership staff is foundational to achieving the Strategy's shared vision—a future in which people in Canada have equitable access to quality cancer care, fewer people develop cancer, more people survive cancer and those living with the disease have a better quality of life. It is with great pleasure that we confirm the Partnership's work in the coming year will be guided by incoming Board Chair Jeff Zweig. Jeff joined the Partnership's Board of Directors in 2016 and is genuinely passionate about achieving the Strategy's vision. We would also like to extend our sincerest gratitude to former CEO Cynthia Morton—who retired in November 2021—for her tireless efforts to champion health equity and keep patients connected to their care team during the COVID-19 pandemic.

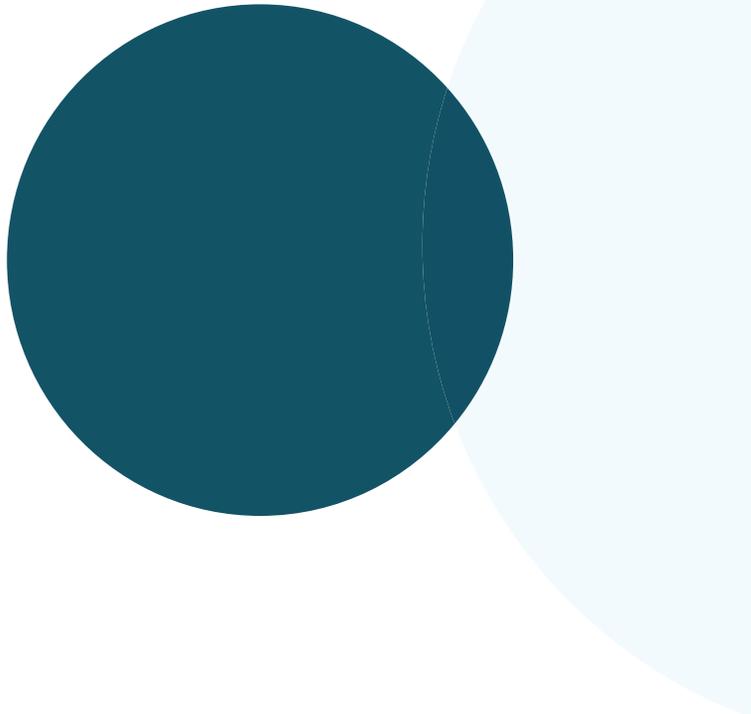
As we shift our attention to the next phase of implementing the Strategy, we thank you for your commitment to better meet the needs of all people in Canada affected by cancer.

Dr. Graham Sher, O.C.
Chair



Dr. Craig Earle
Chief Executive Officer





PUTTING EQUITY AT THE FOREFRONT OF CANCER CARE

In Canada, we have come to expect excellence from our healthcare system, and cancer care is no exception. But the system's resilience was tested by the COVID-19 pandemic, and longstanding inequities within the system have deepened.

It's been 15 years since the cancer community began working together to achieve the goals of the *Canadian Strategy for Cancer Control* (the Strategy), and the pandemic made clear once again the value of this collaborative approach. Together, the Partnership and its partners supported patients and families—and the cancer and health systems—through successive waves of the COVID-19 pandemic.

This commitment to collaborative action and a shared vision of the changes needed to better support people with cancer have led to many advances across the system. This year, the Partnership sustained that momentum as it delivered on 2022 outcomes, while supporting pandemic recovery and planning and implementing work on priorities set out in the refreshed Strategy.

ADDRESSING DISPARITIES IN ACCESS, EXPERIENCE AND OUTCOMES

Despite significant improvements in cancer control, not everyone in Canada is benefiting equally. Some populations continue to face systemic barriers to high-quality care—and the resulting disparities in access, experience and outcomes are all too real.

The Partnership's work is firmly anchored in the Strategy's focus on achieving equitable access to quality cancer care for all people in Canada. All programs of work prioritize First Nations, Inuit and Métis and equity-deserving populations, including recent immigrants, racialized communities and people who live in rural and remote areas. With support from the Partnership, partners led the following equity-advancing initiatives in 2021/22:

- **Taking action on self-determined priorities:** Developing and implementing First Nations, Inuit and Métis Peoples-specific, self-determined cancer strategies and priorities
- **Implementing Canada's action plan to eliminate cervical cancer:** Engaging with communities with lower HPV immunization rates to remove barriers to vaccination and planning for HPV primary screening for cervical cancer, including self-sampling in some jurisdictions
- **Working to increase screening rates for colorectal cancer:** Partnering with community leaders and organizations in communities experiencing inequities to increase participation in colorectal cancer screening programs

Staff and board members have all received cultural awareness training and First Nations, Inuit and Métis priorities are integrated in the early stages of all work.

- **Making lung cancer screening accessible:** Working with First Nations, Inuit and Métis and communities at high risk for lung cancer to ensure that lung cancer screening programs are developed to address their needs and include integrated smoking cessation support
- **Facilitating pandemic recovery:** Identifying and implementing innovative strategies to reduce pandemic screening backlogs while contributing to increased health equity over the longer term
- **Supporting new approaches to cancer care:** Planning for the implementation of innovative models of care that support equitable access, experience and outcomes, while addressing health human resource challenges exacerbated by the pandemic.

This work, together with initiatives in the 2022-27 business plan, will help ensure a high-quality and sustainable cancer system that delivers equitable access, experience and outcomes to all people in Canada.

A fuller picture of these initiatives and other accomplishments with partners in 2021/22 is presented in the pages that follow.

PRIORITIZING HEALTH EQUITY: FROM WORDS TO ACTION

Health equity is at the forefront as the Partnership moves forward with its 2022-27 work—and that requires new ways of thinking and working. The Partnership has adopted a health equity approach so that planning and implementation of new initiatives prioritizes systemically excluded populations.

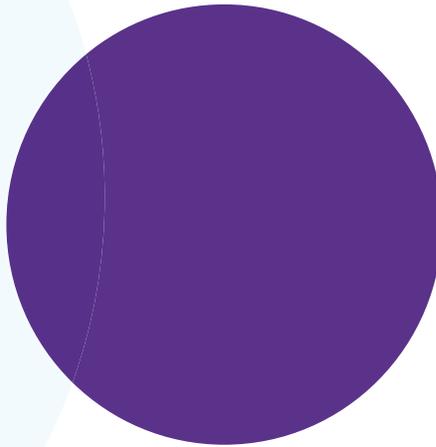
Prioritizing health equity recognizes that a multi-faceted approach is needed to achieve change. It requires understanding inequities and barriers experienced by populations who have been systemically excluded, ensuring the right partners are engaged and building on the strengths of these communities to co-create and co-implement solutions to achieve health equity.

The Partnership has prioritized development of awareness and skills, and staff have received foundational training in diversity, equity and inclusion and continue to build their own capacity. Policies and practices have been reviewed and refreshed, and a health equity framework is being developed to guide all initiatives and ensure accountability for the Partnership and partners.

The focus on health equity is also guiding the process for planning new work. The Partnership will co-create project proposals with partners to address identified inequities; and partners will also be encouraged to invite community and equity-focused organizations to the planning table and actively engage them in planning and implementation.

These efforts are strengthened by the Partnership's continued commitment to reconciliation through meaningful engagement with First Nations, Inuit and Métis partners. Staff and board members have all received cultural awareness training and First Nations, Inuit and Métis priorities are integrated in the early stages of all work.

Canada's cancer system **can** deliver equitable access, experience and outcomes. Work has already begun.



THE PARTNERSHIP'S COMMITMENT TO RECONCILIATION

The Canadian Partnership Against Cancer acknowledges that colonial practices and policies continue to impact the well-being of generations of First Nations, Inuit and Métis.

First Nations, Inuit and Métis governments, organizations and communities are leading the work that will result in improved well-being with the development and implementation of Peoples-specific, self-determined solutions. Supporting this work is key to sustainable system change and to closing the gaps in cancer care and outcomes between First Nations, Inuit and Métis and other people in Canada.

We are committed to working in a reconciliatory way with First Nations, Inuit and Métis to improve the cancer system by:

- Implementing the Truth and Reconciliation Commission of Canada's calls to action
- Supporting self-determined, regional and Peoples-specific priorities in the *Canadian Strategy for Cancer Control*
- Supporting partners in their efforts to improve the quality of life and health outcomes of all First Nations, Inuit and Métis patients and families
- Encouraging an organization-wide approach to implementing the *Canadian Strategy for Cancer Control* guided by First Nations, Inuit and Métis governments, organizations, advisors and partners and supported by ongoing, mandatory cultural competency training for Partnership staff





2021/22

YEAR IN
REVIEW

Current initiatives are advancing the priorities and actions of the *Canadian Strategy for Cancer Control*, prioritizing health equity and supporting pandemic recovery.



ACCELERATING INNOVATION TO SUPPORT PANDEMIC RECOVERY

The COVID-19 pandemic fundamentally disrupted the cancer system, leading to delays, backlogs and growing inequities.

The Partnership is working with partners to address the ongoing impact, while building a resilient and equitable system for the future.

The disruptions caused by the pandemic were swift and far-reaching—school-based HPV immunization and cancer screening programs paused, surgeries postponed or cancelled, and cancer symptoms missed as many people were unable to see specialists or their primary care providers in person. In a 2021 survey by the Canadian Cancer Survivor Network, half of all cancer patients said their care appointments had been cancelled, postponed or rescheduled.¹

Up to

40%

fewer cancer screening tests were conducted in 2020 than in 2019

Cancer surgeries decreased by almost

30%

in April and May 2020

The impact of these disruptions will be long-lasting. For example, Partnership modelling shows that as a result of decreased screening in the first wave of the pandemic alone, an additional 3,200 people could be diagnosed with colorectal cancer and an additional 550 people could be diagnosed with late-stage breast cancer between 2020 and 2029. The longer screening is delayed, the more cancers and the more later-stage cancers will be detected, leading to more cancer deaths that could have been avoided.²

RESPONDING AND INNOVATING

Throughout the pandemic, the Partnership worked with partners to accelerate innovations that would support safe delivery of cancer services, while contributing to increased health equity and quality of care over the longer term. These include actions to decrease false positive rates for mammograms, to support wider use of mail-out fecal tests to screen for colorectal cancer and shift to HPV primary testing for cervical cancer (which allows for self-sampling).

As screening resumed, jurisdictions moved quickly to identify and implement strategies to reduce breast and colorectal screening backlogs. In 2021/22, the Partnership used its OncoSim simulation tool to model the potential impacts and outcomes of different strategies to help jurisdictions in their decision-making. The Partnership also continued to facilitate shared learning, bringing jurisdictions together to discuss the impact of successive waves of the pandemic and innovative approaches to screening backlog recovery.

PRIORITIZING CANCER CARE

As the pandemic continues to evolve, government decision-makers face competing pressures in determining where to allocate resources in the post-pandemic era. A new online resource developed by the Partnership this past year makes the case for prioritizing cancer due to the burden of disease and the magnitude of avoidable deaths. [The road to recovery: Cancer in the COVID-19 era](#) focuses on three areas that require increased attention from policy-makers and cancer care leaders:

- **Solving health human resource shortages:** Burnout and attrition among cancer care providers, particularly nurses, therapists and technicians, are affecting the ability of the cancer system to meet current needs.

- **Preparing for the surge in cancer cases:** The system will need more capacity to respond optimally to the potential surge in cases and delayed care needs caused by screening, diagnosis and treatment disruptions.
- **Leveraging the potential of new models of care:** New models of care that deliver more efficient, equitable care with existing resources can help address capacity and access issues, but investment is required.

Equally important, *The road to recovery* acknowledges that COVID-19 has not affected everyone equally and that existing inequities have been further exacerbated by the pandemic. It also describes challenges faced by First Nations, Inuit and Métis, and shares community responses to keep community members safe during the pandemic while ensuring healthcare needs are met.

Using data and examples of innovative solutions from across the country, *Road to recovery* identifies areas of focus and potential actions needed to address the challenges ahead and highlights ways that health equity can be at the forefront of Canada's pandemic recovery.

ADDRESSING EMERGING NEEDS

As the focus shifts to recovery, the Partnership will continue to support partners as they adapt to the realities of the post-pandemic health system. At the same time, the Partnership will prioritize strategies to improve health equity and support the adoption of new and effective models of care to help reduce pressure on health human resources across the system. The Partnership's new business plan will guide this work over the next five years, as it continues its role as steward of the *Canadian Strategy for Cancer Control* and works with partners to advance the refreshed Strategy's priorities and actions.



EXPANDING ACCESS TO PALLIATIVE CARE

Palliative care provides patients with support for the physical and emotional symptoms that can make the cancer experience more difficult.

However, access to palliative care varies dramatically across the country, and people in rural and remote communities are particularly challenged when it comes to finding and accessing supports. An innovative model of care supported by the Partnership and Healthcare Excellence Canada (HEC) is helping to change that.

Over

7,000

paramedics trained in palliative care, 2,000 more than originally planned

93%

of patients in centres that implemented patient-reported outcomes (PROs) can report on their symptoms so they get the supports they need

DELIVERING PALLIATIVE CARE AT HOME

For patients with palliative care needs who prefer to have their pain and symptoms managed at home, urgent problems such as pain or difficulty breathing often require a 911 call and a trip to the emergency department for relief. Now paramedics are receiving palliative care training so they can assess and treat patients at home.

The model was first introduced in Alberta, Nova Scotia and Prince Edward Island, and has since expanded to six additional jurisdictions (British Columbia, Saskatchewan, Manitoba, Ontario, New Brunswick and Newfoundland and Labrador), who have trained more than 7,000 paramedics to date. This successful program also continues to evolve. For example, during the pandemic, the program took on added significance as healthcare systems tried to keep patients out of hospital whenever possible. As a result, the British Columbia program that began in five regions has since rolled out province-wide. And in Newfoundland and Labrador, the program launched in the St. John's area has now been adapted to fit the needs of 16 surrounding rural communities.

With the program implemented across the country, work is underway to ensure its sustainability and further spread. For example, Saskatchewan has embedded the training program into its standard curriculum for paramedics. The Partnership and HEC have also developed an extensive [change package](#) to guide paramedic services interested in applying this approach to care within and beyond the cancer care system. The resource summarizes the core elements required to implement the model, as well as experiences and learnings from teams who have successfully implemented the approach.

INTRODUCING PALLIATIVE CARE EARLIER

Palliative care is not just about end-of-life care. High-quality palliative care focuses on identifying and providing the supports people need as early as possible, so they can live as fully and comfortably as possible throughout their cancer journey.

Patient-reported outcomes (PROs) measurement tools help identify patients who would benefit from palliative care by screening for symptoms such as pain, fatigue, nausea and depression. The Partnership has supported seven jurisdictions—Yukon, Northwest Territories, British Columbia, Saskatchewan, Nova Scotia, Prince Edward Island and Newfoundland and Labrador—to expand their use of PROs

with a particular focus on earlier introduction of palliative care. Much of this effort has been on palliative care training for clinicians, and skills have improved significantly. For example, 71 per cent of healthcare providers have increased their capacity to manage symptoms.

IMPLEMENTING A NATIONAL PALLIATIVE CARE STANDARD

Symptom management is one example of the skills and knowledge (competencies) required to deliver high-quality palliative care. Together with Health Canada, the BC Centre for Palliative Care and Pallium Canada, the Partnership established a national standard for these competencies with the [Canadian interdisciplinary palliative care competency framework](#), released this past year.

Over 20 national and provincial healthcare organizations have endorsed the standards to date, and partners have started to implement and embed the competencies and self-assessment tools within curricula, hiring practices and accreditation standards. For example, Yukon is using self-assessments with palliative care nurses and long-term care staff to identify gaps in their palliative care knowledge so that targeted training can be developed. The framework also informed Accreditation Canada's new long-term care standard.

In addition, the Partnership is developing a digital learning app with Pallium Canada, a leader in palliative care education. The app will allow healthcare providers to do a self-assessment and then connect them to a library of content to meet their learning needs.

PROVIDING CULTURALLY SAFE PALLIATIVE CARE

Improving access to palliative care also means improving access to culturally safe palliative care in collaboration with First Nations, Inuit and Métis.

To begin this work, the Partnership brought together First Nations, Inuit and Métis Elders and Knowledge Carriers, Indigenous health professional associations, palliative and home care organizations, community health professionals and researchers. The meetings identified gaps that need to be addressed, as well as leading practices in palliative care that currently exist within Indigenous communities. A resource on best practices in palliative care for First Nations, Inuit and Métis is being developed.



REDUCING BARRIERS TO COLORECTAL CANCER SCREENING

Colorectal cancer is one of the most treatable cancers if caught early. But not enough people in Canada participate in regular screening.

In fact, even where screening rates are highest, only 55 per cent of those who are eligible take advantage of organized screening programs.³ The reality is that many people face barriers that make it difficult for them to participate. These barriers are often complex and influenced by social determinants of health such as income, geography and immigration status, as well as cultural sensitivities. Addressing them requires focused efforts at the community level to understand the issues and work with communities to co-create solutions.

2X

Screening participation doubled in the northern region of Northwest Territories through a community-informed awareness campaign

Wait times for colonoscopy in Saskatoon reduced by

49%

through a centralized waitlist and scheduling system

BREAKING DOWN BARRIERS

With funding from the Partnership, five jurisdictions (Northwest Territories, Alberta, Manitoba, New Brunswick and Newfoundland and Labrador) have engaged with First Nations, Inuit and Métis and other partners, as well as populations experiencing inequities, to co-develop approaches that meet the needs of those communities. They're already seeing progress.

Northwest Territories used the opportunity to implement its first organized colorectal cancer screening program. Working closely with local community health representatives, healthcare providers and trusted community members, Northwest Territories launched a localized, culturally appropriate community awareness campaign in its most northern region—an area with the lowest colorectal cancer screening rates in the territories. Colorectal screening programs rely on a simple fecal test (FIT) that individuals complete at home and return for processing. The campaign launched ahead of the distribution of the FIT kits and included posters in Gwich'in, Inuvialuktun, French and English languages, newspaper and radio ads, social media posts and local community champions. The result was encouraging: screening participation rates doubled, and the lessons learned will be used to support rollout to all remaining regions in the Northwest Territories.

In Newfoundland and Labrador, screening data was analyzed to identify areas of the province with lower screening participation. The team then engaged with community partners, Indigenous communities and primary care providers (including those serving people who are homeless, refugees and populations that have been underserved) on strategies to improve participation. To address literacy and language issues, illustrated instructions were developed for FIT kits, and instructions were also translated into Innu and Inuit.

CREATING A RESILIENT SCREENING SYSTEM

The COVID-19 pandemic presented additional challenges to screening participation across the country. Many programs were paused or reduced their capacity; others had to make significant changes. Partnership funding allowed Alberta to switch to mail-out tests so people did not have to visit their family doctor to pick up a kit—an ongoing concern during COVID-19. Manitoba will soon follow.

The move to mail-out tests has an added benefit: fewer barriers to participation. People don't have to juggle work and childcare schedules to pick up a test during office hours and people who live in rural and remote areas no longer have to travel to a doctor's office.

REDUCING WAIT TIMES FOR COLONOSCOPY

Increasing the number of people completing fecal tests is only one step in the early detection of colorectal cancer. Individuals with an abnormal test result must also have timely access to a colonoscopy to confirm or rule out cancer. Funding from the Partnership has allowed six jurisdictions (Yukon, Saskatchewan, Manitoba, Quebec, Nova Scotia and Prince Edward Island) to take steps to reduce wait times.

For example, Saskatchewan piloted a centralized waitlist and scheduling system in Saskatoon that prioritizes patients with suspicion of colorectal cancer and makes it easy to fill spots that open up due to cancellations. As a result of the new system, wait times have been reduced by 49 per cent, despite pandemic disruptions. And in Manitoba, the province's screening program was expanded to create a single point of entry for all individuals at risk of colorectal cancer, with updated screening guidelines and pathways to ensure they receive appropriate and timely care.

MONITORING QUALITY INDICATORS

Screening programs must continually monitor their performance to ensure quality and evaluate the effectiveness of efforts to increase screening participation. To support this process, the Partnership relaunched its screening monitoring report in 2021/22 in a streamlined, digital format. Released every two years, [the report](#) allows programs across the country to assess their performance against their peers, identify areas where attention is needed and learn from the experience of other jurisdictions.



ELIMINATING CERVICAL CANCER

Canada is on its way to eliminating cervical cancer by 2040.

To reach that goal, partners across the country are taking action on the key priorities in Canada's [Action Plan for the Elimination of Cervical Cancer in Canada](#): improving human papillomavirus (HPV) vaccination rates and implementing primary HPV screening with appropriate and timely follow-up.

But cervical cancer will only be eliminated if everyone has equitable access to the highest quality prevention, screening and care. Currently, the incidence of cervical cancer is higher among people living in rural or remote areas, people with lower income, recent immigrants and First Nations, Inuit and Métis.⁴ That has to change.

WITH FUNDING FROM THE PARTNERSHIP:

3

National organizations are identifying strategies to increase HPV vaccination among under-immunized groups

7

Provinces are planning for transition to HPV primary testing

1

National organization is developing guidelines to improve follow-up care for people testing positive for HPV

IMPROVING VACCINATION RATES

Most cervical cancer is caused by HPV, a common sexually transmitted infection. The good news is that HPV vaccination can prevent more than 90 per cent of cases, and Canada has set a target to vaccinate 90 per cent of 17-year-olds by 2025.

However, HPV vaccination rates vary across the country, a problem that worsened during the COVID-19 pandemic as school-based vaccination programs were put on hold. For example, in Ontario, vaccination rates dropped from about 60 per cent of 12-year-olds in 2018/19 to less than one per cent in 2020/21.⁵

To meet immunization goals, the Partnership has funded three national groups—the Urban Public Health Network; the Rural, Remote and Northern Public Health Network; and the Public Health Physicians of Canada—to examine regional data to better understand who isn't being vaccinated and why. Insights will also be gathered from focus groups with youth and parents in under-immunized groups, leaders of school-based immunization programs and others. The aim is to identify barriers that prevent youth from participating in existing programs, as well as potential solutions to boost immunization rates.

The Urban Public Health Network, which includes medical officers of health from Canada's largest urban centres, is building relationships with First Nations, Inuit and Métis organizations and governments in both urban and rural areas to understand barriers to HPV immunization uptake and how to address them. This engagement has laid the foundation for long-lasting, sustainable partnerships that will support data-sharing and the co-creation of strategies to address barriers to vaccine uptake in those communities.

ADDRESSING EQUITY BY EXPANDING VACCINE ACCESS

School programs don't reach everyone—and the pandemic has added to the challenge. While some provinces and territories provide publicly funded catch-up programs for young people who miss out, eligibility varies. For those who don't qualify, the cost can be significant: up to \$300 for each of the two to three doses required.⁶ Expanding eligibility to all young people and making vaccines available in more locations would improve uptake, and the Partnership has provided evidence to support this shift.

As part of this work, the Partnership developed a resource on HPV immunization to assist governments, public health, health organizations and others involved in the issue. The

resource provides an overview of the evidence on HPV immunization, barriers to access and eligibility for publicly funded vaccination.

SHIFTING TO HPV PRIMARY TESTING

The elimination of cervical cancer also depends on moving from Pap tests to HPV tests as the primary screening tool. HPV screening identifies pre-cancers earlier. This allows for earlier intervention, if needed, which in turn results in a lower chance of developing cervical cancer.⁷ The Partnership is funding seven provinces (British Columbia, Saskatchewan, Manitoba, New Brunswick, Nova Scotia, Prince Edward Island and Newfoundland and Labrador) to help them make the transition.

Most provinces are currently in the planning phase and many have faced delays due to COVID-19. Some will be implementing self-sampling, which allows people to collect their own sample at home or in a clinic setting. Self-sampling is a valuable tool in improving equitable access to screening, providing what could be a more acceptable option for individuals with a history of trauma or discrimination, people living in rural or remote areas and those without a primary care provider.

British Columbia launched an HPV primary screening self-sampling pilot in 2021/22 and is engaging First Nations and Métis, as well as diverse populations, to gather valuable information on the supports and processes required by patients and providers. The province is already sharing its approach and experience with other jurisdictions.

As provinces put their plans in place, they can also learn from countries like the Netherlands, Australia and the United Kingdom, which have already implemented HPV primary screening. The Partnership conducted an [environmental scan](#) to identify these learnings and successful strategies that could be adapted for the Canadian context. The Partnership also collaborated with the Canadian Agency for Drugs and Technologies in Health (CADTH) on an [evidence review of self-sampling devices](#) to look at important topics such as availability, cost-effectiveness and patient and provider experience and acceptability.

Work is also underway to ensure that people who test positive for HPV receive appropriate follow-up. The Partnership is funding the Society of Gynecologic Oncology of Canada to develop national clinical guidelines for referring these individuals for colposcopy, the primary follow-up test.



ADDRESSING THE NEEDS OF CANCER SURVIVORS

With improvements in finding and treating cancer, more people with cancer are living long lives.

But finding their “new normal” can be challenging, and cancer survivors often have difficulty getting the supports they need.

Primary and community care professionals are key partners in supporting people once their cancer treatment ends, and the Partnership is helping providers fulfill that role.

THE PARTNERSHIP AND THE MENTAL HEALTH COMMISSION OF CANADA ARE RAISING AWARENESS ABOUT THE CONNECTION BETWEEN MENTAL HEALTH AND CANCER:

1 IN 5

Canadians experience a mental health problem each year, and the risk is higher for people living with cancer

People treated for cancer are

2X

as likely to have depression and anxiety

IMPROVING CONTINUITY OF CARE

Following treatment, people with cancer return to their primary care provider. However, there is often a lack of coordination and communication between cancer centres and primary care about what care is required. Primary care providers may also lack the knowledge or time to provide psychosocial support and be unaware of resources in the community. As a result, cancer survivors and their families don't always get the care and support they need for their physical, mental, emotional and practical needs.

A Partnership-funded pilot project in Quebec is working to improve continuity of care and provide survivors with personalized support as they transition out of the cancer care setting. Members of the cancer centre team ensure they transfer information about the patient's cancer, treatment and follow-up care to the primary care provider through the use of tools and templates. Patients have access to a digital toolkit of educational resources and supports, as well as access to a nurse navigator and community resources.

In Alberta, the Partnership is supporting change management for an existing province-wide initiative designed to break down the traditional silos of oncology and primary care. The initiative ensures that primary care providers receive transfer letters from cancer centres with information on follow-up care and are knowledgeable about guidelines for survivorship care and patient resources.

ADDRESSING MENTAL HEALTH NEEDS

Cancer survivors are more likely to experience mental health issues than people without cancer. In fact, it's estimated that people treated for cancer are twice as likely to have depression and anxiety.⁸ This past year, the Partnership and the Mental Health Commission of Canada partnered on several resources that explore the relationship between mental health and cancer (and other chronic diseases). The in-depth report and fact sheets will help to raise awareness among primary care providers, community agencies and policy-makers about the importance of mental health screening throughout the cancer journey and the need for quality mental services to support survivors and their families.

The Partnership is also funding the Canadian Cancer Society (CCS) to help survivors find existing mental health and survivorship resources. The CCS is working with partners to ensure people with cancer are routinely referred to the CCS's Cancer Information Helpline and Community Service Locator (CSL). The helpline and CSL connect people to resources near them, including support groups and counselling.

THE ECONOMIC BURDEN OF CANCER ON PEOPLE WITH CANCER AND THEIR FAMILIES

A study completed by the Partnership in 2021/22 reveals that for individuals, the impact of cancer is not only physical and emotional—but also financial.

Most studies on the economic burden of cancer have focused on costs to the health system. However, a Partnership study has demonstrated that a third of the financial burden is carried by people with cancer and their families.

People with cancer have to pay for many cancer-related expenses themselves, including medications, at-home care and the costs of attending appointments. They also may be unable to work for extended periods of time, resulting in lost income. While the study found that the burden is highest in the first year after diagnosis, costs often continue to be high in subsequent years.

This combination of out-of-pocket expenses and lost income makes cancer care unaffordable for many people, particularly for those with low income. By providing a better picture of the economic burden of cancer, the Partnership hopes to drive policy solutions that ensure all people with cancer receive access to the supports they need.



TAKING ACTION TO IMPROVE CANCER CARE FOR FIRST NATIONS, INUIT AND MÉTIS

Canada's cancer strategy is focused on meaningful change to improve cancer care and outcomes for First Nations, Inuit and Métis.

And change is happening. The Partnership is funding 29 partners to take action on Peoples-specific, self-determined priorities and initiatives across the country. Over 130 Indigenous governments, organizations and community partners are involved, and more than 500 communities will benefit.

MOVING FORWARD ON SELF-DETERMINED PRIORITIES

Partners are developing Peoples-specific cancer plans or implementing existing plans in all 13 provinces and territories and leading work towards self-determined priorities. As part of this work, partner-led initiatives are addressing all aspects of the patient journey.

Several projects completed their work in 2021/22, for example:

- **Promoting smoking cessation and healthy living:** The Métis Nation of Ontario developed a number of Métis-specific resources, including tobacco cessation supports, healthy living workshops with training for facilitators to ensure ongoing delivery, and a "Champions of Change" video series highlighting stories of Métis citizens.
- **Developing smoking cessation services:** The Canadian Cancer Society worked with First Nations, Inuit, Métis and urban Indigenous community partners in Ontario, Saskatchewan and Manitoba to develop and implement Talk Tobacco, which provides telephone, text and live-chat smoking/vaping cessation supports and online resources.

Other work underway includes:

- **Establishing an organized colorectal screening program in Nunavut:** Plans for a territory-wide screening program are well underway; the program's business plan was approved by the territorial legislature and permanent staff have been hired to develop and manage the program.
- **Developing a culturally appropriate screening awareness campaign in British Columbia:** To increase cancer screening rates among First Nations, the First Nations Health Authority is launching an awareness campaign that reflects the needs of Indigenous people and uses culturally appropriate images and messaging.
- **Developing a First Nations cancer plan in New Brunswick:** Neqotkuk Health Center is leading the development of a comprehensive cancer plan through partnerships with a broad group of stakeholders, including the 16 First Nations communities in the province, tribal councils and Indigenous organizations, the New Brunswick Cancer Network, regional health authorities and non-profit cancer organizations.
- **Improving the journey to diagnosis in Labrador:** Labrador Indigenous partners are working to improve the pre-diagnosis journey for Innu and Inuit through community engagement, including developing tools and resources to support people with cancer and their families.

Despite project delays due to COVID-19, partner relationships have remained strong thanks to virtual connections, and the Partnership continues to provide ongoing support. As part of that support, the Partnership hosted two knowledge-sharing workshops where partners could share successes and challenges and discuss how to build sustainability within and beyond their projects.

The Partnership also continues to co-host meetings with leads for Indigenous health from other pan-Canadian health organizations to explore opportunities to enhance collaboration with First Nations, Inuit and Métis partners, while avoiding duplication among organizations.

SUPPORTING INDIGENOUS-GOVERNED RESEARCH AND DATA SYSTEMS

Peoples-specific, self-determined data is key to quantifying disparities and supporting community-led efforts to improve First Nations, Inuit and Métis access, experience and outcomes in cancer care. That's one of the reasons First Nations-, Inuit- and Métis-governed research and data systems are an identified priority in Canada's cancer strategy.

To better understand how to support this work, the Partnership funded the Alberta First Nations Information Governance Centre to complete an environmental scan and conduct interviews and focus groups with Indigenous data and research experts, Knowledge Keepers and Elders. The work will identify current gaps in First Nations, Inuit and Métis cancer control data and research, as well as best and promising practices that can be supported and spread.

Many promising approaches for Indigenous-led data governance are already underway across the country. Two partners, Métis Nation Saskatchewan and the Saskatchewan Cancer Agency (SCA), have signed a data-sharing agreement and are partnering with the University of Saskatchewan and the Partnership on a unique data project to improve cancer surveillance. The project will link Métis Citizen information with patient and client profiles in SCA's cancer registry and screening databases, allowing cancer incidence in the Métis population of Saskatchewan to be monitored and providing valuable information for targeted programs and services.



“Using engagement data from 2018 and 2019 community consultations, we launched a Cancer Journey Guidebook and a Cancer Journey Video Resource to support Métis Albertans and their loved ones on a cancer journey. Through funding from CPAC, we have witnessed increased uptake for our Cancer Transportation Program. This program offers financial assistance to Métis Albertans traveling for cancer-related appointments.”

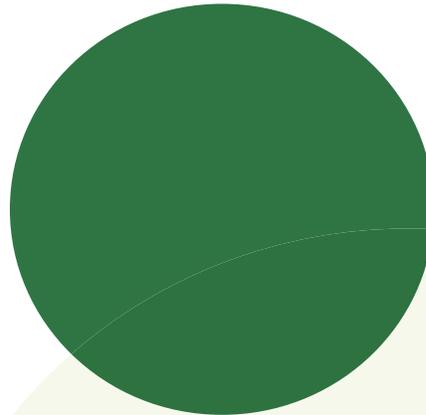
MÉTIS NATION ALBERTA

“The First Nations of Quebec and Labrador Health and Social Services Commission supports the First Nations communities of Quebec in the implementation of community-based cancer control projects, notably through training activities and exchange sessions on cancer prevention, screening and control. Several initiatives are funded in the communities, some of which are focused on cancer screening, prevention, tobacco control and sun safety.”

FIRST NATIONS OF QUEBEC AND LABRADOR

“As CINA collaborates with CPAC to act on the priorities of the Strategy for the Indigenous health system, we recognize the unique contributions and knowledge of all contributors. A meaningful, strategic partnership enables teams to bring the best of their talent and strengths forward and it’s rewarding to see functional and creative solutions unfold. Together, we have leveraged open and effective communication channels between CINA and CPAC to align on expectations. The learning opportunities for all partners have been a welcome journey.”

CANADIAN INDIGENOUS NURSES ASSOCIATION



OTHER HIGHLIGHTS



IMPLEMENTING INNOVATIVE MODELS OF CARE

Across Canada, jurisdictions are looking for new models of cancer care that support quality and efficiency and achieve health equity for systemically excluded populations. The need for innovative approaches has become even more pronounced since the pandemic, which widened inequities and further challenged a system already struggling to meet demand.

New models of care deliver services using innovative approaches that better meet the needs of people with cancer and use health system resources more effectively, such as training family physicians to deliver chemotherapy (supervised remotely by medical oncologists) or having nurse practitioners coordinate follow-up care in rural communities.

Through wide consultation with jurisdictions and others, the Partnership identified common challenges and areas where new models of care are needed, including:

- Improving coordination between the cancer system and primary care to better support people with cancer
- Optimizing the scopes of practice for cancer team members to address staffing shortages and provide care closer to home
- Using network models to expand access to specialized services and person-centred care.

The Partnership's new [Models of Care Toolkit](#), launched in 2021/22, shares examples of innovative care models and best practices in Canada and internationally that address these needs and highlights where new approaches to virtual care and patient navigation can further enhance care. Each example provides a description of the model, where it is being used and who to connect with to learn more. The tool also includes guidance on engaging First Nations, Inuit and Métis to identify and implement culturally safe models of care.

Over the next five years, the Partnership will invest \$13 million in new models of care across Canada; the ideas and information in the toolkit will help health system leaders to develop these projects.

In addition, the Partnership continues to develop OncoLocate, a geo-mapping tool that maps the location of cancer specialists such as oncologists, pathologists and select surgical specialties against local data on cancer burden (new cases, deaths, prevalence). The tool will help jurisdictions to better identify where there are health human resources supply and demand issues and will inform how new or existing innovative models of care can be applied to improve access to care, support efficiencies in the system and support equitable cancer care.



IMPLEMENTING LUNG CANCER SCREENING PROGRAMS ACROSS CANADA

Lung cancer is the leading cause of cancer death in Canada. However, early diagnosis dramatically increases survival. In fact, screening people at high risk can reduce deaths from lung cancer by up to 24 per cent.

As a result, provinces across Canada are moving quickly to establish organized lung cancer screening programs for people at high risk for this disease. Ontario was the first to launch, building on an earlier pilot to establish the program at four sites in 2021. With support from the Partnership, other provinces are not far behind. In spring 2022, British Columbia launched a province-wide program, and screening is underway at seven sites in Quebec as part of a pilot that will guide implementation across the province. Partners in Alberta, Saskatchewan, Manitoba, New Brunswick, Nova Scotia, Prince Edward Island and Newfoundland and Labrador are also working on their own plans for pilots or programs. All will benefit from Ontario's experience and expertise; with funding from the Partnership, Ontario's program is providing other jurisdictions with resources, one-on-one support and educational sessions on issues such as patient recruitment and quality assurance.

The need for lung cancer screening among First Nations, Inuit and Métis is particularly acute. First Nations, Inuit and Métis are disproportionately impacted by lung cancer, and provinces are working closely with these communities to ensure programs address their specific needs. Smoking-cessation supports, including culturally appropriate supports, will also be an integral part of all lung cancer screening programs.

As the number of organized lung cancer screening programs across the country continues to grow, the Partnership is putting in place infrastructure to support consistent, high-quality screening across all programs. For example, the Partnership funded the Canadian Association of Radiologists and the Canadian Society of Thoracic Radiology to develop a lung cancer screening accreditation program, and educational modules for quality assurance are also under development.



HELPING PEOPLE WITH CANCER TO QUIT SMOKING

When a person with cancer stops smoking, their treatment becomes more effective and their chance of survival increases. Across the country, cancer centres are helping them to quit. Over the past five years, funding from the Partnership has allowed centres to expand this support significantly: 87 per cent of cancer centres now integrate smoking cessation supports into their outpatient settings, up from 26 per cent in 2016.

However, more needs to be done. Smoking cessation medications can more than double the likelihood that someone will quit smoking,⁹ but many people aren't able to access or pay for these medications. Funding from the Partnership allowed several provinces to provide free smoking cessation medications during the pandemic—including by mail—when in-person smoking cessation counselling was suspended. However, few jurisdictions offer free medication to people with cancer on an ongoing basis.

To address this gap, the Partnership created a [business case](#) to help cancer centres make the case that all people with cancer should receive free smoking cessation medications where they receive cancer care. In response, one jurisdiction—the Northwest Territories—has already taken action to address the access challenges faced by people in remote areas. While the territory covers the cost of smoking cessation medications, people experience difficulty getting them. Few remote communities have a pharmacy, and community health centres can only supply medications that are listed on the territorial formulary. Northwest Territories has now revised the formulary and plans to make the medications available at health centres across the territory.

The Partnership is also working to improve supports for First Nations, Inuit and Métis across the country. Cancer centres have started partnering with First Nations, Inuit and Métis organizations and communities to expand the availability and quality of culturally appropriate smoking cessation supports; 45 per cent of cancer care settings now offer these supports.



IMPROVING QUALITY THROUGH SYNOPTIC REPORTING

For more than a decade, the Partnership has played a leading role in funding and supporting the adoption of electronic synoptic reporting across the country. The benefits of synoptic reporting are significant. By standardizing how pathology and surgical data is gathered and reported, it ensures clinicians have clear and complete information to inform treatment decisions. Just as important, synoptic data provides important opportunities for quality improvement, as it allows variations in practice and outcomes to be tracked across organizations and the system.

In its final work in this area, the Partnership funded six jurisdictional teams across Canada to focus on this potential for quality improvement. Despite challenges created by the pandemic, the teams completed 23 quality improvement projects in 2021/22, and almost all resulted in significant improvements to patient care.

The projects immersed surgeons and pathologists in quality improvement practices. Feedback reports helped them use the data to learn about their own clinical practice and compare themselves to peers at their site and in other jurisdictions. During multidisciplinary community of practice sessions, they also discussed the root causes of differences in patient care and how they could be addressed.

Small changes often led to big gains. For example, previously in Prince Edward Island, all endometrial biopsies were sent to Halifax for assessment, and patients often waited over a week for results. By making changes to the information included in the synoptic template, gynecologists were able to determine which biopsies did not need to be referred to Halifax and which needed to be sent immediately. As a result, turnaround time for endometrial cancer biopsies improved dramatically: from 8.8 days to 1.3 days. In Alberta, a review of synoptic data revealed that not all patients with thyroid cancer were receiving an ultrasound, a best practice to accurately determine cancer stage. The resulting discussions among surgeons and a change to the synoptic template led to significant improvement: the percentage of patients receiving an ultrasound assessment jumped from 65 per cent to 92 per cent.

Evaluation of the projects also points to a longer-term cultural change. Among the participating clinicians, 95 per cent reported they are likely to use synoptic data for improving patient care and 89 per cent for discussing care gaps with their peers.



ENSURING EQUITABLE ACCESS TO CLINICAL TRIALS

Participation in clinical trials is often not an option for people with cancer who live in rural and remote areas because they live too far from the urban-based cancer centres where the trials are held. This lack of access creates a troubling inequity; clinical trials provide patients with important and early access to innovative treatments and technologies that can improve outcomes and quality of life. And without a representative mix of participants, research results may not apply to the whole population.

With funding from the Partnership, the Canadian Cancer Clinical Trials Network (3CTN) is piloting a new model to make clinical trials more accessible, no matter where someone lives. The Canadian Remote Access Framework for Clinical Trials (CRAFT) uses a hub-and-spoke model to allow local or regional health centres to operate as satellites of larger cancer centres. The model is being tested in British Columbia, Ontario and Newfoundland and Labrador. In each province, a major health centre is conducting a clinical trial in partnership with two smaller regional hospitals, which are delivering the care and monitoring patients enrolled in the trial. For example, in British Columbia, patients in Terrace are participating in a trial of non-invasive radiation therapy based in Prince George, a day's drive away. And in Newfoundland, patients from Grand Falls-Windsor with advanced prostate cancer can participate in a drug trial based more than 400 km away, in St. John's.

The pilot provides the opportunity to test the model for different types of clinical trials and learn from the experience of all sites involved. Patient experience will also be tracked, so the model can be adjusted as needed. In addition to expanding treatment options for people in rural and remote areas, the new model provides an important benefit for researchers. Trials can now include a broader cross-section of the population, leading to findings that might be more reliable and generalizable to the entire population.



INVOLVING PATIENTS IN CANCER RESEARCH

The latest developments in Canadian cancer research were highlighted at the biennial Canadian Cancer Research Conference (CCRC), hosted by the Canadian Cancer Research Alliance. In response to the pandemic, the 2021 CCRC pivoted to a virtual event which brought together almost 800 members of the Canadian cancer research community—including patient partners.

Thanks to the Patient Involvement in Cancer Research Program (PIP), these patients are active participants in the conference, co-chairing all keynote and concurrent sessions and bringing their perspective to presentations and discussions. This year a record number of people from across Canada applied for the 25 PIP program spots. As part of the PIP, patient partners were involved in adjudicating a research grant for trainees and early career investigators that focuses on patient-oriented research.

This visible and active role of patients in the conference is shifting perceptions among researchers. In a post-conference survey, 87 per cent of attendees indicated they were interested in involving patients or caregivers in their research, a percentage that has steadily risen since the PIP program was first introduced in 2017.

The conference also continues to proactively encourage more diverse voices and participation. For the 2021 conference, increased outreach to First Nations, Inuit and Métis partners and the Indigenous research community resulted in an Indigenous cancer research stream with a keynote speaker, concurrent session, a variety of oral and poster presentations and a workshop on Indigenous research ethics.



USING PATIENT-REPORTED OUTCOMES TO IMPROVE CARE

The use of patient-reported outcomes (PROs) measurement tools ensures patients with cancer are regularly screened for symptoms that make the cancer experience more difficult, such as pain, fatigue, nausea, anxiety and depression.

However, clinicians need easy and timely access to the resulting information in order to provide patients with the supports they need; integrating the data into clinical information systems is key. Several jurisdictions had Partnership-funded initiatives underway when the pandemic began, creating a new set of challenges. PROs questionnaires are usually completed when a patient has a clinic appointment; with the shift to virtual visits, this symptom screening was not taking place and many patients were missing out on referrals to psychosocial and other supports.

In response, a number of provinces accelerated the move from paper to electronic questionnaires—and several moved to at-home access. For example, New Brunswick and Nova Scotia launched an electronic platform that allows patients undergoing radiation treatment to complete their PROs assessment from their home computer or phone. Newfoundland and Labrador will soon follow suit for some patients seen at cancer centres. And in Quebec, a smart phone app allowed some patients with cancer to report their symptoms electronically, as well as complete their COVID-19 screening and appointment check-in for in-person visits.

With support from the Partnership, Alberta has taken the use of PROs even further, exploring how they can be used to ensure high-quality symptom management when care is delivered virtually. For example, a patient with fewer symptoms might do well with telephone support, while someone with more symptoms might need an in-person visit with a multidisciplinary team. Alberta is also testing whether PROs can be used to predict the percentage of patients who will have a high number of symptoms. This information could help ambulatory clinics plan for enough longer appointments to meet the needs of complex patients and schedule sufficient staff.



SUPPORTING ADOLESCENTS AND YOUNG ADULTS WITH CANCER

For adolescents and young adults undergoing cancer treatment, loss of fertility is a significant risk. Too many of them discover this after treatment, when fertility preservation strategies are no longer an option. The Partnership is working with partners to ensure conversations about fertility take place before the start of treatment, and that patients and their families have the information they need to make an informed decision.

To facilitate these conversations, Ontario and Alberta are including a question about fertility concerns in the patient-reported outcomes tools that cancer programs use to gather information about a patient's symptoms and concerns. New clinical pathways will ensure that referrals to a fertility clinic can happen quickly. And tailored education materials will provide patients and their families with information to help them decide what they want to do.

Both provinces are particularly focused on meeting the needs of young First Nations, Inuit and Métis and out-of-province patients. Alberta provides care for adolescents and young adults from the Northwest Territories who have cancer and Ontario provides care for Nunavut residents. Neither of those northern jurisdictions have fertility services, so the clinical pathways must address access for these out-of-province patients, and all educational materials must be culturally appropriate.

A recent Partnership survey found that once their cancer treatment is complete, adolescents and young adults also need help from their primary care provider to manage related health issues, including fatigue, mental health and ongoing monitoring for cancer recurrence. To raise the awareness of primary care providers and give them the tools they need, the Partnership developed a digital video and two tools with information on local supports for patients. Canadian Cancer Society staff also have access to the tools and the Northwest Territories, Alberta and Quebec are adapting them to include local resources.



PAN-CANADIAN AND INTERNATIONAL COLLABORATIONS

USING DATA TO DRIVE SYSTEM CHANGE

The Partnership works closely with other pan-Canadian health organizations (PCHOs) and international partners on areas of common interest. Through these collaborative efforts, the Partnership and others share expertise and learnings that help all partners to advance their work. Current collaborations include the following data-focused initiatives:

- **Developing a pan-Canadian data strategy:**

The gaps in Canada's health data system became apparent during the pandemic, when policy-makers had difficulty accessing timely, comprehensive data to inform decision-making. The federal government is working to address the issues through the development of a pan-Canadian health data strategy, and the Partnership and the Canadian Cancer Society are contributing by co-leading the development of a *pan-Canadian cancer data strategy*. The strategy will establish a common overarching framework and identify short-, medium- and long-term data priorities for policy-makers, researchers and other stakeholders to guide improvements and investments, so the cancer system can respond quickly when funding becomes available. A wide range of organizations and individuals are participating, including PCHOs, provincial cancer organizations, patient and family advisors, national Indigenous organizations and regional Indigenous data governance organizations.

Linking data on cancer diagnoses and outcomes with data on immigration, employment income and out-of-pocket spending allows detailed analysis of the economic burden of cancer using an equity lens.

- **Providing modelling data to support decision-making:**

Data models have become an essential tool to predict the impact of the pandemic and guide decision-making. The Partnership's OncoSim tool modelled outcomes to inform decisions on everything from strategies to reduce screening backlogs to plans for new lung cancer screening programs. Additionally, the Partnership supported researchers to develop and disseminate modelling to predict the impact of cancer diagnosis and treatment delays on cancer outcomes.

Throughout the pandemic, the Partnership co-sponsored the [COVID-19 and Cancer Global Modelling Consortium](#) that provided modelling data to help manage pandemic challenges and inform pandemic recovery. The Partnership also participated in a modelling community of practice created by the Canadian Association of Provincial Cancer Agencies (CAPCA) that facilitated connections and information-sharing among modelling groups.

- **Conducting equity-focused analysis to address gaps in the system:**

A joint effort by the Partnership, the Canadian Centre for Applied Research in Cancer Control and Statistics Canada has linked data from the Canadian Cancer Registry with national databases such as the census and Statistics Canada's annual survey of household spending. Linking data on cancer diagnoses and outcomes with data on immigration, employment income and out-of-pocket spending allows detailed analysis of the economic burden of cancer using an equity lens. Research funded by the Partnership is already highlighting the financial challenges faced by people with cancer and providing valuable insights to inform policy.

The Partnership has also conducted equity-focused analyses to support an upcoming special topic report focused on cancer prevalence, to be published by the Canadian Cancer Society, Statistics Canada and the Public Health Agency of Canada. The analysis highlights how cancer burden varies depending on a person's income and where they live.

- **Tracking variations in care to guide quality improvement:**

Survival rates for cancer vary across countries, and the International Cancer Benchmarking Partnership (ICBP) is analyzing data from nine countries to determine why. As an ICBP member, the Partnership worked with nine provinces to gather and analyze Canadian data, including the number of patients who are diagnosed as a result of an emergency department visit. When people are not diagnosed early through screening programs or primary care, it suggests gaps in the system. While Canada generally does well compared to other countries, nearly one in three people is diagnosed in the emergency department, and significant variation exists between provinces. By participating in this benchmarking, jurisdictions are better able to understand what is driving outcomes for patients and where they need to focus quality improvement efforts.



COLLABORATING TO ADVANCE CANCER CARE

Since 2006, the Strategy has united partners across the country in efforts to reduce the burden of cancer and improve cancer prevention, screening and care.

Today, the Partnership and partners face new challenges and new opportunities to ensure a sustainable health system and an equitable cancer experience for all people in Canada—especially systemically excluded communities who continue to experience inequities in access, experience and outcomes. The Strategy will guide the work ahead, and the Partnership will continue to build on lessons learned before and during the COVID-19 pandemic on how best to support partners and drive meaningful progress toward the Strategy's goals.

ADVANCING THE STRATEGY IN 2022/23

In 2022/23, the Partnership will support partners to complete work delayed by the pandemic, begin new initiatives to implement the 2022-27 business plan and adopt fresh approaches to improve health equity in the cancer system. This work will be grounded in the priorities and actions set out in the Strategy and the business plan's four anchors: equity, pandemic recovery, stewardship and organizational excellence. Initiatives in the coming year will prioritize the focus on health equity and include the following:

- **Implementing innovative models of care:** The Partnership will fund implementation and evaluation of innovative models of care that advance health equity, efficiency and quality within the cancer system.
- **Eliminating cervical cancer:** Work to improve HPV vaccination rates among under-immunized groups and ongoing planning for HPV primary testing will advance Canada's goal to eliminate cervical cancer by 2040.

- **Introducing lung cancer screening:**

Organized lung cancer screening programs will continue to roll out across the country, with a focus on engaging First Nations, Inuit and Métis to co-create culturally safe programs.

REPORTING TO CANADIANS

The Partnership has also created an online progress reporting tool that allows all people in Canada to monitor progress on the Strategy's eight priorities. Provinces and territories are reporting indicator data for five of the priorities, as well as goals for each area and the work underway to achieve them. This marks the first time that many of the indicators have been monitored and reported at a pan-Canadian level, and the tool provides an important opportunity for the public to learn about the progress being made to improve cancer care within each jurisdiction.

For the Strategy's three Peoples-specific, self-determined priorities, the Partnership is working with First Nations, Inuit and Métis organizations, Elders and Knowledge Keepers to co-create stories of progress that are strength-based and meaningful to First Nations, Inuit and Métis. These stories will include data from Indigenous-led surveys, healthcare datasets, and interviews and community engagement sessions with people who have lived experience of the cancer journey.

The Partnership's history of strong partnerships and alignment on strategic priorities has created momentum for significant and sustained innovation in cancer care in Canada. Together with existing and new partners, the Partnership will continue to drive this innovation and create a more sustainable and equitable cancer system for the future.

BOARD OF DIRECTORS

April 1, 2021 – March 31, 2022



Graham Sher, MD

Chair, Canadian Partnership Against Cancer;
Chief Executive Officer, Canadian Blood Services



Jeff Zweig

Chair Elect and Vice-Chair, Canadian Partnership Against Cancer; President and Chief Executive Officer, Mosaic Forest Management



Julien Billot

Chief Executive Officer, Scale Ai; Adjunct Professor, HEC Montreal



Ruby Brown

Deputy Minister of Health, Government of Nunavut *(stepped down April 2021)*



Kim Nguyen Chi, MD

Chief Medical Officer, BC Cancer *(stepped down April 2021)*



Katherine Chubbs

President and Chief Executive Officer, The Good Samaritan Society, Good Samaritan Canada and Good Samaritan Delta View Care Centre Ltd. *(elected June 2021)*



Ewan Clark

Legal Counsel, Cox & Palmer



Teri Collins

Assistant Deputy Minister, Health Services Division, British Columbia Ministry of Health *(elected June 2021; stepped down January 2022)*



Bruce Cooper

Deputy Minister, Health and Social Services, Government of Northwest Territories *(elected June 2021)*



André Corriveau, MD

Public Health and Health Services Delivery Consultant



Michael Crump, MD

Hematologist and Clinician Investigator, Princess Margaret Cancer Centre



Linda Dempster

Vice-President, Patient Experience and Pandemic Response, Fraser Health Authority



Darren Dick

Director of External Relations, Schulich School of Law, Dalhousie University *(stepped down June 2021)*



Craig Earle, MD

Chief Executive Officer, Canadian Partnership Against Cancer



Melanie Fraser

Associate Deputy Minister, Health Services, Ontario Ministry of Health



Desirée Hao, MD

Medical Oncologist, Tom Baker Cancer Centre; Professor of Medicine, Cumming School of Medicine, University of Calgary



Karen Herd

Deputy Minister of Health, Seniors and Active Living, Manitoba



Helen Mallovy Hicks

Corporate Director and former Partner and Global Valuation Leader, PricewaterhouseCoopers LLP



Eshwar Kumar, MD

Medical Officer, New Brunswick Cancer Network, Department of Health



David Lai

Corporate Director and Director, Technology Infrastructure and Operations, McCarthy Tétrault (*elected October 2021*)



Darren Larsen, MD

Senior Advisor, Canadian Healthcare, Accenture; Lecturer, Department of Family and Community Medicine and the Institute for Health Policy Management and Evaluation, University of Toronto



Jean Latreille, MD

Observer; National Director, Programme Québécois de cancérologie (Quebec cancer control program), Quebec Ministry of Health and Social Services



Cynthia Morton

Chief Executive Officer, Canadian Partnership Against Cancer (*retired October 2021*)



Mary O'Neill

Corporate Director (*stepped down October 2021*)



Michelle Owen

Observer; Director, Programs Division, Health Care Programs and Policy Directorate, Health Canada (*joined December 2021*)



David Sabapathy, MD

Deputy Chief Public Health Officer, Prince Edward Island Department of Health and Wellness



Andrea Seale

Chief Executive Officer, Canadian Cancer Society



Cheryl Smith

Reeve, Rural Municipality of St Laurent; Director, Interlake District for the Association of Manitoba Municipalities



Kendal Weber

Assistant Deputy Minister, Strategic Policy Branch, Health Canada (*elected October 2021; stepped down January 2022*)

INDEPENDENT AUDITOR'S REPORT

*To the Members of Canadian Partnership Against
Cancer Corporation*

OPINION

We have audited the accompanying financial statements of Canadian Partnership Against Cancer Corporation (the "Partnership"), which comprise the statement of financial position as at March 31, 2022, and the statements of operations, changes in net assets and cash flows for the year then ended, and notes to the financial statements, including a summary of significant account policies.

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of Canadian Partnership Against Cancer Corporation as at March 31, 2022, and its results of operations and cash flows for the year then ended in accordance with Canadian accounting standards for not-for-profit organizations.

BASIS FOR OPINION

We conducted our audit in accordance with Canadian generally accepted auditing standards. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are independent of the Partnership in accordance with the ethical requirements that are relevant to our audit of the financial statements in Canada, and we have fulfilled our ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

RESPONSIBILITIES OF MANAGEMENT AND THOSE CHARGED WITH GOVERNANCE FOR THE FINANCIAL STATEMENTS

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian accounting standards for not-for-profit organizations, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is responsible for assessing the Partnership's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless management either intends to liquidate the Partnership or to cease operations, or has no realistic alternative but to do so.

Those charged with governance are responsible for overseeing the Partnership's financial reporting process.

AUDITOR'S RESPONSIBILITIES FOR THE AUDIT OF THE FINANCIAL STATEMENTS

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with Canadian generally accepted auditing standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

As part of an audit in accordance with Canadian generally accepted auditing standards, we exercise professional judgment and maintain professional skepticism throughout the audit. We also:

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Partnership's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management.
- Conclude on the appropriateness of management's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Partnership's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Partnership to cease to continue as a going concern.
- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

We communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

BDO Canada LLP

Chartered Professional Accountants,
Licensed Public Accountants

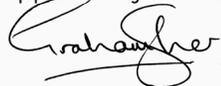
Oakville, Ontario

June 22, 2022

Statement of operations and changes in net assets

Year ended March 31	2022	2021
	\$	\$
Expenses		
Prevention	3,387,515	2,929,094
Screening	5,719,950	3,525,864
Cancer diagnosis and care	2,291,612	3,005,194
Patient experience	6,256,838	5,055,076
Research	8,346,943	
5,392,956		First Nations, Inuit and
Métis cancer control	7,331,128	7,208,563
System performance	3,328,776	2,557,387
Strategy and analysis (Note 5)	2,420,309	2,971,601
Knowledge mobilization (Note 5, 9)	2,682,783	3,189,848
Public engagement and outreach	1,996,296	1,808,365
Program support	2,032,938	2,028,999
	45,795,088	39,672,947
Operating expenses (Note 4, 9)	8,912,436	8,343,598
	54,707,524	48,016,545
Revenue		
Government of Canada (Note 7)	54,419,050	47,001,768
Healthcare Excellence Canada	100,000	957,097
Other funding	188,474	57,680
	54,707,524	48,016,545
Excess of revenue over expenses for the year, and net assets at the end of the year	-	-

Approved by the Board of Directors



Graham Sher

Chair of the Board of Directors



Helen Mallovy Hicks

Chair of the Finance, Audit and Risk Committee

Statement of financial position

As at March 31	2022	2021
	\$	\$
Assets		
Current		
Cash	4,448,582	4,668,046
Short-term investments	8,037,660	5,020,979
Accounts receivable	615,617	304,820
Projects in process – advances (Note 3)	2,752,795	6,344,986
Prepaid expenses	677,462	689,460
	16,532,116	17,028,291
Capital assets (Note 4)	2,035,624	2,547,156
Intangible assets (Note 5)	-	113,953
	2,035,624	2,661,109
	18,567,740	19,689,400
Liabilities and Net Assets		
Current		
Accounts payable and accrued liabilities	5,224,583	4,337,518
Government remittances payable (Note 6)	75,027	52,748
Deferred contributions – Expenses of future periods (Note 7(a))	10,840,807	12,216,320
	16,140,417	16,606,586
Deferred contributions – Capital and intangible assets (Note 7(b))	1,530,276	2,073,813
Lease inducements (Note 8)	897,047	1,009,001
	2,427,323	3,082,814
	18,567,740	19,689,400
Net assets	-	-
	18,567,740	19,689,400

Commitments and Guarantees (Notes 10 and 11)

Statement of cash flows

Year ended March 31	2022	2021
	\$	\$
Increase (decrease) in cash		
Operating activities		
Government of Canada contributions received (Note 7)	52,500,000	51,000,000
Other contributions received	555,635	1,020,403
Interest received on short-term investments	70,829	72,456
Interest paid to Government of Canada	(63,281)	(110,864)
Cash paid for programs and operating expenses	(50,214,028)	(46,837,962)
	2,849,155	(5,144,033)
Investing activities		
Purchase of short-term investment	(7,000,000)	(9,500,000)
Redemption of short-term investment	4,001,145	7,500,000
	(2,998,855)	(2,000,000)
Financing activities		
Purchase of capital and intangible assets	(69,764)	(188,131)
	(69,764)	(188,131)
Increase (decrease) in cash	(219,464)	2,955,902
Cash, beginning of year	4,668,046	1,712,144
Cash, end of year	4,448,582	4,668,046

Notes to the financial statements

1. DESCRIPTION OF THE ORGANIZATION

Canadian Partnership Against Cancer Corporation (the "Partnership") was incorporated on October 24, 2006 under the Canada Corporations Act and commenced start-up operations on January 1, 2007 to implement the Canadian Strategy for Cancer Control. In June 2013, the Partnership submitted Articles of Continuance to Industry Canada and transitioned to the *Canada Not-for-profit Corporations Act* (CNCA).

In implementing the Canadian Strategy for Cancer Control, the Partnership plays a unique role working with partners to support multi-jurisdictional uptake of the knowledge emerging from cancer research and best practices in order to optimize cancer control planning and drive improvements in quality of practice across the country. Partners include provincial and territorial cancer programs; federal organizations and agencies; First Nations, Inuit and Métis organizations; national health and patient organizations; and individual experts who provide strategic cancer control insight and advice from both patient and professional perspectives.

With a focus on the full cancer continuum from prevention and treatment through to survivorship and end-of-life care, the Partnership supports the collective work of the broader cancer control community in achieving long-term outcomes that will have a direct impact on the health of Canadians to:

- a) reduce the incidence of cancer;
- b) lessen the likelihood of Canadians dying from cancer; and
- c) enhance the quality of life of those affected by cancer.

The Partnership is primarily funded through an agreement with the Government of Canada. The initial funding agreement provided a contribution of \$240.4 million over five years ending March 31, 2012.

The second funding agreement provided a contribution of \$239.6 million over the period of April 1, 2012 to March 31, 2017. The Contribution Agreement signed in March 2017 with the Government of Canada providing a contribution of \$237.5 million over five years ending March 31, 2022 was extended to March 31, 2023 due to the impact of the COVID-19 pandemic. On March 10, 2022, the Partnership signed a fourth Contribution Agreement with the Government of Canada, providing \$237.5 million over the next 5 years ending March 31, 2027.

The Partnership is registered as a not-for-profit Corporation under the *Income Tax Act* and, accordingly, is exempt from income taxes.

2. SIGNIFICANT ACCOUNTING POLICIES

Financial statement presentation

These financial statements have been prepared in accordance with Canadian accounting standards for not-for-profit organizations and include the following significant accounting policies:

Revenue recognition

The Partnership follows the deferral method of accounting for restricted contributions. Contributions from the Government of Canada are recognized as revenue in the fiscal year in which the related expenses are recognized.

Contributions for the purchase of capital and intangible assets are recorded as deferred contributions—capital and intangible assets, and subsequently recognized as revenue over the same terms and on the same basis as the amortization of the related capital and intangible assets.

Short-term investments

Short-term investments consist of deposits in high interest savings accounts and deposits with a maturity at acquisition of less than 1 year. Under the terms of the Contribution Agreement with the Government of Canada, investment income, which consists entirely of interest, is for the account of the Government of Canada and is recorded on an accrual basis.

Capital assets

Capital assets are recorded at cost and are amortized over their estimated useful life on a straight-line basis using the following rates:

Information technology and telecommunication	3 years
Furniture and equipment	5 years
Leasehold improvements	Over the term of the lease

Intangible assets

Intangible assets are recorded at cost and are amortized over their estimated useful life on a straight-line basis using the following rates:

Portal and software development	3 years
---------------------------------	---------

Financial instruments

The Partnership considers any contract creating a financial asset or financial liability a financial instrument. The Partnership accounts for the following as financial instruments:

- cash
- short-term investments
- accounts receivable
- projects in process
- accounts payable and accrued liabilities
- government remittances payable

A financial asset or liability is recognized when the Partnership becomes party to contractual provisions of the instrument. The Partnership removes financial liabilities, or a portion thereof, when the obligation is discharged, cancelled or expires.

The Partnership initially measures its financial assets and financial liabilities at fair value. In the case of a financial asset or financial liability not being subsequently measured at fair value, the initial fair value will be adjusted for financing fees and transaction costs that are directly attributable to its origination, acquisition, issuance or assumption. The Partnership subsequently measures all of its financial assets and financial liabilities at cost or amortized cost less impairment.

At the end of each reporting period, the Partnership assesses whether there are any indications that financial assets measured at cost or amortized cost may be impaired. When there is any such indication of impairment, the Partnership determines whether a significant adverse change has occurred during the period in the expected timing or amount of future cash flows from that financial asset. Where this is the case, the carrying amounts of the assets are reduced to the highest of the expected value that is actually recoverable from the assets either by holding the assets, by their sale or by exercising the right to any collateral, net of cost. The carrying amounts of the assets are reduced directly or through the use of an allowance account and the amount of the reduction is recognized as an impairment loss in the statement of operations.

Use of estimates

Management reviews the carrying amounts of items in the financial statements at each statement of financial position date to assess the need for revision or any possibility of impairment. Many items in the preparation of these financial statements require management's best estimate. Management determines these estimates based on assumptions that reflect the most probable set of economic conditions and planned courses of action.

These estimates are reviewed periodically and adjustments are made to excess of revenue over expenses as appropriate in the fiscal year they become known.

Items subject to significant management estimates include the estimated useful life of capital and intangible assets. Actual results could differ from those estimates.

3. PROJECTS IN PROCESS – ADVANCES

Projects in process – advances represent projects where the Partnership has advanced funds to third party partners where project milestones were in process and funds have not been expended by the third-party partner.

4. CAPITAL ASSETS

			2022	2021
	Cost	Accumulated Amortization	Net book Value	Net book Value
	\$	\$	\$	\$
Information technology and telecommunication	1,171,936	1,122,973	48,963	109,394
Furniture and equipment	914,893	840,899	73,994	214,933
Leasehold improvements	3,247,695	1,335,028	1,912,667	2,222,829
	5,334,524	3,298,900	2,035,624	2,547,156

Included in operating expenses is amortization expense related to capital assets of \$581,296 (2021 – \$597,128).

During the year, the Partnership disposed capital assets with a cost of \$420,455 (2021 – nil) which were fully amortized.

5. INTANGIBLE ASSETS

			2022	2021
	Cost	Accumulated Amortization	Net book Value	Net book Value
	\$	\$	\$	\$
Portal and software	1,670,405	1,670,405	-	113,953
	1,670,405	1,670,405	-	113,953

Included in Strategy and analysis and knowledge mobilization expenses is amortization expense related to intangible assets of \$113,953 (2021 – \$113,954). No intangible assets were disposed during the year (2021 – nil).

6. GOVERNMENT REMITTANCES PAYABLE

	2022	2021
	\$	\$
Interest received on short-term investments payable	30,690	18,303
Employee withholdings and other payable	44,337	34,445
Government remittances payable	75,027	52,748

7. DEFERRED CONTRIBUTIONS**(a) Expenses of future periods**

Deferred contributions are restricted for expenses of future periods.

	2022	2021
	\$	\$
Deferred contributions, beginning of year	12,216,320	
7,777,085		Current year contribution
from Government of Canada	52,500,000	51,000,000
Interest earned on contributions received	75,667	65,017
	64,791,987	58,842,102
Amount recognized as revenue during the year	(53,805,749)	(46,372,634)
Amount applied towards capital and intangible assets acquired	(69,764)	(188,131)
Interest paid to Government of Canada	(44,978)	(46,714)
Interest payable to Government of Canada	(30,689)	(18,303)
Deferred contributions, end of year	10,840,807	12,216,320

(b) Capital and intangible assets

Deferred contributions related to capital and intangible assets include the unamortized portions of contributions with which assets were purchased.

	2022	2021
	\$	\$
Deferred contributions, beginning of year	2,073,813	2,514,816
Contributions applied toward capital and intangible asset purchases	69,764	188,131
Amount amortized to revenue during the year	(613,301)	(629,134)
Deferred contributions, end of year	1,530,276	2,073,813

Total Government of Canada revenues recognized of \$54,419,050 (2021 – \$47,001,768) during the year include amounts amortized to revenues from capital and intangible assets.

8. LEASE INDUCEMENTS

The lease inducements include the following amounts:

	2022	2021
	\$	\$
Leasehold improvements	505,348	587,296
Free rent and other	391,699	421,705
Total lease inducements	897,047	1,009,001

During the year, leasehold improvements and other inducements of \$30,006 (2021 – provided \$12,751) were amortized. The amortization of leasehold improvements allowances is \$81,948 (2021 – \$81,948).

9. ALLOCATION OF EXPENSES

The Partnership's website and other digital assets are key channels of supporting multi-jurisdictional uptake of knowledge emerging from cancer research and best practices to drive improvements in quality of practice and optimize cancer control planning across the country. As such, some information technology and human resources expenses have been allocated on the basis of level of effort to Knowledge mobilization program - \$1,812,564 (2021 – \$2,028,840).

10. COMMITMENTS

Contractual commitments

As of March 31, 2022 the Partnership has contractual commitments related to specific projects and professional services amounting to approximately \$26.7 million (2021 – \$42.7 million) which are subject to terms and conditions as set out in the related agreements. More specifically, project related commitments are contingent upon meeting contractually defined milestones and deliverables. These are as follows:

	(000's)
	\$
2023	25,422
2024 and thereafter	1,327
	<u>26,749</u>

Operating lease commitments

The future minimum lease payments for premises and equipment for the next 5 years and thereafter are as follows:

	(000's)
	\$
2023	750
2024	750
2025	750
2026	793
2027	802
2028 and thereafter	935
	<u>4,780</u>

11. GUARANTEES

In the normal course of operations, the Partnership enters into agreements that meet the definition of a guarantee.

The Partnership has provided indemnities under a lease agreement for the use of operating facilities. Under the terms of this agreement the Partnership agrees to indemnify the counterparties for various items including, but not limited to, all liabilities, loss, suits, and damages arising during, on or after the term of the agreement. The maximum amount of any potential future payment cannot be reasonably estimated. The Partnership has purchased commercial property and general liability insurance with respect to these indemnities.

The Partnership has indemnified its present and future directors, officers and employees against expenses, judgments and any amount actually or reasonably incurred by them in connection with any action, suit or proceeding in which the directors are sued as a result of their service, if they acted honestly and in good faith with a view to serving the best interest of the Partnership. The nature of the indemnity prevents the Partnership from reasonably estimating the maximum exposure. The Partnership has purchased directors' and officers' liability insurance with respect to this indemnification.

12. CONTINGENCIES

The Partnership is a member of Healthcare Insurance Reciprocal of Canada (HIROC), which was established by hospitals and other organizations to self-insure. If the aggregate premiums paid are not sufficient to cover claims, the Partnership will be required to provide additional funding on a participatory basis.

Since the inception, HIROC has accumulated an unappropriated surplus, which is the total of premiums paid by all subscribers plus investment income less the obligation for claims reserves and expenses and operating expenses. Each subscriber which has an excess of premium plus investment income over the obligation for their allocation of claims reserves and operating expenses may be entitled to receive distributions of their share of the unappropriated surplus at the time distributions are declared by the Board of Directors of HIROC.

13. PENSION PLAN

The Partnership is a member of the Healthcare of Ontario Pension Plan ["HOOPP"]. HOOPP is a multi-employer defined benefit pension plan that is being accounted for as a defined contribution pension plan as sufficient information is not available to follow the accounting guidelines for a defined benefit pension plan. The employer contributions made by the Partnership to the plan in the current year amounted to \$1,421,998 (2021 - \$665,862) and are included in the Statement of operations and changes in net assets.

14. COVID-19

On March 11, 2020, the World Health Organization declared the COVID-19 outbreak as a pandemic, based on the rapid increase in exposure globally.

There could be further impact from COVID-19 that could affect the timing and amounts recognized in the Partnership's financial results. Management is actively monitoring the impact on its financial condition, operations, third party partners, suppliers, sector, and workforce. The full potential impact of the ongoing pandemic on the Partnership is not known at this time.

THIRD PARTIES

The organizations listed below received funding from the Canadian Partnership Against Cancer during the 2021/22 year to advance the work of the *Canadian Strategy for Cancer Control*. These organizations were engaged in accordance with our procurement policy available at partnershipagainstcancer.ca.

- Alberta First Nations Information Governance Centre
- Alberta Health Services
- Association pour la Santé Publique du Québec
- BC Cancer
- BC Cancer Foundation
- Canadian Association of Provincial Cancer Agencies
- Canadian Association of Radiologists
- Canadian Association of Thoracic Surgeons
- Canadian Cancer Society
- Canadian Indigenous Nurses Association
- Canadian Organization of Medical Physicists
- Canadian Virtual Hospice
- CancerCare Manitoba
- CISSS de Laval
- CIUSSS – Ouest-de-l’Île-de-Montréal
- Government of Yukon
- Eastern Health - Newfoundland and Labrador
- First Nations Health Authority
- First Nations of Quebec and Labrador
- Health PEI
- Institut universitaire de cardiologie et de pneumologie de Québec
- Interlake-Eastern Regional Health Authority
- Kenora Chiefs Advisory
- Lennox Island Health Centre
- Manitoba Métis Federation Inc.
- McGill University
- McMaster University
- Mental Health Commission of Canada
- Métis Nation of Alberta
- Métis Nation of British Columbia
- Métis Nation of Ontario
- Métis Nation–Saskatchewan
- Métis National Council
- Negotkuk Health Centre
- New Brunswick Department of Health
- Northern Inter-Tribal Health Authority
- Government of Northwest Territories
- Nova Scotia Health Authority
- Nunatsiavut Government
- Nunavik Regional Board of Health and Social Services
- Ontario Health
- Ontario Institute for Cancer Research
- Ottawa Hospital Research Institute
- Pediatric Oncology Group of Ontario
- Prince Albert Métis Women’s Association
- Statistics Canada
- Regional Municipality of York
- Rural Municipality of St. Laurent
- Saskatchewan Cancer Agency
- Saskatchewan Health Authority
- Simon Fraser University
- St. Michael’s Hospital
- University of Toronto
- University of Alberta
- Union of Nova Scotia Mi’kmaq (previously Union of Nova Scotia Indians)
- University Health Network
- Urban Public Health Network
- Yukon Hospital Corporation

MATERIALS

PUBLISHED

April 1, 2021 to March 31, 2022

PREVENTION

[Financial coverage of smoking cessation medications in Canada, 2021](#)

[Business case to improve access to smoking cessation medications in Canada](#)

[Smoking cessation in cancer care across Canada, 2020](#)

[Alcohol policy and cancer in Canada](#)

[Physical activity and cancer in Canada](#)

SCREENING

[Monitoring and evaluation of colorectal cancer screening quality indicators](#)

[Modelling scenarios for screening prioritization during the COVID-19 pandemic](#)

[Self-sampling devices for HPV testing: Horizon scan](#)

PERSON-CENTRED PERSPECTIVE

[Business case for oncofertility screening in the cancer system](#)

[Fertility preservation services coverage in Canada](#)

[Paramedics and palliative care: Bringing vital services to Canadians change package](#)

[The Canadian interdisciplinary palliative care competency framework](#)

[Supporting seamless transitions between cancer programs and primary care](#)

[Approaches to addressing mental health & return to work needs of cancer survivors: An environmental scan](#)

[Primary care tools supporting adolescent and young adult cancer survivors](#)

[Towards better mental and physical health: Preventing and managing concurrent mental and physical conditions: A scoping and rapid realist review](#)

[Quick facts: Mental health and chronic disease](#)

[Quick facts: Mental health and cancer](#)

ENHANCE COORDINATION OF CANADIAN CANCER RESEARCH

[Canada's research investment in childhood and adolescent cancers, 2005-2019](#)

[Canada's investment in cancer risk and prevention research, 2005-2019](#)

[Canada's investment in cancer survivorship research, 2005-2019](#)

[Canada's research investment in palliative and end-of-life cancer care, 2005-2019](#)

[Canada's investment in early translational cancer research, 2005-2019](#)

[What do we mean when we ask for more metastatic breast cancer research?](#)

[Recommendations to guide implementation planning for cancer health services and policy research in Canada](#)

[Evaluation of the 2021 virtual PIP and recommendations for future programs](#)

[Canadian Cancer Research Conference 2021 scientific program](#)

[Final report of the 6th Biennial Canadian Cancer Research Conference](#)

CANCER SYSTEM PERFORMANCE

[Canadian Strategy for Cancer Control progress reporting tool](#)

[The road to recovery: Cancer in the COVID-19 era](#)

SUSTAINABLE SYSTEM DESIGN

[Models of care toolkit](#)

[Predicted impact of Covid-19 on cancer outcomes \(2020-2030\): An interactive app](#)

[Cancer in Canada: Future projections interactive tool](#)

[Colorectal cancer screening during the COVID-19 pandemic: Impact of paused screening and evaluation of strategies to reduce delays](#)

[Prioritisation of colonoscopy services in colorectal cancer screening programmes to minimise impact of COVID-19 pandemic on predicted cancer burden: A comparative modelling study](#)

[Participatory simulation modeling to inform colorectal cancer screening in a complex remote northern health system: Canada's Northwest Territories](#)

[The OncoSim breast cancer microsimulation model](#)

[The economic burden of cancer in Canada from a societal perspective](#)

CORPORATE

[In this together: Annual report 2020/21](#)

[Canadian Partnership Against Cancer/Canadian Cancer Society Know your body campaign](#)



OTHER

REPORTING

The Partnership had 122 full-time permanent staff and 15 fixed-term staff, as of March 31, 2022. There are four divisions reporting to the Chief Executive Officer, each headed by a Vice President. The divisions are Cancer Control, Strategic Partnerships, Finance and Corporate Services, and Cancer Systems, Performance and Innovation.

Since the Partnership was established in 2007, its compensation philosophy has been guided by Board-approved principles that include providing a fair compensation package to Partnership employees that is regularly benchmarked to the market and comparator organizations, is publicly responsible and is able to attract and retain highly qualified staff to steward the *Canadian Strategy for Cancer Control*. More specifically, Partnership staff salary ranges are set against the 50th percentile of benchmarking data, and staff are eligible for annual salary adjustments based on merit.

Additional information can be found at www.partnershipagainstcancer.ca.

REFERENCES

1. Canadian Cancer Survivor Network. Impact of COVID-19 crisis on cancer patients and their ability to receive treatment. 3rd survey. [Internet]. Ottawa (ON): Canadian Cancer Survivor Network; 2021 July 30 [cited 2022 July 12]. 103 p. Available from: https://survivornet.ca/wp-content/uploads/2021/08/Survey-3-CCSN-Impact-on-Cancer-Patients-3rd-Report_July-30-2021.pdf
2. Parmar A, Eskander A, Sander B, Irish JC, Chan KKW. Impact of cancer surgery slowdowns on patient survival during the COVID-19 pandemic: a microsimulation modelling study. CMAJ. 2022; 194(11):e408-14. DOI: <https://doi.org/10.1503/cmaj.202380>
3. Canadian Partnership Against Cancer. Monitoring and evaluation of colorectal cancer screening quality indicators. [Internet]. Toronto (ON): Canadian Partnership Against Cancer; 2021 Oct [cited 2022 July 12]. Available from: <https://www.partnershipagainstcancer.ca/topics/colorectal-indicators-2017-2018/indicators/participation-rate/>
4. Canadian Partnership Against Cancer. Action plan for the elimination of cervical cancer in Canada, 2020–2030. [Internet]. Toronto (ON): Canadian Partnership Against Cancer; 2020 [cited 2022 July 12]. 48 p. Available from: <https://www.partnershipagainstcancer.ca/topics/elimination-cervical-cancer-action-plan/>
5. Public Health Ontario. Immunization coverage report for school-based programs in Ontario: 2019-20 and 2020-21 School Years. [Internet]. Toronto (ON): Public Health Ontario; 2021 Nov 29 [cited 2022 July 12]. 24 p. Available from: <https://www.publichealthontario.ca/-/media/documents/i/2021/immunization-coverage-2019-2021.pdf>
6. Earle C. Policy change is needed to eliminate cervical cancer. The Hill Times. 2021 June 9;Sect. Advertorial:3. Available from: https://www.hilltimes.com/wp-content/uploads/2021/06/060921_ht_1.pdf
7. Canadian Partnership Against Cancer. HPV primary screening and abnormal screen follow-up for cervical cancer. [Internet]. Toronto (ON): Canadian Partnership Against Cancer; 2021 Mar [cited 2022 July 12]. 81 p. Available from: <https://www.partnershipagainstcancer.ca/topics/hpv-primary-screening-environmental-scan/>
8. Mental Health Commission of Canada. Quick Facts: Mental Health & Chronic Disease. [Internet]. Ottawa (ON): Mental Health Commission of Canada; 2021 Nov 22 [cited 2022 July 12]. 4 p. Available from: <https://mentalhealthcommission.ca/resource/quick-facts-mental-health-chronic-disease/>
9. U.S. Department of Health and Human Services. Smoking Cessation: A report of the Surgeon General. [Internet] Atlanta (GA): U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; 2020 [cited 2022 July 12]. 700 p. Available from: <https://www.cdc.gov/tobacco/sgr/2020-smoking-cessation/index.html#full-report>

PARTNERSHIPAGAINSTCANCER.CA

145 King Street West, Suite 900
Toronto, Ontario M5H 1J8
TEL: 416.915.9222
TOLL-FREE: 1.877.360.1665
info@partnershipagaincancer.ca

