IN THIS TOGETHER

Innovating through the pandemic

ANNUAL REPORT 2020/21

CANADIAN PARTNERSHIP AGAINST CANCER

“The pandemic required real-time responsiveness from the Partnership in order to meet the needs of our partners and the needs of people with cancer, whose disease did not stop even as much of the world did.”

Leadership message, page 4

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LEADERSHIP MESSAGE

For more than a year now, health and cancer systems across Canada have been responding to the COVID-19 pandemic. It has been a very vulnerable time for people with cancer, and the Canadian Partnership Against Cancer (the Partnership) has worked tirelessly with partners to sustain, restore and redesign services affected by COVID-19.

The Partnership's Board of Directors was convening in Ottawa on March 11, 2020 when the World Health Organization (WHO) declared COVID-19 a pandemic. In response to the WHO's announcement, the Partnership did what many organizations have had to do since the onset of the pandemic—we pivoted. We quickly cancelled plans for the in-person gathering of partners associated with the Board meeting and instead implemented social-distancing protocols to ensure the safety of Board members and Partnership staff.

That was just the beginning of the Partnership's response. We took immediate action with cancer agencies across Canada to keep patients informed and connected to their cancer teams. We postponed or cancelled all in-person meetings and shifted to virtual meetings and a fully remote work environment. We supported Indigenous partners with additional project support where it was needed, and provided partners, clinicians and remote patients with virtual tools to stay connected with each other.

The Partnership's role as steward of the *Canadian Strategy for Cancer Control* (the Strategy) has evolved in the almost 15 years we've been accountable to people in Canada for achieving the Strategy's goals. Even under normal circumstances, it's an ambitious task for a steward to work with partners across Canada to increase equity in the cancer system and achieve a future in which fewer people develop cancer, more people survive cancer and those living with the disease have a better quality of life. The pandemic required real-time responsiveness from the Partnership in order to meet the needs of our partners and the needs of people with cancer, whose disease did not stop even as much of the world did.

The pandemic also required the Partnership to work differently with partners to sustain our long-term initiatives. We needed to understand and meet the unique challenges every jurisdiction faced. When many partners needed to redeploy resources to support COVID-19 efforts, Partnership staff provided additional support or helped identify local resources to augment the capacity of partners to continue to drive important change in cancer care. We championed, funded and assisted in the design and implementation of innovative approaches that not only supported the restoration of cancer services, but also accelerated the adoption of new practices to advance patient care and deliver on the priorities and actions of the refreshed Strategy. In particular, we focused on new supports to address the greatest regional, demographic and income-based disparities in access and in care in order to ensure those most vulnerable would not fall even further behind because of the pandemic.

> "With the refreshed Strategy as our guide and the shadow of the pandemic always nearby, the Partnership will continue to create alignment across Canada to achieve our strategic priorities, sustain a world-class cancer system through innovation and create an accessible, equitable cancer system for all people in Canada."

Tragic events such as the murder of George Floyd and the anti-racism protests and social awakening it ignited around the world, heightened our awareness of the systemic barriers people in Canada face when trying to access quality cancer care. In addition to reminding us of our obligations to all people in Canada, these events also shone a light on our responsibility to keep the Partnership's diverse staff engaged in the essential—and urgent—pursuit of diversity, equity and inclusion in all we do and how we do it.

Internally, we embarked on a journey with staff guided by our Chief Diversity Officer and enabled by staff-driven tables such as the Diversity, Equity and Inclusion Committee. We are committed to ensuring we have the skills and awareness to be the steward of a Strategy grounded in equity and to meaningfully contribute to eliminating racism in health care. Racism in all its forms is intolerable, and we must do more as individuals, an organization and a country to build systems that address every person's needs and contribute to an equitable and just society. The Partnership will continue this important dialogue with staff, our Board of Directors and our hundreds of partners across Canada to ensure that diversity, equity and inclusion are at the forefront of our work and an expectation of funded partners.

Strengthening our ongoing collaboration with federal, provincial and territorial governments and our pan-Canadian health-care partners is another way the Partnership remains aware of emerging challenges. This collaborative approach also allows us to identify opportunities to address these challenges together and support the health system at this critical time.

With the refreshed Strategy as our guide and the shadow of the pandemic always nearby, the Partnership will continue to create alignment across Canada to achieve our strategic priorities, sustain a world-class cancer system through innovation and create an accessible, equitable cancer system for all people in Canada.

As this title of this annual report says—we remain *in this together.*

Dr. Graham Sher
Chair

Cynthia Morton
Chief Executive Officer

INNOVATING THROUGH A PANDEMIC

Canada is fortunate to have a world-class cancer system—one committed to identifying and addressing inequities. That system was tested this past year, and health-care inequities grew, as repeated waves of COVID-19 swept the country. In response, partners across the system urgently embraced innovation to sustain and protect care.

The pandemic's impact on all aspects of health care was, and continues to be, far-reaching. Health and cancer systems, health-care professionals, and most importantly, people with cancer—all experienced the pandemic's devastating effects.

Many cancer screening programs were put on hold in the first wave, resulting in missed opportunities to diagnose cancer early when it is highly treatable. In 2020, Partnership modelling projected that a six-month interruption in screening could result in an additional 400 breast cancer deaths and 770 colorectal cancer deaths. Some cancer surgeries were cancelled and the overall volume of cancer surgeries decrease by 20 per cent from April to September 2020,[1] as hospitals reallocated resources in response to COVID-19. Pandemic restrictions made doctors' offices and emergency departments less accessible and people fearful of contact, so cancer symptoms were not identified as early as they normally would be.

These service disruptions added to longstanding inequities in access to screening and cancer care. First Nations, Inuit and Métis and populations frequently underserved by the cancer system—people with lower income, new immigrants, people living in rural and remote areas—continue to be disproportionately affected.[2] The pandemic also created other problems. People were reluctant to return to the health-care system when screening and other appointments were offered, even when they had symptoms associated with cancer.

Responding to the pandemic

In the face of these challenges, the Partnership's role as steward of Canada's cancer strategy took on new significance. Many of our partners focused on responding to the pandemic and maintaining access to services, and the Partnership moved quickly to support partners, system leaders and patients through the following initiatives:

- **Ensuring patients stayed connected to their cancer teams:** Funding from the Partnership supported partner initiatives in virtual care and additional supports for First Nations, Inuit and Métis travelling for cancer care.
- **Restoring cancer services by adopting innovation:** The Partnership worked with partners and others to provide guidance to safely restore screening, support the adoption of innovative screening models and provide expert advice on how to prioritize cancer surgeries.
- **Boosting partner capacity:** Project management support from the Partnership enabled smaller jurisdictions to participate in the Partnership's innovative lung cancer screening initiative and supported ongoing projects of First Nations, Inuit and Métis partners as they and other partners redeployed staff to community COVID-19 efforts.

Accelerating innovations against cancer

While the pandemic dramatically altered the delivery of care, it also created an urgent need to accelerate innovation across the cancer system and advance the priorities of the Strategy.[3] The Partnership has seized that opportunity and is working with partners on innovations that support the safe delivery of cancer services during the pandemic and increase equity and quality of care in the long term. For example, Partnership funding is enabling a more rapid shift to human papillomavirus (HPV) testing for cervical cancer (including self-sampling at home) and a broader use of mail-out fecal tests for colorectal screening. These strategies will reduce in-person interactions with the health-care system and the need for travel to physicians' offices, important considerations during a pandemic. However, they will also advance a larger goal: increasing access to cancer screening and care for First Nations, Inuit and Métis and underserved populations, including people living outside urban areas.

The Partnership has also made a significant, initial investment to accelerate the introduction of lung cancer screening programs across the country. Here, too, the focus is on removing barriers to equitable access. As part of their planning, partners are working with First Nations, Inuit and Métis and underserved populations to co-create programs that will address the specific needs of those communities. Canada is an international leader in adopting lung cancer screening, with these populations given first priority.

Sustaining the momentum to deliver better cancer care

The Partnership and its partners have worked tirelessly to keep patients with cancer connected to care and to restore cancer services affected by COVID-19. At the same time, we continued to drive progress on the priorities and actions set out in Canada's cancer strategy. Across the country, more paramedics are now trained to deliver palliative care, so vulnerable people in Canada can avoid the hospital and receive care safely at home. Partners are working with First Nations, Inuit and Métis and underserved communities to remove barriers so they can access colorectal cancer screening, and the number of cancer centres offering smoking cessation programs to patients continues to grow. These and other initiatives are reflected in the pages that follow, which provide the highlights of our efforts and accomplishments with partners across Canada in the past year.

MEETING THE CHALLENGES OF COVID-19

The COVID-19 pandemic affected cancer care dramatically. Partners faced new challenges in delivering services, and patients with cancer experienced uncertainty about the availability of care.

To ensure patients remained connected to their cancer teams, the Partnership provided an immediate $1.3 million in funding and technological support to help partners keep patients and families informed and connected to their cancer teams. These supports also kept clinicians connected to each other, so care for patients remained coordinated and holistic.

The early COVID-19 relief projects took many forms. Partners bought iPads and other equipment to support the move to virtual care, and Indigenous partners also used these devices to engage with community health-care providers as they continued their work to develop cancer plans. The Partnership supported other partners in their efforts to reduce the need for in-person clinic visits, such as delivering medication to patients' homes. Several provinces focused on the additional challenges faced by First Nations, Inuit and Métis and other people in remote communities, including the need for longer stays when travelling for cancer care due to COVID-19 isolation requirements. With Partnership support, Manitoba covered the unanticipated cost of accommodations and grocery cards for Inuit patients staying in Winnipeg for medical appointments and helped First Nations communities remain virtually connected to information and resources through radio and enhanced social media. In Ontario, "wellness baskets" containing traditional foods, blankets and children's activities were provided to Inuit patients to reduce anxiety while away from home for many months. Indigenous nurse navigators were also provided with additional resources for items like food vouchers and traditional medicine kits to support patients and their families.

Addressing reductions in cancer screening

The pandemic's impact quickly became evident in Canada's cancer screening programs, as many paused or reduced services. When planning began for the resumption of screening after the first wave, one thing was clear: The pandemic had created an urgent need—and opportunity—for innovation. The Partnership and its partners have leveraged that opportunity to accelerate important system changes. These innovations are foundational to the refreshed Strategy to ensure Canada's cancer system remains world-class and to address pandemic concerns so that screening can continue in any future waves. Just as important, the innovations the Partnership is supporting will increase equitable access to high-quality cancer care and ensure a sustainable cancer system for the future.

With $3.4 million in funding from the Partnership, 11 jurisdictions are taking action to:

- **Accelerate** the move to HPV primary screening for cervical cancer which enables self-sampling at home, reduces in-person contact and drives Canada toward its goal of eliminating cervical cancer (see page 20);
- **Increase** the direct mail-out of fecal tests for colorectal cancer to reduce the need for visits to primary care providers and improve participation rates in colorectal cancer screening (see page 18); and
- **Reduce** abnormal call rates (false positives) for mammograms to reduce unnecessary additional testing (see page 28).

Providing guidance for pandemic decision-making

The Partnership also worked with cancer agencies, pan-Canadian health organizations (PCHOs), national associations, clinical experts and patient advisors to develop two new guidance documents to safeguard the delivery of cancer screening and prioritize cancer surgery in Canada. *Management of cancer screening services during the COVID-19 pandemic and building resilient, safer and equitable screening services* provides the cancer screening community with the best available evidence and expert recommendations on how to prioritize and safely continue screening during future waves of the pandemic.[4] *Guidance for management of cancer surgery during COVID-19 pandemic* provides decision-makers and clinicians with evidence-based principles to guide prioritization of cancer surgeries in the face of ongoing pandemic-related delays and cancellations.[5]

Adapting supports to meet the needs of those with cancer

Throughout the pandemic, the Partnership has continued to support partners as they adapt to meet the needs of people with cancer during an uncertain and constantly changing environment. Partnership funding has supported initiatives to:

- **Expand virtual or alternate models of care**, including gathering and using patient-reported outcomes virtually to ensure patients are connected to the supports they need;
- **Provide virtual smoking cessation counselling** and free nicotine replacement therapy to help patients with cancer quit smoking;
- **Provide travel-related supports** for First Nations, Inuit and Métis patients travelling from the territories to Ontario, Manitoba or British Columbia for cancer care; and
- **Increase technology supports** in the Northwest Territories to support virtual collaboration between patients and cancer care providers.

The Canadian Cancer Society (CCS) is a key partner in many of our efforts to ensure the needs of patients and caregivers are understood and met. This was especially true through the pandemic, and the Partnership supported CCS in expanding its online resources to connect patients and survivors with the support they need, including new culturally relevant, virtual smoking cessation services for First Nations, Inuit and Métis through Talk Tobacco.

As the short- and long-term impacts of the pandemic persist, the Partnership will continue to work with other pan-Canadian health organizations, partners and networks across the country to sustain and transform cancer care to meet the needs of all people with cancer now and into the future.

Working at the national level: Collaborating with other pan-Canadian health organizations

The Partnership works closely with other PCHOs to advance our common work. These collaborative efforts have been strengthened through the pandemic, as PCHOs came together with Health Canada to support federal, provincial and territorial efforts to sustain and restore health services across the country.

The following initiatives reflect some of these shared efforts:

Developing a pan-Canadian cancer data strategy: The pandemic shone a light on gaps across Canada's health data system, including the lack of timely, comprehensive data and the inability to fully answer key questions asked by policy-makers. The federal government is working with provinces and territories to address these issues through Canada's health data strategy. To contribute to this work, the Partnership and the Canadian Cancer Society are co-leading the development of a pan-Canadian cancer data strategy. Participating organizations include the Canadian Association of Provincial Cancer Agencies (CAPCA), the Canadian Institute for Health Information, Canadian Institutes of Health Research, Strategy for Patient-Oriented Research, the Public Health Agency of Canada and Statistics Canada.

Solving health human resource challenges: The pandemic also exacerbated long-standing human resource challenges across the system, including staffing shortages and burnout. Led by the Partnership, a working group of PCHOs is looking at current human resources initiatives to identify opportunities to work collaboratively and accelerate work underway. These initiatives focus on how to anticipate where human resources are needed, how to train and recruit, and how to plan for the role technology and technologists will play in performing future health system work. Among those participating are the Canadian Agency for Drugs and Technologies in Health, Canada Health Infoway, the Canadian Centre on Substance Use and Addiction, Healthcare Excellence Canada (the organization formed through the amalgamation of the Canadian Foundation for Healthcare Improvement and the Canadian Patient Safety Institute) and the Mental Health Commission of Canada. CAPCA has prioritized this work with the Partnership.

Supporting decision-makers with modelling data: Throughout the pandemic, there has been increased reliance on data models—such as the Partnership's OncoSim tool—to guide planning. The Partnership is participating in a new modelling community of practice created by CAPCA to share data, analyses and learnings to address the impact of pandemic-related closures and delays. To further support provincial and territorial decision-making, the Partnership also co-sponsors an international consortium that is providing modelling data during the pandemic and post-pandemic recovery. Key partners include the International Agency for Research on Cancer, the International Cancer Screening Network and the Cancer Council NSW in Australia.

Enhancing collaboration with First Nations, Inuit and Métis partners: Leads for Indigenous health from within the PCHOs are coming together to explore opportunities to enhance collaboration with First Nations, Inuit and Métis partners, while avoiding duplication among organizations.

2020/21 YEAR IN REVIEW

Despite delays caused by COVID-19, the Partnership and its partners continued to advance the priorities of the *Canadian Strategy for Cancer Control*. Innovation—to achieve equity and sustain world-class cancer care—remains essential.

EXPANDING ACCESS TO PALLIATIVE CARE ACROSS CANADA

To live well with cancer, individuals and families need support for the physical and emotional symptoms that can make the cancer experience so difficult. High-quality palliative care provides this support, and introducing it early can help people live more fully and comfortably throughout their cancer journey. Patient-reported outcomes (PROs) tools are helping clinicians do that.

GOAL:

7,000

paramedics trained to assess and treat palliative care patients at home by 2022

2,000

more than originally planned

TO DATE:

More than

4,400

paramedics trained

PARAMEDICS ARE:

Taking up to 80% fewer

palliative care patients to the hospital

Spending 30 minutes

less in the home during palliative care 911 calls

Palliative care patients and families are very satisfied with the care they are receiving, and patients are staying out of emergency departments, a priority during the pandemic.

PROs are used to screen patients for symptoms such as pain, fatigue, nausea, anxiety and depression, so clinicians can refer patients to the services—the palliative care—they need. The Partnership has supported the implementation of PROs across the country since 2012, and is now helping seven jurisdictions —Yukon, Northwest Territories, British Columbia, Saskatchewan, Nova Scotia, Prince Edward Island and Newfoundland and Labrador—expand the use of PROs to identify patients who would benefit from palliative care earlier.

Training paramedics to deliver palliative care at home

For people receiving end-of-life palliative care, most would prefer to remain at home with appropriate support. However, families often have to call 911 when urgent problems arise. In the past, that meant a trip to the emergency department, but a new model of care is training paramedics to assess and treat patients with palliative care needs at home instead.

First implemented in Alberta, Nova Scotia and Prince Edward Island, the model is now being rolled out in seven more jurisdictions with joint support from the Partnership and Healthcare Excellence Canada. Paramedics in five provinces are already trained and delivering palliative care (British Columbia, Saskatchewan, Manitoba, New Brunswick and Newfoundland and Labrador) and two regions in Ontario began training in the past year. The initiative has also expanded in response to the pandemic, as health-care systems try to keep patients out of hospital whenever possible. More than 7,000 paramedics will now be trained by 2022, 2,000 more than originally planned.

Over 4,400 paramedics have been trained to date, and patients are already benefitting. Paramedics are taking up to 80 per cent fewer palliative care patients to the hospital, and patients and families are very satisfied with the care they are receiving. The model is also more efficient: on average, paramedics are spending 30 minutes less on each call when they treat patients at home.[6]

Developing a national standard for palliative care in Canada

Despite the growing need for palliative care services, there aren't enough health professionals with the necessary skills and knowledge; a 2014 survey of primary care physicians and nurses found that most did not feel comfortable or prepared to provide palliative care.[7]

To address this gap, the Partnership worked in collaboration with Health Canada, the BC Centre for Palliative Care and Pallium Canada to develop the *Canadian interdisciplinary palliative care competency framework*. The framework, which will be rolled out in the coming year, builds on several existing provincial frameworks to establish a national standard for the skills and knowledge (the competencies) required to deliver high-quality palliative care across all settings—cancer centres, palliative care clinics, long-term care, primary care or home care. The framework's self-assessment tools will help staff in these settings to identify gaps in their palliative care knowledge and help organizations to design educational programs to meet those needs. With advice from First Nations, Inuit and Métis Advisors, competencies for providers caring for First Nations, Inuit and Métis were included. The Partnership is also planning to engage First Nations, Inuit and Métis to better understand their palliative care priorities and needs and identify promising practices that can be scaled up.

ACCELERATING THE DEVELOPMENT OF LUNG CANCER SCREENING PROGRAMS

Lung cancer is the most common—and deadly—cancer in Canada. However, survival increases dramatically with early diagnosis: screening those at high risk for lung cancer can reduce deaths by up to 24 per cent.[8]

$5 million

in funding to 10 provinces and 1 professional association to support the development of organized lung cancer screening

PEOPLE WITH LOWER INCOME ARE NEARLY:

2x

more likely to be diagnosed with lung cancer than those with higher income and are less likely to survive

FIRST NATIONS ADULTS ARE:

35%

less likely to survive lung cancer five years after diagnosis

Establishing organized lung cancer screening programs for those at high risk is a key priority of the refreshed Strategy, and the Partnership is providing an initial $5 million to support partners to speed the process.

As a result, planning and development is already well underway across the country. Partners are engaging a diverse group of community partners and health providers—including radiologists, thoracic surgeons and public health and smoking cessation professionals—to develop screening pathways. They can also draw on nearby experience. Ontario ran a pilot screening program for the past three years (now the Ontario Lung Screening Program), and British Columbia and Alberta have each led lung cancer screening research activities. The Partnership is also funding the Canadian Association of Radiologists and the Canadian Society of Thoracic Radiology to develop accreditation and educational resources to support the new screening programs.

Canadians can expect to see swift progress on lung cancer screening. British Columbia will be the first province to launch a province-wide program in spring 2022. Quebec recently launched a two-year pilot project that will support engagement with underserved populations and Indigenous communities to ensure equitable access to lung cancer screening for rural, remote and First Nations communities in the province. In addition, partners in Alberta, Saskatchewan, Manitoba, Ontario, New Brunswick, Nova Scotia, Prince Edward Island and Newfoundland and Labrador are working on plans for pilots or programs to be launched or scaled up within their jurisdictions. Smoking-cessation supports are an essential part of these screening programs and are included in the planning.

Reaching equity

New programs will include a strong emphasis on First Nations, Inuit and Métis and people who have been underserved by the cancer system in the past, including individuals with lower income and people living in rural and remote areas. The Partnership is funding partners to work with these communities to co-create accessible programs that will address their specific needs.

The need for this kind of targeted effort has never been greater. The Partnership's recent report *Lung cancer and equity: A focus on income and geography* found alarming differences in access to lung cancer care among some populations, as well as differences in outcomes. For example, people with lower income are nearly twice as likely to be diagnosed with lung cancer than those with higher income and are less likely to survive.[9] And First Nations adults are 35 per cent less likely than non-Indigenous populations to survive lung cancer five years after diagnosis.[10]

Designing lung cancer screening programs to meet the needs of First Nations, Inuit and Métis and underserved communities is an important step forward. Addressing the higher rates of smoking in particular populations, such as Indigenous populations and people living in remote or rural areas, is another. The new programs will include culturally appropriate smoking-cessation supports to help people access the support they need to quit.

INCREASING PARTICIPATION IN COLORECTAL CANCER SCREENING

Colorectal cancer is the third most diagnosed cancer and the second leading cause of cancer death in Canada.[11] Screening can help prevent colorectal cancer or catch it early when it is highly treatable, but participation rates for screening programs remain stubbornly low.

GOAL:

100%

of provinces and territories using Partnership information to implement strategies to reduce disparities in cancer screening by 2022

TO DATE:

10 of 13

jurisdictions are implementing strategies

PEOPLE WITH LOWER INCOME ARE:

14%

less likely to be screened for colorectal cancer than people with higher income

One reason for this is growing pains. Organized breast and cervical cancer screening programs have existed across Canada for some time, but screening programs for colorectal cancer are relatively new. While programs are now in place in 10 jurisdictions, most were launched within the last decade—and to date, none have achieved the 60 per cent screening participation target.

The pandemic further compounded the problem, as screening programs paused or reduced their capacity. However, with support from the Partnership, changes are underway across the country that will help programs expand their reach—particularly to groups that experience inequities in access—and build capacity for timely follow-up.

Colorectal screening programs rely on a simple fecal test that individuals complete at home and return for processing by a laboratory. Most provinces and territories mail out the test, but in Alberta and Manitoba, patients have to pick up the test kit from their family doctor—a challenge during COVID-19 when in-person health visits have been reduced. With funding from the Partnership, the two provinces are now shifting to mail-out tests. The change addresses pandemic concerns, but also promises to improve participation by eliminating unnecessary travel for people living in rural and remote areas and reaching people who don't have a primary care provider.

Reducing barriers for First Nations, Inuit and Métis and underserved populations

Targeted approaches will be required to address barriers that keep participation low among specific populations, including people with lower income, new immigrants and First Nations, Inuit and Métis. The inequities are real: People with lower income are 14 per cent less likely to be screened for colorectal cancer than people with higher income.[12] And despite an increase in colorectal cancer screening among new immigrants over the past decade, their screening rates still remain lower than Canadian-born individuals.[12]

To address these gaps, the Partnership is supporting five jurisdictions (Northwest Territories, Alberta, Manitoba, New Brunswick, Newfoundland and Labrador) to work with First Nations, Inuit and Métis and underserved populations to understand the barriers that prevent people from accessing colorectal cancer screening programs and to create solutions tailored to the challenges faced by these communities.

Despite delays due to the pandemic, efforts to engage these communities have already begun. For example, Alberta is working with groups like Calgary's Punjabi Community Health Services to recruit participants for online focus groups to problem-solve together. International medical graduates serve as community liaisons, providing live language translation for the sessions and culturally appropriate information on cancer screening. Across the country, New Brunswick is working with food banks to reach individuals with lower income and learn what prevents them from participating in screening and what can be done to remove those barriers.

To help partners identify communities with particularly low screening rates, the Partnership developed a geo-mapping tool and trained jurisdictions in its use. A new toolkit,[12] *Equity-focused interventions to increase colorectal cancer screening: Program pack,* provides evidence-based interventions to address the barriers faced by these populations, and partners will be working with local communities to tailor these interventions so they have more impact.

Reducing wait times for patients with suspicion of colorectal cancer

As the number of people completing fecal tests increases, the system must also be ready to provide appropriate, timely follow-up. Canadian guidelines recommend that people with an abnormal fecal test have a follow-up colonoscopy within 60 days to confirm or rule out colorectal cancer,[13] but few provinces and territories are meeting that target. Slowdowns due to COVID-19 have made the problem worse.

With funding from the Partnership, six jurisdictions (Yukon, Saskatchewan, Manitoba, Quebec, Nova Scotia and Prince Edward Island) are now working to improve their performance. Yukon is replacing aging colonoscopy equipment to improve efficiency and safety, while in Saskatchewan, a centralized colonoscopy waitlist and scheduling system are being implemented to reduce inequities and inefficiencies. Nova Scotia is ensuring that individuals at high risk are prioritized and focusing on more appropriate use of fecal tests, and Quebec is also changing its referral processes to improve how patients are prioritized for colonoscopy. In Manitoba, work is underway to improve screening for people with risk factors by creating a centralized screening registry and adding a pre-screening test. And Prince Edward Island is implementing a new navigation program to streamline the screening process and support patients throughout the process.

ELIMINATING CERVICAL CANCER

Partners across the country are moving quickly on Canada's ambitious goal to eliminate cervical cancer by 2040.

NATIONAL TARGET:

90%

of 17-year-olds vaccinated against HPV by 2025

$3 million

in funding to support HPV vaccination and HPV primary screening

9 of 13

jurisdictions actively planning implementation of HPV primary screening

Launched by the Partnership in November 2020, the *Action plan for the elimination of cervical cancer in Canada* calls for immediate action on several priorities, including improving HPV immunization rates and implementing primary HPV screening.[14]

Addressing inequities in HPV vaccination rates

Nearly all cases of cervical cancer are caused by the human papillomavirus (HPV). Although HPV vaccines are highly effective, vaccination rates in school-based vaccination programs across Canada vary widely—from 57 to 91 per cent.[15] To address this variation, the Partnership is providing $1.6 million to help jurisdictions reach the national target of vaccinating 90 per cent of 17-year-olds by 2025.[16]

Three national organizations are leading the efforts: the Urban Public Health Network, which includes medical officers of health from Canada's largest cities; the Rural, Remote and Northern Public Health Network, a network of medical officers of health from rural and remote regions, including First Nations and Inuit communities; and the Public Health Physicians of Canada, the professional association representing this group of physician specialists across the country.

These organizations reach into almost every area of Canada. However, to improve vaccination rates across the country, more must be known about those who aren't vaccinated and why. Data analysts are being hired to examine regional data for insights. At the same time, focus is being placed on building relationships with under-immunized communities—including First Nations, Inuit and Métis, racialized communities and youth who don't attend school—to better understand their needs and the barriers that prevent them from participating in existing vaccination programs. Lessons are also being learned from the rollout of COVID-19 vaccines across the country. All of this work will set the stage for designing and implementing innovative approaches to address inequities and increase vaccine uptake in these groups and others.

Introducing HPV Primary Testing

Shifting from Pap tests to the HPV test, which is more effective at detecting pre-cancers, will help eliminate cervical cancer. The Partnership is providing $1.4 million to support implementation of HPV as the primary screening test (to replace the PAP test) in seven provinces: British Columbia, Saskatchewan, Manitoba, New Brunswick, Nova Scotia, Prince Edward Island and Newfoundland and Labrador. These provinces will also benefit from the experience of Ontario, which will be one of the first provinces to adopt HPV primary screening.

Partners are using the funding to plan or pilot HPV primary screening within their jurisdictions. Some projects will include self-sampling, which enables people to collect their sample themselves at home or in a clinic setting and addresses concerns regarding privacy, confidentiality and lack of comfort with the clinician-administered Pap test. When the test is administered at home, it also reduces the need for in-person interactions with the health system, a particular concern during the COVID-19 pandemic.

The Partnership is also supporting the Society of Gynecologic Oncology of Canada to update current guidelines for colposcopy, the primary follow-up test to confirm an abnormal cervical cancer screening test. The updated guidelines will include recommendations for individuals who test positive for HPV and will address barriers to follow-up care, including those faced by First Nations, Inuit and Métis.

HELPING PATIENTS WITH CANCER TO QUIT SMOKING

Patients with cancer who stop smoking can lower their risk of dying from cancer by up to 40 per cent.[17] Across the country, cancer centres are helping them to quit.

GOAL:

100%

of cancer centres providing smoking cessation support by 2022

TO DATE:

87%

of cancer centres have implemented smoking cessation supports, a 14-percentage point increase over the previous year

14

percentage point increase in cancer centres providing culturally appropriate smoking cessation support

With funding from the Partnership, 87 per cent of cancer centres have implemented smoking cessation supports, a 14-percentage point increase over the previous year and a step closer to the goal of smoking cessation in all centres by 2022.

However, cancer centres faced a challenge this year when COVID-19 severely limited in-person visits for smoking cessation counselling. To help jurisdictions respond, the Partnership supported partners as they adapted their approaches, and in some cases, provided them with additional funding to explore new options for supporting patients. For example, Newfoundland and Labrador provided smoking cessation counselling by telephone and mailed out nicotine replacement therapy (NRT), while Saskatchewan provided NRT free of charge to patients and Nova Scotia provided it free to patients with financial need.

Better access to smoking cessation medications will remain a priority even after pandemic restrictions loosen. Across Canada, there are gaps in coverage and many people don't qualify for subsidized or free treatment. The Partnership is currently developing a business case that will help partners make the case for publicly funded smoking cessation medications for patients with cancer. The argument is compelling. In addition to improving patient outcomes, smoking cessation promises significant savings for the health-care system: $50 to $74 million for every five per cent of patients with cancer who quit smoking.[18]

Providing culturally appropriate supports

Across the country, cancer centres continue to partner with First Nations, Inuit and Métis organizations and communities to expand the availability of culturally appropriate smoking cessation supports. The number of centres providing these supports rose to 44 per cent, an increase of 14 percentage points over the previous year. Supports include a Partnership-funded, Indigenous-specific quitline, Talk Tobacco,[19] that was launched in Ontario by the Canadian Cancer Society and has now expanded to Saskatchewan and Manitoba. The quitline provides culturally safe smoking cessation support in 24 Indigenous languages.

Smoking cessation within cancer centres will only be successful if it is fully integrated into the care provided. With this in mind, the Partnership funded the Centre for Addiction and Mental Health to develop an online self-study module for use by doctors, nurses and smoking cessation educators working in cancer centres across Canada. The course provides information and tools to help staff assess commercial tobacco use and to use best practice approaches to help patients quit. Created with the help of experts and people working in smoking cessation, the module launched in October 2020. More than 160 health professionals registered for the course in the first six months, and participants rated the course very highly.[20]

IMPROVING CANCER CARE FOR FIRST NATIONS, INUIT AND MÉTIS

Canada's refreshed cancer strategy commits to closing gaps in cancer care and outcomes by supporting health equity for First Nations, Inuit and Métis as well as efforts to bring culturally safe care closer to home. And work is already underway.

CURRENTLY, THERE ARE:

13
provinces and territories developing and implementing Peoples-specific cancer plans

130 partners
taking action to benefit more than

500 communities

"As we begin to emerge from the past challenging year and continue to be hopeful for better days, we look forward to continuing this partnership, adapting strategies and building community connections and collaborations that improve health outcomes and cancer care for urban Inuit in Ontario."

Tungasuvvingat Inuit – Ontario

"The partners in our initiative, Kmawuhsahtipon – Togi Pematioog – Moving Forward Side-by-Side, have been learning about each other and what is helpful for First Nations people affected by cancer. We are working together to improve cancer outcomes for First Nations people in New Brunswick."

Tobique Indian Band Health Department – New Brunswick

"Learning from the experiences of our Cancer Transportation pilot program and Healthy Food program that provides food security for Métis cancer patients, we used COVID-19 relief funds to launch our first Medical Transportation and Accommodation program. Through consultation with Métis cancer patients, survivors and caregivers, we also developed a Métis-specific Guidebook and Journal for Métis cancer patients that will be available in cancer centres and regional offices in Saskatchewan."

Métis Nation–Saskatchewan (MN-S) – Saskatchewan

The Partnership is funding 29 partners—20 of them First Nations, Inuit and Métis governments and organizations—to take action on Peoples-specific, self-determined priorities through planning or implementing cancer plans in all 13 provinces and territories. The plans will improve the cancer journey and cancer outcomes for First Nations, Inuit and Métis, while addressing the need for culturally safe care across the country. The resulting initiatives involve over 130 First Nations, Inuit and Métis governments, organizations and community partners across the country. More than 500 communities will benefit.

The initiatives address all aspects of the patient journey and include the following examples of partner-led work:

- The First Nations of Quebec and Labrador Health and Social Services Commission is supporting First Nations communities in Quebec to implement community-led cancer control projects, some of which focus on cancer screening, prevention, tobacco control and sun safety.
- In Nova Scotia, the Union of Nova Scotia Mi'kmaq has implemented a youth healthy living social media campaign with a focus on smoking cessation and prevention.
- In the Northwest Territories, partners are working with the Government of Northwest Territories Health and Social Services to implement an organized colorectal cancer screening program that uses a Peoples-specific approach.
- CancerCare Manitoba and an extensive network of Indigenous partners are creating a network of First Nations, Inuit and Métis "community connectors" across the province to provide support and information to their community members as they move through the cancer system.

Meeting the challenges of the pandemic

The pandemic created additional burden and challenges for many of these partners. Despite this, they adapted and continued the work. For its part, the Partnership supported partners as they modified projects and timelines, providing additional project and financial management support where needed. Three virtual knowledge exchange meetings also provided the opportunity for partners to share project learnings, including those related to working through the pandemic.

Committing to reconciliation

The Partnership continues its commitment to reconciliation as it works to integrate First Nations, Inuit and Métis priorities in the early stages of all its work through meaningful engagement with First Nations, Inuit and Métis partners and advisors. The Partnership also continues to provide cultural awareness training to all Partnership staff in response to the calls to action of the Truth and Reconciliation Commission. All staff and board members have now completed training, and a plan is in place for training new staff.

OTHER HIGHLIGHTS

Assessing the financial impact of cancer

Cancer impacts a person's health, but it can also affect their employment and personal finances. Until now, data on the economic burden of cancer for patients, survivors and their families has been limited. For example, patients have to pay for many expenses themselves, including some medications, childcare, at-home care and the cost of getting to appointments (travel and parking fees). Yet little is known about how significant those costs are and how they vary across the country.

The Partnership is partnering with Statistics Canada to address this gap. For the first time, the Partnership will be able to examine out-of-pocket spending for patients with cancer by linking data from the Canadian Cancer Registry with data from the national survey of household spending. The result provides a snapshot of out-of-pocket health-care costs for people with cancer by region, cancer type, geography (urban or rural) and sociodemographic characteristics (e.g., income level). The analysis will shed light on disparities—for example, the differences in out-of-pocket expenditures between regions—and inform policy solutions to better support patients through their cancer journey and survivorship.

A second data linkage project now underway with Statistics Canada and the Canadian Center for Applied Research in Cancer Control will look at the short- and long-term impact of cancer on income. Many people are off work during treatment, resulting in lost income. And for adolescents and young adults, cancer can affect their ability to attend university and delay the start of careers, limiting higher paying jobs in the future. The analysis will look across jurisdictions, age groups and income groups to provide much needed information to guide policy and back-to-work supports from government and employers.

The Partnership's investment in the data linkages also opens the door for more research in this area. With the linkage now in place, the data from these and similar projects will be made available to researchers across the country through the Research Data Centres, ensuring this body of research will continue to grow.

Addressing loss of fertility in adolescents and young adults with cancer

For adolescents and young adults with cancer, the potential loss of fertility due to cancer treatments is a major source of distress. Too often, they learn of the risks after treatment, when fertility preservation is no longer an option.

To ensure the conversation takes place when it matters most, the Partnership is working with partners to include 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. A new oncofertility pathway will also ensure patients and their families receive information and referrals to fertility preservation services before cancer treatment begins. And the Partnership has developed a business case to help partners advocate for publicly funded fertility services for patients with cancer. The costs of sperm banking or egg harvesting present financial barriers for many patients and most jurisdictions do not cover the cost.

As part of this work, the Partnership sought input from those affected by oncofertility issues. More than 100 adolescents and young adults with cancer, cancer survivors and caregivers provided input.

Using patient-reported data to improve symptom management

The use of patient-reported outcomes (PROs) tools ensures patients with cancer—especially those with high symptom burden and palliative care needs—are regularly screened for the physical and emotional symptoms that can make the cancer experience so difficult, including pain, fatigue, nausea, anxiety and depression. With funding from the Partnership, Alberta and Quebec are leading the way in integrating that information into clinical information systems.

In Alberta, an easy-to-read dashboard allows clinicians to track changes and trends in a patient's symptoms from visit to visit and refer them to the supports they need. The aggregated PROs data is also used to guide staffing; analysis has shown that patients with certain cancers frequently require more symptom management support from a multidisciplinary team. Alberta is also exploring an innovative model that uses PROs to provide effective virtual cancer care for people in rural and remote areas. For example, patients with fewer symptoms might have a telephone or online check-in with a clinic nurse, while those with more symptoms would be scheduled for a longer virtual or in-person visit with a multidisciplinary team.

In Quebec, some patients with cancer can now report symptoms using an app on their cellphone. They can also use their phone to check in to appointments remotely and complete their COVID-19 screening—innovations designed to reduce in-person encounters during the pandemic.

Other provinces are also shifting to collecting PROs electronically. A new joint initiative between New Brunswick and Nova Scotia will focus on electronic collection and reporting of PROs for patients receiving radiation treatment.

Reducing abnormal call rates for breast cancer screening

Across Canada, abnormal call rates (ACR) for breast cancer screening—the percentage of mammograms identified as abnormal and requiring follow-up—exceed national targets. As a result, people who might not have cancer may be called back for unnecessary follow-up tests, creating stress for patients and additional burden on health-care resources. From 2008 to 2017, abnormal call rates for initial screens rose from 11.5 per cent to 17 per cent and ACRs for subsequent screens rose from six per cent to almost eight per cent.[21]

To address this, the Partnership worked with the radiology and breast screening communities to develop the *Pan-Canadian framework for action to address abnormal call rates in breast cancer screening*.[21] Endorsed by the Canadian Society of Breast Imaging, the framework outlines evidence-informed approaches to optimize ACRs. This work took on increased importance as programs resumed screening after the pandemic's first wave and remains critical in a system facing future disruptions; false positives lead to unnecessary contacts with the health-care system and the use of resources needed to clear screening backlogs.

The next step is putting the framework's recommendations into action, and work has already begun. For example, with funding from the Partnership, Manitoba is modifying staffing and workflows to have more than one radiologist interpret results for abnormal mammograms (double reading).

Improving the quality of cancer surgery

More than 80 per cent of people diagnosed with cancer will need surgery.[22] It is often the only way to cure cancer and reduces the need for other costly treatments, such as chemotherapy and radiation.

Over the past four years, the Partnership has collaborated with clinical leaders and cancer programs to develop pan-Canadian standards to improve surgical quality for breast, rectal, thoracic and gynecologic surgeries.[23,24,25,26] The Partnership also brought all 11 pan-Canadian surgical societies together for the first time to form the Canadian Network of Surgical Associations for Cancer Care (CANSACC).

This year, the network released the *Pan-Canadian action plan: Optimizing cancer surgical care in Canada*.[27] Endorsed by all the societies, the action plan outlines five priorities to ensure high-quality, coordinated surgical cancer care in Canada. In particular, the plan emphasizes the need for equity across the system: A key priority is eliminating barriers to surgical cancer care for vulnerable and underserved populations. With the action plan as a roadmap, CANSACC will now begin work with key partners to translate the priorities into meaningful change across the cancer system.

Improving quality through synoptic reporting

Surgeons and pathologists across the country are sharing synoptic data on their practices and outcomes to improve the quality of cancer care.

Synoptic reporting uses standardized templates to gather and report information in the medical record. The information is used to make treatment decisions, but it also offers the opportunity to track variations occurring across clinicians, organizations and regions and to identify where change is needed. Six Partnership-funded projects across Canada are using this data to identify and address gaps to improve cancer diagnosis and treatment.

The projects provide clinicians with feedback reports detailing their own data, as well as that of other surgeons or pathologists. Each project has evidence-based quality improvement targets and local community of practice (CoP) events that provide an opportunity for clinicians to review and reflect on their own performance, connect with other pathologists and surgeons and learn about quality improvement approaches. To date, over 85 CoP events have taken place, with over 500 clinicians participating.

Meeting the need for health-care professionals

As the number of people with cancer continues to increase, the cancer system is struggling to meet the demand for trained health professionals. Specialists provide the majority of cancer care, but there are a limited number of them and they are mostly located in larger centres.

The Partnership is developing a geo-mapping tool to help jurisdictions better understand where they have health human resources supply and demand issues. The tool, which will launch in 2022, will map the availability of eight types of cancer professionals against new cancer cases, deaths and prevalence of cancer. The mapping is available at the jurisdictional, health region and postal code level to help jurisdictions locate disparities and begin to identify solutions.

Some of those solutions may be found in a models of care environmental scan that the Partnership is developing. Through interviews and workshops across the cancer system, the Partnership has identified areas of care where innovative models could help to address human resource challenges. These include models that improve integration with primary care so follow-up care can be delivered closer to home and hub-and-spoke models that allow more locations to deliver care by linking them to a cancer centre "hub" for specialized expertise.

The environmental scan, which will be released this fall, will highlight innovative Canadian and international models and the key elements necessary to implement them.

Helping cancer survivors access mental health supports

Cancer survivors often struggle with physical and emotional concerns. In fact, a Partnership study found that 80 per cent of survivors experienced mental health challenges—and that few received the support they needed.[28]

Connecting survivors to community supports is key. The Canadian Cancer Society provides an online Cancer Information Helpline and a Community Service Locator that links patients, survivors and caregivers to resources near them, including support groups and counselling. With funding from the Partnership, CCS is expanding its listings of mental health resources and engaging the health-care system, community pharmacists, home care, other community organizations and telehealth partners in referring survivors to these resources. Visits to the community service locator have increased by 89 per cent in just six months. The Partnership is also funding the Cancer and Work website to develop an online course for primary care providers to equip them to support cancer survivors navigating a return to work.

Increasing access to clinical trials in rural and remote areas

Clinical trials allow researchers to test new approaches for preventing, diagnosing and treating cancer. They also allow patients access to innovative treatments and technologies that may improve their outcomes or quality of life. Yet an estimated 10 million Canadians in rural and remote areas aren't able to participate in clinical trials because they live too far from the nearest cancer centre.[29,30]

With funding from the Partnership, the Canadian Cancer Clinical Trials Network (3CTN) has developed the Canadian Remote Access Framework for Clinical Trials (CRAFT) to make clinical trials more accessible, no matter where a person lives.[31] The framework uses a hub-and-spoke model to allow local or regional health centres to operate as satellites of larger cancer centres and deliver the care and monitoring required to enroll patients in a trial. Sites in British Columbia, Ontario and Newfoundland and Labrador will pilot the model in the coming year.

This work is breaking new ground for Canada's wider research community. Not only does it open up the possibility of expanded treatment options for all patients with cancer regardless of where they live, it also strengthens cancer research. In future, participants in clinical trials will represent a broader cross-section of the population, making their findings more reliable and generalizable to the entire population.

The Partnership is also working to expand the number of clinical trials available for adolescents and young adults with cancer (AYA). Partnership funding is enabling 3CTN to support AYA trials through C[17], a network of pediatric centres.

LEADING THROUGH INNOVATION IN 2021/22

Sustaining quality care through a crisis while making meaningful progress toward the goals of the Strategy

The pandemic has had a disproportionate impact on underserved populations, deepening already existing inequities within the health and cancer systems. This reality has guided the Partnership's ongoing efforts to help partners respond to the pandemic, and strengthened our commitment to advancing actions that will deliver the Strategy's vision of an equitable cancer system for all people in Canada. As steward of the Strategy, we will continue to work with partners and the cancer system to ensure quality, timely care for all people in Canada.

The Partnership will continue to design, fund and implement initiatives to achieve our 2022 outcomes and build momentum into the future. This work, which reflects priorities identified in the Strategy, includes the following:

- **Establishing lung cancer screening programs:** The rollout of organized lung cancer screening will continue, with advanced planning underway to pilot programs across the country.
- **Eliminating cervical cancer:** With support from the Partnership, partners will restore and redesign HPV immunization programs to reach more young people, including First Nations, Inuit and Métis youth; accelerate implementation of HPV primary screening, including self-sampling—an important option to reach underserved populations; and enable more timely follow-up for those who need it.
- **Reporting to Canadians:** The Partnership will launch its online public reporting tool, a new approach to reporting to patients and the public on progress being made on the Strategy and the state of cancer control in Canada.
- **Implementing new models of care:** The Partnership will provide resources and supports to help jurisdictions implement new ways of delivering care to address health human resource shortages and bring cancer care closer to home.

In addition, the Partnership will extend a number of existing projects with partners that were delayed due to COVID-19.

Planning for the next phase of work

The Partnership will also develop its 2022-27 business plan, with a focus on advancing the priorities and actions set out in the Strategy as well as supporting partners and the health system in post-pandemic recovery. This will include both new work and accelerating successful existing initiatives, such as our work to implement lung cancer screening, eliminate cervical cancer and build more resilient cancer screening programs.

Throughout the pandemic, the Partnership has worked closely with partners to support their needs as they adapted to a rapidly changing health-care environment. Building on this experience, we will continue to evolve and shift how we work to best support our partners in a pandemic and post-pandemic world.

The Partnership's commitment to improving equity within the cancer system will call on us and our partners to adopt fresh approaches and engage with new partners as we work collaboratively to achieve our 2027 outcomes. In doing so, we will draw on nearly 15 years of experience building strong partnerships and creating alignment on strategic priorities across Canada. Working collaboratively, we will continue to innovate against cancer and create a sustainable and more equitable cancer system for the future.

BOARD OF DIRECTORS

April 1, 2020 – March 31, 2021

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

Helen Mallovy Hicks
Vice-Chair, Canadian Partnership Against Cancer; Partner and Global Valuation Leader, PricewaterhouseCoopers LLP

Julien Billot
Chief Executive Officer, Scale AI;
Adjunct Professor, HEC Montreal

Ruby Brown
Deputy Minister of Health, Government of Nunavut

Kim Nguyen Chi, MD
Chief Medical Officer, BC Cancer
(elected October 2020)

Ewan Clark
Legal Counsel, Cox & Palmer

André Corriveau, MD
Public Health 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
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Melanie Fraser
Associate Deputy Minister, Health Services, Ontario Ministry of Health

Desirée Hao, MD
Medical Oncologist, Tom Baker Cancer Centre; Associate Professor of Medicine, Cumming School of Medicine, University of Calgary

Karen Herd
Deputy Minister of Health, Seniors and Active Living, Manitoba

Abby Hoffman
Observer; Assistant Deputy Minister, Strategic Policy Branch, Health Canada *(stepped down June 2020)*

Eshwar Kumar, MD
Medical Officer, New Brunswick Cancer Network, Department of Health

Darren Larsen, MD
Chief Medical Officer, OntarioMD

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

Mary O'Neill
Corporate Director

Ian Rongve
Assistant Deputy Minister, Provincial, Hospital and Laboratory Services Division, British Columbia Ministry of Health *(stepped down July 2020)*

David Sabapathy, MD
Deputy Chief Public Health Officer, PEI 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
Observer; Assistant Deputy Minister, Strategic Policy Branch, Health Canada *(joined June 2020)*

Jeff Zweig
President and Chief Executive Officer, Mosaic Forest Management

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, 2021, 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, 2021, 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.

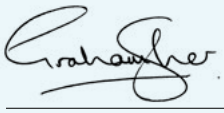
BDO Canada LLP

Chartered Professional Accountants,
Licensed Public Accountants
Oakville, Ontario
June 23, 2021

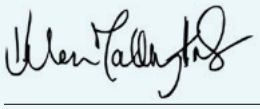
Statement of operations and changes in net assets

Year ended March 31	**2021**	2020
	$	$
Expenses		
Prevention	**2,929,094**	3,332,119
Screening	**3,525,864**	2,960,397
Cancer diagnosis and care	**3,005,194**	2,897,651
Patient experience	**5,055,076**	5,553,149
Research	**5,392,956**	6,617,845
First Nations, Inuit and Métis cancer control	**7,208,563**	7,518,054
System performance	**2,557,387**	2,227,606
Strategy and analysis (Note 5)	**2,971,601**	3,124,533
Knowledge mobilization (Note 5, 9)	**3,189,848**	4,024,167
Public engagement and outreach	**1,808,365**	1,851,658
Program support	**2,028,999**	1,785,313
	39,672,947	41,892,492
Operating expenses (Note 4, 9)	**8,343,598**	7,997,379
	48,016,545	49,889,871
Revenue		
Government of Canada (Note 7)	**47,001,768**	48,740,258
Canadian Foundation for Healthcare Improvement	**957,097**	500,000
Other funding	**57,680**	649,613
	48,016,545	49,889,871
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	2021	2020
	$	$
Assets		
Current		
Cash	**4,668,046**	1,712,144
Short-term investments	**5,020,979**	3,003,132
Accounts receivable	**304,820**	444,036
Projects in process – advances (Note 3)	**6,344,986**	5,473,903
Prepaid expenses	**689,460**	824,698
	17,028,291	11,457,913
Capital assets (Note 4)	**2,547,156**	2,956,153
Intangible assets (Note 5)	**113,953**	227,907
	2,661,109	3,184,060
	19,689,400	14,641,973
Liabilities and Net Assets		
Current		
Accounts payable and accrued liabilities	**4,337,518**	3,198,298
Government remittances payable (Note 6)	**52,748**	73,576
Deferred contributions – Expenses of future periods (Note 7(a))	**12,216,320**	7,777,085
	16,606,586	11,048,959
Deferred contributions – Capital and intangible assets (Note 7(b))	**2,073,813**	2,514,816
Lease inducements (Note 8)	**1,009,001**	1,078,198
	3,082,814	3,593,014
	19,689,400	14,641,973
Net assets	**–**	–
	19,689,400	14,641,973

Commitments and Guarantees (Notes 10 and 11)

Statement of cash flows

Year ended March 31	**2021**	2020
	$	$
Increase (decrease) in cash		
Operating activities		
Government of Canada contributions received (Note 7)	**51,000,000**	51,000,000
Other contributions received	**1,020,403**	1,321,992
Interest received on short-term investments	**72,456**	207,826
Interest paid to Government of Canada	**(110,864)**	(206,826)
Cash paid for programs and operating expenses	**(46,837,962)**	(53,332,730)
	5,144,033	(1,009,738)
Investing activities		
Purchase of short-term investment	**(9,500,000)**	(3,000,000)
Redemption of short-term investment	**7,500,000**	2,638,435
	(2,000,000)	(361,565)
Financing activities		
Purchase of capital and intangible assets	**(188,131)**	(319,763)
Lease inducements	**–**	–
	(188,131)	(319,763)
Increase (decrease) in cash	**2,955,902**	(1,691,066)
Cash, beginning of year	**1,712,144**	3,403,210
Cash, end of year	**4,668,046**	1,712,144

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. On March 17, 2017, the Partnership signed a Contribution Agreement with the Government of Canada, providing a contribution of $237.5 million over five years ending March 31, 2022. Funding is subject to terms and conditions set out in the Contribution Agreement, including there being an appropriation of funds by the Parliament of Canada for the next fiscal year.

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

	Cost	Accumulated Amortization	**2021 Net book Value**	2020 Net book Value
	$	$	**$**	$
Information technology and telecommunication	1,528,936	1,419,542	**109,394**	230,399
Furniture and equipment	908,584	693,651	**214,933**	246,008
Leasehold improvements	3,247,695	1,024,866	**2,222,829**	2,479,746
	5,685,215	3,138,059	**2,547,156**	2,956,153

Included in operating expenses is amortization expense related to capital assets of $597,128 (2020 – $776,761).
No capital assets were disposed of during the year (2020 – $279,838).

5. Intangible assets

	Cost	Accumulated Amortization	**2021 Net book Value**	2020 Net book Value
	$	$	**$**	$
Portal and software	1,670,405	1,556,452	**113,953**	227,907
	1,670,405	1,556,452	**113,953**	227,907

Included in Strategy and analysis and knowledge mobilization expenses is amortization expense related to intangible assets of $113,954 (2020 - $113,954). No intangible assets were disposed during the year (2020 – nil).

6. Government remittances payable

	2021	2020
	$	$
Interest received on short-term investments payable	**18,303**	64,151
Employee withholdings and other payable	**34,445**	9,425
Government remittances payable	**52,748**	73,576

7. Deferred contributions

(a) Expenses of future periods

Deferred contributions are restricted for expenses of future periods.

	2021	2020
	$	$
Deferred contributions, beginning of year	**7,777,085**	5,028,339
Current year contribution from Government of Canada	**51,000,000**	51,000,000
Interest earned on contributions received	**65,017**	201,517
	58,842,102	56,229,856
Amount recognized as revenue during the year	**(46,372,634)**	(47,931,491)
Amount applied towards capital and intangible assets acquired	**(188,131)**	(319,763)
Interest paid to Government of Canada	**(46,714)**	(137,366)
Interest payable to Government of Canada	**(18,303)**	(64,151)
Deferred contributions, end of year	**12,216,320**	7,777,085

(b) Capital and intangible assets

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

	2021	2020
	$	$
Deferred contributions, beginning of year	**2,514,816**	3,003,820
Contributions applied toward capital and intangible asset purchases	**188,131**	319,763
Amount amortized to revenue during the year	**(629,134)**	(808,767)
Deferred contributions, end of year	**2,073,813**	2,514,816

Total Government of Canada revenues recognized of $47,001,768 (2020 – $48,740,258) during the year include amounts amortized to revenues from capital and intangible assets.

8. Lease inducements

The lease inducements include the following amounts:

	2021	2020
	$	$
Leasehold improvements	**587,296**	669,244
Free rent and other	**421,705**	408,954
Total lease inducements	**1,009,001**	1,078,198

During the year, leasehold improvements and other inducements of $12,751 (2020 – $12,751) were provided. The amortization of leasehold improvements allowances is $81,948 (2020 – $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 – $2,028,840 (2020 – $2,006,324).

10. Commitments

Contractual commitments

As of March 31, 2021 the Partnership has contractual commitments related to specific projects and professional services amounting to approximately $42.7 million (2020 - $46.5 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)
2022	$	42,663

Operating lease commitments

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

		(000's)
2022	$	742
2023	$	750
2024	$	750
2025	$	750
2026	$	793
2027 and thereafter	$	1,737
	$	5,522

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

During the year, the Partnership changed its pension plan to the Healthcare of Ontario Pension Plan ["HOOPP"] and substantially all of the employees of the Partnership are members of 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 $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 2020/21 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 Radiologists
- Canadian Association of Thoracic Surgeons
- Canadian Cancer Society
- Canadian Indigenous Nurses Association
- Canadian Organization of Medical Physicists
- Canadian Virtual Hospice
- CancerCare Manitoba
- Centre for Addiction and Mental Health
- Centre for Effective Practice
- CIUSSS – Ouest-de-l'Ile-de-Montréal
- CIUSSS de l'Estrie-Centre hospitalier universitaire de Sherbrooke
- Eastern Health – Newfoundland and Labrador
- First Nations Health Authority
- Government of Northwest Territories
- Government of Yukon
- Health PEI
- Horizon Health Network
- Institut universitaire de cardiologie et de pneumologie de Québec
- Interlake-Eastern Regional Health Authority
- Kenora Chiefs Advisory
- Lennox Island Health Centre
- Manitoba Metis Federation Inc.
- McMaster University
- Métis Nation of Alberta
- Métis Nation of British Columbia
- Métis Nation of Ontario
- Métis National Council
- Métis Nation–Saskatchewan
- New Brunswick Department of Health
- Newfoundland and Labrador Centre for Health Information
- Northern Inter-Tribal Health Authority
- 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
- Regional Municipality of York
- Rural Municipality of St. Laurent
- Saskatchewan Cancer Agency
- Saskatchewan Health Authority
- Simon Fraser University
- St. Michael's Hospital
- Statistics Canada
- Tobique Indian Band Health Department
- Tungasuvvingat Inuit
- Union of Nova Scotia Mi'kmaq
- University Health Network
- University of Alberta
- University of Toronto
- University of Western Ontario
- Urban Public Health Network
- Young Adults Cancer Canada
- Yukon Hospital Corporation

MATERIALS PUBLISHED

April 1, 2020 to March 31, 2021

Develop and implement national prevention program and policies

Action Plan for the Elimination of Cervical Cancer in Canada, 2020-2030

HPV Primary Screening and Abnormal Screen Follow-up: Environmental Scan

HPV Immunization for the Prevention of Cervical Cancer

Smoking Cessation Aids Coverage in Canada, March 2020

Increase access to high-quality, person-centred cancer screening

Management of Cancer Screening Services During the COVID-19 Pandemic and Building Resilient, Safer & Equitable Screening Services: Guidance document

Pan-Canadian Framework for Action to Address Abnormal Call Rates in Breast Cancer Screening

Cervical Cancer Screening in Canada: Environmental Scan (2019-2020)

Colorectal Cancer Screening in Canada: Environmental Scan (2019-2020)

Breast Cancer Screening in Canada: Environmental Scan (2019-2020)

Lung Cancer Screening in Canada: Environmental Scan (2019-2020)

Equity-Focused Interventions to Increase Colorectal Cancer Screening

Identifying Features of Screening Approaches for People at Increased Risk of Colorectal Cancer

Implement quality standards and innovations in care

Guidance for Management of Cancer Surgery During COVID-19 Pandemic

Pan-Canadian Action Plan: Optimizing Cancer Surgical Care in Canada

Improve transitions for patients

Addressing the Mental Health and Return-To-Work Needs of Cancer Survivors

Identifying Educational Approaches and Resources to Support Seamless Transitions Between Cancer Programs and Primary Care

Enhance coordination of Canadian cancer research

Pan-Canadian Vision for Cancer Research

Cancer Research Investment in Canada, 2018

First Nations, Inuit and Métis cancer strategy implementation

www.partnershipagainstcancer.ca/about-us/who-we-are/first-nations-inuit-metis (launched new First Nations, Inuit and Métis section, April 2020)

Maximizing value of data through knowledge mobilization

Lung Cancer and Equity: A Focus on Income and Geography

Quantify the burden of cancer

Economic Burden of Cancer (infographic)

The Indirect Cost Burden of Cancer Care in Canada: A Systematic Literature Review

The Psychosocial Cost Burden of Cancer: A Systematic Literature Review

The Out-of-Pocket Cost Burden of Cancer Care in Canada: A Systematic Literature Review

Models of care

Rapid Synthesis: Enhancing Shared-care Models Between Primary-care Teams and Oncology in Post-treatment Care

Corporate

Doing What Can Only be Done Together: Annual Report 2019/2020

OTHER REPORTING

The Partnership had 119 permanent staff and 22 fixed-term staff, as of March 31, 2021. 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.

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