Prioritization, Costing and Resource Mobilization for NCCPs

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Good practices for NCCP planning

- Government stewardship & ownership: for leadership, ownership, accountability, resource allocation
- Alignment with relevant global and regional initiatives
- Aligns with national health strategy , overall govt agenda and other health programs
- Multisectoral and multistakeholder engagement
- Equity, human rights, pt-centred

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Government-led process, with stakeholder engagement and participation

PHASE 1 – Planning and preparation	PHASE 2 – Conducting the situation analysis	PHASE 3 – Formulating goal(s), objectives, interventions and activities	PHASE 4 – Developing the metrics and activities for monitoring, evaluation and review	PHASE 5 – Costing	PHASE 6 – Consensus and endorsement, dissemination and resource mobilization
Establishing a core organizing team	Review of epidemiology and determinants of TB[a]	Formulating goal(s) and objectives	Formulating indicators and targets for activities and subactivities	Producing cost estimates	Consensus and endorsement
Developing a costed roadmap	TB programme review[b]	Identifying priority interventions	Outlining activities for monitoring, evaluation	Identifying projected funding and sources	Dissemination and advocacy
Confirming and mobilizing resources	Data and evidence consolidation	Determining epidemiological (coverage) targets			Resource mobilization
	Synthesis by stakeholders	Formulating activities and subactivities			
		Contingency planning			

9–12 months

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Adapted from 9789240052055-eng.pdf (who.int)

Prioritization

- During planning, goals and objectives are identified to define the priority interventions and target setting (**prioritization)**. The M&E framework is also defined at this stage.
- The process of making choices between different options to address the most important health needs given scarce resources.
- Should be evidence-based, unbiased, impartial and should be seen as fair by all affected parties
- Priorities reflect a compromise among stakeholders
- Societal values and goals should guide

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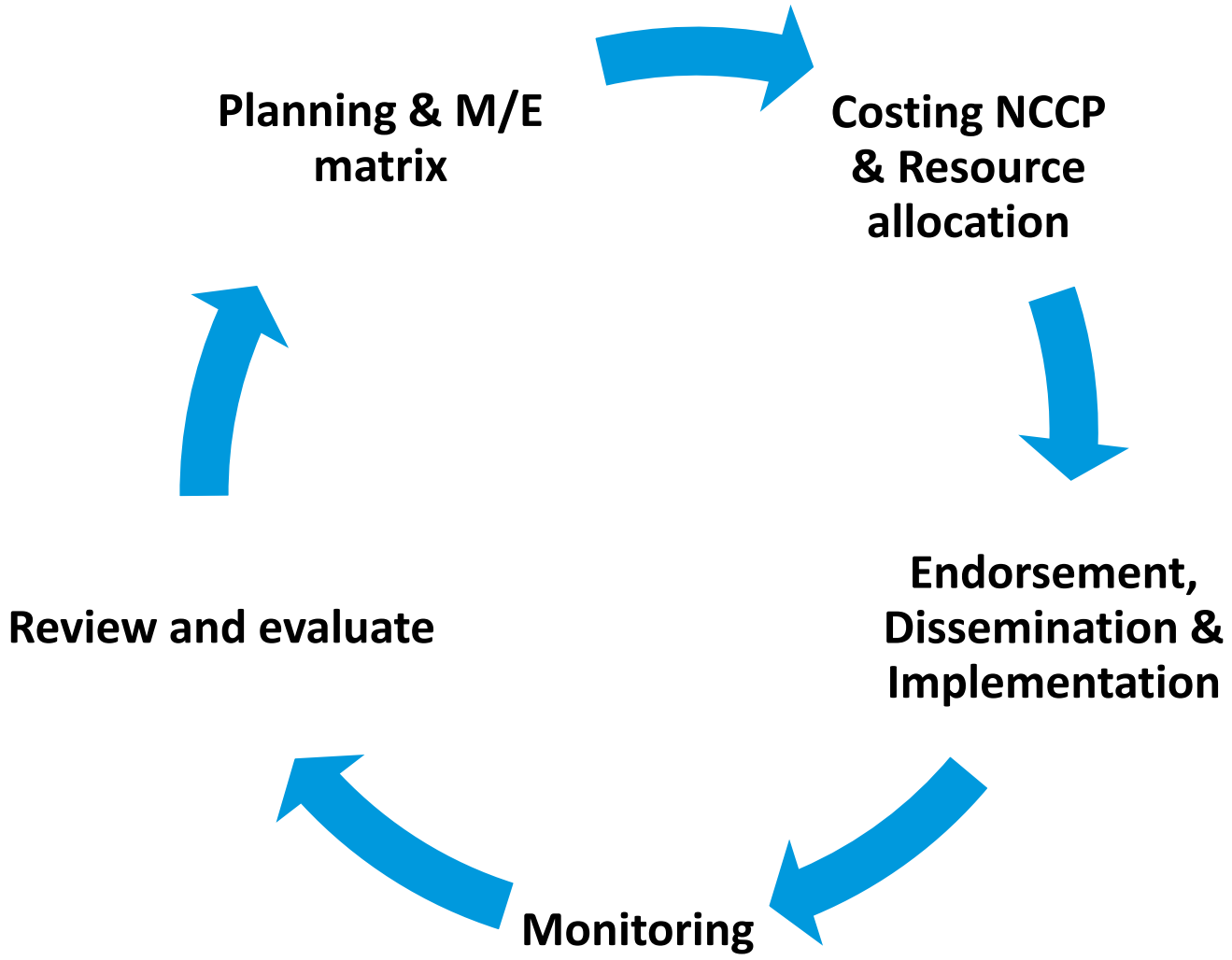
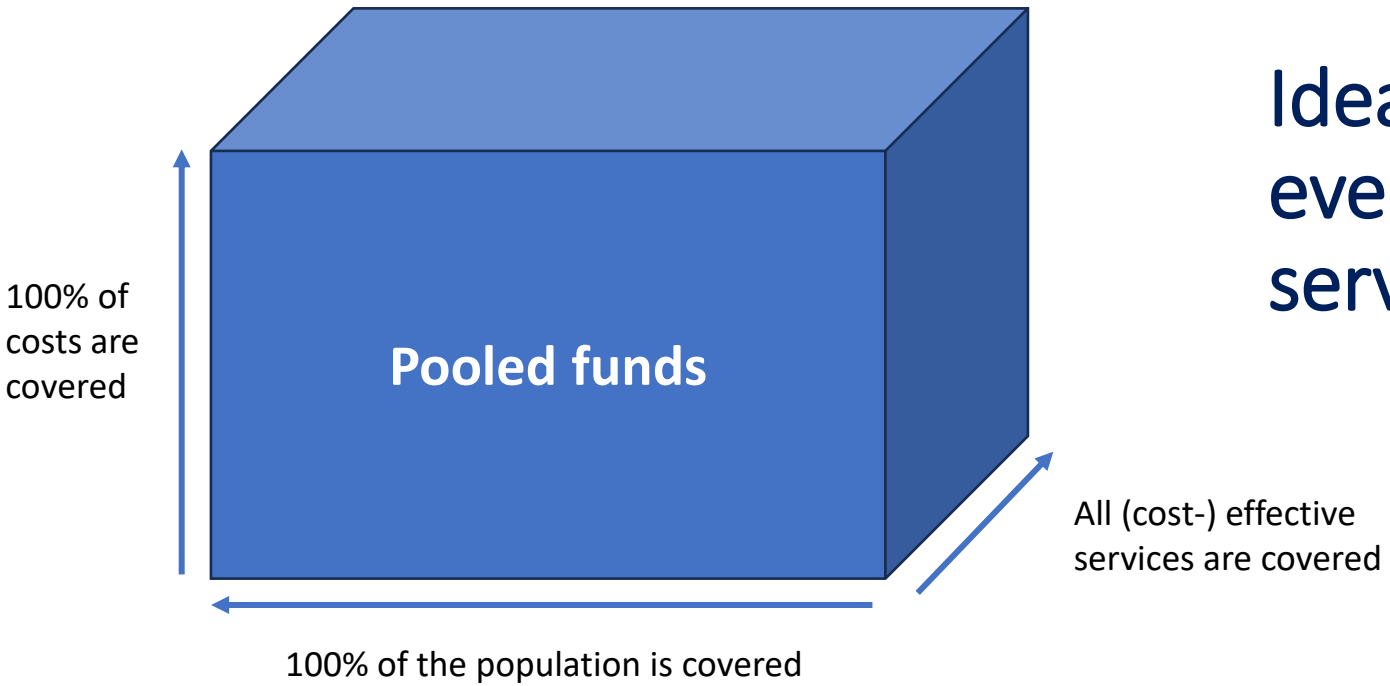
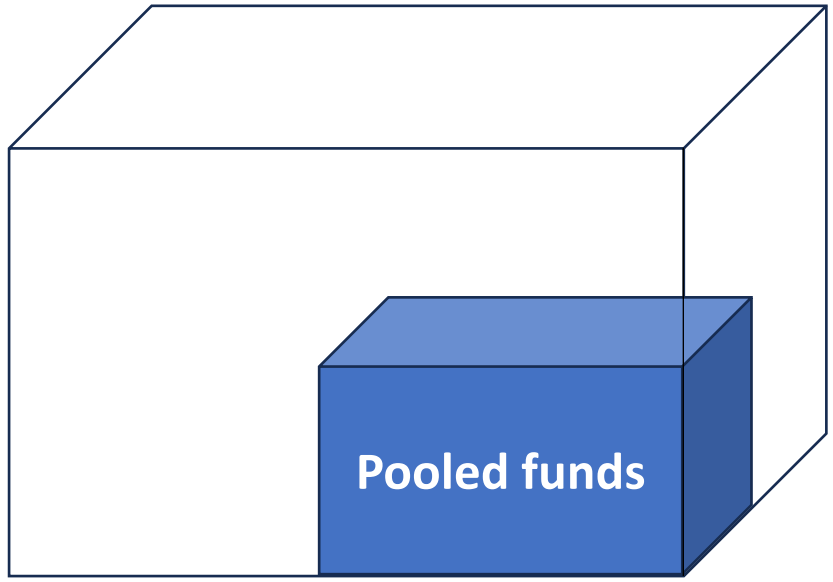
The Phases of a Program Management Cycle



Universal health coverage and cancer

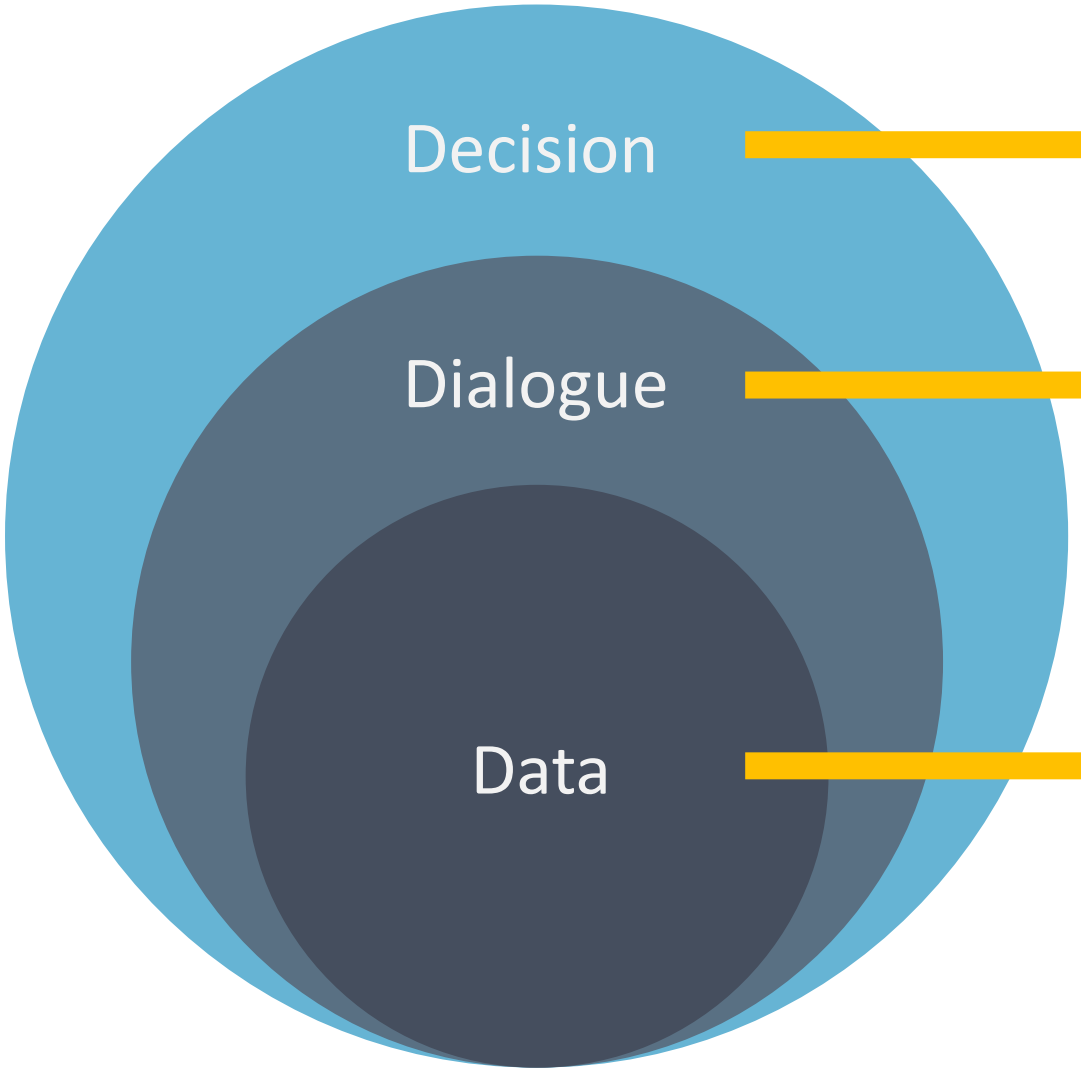


Ideally we would like to cover everyone with effective cancer services



But we have limited resources.
So how do we proceed?

The 3Ds of decision making



- Inform evidence-based decisions
- Legal basis for link from HTA to policy
- Recommendatory vs binding

- Dialogue phase by all appropriate stakeholders in a transparent deliberative process using data from the first phase.

- National burden of disease
- Economic evaluation
- Budget impact
- Health system feasibility

Systematic process, institutionalized with legal basis

Source: WHO 2021a

Priority-setting policy dialogue

Status quo: Lack of prioritization

Domain	Example	Process & Outcome
Cancer control plan	**70%** NCCPs include breast cancer screening **YET….**Feasible & cost-effective in **<20%**	Political but should be based on: Data → Dialogue → Decision-making
Benefit package (UHC)	**<20%** of packages include palliative care **YET…40+%** of packages in LIC cover screening	
Treatment standards	**20%** of nEMLs include bevacizumab but **not asparaginase**	

Cancer control **doesn't need** to be expensive…

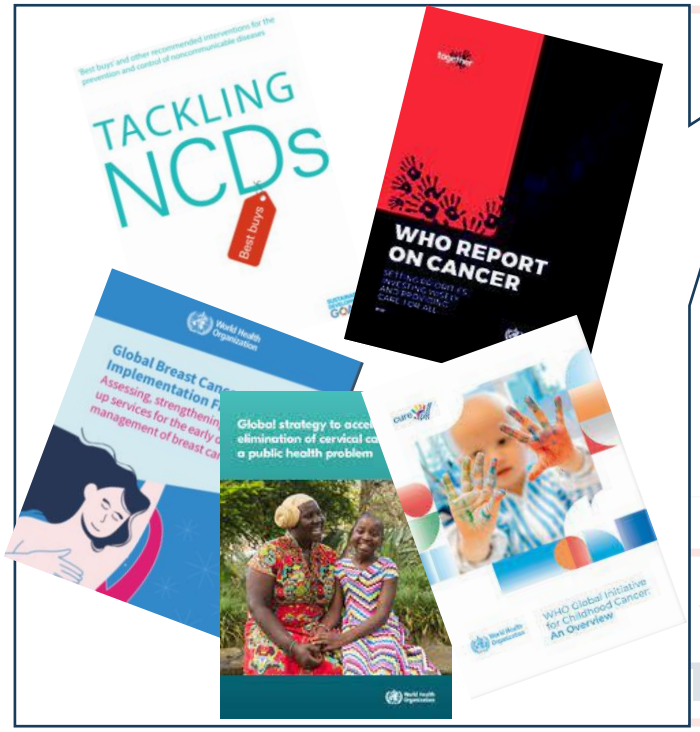
But, it does need to be **prioritized**

Basic package implementable for $US 5-10 per capita

Priority-setting policy dialogue

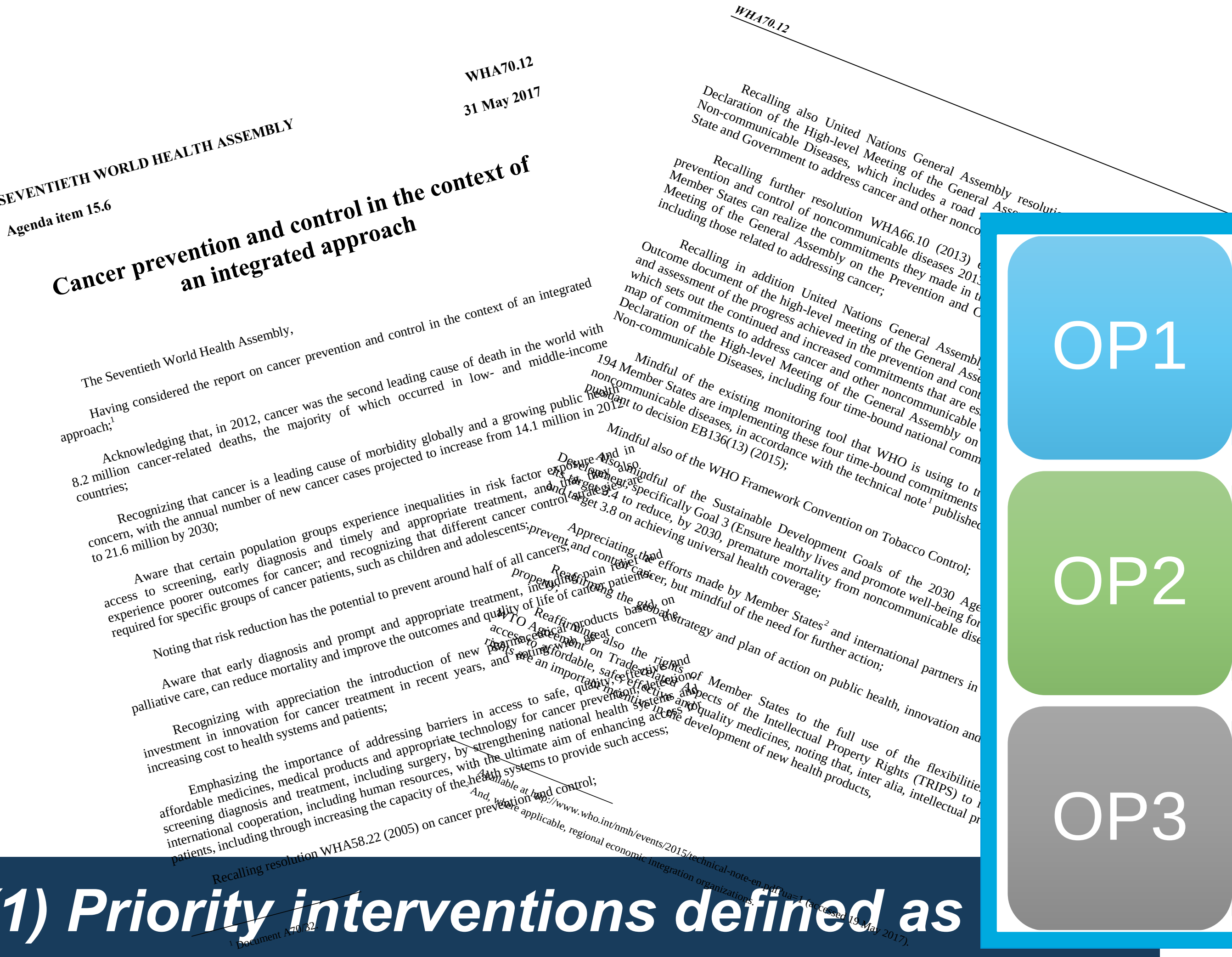
Status quo: Lack of prioritization

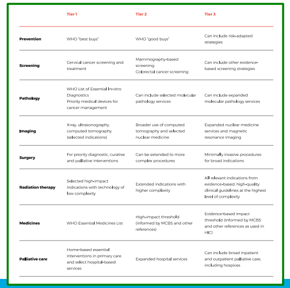
Domain	Example	Process & Outcome
(1) Define interventions		Political but should be based on: Data → Dialogue → Decision-making
(2) Focus on scale-up		
(3) Evaluate system readiness		

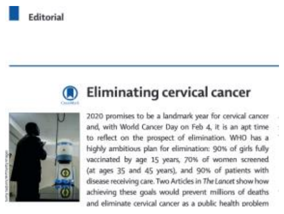


(1) Defining priority interventions

Best investment must reach scale & achieve value for money







OP1	Develop **resource-stratified tool kits** to establish and implement comprehensive programmes… **leveraging work of other organizations**
OP2	Collect, synthesize and disseminate evidence on the **most cost-effective interventions**…and to make an **investment case** for cancer
OP3	Strengthen the capacity of the Secretariat to support implementation of cost-effective interventions and **country-adapted models**…

(1) Priority interventions defined as buys"

Country Example

WHO, IARC, IAEA prioritization

1st Feasibility assessment, scenarios and priorities

Management Policies	
Cancer guidelines	yes
Cancer guidelines incl drug-specific protocols	yes
Cancer guidelines (utilized in >50% facilities)	yes
Cancer guideline (last updated)	2019
Cancer guidelines (include referral criteria)	yes
Breast cancer early detection pgm/guidelines	yes
Cervical cancer early detection pgm/guidelines	yes
Colon cancer early detection pgm/guidelines	no
Childhood cancer early detection pgm/guidelines	no
Breast cancer defined referral	
Cervical cancer defined referral	
Colon cancer defined referral	
Childhood cancer defined referral	no
Breast cancer screening pgm	yes
Breast cancer screening pgm (type)	opportunistic
Breast cancer screening pgm (method)	clinical breast exam
Breast cancer screening pgm (coverage)	>50% and <70%
Breast cancer screening pgm (target age start)	15
Breast cancer screening pgm (target age end)	60
Breast screening test performance (sens)	
Breast screening test performance (sens)	
Cervical cancer screening pgm	yes
Cervical cancer screening pgm (type)	opportunistic
Cervical cancer screening pgm (method)	visual inspection
Cervical cancer screening pgm (coverage)	>50% and <70%
Cervical caner screening (STEPS)	
Cervical cancer screening pgm (target age start)	15
Cervical cancer screening pgm (target age end)	60

Goal: ↑coverage by 1% per yr, focusing on women + children

2nd Health system planning & capacity

EQUIPMENT

Pathology
Radiology
Cancer Diagnosis
Prostate Cancer Diagnosis
Palliative care

CONSUMABLES

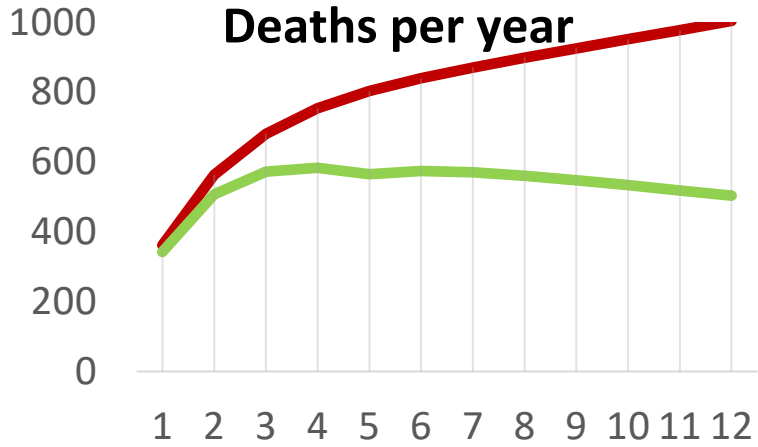
Records
Endoscopy
Radiology and Nuclear Medicine Treatment
Palliative care.

TRAINING

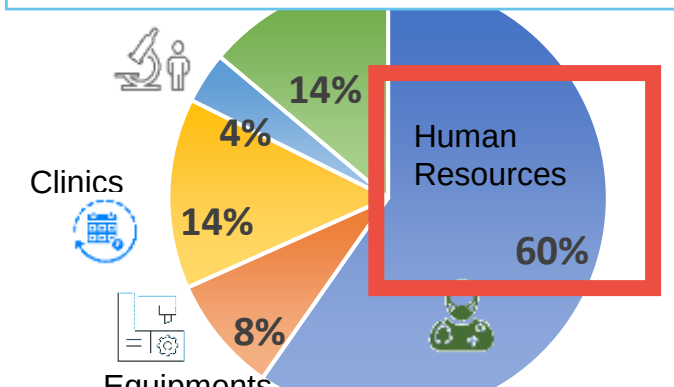
In service training
Quality control programs
Early Diagnosis Policies
Service Organization
Others

Capacity: workforce as bottleneck to reach goal

3rd Generate business model

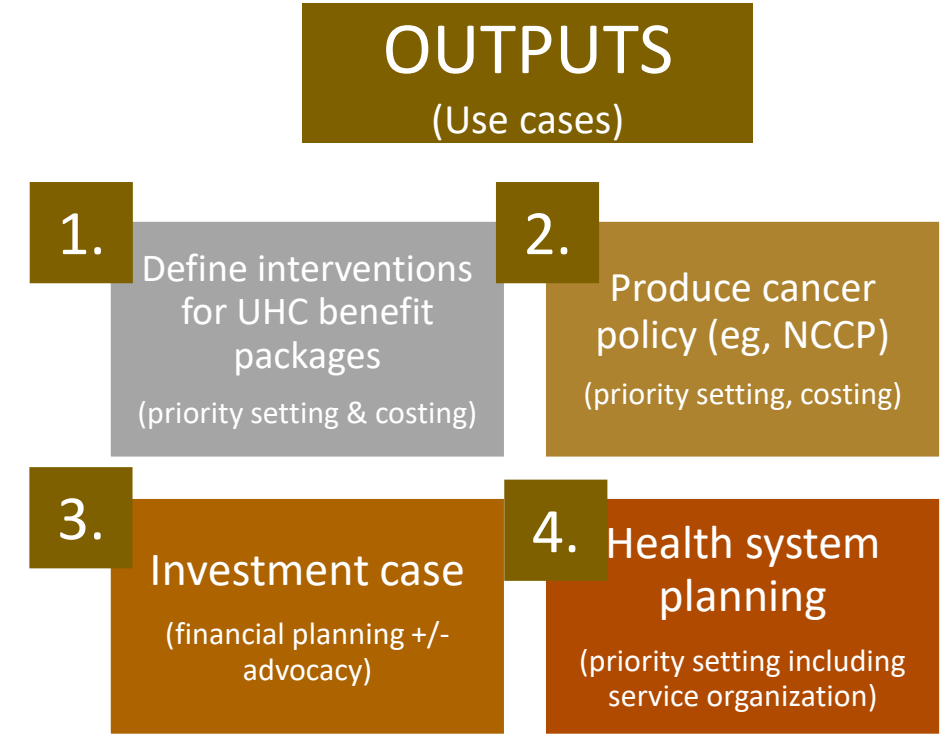


Investment: ↑$US 0.30 to save 100 lives per year (50% <60yo)



Use cases

- Matching tools to country-based stakeholder needs



Justifications:

(1) **<30%** MBP include essential cancer services
(2) **9%** NCCP are costed
(3) **<5%** ODA allocated to cancer
(4) **>70%** cancer programs w/ insufficient HWF

Use cases

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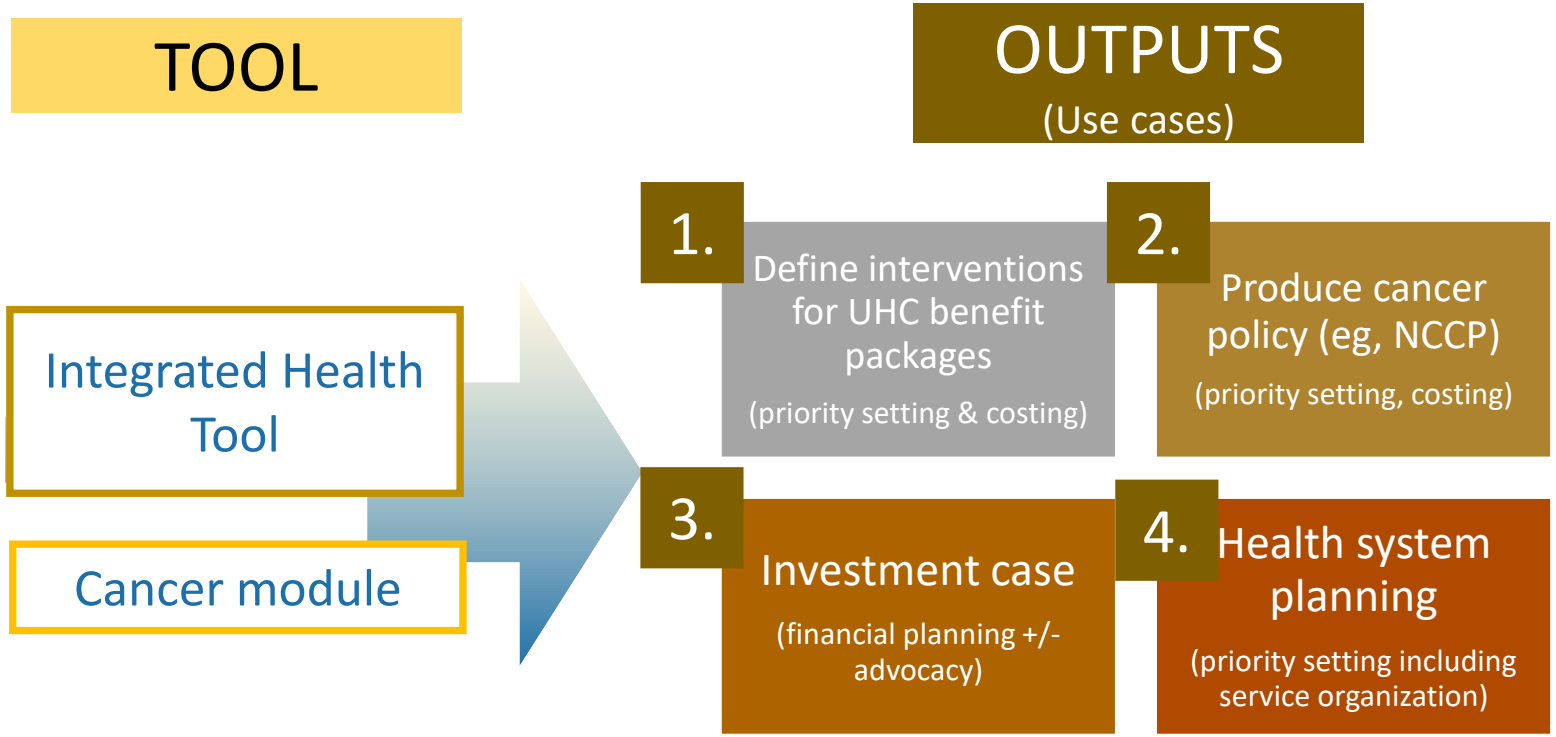

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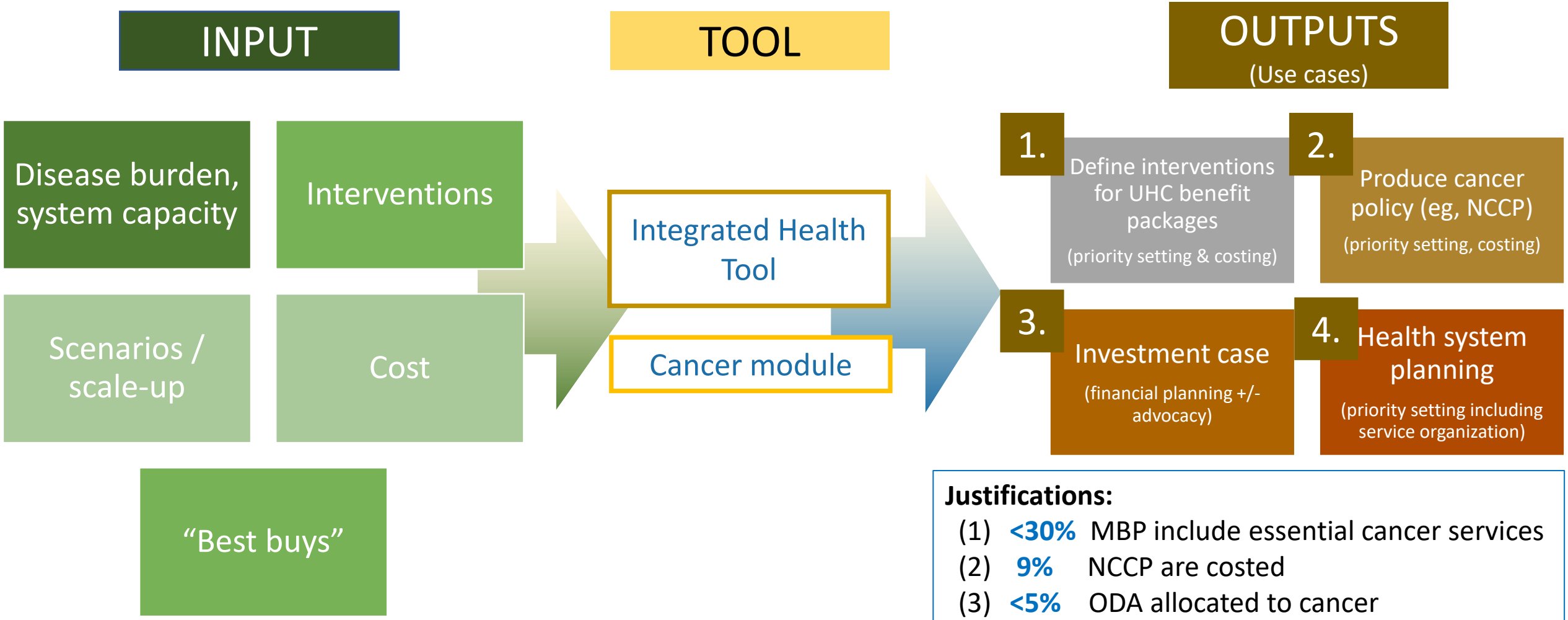

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WHO-IARC Costing Tool structure

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Inputs

Data validation

Establish interventions & scale-up

Outputs

Data

Dialogue

Decision

Assessment tool

Situational analysis
Country database

Tool structure

Inputs

Data validation

Data

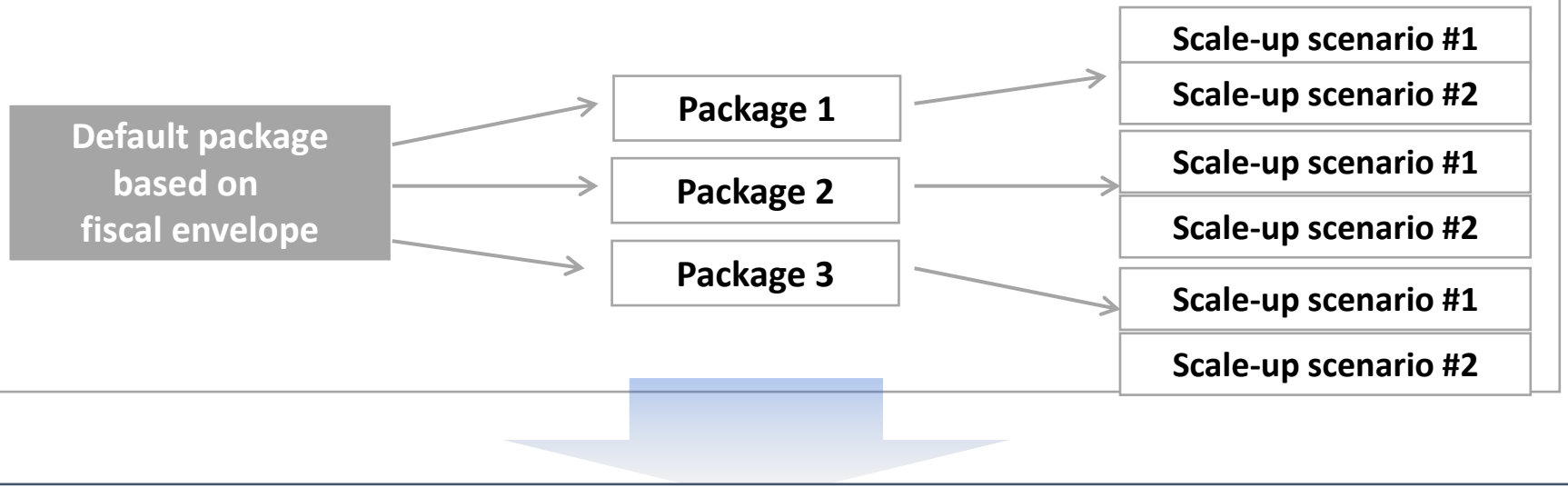
Dialogue

Data inputs

- ✓ **Disease burden**
  - ✓ By cancer, by 5yr age cohort
  - ✓ Stage distribution
- ✓ **Current outcomes**
  - ✓ Survival by stage by cancer
  - ✓ Treatment delays, abandonment
- ✓ **Health system capacities**
  - ✓ Workforce by occupation
  - ✓ Technology availability (by facility)
  - ✓ Expenditure on cancer (including meds)
  - ✓ Referral to private sector or globally
  - ✓ MoH capabilities & governance

→ **Service coverage** (by cancer) (patients per facility)

SELECTING PACKAGE & SCALE-UP SCENARIOS



OUTPUTS

Health Impact
- Lives saved
- Cases averted
- DALYs / HLYg

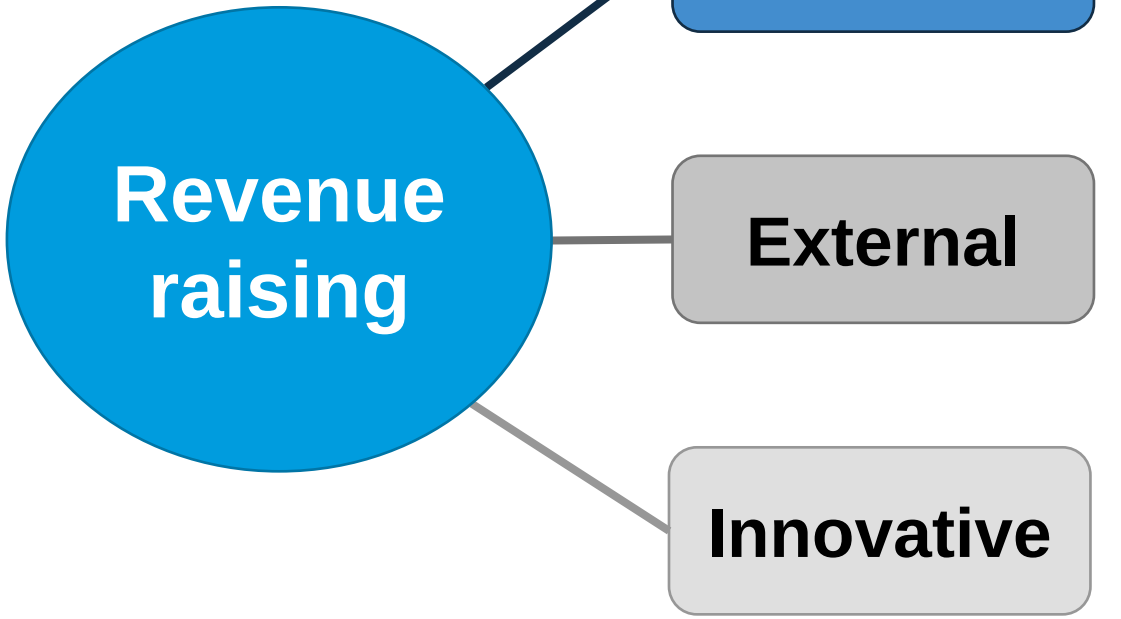
Health System Requirements
- Facilities
- Health workforce
- Capital & recurrent costs
- Programmatic costs

Scale-Up
- Costs
- Coverage rates

Total Costs
- Costs
- *Financing approaches*

Sources of funding

Who is providing the financing?



(1) Prefinancing:
- **(a) Mandatory** (general govern't expenditure)
- **(b) Voluntary** (eg, private insurer, community-based)

(2) Out-of-pocket payment (OOP)

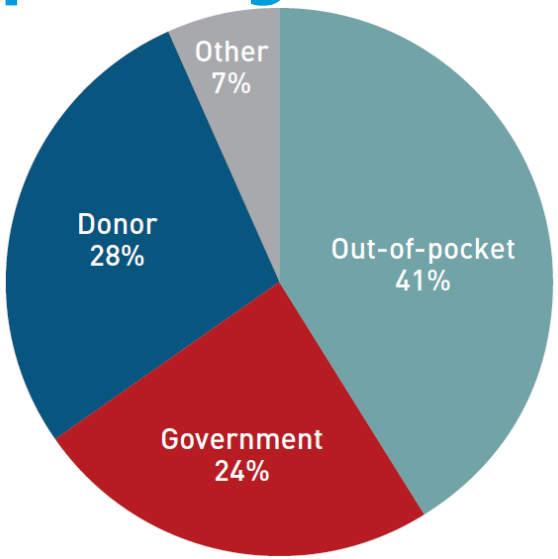
(1) Loans for national/international banks
(2) Grants from donors, development assistance
(3) In-kind support (minor)

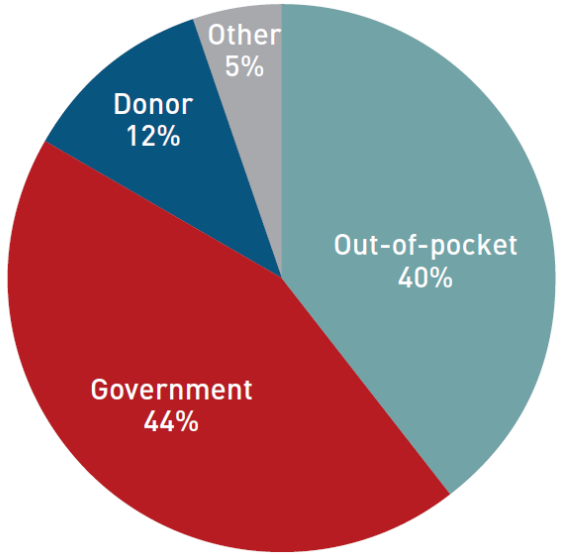
e.g. Innovative financing instruments

Share of health spending

Burden of OOP

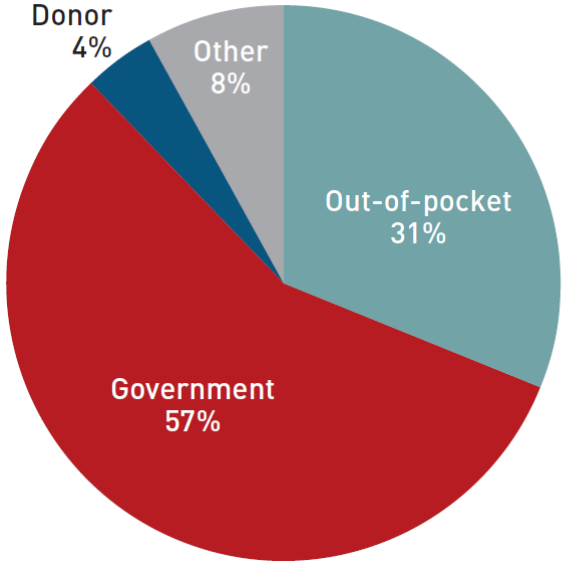
Low income

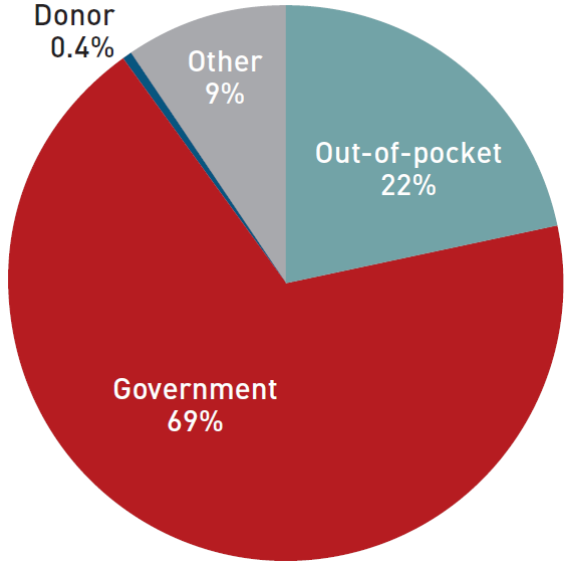




Lower middle income

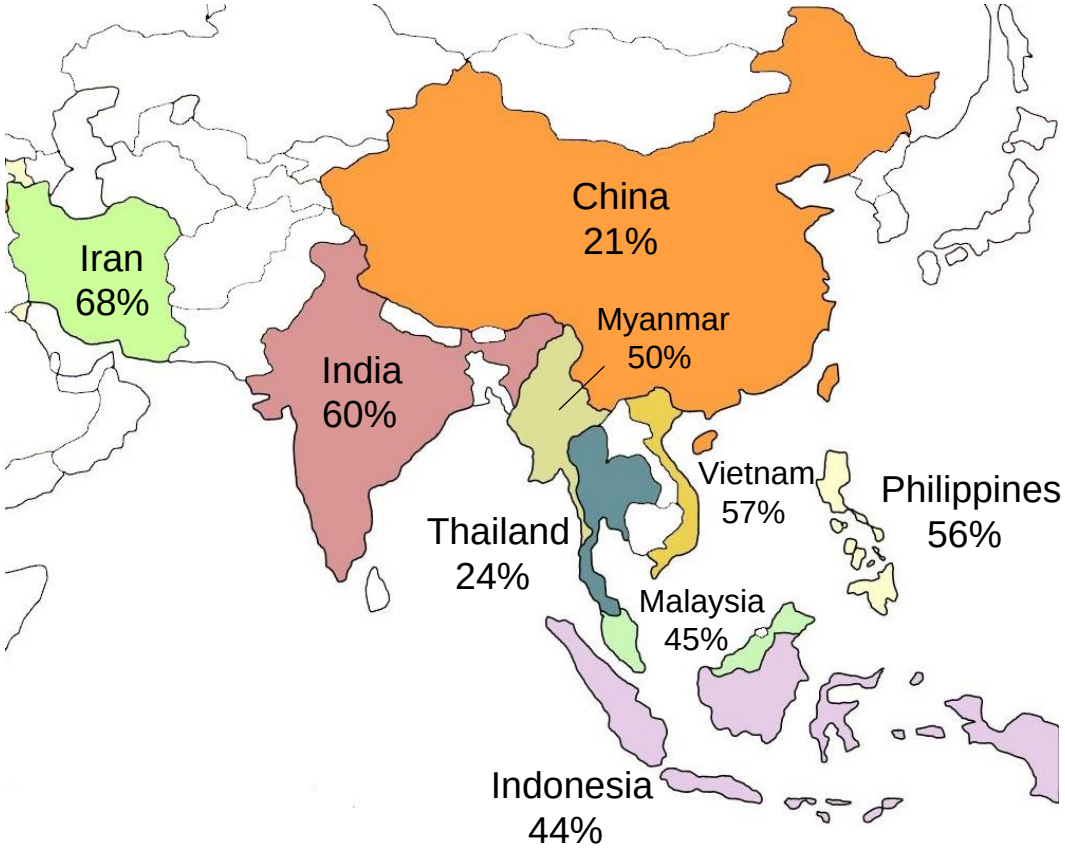
Upper middle income





High income

Financial burden of cancer to households



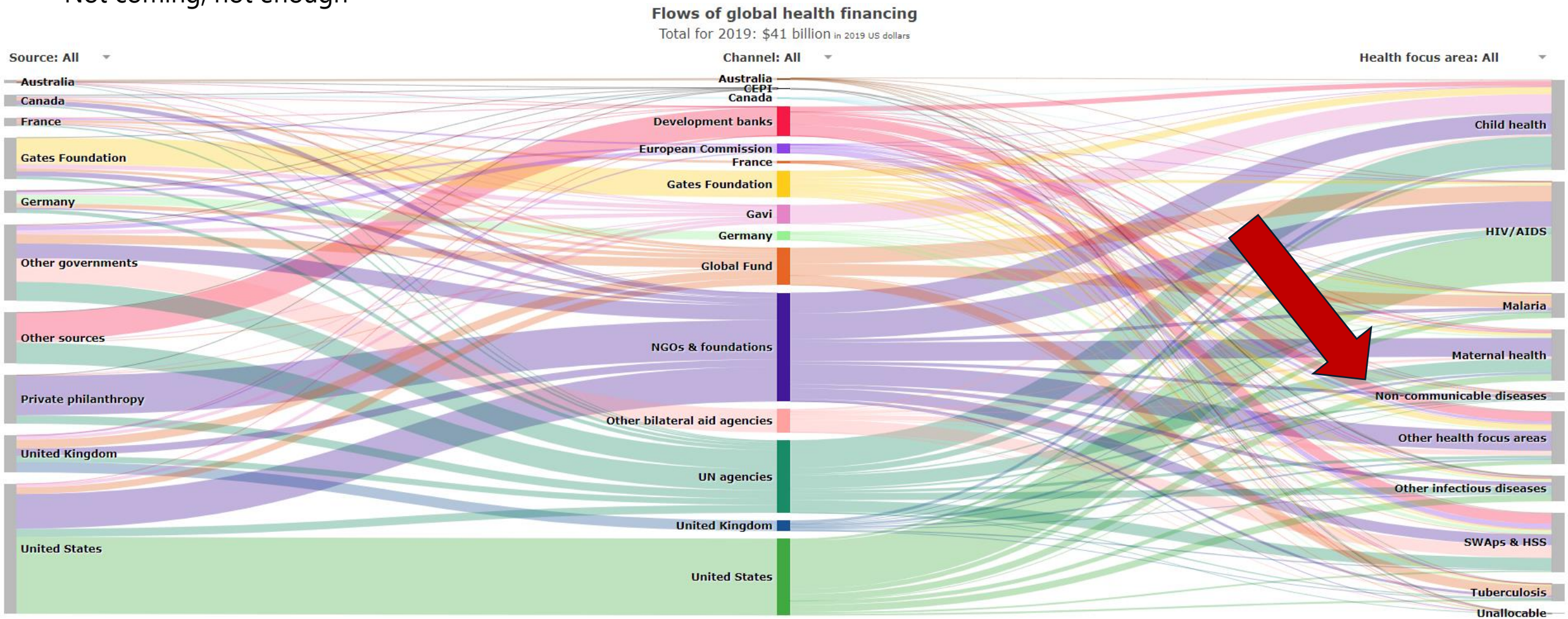
Financial catastrophe due to the costs of cancer treatment

- In many countries, families bear cost of cancer care
- Large out-of-pocket spending puts a heavy burden on families, especially poor
- ***50-90% risk*** of impoverishment due to catastrophic health spending → generational impoverishment.
- ***30-80% risk*** of abandonment

Source: Jan *et al.* 2018. *Lancet* 391(10134):2047-2058; Rajpal *et al.* 2018. *PLoS ONE* 13(2): e0193320; Hoang 2017, *BioMed Res Int*, https://doi.org/10.1155/2017/9350147

Development assistance (grants)

Not coming, not enough



In 2019, $730 million DAH for NCDs

Source: https://vizhub.healthdata.org/fgh

Making cancer care available

Health financing system

How do we spend it? ***(economic factors)***

- To promote equitable, resource use?
-

So, where do we go from here?

Where does the money come from? ***(financial factors)***

- To ensure sufficient and sustainable financing?

Actions that facilitate implementation of national strategic plans

The main actions that facilitate the implementation of NSPs are:

1. **Supportive supervision**- a facilitative approach that enables mentorship, joint problem solving and communication between the mentee and supervisor
2. **Monitoring**
3. **Evaluation**
4. **Reviews** (quarterly, annual, mid-term of end term)

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Guiding principles: *governance, capacity building & accountability*

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Strategies for impact

Foundations for success

Decision-making: Data, Dialogue

Monitor	9%	monitored plan
Governance	28%	dedicated staff
Training, capacity building, cost recovery	~50%	purchase techn without training
Implementation strategy	10%	operational approach

Threats to impact

	Before plan implementation*	After plan implementation†	p value‡
Absolute change in prevalence of smoking in men, 2000–15§ [24]			
All countries (n=59)	−2·1% (4·2)	−1·4% (4·0)	0·17
Tobacco strategy specified (n=53)	−2·0% (4·4)	−1·2% (4·2)	0·07
Tobacco strategy not specified (n=6)	−3·8% (1·4)	−3·3% (1·2)	0·10
Availability of breast cancer screening programme, 2010–15¶ [8]			
All countries (n=48)	42 (88%)	36 (75%)	0·10
Breast cancer screening strategy specified (n=43)	38 (88%)	34 (79%)	0·70
Breast cancer screening strategy not specified (n=5)	4 (80%)	2 (40%)	0·07
New radiotherapy units acquired per year, 1965–2018 [25]			
All countries (n=60)	1·9 (2·9)	3·7 (4·8)	0·01
Radiotherapy mentioned (n=33)	2·4 (3·7)	4·9 (5·9)	0·01

Effective cancer strategy requires

- ✓ Resources to operationalize
- ✓ MoH focal point
- ✓ Investment in infrastructure & workforce
- ✓ **Robust M&E mechanism with acccountability**

A well-structured evidence-based, costed NCCP with clearly defined goals, targets and clear monitoring and evaluation framework is in itself a resource mobilization tool.

Why? Funding gap identified during costing exercise is highlighted during the dissemination exercise and can be used to reach out to funding partners.

Conclusions

Where to go from here

- ✓ **Costing is essential**.

  Approach should focus on **process**, not outcome: **ownership is important**

  - Priority-setting, stakeholder-led **"dialogues"** foundational to success, founded on "**data**"
  - "Decision": **align timing** with broader policy discussions (eg, national health plans)

- ✓ Priority setting **can be** done by cancer type and intervention type

- ✓ WHO – working with IARC, IAEA, ICCP and others – have tools to support

  - **Data-driven** decisions are best, based on **health systems investments**

- ✓ Financing cancer control: requires **multi-dimensional dialogues**

  Based on need and financing streams (eg, governmental agencies, development banks)

  Must focus on **domestic financing** for sustainability

  Investment cases must show the **full social and economic impact of cancer**

Thank you

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S.NO.	Name of technical resource	Link to resources	What year was this resource last updated?
1	Cancer control : knowledge into action : WHO guide for effective programmes ; module 1. Planning	https://www.who.int/publications/i/item/9241546999	2006
2	Cancer control: Prevention	https://www.who.int/publications/i/item/9241547111	2007
3	Cancer control: Early detection	https://www.who.int/publications/i/item/9789241547338	2006
4	Cancer control: Diagnosis and treatment	https://www.who.int/publications/i/item/9241547406	2011
5	Cancer control: Palliative Care	https://www.who.int/publications/i/item/9241547345	2014
6	Cancer control: Policy and advocacy	https://www.who.int/publications/i/item/9241547529	2008
7	Global breast cancer initiative implementation framework: assessing, strengthening and scaling up of services for the early detection and management of breast cancer: executive summary	https://www.who.int/publications/i/item/9789240067134	2023
8	Global breast cancer initiative implementation framework: assessing, strengthening and scaling up of services for the early detection and management of breast cancer	https://www.who.int/publications/i/item/9789240065987	2023
9	National Cancer Control Programmes	https://www.who.int/publications/i/item/national-cancer-control-programmes	2002
10	WHO Guide to cancer early diagnosis	https://www.who.int/publications/i/item/9789241511940	2017
11	Guide for establishing a pathology laboratory in the context of cancer control	https://www.who.int/publications/i/item/guide-for-establishing-a-pathology-laboratory-in-the-context-of-cancer-control	2020
13	Roadmap towards a National Cancer Control Programme	https://www.iaea.org/sites/default/files/19/10/milestones-document-2019.pdf	2019
14	National cancer control programmes core capacity self-assessment tool	https://www.who.int/publications/i/item/national-cancer-control-programmes-core-capacity-self-assessment-tool	2011