CANCER WORKFORCE: COMPETENCIES TO PROVIDE INTEGRATED, PEOPLE-CENTRED CANCER CARE

It’s about the people: assessing the gaps and planning the workforce

Alexandru Eniu, Romania
Cancer Institute “Ion Chiricuta”, Department of Breast Tumors
UICC World Cancer Congress, Kuala Lumpur, Malaysia, 4th October 2018
ESMO IN A NUTSHELL
Europe’s leading Medical Oncology Society

ESMO is the leading European professional organisation for medical oncology, working across Europe and around the world to erase boundaries in cancer care and to provide medical oncology education within an integrated approach to cancer care.

ESMO has over 18,000 members from 150 countries.
The ESMO Asia Congress keeps delegates up to date with the latest developments in the field of oncology research and clinical practice in a way that is relevant to the region and provides the opportunity for networking with local and international peers.
ESMO’S 2020 VISION:
ACCESS TO CANCER CARE

ESMO’s 2020 vision statement recognises that progress in the management of cancer care can and will only occur when high quality care is both available and affordable to everyone everywhere!

ESMO’s vision supports that of World Health Organization and the United Nations, which is to reduce mortality from cancer and promote universal health coverage because health is a basic human right.
Reduce premature mortality from non-communicable diseases, which include cancer, by one-third by 2030
Objective: To improve health, social and economic development outcomes by ensuring universal availability, accessibility, acceptability, coverage and quality of the health workforce

<table>
<thead>
<tr>
<th>Evidence-based policies to optimize the workforce</th>
</tr>
</thead>
<tbody>
<tr>
<td>• To optimize performance, quality and impact of the health workforce through evidence-informed policies on human resources for health, contributing to healthy lives and well-being, effective universal health coverage, resilience and strengthened health systems at all levels.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Catalyse investment in health labour markets</th>
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<tbody>
<tr>
<td>• To align investment in human resources for health with the current and future needs of the population and of health systems, taking account of labour market dynamics and education policies; to address shortages and improve distribution of health workers, so as to enable maximum improvements in health outcomes, social welfare, employment creation and economic growth.</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Build institutional capacity and partnerships</th>
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<tbody>
<tr>
<td>• To build the capacity of institutions at sub-national, national, regional and global levels for effective public policy stewardship, leadership and governance of actions on human resources for health.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Collect data for monitoring and accountability</th>
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<tbody>
<tr>
<td>• To strengthen data on human resources for health, for monitoring and ensuring accountability for the implementation of national and regional strategies, and the WHO Global Strategy.</td>
</tr>
</tbody>
</table>
The 2017 WHO Cancer Resolution demonstrates the importance the WHO and its member states place on the need to address cancer as a leading cause of death worldwide. It calls for countries to promote the optimisation of the current oncology workforce, and anticipate its future requirements.
THE CHALLENGE: MISSING 18,000 HEALTHCARE PROFESSIONALS

The UN High-Level Commission on Health Employment and Economic Growth estimated a shortage of 18,000,000 healthcare professionals to attain the UN Sustainable Development Goals by 2030. The WHO Africa Region (AFRO) will lack twice as many healthcare professionals as the other regions.
HOW WILL WE OPTIMIZE THE CANCER WORKFORCE?

WHO Health Workforce Optimization Study for Cancer Care in partnership with ESMO
A literature review shows that high-income countries have a good overall ratio of all providers (0.7), while low- and middle-income countries have workforce shortages. On the global map below, the lighter the color, the lower the ratio of providers to patients. This data is not yet published.
How provider to patient ratios correlate to patient outcomes:
Fewer providers (light yellow) correlates to higher mortality (dark red)
WHAT THE LITERATURE TELLS US:
HOW MANY ONCOLOGISTS DO WE NEED?

Providers per 100 cancer patients based on country income levels *

Optimal ratios

Current ratios

* Unpublished data. Average values per income levels validated through literature search and expert consultations. Values for LMIC and LIC are estimates.
WHO WORKFORCE STAFFING TOOL: THE MODEL

Cancer continuum → Medical interventions → Time to perform each intervention → Professional competencies

Unpublished data
WHO WORKFORCE STAFFING TOOL: THE WORKLOAD ESTIMATION

Unpublished data

Country burden

Time for each intervention

4 Stages of disease distribution

15 tumor types cover 80% of cancer

Number of providers for 100 cancer patients instead of
Number of providers per 1,000 inhabitants
Example: regional cancer burden and stage distribution for lung cancer (data from one UK cancer registry)

<table>
<thead>
<tr>
<th>LUNG C34</th>
<th>Stage Distribution in %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incidence</td>
<td>Stage I</td>
</tr>
<tr>
<td>4,038</td>
<td>20%</td>
</tr>
</tbody>
</table>
WHO WORKFORCE STAFFING TOOL: TIME CALCULATIONS

- The time to perform medical interventions for the entire cancer continuum for 4 stages of 15 tumor types.
- Workload estimate calculated based on the required time in minutes for each competency per year.
- Data validation obtained through literature search and expert consultation.

15 Tumour Types
- Lung
- Breast
- Colorectal
- Prostate
- Stomach
- Liver
- Cervix Uteri
- Corpus Uteri
- NHL
- Leukaemia
- Lip, Oral Cavity
- Oesophagus
- Bladder
- Kidney
- Pancreas

Unpublished data
WHO WORKFORCE STUDY: GLOBAL STRATEGY COMPONENTS

- Training of the Workforce
- Inflow / Outflow of people in the Workforce
- Maldistribution / Inefficiencies of the functioning of the Workforce
- Regulation of private sector workforce
WHO WORKFORCE STUDY: SURVEY FOR DATA GATHERING

Module 1: The Cancer Workforce
Module 2: Education and early career development
Module 3: Regulation of professional qualifications
Module 4: Professional associations
Module 5: Policies, national cancer plans and legislation
Module 6: Cancer workforce planning models and infrastructure
Module 7: Country progress
### Modelling Scenarios

1. Increase in the number of graduate oncology professionals
2. Reduce the voluntary attrition rate of oncology professionals
3. Change in the number of cancer cases
4. Increase in intervention efficiency
5. Optimization of existing workforce
6. Combination of increased intervention efficiency and optimization
HOW GLOBAL STRATEGY FEEDS INTO WORKFORCE MODELLING SCENARIOS

Global Strategy Components

- Policies on production
  - on infrastructure and material
  - on enrolment
  - on selecting students
  - on teaching staff

- Policies to address inflows and outflows
  - to address migration and emigration
  - to attract unemployed health workers
  - to bring health workers back into the health care sector

- Policies to address maldistribution and inefficiencies
  - to improve productivity and performance
  - to improve skill mix composition
  - to retain health workers in underserved areas

- Policies to regulate the private sector
  - to manage dual practice
  - to improve quality of training
  - to enhance service delivery

Workforce Modelling Scenarios

1. Increase in the number of graduate oncology professionals
2. Reduce the voluntary attrition rate of oncology professionals
3. Change in the number of cancer cases
4. Increase in intervention efficiency
5. Optimization of existing workforce
6. Combination of increased intervention efficiency and optimization
WHO WORKFORCE STUDY: THE OUTPUTS

Goal: to expand health coverage and other services by including workforce policies in national cancer control plans

Step 1: WHO tool for comprehensive situational analysis
- Identifies gaps and inefficiencies in cancer workforce
- Estimates workforce requirements for strategic staffing

Step 2: In-country policy formulation and technical support
- Identifies evidence-based, context-appropriate policies
- Facilitates technical cooperation
- Defines health system capacities and workforce competency
Good health is a basic human right and a prerequisite for sustainable development.

Universal Health Coverage cannot be achieved without rapid scale-up of the health workforce and expanding health coverage to the entire population.

Workforce needs must be linked to national priorities for cancer programmes, and planned and budgeted for in national cancer control plans.

Effective short-, medium- and long-term health workforce strategies exist and should be implemented.

WHO will provide guidance and tools to governments to implement these strategies and will support countries to be able to tailor them to their national needs.

WHO is working in partnership with ESMO to launch a cancer workforce study whose global impact will be key to achieving universal health coverage and saving lives.
THANK YOU!

@aleniu@iocn.ro
Cancer workforce: competencies to provide integrated, people-centred cancer care – a pilot from two countries

Supporting the cancer workforce to develop the skills needed to meet the holistic needs of people living with cancer to support delivery of person-centred care

Dr. Fran Woodard, Executive Director Policy and Impact
Macmillan Cancer Support
Content

1. Cancer population context for UK

2. Workforce challenges and understanding the workforce

3. Understanding needs of people with cancer

4. Solutions – workforce and models of care delivery

5. Influencing
The big picture for cancer in the UK

1970: Cancer is mostly about dying from cancer

1990: Cancer is increasingly about living with cancer

2010 onwards: 

- **1.2m** Living with cancer (59% aged 65+)
- **2.5m** Living with cancer (66% aged 65+)
- **5.3m** Living with cancer (78% aged 65+)

Average survival:
- **1 year**
- **2 year**
- **10 year**
- **10+ year**

Macmillan Cancer Support, registered charity in England and Wales (261017), Scotland (SC039907) and the Isle of Man (604). MAC14053. Updated July 2018
Cancer context and population in the UK

Almost 360,000 people in the UK diagnosed with cancer every year

<table>
<thead>
<tr>
<th>Cancer Type</th>
<th>Number</th>
</tr>
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<tbody>
<tr>
<td>Female breast</td>
<td>54,744</td>
</tr>
<tr>
<td>Prostate</td>
<td>47,107</td>
</tr>
<tr>
<td>Lung</td>
<td>46,341</td>
</tr>
<tr>
<td>Colorectal</td>
<td>41,780</td>
</tr>
<tr>
<td>Skin</td>
<td>15,906</td>
</tr>
<tr>
<td>Non-Hodgkin Lymphoma</td>
<td>13,622</td>
</tr>
<tr>
<td>Kidney-renal*</td>
<td>12,528</td>
</tr>
<tr>
<td>Head and neck</td>
<td>12,055</td>
</tr>
<tr>
<td>Bladder</td>
<td>10,169</td>
</tr>
<tr>
<td>Pancreas</td>
<td>9,912</td>
</tr>
</tbody>
</table>

*calculated using ICD-10 codes C64–C66, C68.

Older people living with cancer will treble by 2040

Number of older people (65 and over) living with a cancer diagnosis in the UK

- **2010**: 1,309,000
- **2040**: 4,109,000

Broadly 3 groups of cancer – pathways are different

Group 1
Many live for more than a decade

Group 2
Most similar to a long-term condition

Group 3
Survival for the majority is short term
Workforce are under pressure

- **11.1 per cent** of NHS nursing posts are vacant, with over **40,000** registered nurse vacancies – nearly double that in 2013 (RCN, 2017).

- There is a heavy reliance on agency staff – equating to **30,000** full-time equivalent nurses.

- The number of nurses employed by the NHS has fallen for the first time on a year-on-year basis since 2013.

- In 2015, nearly half the nursing workforce was aged 45 or over, with 14 per cent aged over 55.

- The average age of a nurse leaving the NMC register has reduced steadily from 55 years of age in 2013 to 51 in 2017.
Summary of challenges

• More people living longer with cancer

• People with cancer and other long term conditions

• An ageing population

• A workforce that is stretched that requires different ways of working, knowledge and skills

• Lack of joined up coordinated care across sectors
How we understand the size of the problem to find solutions

- Know the current and future workforce picture
- What the challenges are for the workforce
- What the challenges are for people with cancer
Workforce census – to understand the size, state and composition of the non-medical cancer workforce

Who?

• Specialist cancer nurses
• Adult Chemotherapy nurses
• Cancer Support Workers (band 3 and 4 used in this analysis)
• Specialist palliative care nurses (who see over 50% cancer patients)

What?

• Job title
• Agenda for Change banding
• Area of practice
• Specialist training required for the post *
• If post covers Cancer of Unknown Primary
• If post covers Secondary/metastases *
• If post filled or vacant
• Gender
• Age band
• WTE
• Proportion of time in cancer *
• Macmillan badged
• Nationality *
• Setting *
• Location of care *
• Country
• Region
• Provider * New
Whole time equivalent numbers for each role

The report provides information about four different types of posts employed within the NHS (numbers are calculated based on whole time equivalents (WTE) working in cancer):

- **4,020** Specialist cancer nurses
- **2,686** Adult chemotherapy nurse posts
- **635** Cancer support workers
- **978** Specialist palliative care nurses
A survey via the four Professional Bodies that represent Dietitians, Occupational Therapists, Physiotherapists and Speech and Language Therapists across the UK.

Rehabilitation is a central element of cancer care. Although many AHPs do not work solely with those with cancer, their role is vital in supporting people living with cancer.

To better understand the composition and cancer caseload of the AHP workforce, we invited everyone from 4 of the professions to take part in an online survey.

Composition  
- Age, gender, pay bands, setting, funding.

Cancer caseload  
- The proportion that supports PLWC, their average cancer workload, which cancer types they saw & which interventions they carried out.
We’re using data to understand the needs of people living with cancer
Electronic Holistic Needs Assessment

It’s how the needs of people living with cancer can be assessed and met.

It collects valuable data which can tell us how we’re doing against our objectives.
“How do we get thousands of rows of concerns data into a meaningful message? How do we fit this in to types of need?”

EHNA Outputs Jun 2017 - Jun 2018

1. Physical concerns are more likely to be rated as 'high'.
2. Practical concerns are more likely to be rated as 'high'.
3. Most people didn’t express financial concerns.

Age by top 5 concerns:
- Tired, exhausted or fatigued: Concerns increase with age.
- Worry, fear or anxiety: Worry, fear, and anxiety are big factors for younger people.
- Sleep problems: Concerns about pain increase with age.
- Pain or discomfort: Concerns increase with age.
- Eating appetite or taste: Concerns increase with age.

Most people didn’t express financial concerns.
Understanding needs

- Isolation
- Unmet social care needs
- Return to normality - Regaining control
- Information and communication
- Poverty
- Deteriorating health & wellbeing
- Dying a dignified death
- Return to work
- Dealing with emotional legacy
- Treatment - Coping & recovering
- Dealing with late effects
Approaches – improving training and competencies

• Improving career pathways to and through specialist cancer roles.
• Improving skill mix and introducing new types of cost-efficient roles.
• Enhancing the skills and confidence of existing staff, and communication between them.
• Competency based approach
Approaches – different ways of working

• Improving ways of working.
• Interventions that enable personalisation
• Exploring how new ways of understanding the cancer population to support workforce planning based on need rather than tumour type
Personalised Care

**What:**
- Conversation
- Navigation
- Needs assessment
- Care plan

**How:**
- People
- Relationships
- Model
- Tools

**Where:**
- Acute
- Primary
- Digital
- Community
Models to support personalised care and support

Recovery Package - a set of interventions to assess, plan, coordinate and communicate

• The Recovery Package seeks to provide people diagnosed and living with cancer the support they need to lead the best possible life they can.

• To do this the Recovery Package contributes to improving patient experience and personalisation of care, which can impact some quality of life and health outcomes for some people.

• It aims to ensure that from diagnosis, or soon after diagnosis, people’s changing needs are identified and addressed so that their care is person-centred and their health and wellbeing needs are supported.
What is the problem and how can a framework help?

**Problems**

- Evidence indicates that people living with cancer have common unmet needs across the cancer pathway
- The workforce does not routinely address those needs in a timely way
- The workforce is not routinely optimising the combined skills of team to address needs

**Solution**

- Clarify what competencies are needed at what level in the workforce to address common unmet needs
- Use this to assess existing teams levels of competency
- Work with teams to identify possible solutions e.g. training or new roles
Shifts we want to see

Developing framework and capability to deliver workforce improvement

<table>
<thead>
<tr>
<th>Now</th>
<th>Action</th>
<th>Future</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Unclear about who does what</td>
<td>• Define competencies required at each level</td>
<td>• Job descriptions based on clearly defined competencies</td>
</tr>
<tr>
<td>• Varied approaches to workforce development</td>
<td>• Develop training &amp; resources in using competency framework</td>
<td>• Standardised evidenced based approach to workforce development</td>
</tr>
<tr>
<td>• Person centred care is patchy</td>
<td>• For each common unmet need define competencies required</td>
<td>• Clarity about mix of competencies required according to patient need</td>
</tr>
<tr>
<td>• Varied and unclear requirement for training needs</td>
<td>• Assess teams current competencies against framework</td>
<td>• Identify gaps in competencies and agree action plan to address</td>
</tr>
</tbody>
</table>
### Illustration - workforce competencies required for fatigue

<table>
<thead>
<tr>
<th>Skill type/level</th>
<th>Unregistered</th>
<th>Registered</th>
<th>Advanced</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assess</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Plan/ treat</td>
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<tr>
<td>Enable</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Link</td>
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</table>

- **Screen for treatable causes** such as anaemia, hypothyroidism, depression, anxiety, weight loss, pain, medication side effects, infection, anorexia, malabsorption & other co morbidities

- **Appropriately reassess & refer on multidisciplinary working** including reassessment of exercises & progression where appropriate

- **Help the patient develop approaches** to lifestyle and health management. Work together with the patient not only to adopt the principles of healthy living, but specify strategies and actual behaviours that will optimise the health of each individual

- **Arrange services and support** with other health care providers. Exchanging information & negotiate services and support with other health care providers in order to facilitate continuity of care for patients.
Benefits of a competency framework approach

For patients
Access timely assessment of holistic needs and person centred support
Receive support from competent staff regardless of type of post

For workforce
Facilitates personal and team development
Frees up capacity of senior staff to manage complex care and act in consultant role

For system
Supports efficient & flexible workforce
Potential to improve retention

For Macmillan
Clarity about level & type of skills needed for investment & influencing
Potential to develop volunteers in appropriate competencies
Provides focus for learning & development
Key influencing reports

1. Frontline – Workforce pressures in the national health service, Sept 2017

2. Thinking Differently: Macmillan’s vision for the future cancer workforce in England, February 2017
Our purpose

TO HELP EVERYONE WITH CANCER LIVE LIFE AS FULLY AS THEY CAN
Our benefit

YOUR BEST WAY THROUGH
Thank you – Any Questions?

Dr. Fran Woodard
Executive Director of Policy & Impact
Macmillan Cancer Support

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@franwoodard
CANCER WORKFORCE: STRATEGIES TO PROVIDE INTEGRATED, PEOPLE-CENTRED CANCER CARE

Strategies to Build Health Workforce Capacity: St Jude Experience in Childhood Cancer

Catherine Lam, MD, MPH, FRCPC, FAAP
Director, Health Systems Unit
Director, Asia Pacific Regional Program
Associate Professor, Faculty Pediatric Oncologist
Departments of Global Pediatric Medicine and Oncology
Vision of St. Jude Global

For 25 years, we have worked with collaborators around the world to improve care delivery

International Outreach Program

Department of Global Pediatric Medicine

St. Jude Global Alliance

Education

Program Building

Research

That every child diagnosed with cancer or a blood disorder will have access to quality care no matter where they live
Equipping & Sustaining the Workforce

- Recruit
- Train
- Retain
- Integrate
- Promote

- Individual-based
- Unit/Program-based
- Hospital-based
- Community-based
- Network-based
Workforce: Levers of Change

Fostering role recognition
Nature and quality of work environment

Economy, population and broader societal drivers

Education sector

Education in health
Education in other fields

Pool of qualified health workers *
Migration
Abroad

Labour market dynamics

Employed
Unemployed
Out of labour force

Health care sector **

Health workforce equipped to deliver quality health service

Other sectors

Universal health coverage with safe, effective, person-centred health services

Adapted from WHO 2016 Global Strategy on HRH: Workforce 2030
Training, Organizational & Funding Support

50+ multidisciplinary team members

New disciplines, career tracks, and team roles

Increased Local Role Recognition and Financing

Increased visibility and recognition of specialized competencies and distinct roles

Increased sustainable local financing support for workforce & work environment

Enhanced Workforce Engagement and Regional Roles, with Maturation of Program Portfolios

Boosted morale: engagement of leadership, specialty, primary care and community-based workforce

Linkages across training programs and regional network
Philippines Childhood Cancer Workforce SWOT
Within National Health System Context

<table>
<thead>
<tr>
<th>Health System Block</th>
<th>Strengths</th>
<th>Weaknesses</th>
<th>Opportunities</th>
<th>Threats</th>
</tr>
</thead>
</table>
| Health Workforce    | • Committed, motivated and trainable workers | • Lack of Specialists  
• Lack of training programs  
• High turnover  
• Limited permanent government salaried plantilla positions | • Ped Onc Fellowship Program  
• Nursing positions | • Change in Political priorities  
• Attractive overseas opportunities for providers and nurses |
Workforce: Levers of Change

Exposure to quality education
Engaging & equipping teaching staff & students

Fostering role recognition
Nature and quality of work environment
Asia Pacific Program
Local Systems-based Workforce Strengthening

Sample assessments of education sector

• Assessing cancer awareness and literacy in lay public, undergraduate medical and allied health programs

• Assessing availability and nature of training (e.g. pathology, radiation oncology, social work, child life)

• Assessing educational program design, curriculum content, delivery, and evaluation (EPAT tool)

• Assessing educational and work culture, workforce and skills mix (PrOFILE tool)

• Assessing policy and fiscal environment for sustainable workforce (C5 tool)

Strategies to increase pool of qualified health workers

• Exposure to childhood cancer in undergraduate medical and nursing and primary care / general pediatric programs (lectures, rotations, research electives)

• Governance for international partnerships and support (operational/financial) for training

• Nationally-approved training program with structured curriculum (e.g. for pediatric hem/oncology fellowship)

• Facilitate multidisciplinary learning & continuing education culture – online & on-site (e.g. Myanmar network > 4-fold growth)

• Local governance supporting funded non-rotating positions and career path for qualified trainees
Central America Pediatric Oncology Fellowship Training Program

Guatemala (UNOP)

• Local fellowship program opened to regional trainees

• 2003 – 2018: 23 graduates
  • < 5% attrition rate
  • Selected with planned position at home institution

• >90% of pediatric oncologists in the region are graduates
  • ~50% in leadership positions
  • >60% academically active in research

• > 50% increase in number of patients seen

• First pediatric hematology-oncology fellowship training program to seek international accreditation by ACGME-I (in progress)
St. Jude Global Education
Open access distance learning

Content
• Educational seminars
• Online classroom courses (self-paced and instructor-led)
• Web-based collaboration tools
• Oncopedia
  • Cases, images, and chapters
  • Moderated discussions
• Live online meetings

> 1,600 online seminars
37 self-paced courses
36 instructor-led courses
Multi-lingual, multidisciplinary content
Users in the last year
• 7,190 active users
• 150 countries
• 45,585 content views
• 2,274 meetings (2,107 participants)

www.cure4kids.org
Questions to be Discussed

- Given limitations in diagnostic tests (urine VMA and NSE), can NBL diagnosis be made on clinical presentation and morphology as in this case?

- What is the rate of febrile neutropenia complications in the intermediate risk regimen, A3961? We prescribe GCSF routinely, but is expensive. Does prophylactic antibiotics (Cefixime) lessen the episodes of febrile neutropenia? (Our patients are malnourished with poor oral hygiene, and live in overcrowded places)

Chat (Everyone)

Patricia Alcasabas, Philippines 3: We have free chemo now from the government for all solid tumors but GCSF is not available. Nehal Parikh, US: When will you re-assess?

Patricia Alcasabas, Philippines 3: IMy connection is so poor and cannot hear the discussions well and on real time :)

Patricia Alcasabas, Philippines 3: Thanks! Our half way house will open this Feb

stephen shochat, US 2: I think it would be resectable without too much difficulty. May develop Horner’s syndrome post-op.
Asia Pacific Regional Program

Asia Pacific Tumor Board Members: 195
Institutions: 53+ (49 in Asia)
Countries: 20
(as of June 2018)

St. Jude VIVA Preforum Workshops and Pre-Workshop Symposia
Retinoblastoma 2017
Pathology 2018
Regional Retinoblastoma Protocol Project
More than 100 Providers trained across more than 18 Countries
St. Jude Global Academy
Training Seminars – Class of 2018

2018 St Jude Global Academy – Infectious Disease Training

<table>
<thead>
<tr>
<th>Learning Modules</th>
<th>Distance</th>
<th>Residential</th>
</tr>
</thead>
<tbody>
<tr>
<td>Week</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Enhancers</td>
<td>SE</td>
<td>M1-R</td>
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</tbody>
</table>

20 institutions
17 countries
5 regions

www.cure4kids.org

2018 St Jude Global Academy – Infectious Disease Training

<table>
<thead>
<tr>
<th>Day</th>
<th>1</th>
<th>2</th>
<th>3</th>
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<th>5</th>
<th>6</th>
<th>7</th>
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<td>Themes</td>
<td>Education</td>
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<td>Infection Case I Diagnosis</td>
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<td>Infection Case II Treatment</td>
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<td>Prevention &amp; Risk of Infection</td>
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<td>Infection Essentials</td>
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<td>Leadership Forum</td>
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<td>Research Project Workshop</td>
<td></td>
<td>Research Essentials</td>
<td></td>
<td>Graduation</td>
<td></td>
<td>Healthcare Organization</td>
<td></td>
<td>St Jude PIDS:</td>
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<tr>
<td></td>
<td>Graduation</td>
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<td></td>
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</tbody>
</table>

Abbreviations: M=Module; SE=Subject Expert; R=Review
MSc in Global Child Health

- Two-year program with 10-15 students/year
  - US and international students
- Blended model: On Campus + Distance
  - Health systems innovation
  - Clinical research
  - Population science
- 2-year capstone funded projects to advance care and research within a region

- First class Summer 2019
Challenge: Policy Gap
St. Jude National Cancer Control Plans (NCCP) Analytic Program (2014-Present; PI: Catherine Lam)

880+ Files Identified & Screened for Inclusion
- 396 ICCP
- 96 WHO NCD Repository
- 333 WHO National Health Planning Database
- 58+ Other sources

462 Files Included for Review - NCCP Core Bank

263 Files Included for Full Coding
- 131 Cancer, 96 NCD, 36 Health
- Median 51 pages (1-426)

Representation:
- 165 distinct sites (157 countries)
- 6 WHO Regions
- All income settings
- 7 languages analyzed (5 with coding sets)

Fewer than 30% of national policies mention workforce needs for children with cancer (in development)

Missed opportunities to connect sectors (e.g. traditional health, benign hematology, palliative care) (BJC 2015, PBC 2017)

- Pediatric Oncology Included
- No Pediatric Oncology Included
- Plan status not available
Challenge: Policy Gap
St. Jude National Cancer Control Plans (NCCP)
Analytic Program (2014-Present; PI: Catherine Lam)

- Of the 6 elements of the Global Health Workforce Alliance (WHO/USAID) Human Resources for Health (HRH) Framework:
  - **Education** was the most commonly included element within national plans inclusive of workforce needs
  - **Financing** was the least commonly included element

Moreira D, Ritter JE, Lam CG, in development
Universal health coverage with safe, effective, person-centered health services

Exposure to quality education
Engaging & equipping teaching staff & students

Fostering role recognition
Nature and quality of work environment

Adapted from WHO 2016 Global Strategy on HRH: Workforce 2030
Special Thanks

Dr. Tricia Alcasabas
Dr. Federico Antillon
Dr. Miguela Caniza
Dr. Mae Dolendo
Dr. Aye Aye Khaing
Dr. Monika Metzger
Dr. Daniel Moreira
Dr. Shaloo Puri
Dr. Ibrahim Qaddoumi
Ms. Julie Ritter
Dr. Carlos Rodriguez-Galindo
Thank you 고맙습니다 cảm ơn bạn ขอบใจ salamat คุณมั่นคง ร่าฆีมต้า cara ต่ำ สู้ธิี rahmat wazviita баярлалaa

clam@stjude.org
Model and framework to formulate policies

Putting it all together

André Ilbawi, MD
Medical Officer, Cancer Control
World Health Organization
ilbawia@who.int

Conflicts of Interest: None

Special thanks to Dr Dario Trapani, WHO Consultant
Differences in Cancer Outcomes Correlate with Workforce Density
Framing the Dialogue

How to build capacity when gaps are significant?

1. Setting global agenda through **Global Strategy** for HRH 2030
2. Developing **policy dialogue** for cancer health workforce
   - Estimating unmet need through novel tool
   - Providing evidence-based strategies for capacity building
     1. ↑ # of providers through training positions
     2. ↓ attrition rates
     3. Improve efficiency through service prioritization
     4. ↑ intervention efficiencies (e.g. telepathology)
     5. Optimize workforce through organizational structure

http://www.who.int/universal_health_coverage
## Comparison Between Two Countries

### Ethiopia vs United Kingdom

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Ethiopia FTE/100,000</th>
<th>United Kingdom FTE/100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical oncologist</td>
<td>0.4</td>
<td>5.6</td>
</tr>
<tr>
<td>Radiation oncologist</td>
<td>0.3</td>
<td>2.0</td>
</tr>
<tr>
<td>Medical physicist</td>
<td>0.1</td>
<td>0.7</td>
</tr>
<tr>
<td>Surgical oncologist</td>
<td>0.1</td>
<td>1.3</td>
</tr>
<tr>
<td>Paediatric oncologist</td>
<td>3</td>
<td>33</td>
</tr>
</tbody>
</table>

### Incidence and Mortality

- **Ethiopia 2012**
  - Breast: 0.3
  - Cervix uteri: 0.3
  - Ovary: 0.1
  - Colorectum: 0.4
  - Prostate: 0.1
  - Leukaemia: 0.1
  - Non-Hodgkin lymphoma: 0.7
  - Lung: 0.1
  - Oesophagus: 3
  - Thyroid: 3

- **United Kingdom 2012**
  - Breast: 40
  - Cervix uteri: 20
  - Ovary: 10
  - Colorectum: 5
  - Prostate: 5
  - Leukaemia: 2
  - Non-Hodgkin lymphoma: 1
  - Lung: 1
  - Oesophagus: 0
  - Thyroid: 0

---

### Comparison Between Two Countries

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Ethiopia FTE/100 pts</th>
<th>Ethiopia FTE/100,000</th>
<th>United Kingdom FTE/100,000</th>
<th>United Kingdom FTE/100 pts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical oncologist</td>
<td>0.6</td>
<td>0.4</td>
<td>5.6</td>
<td>0.85</td>
</tr>
<tr>
<td>Radiation oncologist</td>
<td>0.4</td>
<td>0.3</td>
<td>2.0</td>
<td>0.3</td>
</tr>
<tr>
<td>Medical physicist</td>
<td>0.2</td>
<td>0.1</td>
<td>0.7</td>
<td>0.1</td>
</tr>
<tr>
<td>Surgical oncologist</td>
<td>0.2</td>
<td>0.1</td>
<td>1.3</td>
<td>0.2</td>
</tr>
<tr>
<td>Paediatric oncologist</td>
<td>5</td>
<td>3</td>
<td>33</td>
<td>5</td>
</tr>
</tbody>
</table>

**Notes:**
- The data represents the number of full-time equivalent (FTE) positions per 100,000 population for each occupation in Ethiopia and the United Kingdom.
- The data is specific to 2012.
**Prioritization & Costing Tool**

### Situational analysis

- Assessment of country by a preliminary assessment, providing information on health workforce
- Select services based on priorities, health system capacity
- Estimate the **unmet need** requirements & inefficiencies at national-level

### Policy formulation & Technical support

- Analyse gaps for in-country dialogue to inform policy decisions about **prioritization** for cancer workforce

---

**Goal**

*to improve access to trained providers & cancer services*
**Cancer care service availability.**

Which of the following cancer care services are available in your country (including private and public sector)?

*Check any that apply.*

- [x] Radiology
- [x] Pathology
- [ ] Nuclear medicine
- [x] Surgery
- [ ] Genetic testing
- [ ] Systemic therapy
- [ ] Paediatric oncology
- [x] Radiation oncology
- [ ] Radiation safety
- [ ] Palliative care
- [ ] Oncology social work
## Cancer care occupations.

Which of the following cancer care occupations exist in your country (including private and public sector)?

*Check any that apply*

- [ ] Check all
- [ ] Radiographer / medical imaging technician
- [ ] Radiologist
- [ ] Anatomic pathologist
- [ ] Surgical oncologist
- [ ] Radiation oncologist
- [ ] Breast surgeon
- [ ] Medical oncologist
- [ ] Oncology pharmacist
- [ ] Biomedical laboratory scientist
- [ ] Oncology nurse
- [ ] Medical physicist
- [ ] Clinical officer / non-physician in surgery
- [ ] Gynaecologic oncologist
- [ ] Plastic surgeon
<table>
<thead>
<tr>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>→ Estimate unmet need</td>
</tr>
<tr>
<td>→ Inefficiencies between facilities</td>
</tr>
<tr>
<td>→ Scope of practice</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>301vi. to perform tissue handling, transportation, tissue assessment, sectioning and staining, analysis of tissue sections?</td>
</tr>
<tr>
<td>301vii. to perform?</td>
</tr>
</tbody>
</table>

- Pathologist
- Pathology technician
- Other health professional (specify ______)
- Service not available
Framing the Dialogue

How to build capacity when gaps are significant?

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2. Developing **policy dialogue** for cancer health workforce
   - Estimating unmet need through novel tool
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     1. ↑ # of providers through training positions
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     3. Improve efficiency through service prioritization
     4. ↑ intervention efficiencies (e.g. telepathology)
     5. Optimize workforce through organizational structure
Global Strategy Components

Policy Levels to Shape Health Labour Markets

- Education sector
  - Education in health
  - Education in other fields
  - Pool of qualified health workers
    - Migration
      - Abroad

- Labour market dynamics
  - Employed
  - Unemployed
  - Out of labour force
    - Other sectors
  - Health care sector
    - Health workforce equipped to deliver quality health service

**Policies on production**
- on infrastructure and material
- on enrolment
- on selecting students
- on teaching staff

**Policies to address inflows and outflows**
- to address migration and emigration
- to attract unemployed health workers
- to bring health workers back into the health care sector

**Policies to address maldistribution and inefficiencies**
- to improve productivity and performance
- to improve skill mix composition
- to retain health workers in underserved areas
<table>
<thead>
<tr>
<th><strong>1. Incr # graduate oncology professionals</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cervical Cancer Prevention Training in Tanzania</td>
</tr>
<tr>
<td>Global health Service Partnership</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>2. Reduce voluntary attrition rate</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial incentives and rural allowance (Indonesia)</td>
</tr>
<tr>
<td>Retention package, with fees for providers and family i.e. school &amp; allowance (Zambia)</td>
</tr>
<tr>
<td>Training opportunities (Thailand, South Africa)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>3. Change in the number of cancer cases</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>New breast cancer screening in country</td>
</tr>
<tr>
<td>Estimations of cancer workforce for breast cancer screening</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>4. Increase in intervention efficiency</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Telepathology</td>
</tr>
<tr>
<td>Time-saving (1/3 time for telecytology)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>5. Optimize existing workforce</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Evidence-based policies do exist... but, few for cancer in LMIC</td>
</tr>
<tr>
<td>&gt;6,000 abstracts reviewed</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>6. Combo incr efficiency &amp; optimization</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Telemedicine</td>
</tr>
<tr>
<td>Telepathology</td>
</tr>
<tr>
<td>Supportive supervision</td>
</tr>
<tr>
<td>Role-delegation/task-shifting</td>
</tr>
<tr>
<td>Nurses prescribing oral morphine (Rwanda)</td>
</tr>
</tbody>
</table>
1. Increase in number of professionals

Attract, Recruit, and Retain a Prepared and Diverse Workforce to expand the capacity of the workforce

Global Health Service Partnership

Public-private partnership

Cervical Cancer Prevention Training in Tanzania

refresher training in VIA and cryotherapy for local trained providers and key district and university leadership

Helping the achieve met of Tanzania’s goal to address cervical cancer elimination
2. Reduce voluntary attrition rate

Voluntary annual attrition rate 1-17%

69% have intentions to leave their current health facility*

NCHHSTP workforce strategy for development and capacity building

HIC: 2%
MIC: 10%
LIC: 15%

Financial incentives and rural allowance for working in remote areas (Indonesia)
Training opportunities (Thailand, South Africa)
Retention package (e.g. allowance for providers and family) (Zambia)

1. The use of incentives and compulsory services
2. Improving working conditions
3. Improving living conditions

Low salaries
Lack of CME, prof develop
Lack of effective supervision
Weak regulatory environments
Isolation (rural areas)
Poor working conditions
Stress or large caseloads
Lack of motivation/low job satisfaction

Lehmann U, BMC Health Serv Res 2008 • Bonenberger, Human Resources for Health 2014 • Casto Lopes S, Human Resources for Health 2014 • Dean HD, Jam pere 2014
3. Prioritizes high-impact cancer services (e.g. BC screening)

**TABLE 3: Projected Numbers of Women 40 Years Old and Older and Radiologists per 100,000 Population by Year**

<table>
<thead>
<tr>
<th>Country</th>
<th>Population</th>
<th>Radiologists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Algeria</td>
<td>35,101,720</td>
<td>788</td>
</tr>
<tr>
<td>Benin</td>
<td>8,532,547</td>
<td>12</td>
</tr>
<tr>
<td>Burkina faso</td>
<td>14,902,785</td>
<td>26</td>
</tr>
<tr>
<td>Dithrouy</td>
<td>900,000</td>
<td>1</td>
</tr>
<tr>
<td>Egypt</td>
<td>81,713,517</td>
<td>1250</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>80,000,000</td>
<td>100</td>
</tr>
<tr>
<td>Kenya</td>
<td>36,800,000</td>
<td>105</td>
</tr>
<tr>
<td>Libya</td>
<td>6,173,579</td>
<td>30</td>
</tr>
<tr>
<td>Mauritania</td>
<td>3,364,940</td>
<td>11</td>
</tr>
<tr>
<td>Morocco</td>
<td>34,343,219</td>
<td>450</td>
</tr>
<tr>
<td>Nigeria</td>
<td>130,000,000</td>
<td>300</td>
</tr>
<tr>
<td>Rwanda</td>
<td>10,473,282</td>
<td>7</td>
</tr>
<tr>
<td>Sudan</td>
<td>40,218,466</td>
<td>200</td>
</tr>
<tr>
<td>Sychelles</td>
<td>85,000</td>
<td>3</td>
</tr>
<tr>
<td>Tanzania</td>
<td>41,048,532</td>
<td>30</td>
</tr>
<tr>
<td>Tunisia</td>
<td>10,383,577</td>
<td>450</td>
</tr>
<tr>
<td>Uganda</td>
<td>32,369,558</td>
<td>38</td>
</tr>
<tr>
<td>Zambia</td>
<td>11,862,740</td>
<td>2</td>
</tr>
</tbody>
</table>

For the empty spaces, there is no data available

**2.4 FTE radiologists interpreting mammograms per 10,000 women aged 40 and older**

Pathologist  
RX technician  
Oncologists

10 FTE per million
4. Increase in intervention efficiency

**Reduction of paperwork and regulations**

**Improved IT such as electronic medical records**

**Remote diagnostics**

**Telepathology**

**Uneven distribution of pathology resources**

Only 1 surgical pathology laboratory is available in Zambia for a population of 12 million people

Feasible in resource-limited settings (i.e. Zambia, Rwanda)

**Reliable**

Positive and negative predictive values of 95-100%

“Routine use of telepathology compares well with conventional microscopy”

Discrepancy rate 0.3 - 2.4%

**Efficient**

Greater efficiency in terms of time for diagnosis and turn-around time, especially where a pathologist is not available onsite.

Time-saving (1/3 time for teleytology)

Time for reporting < 24h
5. Optimization of existing workforce (organization)

Optimize role & organization of providers to realize the full value of workforce
Ensure time efficient (e.g. OR turnover)
Consider supportive supervision or role delegation

Supportive supervision

- Focus on improving performance and building relationships.
- More like a teacher, coach, mentor.
- Use local data to monitor performance and solve problems.
- Follow up regularly.
- Only support provided.

Role delegation

Mozambique

STEM project (Support, Train and Empower)

- Workshops with managers on human resource
- Intensive training in supervisory
- Action learning sets for staff engaged in supervision

"...Rwanda would become the first low- and middle income country to fulfill an ambition to make palliative care universally accessible."
Priority Medical Devices: model

Dimensions

Facility
- Capital expenditure
- Frequencies of use
- Purpose (Cancer specific)
- Consumable
- Facility equipment

Cancer type
- 15 tumour types
- Link to competencies
- Care continuum
- Level of priority
  - 3 levels
  - Resource stratify

Patient
- Use per patient
- Performance
- Life span

### Priority Medical Devices: model

#### Continuum

<table>
<thead>
<tr>
<th>Continuum</th>
<th>Competency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis</td>
<td>Early diagnosis</td>
</tr>
<tr>
<td>Screening</td>
<td>Clinical Breast Exam</td>
</tr>
</tbody>
</table>

#### Level of Priority I (Basic) vs. Level of Priority II (Intermediate) vs. Level of Priority III (Advanced)

#### Example Devices

- **breast:** Biennial palpation of breast and axillary lymph nodes, MRI, mammography, CT, PET scan, breast MRI, flexible sigmoidoscopy, colonoscopy, FOBT, fecal occult blood test, colonoscopy

#### Medical Oncology

<table>
<thead>
<tr>
<th>Competency</th>
<th>Capital Expenditure Devices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infusion giving set (adult, children)</td>
<td>VF</td>
</tr>
<tr>
<td>Infusion pump administration set</td>
<td>VF</td>
</tr>
<tr>
<td>Elastomeric pump (I.e.</td>
<td>D</td>
</tr>
</tbody>
</table>

#### Radiation Oncology

<table>
<thead>
<tr>
<th>Competency</th>
<th>Capital Expenditure Devices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan RT</td>
<td>Linear Accelerator (LINAC)</td>
</tr>
<tr>
<td>Conventional simulator</td>
<td>Conventional simulator</td>
</tr>
</tbody>
</table>

#### Frequencies you use for cancer (FV, very frequently; O, occasionally; R, rarely)

<table>
<thead>
<tr>
<th>Continuum</th>
<th>Competency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiation Oncology</td>
<td>Plan RT</td>
</tr>
<tr>
<td></td>
<td>Conventional simulator</td>
</tr>
<tr>
<td></td>
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</tbody>
</table>

#### Use for multiple(m) or single(s) cancer

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</table>

#### One-time cost (at) or consumable (c)

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#### Infrastructure (inf) or cancer specific investment (inv)

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</thead>
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</tr>
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<td></td>
<td>Linear Accelerator (LINAC)</td>
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</tbody>
</table>

#### Intervention per patients/year

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</tr>
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<tr>
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<td>Linear Accelerator (LINAC)</td>
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</tbody>
</table>

#### Max intervention/year

<table>
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<th>Competency</th>
</tr>
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<tbody>
<tr>
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<tr>
<td></td>
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</tbody>
</table>

#### Average life expectancy/service life/lifespan of the device

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</tr>
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<td></td>
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</tr>
</tbody>
</table>

### Example Devices

- HPV DNA Test, Gynaecological examination/treatment table, speculum, Visual inspection with acetic acid, Colposcope, Faecal immunochemical testing (FIT) + FOBT immunochemical analyzer, Guaiac faecal occult blood test (gFOBT), stool DNA test, CT colonography, breast X-ray, breast ultrasound, breast MRI, Low-dose chest (CT) scan,
Step 1: WHO tool for comprehensive situational analysis

- Identifies gaps & inefficiencies in cancer workforce
- Estimates workforce requirements for strategic staffing

Step 2: Policy formulation & technical support

- Identify evidence-based, context-appropriate policies
- Facilitate technical cooperation
- Define health system capacities & workforce competency

Goal: to expand coverage & services
Quality in Workforce Training

Mere availability of health workers is **not** sufficient

- People empowerment
- Develop their full capacities
- Seize employment and social opportunities
- Boosting future innovation and development
- Expands labour market opportunities and reduces social inequalities

**Quality in Workforce Training**

- equitably distributed and **accessible**, competent and motivated, empowered to deliver **quality** care, adequately supported by the health system

http://www.who.int/hrh/resources/global_strategy_workforce2030_14_print.pdf
“What good does it do to offer free maternal care and have a high proportion of babies delivered in health facilities if the quality of care is sub-standard or even dangerous?”

-Dr Margaret Chan
Immediate Past Director General, WHO
“What good does it do to offer free maternal care and have a high proportion of babies delivered in health facilities if the quality of care is sub-standard or even dangerous?”

-Dr Margaret Chan
Immediate Past Director General, WHO

Prioritize Quality

“What Gets Measured, Gets Done”

15-25% survival difference = 1-2 mil lives/year

Why?

• Failure to organize, coordinate service
• Limited workforce expertise
• Out-dated practice guidelines
• Not timely or geographic accessibility
Major gaps in health workforce

- Country-specific approach needed tailored to disease burden, regulatory framework & health system
- Analysis should be linked to larger workforce and system capacity

Workforce needs must be linked to national priorities for cancer programmes (e.g. screening, type of treatment)

Effective short-, medium- and long-term strategies exist and should be implemented

WHO producing guidance on these strategies and tailoring strategies to particular context/country
THANK YOU

Dr Dario Trapani: Dario.Trapani@ieo.it
Dr André Ilbawi: ilbawia@who.int