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Multinational Lung Cancer Control Programme

Bristol-Myers Squibb Foundation

Submitted as part of Access Accelerated

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The information in this report has been submitted by the company concerned to the Access Observatory as part of its commitment to Access Accelerated. The information will be updated regularly. For more information about the Access Observatory go to www.accessobservatory.org

The information contained in this report is in the public domain and should be cited as: Bristol-Myers Squibb, Multinational Lung Cancer Control Programme (2021), Access Observatory Boston, US 2021 (online) available from www.accessobservatory.org

Program Description

Program Overview

1 Program Name

Multinational Lung Cancer Control Programme

2 Diseases program aims to address

- Cancer (Breast, Cervical, Hematological, General)

3 Beneficiary population

- Age group: Adults (15-64 years), Elderly (65+ years)
- Genders: Female, Male
- Special populations: People with low income, Rural populations, Urban populations, General population

4 Countries

- South Africa
- Kenya
- Ethiopia
- Tanzania
- Lesotho
- Swaziland

5 Program start date

June 01, 2017.

6 Anticipated program completion date

Completion date not specified.

7 Contact person

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8 Program summary

The Multinational Lung Cancer Control Program (MLCCP) is a lung cancer programme implemented in six countries in sub-Saharan Africa namely Ethiopia, Eswatini - formerly known as Swaziland, Kenya, Lesotho, South Africa and Tanzania funded through the Bristol Myers Squibb Foundation Global Cancer Disparities Africa Initiative. The primary aim of the program is to improve access to early diagnostic services for lung cancer by addressing the barriers to cancer care. The program is implemented by varying established non-profit organisations responding to TB, HIV and other major diseases to address the needs of populations by partnering with respective Ministries of Health, academic institutions and major tertiary hospitals. Furthermore, the program supports establishment of centres of excellence with the aim of generating evidence based data through a strong research focus specifically for lung cancer and other cancers to inform guidelines and policies as well as models of care that will lead to timely diagnosis of lung cancer that may lead to improved outcomes in providing supportive care for the patients and their families from the time of diagnosis. Another major component of the MLCCP is capacity building focusing on professional development in lung cancer screening, diagnosis and management for health service providers.

MLCCP common objectives include:

- To raise awareness on lung cancer and to quantify the true burden of lung cancer in the specific regions of the four countries
- To validate the tools for screening high-risk groups for lung cancer in the community
- To identify and mitigate the barriers to lung cancer care
- To assess the risk factors associated with lung cancer in sub-Saharan Africa
- To establish standardized diagnostics and pathology evaluation and reporting
- To establish a biobank for storage of the lung pathology specimen for potential transnational research

Program Overview

8 [Program Summary](#) The 6 countries are embedded in the following key areas of lung cancer management:

- Prevention
- Screening /Case Identification
- Early Detection
- Diagnosis
- Treatment & Survivorship
- Palliative Care
- Community Awareness
- Capacity Building & Training
- Research
- Monitoring and Evaluation
- Collaboration & Partnerships
- Financing

Program partnerships in the MLCCP play a vital role in harnessing collaborative approaches in mitigating and finding probable solutions to lung cancer management in all program countries.

Program Strategies & Activities

9 Strategies and activities

Strategy 1: Community Awareness and Linkage to Care

ACTIVITY	DESCRIPTION
Planning	<p>Meetings with respective ministries of health, local communities and structures for buy-in and forge partnerships for the program in all the implementing countries.</p> <p>The program has a series of research questions related to lung cancer burden, risk factors, knowledge, attitudes, practices and beliefs(KAPB), patient pathway and access to care and supportive services. This information will inform interventions and also policy and programs by relevant governments. This activity requires meticulous planning and consultations with various partners and stakeholders to tailor and weave in the research component during implementation.</p>
Communication	<ul style="list-style-type: none"> - Development of awareness campaigns among the general population on priority cancers including lung cancer to be rolled out in communities. - Create and disseminate lung cancer IEC materials.
Mobilization	<p>Community and leadership mobilization to support interventions is integral to the MLCCP across all sites. The activities around this include community outreach events, community meetings with community leaders and community healthcare workers and volunteers.</p>

Strategy 2: Health Service Strengthening

ACTIVITY	DESCRIPTION
Planning	<p>Ongoing meetings with relevant local institutions to assess main access barriers and identify risk factors.</p>
Training	<ul style="list-style-type: none"> - Training programs for local healthcare workers to standardized and improve cancer quality of care. - Train cancer registry staff to properly document cases. - Train administrators and researchers on bio-banking's importance in research and care. - Training of project staff on data management and synthesis. - Strengthen hospital-based cancer surveillance/ registries through trainings. - Skills and Capacity Building: result in more than 20 post graduates degrees from young researchers involved involved as Co-PIs or research assistants; 5 PhDs are expected and 15 Masters Degrees across all sites. MLCCP has adopted a unique strategy of utilizing internal resources to add to the body of knowledge, improve experts in the topics and fields, improve academic achievement and groom young researchers.

Program Strategies & Activities

9 Strategies and activities, cont.

ACTIVITY	DESCRIPTION
Infrastructure	<ul style="list-style-type: none"> - Establish a biobank for storage of the lung pathology specimen for potential translational research. - Procurement of equipment, security measures and IT. - Improve the physical and equipment infrastructure to enhance patient diagnosis, treatment and outcomes. - Refurbishment (renovations) of existing structures to provide lung cancer services. - Procurement of cancer care equipment. - Provide vehicles for transporting patients and project staff for outreach activities.
Technology	<ul style="list-style-type: none"> - Introducing electronic data collection and management systems. - Creation and validation of risk-factor screening tools for lung cancer. - Upgrade the existing data infrastructure to improve patient quality of care, monitor service delivery and lung cancer data.
Management	<ul style="list-style-type: none"> - Creation/establishment of boards/committees for assessment of lung cancer cases. - Feedback and sharing of lesson learned over the implementation period. - Standardization of standard operating procedure and policies to standardize testing across the program sites. - Development of the first South African Lung Cancer Continuum of Care Guidelines in partnership with the National Department of Health: Chronic Diseases, Disability and Geriatrics Department.

Program Strategies & Activities

9 Strategies and activities, cont.

Strategy 3: Health Service Delivery

ACTIVITY	DESCRIPTION
Screening	Establish mobile community screening and community support services to conduct the lung cancer screening.
Diagnosis	<ul style="list-style-type: none"> - To establish standardised diagnostics and pathology evaluation and reporting through the use of standardized SOPs on screening and diagnosis. - Track patient outcomes in order to influence government policy for screening & early diagnosis.
Treatment	Kenya, Tanzania, Ethiopia and South Africa partners have oncology and radio therapy centers and will treat patients according to existing in-country standard of care. Treatment referrals to government hospitals will be done for further management. Eswatini and Lesotho refer their cancer patients to South Africa for treatment.
Retention	<ul style="list-style-type: none"> - Psycho-social support components as well and enhanced palliative care services. - Enhance treatment adherence and follow-up (psychosocial support, appointment reminders, workshops) for newly diagnosed and cancer survivor patient.

10 Strategy by country

STRATEGY	COUNTRY
Community Awareness and Linkage to Care	Swaziland, Kenya, Tanzania, South Africa, Ethiopia, Lesotho
Health Service Strengthening	Swaziland, Kenya, Tanzania, South Africa, Ethiopia, Lesotho
Health Service Delivery	Swaziland, Kenya, Tanzania, South Africa, Ethiopia, Lesotho

Companies, Partners & Stakeholders

11 Company roles

COMPANY	ROLE
Bristol-Myers Squibb	Sponsor and funder.

12 Funding and implementing partners

PARTNER	ROLE/URL	SECTOR
Bristol-Myers Squibb Foundation	Sponsor and funder. https://www.bms.com/about-us/responsibility/bristol-myers-squibb-foundation.html	Private
John Taolo Getsewe Provincial Department of Health	John Taolo Getsewe Provincial Department of Health – formulates Policies, and provides the facilities, health care providers and expertise for the project. Supports the MLCCP strategies and activities.	Public
Eswatini Hospice at Home	Collaborating partner with Eswatini National Cancer Control Unit. Will provide palliative care services and facilitates trainings.	Public
Wits Health Consortium (Pty) Ltd - Centre of Respiratory Excellence	The WHC implements and supports the operation of the MLCCP as one of the program site in South Africa. Its implements the MLCCP through service delivery, capacity building, research and provides palliative care support, and mentorship. Wits Health Consortium established a Centre of Respiratory Excellence (CORE) in Gauteng Province (South Africa) based at Helen Joseph Hospital (HJH), and to formalize a tripartite service delivery, training and research partnership with Chris Hani Baragwanath Academic Hospital (CHBAH) and Charlotte Maxeke Johannesburg Academic Hospital (CMJAH) respiratory departments. The centre incorporates a multi-disciplinary team of pulmonologists, histopathologists (based at the National Institute of Occupational Diseases (NIOH)), oncologists, radiologists, nurses,	Public
Moi Teaching and Referral Hospital/ AMPATH, Kenya	<u>A partnership between Moi University, Moi Teaching and Referral Hospital, North American universities led by Indiana University, and the Kenyan Government. It uses an academic model providing access to health care/MOI teaching and referral hospital . It improved understanding of lung cancer pathways and access to early diagnostic services for lung cancer by addressing the barriers of cancer care through working with communities. The recently awarded Phase II of the project seeks to conduct a retrospective lung cancer study to establish the survival rate of the Phase I lung cancer patients and to establish a seamless referral system from community to facility level.</u> https://www.ampathkenya.org	Public

(Continued on next page)

Companies, Partners & Stakeholders

12 Funding and implementing partners, Cont.

PARTNER	ROLE/URL	SECTOR
Mathiwos Wondu Ye Ethiopia Cancer Society	<u>Mathiwos Wondu Ye Ethiopia Cancer Society aims to improve early screening, diagnosis, treatment and survival of lung cancer in four regions in Ethiopia (Amhara, Addis Ababa, Oromia and Afar regions) through training of healthcare providers at regional and district hospitals and awareness</u>	Public
National University of Lesotho, Faculty of Health Sciences	<u>National University of Lesotho, Faculty of Health Sciences aims to reduce cancer related morbidity and mortality and improve the quality of life for cancer patients in Lesotho by providing flagship comprehensive oncology clinical and palliative care for cancer patients through the Senkatana Oncology Clinic.</u>	Public
Wits Health Consortium (Pty) Ltd/Nelson Mandela Academic Hospital	<u>Wits Health Consortium/Nelson Mandela Academic Hospital in South Africa is a MLCCP site which aims to improve the quality of life for lung cancer patients by establishing a sustainable multidisciplinary collaborative for a decentralization lung cancer care through appropriately trained and capacitated health professionals and community health workers who will screen, diagnose, care and support lung cancer patients.</u>	Public
TB HIV Care/Eastern Cape Collaborative Community Cancer Initiative	<u>TB/HIV Care is an NPO based in South Africa that supports improved patient outcomes for lung cancer and other common cancers affecting people living in the drainage area of the Nelson Mandela Academic Hospital by raising community awareness of lung cancer, promoting and linking people to screening, supporting navigation through the health system as well as supporting palliative and survivorship activities. The organization works with five community based NGOs in the Eastern Cape province.</u>	Public
Wits Health Consortium (Pty) Ltd/Chris Hani Baragwanath Academic Hospital	<u>Wits health Consortium (Pty) Ltd /Chris Hani Baragwanath Academic Hospital will establish a holistic adult cancer care and treatment center of excellence at the Chris Hani Baragwanath Academic Hospital focusing on the five most common adult cancers (breast, cervix, colorectal, lung and prostate cancers). Palliative care training and implementation is also a strong component of this project.</u>	Public
Eswatini National Cancer Control Unit and Cancer Registry	<u>This unit is the implementing partner in Eswatini through the Ministry of Health. Will support screening and health promotion of cervical and breast cancer.</u>	Public
Wits Health Consortium (Pty) Ltd/Health Economics and Epi-	<u>Will provide a set of costing models of specified interventions in the first developed Lung Cancer Continuum of Care Guidelines for South Africa.</u>	Public
University Research Co.,LLC (URC)	<u>URC is NPO is one of the MLCCP site based in Eswatini . It was dedicated to improving the quality of health care, social services, and health education. In Eswatini, URC works with the Ministry of Health and other stakeholders to provide technical assistance for scaling up provision and access to comprehensive, integrated, quality and decentralized HIV/TB services. Our other focus areas include HSS, in-service training, capacity development, behavioral change communication, research, improving quality of care, innovations and technology. URC is a professional non-government organization in Swaziland, affiliated with URC-CHS that will provide technical expertise, assistance and consultation to assist the Swaziland National Cancer Registry with implementation of the Lung Cancer Project activities.</u> http://www.urc-chs.com/	Public

(Continued on next page)

Companies, Partners & Stakeholders

12 Funding and implementing partners, cont.

PARTNER	ROLE/URL	SECTOR
Cancer Charity Workers/Robert Mangaliso Sobukwe Hospital (Former Kimberley Hospital Complex) (KHC) Oncology Department	KHC Oncology Department leads the implementation of the establishment of a Lung Cancer Centre of Excellence at the KHC Oncology Department. KHC also provide lung, Breast and Cervical Cancer awareness, screening, referral, patient navigation, treatment adherence services and palliative care in the John Taolo Getsewe (JTG) District.	Public
Bugando Medical Centre	<p><u>Bugando Medical Centre is a partner involved in: (1) Validating the tool for lung cancer screening of high-risk groups for lung cancer (TB, HIV, Smokers, etc.), including the pilot of the tool; (2) Developing a data management strategy to document all the cancer patients enrolled into the program and their demographics, as well as the reasons for delays in diagnosis and care throughout the continuum of lung cancer care.(3) Developing standardized synoptic pathology reporting, diagnostic algorithms and treatment protocols for lung cancer (4) Treatment Protocol development(5) Local Standard Operating Procedures for Specimens Storage and (6) Training. The Phase II grant aims to strengthen the referral system of lung cancer suspects and patients through the continued care of patients identified in Phase I in need of further investigation and management.</u></p> <p>http://www.bugandomedicalcentre.go.tz</p>	Public
Catholic University of Health and Allied Sciences (CUHAS)	<p><u>Catholic University of Health and Allied Sciences is a partner that supports Bugando Medical Centre to establish and test infrastructure for ongoing monitoring of lung cancer screening, detection, treatment and outcomes, in order to inform ongoing improvement in cancer related prevention, health systems and policy solutions.</u></p> <p>https://www.bugando.ac.tz/</p>	Public
University of Kwazulu-Natal and Provincial Department of Health/ Addington Regional Hospital	<p><u>University of Kwazulu-Natal, Provincial Department of Health/Addington regional hospital aims to improve early diagnosis of lung cancer by establishing outreach screening services and establishing a regional lung cancer diagnostic and care center in KZN, South Africa.</u></p>	Public
New Dimension Consulting (NEDICO)	<p><u>Provides monitoring and evaluation support to the MLCCP across the six countries which includes data analysis, reporting and data related technical assistance</u></p>	Private

Local Context, Equity & Sustainability

15 Local health needs addressed by program

Globally, there are approximately 1.8 million new cases of lung cancer per year.¹ Lung Cancer accounts for highest cancer-related mortality globally. Despite this, many African countries lack information regarding the epidemiology of lung cancer and its control. There is also the compounding heavy burden of comorbidities in Sub-Saharan Africa, including HIV and TB.

In most African settings, there is low cancer awareness, uncoordinated or absent screening services, late cancer diagnoses, when therapeutic solutions, where available, are less likely to be effective.⁷ In addition, cultural beliefs in these settings influence health seeking behavior, with patients with warning signs and those with clinical signs suggestive of cancer or diagnosed with cancer resorting to alternative medicine either preferentially, or in parallel with modern medicine.⁷ For example, the number of lung cancer cases reported from 2 of the collaborating centers (Eldoret in Kenya and Mwanza in Tanzania), over the preceding period was extremely small, for Eldoret-Kenya only 53 cases 2011-2014 and for Mwanza 69 cases over 5 years. All these factors have contributed to lack of a true burden estimation in this region, which this program will address

The MLCCP project was conceived to focus on improvement of access to early diagnostics and addressing the barriers to optimal outcomes of lung cancer based in local contexts of the 6 countries. Given the presence and confluence of these risk factors (tobacco use, HIV, TB, HIV/TB co-infection, mining history), the 6 countries were keen to investigate the burden of lung cancer in their own countries

High levels of poverty in the MLCCP sites healthcare remains largely the burden of the state with the Ministries of Health holding overall responsibility for health care, with a specific responsibility for the public sector. The cancer burden reported for sub-Saharan Africa might be underestimated due to lack of appropriate diagnosis, poor access to care, limitations in technical workforce and infrastructure, and the low quality of cancer data systems in Africa compared with those in developed countries. The lower cancer incidence and mortality in sub-Saharan Africa than in other regions could also be partly explained by cancer not being prioritised by international donors or the health ministries in sub-Saharan Africa.

By partnering with local hospitals and universities, as well as the ministries of health across program sites, this program has been designed considering the existence of local resources (capacity and infrastructure) and the country's policies and strategic plans. Local practice and policies are actively included in design and implementation through surveys, active participation of local professionals, trainings preparations, creation of awareness resources and other materials in contribution to improvement of cancer outcomes.

a How needs were assessed

A formal needs assessment was not done. However, collaborations, rigorous consultations with all relevant stakeholders have been key in identifying and prioritising interventions.

b Formal needs assessment conducted

No.

16 Social inequity addressed

Yes, through awarding of grants that aim to provide health services and patient support structures to rural and hard to reach communities.

Local Context, Equity & Sustainability

17 Local policies, practices, and laws considered during program design

POLICY, PRACTICE, LAW	APPLICABLE TO PROGRAM	DESCRIPTION OF HOW IT WAS TAKEN INTO CONSIDERATION
National regulations	Yes	All applicable policies and guidelines pertaining to this aspect of designing the program were taken into consideration across implementing sites.
Procurement procedures	Yes	All applicable policies and guidelines pertaining to this aspect of designing the program were taken into consideration across implementing sites.
Standard treatment guidelines	Yes	All applicable policies and guidelines pertaining to this aspect of designing the program were taken into consideration across implementing sites.
Quality and safety requirements	Yes	All applicable policies and guidelines pertaining to this aspect of designing the program were taken into consideration across implementing sites.
Remuneration scales and hiring practices	Yes	All applicable policies and guidelines pertaining to this aspect of designing the program were taken into consideration across implementing sites.

18 How diversion of resources from other public health priorities are avoided

All MLCCP sites submitted proposals that were based on understanding the burden of lung cancer in the respective countries. Funding was granted based on the detailed proposals approved and budgets were tailored accordingly. Biannual reports are received from partners and quarterly meetings held with project leads to track activities and expenditure progress. The grants are awarded to already established oncology centres where personnel is already focused on this patient pool. The grants create jobs and sharpen expertise. It supports salaries, technical, clinical and project management activities directly instead of diverting.

19 Program provides health technologies (medical devices, medicines, and vaccines)

No.

20 Health technology(ies) are part of local standard treatment guidelines

N/A.

21 Health technologies are covered by local health insurance schemes

N/A.

22 Program provides medicines listed on the National Essential Medicines List

N/A.

Additional Program Information

24 Additional program information

Some of the first grants awarded have come to an end and have entered into a Phase II based on the findings of their Phase I grant outcomes. A notable development in advancing lung cancer care in the collaboration.

a Potential conflict of interest discussed with government entity

No.

25 Access Accelerated Initiative participant

No.

26 International Federation of Pharmaceutical Manufacturers & Associations (IFPMA) membership

Yes.

Program Indicators

PROGRAM NAME

Multinational Lung Cancer Control Programme

27 List of indicator data to be reported into Access Observatory database

INDICATOR	TYPE	STRATEGY	2017-2020
1 Number of community members educated on lung cancer	Output	Community Awareness and Linkage to Care	1,054,692 people
2 Number of healthcare workers trained to provide lung cancer screening, diagnosis and treatment services	Output	Health Service Delivery	6,104 people
3 No. of clients screened found with lung mass	Output	Health Service Delivery	1,370 people
4 No. of clients screened found with lung mass who received diagnosis	Output	Health Service Delivery	1,063 people
5 No. of clients who were diagnosed with lung cancer	Output	Health Service Delivery	656 people
6 No. of clients who were diagnosed with lung cancer referred for treatment	Output	Health Service Delivery	590 people
7 No. of patients who are currently on lung cancer treatment	Output	Health Service Delivery	27 people
8 No. of patients who were started on treatment who were lost to follow-up	Output	Health Service Delivery	61 people
9 Number of lung cancer patients who died	Output	Health Service Delivery	351 people
10 No. of patients who received lung cancer treatment	Output	Health Service Delivery	---
11 No. of clients who received lung cancer screening	Output	Health Service Delivery	1,297 people
12 No. of clients screened found with lung mass referred for diagnosis	Output	Health Service Delivery	1,297 people

INDICATOR **Number of community members educated on lung cancer**

STRATEGY COMMUNITY AWARENESS AND LINKAGE TO CARE

ITEM	DESCRIPTION
Definition	Number of individuals that received lung cancer education through IEC or community aware
Method of measurement	Counting of community members reached during outreach events or community meetings with lung cancer education.
28 Data source	Routine program data
29 Frequency of reporting	Once per year

	RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
30 Data collection	Community volunteers, Project officer, M and E officer and Project Manager	Each participating community member fills or have their details filled in the community awareness attendance register and they sign. This is completed for each community awareness event. The project officer and M and E officer verify and sign each completed page	Ongoing
31 Data processing	Community volunteers, Project officer, M and E officer and Project Manager	The project manager and M and E officer reviews the attendance registers once every week, then the data entry officer also reviews when capturing the data in RedCAP and Point of Care databases. Any data inconsistencies are referred back to the project officer for correction. Data cleaning is further done by the technical assistance Statistician before further analysis and reporting.	Monthly
32 Data validation	Bristol-Myers Squibb Foundation	A member of the BMSF M and E technical assistance team conducts data quality audits once every year.	

33 Challenges in data collection and steps to address challenges

Completion of awareness event registers in large group events with some participants illiterate. Community volunteers assist participants in properly completing the attendance registers. Each participant asked to bring their national ID to the awareness event.

INDICATOR

2017-2020

1	Number of community members educated on lung cancer	1,054,692 people
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Comments:

INDICATOR **Number of healthcare workers trained to provide lung cancer screening, diagnosis and treatment services**

STRATEGY HEALTH SERVICE DELIVERY

ITEM	DESCRIPTION
Definition	Number of individual healthcare workers received training to provide LUNG cancer screening, diagnosis and treatment services
Method of measurement	Counting of HCWs trained. The program also looks more into those HCWs who apply the new skills taught or show improvement of knowledge.
28 Data source	Routine program data
29 Frequency of reporting	Once per year

	RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
30 Data collection	Project officer, M and E officer and Project Manager	Each training participant fills and sign the training attendance register on each day of the training. The project officer and M and E officer verify and sign each completed page.	Ongoing
31 Data processing	Project officer, M and E officer and Project Manager	The project manager and M and E officer reviews the training attendance registers once every week after the training has been conducted. Then the data entry officer also reviews when capturing the	Monthly
32 Data validation	Bristol-Myers Squibb Foundation	A member of the BMSF M and E technical assistance team conducts data quality audits once every year.	

33 Challenges in data collection and steps to address challenges

None

INDICATOR

2017-2020

2 Number of healthcare workers trained to provide lung cancer screening, diagnosis and treatment services	6,104 people
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Comments:

INDICATOR Number of clients screened found with lung mass

STRATEGY HEALTH SERVICE DELIVERY

ITEM	DESCRIPTION
Definition	Number of individual clients who were found with lung mass
Method of measurement	Counting of clients found with lung mass among those screened
28 Data source	Routine program data
29 Frequency of reporting	Once per year

	RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
30 Data collection	Clinician, project officer, project manager, data capturer and M and E officer	Each client will have a lung cancer screening form completed by the professional health care workers at the health facilities or at outreach sites. The project manager and M and E officer verify and sign on the completed screening form. The data capturer captures data in RedCAP and Point of Care database.	Ongoing
31 Data processing	Clinician, project officer, project manager, data capturer and M and E officer	The project manager and M and E officer reviews the completed screening forms and RedCAP & Point of Care database once every week, then the data entry officer also reviews when capturing the data in RedCAP and Point of Care. Any data inconsistencies are referred back to the project officer for correction. Data cleaning is further done by the technical assistance Statistician before further analysis and reporting.	Weekly
32 Data validation	Bristol-Myers Squibb Foundation	A member of the BMSF M and E technical assistance team conducts data quality audits once every year.	

33 Challenges in data collection and steps to address challenges

None.

INDICATOR

2017-2020

3 Number of clients screened found with lung mass	1,370 people
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Comments:

INDICATOR **Number of clients screened found with lung mass who received diagnosis**

STRATEGY HEALTH SERVICE DELIVERY

ITEM	DESCRIPTION
Definition	Number of individual clients screened and found with Lung mass who received diagnosis
Method of measurement	Counting of clients found with lung mass and who received diagnosis.
28 Data source	Routine program data
29 Frequency of reporting	Once per year

	RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
30 Data collection	Clinician, project officer, project manager, data capturer and M and E officer	Each client will have a lung cancer screening form completed by the professional health care workers at the health facilities or at outreach sites. The project manager and M and E officer verify and sign on the completed screening form. The data capturer captures data in RedCAP and Point of Care database.	Weekly
31 Data processing	Clinician, project officer, project manager, data capturer and M and E officer	Each client will have a patient file completed by the clinicians at health facilities. The project manager and M and E officer verify and sign on the completed screening form. The data capturer captures data in RedCAP and Point of Care database.	Weekly
32 Data validation	Bristol-Myers Squibb Foundation	A member of the BMSF M and E technical assistance team conducts data quality audits once every year.	

33 Challenges in data collection and steps to address challenges

None.

INDICATOR

2017-2020

4 No. of clients screened found with lung mass who received diagnosis	1,063 people
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Comments:

INDICATOR **Number of clients who were diagnosed with lung cancer**

STRATEGY HEALTH SERVICE DELIVERY

ITEM	DESCRIPTION
Definition	Number of individual clients who were diagnosed with Lung cancer
Method of measurement	Counting of clients diagnosed with lung cancer.
28 Data source	Routine program data
29 Frequency of reporting	Once per year

	RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
30 Data collection	Clinician, project officer, project manager, data capturer and M and E officer	Each client will have a patient file completed by the clinicians at health facilities. The project manager and M and E officer verify and sign on the completed screening form. The data capturer captures data in RedCAP and Point of Care database.	Ongoing
31 Data processing	Clinician, project officer, project manager, data capturer and M and E officer	The project manager and M and E officer reviews the completed patient file and RedCAP & Point of Care database once every week, then the data entry officer also reviews when capturing the data in RedCAP and Point of Care. Any data inconsistencies are referred back to the project officer for correction. Data cleaning is further done by the technical assistance Statistician before further analysis and reporting.	Monthly
32 Data validation	Bristol-Myers Squibb Foundation	A member of the BMSF M and E technical assistance team conducts data quality audits once every year.	

33 Challenges in data collection and steps to address challenges

None.

INDICATOR

2017-2020

5 No. of clients who were diagnosed with lung cancer	656 people
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Comments:

INDICATOR **Number of clients who were diagnosed with lung cancer referred for treatment**

STRATEGY HEALTH SERVICE DELIVERY

ITEM	DESCRIPTION
Definition	Number of clients who were diagnosed with Lung cancer and referred for treatment
Method of measurement	Counting of clients diagnosed with lung cancer and referred FOR further treatment and care.
28 Data source	Routine program data
29 Frequency of reporting	Once per year

	RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
30 Data collection	Clinician, project officer, project manager, data capturer and M and E officer	Each client will have a patient file completed by the clinicians at health facilities. The project manager and M and E officer verify and sign on the completed screening form. The data capturer captures data in RedCAP and Point of Care database.	Ongoing
31 Data processing	Clinician, project officer, project manager, data capturer and M and E officer	The project manager and M and E officer reviews the completed patient file and RedCAP & Point of Care database once every week, then the data entry officer also reviews when capturing the data in RedCAP and Point of Care. Any data inconsistencies are referred back to the project officer for correction. Data cleaning is further done by the technical assistance Statistician before further analysis and reporting.	Monthly
32 Data validation	Bristol-Myers Squibb Foundation	A member of the BMSF M and E technical assistance team conducts data quality audits once every year.	

33 Challenges in data collection and steps to address challenges

None.

INDICATOR

2017-2020

6 No. of clients who were diagnosed with lung cancer referred for treatment	590 people
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Comments:

INDICATOR **No. of patients who are currently on lung cancer treatment**

STRATEGY HEALTH SERVICE DELIVERY

ITEM	DESCRIPTION
Definition	Number of individual s clients who are currently on Lung Cancer treatment
Method of measurement	Counting of total number of patients who are currently on lung cancer treatment through the program
28 Data source	Routine program data
29 Frequency of reporting	Once per year

	RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
30 Data collection	Clinician, project officer, project manager, data capturer and M and E officer	Each client will have a patient file completed by the clinicians at health facilities. The project manager and M and E officer verify and sign on the completed screening form. The data capturer captures data in RedCAP and Point of Care database.	Ongoing
31 Data processing	Clinician, project officer, project manager, data capturer and M and E officer	The project manager and M and E officer reviews the completed patient file and RedCAP & Point of Care database once every week, then the data entry officer also reviews when capturing the data in RedCAP and Point of Care. Any data inconsistencies are referred back to the project officer for correction. Data cleaning is further done by the technical assistance Statistician before further analysis and reporting.	Monthly
32 Data validation	Bristol-Myers Squibb Foundation	A member of the BMSF M and E technical assistance team conducts data quality audits once every year.	

33 Challenges in data collection and steps to address challenges

None.

INDICATOR

2017-2020

7 No. of patients who are currently on lung cancer treatment	27 people
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Comments:

INDICATOR **Number of patients who were started on treatment who were lost to follow-up**

STRATEGY HEALTH SERVICE DELIVERY

ITEM	DESCRIPTION
Definition	Number of individuals clients who were in treatment who were lost to follow up
Method of measurement	Counting of patients who started on lung cancer treatment in the program and were lost to follow-up.
28 Data source	Routine program data
29 Frequency of reporting	Once per year

	RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
30 Data collection	Clinician, project officer, project manager, data capturer and M and E officer	Each client will have a patient file completed by the clinicians at health facilities. The project manager and M and E officer verify and sign on the completed screening form. The data capturer captures data in RedCAP and Point of Care database.	Ongoing
31 Data processing	Clinician, project officer, project manager, data capturer and M and E officer	The project manager and M and E officer reviews the completed patient file and RedCAP & Point of Care database once every week, then the data entry officer also reviews when capturing the data in RedCAP and Point of Care. Any data inconsistencies are referred back to the project officer for correction. Data cleaning is further done by the technical assistance Statistician before further analysis and reporting.	Monthly
32 Data validation	Bristol-Myers Squibb Foundation	A member of the BMSF M and E technical assistance team conducts data quality audits once every year.	

33 Challenges in data collection and steps to address challenges

None.

INDICATOR

2017-2020

8 No. of patients who were started on treatment who were lost to follow-up	61 people
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Comments:

INDICATOR **Number of lung cancer patients who died**

STRATEGY HEALTH SERVICE DELIVERY

ITEM	DESCRIPTION
Definition	Number of individual lung cancer clients who died
Method of measurement	Count of total number of patients who were lung cancer patients in the program and subsequently died during care
28 Data source	Routine program data
29 Frequency of reporting	Once per year

	RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
30 Data collection	Clinician, project officer, project manager, data capturer and M and E officer	Each client will have a patient file completed by the clinicians at health facilities. The project manager and M and E officer verify and sign on the completed screening form. The data capturer captures data in RedCAP and Point of Care database.	Ongoing
31 Data processing	Clinician, project officer, project manager, data capturer and M and E officer	The project manager and M and E officer reviews the completed patient file and RedCAP & Point of Care database once every week, then the data entry officer also reviews when capturing the data in RedCAP and Point of Care. Any data inconsistencies are referred back to the project officer for correction. Data cleaning is further done by the technical assistance Statistician before further analysis and reporting.	Monthly
32 Data validation	Bristol-Myers Squibb Foundation	A member of the BMSF M and E technical assistance team conducts data quality audits once every year.	

33 Challenges in data collection and steps to address challenges

None.

INDICATOR

2017-2020

9 Number of lung cancer patients who died	351 people
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Comments:

INDICATOR **Number of patients who received lung cancer treatment**

STRATEGY HEALTH SERVICE DELIVERY

ITEM	DESCRIPTION
Definition	Number of individual clients who received lung cancer treatment
Method of measurement	Counting of patients who received lung cancer treatment through the program.
28 Data source	Routine program data
29 Frequency of reporting	Once per year

	RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
30 Data collection	Clinician, project officer, project manager, data capturer and M and E officer	Each client will have a patient file completed by the clinicians at health facilities. The project manager and M and E officer verify and sign on the completed screening form. The data capturer captures data in RedCAP and Point of Care database.	Ongoing
31 Data processing	Clinician, project officer, project manager, data capturer and M and E officer	The project manager and M and E officer reviews the completed patient file and RedCAP & Point of Care database once every week, then the data entry officer also reviews when capturing the data in RedCAP and Point of Care. Any data inconsistencies are referred back to the project officer for correction. Data cleaning is further done by the technical assistance Statistician before further analysis and reporting.	Every month
32 Data validation	New Dimensions Consulting	M and E officer, technical assistance Statistician, M and E technical assistance team (New Dimension Consulting)	

33 Challenges in data collection and steps to address challenges

None.

INDICATOR

2017-2020

10 No. of patients who received lung cancer treatment	---
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Comments:

INDICATOR **Number of clients who received lung cancer screening**

STRATEGY HEALTH SERVICE DELIVERY

ITEM	DESCRIPTION
Definition	Number of individual clients screened found for LUNG cancer
Method of measurement	Counting of clients who were screened and found with a lung mass and referred for diagnosis
28 Data source	Routine program data
29 Frequency of reporting	Once per year

	RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
30 Data collection	Clinician, project officer, project manager, data capturer and M and E officer	Each client will have a lung cancer screening form completed by the professional health care workers at the health facilities or at outreach sites. The project manager and M and E officer verify and sign on the completed screening form. The data capturer captures data in RedCAP and Point of Care database.	Ongoing
31 Data processing	Clinician, project officer, project manager, data capturer and M and E officer	The project manager and M and E officer reviews the completed screening forms and RedCAP & Point of Care database once every week, then the data entry officer also reviews when capturing the data in RedCAP and Point of Care. Any data inconsistencies are referred back to the project officer for correction. Data cleaning is further done by the technical assistance Statistician before further analysis and reporting.	Every month
32 Data validation	New Dimension Consulting	M and E officer, technical assistance Statistician, M and E technical assistance team (New Dimension Consulting)	

33 Challenges in data collection and steps to address challenges

None.

INDICATOR

2017-2020

11 Number of clients who received lung cancer screening	1,297 people
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Comments:

ITEM	DESCRIPTION
Definition	Number of individual clients screened found for lung cancer
Method of measurement	Counting of clients who were screened and found with a lung mass and referred for diagnosis
28 Data source	Routine program data
29 Frequency of reporting	Once per year

	RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
30 Data collection	Clinician, project officer, project manager, data capturer and M and E officer	Each client will have a lung cancer screening form completed by the professional health care workers at the health facilities or at outreach sites. The project manager and M and E officer verify and sign on the completed screening form. The data capturer captures data in RedCAP and Point of Care database.	Ongoing
31 Data processing	Clinician, project officer, project manager, data capturer and M and E officer	The project manager and M and E officer reviews the completed screening forms and RedCAP & Point of Care database once every week, then the data entry officer also reviews when capturing the data in RedCAP and Point of Care. Any data inconsistencies are referred back to the project officer for correction. Data cleaning is further done by the technical assistance Statistician before further analysis and reporting.	Monthly
32 Data validation	New Dimension Consulting	M and E officer, technical assistance Statistician, M and E technical assistance team (New Dimension Consulting)	

33 Challenges in data collection and steps to address challenges

None.

INDICATOR

2017-2020

12 No. of clients received lung cancer screening	1,297 people
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Comments:

Appendix

This program report is based on the information gathered from the Access Observatory questionnaire below.

Program Description

PROGRAM OVERVIEW

1 Program Name

2 Diseases program aims to address:

Please identify the disease(s) that your program aims to address (select all that apply).

3 Beneficiary population

Please identify the beneficiary population of this program (select all that apply).

4 Countries

Please select all countries that this program is being implemented in (select all that apply).

5 Program Start Date

6 Anticipated Program Completion Date

7 Contact person

On the public profile for this program, if you would like to display a contact person for this program, please list the name and email address here (i.e. someone from the public could email with questions about this program profile and data).

8 Program summary

Please provide a brief summary of your program including program objectives (e.g., the intended purposes and expected results of the program; if a pilot program, please note this). Please provide a URL, if available. Please limit replies to 750 words.

PROGRAM STRATEGIES & ACTIVITIES

9 Strategies and activities

Based on the BUSPH Taxonomy of Strategies, which strategy or strategies apply to your program (please select all that apply)?

10 Strategy by country

If you have registered one program for multiple countries, this question allows you to provide a bit more specificity about each country (e.g. some countries have different strategies, diseases, partners, etc.). Please complete these tables as applicable. For each portion you have you selected from above (program strategies), please identify which country/countries these apply.

COMPANIES, PARTNERS AND STAKEHOLDERS

11 Company roles

Please identify all pharmaceutical companies, including yours, who are collaborating on this program:

What role does each company play in the implementation of your program?

12 Funding and implementing partners

Please identify all funding and implementing partners who are supporting the implementation of this program (Implementing partners is defined as either an associate government or non-government entity or agency that supplements the works of a larger organization or agency by helping to carry out institutional arrangements in line with the larger organization's goals and objectives.)

a. What role does each partner play in the implementation of your program? Please give background on the organization and describe the nature of the relationship between the organization and your company. Describe the local team's responsibilities for the program, with reference to the program strategies and activities. (response required for each partner selected).

b. For each partner, please categorize them as either a Public Sector, Private Sector, or Voluntary Sector partner. (Public Sector is defined as government; Private Sector is defined

as a business unit established, owned, and operated by private individuals for profit, instead of by or for any government or its agencies. Generation and return of profit to its owners or shareholders is emphasized; Voluntary Sector is defined as Organizations whose purpose is to benefit and enrich society, often without profit as a motive and with little or no government intervention. Unlike the private sector where the generation and return of profit to its owners is emphasized, money raised or earned by an organization in the voluntary sector is usually invested back into the community or the organization itself (ex. Charities, foundations, advocacy groups etc.)

c. Please provide the URL to the partner organizations' webpages

13 Funding and implementing partners by country

If you have registered one program for multiple countries, this question allows you to provide a bit more specificity about each country (e.g., some countries have different strategies, diseases, partners, etc.). Please complete these tables as applicable. For each portion you have selected from above (funding and implementing partners), please identify which country/countries these apply.

14 Stakeholders

Please describe how you have engaged with any of these local stakeholders in the planning and/or implementation of this program. (Stakeholders defined as individuals or entities who are involved in or affected by the execution or outcome of a project and may have influence and authority to dictate whether a project is a success or not (ex. Ministry of Health, NGO, Faith-based organization, etc.). Select all that apply.

- Government, please explain
- Non-Government Organization (NGO), please explain
- Faith-based organization, please explain
- Commercial sector, please explain
- Local hospitals/health facilities, please explain
- Local universities, please explain
- Other, please explain

LOCAL CONTEXT, EQUITY & SUSTAINABILITY

15 Local health needs addressed by program

Please describe how your program is responsive to local health needs and challenges (e.g., how you decided and worked together with local partners to determine that this program was appropriate for this context)?

a How were needs assessed

b Was a formal need assessment conducted

(Yes/No) If yes, please upload file or provide URL.

16 Social inequity addressed

Does your program aim to address social inequity in any way (if yes, please explain). (Inequity is defined as lack of fairness or justice. Sometime 'social disparities,' 'structural barriers' and 'oppression and discrimination' are used to describe the same phenomenon. In social sciences and public health social inequities refer to the systematic lack of fairness or justice related to gender, ethnicity, geographical location and religion. These unequal social relations and structures of power operate to produce experiences of inequitable health outcomes, treatment and access to care. Health and social programs are often designed with the aim to address the lack of fairness and adjust for these systematic failures of systems or policies.*)

*Reference: The definition was adapted from Ingram R et al. Social Inequities and Mental Health: A Scoping Review. Vancouver: Study for Gender Inequities and Mental Health, 2013.

17 Local policies, practices, and laws considered during program design

How have local policies, practices, and laws (e.g., infrastructure development regulations, education requirements, etc.) been taken into consideration when designing the program?

18 How diversion of resources from other public health priorities are avoided

Please explain how the program avoids diverting resources away from other public health priorities? (e.g. local human resources involved in program implementation diverted from other programs or activities).

19 Program provides health technologies

Does your program include health technologies (health technologies include medical devices, medicines, and vaccines developed to solve a health problem and improve quality of lives)? (Yes/No)

20 Health technology(ies) are part of local standard treatment guidelines

Are the health technology(ies) which are part of your program part of local standard treatment guidelines? (Yes/No) If not,

what was the local need for these technologies?

21 Health technologies are covered by local health insurance schemes

Does your program include health technologies that are covered by local health insurance schemes? (Yes/No) If not, what are the local needs for these technologies?

22 Program provides medicines listed on the National Essential Medicines List

Does your program include medicines that are listed on the National Essential Medicines List? (Yes/No) If not, what was the local need for these technologies?

23 Sustainability plan

If applicable, please describe how you have planned for sustainability of the implementation of your program (ex. Creating a transition plan from your company to the local government during the development of the program).

ADDITIONAL PROGRAM INFORMATION

24 Additional program information

Is there any additional information that you would like to add about your program that has not been collected in other sections of the form?

a Potential conflict of interest discussed with government entity

Have you discussed with governmental entity potential conflicts of interest between the social aims of your program and your business activities? (Yes/No) If yes, please provide more details and the name of the government entity.

25 Access Accelerated Initiative participant

Is this program part of the Access Accelerated Initiative? (Yes/No)

26 International Federation of Pharmaceutical Manufacturers & Associations (IFPMA) membership

Is your company a member of the International Federation of Pharmaceutical Manufacturers & Associations (IFPMA)? (Yes/No)

Program Indicators

INDICATOR DESCRIPTION

27 List of indicator data to be reported into Access Observatory database

For this program, activities, please select all inputs and impacts for which you plan to collect and report data into this database.

28 Data source

For this indicator, please select the data source(s) you will rely on.

29 Frequency of reporting

Indicate the frequency with which data for this indicator can be submitted to the Observatory.

30 Data collection

- Responsible party: For this indicator, please indicate the party/parties responsible for data collection.
- Data collection — Description: Please briefly describe the data source and collection procedure in detail.
- Data collection — Frequency: For this indicator, please indicate the frequency of data collection.

31 Data processing

- Responsible party: Please indicate all parties that conduct any processing of this data.
- Data processing— Description: Please briefly describe all processing procedures the data go through. Be explicit in describing the procedures, who enacts them, and the frequency of processing.
- Data processing — Frequency: What is the frequency with which this data is processed?

32 Data validation

Description: Describe the process (if any) your company uses to validate the quality of the data sent from the local team.

33 Challenges in data collection and steps to address challenges

Please indicate any challenges that you have in collecting data for this indicator and what you are doing to address those challenges.

