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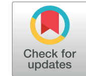
Editorial

Co-creating cancer control strategies in a strained healthcare landscape



Cancer and other non-communicable diseases (NCDs) including injuries and mental health disorders are now widely recognized as the most significant existential threat, not only to healthcare systems in low- and middle-income countries but also to the global social-economic order. This is compounded by a heavy burden of new and re-emerging infectious diseases. The bidirectional relationship between some infectious diseases like human immunodeficiency virus (HIV), tuberculosis (TB), and non-communicable diseases is well established.[1] Additionally, infectious agents like human papillomavirus (HPV) are linked to cancer causation.[1] This creates both an overlap and an opportunity in funding and amalgamation of services to leverage on the well-developed, better funded HIV and TB care infrastructure.

Patients with HIV are living longer because of antiretroviral drugs but are at a much higher risk of developing cancers and other NCDs. Integrating care should be obvious and logical but is hindered by systemic and institutional barriers such as parallel programming and human resource shortages. Adeyemi et al.[1] demonstrated that integrating NCD care in HIV programing is not only cost-effective but also gives patients a level of control and prioritizes their needs. Patients with multiple comorbidities who have to attend stand-alone disease-focused services end up making numerous clinic visits on different days for different conditions. For instance, a patient with HIV-associated malignancy and diabetes would have to visit the hospital three different times – for endocrinology, HIV care, and oncology consults. Too often the frequent clinic visits are for services like a simple medication refill prescription that can be handled in one sitting.

Whereas the major NCDs (cancer, cardiovascular diseases, chronic pulmonary diseases, and diabetes) share many risk factors, integration of services for their control and prevention has been slow and uncoordinated in many sub-Saharan African countries.[2] Restricted grant funding means the ministries of health can only implement what funders want. This explains the emergence of multiple standalone sometimes duplicate parallel programs with poor resource utilization.[3]

The vast majority of the social and economic determinants of health are outside of the purview of the health system. They require a multidimensional, multipronged approach across all sectors of the society. Among the risk factors, promotion of unhealthy diets, tobacco, and alcohol as well as air pollution are some of the drivers of NCDs which require regulation by other government agencies that are prone to make decisions based on economics and political factors, but not population health. A resilient healthcare system should be able to withstand industry pressure and ensure profit considerations do not take precedence over population health.[4]

World Health Organization (WHO) member states have signed numerous global commitments to reduce and/or end NCDs-related suffering, disabilities, and deaths. Disappointingly, sound evidenced based policies and political action to deploy appropriate strategies and resources has been slow. Oncology nurses beyond the chemotherapy room can play an advocacy role and make a contribution to context-specific implementation and evaluation of commitments made by their governments such as the Sustainable Development Goals (SDGs),[5,6] WHO "Best Buys,"[7] the UN Political Declaration on Prevention and Control of Non-Communicable Diseases[5] and the UN Political Declaration on Universal Health Coverage (UHC).[3]

The wave of UHC implementation is sweeping across many low- and middle-income countries across Africa and around the world. Though, in 2023 world leaders committed to redouble efforts to achieve UHC by 2030,[8] a clear picture is yet to emerge of how full implementation of UHC will look like and mean to people with cancer and their families. Different models may be used to implement UHC in different countries but the principles are the same: No one should suffer catastrophic health expenditure or die because of who they are and where they live. Oncology nurses around the world play a critical role in ensuring cancer care is available and accessible to all who need it in keeping with the tenets of UHC.[3]

WHO "best buys" endorsed in 2017 comprised of 16 practical and cost-effective interventions that work and can be delivered at the primary health level (WHO 2017).[9] An expanded list of 28 "best buys" was adopted during the 76th World Health Assembly in 2023.[10] At the core of the "best buys" is emphasis on health promotion, and disease prevention through interventions such as stringent tobacco control measures, HPV vaccination for girls and reducing sugar and salt in food preparations. Community partnerships and stakeholder engagement in a supportive political, social, and economic environment are key to successful adoption and implementation of these interventions. At the primary health care level, it is the nurses who drive the "best buys" agenda, an underrated contribution that cannot be achieved in boardrooms. However, nurses must seek allies and partnerships with cancer civil society and patient-led organizations to pressure governments to develop, fund, and implement national cancer and NCDs control plans and to keep commitments to international declarations. Alliances between professionals, lay advocates and cancer survivors have shaped the cancer policy and legislation landscape in Kenya and across many African countries through consistent advocacy. Beyond advocacy, the contribution of civil society and patient groups in cancer education, prevention, screening, and rehabilitation has not been well quantified and costed. A clear well-documented framework of engagement between governments and civil society organizations is needed to institutionalize and leverage community networks to co-create sustainable solutions.

Climate change now presents a complex threat to an already fragile health ecosystem and an urgent imperative to act. Siiba et al.[11] in a systematic review found that extremes of weather from drought to flooding

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disrupt healthcare for people living with cancer, diabetes, and cardiovascular disease. These patients were at risk of exacerbation of health problems following such disasters because of interruptions with their treatment, problems with drug supplies chains, or inability to access healthcare due transport disruptions.[11] Mitigating the devastating impact of climate change on human development is way beyond the health system yet the resultant disease, suffering and deaths are a medical problem.

Effective cancer control in this constantly evolving landscape requires oncology nurses who have a solid understanding of how climate change impacts their practice and who are also tuned to the rapid advancements in medicine and the developments in pharmaceutical and technology. Science continues to unlock cancer and demystify its biology creating new personalized therapies which promise higher cure rates while technology is constantly providing new avenues for drug delivery and monitoring patients. Therefore, re-imagining efficient, practical, cost-effective patient-centric programing calls for new paradigms in service delivery that prioritizes what patients' needs and not medical expediencies. Nurses are generally pragmatic and would be best placed to provide leadership in planning, implementing, and scaling-up of well-coordinated and harmonized clinic schedules for the more common infectious diseases (HIV, TB Malaria) and the more common NCDs (hypertension, cancer, diabetes, chronic respiratory diseases). Such nurse-led interventions would save patient's time, resources and potentially improve their quality of life.

Multiple and conflicting priorities facing healthcare systems across the world do not always allow for or accommodate other “non-conventional non-traditional” complementary services that patients need. Therapies such as relaxation techniques, support groups, art and music therapy are left to civil society or cancer charities to provide. Yet they are an important component of any comprehensive care programs. Lee et al.[12] have shown the benefits of complementary therapies on the overall well-being and quality of life of cancer patients. Co-creating solutions to improve quality of life of people with cancer will necessitate mainstreaming of complementary therapies within the healthcare system.

A prerequisite for reimagining and co-creating cost-effective, evidence-based, culturally acceptable, and rapidly deployable interventions is political will, visionary leadership, and an all-inclusive people-led, people-owned integrated and comprehensive cancer control plan. The limited resources needed for prevention, screening, early detection, treatment, and rehabilitation of persons at risk of or suffering from cancer can only be utilized in a balanced and equitable way within the framework of well-funded UHC. Grassroots community engagement is fundamental to co-creating meaningful and culturally acceptable approaches for implementation of global and national strategies for prevention and control of cancer and other non-communicable diseases.

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Declaration of competing interest

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Declaration of Generative AI and AI-assisted technologies in the writing process

No AI tools/services were used during the preparation of this work.

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