Advancing Access: a practical advocacy toolkit for improving access to NCD medicines, diagnostics and medical devices

10 November 2026

NCD Alliance

UNIVERSITÉ DE GENÈVE

NCD POLICY LAB

Welcome

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Agenda

- Welcome
- Global Priorities to improve access to NCD medicines, diagnostics and devices
- Advancing Access: A practical advocacy toolkit for improving access to NCD medicines, diagnostics and medical devices
- Selection and pricing of insulin analogues in Brazil: **Karla Melo, Brazilian Diabetes Society**
- Insulin access learnings for COPD and asthma: **David Halpin, Global Initiative for Chronic Obstructive Lung Disease**
- Learnings from HIV forecasting in Tanzania: **Kaushik Ramaiya, East Africa NCD Alliance**
- Capacity-building for NCD forecasting in Uganda: **Aston Nuwagira & Clarke Bhandari Cole, Clinton Health Access Initiative**
- Pooled procurement of antihypertensives in the Americas: **Christopher Lim, PAHO Strategic Fund**
- Q&A

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Register your interest in peer-to-peer learning here

Advancing Access: Global priorities to improve access to NCD medicines, diagnostics and medical devices

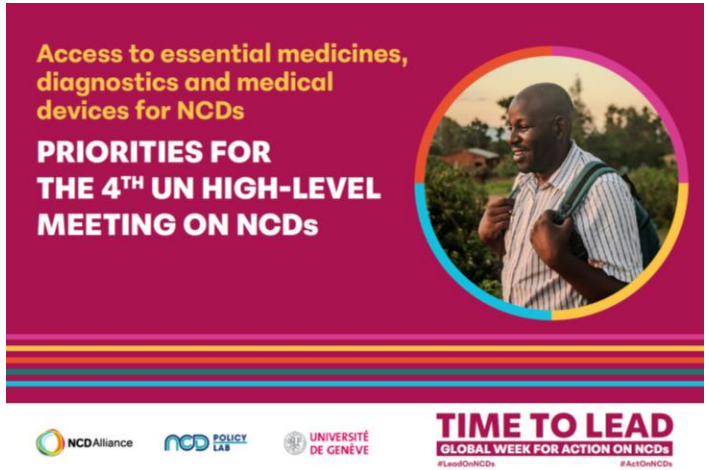
David Beran, University of Geneva

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Advocacy brief on access to medicines, diagnostics and medical devices



1. **Facilitate the transfer of technology, skills, and know-how** to scale up affordable, quality-assured production of NCD medicines, diagnostics, and health technologies, supported by initiatives like the Medicines Patent Pool
2. **Develop and implement pricing policies** that reduce out-of-pocket expenses, regulate mark-ups, and promote public-private partnerships while fostering transparency in pricing, patents, and clinical trial data to ensure equitable access to NCD medicines and technologies.
3. **Streamline regulatory processes** across countries, expand WHO Pre-Qualification to cover more NCD treatments, and promote collaborative registration to ensure faster, affordable access to essential medicines and diagnostics in LMICs.
4. **Build capacity for effective forecasting and supply chain management, and promote pooled procurement** to reduce costs, improve distribution, and ensure a steady supply of quality-assured NCD medicines and technologies.
5. **Ensure the rational selection and procurement of NCD medicines and diagnostics in Universal Health Coverage (UHC) packages**, implementing WHO guidelines, PEN, and 'Best Buys' to align interventions with national health priorities.

The NCD Alliance, NCD Policy Lab and the University of Geneva developed this policy brief in collaboration with the following organizations:

International Diabetes Federation · The Union · UICC · World Heart Federation · one neurology · RESOLVE TO SAVE LIVES · MedAccess · Blue Circle Diabetes Foundation · medicines patent pool · FIND · EFNA · HAI Health Action International · London School of Hygiene & Tropical Medicine · Centre for Global Chronic Conditions · Global Asthma Network · World Sleep Society · Santé Diabète · United for Global Mental Health

HLM 4: Political Declaration: Improved access to essential NCD medicines, diagnostics and other health technologies



At least 80% of primary health care facilities in all countries have availability of World Health Organization-recommended essential medicines and basic technologies for noncommunicable diseases and mental health conditions, at affordable prices, by 2030.



At least 60% of countries have financial protection policies or measures in place that cover or limit the cost of essential services, diagnostics, medicines and other health products for noncommunicable diseases and mental health conditions by 2030.

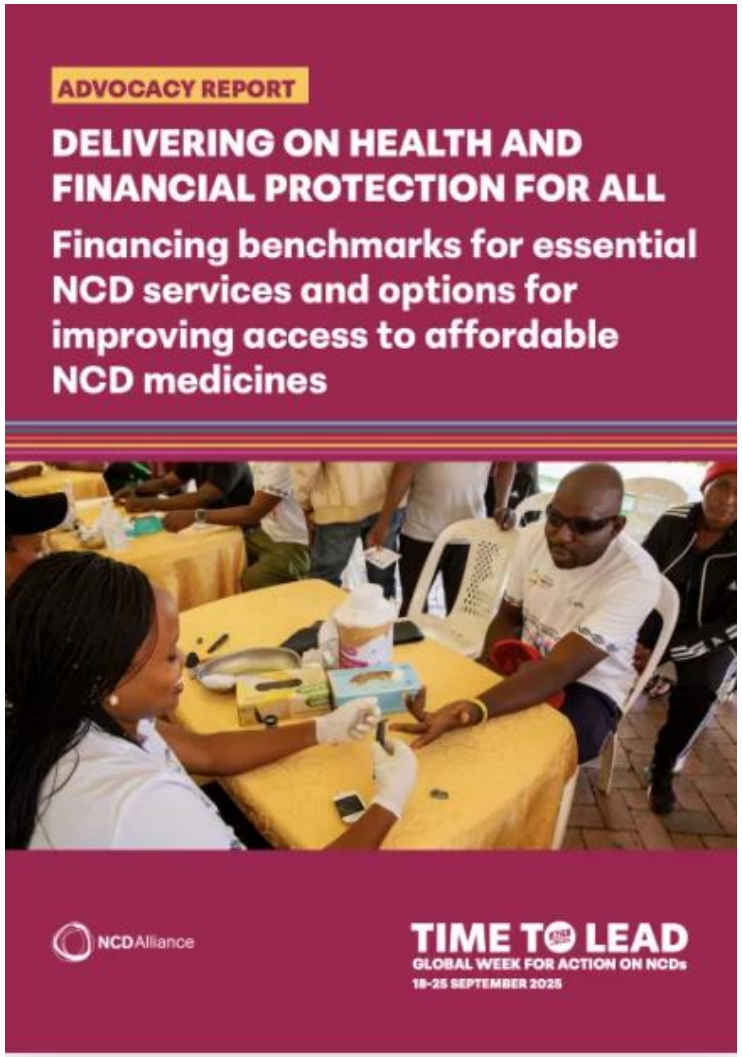
Key win: inclusion of operational language on access (pricing policies, transparency, transfer of technology vs TRIPS/Doha, etc) - **influence of NCDA messaging**



Building on the HLM Targets and Brief

- Co-organisation of a challenge during the Hackccess Hackathon
- Organisation of workshop with advocates, WHO ***(presence of multiple representatives over 2 days)*** and other stakeholders in Geneva to discussed shared priorities for advocacy
- The Global NCD Access Advocacy Plan (GNAAP): development of an advocacy toolkit

In parallel: NCDA Policy brief on Financing Benchmarks for NCD Care



- Access to medicines is the largest bottleneck to expanded NCD services.
- Two big issues drive access challenges: under-investment and inefficient use of current resources.
- 20–50% reduction in spending needs possible if countries procured at lowest observed prices.

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Advancing Access: Global Priorities on Access to NCD Medicines, Diagnostics and Devices

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sign-ons from CSOs, lived experience advocates and national and regional alliances

For Member States

- Align and implement national policies, guidelines and lists
- Streamline and strengthen regulation, forecasting, pric ing and procurement
- Ensure affordability via appropriate pricing policies
- Regional and international collaboration
- NCD products financed as part of UHC
- Transparent health budgets with disaggregated NCD spending data

For the World Health Organization

- Keep NCD access central to WHO efforts across departments
- Provide technical support to apply WHO guidance nationally and regionally and follow-up on implementation
- Promote regulatory harmonisation, broader expansion of PQ and CRP to NCDs
- Support regional and global initiatives on availability and affordability

For other actors

- Global health initiatives: support integrated, person-centred care addressing both IDs and NCDs
- Civil society: work together to avoid siloes, monitor and hold stakeholders to account
- **Civil society: strong, cross-disease, evidence-based technical advocacy, supported by the Advancing Access toolkit**
- Private sector: clinical trials, affordability, supply and intellectual property

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Advancing Access: a practical advocacy toolkit for improving access to NCD medicines, diagnostics and medical devices

Rosalind Turkie, NCDA

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Advancing Access: a practical advocacy toolkit to improve access to essential NCD medicines, diagnostics and medical devices

- Building on the Global Priorities: how to take forward the recommendations?
- Promotes a unified, cross-disease approach to shared access barriers
- Designed to complement – not duplicate – existing efforts
- Response to limitations of current commitments

Advancing Access Toolkit – an online, interactive advocacy resource designed to support advocates working on NCDs and access



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How to use the Advancing Access advocacy toolkit?

The sections of this toolkit guide users to gather information that is relevant for **assessing the different steps of the access pathway**, before developing a **context-specific set of evidence-based advocacy actions**. The toolkit provides guidance for driving system-level change, and it also allows users to analyse barriers linked to specific products if they choose this more granular approach.

ADVANCING ACCESS:
Advocacy though five key steps of the pharmaceutical value chain

SNAPSHOTS
A high-level view of each step: What it is, why it matters, related problems and barriers, and who is responsible.

KNOWLEDGE CHECKLISTS
Deepen the understanding of each step by gathering important information about access in a local context.

ADVOCACY STRATEGIES
A selection of advocacy actions and tips to consider and adapt for use in developing a locally tailored advocacy strategy.

Follow-the-Product barrier analysis

An analysis of a specific chosen NCD medicine or medical device which is linked to access problems in a given context. Helps identify barriers and advocacy actions to address them.

Tools and initiatives

Existing resources which will support advocates in gathering information and/or carrying out advocacy actions.

TOOLS AND INITIATIVES

Templates and resources

Customisable templates and other resources designed especially for access advocacy.

TEMPLATES AND RESOURCES

Advancing Access product list

A compiled list of WHO-recommended NCD medicines and medical devices, to be used in primary healthcare systems with strong referral systems to secondary and tertiary care.

ANNEX 2

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The toolkit focuses on supporting advocacy to improve access to NCD medicines and medical devices by addressing **five system-level problems** that are commonly observed in health systems. Some or all of these problems may be observed in a given country. These problems are the entry point for the Follow-the-Product barrier analysis.

Five commonly observed access problems:

1. Medicines/devices are not prescribed or used in the country
2. Medicines/devices are used but are not available or continuously available in public facilities or pharmacies
3. Medicines/devices are available but are not of adequate quality
4. Medicines/devices are available but unaffordable
5. Medicines/devices are not being reimbursed and people must pay out of pocket (both public and private sector)



This toolkit recognises its own limitations. Most of its suggested advocacy actions are directed towards governments and other public sector actors, but many important access barriers are influenced by stakeholders beyond government, including (but not limited to) pharmaceutical companies (both the research-based and the generics and biosimilar industry), wholesalers, health insurers and other private sector actors as well as donors. Broader health system challenges, such as health workforce strengthening, prescribing, and patient medication adherence and use, may also influence access but are not addressed in detail here.



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STEP 1

SELECTION

Selection Snapshot

What is it

'Selection' is the national process by which medicines and medical devices are assessed, prioritised, and included on a country's Essential Medicines List (EML), Essential Diagnostics List (EDL), standard treatment guidelines (STGs), and/or reimbursement list and national formularies.

Why it matters

Selection can be considered the gateway to public access, and is inextricable from reimbursement. Medicines and medical devices that are not included in national lists or guidelines are far less likely to be procured, publicly funded or routinely used within the health system. Decisions made during selection can also trigger downstream discussions on issues such as pricing and population coverage.

Problems and barriers

Access barriers within the Selection step can contribute to four of the five **health system problems** highlighted in this toolkit:

- Medicines/devices are not prescribed or used in the country
- Medicines/devices are used but are not available or continuously available in public facilities or pharmacies
- Medicines/devices are available but unaffordable
- Medicines/devices are not being reimbursed and patients must pay out of pocket

These are some of the most common **selection-related barriers** driving the problems above:

- Medicines/devices are not included in national EML / EDL and/ or reimbursement, formulary, or procurement lists
- National lists are outdated (not updated in last three to five years)
- Lists and treatment guidelines, NCD policies and/ or prescribing are misaligned

TOOLS AND INITIATIVES

Selection-related tools and initiatives which can support your advocacy work:

- WHO Model List of Essential Medicines (EML) and the WHO Model List of Essential Medicines for Children (EMLc)
- WHO Model List of Essential In Vitro Diagnostics
- WHO Selection of essential medicines at country level: Using the WHO model list of essential medicines to update a national essential medicines list
- WHO Package of Essential Noncommunicable (PEN) Disease Interventions for Primary Health Care
- WHO PEN-Plus

Additional disease-specific technical packages and tools

- WHO How to develop and implement a national drug policy 2nd edition
- UHC Compendium and the Service Package Delivery and Implementation (SPDI) Platform
- WHO report Tackling NCDs: best buys and other recommended interventions for the prevention and control of noncommunicable diseases, 2nd ed



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Knowledge Checklist

1. Country's Essential Medicines List, reimbursement list, procurement list, and/or national formulary(ies)

What this is

These lists define which medicines and medical devices are officially prioritised for procurement, public financing, reimbursement and use within the national health system. They will often be the starting point for access-related advocacy work and will inform the selection-related questions which are included in the Product Analysis for problems 1, 2, 4 and 5.

Where to find it

- Ministry of Health website
- National Medicines Regulatory Authority website
- WHO country office (may hold copies of the most recent national EML or be able to advise where it can be obtained, particularly if WHO provided technical support during the last update)
- WHO Repository of national EMLs (for country-submitted EMLs) or list of electronic essential medicines lists

Key points to check

- Existence of the list/s
- Whether the list/s influence procurement decisions
- Date of last update (ideally within the last three to five years)
- Alignment of the list/s with treatment or clinical guidelines
- Inclusion (or omission) of core NCD medicines and medical devices *(See Advancing Access product list)*

2. Knowledge of the national selection committees and selection processes

What this is

Understanding who decides which medicines and medical devices are included (e.g. national medicines/therapeutics committee), how often they meet, and what criteria they use for deciding which medicines and medical devices to prioritise for procurement and public funding.

This information will be useful for selection-related advocacy work, ensuring communications reach the most relevant bodies and individuals. It will also inform the *Stakeholder Mapping*.

Where to find it

- Ministry of Health website or UHC policy documents
- National drug or pharmaceutical policy documents
- Terms of Reference (ToR) for EML or Health Technology Assessment (HTA) committees (if published)
- Direct engagement with:
  - Ministry of Health pharmaceutical services departments
  - WHO country offices
  - Health professionals
  - Public hospitals and health facilities

Key points to check

- Who/ which institution makes selection decisions?
- What criteria or guiding documents are used to decide which products are prioritised for procurement and public funding?



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Advocacy Strategy: Selection

Advocacy aim: All national selection lists are updated, harmonised with treatment guidelines and NCD policies, and used for guiding reimbursement.

Action 1

Update national selection lists and treatment guidelines, ensuring key NCD medicines and medical devices are included.

How to do this

- Start by mapping what already exists – obtain the country's nEML, nEDL and STGs for the relevant disease area, and identify gaps against the WHO lists (EML, EDL, PEN and disease-specific packages) (note that adaptation of the WHO lists to national contexts is to be expected). For a collated list, the *Advancing Access list of NCD medicines and medical devices* can be used.
- Where a key NCD medicine or medical device is missing, prepare a short evidence brief (with burden of disease data, WHO recommendation status) to support an addition request to the national EML committee. This approach is most effective if collaboration with relevant professional medical associations or key health professionals is possible.
- If no review has happened in several years, request the review cycle directly from the Ministry of Health and/or selection committee.

Mitigating obstacles

- If review cycles are infrequent or absent, propose a fixed review schedule (e.g. aligned to WHO's biennial EML update) as a concrete policy ask.
- If the committee has limited technical capacity, offer to connect them with civil society, professional medical associations or academic technical networks that can support evidence review.
- If a meeting is difficult to secure, make the request through a patient organisation or professional medical association with existing government relationships.

Stakeholders

- Ministry of Health, national EML committee, medical professionals and patient organisations.

Tips for advocates

- In 2027 the WHO will celebrate 50 years of the EML – leverage this as an advocacy/campaign opportunity to request the government to update the national EML.
- If the country's lists are not publicly available, document this lack of transparency as a barrier to accountability.
- Reach out to clinicians and academics who may be working on similar issues and can provide technical insight and influence on lists.



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CASE STUDY

Selection and reimbursement of insulin analogues in Brazil

This case study was provided by Mark Barone.

Key message

Combining listing with pricing policies allowed Brazil to expand access to insulin analogues for both type 1 and type 2 diabetes while protecting the long-term sustainability of public healthcare budgets.

In 2017, rapid-acting insulin analogues were incorporated into Brazil's Unified Health System (SUS) for people with type 1 diabetes following assessment by the National Commission for the Incorporation of Technologies (CONITEC). While the clinical benefits of rapid-acting analogues were recognised, affordability and budget impact presented challenges. These were overcome through subsequent price negotiations and large-scale public procurement, which helped reduce costs and support their availability through the public health system at no cost to patients.

A similar approach was adopted for long-acting insulin analogues. **In 2019, Brazil incorporated long-acting insulin analogues for type 1 diabetes, but explicitly conditioned incorporation on achieving a treatment cost equal to or lower than that of human NPH insulin.** Over the following years, technical assessments were conducted to establish therapeutic equivalence and acceptable price ceilings based on the cost of NPH insulin. These analyses informed national procurement processes, culminating in federal purchases of long-acting analogues in 2024.

The Brazilian experience illustrates how health technology assessment, price negotiation, and centralised procurement can be combined to improve access to insulin analogues while protecting the sustainability of public healthcare budgets. Listing was a key step in the process, enabling it to be prioritised for public financing or procurement and subsequently reimbursed in the public health system.

More recently, Brazil expanded access to both rapid-acting and long-acting insulin analogues for people with type 2 diabetes as part of a broader strategy to strengthen the sustainability and resilience of insulin supply within the public health system. This policy shift was driven not only by clinical considerations but also by increasing global constraints in the supply of human insulins (NPH and regular), prompting the Ministry of Health to diversify treatment options, increase the availability of analogue insulins in Brazil's public universal healthcare system, and invest in domestic production capacity for insulin. **It is important to note that Brazil was able to ensure that the prices of human and analogue insulin were the same, which in many countries is not the case with analogue insulins being substantially more costly than human insulin for health systems and individuals, and with these higher prices not considered justified by existing scientific evidence.**

CASE STUDY

Global to national advocacy: How a WHO EML listing improved national treatment access

This case study was provided by the MS International Foundation.

Key message

Listing on the WHO EML strengthens advocacy, particularly when combined with local evidence-gathering and relationship-building.

In 2023, the MS International Foundation (MSIF) achieved a landmark result: multiple sclerosis (MS) treatments were listed on the WHO EML for the first time. The listing has become a powerful tool for national advocacy, helping MS organisations around the world make the case for national listing, aligned with treatment guidelines, and covered by health benefit packages or national insurance schemes. The same global decision has translated into different national outcomes depending on each country's health system and advocacy route: government subsidies for the products following advocacy linked to the WHO EML listing (Nepal), updated guidelines (UAE), formal registration of a treatment following WHO EML listing (Iran), national EML listing and changing prescribing practice (Malaysia), and insurance coverage of treatments (Ghana, Chile, Albania).

Across these seven countries, the WHO EML listing was used alongside locally gathered evidence (MS registries, patient testimonies, etc), relationship-building with health authorities, regulators and the public, and sustained advocacy engagement. What the listing consistently provided was the legitimacy of a globally recognised, independent recommendation that advocates could point to when making the case for inclusion as an essential medicine, guideline development, registration, or reimbursement, even where in many cases it was never formally cited in a national policy document.

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PROBLEM 1
Medicine/devices not being prescribed (by healthcare professionals) or used in-country

Question

Is the medicine/device included in treatment guidelines and the national EML / EDL, formulary, procurement or reimbursement list?

Answer	Likely barrier(s) identified	Relevant tools	Advocacy focus
Yes	Continue to next question		
No	If the medicine/device is not included in treatment guidelines and the national EML / EDL, formulary, procurement or reimbursement lists, this reduces the likelihood of it being continuously available through the public system and being reimbursed. Inclusion on the national EML is typically a prerequisite for inclusion in reimbursement or health benefit packages, and signals political prioritisation of the medicine/device. Price can be a reason why a medicine/device is not selected for inclusion.	EML, EDL, WHO Selection of essential medicines at country level: Using the WHO model list of essential medicines to update a national essential medicines list; PEN; national STGs	Inclusion of the medicine/device on all relevant lists so it can be prescribed, used and reimbursed. **Note:** WHO EML/EDL should be used to guide selection.
Included in some but not all	If the medicine/device is not included in all relevant lists, if lists are outdated (not revised in the last 3–5 years), or if they are misaligned with one another, this can create gaps in availability. Moreover, in many settings, prescribing is also influenced by what healthcare workers expect to find available: guidelines that are not actively implemented or disseminated may have limited impact on prescribing behaviour. **Note**: Not all countries will have all list types. What matters is that the lists which do exist are aligned and actively used.	EML, EDL, WHO Selection of essential medicines at country level: Using the WHO model list of essential medicines to update a national essential medicines list; PEN; national STGs	Aligning and/or updating relevant lists to include this medicine/device.

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Annex 2

Advancing Access: A collated list of WHO-recommended essential NCD medicines, diagnostics and medical devices for primary healthcare settings

You can download an Excel version of the list here

Please *see Annex 3* to read about the methods used to develop this list.

INN (medicine)/diagnostic/device	Strength/ formulation	EML/EDL	PEN	Operational framework	Additional source/ protocol	Disease area	Notes/remarks
Goserelin		✓	X	X		cancer	therapeutic alternative to Leuprorelin
Leuprorelin	Injection: 7.5 mg; 22.5 mg in pre-filled syringe.	✓	X	X		cancer	
Triptorelin		✓	X	X		cancer	therapeutic alternative to Leuprorelin
Cyclophosphamide	Powder for injection: 500 mg; 1 g; 2 g in vial. Solid oral dosage form: 25 mg; 50 mg.	✓	X	X		cancer	
Methotrexate	Concentrated injection: 1000 mg/10 mL. Injection: 50 mg/2 mL. Powder for injection: 50 mg (as sodium) in vial. Tablet: 2.5 mg (as sodium).	✓	X	X		cancer	
Anastrozole	Tablet: 1 mg.	✓	X	X		cancer	
Tamoxifen	Tablet: 10 mg; 20 mg (as citrate).	✓	X	X		cancer	
Capecitabine	Tablet: 150 mg; 500 mg.	✓	X	X		cancer	
Carboplatin	Injection: 50 mg/5 mL; 150 mg/15 mL; 450 mg/45 mL; 600 mg/60 mL.	✓	X	X		cancer	
Vinorelbine	Capsule: 20 mg; 30 mg; 80 mg. Injection: 10 mg/mL in 1 mL, 5 mL vial.	✓	X	X		cancer	
Human papillomavirus vaccine	Injection: 10 mg/mL in 1 mL, 5 mL vial.	✓	X	X		cancer	
Papanicolaou smear test		X	X	X		cancer	
HPV nucleic acid test		X	X	X		cancer	
VIA screening tools: speculum, light source, acetic acid		X	X	X		cancer	
HPV self-sampling or point-of-care testing		X	X	X		cancer	

Toolkit development

Close engagement with experts on access and NCDs:

12 Global organisations

7 NCDAs, PLW & national organisations

In addition…

15 Global organisations were engaged throughout the toolkit development

PATH · World Stroke Organization · NCDI Poverty Network · International Diabetes Federation · access to medicine FOUNDATION · Global Initiative for Chronic Obstructive Lung Disease · HAI Health Action International · World Heart Federation

TANCDA Tanzania NCD Alliance · East Africa Diabetes Study Group EADSG · Santé Diabète · Renal Patients Society Of Kenya · Eastern Mediterranean NCD Alliance · HCC Healthy Caribbean Coalition · ENCDC Ethiopian NCD Alliance · NCD Alliance · NCD Policy Lab

14 national and regional alliances were engaged throughout the toolkit development

Collaboration with WHO NCD/MH Department



Continuous engagement with WHO and the development of the **Operational Framework**



Advocacy for the implementation of existing WHO technical tools (eg WHO Prequalification, PEN)

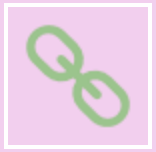


Alignment with WHO-led commitments on access and support for civil society in monitoring progress towards targets

Advancing Access: Strategic objectives



Provide a **toolkit** that cuts across diseases and the pharmaceutical value chain.



Raise **awareness of underused tools** and link them to specific access barriers and products.



Identify **opportunities for joint global and regional advocacy** where political will, technical tools, and civil society momentum can align.

Lived experience expertise

"… help national NCD alliances and CSOs in LMICs engage their ministries of health on Essential Medicines List (EML) updates. **Many of these groups lack the technical vocabulary or clear entry points for such discussions**"

"I would also recommend this toolkit to colleagues working in WHO country offices and to regional NCD alliances who regularly interface with procurement and regulatory stakeholders. **It would be particularly useful for those who are technically oriented but less experienced in translating technical bottlenecks into actionable advocacy asks**"



Advancing Access consultation: Mohammed Seyam (Our Views, Our Voices Global Advisory Committee)

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Case studies

	VALUE CHAIN STEP
Selection and pricing of insulin analogues in Brazil	1 Selection
Insulin access learnings for COPD and asthma	2 Crosscutting
Learnings from HIV forecasting in Tanzania	3 Forecasting
Capacity-building for NCD forecasting in Uganda	4 Forecasting
Pooled procurement of antihypertensives in the Americas	5 Procurement

Case study: Selection and pricing of insulin analogues in Brazil

How a medical society's health technology assessment dossier achieved the approval for rapid-acting insulin analogues in the Brazilian Unified Health System (SUS)

Karla Melo, MD, PhD (Melo, KFS)

Vice-President and Government Affairs Advisor, Brazilian Diabetes Society (SBD)

Member of Insulin WG/Ministry of Health

Living with type 1 diabetes for 51 years

I have no conflicts of interest for this presentation

Webinar · NCD Alliance · Université de Genève · NCD Policy Lab · 10 November 2026

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SBD Sociedade Brasileira de Diabetes

The unmet need: poor control, unequal access

90%

of people with type 1 diabetes had HbA1c above 7% (10 largest cities)

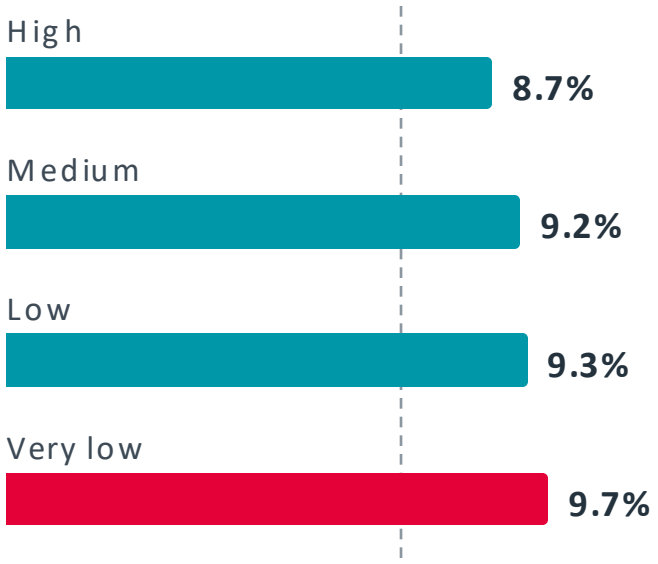
13%

of adults in SUS tertiary care reached HbA1c < 7%

47.5%

had HbA1c of 9% or higher

Mean HbA1c by economic class



By region (SUS specialist clinics)

Region	HbA1c	Intensive*	Pump
North/Northeast	9.4%	48.7%	0.2%
Southeast	9.1%	64.7%	1.6%
South	9.4%	73.0%	1.2%
Midwest	9.1%	50.9%	1.7%

*Three or more daily injections of short-acting insulin

- **The poorest had the worst control;**
- **The North and Northeast regions had the least access to intensive treatment and higher HbA1c (vs Southeast).**

Sources: Mendes et al., 2010; Brazilian Type 1 Diabetes Study Group, 3,591 patients in 28 public clinics (Gomes et al., 2012 and 2013).

The 2016 submission: from no to yes

Sept 2014

CONITEC rejects all insulin analogues **for type 1** and type 2 **diabetes**

June 2016

SBD submits a dossier on **rapid-acting** analogues for type 1 diabetes

Preliminary

CONITEC's first view: do not incorporate

Consultation

Public consultation 25: **1,092 contributions + 29,382 petition signatures (online and paper)**

51st plenary

Unanimous yes, " subject to price negotiation"

Feb 2017

Ordinance SCTIE 10/2017; clinical protocol 2018

What was different this time

- Rapid-acting analogues, type 1 diabetes only
- Brazilian data on hypoglycaemia, utilities and real SUS prices
- Economics framed around the price gap, not the molecule
- Patients and professionals mobilised in the consultation

The dossier (items 3–5):

Quality-of-life study → cost-utility model → budget impact

Sources: CONITEC Report 245 (Feb 2017); Ordinance SCTIE/MS 10, 21 Feb 2017; CONASS Technical Note 07/2018.

Building Brazilian evidence

EFFECT

Systematic review & meta-analysis[1] · 22 RCTs, 6,235 patients

Primary outcomes	Rate ratio or MD (95% CI)	Data
All hypoglycaemic episodes	0.93 (0.87–0.99) · −7%*	6,180 pts · 20 RCTs
Nocturnal hypoglycaemia	0.55 (0.40–0.76) · −45%	1,995 pts · 8 RCTs
Severe hypoglycaemia	0.68 (0.60–0.77) · −32%	5,945 pts · 15 RCTs
Postprandial glucose	−19.4 mg/dL (−21.5 to −17.4)	5,031 pts · 15 RCTs

Secondary outcomes	Result	Data
HbA1c	−0.13% (−0.16 to −0.10)	5,204 pts · 15 RCTs
Quality of life / satisfaction	More flexibility; DTSQ +2.3 in one RCT	5 RCTs, not pooled

ITEM 3 · UTILITIES

Multicentre QoL study[2]

0.801 → 0.737

Median EQ-5D utility (Brazilian tariff): low vs high frequency of severe hypoglycaemia (p = 0.02). 221 adults, 3 SUS centres; 34.8% had severe episodes.

COSTS

Real SUS prices

2015

All public purchases in the national Health Price Bank (BPS), by presentation

[1] Melo KFS, et al. Diabetol Metab Syndr. 2019;11:2. doi:10.1186/s13098-018-0397-3
[2] Bahia L, et al. Diabetol Metab Syndr. 2017;9:9. doi:10.1186/s13098-017-0206-4
* Sensitivity analysis excluding high risk of bias (all 22 RCTs: 0.94, 0.89–1.00). SBD dossier (2016).

The economic case in three questions

1 · GOOD VALUE?

Is the health gain worth the extra cost?

Yes, in cartridges

About **R$ 30,456 R$/QALY**, within the limit used in Brazil at the time (ICER < 40.000). Not in vials, where one product was far too expensive.

2 · AT WHAT PRICE?

How much more can the SUS pay?

+ R$ 2.48 to 7.45

per **3 mL cartridge**, compared with regular human insulin, and it still remains good value.

3 · AFFORDABLE?

What would it cost the SUS?

R$ 243–405 M

over **5 years** for about **650,000** people, at the lowest 2015 prices (about R$ 80–133 million per year once everyone is treated).

The clinical benefit was clear. The decision was about price.

"Year of healthy life" = QALY. Source: SBD dossier (2016), items 4 and 5; CONITEC Report 245 (2017). Details in backup slides.

Price is the key: a target for negotiation

The extra price that still means good value, per 3 mL cartridge

+ R$ 2.48 strictest limit (1× GDP per capita)

+ R$ 4.96 intermediate limit (2×)

+ R$ 7.45 upper limit (3×)

What the SUS actually paid in 2015

3 mL cartridge	Price	Extra
Regular human insulin	R$ 16.65	–
Glulisine (pen)	R$ 16.79	+ 0.14
Lispro	R$ 22.26	+ 5.61

In **10 mL vials**, the gap was far larger (+ R$ 19 for lispro, + R$ 104 for glulisine): above every limit.

The message to the Ministry was not "pay what is asked" but "this is the price at which it is good value". Hence: approved, subject to price negotiation.

Source: SBD dossier (2016), tables 4.1 and 4.7; Health Price Bank (BPS), all 2015 public purchases.

The decision: yes, at the right price

What was decided

- Unanimous incorporation for type 1 diabetes, **subject to price negotiation** and a national protocol
- The Ministry buys centrally the analogue with the best cost-minimisation result
- Protocol: specialist follow-up;

The T1D protocol (PCDT): a staircase of therapy

1 Education + NPH + regular

2 Education + NPH + **rapid-acting analogue**

3 Education + **long-** and rapid-acting analogues

Next CGM, AID and apps

Step up after severe hypoglycaemia, frequent non-severe (> 2/week) or nocturnal (> 1/week) hypoglycaemia, or inadequate control for > 1 year.

Outcome of the negotiation: aspart at R$ 12.07 per cartridge, vs R$ 16.65 for regular insulin in 2015.

Supply is part of access: tenders in 2022 and January 2023 drew no bids, and an exceptional import was authorised in May 2023 .

Sources: CONITEC Report 245 (2017); CONASS Technical Note 07/2018; Ministry of Health, Agência Gov (Sept 2023).
PCDT DM1: Portaria Conjunta SAS/SCTIE nº 8, 15 Mar 2018; Portaria Conjunta SAES/SCTIE nº 17, 12 Nov 2019.

Using the Advancing Access toolkit for advocacy

Selection

Society-led HTA dossier with local data; consultation reversed a "no".

Ask: generate local evidence and mobilise in consultations.

Regulation

Three analogues registered; an exceptional import ended the 2023 shortage.

Ask: more registered suppliers, emergency pathways.

Forecasting

Uptake and dose drove the budget; CONITEC judged uptake too low.

Ask: transparent, scenario-based forecasts.

Procurement

Central purchase; cartridge vs vial changed both cost and waste.

Ask: tenders by presentation, watch for empty bids.

Pricing

Threshold analysis set the premium payers could accept.

Ask: state the price at which it IS cost-effective.

Three take-aways

1. Local data beat borrowed conclusions. 2. Turn cost-effectiveness into a price target. 3. Advocacy does not end at the "yes": follow procurement, supply and health professional education.

Where we are now: PWT1DM in Brazil

T1D INDEX

The gap is measured in lives

246,000

"missing people" who would be alive today; 25% never diagnosed

- **520,000** people living with T1D
- **32 years** of healthy life lost per person diagnosed
- **+19.7 years** could be restored with access to advanced care for all

REAL-WORLD DATA

Control in youth is improving

9.4% → 8.2%

HbA1c in 2013 vs estimated HbA1c in 2022; about **53% of reported glucose values were in range** (70–180 mg/dL), ages 0–19

0–5 y	6–10 y	11–15 y	16–19 y
57.6%	57.7%	48.8%	50.2%

Glic app; unpublished, under review. Disclosure: co-founder.

GLOBAL · SEPT 2025

On the WHO Essential Medicines List

3 analogues

Aspart, glulisine and lispro added to the adult and children's lists, **for the first time**.

SBD and 7 partners (SBEM, ForumCCNT, ANAD, FENAD, Diabetes Brasil, ICD-RS, ADJ) supported the application and defended the evidence in *The Lancet Diabetes & Endocrinology* (2026).

From a national "no" to the WHO list: evidence-based advocacy works. But the gap is still measured in lives.

Sources: WHO EML (2025); Melo KFS et al., Lancet Diabetes Endocrinol 2026;14:376; Gomes MBG et al., Acta Diabetol 2012; Melo KFS unpublished data; Gregory GA et al., T1D Index (2022).

Analogues reach primary care and type 2 diabetes

NPH → glargine in primary care

Design Strategy built by the Ministry of Health **Insulin Working Group**; national production through a productive development partnership (PDP)

Feb 2026 Pilot in **4 states**: about 17,000 people eligible; **24%** already on glargine by the end of the pilot

Jul 2026 National roll-out in primary care units (UBS): **T1D aged 2 to <18** and **T1D or T2D aged >70**

254,000+
glargine cartridges sent to 16 states

52,350
reusable pens, with needles

T2D protocol (PCDT 2026): analogues included

Rapid-acting · aspart, lispro, glulisine

Replace regular insulin 1 U : 1 U. Priority: severe or unaware hypoglycaemia, older adults, BMI < 30, renal or hepatic impairment, poor postprandial control, high glycaemic variability, pregnancy.

Long-acting · glargine U100 and degludec

Priority: high risk of nocturnal or severe hypoglycaemia, older adults, BMI < 30, high variability, renal or hepatic impairment, pregnancy. Degludec if hypoglycaemia persists on glargine. From NPH: 1 : 1 if once daily; −20% if twice or more.

From the 2017 "yes" for type 1 diabetes: analogues are moving into primary care and into type 2 diabetes care.

Sources: Ordinances SECTICS/MS 948 and 949/2025 (incorporation); Ordinance SCTIE/MS 13, 21 Feb 2026 (PCDT DM2). Ministry of Health / Agência Gov, 13 Jul 2026; MoH Insulin Working Group (pilot data).

NCD Alliance

UNIVERSITÉ DE GENÈVE

THANK YOU

NCD POLICY LAB

SHARE. DISCUSS. ENGAGE. CHANGE.

#NCDs @ncdalliance

SBD Sociedade Brasileira de Diabetes

NCD Alliance

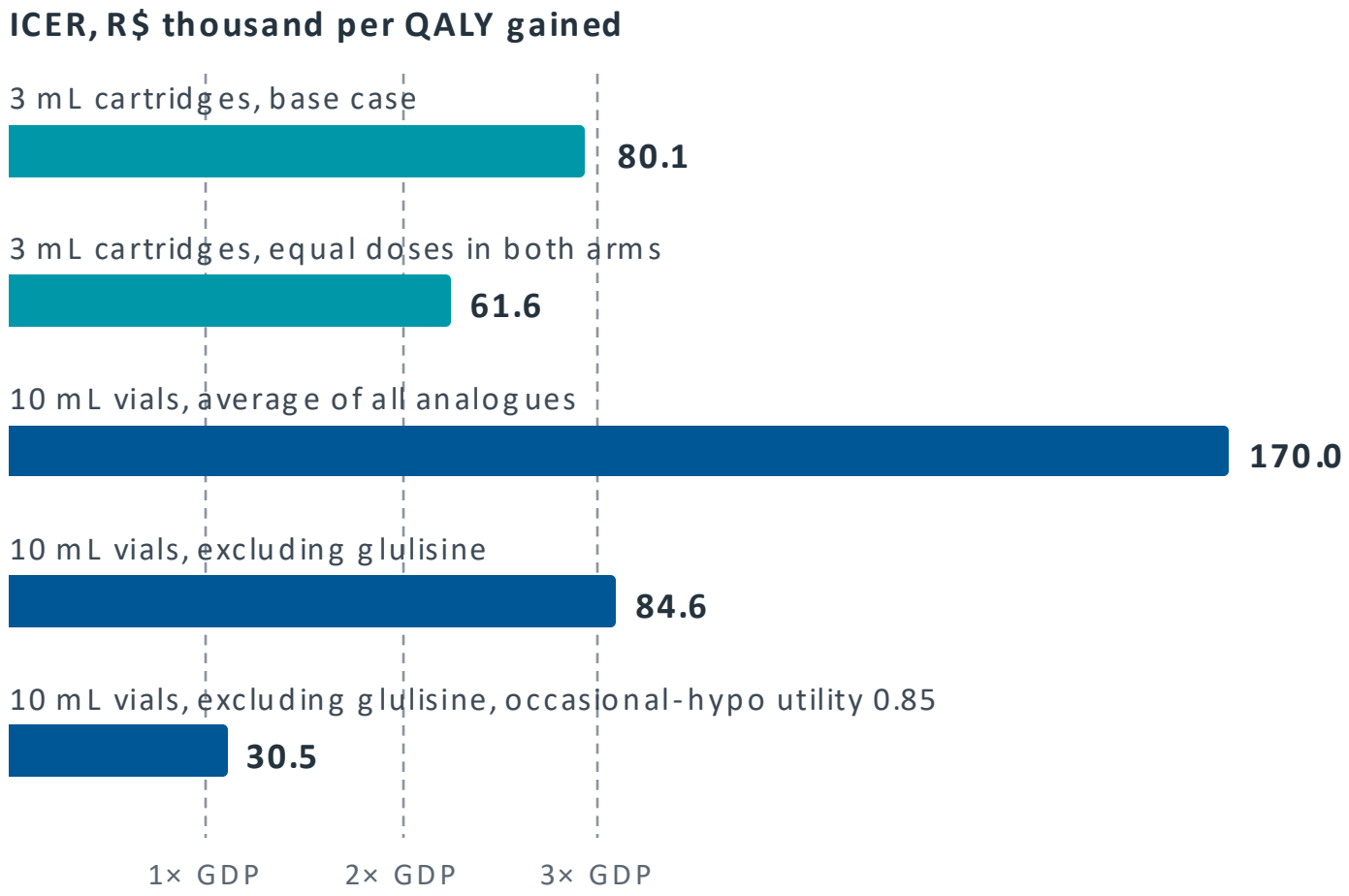
MAKING NCD PREVENTION AND CONTROL A PRIORITY, EVERYWHERE

Backup · Cost-utility results by scenario

The model

- Decision tree, 1-year horizon, SUS perspective
- Analogues vs regular human insulin
- Benefit = fewer severe hypoglycaemias → QALYs
- Costs = insulin only, 2015 SUS prices
- Threshold: 1–3× GDP per capita (R$ 27,229–81,687 per QALY)
- Probabilistic analysis: 1,000 Monte Carlo runs

Annual insulin cost, 3 mL: R$ 278 (regular) vs R$ 418 (analogues)



Dashed lines: willingness-to-pay of 1×, 2× and 3× GDP per capita (2014). Source: SBD dossier (2016), chapter 4.

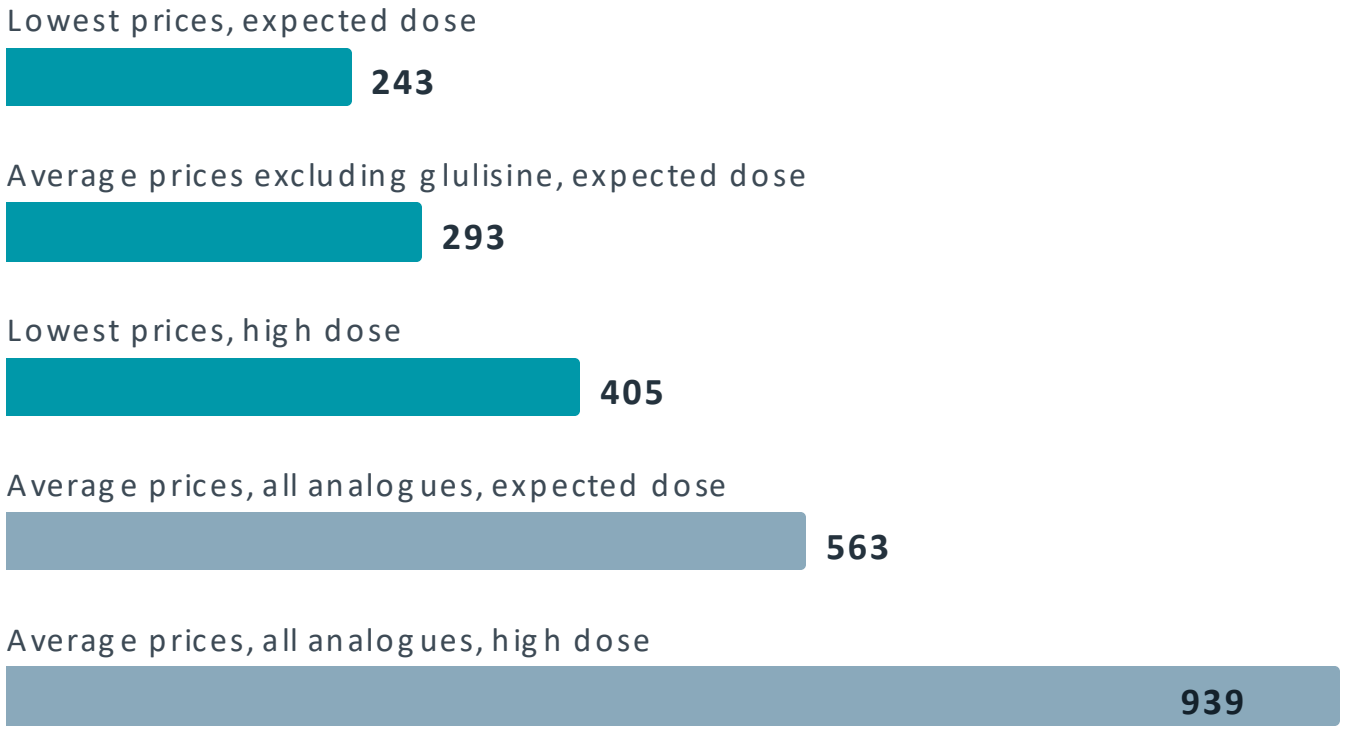
Backup · Budget impact over five years

Assumptions

- 653,000 → 685,000 people with type 1 diabetes (2016–2020)
- Uptake 30% → 40% → 60% → 80% → 100%
- Dose 15.75 IU/day (expected) or 26.25 IU/day (high)
- 2015 purchase mix: 86% of IU bought in vials
- Average or lowest 2015 SUS prices

At full uptake, lowest prices: R$ 80–133 million per year

Incremental cost 2016–2020, R$ million (vial and cartridge mix)



CONITEC used the **R$ 242–404 million** range. Price choice moves the bill more than dose does.

Source: SBD dossier (2016), chapter 5, tables 19–22; CONITEC Report 245 (2017).

Enhancing Access to Inhaled Medicines

Lessons from Insulin Access



Professor David Halpin
University of Exeter Medical School, Exeter, UK
Global Initiative for Chronic Obstructive Lung Disease (GOLD) Board of Directors
Forum of International Respiratory Societies (FIRS) Executive Committee
Global Alliance Against Chronic Respiratory Diseases (GARD) Steering Committee

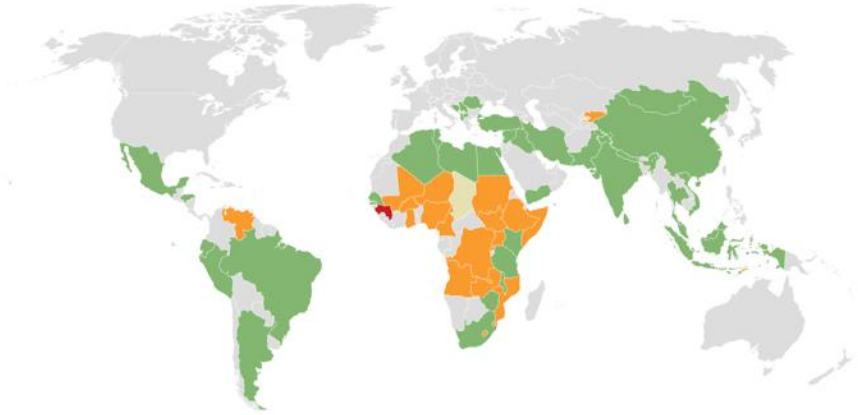
University of Exeter Medical School

Forum of International Respiratory Societies
United for Lung Health

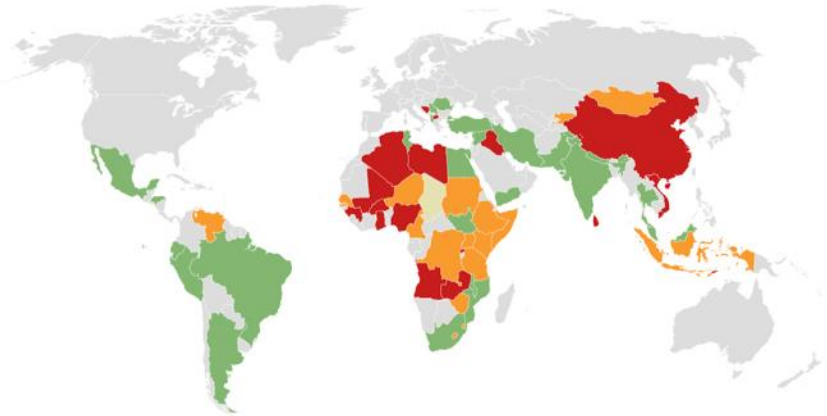
GLOBAL ALLIANCE AGAINST CHRONIC RESPIRATORY DISEASES

Availability & Affordability of Inhaled Medication in LMIC

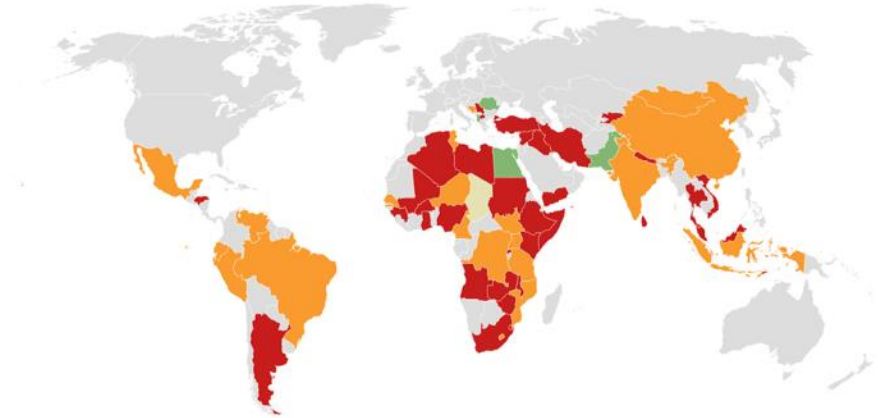
SABA availability & affordability



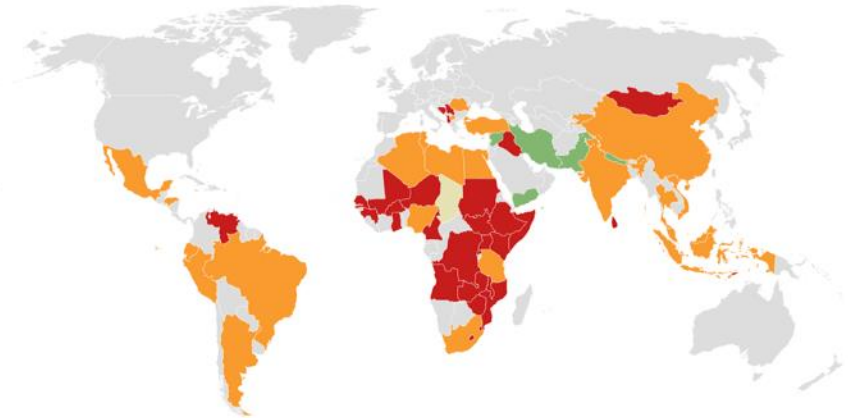
ICS availability & affordability



ICS-formoterol (100+6µg) availability & affordability



LAMA availability & affordability

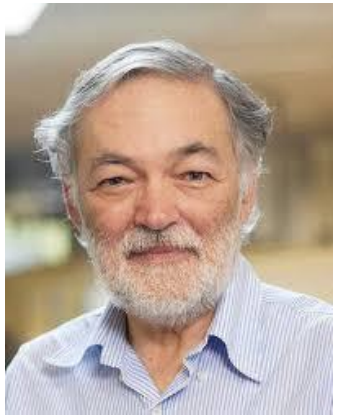


- Available & affordable
- Available but not affordable
- Not available
- No Information available

Stolbrink M, et al Thorax 2024;79:676

FIRS Campaign to Increase Access to Inhaled Medication for COPD & Asthma











Forum of International Respiratory Societies
United for Lung Health

GLOBAL INITIATIVE FOR CHRONIC OBSTRUCTIVE LUNG DISEASE™

The Union
International Union Against Tuberculosis and Lung Disease

Background to Lessons from Insulin Project

Diabetes

- moved from a neglected issue to a global and national agenda priority over the last 20 years
- one of the first non- communicable diseases to see significant attention from LMIC governments
- target of global work documenting the issues
- beneficiary of donors' programs providing financial support to improve the status quo.

NCP Policy Lab has been involved in the Addressing the Challenge and Constraints of Insulin Sources and Supply (ACCISS) work.

Global prevalence & burden of diabetes and COPD & Asthma are similar

Need for long-term maintenance therapy is similar

Administration of Insulin and inhaled therapy is more complex than oral medication

The objective was to assess what lessons from the insulin access project were relevant to inhaled medicines for COPD and asthma

Background to Lessons from Insulin Project

Financial support from the **Swiss Agency for Development & Cooperation**

Part of their work on improving access to medicines and technologies for NCDs, using diabetes as a tracer condition managed by the **NCD Policy Lab at the University of Geneva**

Project was co-ordinated by **The UNION**

Alstonia Impact were commissioned to undertake the work

Alessio Damato (Project co-lead & project management)
Dhananjay (DJ) Vaidyanathan Rohini (Project co-lead & Expert)
Samyukth Ramkumar (Associate, day-to- day execution)



Dr. Cassandra Kelly-Cirino
The Union, Executive Director



Dr. David Halpin
Global Initiative for Chronic Obstructive Lung Diseases (GOLD), member of the board of directors



Dr. Guy Marks
The Union, President



Leith Greenslade
Every Breath Counts, Coordinator



Marina Giachino
NCD Policy Lab, University of Geneve, Researcher



Alessio Damato
Alstonia Impact, Partner

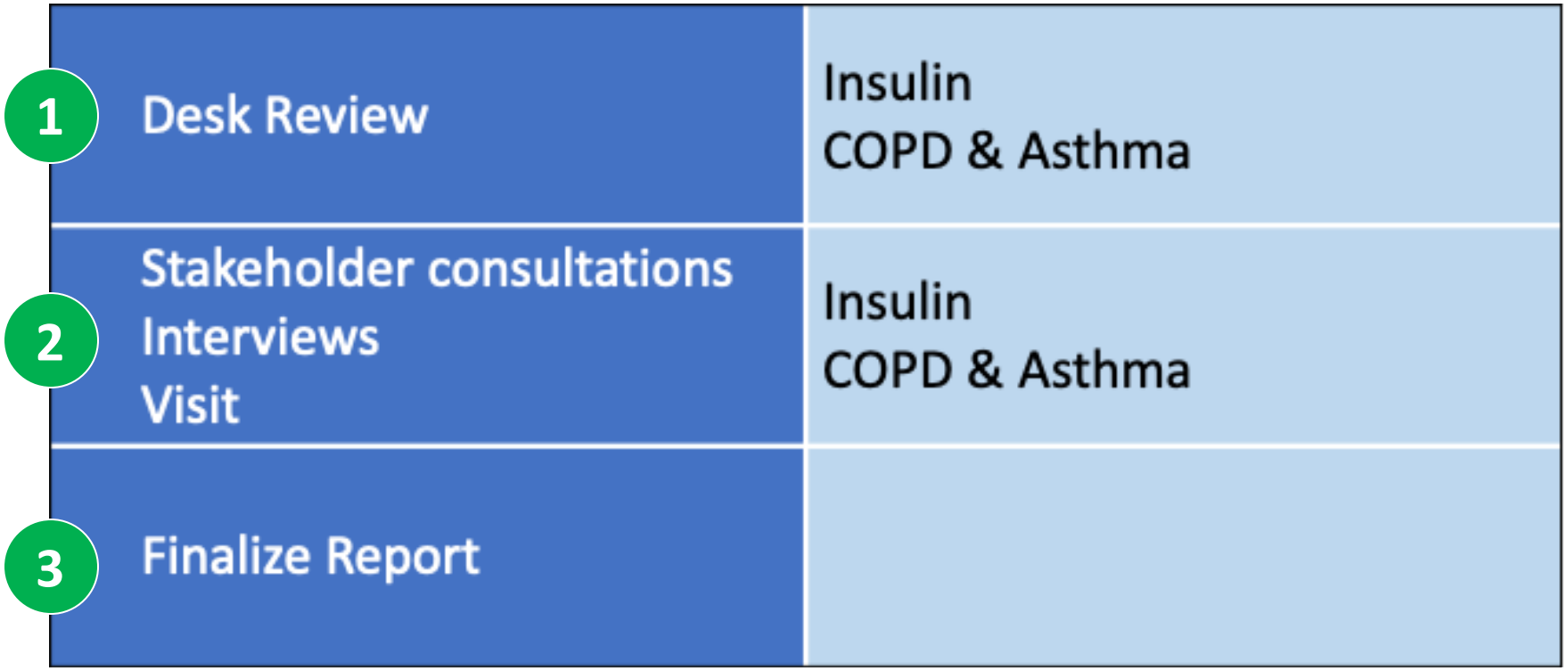


Dhananjay Vaidyanathan Rohini
Alstonia Impact, Partner



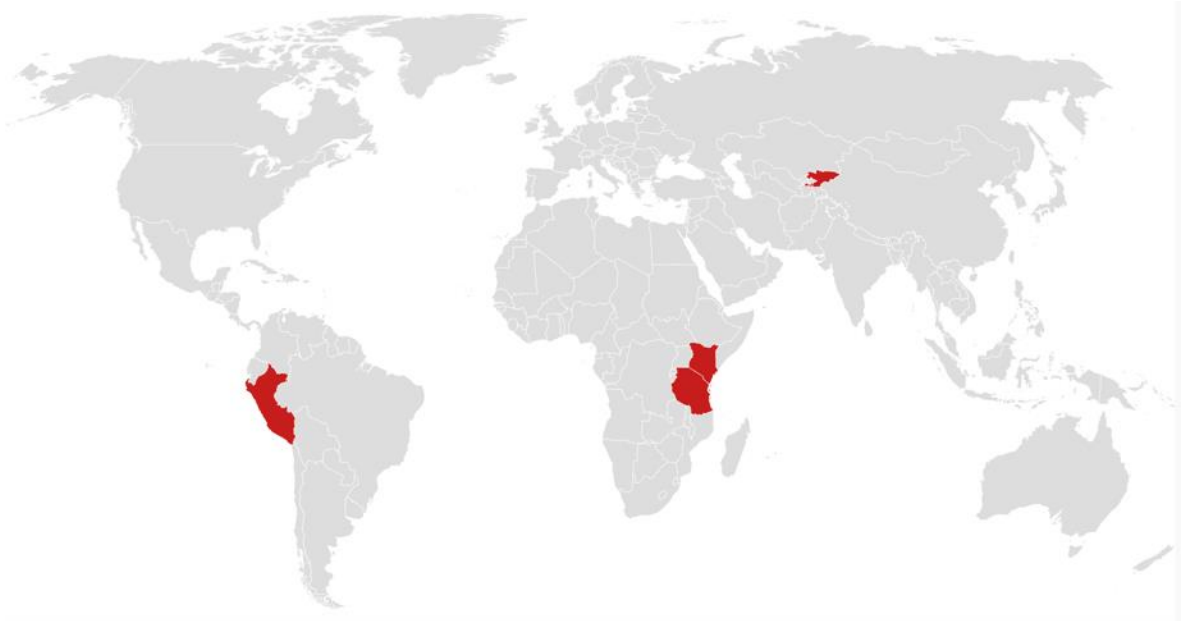
Samyukth Ramkumar
Alstonia Impact, Associate

Methodology of Lessons from Insulin Project



Comparison with Access to COPD & Asthma Medication

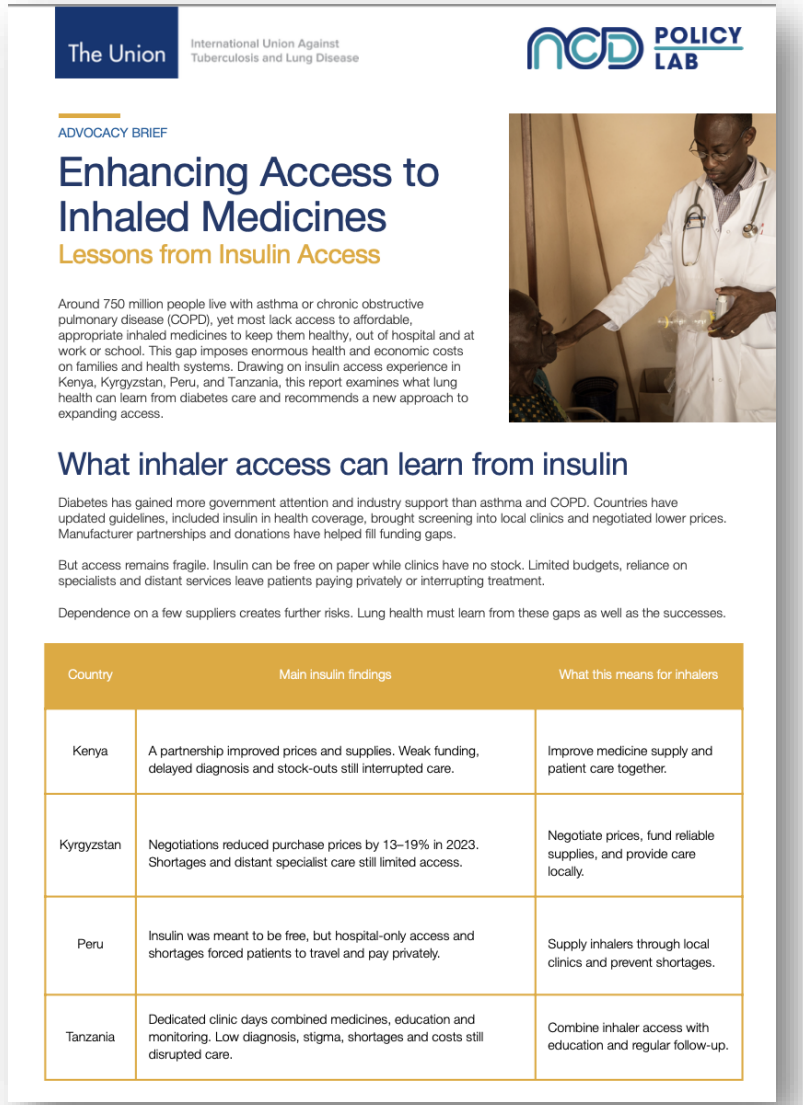
- Global view
- Deep-dive into four countries with distinct health systems:
    - ❖ Kenya
    - ❖ Kyrgyzstan
    - ❖ Peru
    - ❖ Tanzania



Kyrgyzstan, Peru and Tanzania are part of the long-standing Addressing the Challenge and Constraints of Insulin Sources and Supply (ACCISS) project which provides a valuable repository for learning

Kenya was included due to efforts on insulin and inhaled medicines



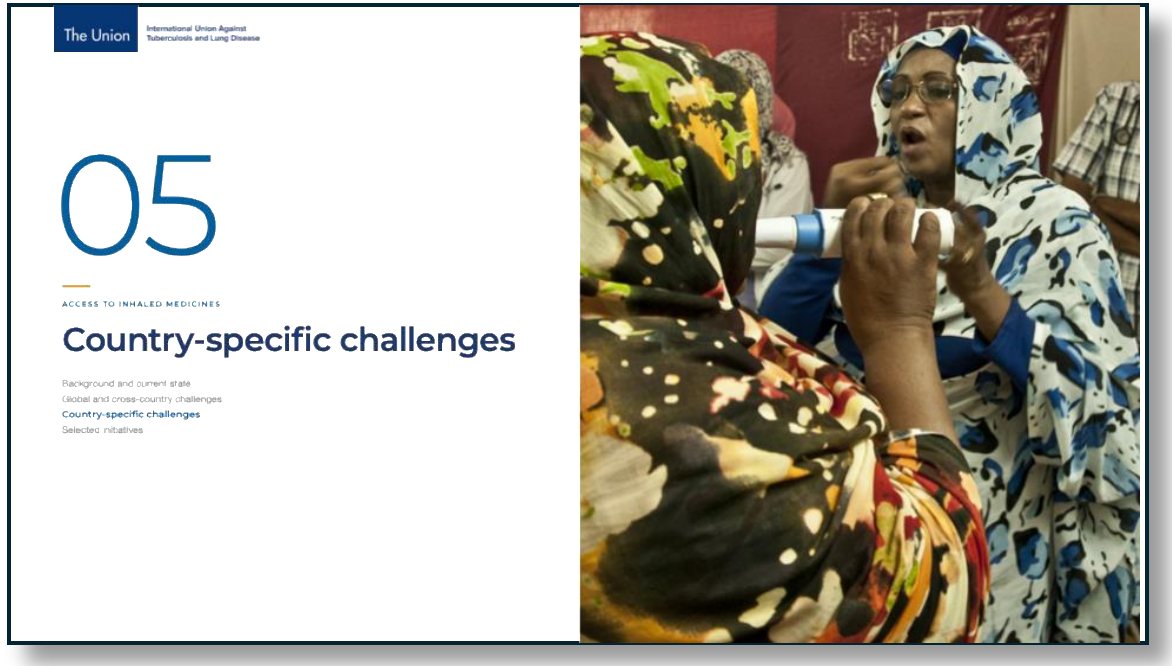


Launch during UNION World Conference on Lung Health in Rio

The Union
WORLD CONFERENCE ON LUNG HEALTH 2026

Results of Lessons from Insulin Project





Lessons Learned from Access to Insulin Analysis

Some lessons can be learnt from initiatives to improve access to

- **Engagement of pharma companies has compensated for lack of major philanthropic donors**
  - **most global/multi-country initiatives are supported by big three insulin firms**
  - **potential problems around manufacturing sustainability and effects on competition**
- **Procurement and supply chain efforts necessary to bring products to people who need them**
- **Demand must be demonstrated before manufacturers will engage at scale**
- **Isolated initiatives that address only part of the problem have usually failed** (e.g., inclusion in EML without significant procurement)
- **Notable LMIC based country initiatives include:**
  - **centralized procurement** (e.g., by Kyrgyzstan) to reduce prices
  - **running decentralized fixed day clinics for diabetes** (e.g., Tanzania).
  - **making insulin free (vs. copay)** has reduced financial burdens on patients, if sufficient supply exists.

Issues with Access to Inhalers

Globally

- low political prioritization and financing
- lack of donor funding
- poorly organized service delivery
- low diagnostic rates
- sub-optimal treatment regimes
- demand must be demonstrated before manufacturers will engage
- isolated initiatives that address only part of the problem have usually failed (e.g., asthma drug facility)
- stigma







Issues with Access to Inhalers

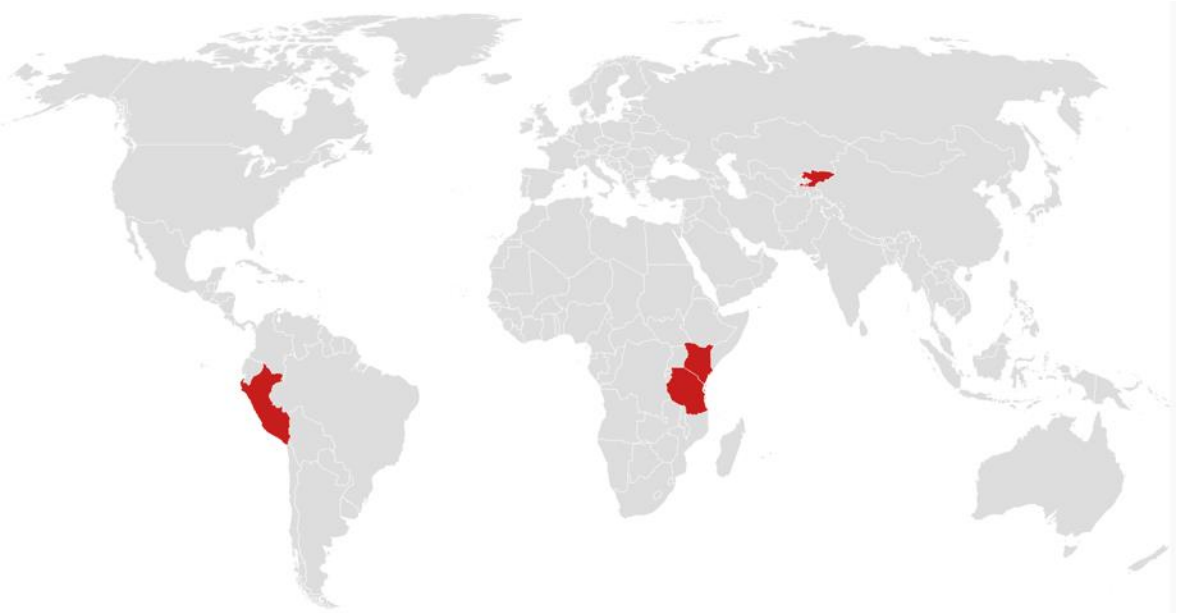








Across the four countries the challenges were largely similar



Results of Lessons from Insulin Project



Favourable & Unfavourable Differences Between Insulin & Inhalers

Favourable differences:

- **Cold chain is not needed** for most inhaled medicines
- **Products for HICs and LMICs are largely the same** (insulin used in HICs and LMICs are very different - leading to shift in attention of insulin suppliers to more expensive analogue insulin or new products)



Unfavourable differences:

- **Much lower attention and budgets from LMIC governments**
- **Much lower attention to diseases from**
  - donors
  - public health stakeholders
  - pharma companies
- **Outdated local guidelines**
  - lack of knowledge about products
  - lower screening and diagnosis rates



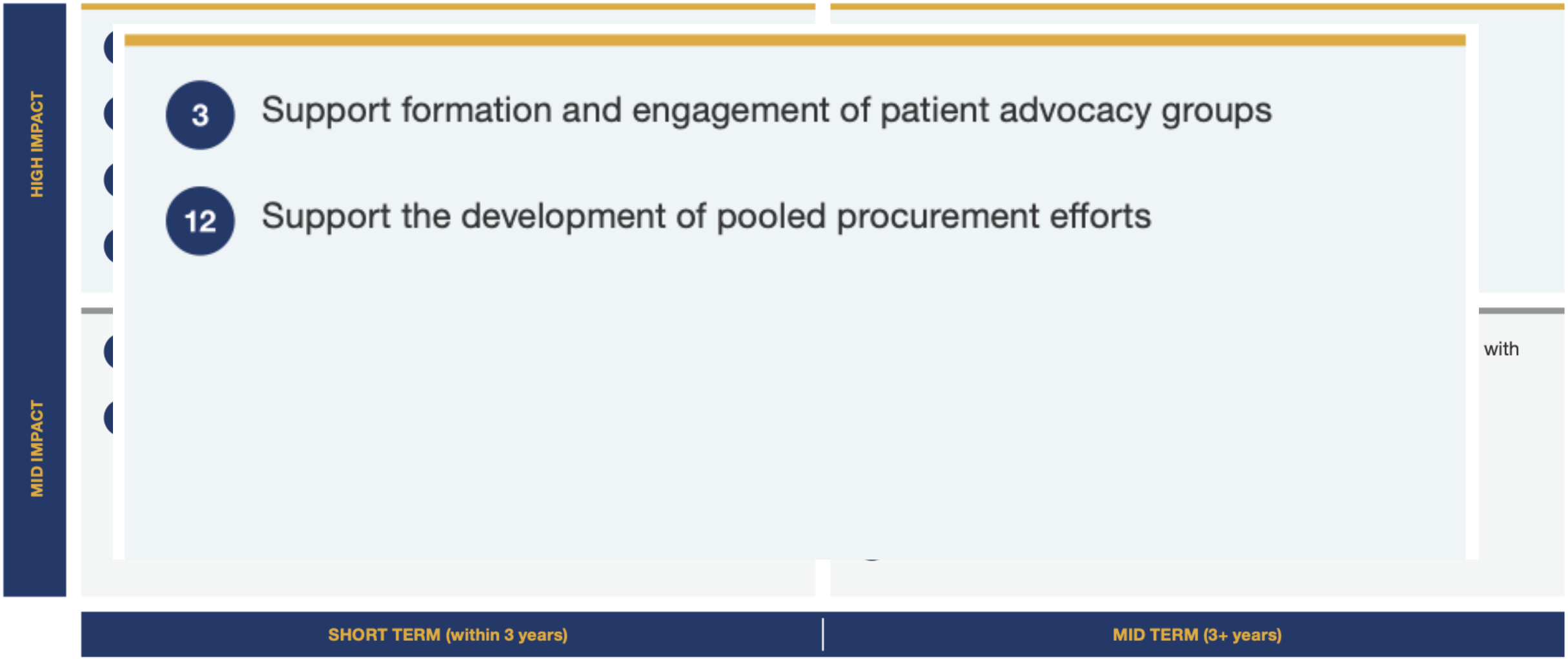
Lessons & Recommendations

	SHORT TERM (within 3 years)	MID TERM (3+ years)
HIGH IMPACT	1 Keep the spotlight on WHA and UN political resolutions and declarations to bring greater attention and resources to problem 4 Provide technical assistance to support countries to align their guidelines to the latest versions 5 Holistic country implementation work in selected LMICs to prove the case that demand exists and can be served 9 Negotiate with pharma companies more affordable prices in LMICs	3 Support formation and engagement of patient advocacy groups 12 Support the development of pooled procurement efforts
MID IMPACT	2 Drive greater attention to field by strategically piggybacking on topics that already have traction 6 Provide opportunistic support by piggybacking on other adjacent efforts	7 Increase in-country competition by supporting firms esp. generics with WHO's CRP procedure to register in more LMICs 8 Support LMIC NRAs with capacity building for inhaled medicines 10 Develop knowledge products to help better articulate challenge, potentially in collaboration with the WHO 11 Support innovators that try to improve current medications

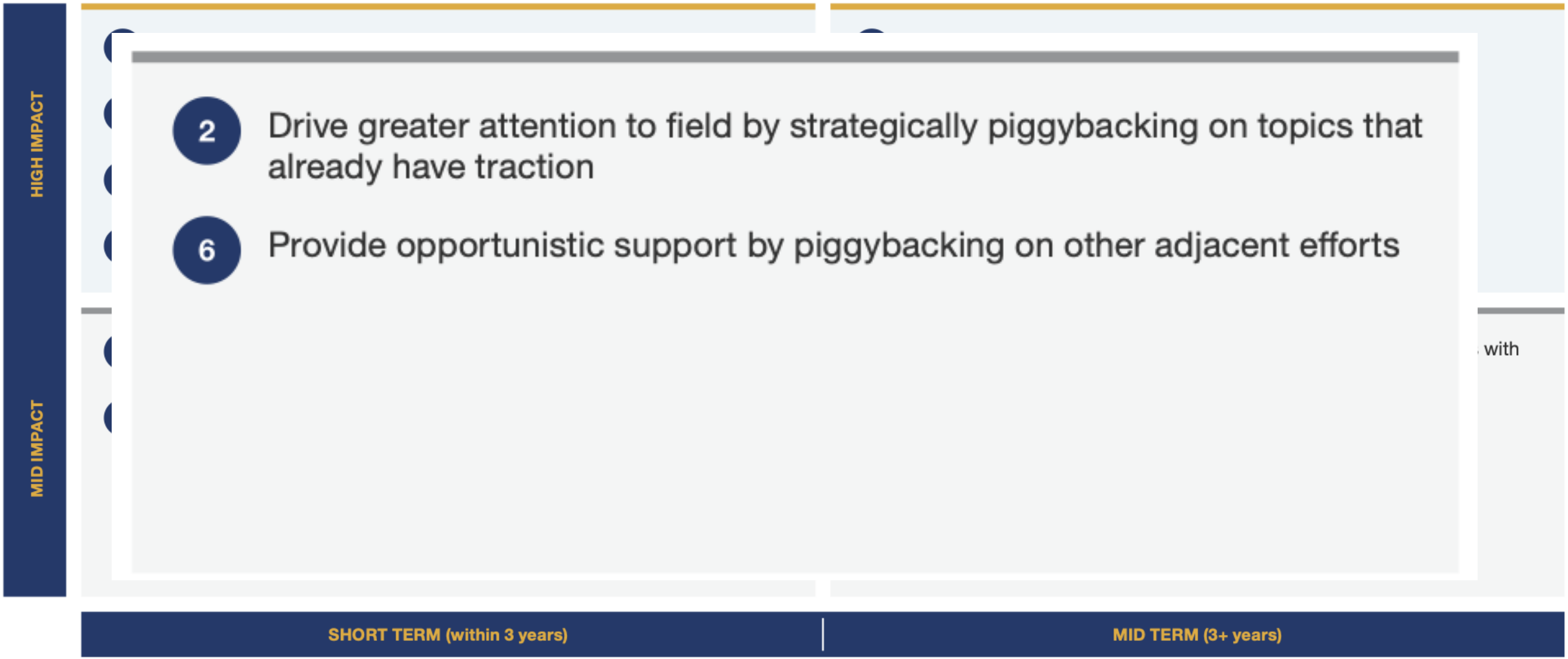
Lessons & Recommendations



Lessons & Recommendations



Lessons & Recommendations




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Vivekananda Nagar
HAPPY PHARMACY
& GENERAL STORES
FREE









Case study: NCD Learning from HIV forecasting in Tanzania

Closing the gap in access to NCD medicines, diagnostics and medical devices

Challenges in low- and middle-income countries, with a focus on sub-Saharan Africa and Tanzania — and how HIV supply-chain lessons and the NCDA–UNIGE Advancing Access toolkit can drive change

Prof Kaushik Ramaiya

TANCDA

EANCDA

NCDAlliance NCD POLICY LAB

THE BURDEN

NCDs cause a third of deaths in Tanzania

~ 33%

of all deaths in Tanzania are due to NCDs

25.9%

of adults have hypertension (national survey)

9.1%

of adults have diabetes (national survey)

65.6%

of people with hypertension in Tanga (2023) did not know it

Globally, NCDs cause about **43 million deaths a year — three in four.**
Tanzania faces this rise while HIV, TB and malaria remain major burdens.

Sources: Annals of Global Health 2023; AFENET Tanga survey 2026; NCD Alliance & UNIGE, Advancing Access toolkit 2026

NCD Alliance NCD POLICY LAB

LOW- AND MIDDLE-INCOME COUNTRIES

Global access targets remain far from met

80%	Availability target for essential NCD medicines and basic technologies — missed by many LMICs in 2025, and renewed at HLM4 for 80% of primary care facilities by 2030.
2×	Out-of-pocket cost per facility visit for NCDs compared with infectious diseases; medicines are a key driver of financial risk.
47%	of the world's population has little or no access to diagnostics; only about 19% have basic tests at primary care in low- and lower-middle-income countries.
26%	of medicines regulators worldwide have reached WHO Maturity Level 3 or 4 — slow approvals limit entry of quality-assured products.

Sources: NCD Alliance & UNIGE, Advancing Access toolkit (2026); Lancet Commission on Diagnostics (2021)

NCD Alliance NCD POLICY LAB

Sub-Saharan Africa: scarce and costly

AVAILABILITY

13%

Median availability of insulin across facilities in nine sub-Saharan African countries — 12% at primary health centres.

AFFORDABILITY

2 days

of wages for the lowest-paid government worker to buy one month of the cheapest generic metformin or glibenclamide.

RISING NEED

23M → 55M

People with diabetes in the region, 2021 to the 2045 projection.

Markets are thin: WHO's first call for insulin prequalification (2019) drew no submissions, and most insulin is imported, adding freight, storage and mark-ups.

Sources: Atun et al., Lancet Diabetes Endocrinol 2017 (SARA data); Mbanya & Mba 2021; IDF Atlas; Advancing Access toolkit (2026)

TANZANIA · SARA 2023

Tanzania: gaps at the facility level

45%	of facilities offer diabetes care, 41% cardiovascular and 24% chronic respiratory care — at dispensaries only 35%, 32% and 16%.
22%	of facilities offering diabetes care had regular insulin; ACE inhibitors 25% and beclomethasone inhalers 12% where those services exist.
1–5%	of facilities had every tracer item for diabetes, cardiovascular or respiratory care; only about a third had guidelines or trained staff.
4%	of facilities had all 15 essential medicines, though general service readiness reached 71%.

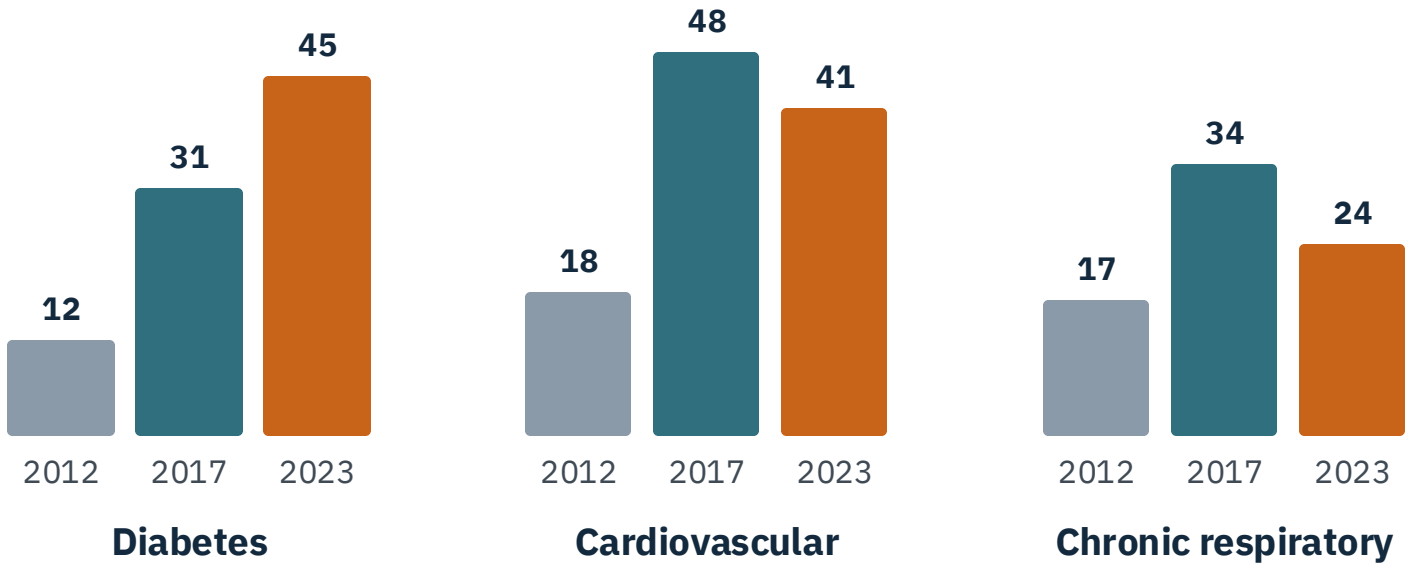
Stock-outs remain the main reason NCD patients leave with incomplete care — so they buy privately, ration doses or stop.

Sources: MoH Tanzania, Service Availability and Readiness Assessment (SARA) 2023; PLOS ONE 2024 (Kilombero, Same)

TANZANIA · SARA TRENDS 2012–2023

More NCD services, but readiness stalls

Share of facilities offering the service (%)



Readiness near 50% for a

Mean tracer-item score, 2012 → 2017 → 2023

Diabetes: 51 → n/a → 53

Cardiovascular: 54 → 43 → 54

Respiratory: 40 → 42 → 50

Services reached more facilities, but each still lacks about half of what it needs.

Sources: MoH SARA 2012, 2017 (via NCD Action Plan 2021–26) and 2023; SARA 2020 NCD data not found online

NCD Alliance NCD POLICY LAB

Tracer items, 2012 vs 2023: little change

% of facilities offering the service that had the item on the day of the survey

Diabetes and CVD	2012	2023	Change
Insulin	34	22	−12
Metformin	57	68	+11
Glibenclamide	52	58	+6
ACE inhibitors	24	25	+1
Thiazide diuretics	31	29	−2
Calcium channel blockers	29	57	+28

Respiratory and capacity	2012	2023	Change
Salbutamol inhaler	35	52	+17
Beclomethasone inhaler	14	12	−2
Peak-flow meter	13	22	+9
Inhaler spacers	11	34	+23
Diabetes guidelines	30	37	+7
Diabetes-trained staff	34	29	−5

Insulin, ACE inhibitors and steroid inhalers — the backbone of chronic care — are no more available than a decade ago.

Sources: MoH SARA 2012 (Tables 4.14–4.16) and SARA 2023 (Figures 43–45). Changes in percentage points.

ROOT CAUSES

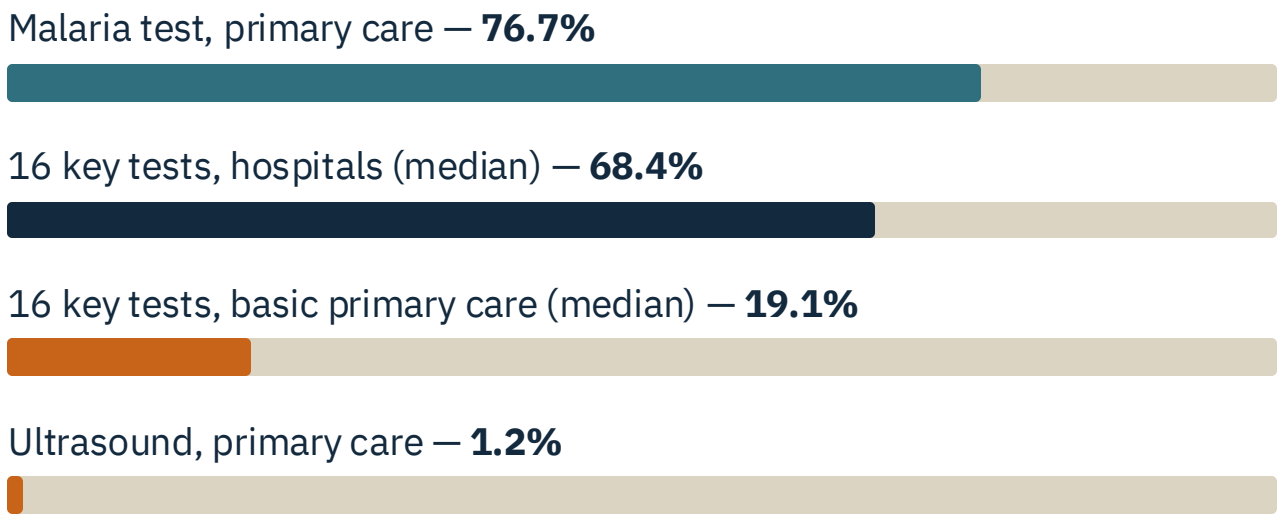
Barriers occur at every step of the chain

Step	What we see in Tanzania and similar settings
Selection	STG/NEMLIT last revised in 2021 (review due every 3–5 years); diagnostics and devices must be listed too; UHI benefit package still being set
Regulation	Few registered suppliers for insulin and newer NCD medicines limit competition; NCDs never had HIV-style import waivers
Forecasting	Facility forecasts rely on consumption, which hides undiagnosed need and stock-outs; forecasts are not matched by budget
Procurement	Late fund releases to MSD trigger stock-outs and emergency private purchases at higher prices
Pricing & financing	Government, Health Basket Fund, NHIF, CHF and user fees flow separately; mark-ups and out-of-pocket costs stay high

Sources: R4D, Systems for Financing Health Products — Tanzania (2025); Advancing Access toolkit (2026)

Diagnostics and devices: the hidden gap

Availability of essential diagnostics in LMICs



Why it matters

HIV and malaria tests reached the last mile through funded programmes; most NCD tests did not.

People never diagnosed never appear in consumption data, so NCD forecasts undercount need.

Tanzania (SARA 2023): BP apparatus is near-universal, but only 22% have peak-flow meters and 34% spacers.

Sources: Lancet Commission on Diagnostics (2021); Lancet Global Health, Oct 2021; MoH Tanzania SARA 2023

THE HIV EXAMPLE

HIV shows what a reliable supply achieves

82.7%

of adults living with HIV knew their status

97.9%

of those diagnosed were on treatment — second 95 target met ahead of 2025

94.3%

of those on treatment were virally suppressed

For about **1.55 million adults**, lifelong medicines reach clinics month after month.
That is the standard NCD patients deserve.

Source: Tanzania HIV Impact Survey 2022–2023 (THIS), summary sheet, December 2023

How the HIV supply chain was built

Generic price collapse

First-line ART fell from over $10,000 to about $100 per person-year.

Pooled, assured buying

Global Fund and PEPFAR pooled demand; WHO prequalification set quality.

A reformed MSD

Global Fund-backed reform, direct delivery to facilities, fewer central stock-outs.

National quantification

One forecasting and supply-planning process for over $300M a year.

Visible data

eLMIS and IMPACT teams put stock data in front of decision-makers.

Planned transitions

DTG regimen switch and multi-month dispensing were forecast and phased.

Sources: MSF Untangling the Web (2016); Global Fund OIG (2018); Githendu et al., BMJ Open 2020; USAID GHSC-TA Tanzania factsheet (2023)

Six HIV lessons that transfer to NCDs

What worked for HIV	What it means for NCD products
Supply confidence: reliable stock drew people into care and created real demand data	Guarantee uninterrupted NCD tracer stock in pilot districts to reveal true demand
Patient cohorts tracked in CTC registers	NCD patient registers that allow enrolment-based forecasting
A national quantification process	Extend the same process to NCD medicines, tests and devices
Pooled demand and generic competition	Pooled national and regional tenders with framework agreements
Quality assurance (WHO PQ, MQAS)	TMDA reliance pathways and MQAS-compliant MSD tenders
Ring-fenced commodity financing	Fund the forecast in the budget and in the UHI benefit package

Sources: Advancing Access toolkit (2026), forecasting case studies (HIV; CHAI); USAID GHSC-TA Tanzania

THE OTHER LESSON

A caution: donor dependence is a risk

> 60%

of Tanzania's HIV budget came from the US before the 2025 funding freeze

TSh 202bn

set aside by government for March–June 2025 to cushion the gap

$38.9M

disbursed by government for ARV procurement in FY 2024/25

What this means for NCDs

HIV commodities were forecast and budgeted in parallel, outside the domestic cycle. ART was largely maintained because MSD distribution held.

Copy HIV's methods, not its structure: build NCD supply on domestic budgets and integrated systems from day one.

Sources: Frontline AIDS accountability report (2025); UNAIDS (2025); ICAP CQUIN Tanzania poster (Nov 2025); R4D (2025)

NCD Alliance NCD POLICY LAB

LAUNCHED 3 SEPTEMBER 2026

The NCDA–UNIGE Advancing Access toolkit

Step 1	Step 2	Step 3	Step 4	Step 5
Selection	Regulation	Forecasting	Pricing	Procurement

For each step

- **Snapshot** — what it is, why it matters, common barriers
- **Knowledge Checklist** — what to find and where
- **Advocacy Strategy** — aim, actions, stakeholders, tips

Built for advocates and "access allies"; no technical background needed.

Follow-the-Product: five problems

1. Not prescribed or used
2. Used but not continuously available
3. Available but poor quality
4. Available but unaffordable
5. Not reimbursed — paid out of pocket

Source: NCD Alliance & University of Geneva NCD Policy Lab, Advancing Access: A practical advocacy toolkit (Sept 2026)

NCD Alliance NCD POLICY LAB

FROM TOOLKIT TO ASKS

Applying the toolkit in Tanzania

Step	Advocacy ask	Lead
Selection	Update STG/NEMLIT against WHO EML, EDL and PEN; include diagnostics and devices; link to the UHI benefit package	MoH, NEMLIT committee
Regulation	Use reliance (WHO CRP, AMA, EAC) to register more quality-assured insulins, statins and inhalers	TMDA
Forecasting	Add NCD products to the national quantification process, using consumption, morbidity and enrolment data	MoH Pharmacy, MSD
Pricing	Adopt a pricing policy per WHO guidance; publish prices; regulate mark-ups; review VAT and duties	MoH, MoF, NHIF
Procurement	MQAS benchmarking; framework contracts; regional pooled buying of NCD tracers; fund the forecast	MSD, MoF, EAC

Asks adapted from the Advancing Access toolkit's Advocacy Strategies (2026) to Tanzania's institutions

NEXT STEPS

A phased roadmap for 2026–2028

0–6 MONTHS

Diagnose

- Follow-the-Product analysis for tracers: insulin, metformin, amlodipine, BP monitors, glucose strips
- Formal data requests to MSD and MoH
- Stakeholder map with TANCDA and professional bodies

6–18 MONTHS

Build

- NCD forecasting group within national quantification
- Pilot enrolment-based forecasts in integrated CTCs and NCD clinics
- Costed budget ask to the Ministry of Finance

18–24+ MONTHS

Scale

- NCD tracers in the UHI package and MSD framework contracts
- Scale integrated HIV–NCD care
- Annual availability and price report, using SARA 2023 tracers as baseline

Integration is feasible: 103 high-volume CTCs in five regions added hypertension and diabetes screening (Afya Yangu Northern, 2023).

NCD Alliance NCD POLICY LAB

From proof to practice

Tanzania already runs a supply chain that keeps over a million people on lifelong HIV treatment. The task now is to make it work for everyone who needs a pill, a test or a device every month for life.

Ministry of Health
Update lists; lead NCD quantification

Ministry of Finance
Fund the forecast, on time

MSD
Framework contracts; MQAS; pooled buying

TMDA
Reliance pathways to widen supply

NHIF / UHI
Cover NCD medicines, tests and devices

Civil society
Use the toolkit; ask for the data

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Thank you

NCD Alliance

NCD POLICY LAB

CLINTON HEALTH ACCESS INITIATIVE

NCD Commodity Forecasting: From National to Facility Systems

Uganda | November 2026



Reforming NCD quantification: from national systems to facility MTCs

COUNTRY CASE STUDY · UGANDA



A two-level approach: national reforms set the standards, facility Medicines and Therapeutic Committees (MTC) apply them



Moving national and facility planning for NCD commodities from historical consumption estimates only to add real, morbidity-driven need

TOOLKIT STEP 3 · FORECASTING

The Challenge and Approach

The Challenge: Historical consumption data severely underestimated the true NCD burden due to undiagnosed patients, recurring stock-outs, and treatment adherence gaps.

System Misalignment: National templates and facility plans relied on previous FY orders rather than disease prevalence and changing burden, so NCD financing never matched real need.

The strategic Shift: national system reforms (methods, policy, prices), then equip facility MTCs to forecast and budget from verified clinical need.

Strategy:

(1) **Nationally**, align policy, National Medical Stores (NMS) templates, Standard Operating Procedures (SOPs) and prices.

(2) **At facilities**, build MTCs that plan from real need using data they already generate from services.

Global priorities brief · Practical advocacy toolkit

National level: What CHAI did with MoH and NMS to strengthen NCD forecasting

STEP 1 · CHAI COLLABORATION WITH THE DEPARTMENTS OF PHARMACEUTICALS AND NATURAL MEDICINES, NCD and NMS

1

National integrated NCD quantification | FY 24/25 to FY 27/28

✓ Co-led with MoH and NMS; national volumes are used to mobilize resources. Both morbidity and consumption-based approaches

2

Revised need-based National Medical Stores planning template

✓ Stock-out-adjusted Average Monthly Consumption (AMC) and e-registry/Electronic Medical Records (EMR) morbidity data feed into the NMS procurement planning templates.

3

Vital, Essential, Non-essential (VEN) Classification | Vital, not just listed

✓ Uganda Clinical Guidelines and Essential Medicines List 2023 disseminated; **core NCD medicines** classed as Vital in NMS planning templates.

4

Procurement Planning SOPs

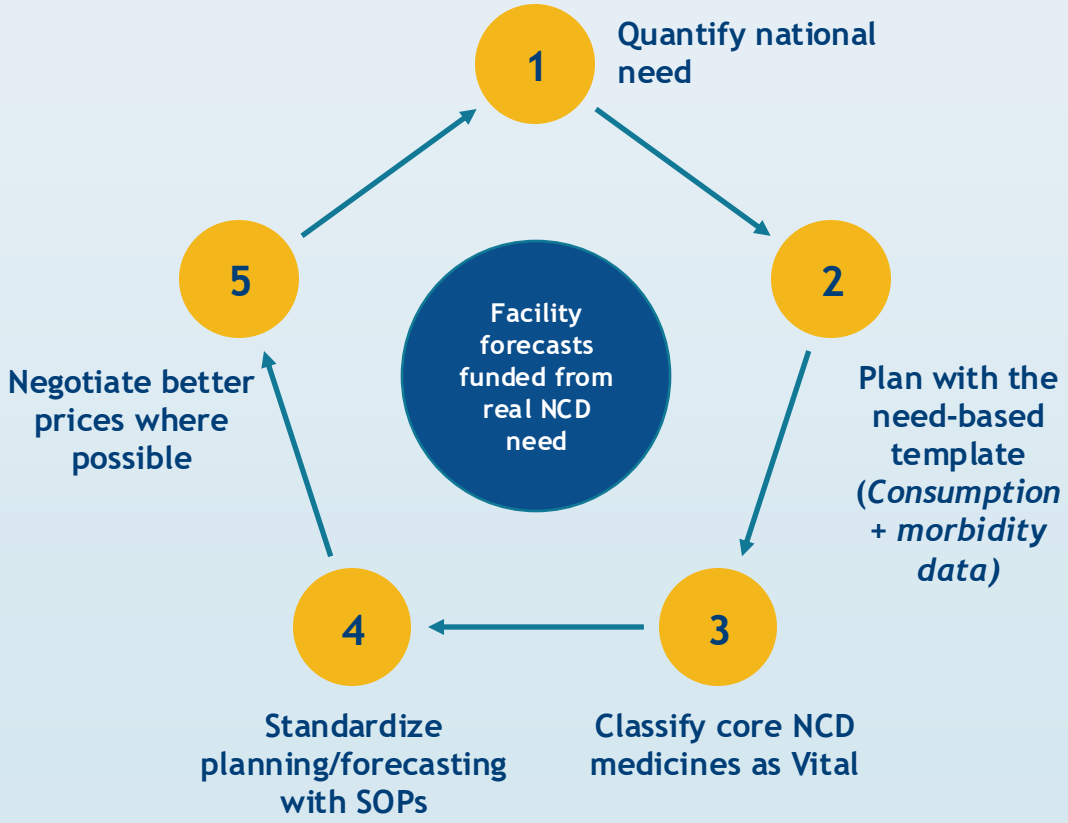
✓ Developed with MoH and embedded in the Pharmaceutical Financial Management Manual 2026 to standardize the planning process at the facility level.

5

Market shaping for glimepiride

✓ Supported NMS to consolidate glimepiride volumes for price negotiation to acquire competitive pricing from suppliers.

HOW THE FIVE REFORMS FEED EACH OTHER



National level: NCD volumes and financing rose following CHAI support to MoH

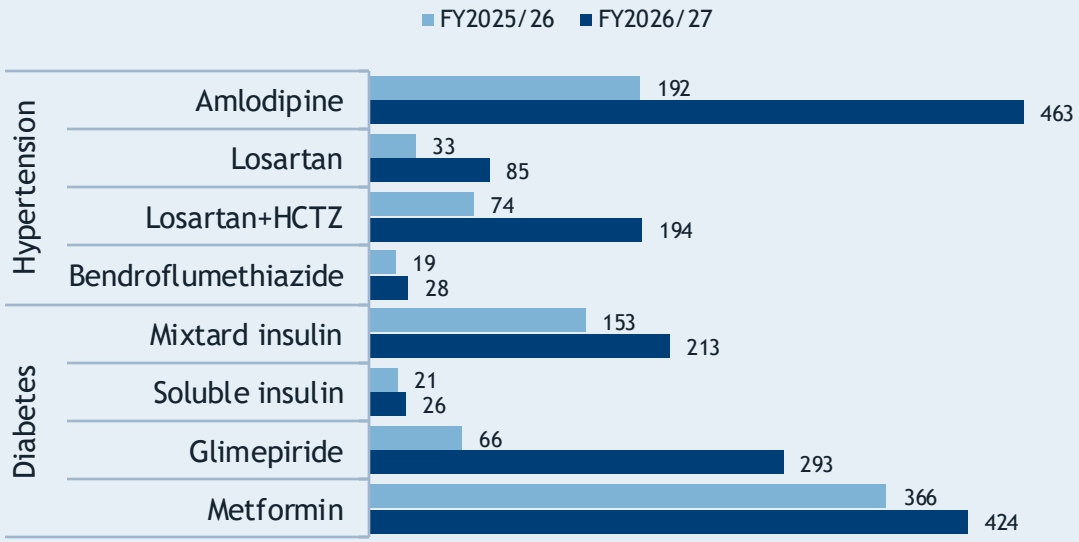
TRENDS FOLLOWING CHAI SUPPORT TO MOH · FY2025/26-FY2026/27

4 of 8 Medicines more than doubled their annual procurement volume.

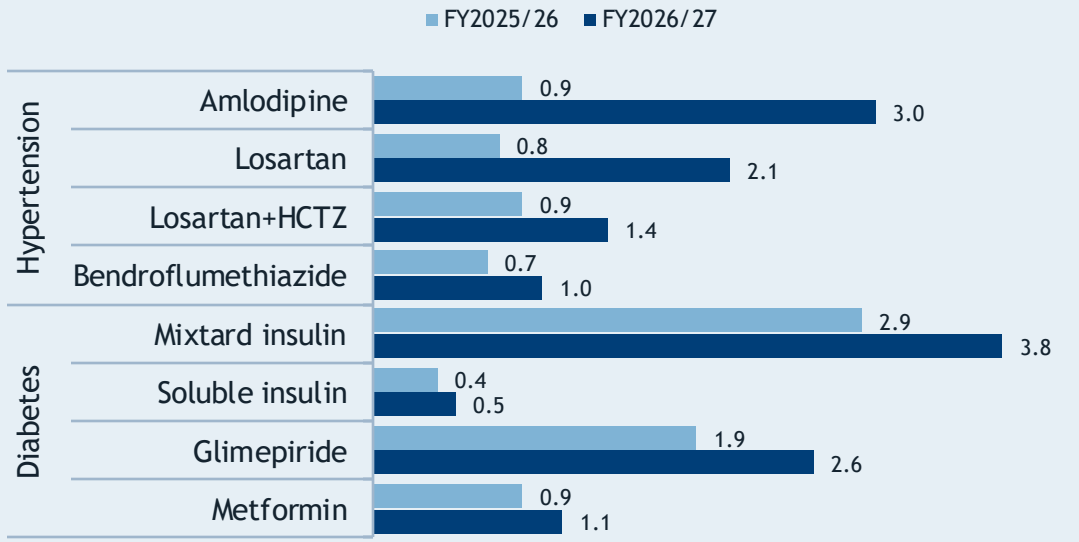
+66% Funding allocation for hypertension (+134%) and diabetes (+31%) medicines:

2× Funding allocation for 8 key medicines grew twice as fast as the overall credit-line budget for essential medicines and supplies

Volumes: annual packs or vials (thousands) forecasted



Financing: annual planned national allocation (UGX billion)



Monthly volumes rose for all 8 medicines. Sustaining this will require the Government to direct more credit-line funds to NCD medicines.

Source: MoH FY2026/27 National Annual Quantification Report for EMHS (Tables 12–13 for values; Table 15 and Annexes F–G for average monthly consumption). Medicines only; figures rounded.

Facility level: Building MTCs in 2 CHAI-Supported districts to apply national tools

1 · Build skills

Abridged NCD curriculum

- Deployed abridged, facility-ready NCD training modules aligned with the UCG and Essential Medicines List (EML) 2023
- Trained over 50 healthcare workers under the supply chain subcommittee of the MTC in 30 facilities

Selecting by UCG/EMHSLU

- MTCs select by current guidance and level of care, adding glimepiride (a newer diabetes medicine) and planning more amlodipine.
- Moved vital NCD lines to the Vital category in facility procurement plans

2 · Fix the data

Applying the adjusted-consumption NMS tool in planning

- MTCs now plan with stock-out-adjusted AMC in the NMS standardised template introduced nationally

Morbidity data used in forecasts

- Registers and EMR data are used to check consumption, so every diagnosed patient is costed in, not just those served.

3 · Prioritise & embed

VEN and ABC analysis

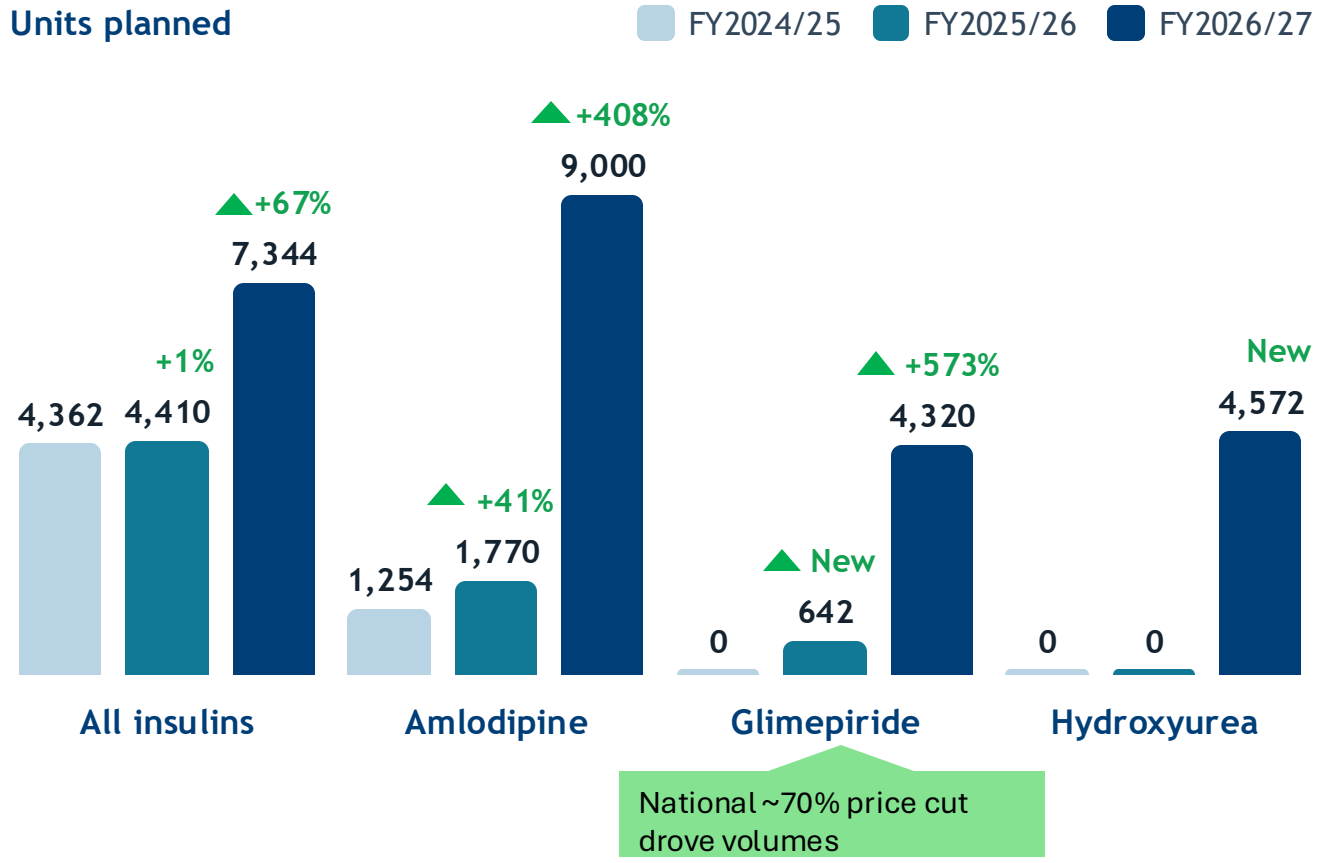
- Ranked medicines by clinical priority (VEN) and by spend (ABC), freeing funds for vital NCD medicines.

SOPs in practice

- MTCs reactivated using the national Procurement Planning SOPs, now part of the MoH Pharmaceutical Financial Management Manual 2026.

Facility results: Scaling NCD commodity volumes and budgets in two CHAI-supported districts in Uganda

With national tools and prices in place, facility NCD commodity volumes rose sharply



1. Budget Expansion (FY2024/25 to FY2026/27): Planned NCD medicine budgets across the 5 facilities rose from UGX 232.4M to **UGX 597.8M**, mainly for hypertension (UGX 28.9M to 206.3M) and diabetes (UGX 96.6M to 190.2M).

2. **Volume Scaling (FY2024/25 to FY2026/27):** Insulins rose from 4,362 to 7,344 units and amlodipine from 1,254 to 9,000 units. Glimepiride was first added in FY2025/26 (642 units, now 4,320) and hydroxyurea in FY2026/27 (4,572 units).

3. Sustainable Financing/Budget optimization: This expansion is financed entirely through facilities' **own** Essential Medicines and Health Supplies **budgets**, rather than parallel donor funding streams.

Source: EMHS procurement plans FY2024/25-FY2026/27, 5 CHAI-supported facilities; budgets annualized

Facility results: Doubling the NCD share of facility EMHS budgets

FACILITY RESULTS · BUDGET SHARE

NCDs' share of facility EMHS budgets more than doubled



Pooled across five CHAI-supported facilities: **UGX 597.8M** planned for NCD medicines in FY2026/27, financed from facilities' own EMHS budgets by reallocating funds within them.

NCD share of total annualised EMHS budget

Every facility raised its NCD share since FY24/25

Facility	FY24/25	FY25/26	FY26/27
General Hospital A	11.8%	13.3%	31.5%
General Hospital B	6.2%	6.4%	17.2%
Health Center IV C	6.0%	7.1%	11.3%
Health Center IV D	2.8%	3.3%	7.4%
Health Center IV E	4.4%	6.7%	6.3%

Lessons for advocates

- **Need-based data is advocacy:** morbidity-informed plans make unmet NCD need visible to budget holders.
- **Governance sustains gains:** well-capacitated MTCs keep applying national tools year after year.

Source: facility EMHS procurement plans; NCD medicines as defined on the previous slide.

Bringing it together: Uganda's progress on "Advancing Access" priorities

80% of primary health care facilities stocked with NCD medicines by 2030

60% of countries covering NCD health products by 2030

1-2% of health aid has gone to NCDs: budgets are domestic

BRIEF PRIORITY	WHAT UGANDA HAS DONE	ASKS TO ADVOCATES
1 **Align:** EML, guidelines & procurement priorities	National: NCD medicines are vital in NMS planning tools. Facility: MTCs select by UCG/EMHSLU guidance	**Make NCD medicines Vital in procurement, not just EML-listing**
2 **Forecast:** invest in data on real need	National: stock-out-adjusted AMC in NMS planning tools. Facility: MTCs use morbidity + consumption data to project needs.	**Require need-based NCD quantification, not just consumption**
3 **Procure & price** strategic purchasing	Market shaping for glimepiride for type 2 diabetes – value for constrained funding.	**Pair national forecasts with price negotiation so budgets buy more**
4 **Account:** disaggregated NCD budgets	National: 8 key hypertension & diabetes medicines +66% in FY2026/27. Facility: NCD share 7.8% to 20.0%;	**Make NCD share of medicines budgets an accountability indicator**

Priorities from Advancing Access: Global priorities (NCD Alliance & University of Geneva NCD Policy Lab, 2026), Member State recommendations

Thank you



Lessons from HEARTS:

Access is a functioning system

PAHO

Pan American Health Organization

World Health Organization
Americas Region

Dr Christopher Lim
Chief, Strategic Fund
limchr@paho.org

The hypertension paradox

We already have effective and affordable medicines for hypertension.

Why do so many people still struggle to control their blood pressure?

Our lesson is simple:

Access is not a product. It is a functioning system.

Simplify first. Pool later

Rationalization as part of a **strategic demand-shaping** approach

WHERE HEARTS STARTED

50+ antihypertensive medicines

100+ preparations used in primary care

Regional harmonization & rationalization

Simpler, evidence-based treatment protocols

8 molecules

Moving toward a core formulary

ALIGN

- **Clinical protocols**
- **National essential medicines lists**
- **Priority products, including fixed-dose combinations**
- **We begin to shape the market**

Regulatory cooperation



PAHO supports

- Regional regulatory strengthening
- Appropriate reliance on assessments

QuantMET

Helping countries **estimate requirements more accurately**

PAHO Pan American Health Organization World Health Organization Americas Region | QuantMET

TRADITIONALLY

Based on **last year's purchases or consumption**



QuantMET uses

- Disease burden
- Treatment regimens
- Patient numbers
- Logistical information

More accurate estimates of country requirements

Turn demand into market power

Consolidated demand enabled:

01 **An international tender**

02 **Longer-term arrangements**
for quality-assured generic medicines

15

antihypertensive medicines with long-term agreements after the international tender (2021-2022)

Up to 90% savings

price differences between national public purchases and PAHO pooled prices for five antihypertensives (2019-2020)

Source: PAHO, paho.org (long-term agreements 2021-2022; price analysis of public procurement data 2019-2020).

Digital transformation as an enabler

Through the **Member States Portal (MSP)**

530+

users served by the MSP

200+

country demand plans processed

Better visibility
for planning and coordination

Not simply to buy cheaper,
but to:

- **Buy smarter**
- **Anticipate risks**
- **Maintain access**

What have we achieved, and what have we learned?

IN 2025

6M+ hyper

10,000+ primary care fa

4 countries procured medicines or equipm RRF

Substantial room to expand uptake

ce lessons

01 **Standardization creates opportunities for scale**

02 **forecasting must be matched by ead supply**

03 The real outcome is not how many tablets we purchase, but **how many patients can continue effective treatment**

Source: PAHO Annual Report 2025; PAHO, HEARTS in the Americas (2025).

From HEARTS to the next generation of NCD access

We welcome the **Advancing Access Toolkit** because it connects directly with what we have learned

FIVE STEPS

01	02	03	04	05
Selection	**Regulation**	**Forecasting**	**Pricing**	**Procurement**
Simplify first: a core formulary of 8 molecules	Regional regulatory strengthening and reliance	QuantMET: estimates based on real needs	Consolidated demand as market power	RRF tender, long-term agreements and the MSP

Opportunities to apply the HEARTS lessons more broadly to other NCDs

PAHO

Pan American Health Organization

World Health Organization

Americas Region

Regional Revolving Fund

Learn more

www.paho.org/en/regional-revolving-fund

Q&A

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Next steps

AFRICA NCDs NETWORK

NCD Relay • Africa 2026

International CPHIA Conference on Public Health in Africa

1. Interested in peer-to-peer learning on NCD Access? Please register your interest
2. Promote the toolkit and priorities and share your thoughts
3. We want to hear about your experience working on NCD access: contact us by email rturkie@ncdalliance.org and jlaurson-doube@ncdalliance.org
4. Upcoming events with UNIGE, ANN, EANCDA and Africa CDC at CPHIA and the Africa NCDs Network Relay: https://ncdsafrica.org/2026/10/16/ann-ncd-relay-africa-2026/#relay-about

Register your interest in peer-to-peer learning here

Download the toolkit and priorities here

NCD Alliance

THANK YOU

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SHARE. DISCUSS. ENGAGE. CHANGE.

#NCDs @ncdalliance

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MAKING NCD PREVENTION AND CONTROL A PRIORITY, EVERYWHERE