Tackling Africa's cancer crisis

Bryan Pearson reports on a unique cross-cutting initiative which is developing a blueprint to tackle Non-Communicable Diseases in general, and cancer in particular

As many a head of state has demonstrated, Africa is not a good place to be if you have any form of cancer. Across the continent, the number of effective treatment centres is lamentable considering the burden of the disease. And set against all other competing calls for funding, cancer repeatedly gets left behind because by its very nature, treatment is very much at the expensive end of the healthcare spectrum.

And if you can get treatment, survival rates are far worse than those attained in high income countries. For example, a five-year survival rate of women with breast cancer in Europe is 82% whereas it is 46% in Uganda, 38% in Algeria, and just 12% in the Gambia.

Given the competition for funding. What does one do? Simply join the Non-Communicable Disease (NCD) lobby and wait for however long it takes for the relatively low hanging fruit (cardiovascular disease/diabetes) to be funded before oncology gets a look-in, or set up an initiative to try to address the fundamental problem?

An interesting such initiative was convened by Takeda Pharmaceuticals in Geneva during the World Health Assembly this year. Through their corporate social responsibility arm, they convened a conference with Amref Africa and Cancer Foundation and brought together a wide range of individuals to 'brainstorm a blueprint' of how NCD services (and oncology services in particular) could be developed. People came from Non-Government Organisations, foundations, supranational organisations, academicians, health professionals, finance, industry, and the business world. The objective was to explore and identify partnership opportunities, and learn from the successes that have been achieved in tackling Communicable Diseases (CDs) such as HIV, tuberculosis (TB) and malaria, and translate that progress to deliver long-term, sustainable approaches that can benefit patients with NCDs. At the end, participants were challenged to split into three groups, each to come up with a measurable follow-up activity which participants would try to deliver against in the coming months. A novel approach indeed.

> "The poorest groups not only bear higher risks for NCDs but, once they develop an NCD, they also face higher health and economic impacts. The poor have less access to medical care, allowing NCDs to progress to advanced states resulting in higher levels of mortality and disability. Given their complexity and chronic character, medical expenditures for treatment of NCDs are a major cause for tipping households into poverty."
>
> *Amartya Sen, Nobel Laureate in Economics*

The meeting opened with Ricardo Marek, President of Takeda's Emerging Markets division pointing out that innovation will be critical if the world is to confront demand for treatments. Leaving the status quo is not an option. He then handed over to Marijke Wijnroks, Chief of Staff and Interim Executive Director of the Global Fund. She mapped out how at the outset of the Fund's work, the leadership thought that there was a simple disjoint between medicines, industry, clinicians, government… and patients. She described the 'big learning experience' as it was realised that in many countries the only way forward would be by helping to build what would in effect be a whole new health system. What existed was simply not fit for purpose. She then talked of how important it was to leverage civil society to help with the 'totally unrealistic' price structures that initially existed for drugs such as antiretrovirals (Original product price per year: US$10 439 versus $2767 for generic options) and how once civil society and governments engaged, scale-up became possible and prices dropped to closer to a more realistic $30 per head per year. She emphasised the importance of decentralisation in the delivery of services and getting the spend to the local level if one was to achieve maximum output. She went on to comment on the ever-changing epidemiology of disease in the world, and on the importance of countries taking greater control of their services as the Overseas Development Assistance (ODA) sums were now declining. She called for cancer screening to be integrated into formal health services and highlighted the co-infection issues of diabetes in the TB caseload. She concluded with four key points: she urged that more domestic finance has to be allocated to healthcare if it is to be sustainable; the importance of new emerging powers to take a fairer share of the ODA streams; the need for continuous innovation; and the need to take a people centred approach in designing the health interventions.

To give added perspective, the meeting was then addressed by Dr. Joseph Kibachio, Head of NCDs in the Ministry of Health in Kenya. He delivered a powerful lecture (with a quite excellent series of PowerPoint slides) which comprehensively captured the complexities every Ministry of Health has in facing what he termed 'the triple burden of disease': the communicable

diseases, the non-communicable disease… and the burden from Road Traffic Accidents and trauma, particularly from high density populations. He demonstrated how while progress has been achieved in reducing premature mortality from communicable, maternal, neonatal and nutritional causes these conditions still account for three out of four premature deaths. At the same time, deaths from NCDs and road traffic accidents have emerged as a leading cause of years of life lost. NCDs are now expected to be the leading cause of ill health and death by 2030 (Figure 1). It is all influenced by rapid urbanisation, changes in diet, changes in risk factors from poverty to behaviour, and improvements in the control of CDs that increase life expectancy.

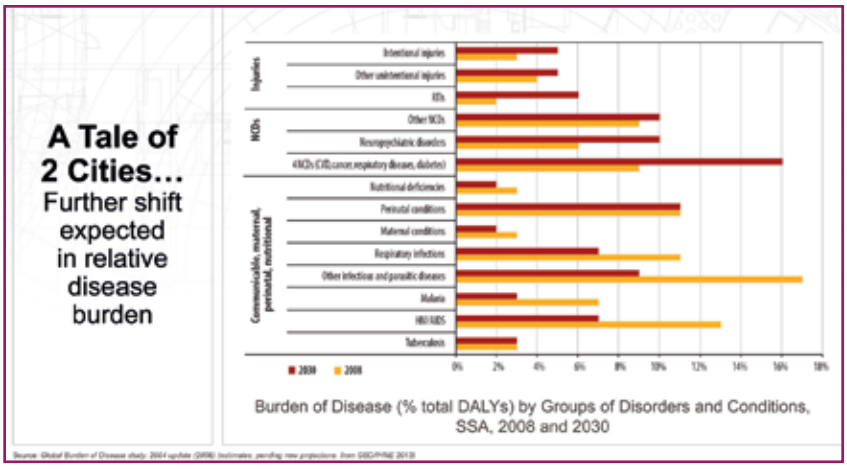

Figure 1.

So with a three-headed monster, rampaging on all fronts, what hope for extending NCD treatment in Africa? There then followed a series of lectures highlighting how barriers can be removed, boundaries can be shifted, and where there is a will… there can be a way. A particularly interesting presentation came from Simon Berry the CEO of ColaLife… the innovative provider of oral hydration therapies in Zambia. He had observed how Coca Cola got everywhere in Africa while many life saving medicines did not. So he designed a ORT package that would fit between the necks of Coke bottles, loaded into a crate. Thus they could be distributed simply and easily… to wherever Coke went. The design was novel and inadvertently won numerous prestigious awards for its ingenuity, style, and potential humanitarian contribution. But a year into the project an unexpected truth emerged. People didn't use these funny shaped packets! So although they had beaten major international brands to global design awards, embarrassingly as appropriate as it had seemed, they had to scrap it. But undaunted, and still with the ColaLife name, the project has continued, and prospered but moved more mainstream in terms of retail outlets and education. And it is having a huge impact in reducing diarrhoeal mortality.

And then there is prevention. With NCDs there is a big evidence-based lobby for not waiting for the disease to arrive at the hospital door, prevent it happening in the first place. Some fine quotes were exhibited to make the point: Margaret Chan, then Director-General of WHO said 'NCDs are a disaster in slow motion' and went on to say 'These are the diseases that break the bank'. The World Economic Forum is quoted as saying that NCDs rank above climate change and alongside the global financial crisis in terms of the global threat they pose. And Ban ki Moon is on record saying: 'If unchecked, NCDs have the potential of crippling growing economies; success will only come by focusing resources on people, not their illnesses; on health, not their disease'.

So there we had it. The problem is huge. The problem is identified… so what are we going to do about it? That was the challenge that was delivered to this interesting array of 'senior talent with an interest'. And after signing up to a 'Blueprint for Success Charter' the invited participants split up into three groups to debate and decide on key initiatives to take forward.

We (the press) weren't invited into the group discussions, so I can only quote the final communiqué, but for the record: Group 1 chose to try to **close infrastructure gaps for primary health care and diagnostics**. Improve early detection options through diagnostic training of local primary health care providers, quality and performance improvement of health care workers, and through integration of cancer services particularly with NCDs, women, children and adolescent's health, creating synergies and cost efficiencies.

Group 2 **chose to collaborate with non-traditional players**. Investigating innovative collaborations and institutionalize partnering with local governments and non-traditional players beyond healthcare such as telecommunications, technology, FoodCo, retail, distribution/postal agency, and governments.

Group 3 **chose to capture greater local epidemiological data**. Capturing and gathering specific information on prevalence and incidence of non-communicable and other chronic diseases in local communities, identifying specific profiles.

Participants have now been challenged to come up with work plans before the end of the year with Project Management and coordination support provided by Takeda's Access to Medicine's Office.

It will be interesting to see what the outcomes might be. Groups 2 and 3 have assigned themselves an important mountain each; while Group 1 looks to have a whole mountain range!

But the significance of all this is surely in the nature of the collaboration. Two decades ago, it was for ministries of health to take the initiative and move services forward. But times are demonstratively changing. Here is an example of a cross cutting international group, including opinion leading African physicians coming together to try to prove that if there is a will, there might just be a way. Innovation is going to be key, but for the over 30 million people from low- and middle-income countries who are currently dying of NCDs each year, it will hopefully provide much more than just a ripple in this enormous pond.