EDITION 2

CONFERENCE NEWSLETTER

AORTIC 2007—6TH INTERNATIONAL CANCER CONFERENCE

CANCER IN AFRICA: CHALLENGES AND OPPORTUNITIES

Pain management

JUST WHAT THE DOCTOR ORDERED

The big consensus among advocates of palliative care (PC) was the importance of pain management. Leading the way in the discussion, Dr Ann Merriman did not dally around the point: "If your patient's got the screaming heebie-jeebies from all the pain, you can't get through to him to help him and neither can his family."

This calls for a comprehensive plan for cheap and effective painkillers on a continent where few countries have access to oral morphine[1]. Dr Merriman spoke from clinical experience with powdered morphine in Uganda. "A lot of people don't know this, but morphine is very cheap. It only gets expensive when manufacturers get involved." Making their own morphine powder from poppy flowers, the Ugandans get about 10 days' supply of morphine for about R4 (60 US cents), or the price of a bread loaf, said Merriman. Similarly, Dr Awuah of Ghana estimated that powdered morphine was available at half or even quarter the previous cost of opiates.

Those drugs also need to be accessible. This means that doctors cannot be the only caregivers with the authority to prescribe painkillers. Several speakers highlighted their government's reluctance to relinquish control of medication from the doctors' hands, yet, as Dr Bactrin of Kenya pointed out, there simply too many patients and too few doctors to make this effective.

"You need fire in the belly," advised Dr Merriman, describing how tenacious advocacy triumphed over stubborn bureaucracy in national health departments. Those countries present who fared best in PC had enjoyed some degree of change in government policy, yet there remains a need for solid policy frameworks to take things forward. Generally, the Francophone nations have fewer formal structures in place and less access to opiates. Dr Merriman's "belly fire" theory called for increased advocacy and public awareness to shift government mentality in favour of PC.

The speakers seemed to agree that training and education in PC is crucial. Adopting a holistic approach, several speakers advocated that this training is needed not only for healthcare workers, community volunteers and family members, but also traditional healers and spiritual leaders. Community volunteers and family members play an important role because a community

approach helps reduce stigma, and offers a vital support system to people with life-threatening illnesses. Several of the speakers were involved with entirely home-based PC projects, which rely heavily on community support to administer medicine and offer spiritual support. Representing South Africa, Dr Alan Barnard advocated taking 'comprehensive care' a step further. He argued that PC starts too late (when the patient is dying) and ends too early (once the patient has died). Instead, he suggests PC should be integrated from the beginning of diagnostic treatment, and should continue after the patient dies, in the form of "bereavement care" and "orphan care" for family members.

In line with her reputation for leading the cause of palliative care in Africa, Dr Merriman also led much of the discussion on Thursday, serving as a kind of chief whip and frequently challenging and debating her colleagues' outlooks on PC. Dr Barnard jokingly referred to her as "the mother" of PC. "She's been a good mother, because she's been disciplining us today. Thanks, mom", he said.

by Murray Hunter

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[1]S. Ramsay. "Raising the profile for palliative care in Africa," *The Lancet*. Vol 358, 9283, p 734.

Making a 'PACT' to work together

The need for multidisciplinary collaboration is an issue which has made its way to the forefront of many discussions and sessions during AORTIC thus far. During Friday afternoon's session on *Radiation Therapy in Africa* the notion of cooperation was once again strongly emphasised by Dr. Samiei, head of *Programme of Action for Cancer Therapy* (*PACT*), a unit of the International Atomic Energy Agency (IAEA). Dr Samiei highlighted the significant benefits that collaboration through organisations such as PACT can have on radiotherapy treatment in developing countries.

With the establishment of *PACT* the IAEA hopes to initiate and fortify a cooperative effort to help more patients receive adequate treatment and survive cancer through early diagnosis. Samiei reported that "radiotherapy is an essential part of the treatment of cancer but there is a huge shortfall of over five thousand machines." The importance of the need for adequate facilities is further emphasised by markers which suggest that this figure is said to rise to ten thousand to meet increased growing demand by 2015.

Samiei further corroborated the need to advocate collaboration and a shared experience by highlighting "the lack of investment in early detection and diagnosis which leads to patient's with curable cancers dying unnecessarily." *PACT* is dedicated to investing in an effective cancer control system which can be adapted for use in many developing nations. Samiei reports that through the "use of radiotherapy as an anchor to build self-sustaining national cancer control programmes in developing countries" the *PACT* initiative is aimed at "putting cancer on the global health agenda."

In his presentation on *Feasibility of Improving Radiotherapy Access and Practice in Africa,* Dr. Twalib Ngoma concurred with the notion that there is a need for a collaborated effort in the treatment of cancer, particularly with regard to the training of professionals. Ngoma stressed the point that the issue was not merely about machinery but was also concerned with human resource management and the need to change our style of thinking and the way we do things. "Sub-standard practices leads to uncertainty of doses given to patients and poor outcome of treatment results," says Ngoma.

Through the cooperation of health care professionals, *PACT* is expected to raise funds to help developing countries establish a comprehensive cancer control infrastructure. This infrastructure will allow them to more effectively meet the challenges of late diagnosis and inadequate human resources, faced by many developing nations, and will thereby enable them to offer more effective treatment to patients in low resource settings.

By Crystal Espin

Breast cancer, link to high mortality in Africa

"Breast cancer is among the five main causes of cancer mortality in women in Africa," said Dr Ndom of Cameroon speaking at the *Breast Cancer* plenary held on Friday morning, "with rankings as the first or second cause of cancer death in most African countries." It is because of these dramatic figures that speakers in the session brought reasons for the cancer's prevalence in developing countries and suggested treatment plans to the forefront of discussions.

Dr Ndom highlighted the challenges of late arrivals and diagnosis, little or limited testing, ignorance, and poverty as the main contributing factors behind the diseases high incidences in developing African nations. He reiterated that delays caused by the unavailability of treatment in developing nations are a significant hindrance on effective patient care. Ndom advocated the importance of timely diagnosis, trained professionals, and follow-ups in reducing the number of breast cancer mortalities.

Dr Paul Goss furthered stressed the point of effective treatment as he pointed out that the high mortality rate of breast cancer in developing countries revealed huge discrepancies. "Women of African descent have a disproportionately higher breast cancer mortality rate", said Goss in his presentation *Evolving Endocrine Therapies in the Prevention and Treatment of Breast Cancer;* "this is coupled with a lower breast cancer incidence rate compared with whites." Goss concluded that part of the cause of developing nations' inability to administer successful breast cancer treatment is the poor representation of African women in clinical trials which specifically address their needs.

According to Dr Elizabeth Murray of The University of Cape Town, South Africa the inadequate representation of African women in clinical trials translates as a predisposition to more aggressive or rapid growing tumours. Murray listed treatment refusal or unavailability and long waiting lists resulting in treatment delay as the major factors behind the diseases aggressive behaviour and the high breast cancer mortality rates of African women.

By Crystal Espin

GOOD CLINICAL PRACTICE IN ONCOLOGY

Nurses leading the fight

Despite a very early morning session, health care professionals relished the chance to hear presentations on Good Clinical Practice. Dr Moodley of the University of Stellenbosch gave a sketch of some of the low points in the history of clinical trials that lead to the establishment of guidelines for conducting clinical research. The Tuskegee study in the United States, conducted from 1932 to 1972, was one such infamous case. The study, whose objectives were to test racial differences in the progression of syphilis, shocked the world when it was revealed that poor black subjects were not informed of their disease status and were denied penicillin for treatment. The study was finally condemned by the Clinton administration in 1997 as inherently racist. The horrors of clinical trials in Nazi concentration camps in the Second World War and the testing on Chinese subjects and Allied POWs by the notorious Japanese Unit 731 were further instances of clinical research gone badly awry. The Nuremberg trials brought world attention to the matter and the Nuremberg Code helped to establish guidelines for good clinical practice.

Professor Falusi of the University of Ibadan in Nigeria noted, however, that contestations surrounding the nature of clinical trials have not altogether disappeared. Drug trials by large pharmaceutical companies in Nigeria have received much media attention recently and throughout the continent continue to be problematic in their treatment of Africans. Clinical research is first and foremost about benefiting people and should be conducted according to the principles of respect, beneficence and justice. Falusi stressed that it essential that the risk-benefit ratio is carefully considered before conducting clinical testing and that the rights of human subjects are prioritised.

Given the history it is little wonder that marginalised groups such as the poor and illiterate are afraid of clinical trials. This has made it more difficult to educate people about vital health issues such as vaccination. Respect amongst researchers and subjects is essential in maintaining relationships of trust and mutual benefit.

As frontline health care workers, nurses are well aware of the importance of respect and trust when dealing with patients. A later session on nursing oncology elucidated the role of nursing in Africa. Lize Maree encouraged nurses, particularly those involved in oncology, to empower themselves through education to better to be able to meet the challenges posed in the African context." Nursing is not well understood even by educated members of society", she said and continued that even doctors sometimes didn't give nursing the credit it is due. Nurses commented that although they had been attending presentations by doctors all day, there were always few doctors in the audience for nursing presentations.

Nurses often form the closest bond with patients and hence are uniquely poised to enter into important psycho-social research. This research can be invaluable in understanding issues such as non-compliance and patient distrust of the health care system. But nurses must also learn to protect themselves. Heather Ely shared her knowledge on practical ways to protect themselves from chemical exposure to chemotherapeutic agents through safe handling techniques. Elizabeth Situma Nagudi and David Makumi Kinyajuni gave the discussion context by discussing the situation of oncological nursing in Uganda and Kenya respectively. Zaina Brown of South Africa gave a talk on the paediatric management of Burkitt's lymphoma. What emerged from the session was a unanimous agreement on the necessity for nurses to network, and share knowledge through the formation of a group which would represent their interests in Africa.

By Charles Human

CERVICAL CANCER

Why is it so common?

This was the title of Prof Isaac Adewole's lecture which reflected upon his research into the reasons for the prevalence of cervical cancer in Africa. Adewole is from the University of Ibadan's College of Medicine in Nigeria. His presentation focused mainly on the socio-economic and cultural factors that contribute to the pervasiveness of the disease on the continent. The research model used took the form of a combination of dynamic focus groups conducted both with healthy women and with women who had been diagnosed with cervical cancer, and combined this with a review of the existing literature on the subject. A number of factors that have laid the foundations for poor health care provision in Africa, has contributed significantly to the proliferation of undetected and untreated cervical cancer in women across the continent.

The more salient factors among these include the unstable political climates of the great majority of African countries, the problem of weak leadership, and the socio-political damage to African countries that is the legacy of colonialism. Poverty and lack of awareness also have a role to play, as do the inequities suffered by women in numerous societies across Africa. Their position as second class citizens – one which is reinforced by cultural, religious and historical conventions – also often means that the lives of women (particularly women between the ages of 40 and 60, who have passed child-bearing age, and are at the highest risk for the onset of cervical cancer) are not considered particularly worth saving.

Adewole emphasised the impact of the sexually transmitted infection (STI) associated with cervical cancer, Human papillomavirus (HPV), on the incidence of the disease in Africa, citing multiple sexual partners and early age of sexual debut as major contributors to the spread of the virus, which is currently associated with almost 100% of cases of cervical cancer. The one behaviour change which could stem the rapid spread of the infection amongst women, who can at once be infected with any number of the over 120 different types of HPV, is regular screening with smear tests. A shortage of resources and lack of education and infrastructure however, render this nigh on impossible, since without screening facilities, the culture of good health-seeking behaviour can not be engendered in Africa's women. Fears, superstition and myths about western medicine also contribute to poor health-seeking behaviour amongst African women.

Immunosuppression as a result of the spread of HIV/AIDS in Africa has also meant that women are increasingly unable to recover from HPV when the dormant virus periodically flares up, thus increasing the likelihood that they will eventually present with cervical cancer.

Solutions to the problem of the high incidence of cervical cancer in Africa are primarily related to good governance and education. Governments should acknowledge the critical nature of the disease on the continent, and allocate funds for the establishment of nationalised cancer screening programmes, initiated and administered by public health authorities. This drive should be supported by the widespread education of the public about the threat of cervical cancer to women and the importance that they undergo regular screening.

By Lindiwe Mazibuko

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