



## CANCER ALLIANCE ADVOCACY TOOLKIT

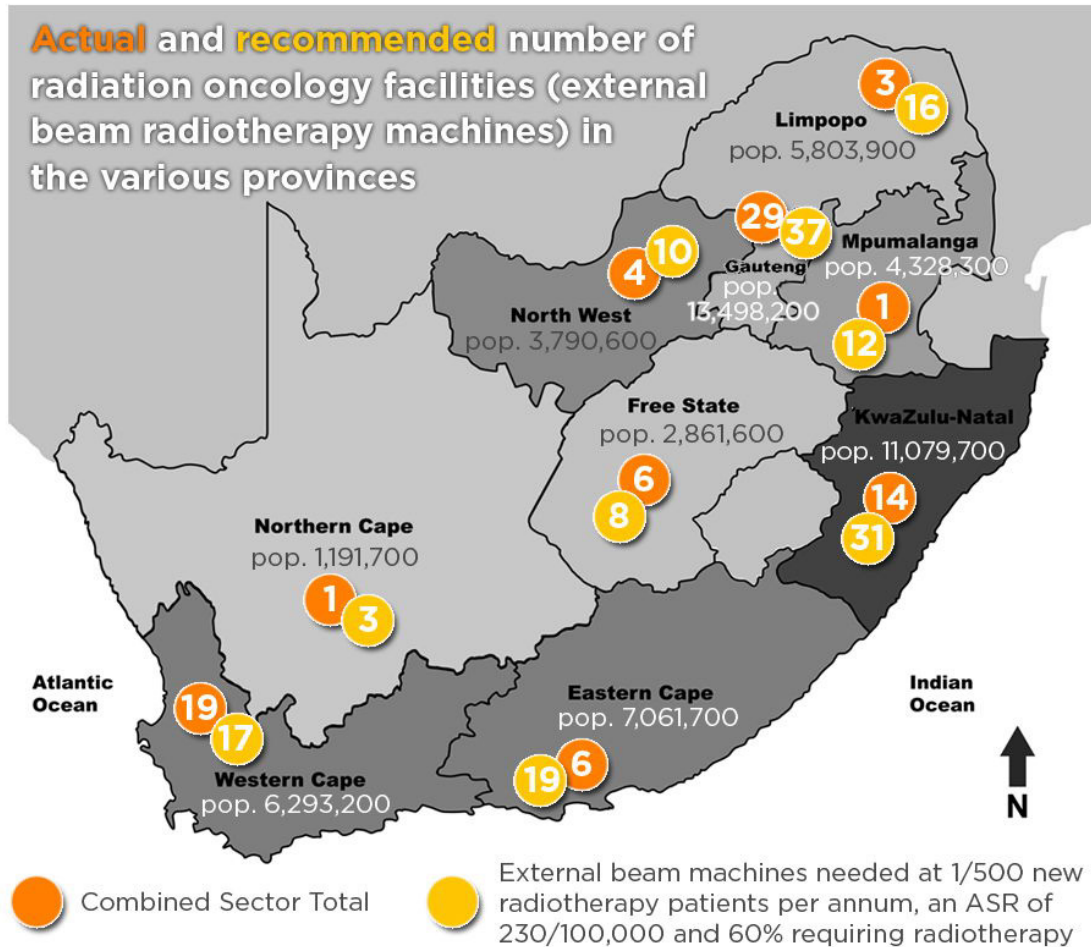
### PRIORITY AREA #7: RE-ENGINEERING THE HEALTH SYSTEM TO ENSURE INTEGRATED CANCER SERVICES

AS CANCER INCIDENCE RISES NATIONALLY, BEHAVIOURAL RISK FACTORS THREATEN TO SEND THE DISEASE ESCALATING TO EPIDEMIC PROPORTIONS. IT IS BECOMING INCREASINGLY URGENT THAT CANCER BE RECOGNISED AS A PRIORITY DISEASE THAT REQUIRES SPECIALISED SERVICES AND A DEDICATED BUDGET. IF WE DON'T ADDRESS SERIOUS SHORTCOMINGS IN THE CONTINUUM OF CARE, SOUTH AFRICANS WILL CONTINUE TO DIE UNNECESSARILY FROM CANCER.

#### THE FACTS

There is little equity of care for cancer patients in South Africa, the first obvious sign being the absence of treatment centres for each of the nine provinces. The map below shows the actual and recommended numbers of radiation oncology facilities (external beam radiotherapy machines) in the various provinces as at March 2017. This lack of proximate affordable, effective and quality cancer services, which enables early diagnosis, appropriate treatment and care, means patients in lower-resourced areas will often suffer and die unnecessarily. [1]





A multi-disciplinary approach to cancer is feasible in all settings – but not without a National Cancer Control Plan (NCCP) to ensure the delivery of locally appropriate, effective solutions, which provide sustainable, quality cancer services.

Without such a properly-funded NCCP, it will be impossible to implement effective patient referral pathways to early and effective access to relevant treatment protocols. Health systems that prioritize timely access to effective cancer treatment ultimately pay more than only lip service to reducing the ever-growing burden of cancer disease in South Africa. [2]

There is an immediate need for sufficient functional radiation treatment facilities that conform to the norms and standards set by the International Atomic Energy Agency (IAEA). The minimum norm is one accelerator per 250 000 people. (See box below.)

In the public sector in South Africa, equipment shortages are common, and where there is equipment, it is frequently outdated and poorly-maintained, combined with inadequate staffing. This impacts negatively on patient waiting lists and treatment outcomes. While the public sector has only 41 radiation oncologists, the private sector has 139 to service only 14% of the population – with state-of-the-art equipment.

## STATUS OF ONCOLOGY FACILITIES IN THE PUBLIC AND PRIVATE SECTORS. UPDATED MARCH 2017

PROVINCE	CHEMOTHERAPY UNITS		RADIOTHERAPY UNITS		EXTERNAL BEAM MACHINES	
	PUBLIC SECTOR	PRIVATE SECTOR	PUBLIC SECTOR	PRIVATE SECTOR	PUBLIC SECTOR	PRIVATE SECTOR
GAUTENG	2	25	2	18	10	19
KWAZULU-NATAL	3	9	3	8	6	8
EASTERN CAPE	2	2	2	2	3	3
WESTERN CAPE	3	13	2	9	8	11
LIMPOPO	1	2	1	1	2	1
MPUMALANGA	0	2	0	1	0	1
NORTH WEST	1	2	1	2	2	2
FREE STATE	2	4	1	2	4	2
NORTHERN CAPE	1	4	0	1	0	1
<b>TOTAL</b>	<b>15</b>	<b>63</b>	<b>10</b>	<b>44</b>	<b>35</b>	<b>48</b>

### ACADEMIC TEACHING HOSPITALS:

- **Separate Medical Oncology and Radiation Oncology:** Johannesburg and Pretoria
- **Combined Clinical Oncology Units:** Bloemfontein, Cape Town, Stellenbosch and Durban
- **Satellite Units:** Klerksdorp, Pietermaritzburg, Polokwane, Port Elizabeth, George, Kimberley and East London

### PRIVATE ONCOLOGY UNITS:

Over **50 in RSA**

- **Medical Oncology:** Gauteng and Western Cape
- **Combined Units:** Gauteng, North West, Mpumalanga, Limpopo, Free State, Western Cape, Eastern Cape, Northern Cape and KwaZuluNatal

### PAEDIATRIC ONCOLOGY UNITS IN SA

**7 Functional oncology units** attached to University Academic Departments.

- 2 Cape Town
- 1 Bloemfontein
- 2 Johannesburg
- 2 Pretoria
- 1 KZN

### 5 "SATELLITE" UNITS

- Polokwane (Limpopo Province)
- East London ( Eastern Cape)
- Port Elizabeth
- Pietermaritzburg
- George Mukhari

**3 Private Facilities** totally dedicated to **Paediatrics** and run by Paediatric Oncologists

**1 Private Facility** – Paediatric Haematology

## REQUIREMENTS FOR RADIOTHERAPY CENTRES

### A STEPWISE APPROACH TO ESTABLISHING AND DEVELOPING RADIOTHERAPY CENTRES

#### **1st level — Core: The basic radiotherapy centre**

The following lists the equipment that should be found in every cancer therapy centre that aims to treat a significant number of patients with cervical cancer with curative intent.

- 1 teletherapy unit (in new centres with possible unstable power and poor environmental controls, the IAEA would recommend cobalt machines rather than linacs)
- 1 HDR brachytherapy machine (when a large number of patients with cancer of the cervix are treated annually)
- 1 mould room capable of producing immobilization devices and custom radiation shields specifically for individual patients treated curatively
- 1 simulator (either conventional or CT simulator) as an aid to planning treatments
- 1 treatment planning system (TPS) with a level of sophistication matched to the complexity of the treatments performed
- 1 set of dosimetry equipment capable of performing reference and relative dosimetric measurements and QA tests to verify proper operation of the therapy equipment and the treatment planning process.
- 4–5 Radiation oncologists
- 3–4 Medical physicists
- 7 Radiation therapy technologists
- 3 Radiotherapy nurses
- 1 Maintenance engineer

#### **2nd Level**

- Has at least the above equipment and staff
- Provides a sustainable and adequate radiotherapy service
- Acts as a model and reference centre at the country level
- Has a QA programme
- Has a patient follow-up programme
- As part of the QA programme, conducts a systematic analysis of own treatment outcomes
- Has training programmes for some or all of the radiotherapy related professions at the national level

#### REFERENCE

International Atomic Energy Agency (2011), Planning National Radiotherapy Services: A Practical Tool, IAEA Human Health Series No. 14. STI/PUB/1462; (ISBN:978-92-0-105910-9); Also available for download at <https://goo.gl/rLjcdf>

Training of associated staff at accredited academic institutions, the cornerstone of future cancer care, is currently under threat with not all these institutions able to meet the growing demand for cancer specialists.

Other important shortcomings are that most cancer patients do not receive:

- Vital information about their disease in their mother tongue.
- Comprehensive psychosocial care.
- The services of patient navigators to guide them through the treatment process.
- Information about the consequences of delayed treatment and long waiting lists.

## SO WHAT DO WE NEED?

- Culturally sensitive, linguistically appropriate local awareness and education programmes to teach the value of prevention and early detection of cancer.
- Access for adults and children to accurate screening and early detection of cancer at all primary healthcare facilities.
- Timely diagnosis at functional diagnostic centres, and efficient referral to further necessary care services.
- Equitable, quality treatment, with the associated provision of equipment and trained human resources for effective, patient-centred care.
- Appropriately trained cancer surgeons to ensure prompt surgical interventions, as well as dedicated theatre availability.
- Access to affordable diagnostic techniques, and essential and other supportive cancer medication, to offer equitable and safe cancer treatment for all. This will avert treatment interruption, which seriously compromises treatment outcomes.
- Sufficient fully-functional and fully-staffed radiation treatment facilities, especially to address the highest-incidence cancers – breast, cervical, prostate, colorectal, and lung cancer.
- Acceptable levels of psycho-social care at all treatment centres, particularly for patients from rural areas and for those who are financially disadvantaged.
- Palliative care services for cancer survivors and their families, especially in the currently critically under-resourced rural areas. This is a vital service that should be available from diagnosis to end-of-life.
- A multi-faceted approach to care, spanning the entire cancer continuum.
- Properly-trained health professionals across the board to implement focused provincial cancer plans. [3]

## WE CANNOT ACHIEVE THIS WITHOUT:

- Recognising cancer as a priority disease, which requires an appropriate, centralised ring-fenced budget.
- A National Cancer Control Strategy and Plan that reflects the full spectrum of multidisciplinary cancer services and infrastructure. This should be devolved to provinces for implementation, monitoring and evaluation.
- A fully-functional, comprehensive National Cancer Registry for adults and children.
- A standard Essential Medicines List for cancer, that conforms to the WHO-recommended EML, and applies countrywide.
- An Intellectual Property Policy that supports access to medicine.
- National minimum standards of disease staging and treatment guidelines that are applied in all provinces, for any cancer affecting adults and children.
- Effective referral pathways, from primary healthcare to oncology diagnostic centres, then on to Cancer Centres of Excellence for required cancer therapy, or for palliative care if required.
- Ongoing training for health professionals associated with cancer care, to ensure professional development and sustainability of service provision, as well as the maintenance of best-practice care standards.
- Effective private-public partnerships so cancer treatment options are well defined and shared equitably across the country.

## HOW CAN WE MEET THE CHALLENGE?

### CHALLENGE 1: A NATIONAL PLAN

Although a South African National Cancer Control Plan was first developed in 1998, limited political will to fund its development means that, 19 years later, there is still no structured and sustainable road map for addressing cancer at a national and provincial level. [4]

The World Health Organisation says such plans are designed to reduce the number of cancer cases and deaths, and improve the quality of life of cancer patients. This is done via the implementation of systematic, equitable and evidence-based strategies for prevention, early detection, diagnosis, treatment and palliation – using available resources. [5]

The WHO also points out that no matter a country's resource constraints, a well-conceived and well-managed NCCP helps reduce the cancer burden, and improves services for cancer patients and their families.

Cancer control programmes require accurate data, including reliable cancer registries. Regulations to compel cancer registration were promulgated in 2011, but adherence is incomplete, with some noticeable gaps. This has resulted in significant under-reporting of cancer incidence. Urgent adjustment to the regulation is required to ensure specialists report the cancer cases they diagnose.

## CHALLENGE 2: PRIORITY AND APPROPRIATE BUDGET:

There is evidence from other low- and middle-income countries that health care systems can be implemented in a cost-effective way, but the key to that success lies in establishing functional primary care health infrastructures, particular for cancers responsive to prevention and early detection efforts. [6]

But the same significant government and financial support, which resulted in expanded access to treatment for HIV/AIDS and other infectious diseases, is essential – or cancer will continue to be relegated to the periphery of the health arena.

It's widely accepted that cancer requires special attention, and the government declaring cancer a priority disease is a good place to start if the burden of disease is to ever be successfully reduced.

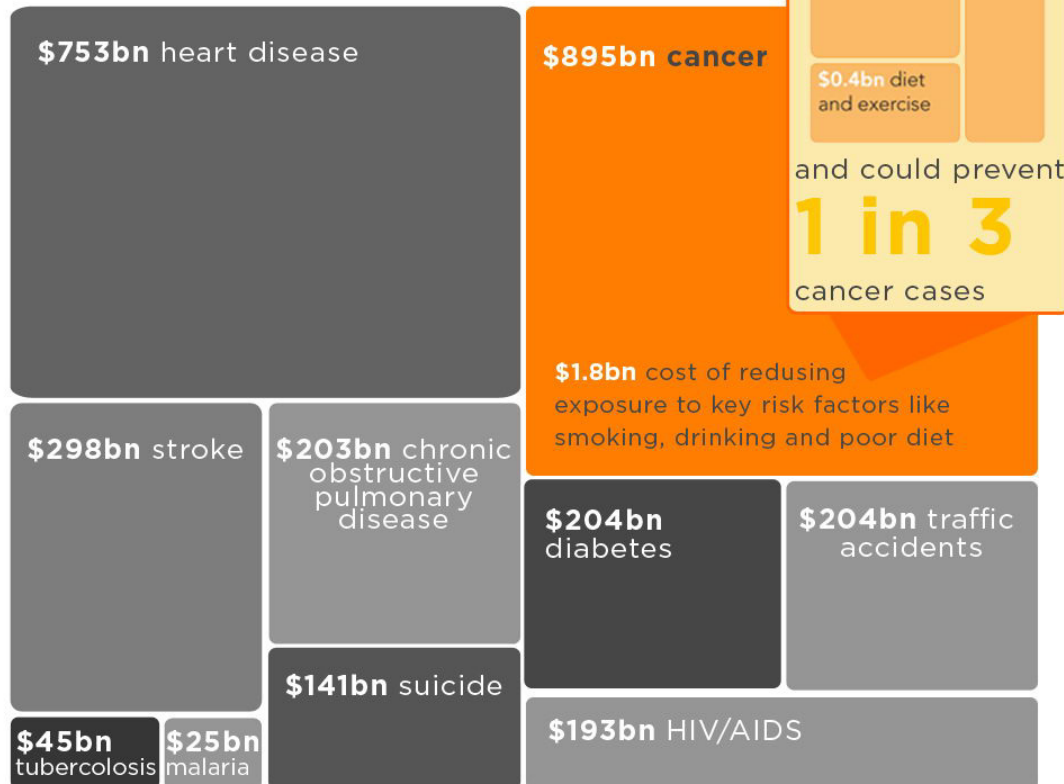
This priority action must translate into expanded service delivery and infrastructure in cancer control. Categorizing cancer as a specialized rather than as a chronic disease would be an important step towards shifting the responsibility for cancer service delivery planning from public health specialists – which is currently mostly the case - to better-equipped oncology specialists.

## THE GLOBAL ECONOMIC CANCER BURDEN

### CANCER IS COSTLY...

THE ECONOMIC COST\* OF CANCER  
EXCEEDS THAT OF ANY OTHER DISEASE

TAKEN FROM THE **UICC** TOOLKIT



\* Economic losses from disability and premature deaths. Excludes direct medical costs.  
Sources: American Cancer Society, Livestrong, World Health Organization.  
See [bit.ly/cancerburden](http://bit.ly/cancerburden) for full data list.

So what are some of the main obstacles? Lack of a dedicated Cancer Directorate at national level to co-ordinate cancer prevention and control management, lack of fully-functional cancer care facilities equipped to meet regional needs, healthcare staff losses thanks to migration from the public sector and across borders, and a lack of collaboration with stakeholders.

### CHALLENGE 3: MEDICINES AND TECHNOLOGY

Improved access and affordability will require effort from a variety of players, including patient advocates, regulators, national health institutions, and industry. But the government, along with international agencies, should take the lead in setting priorities for R&D, and using patent laws. [7]



Investment in infrastructure is also one of the main barriers the government will need to address urgently to improve access to quality cancer care, while also prioritizing access to affordable, effective and quality cancer medicines and technologies.

Public-private partnerships will be vital in South Africa's skewed healthcare environment, especially in the immediate future, to achieve the provision of equitable services to all South Africans. [8] An extensive audit of existing cancer services and staff, in the public and private sectors countrywide, is required to identify service delivery opportunities and gaps.

#### CHALLENGE 4: THE CANCER CARE PATHWAY

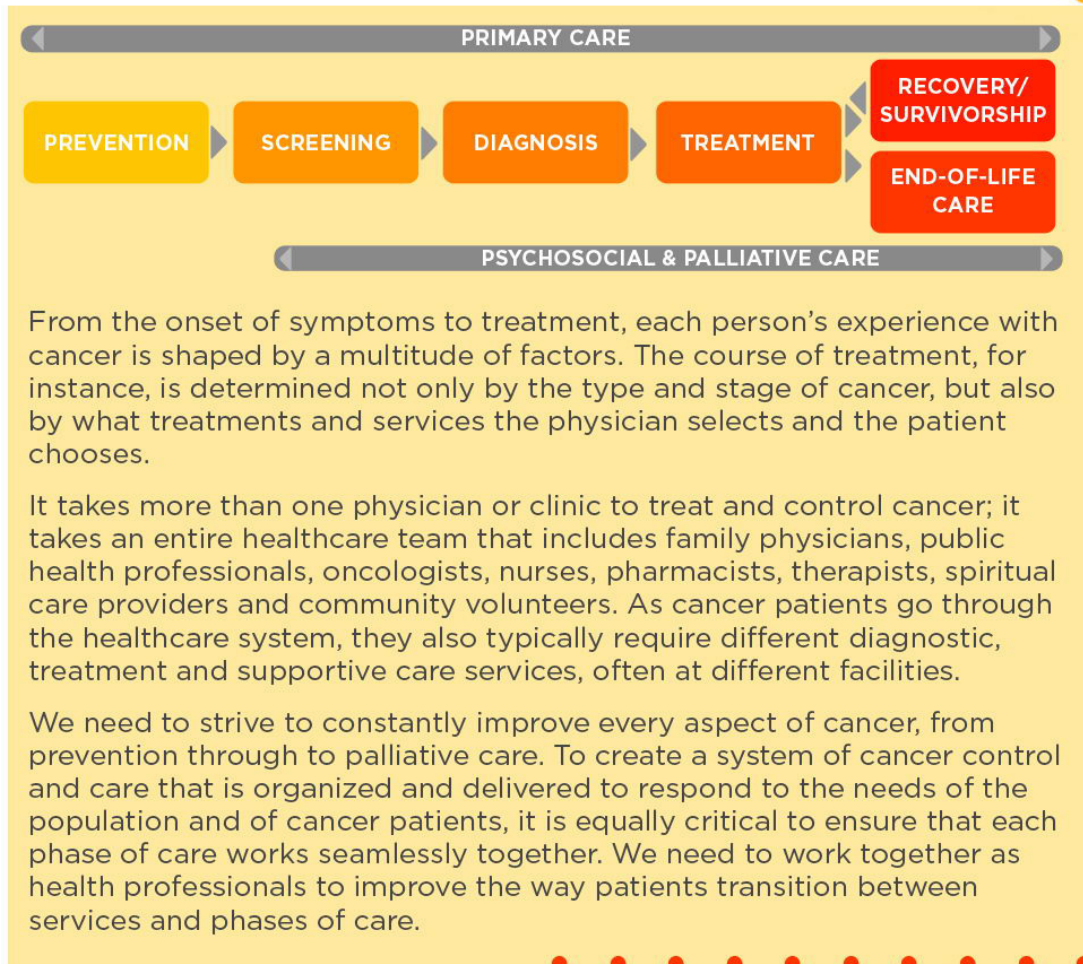
Cancer, by its very nature, requires a specific approach from end to end of the health system to prevent cancers where possible or practical, to ensure awareness and early detection, then proper diagnosis and staging, and finally, rapid referral levels at which the cancer can be immediately treated, in line with modern, effective and cost-effective treatment protocols.

Instead, referral pathways are currently seriously lacking, with so many gaps in the pipeline that a large majority of patients reach end-stage disease, while health practitioners can do little more than provide ameliorative support or palliative care.

This is what a good referral pathway for cancer care should look like:

- From primary care clinic to diagnostic centres for tests and staging, with a monitored time-line of not more than three weeks.
- From diagnostic centres to tertiary treatment hospitals within a monitored time-line for treatment to start within two weeks.
- From treatment hospitals back for follow-up cancer care at primary care clinics, where follow-up is done according to set follow-up protocols based on the patients' diagnosis.
- From treatment hospitals for palliative care for patients with incurable cancer, with proper instruction and scripts for pain management, as well as access to supportive home-based care services.

## CHALLENGE #4: THE CANCER CARE PATHWAY



### CHALLENGE 5: A RIGHTS-BASED APPROACH TO CANCER CARE

The right to health was enshrined in the Constitution of the World Health Organisation in 1946, and included in the Universal Declaration of Human Rights two years later. While most countries worldwide have signed at least one treaty acknowledging the right to health, [9] the reality in many is that inequality is deepening. Gaps in access to cancer services, along with the associated financial risk, are widening in the face of double burden of disease challenges in many low- and middle-income countries, ineffectual health systems, and lack of social protection.

The application of a human rights-based approach to cancer care would acknowledge that access to services is a question of social justice. It would also help identify and address the inequality and discriminatory practices currently hindering access to affordable, quality and timely clinical and supportive care services across the cancer care continuum. [10, 11]

## REFERENCES

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## SOCIAL MEDIA GUIDE

### PRIORITY AREA #7: RE-ENGINEERING THE HEALTH SYSTEM TO ENSURE INTEGRATED CANCER SERVICES

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#### HASHTAGS FOR THIS CAMPAIGN:

**#LetsTalkAboutCancer**

**#RightToHealth**

**#PriorityDisease**

**#FixThePatentLaws**

#### SUGGESTED POSTS

Cancer treatment is not available in all nine provinces of SA. We need equitable services **#LetsTalkAboutCancer #PriorityDisease**

We need a National Cancer Control Plan for locally appropriate, effective solutions, which provide sustainable, quality cancer services

Burden of cancer is growing and we need health services to pay more than lip service to its treatment **#LetsTalkAboutCancer #RightToHealth**

Public sector has only 41 radiation oncologists, private has 139 to service only 14% of the population. This must change **#RightTohealth**

Most cancer patients in SA don't get vital information about their disease in their mother tongue **#LetsTalkAboutCancer**

Most cancer patients in SA don't get comprehensive psychosocial care **#LetsTalkAboutCancer**

Most cancer patients in SA don't get the services of patient navigators to guide them through the treatment process **#LetsTalkAboutCancer**

Most cancer patients in SA don't get information about the consequences of delayed treatment and long waiting lists **#LetsTalkAboutCancer**

To meet the needs, cancer must be recognized as a priority disease, which requires an appropriate, centralized ring-fenced budget

We want a National Cancer Control Strategy and Plan that reflects the full spectrum of multidisciplinary cancer services and infrastructure

Urgent adjustment to the regulation is required to ensure specialists report the cancer cases they diagnose **#LetsTalkAboutCancer**

We want a fully-functional, comprehensive National Cancer Registry for adults and children **#LetsTalkAboutCancer**

We need a standard Essential Medicines List for cancer, that conforms to the WHO-recommended EML, and applies countrywide

There must be an Intellectual Property Policy that supports access to medicine **#LetsTalkAboutCancer #FixThePatentLaws**

There should be national minimum standards of disease staging and treatment guidelines that are applied in all provinces, for any cancer

The key to cost-effective care is a functional primary care health infrastructure **#RightToHealth**

We want effective referral pathways, from primary healthcare to oncology diagnostic centres, then on to Cancer Centres of Excellence

We need ongoing training for health professionals associated with cancer care **#LetsTalkAboutCancer #PriorityDisease**

Effective private-public partnerships are vital so cancer treatment options are well defined and shared equitably **#LetsTalkAboutCancer**

If cancer is a **#PriorityDisease**, service delivery planning shifts from public health to better equipped oncology specialists

Government and international agencies should take the lead in setting priorities for cancer R&D, and **#FixThePatentLaws**

Access to services is about social justice **#LetsTalkAboutCancer #RightToHealth #PriorityDisease #FixThePatentLaw**