

PODIUM

Encouraging partnership across the income divide



Dr Ian Magrath trained in London, UK, and was Chief of the Lymphoma Biology Section at the US' National Cancer Institute (Bethesda, Maryland) until 1999. Since then, he has been President and Director of the International Network for Cancer Treatment and Research (INCTR, Brussels, Belgium), an organisation which helps build capacity for cancer treatment and research in countries with limited resources. One of INCTR's current initiatives is a partnership programme involving individuals and departments predominantly in high income countries.

How big a problem is cancer in low income countries?

In 2007, more than 50% of the 11.3 million patients who developed cancer and 70% of cancer deaths globally were in developing countries, which have 5–10% of global resources. Developing countries will account for an ever increasing fraction of the global cancer burden.

Against that background, what can INCTR do?

Our mission is to help build the capacity for treatment and research, i.e., addressing cancer control issues from early diagnosis to palliative care. We take an evidence-based approach, with education and training for health professionals as the first priority. Developing countries have, by definition, a lack of resources. The discrepancies between rich and poor countries are enormous; for example, 16 histopathologists in Tanzania serve a population of 40 million whereas Switzerland, with its 7 million people, has some 400. Some countries have no

radiotherapy, and no medical oncologists. Many still believe that that a diagnosis of cancer is a death sentence but that tends to be an excuse for inaction and a self-fulfilling prophecy. This attitude is slowly changing and a lot can be done to improve the situation, sometimes at a relatively low cost. The place to start is to improve the efficiency of existing resources: the quality of care received in some parts of the world is extraordinarily poor – largely resulting from the deficit of human resources, but also from limitations in specialised units and equipment. We're trying to give people access to reasonable care; little will be achieved without that.

Where does cancer prevention fit in?

Prevention is very important, particularly tobacco control, and control of predisposing chronic infections, but we have to recognise that the value of primary prevention is not seen for decades so that in the interim period other cancer control measures are essential. Secondary prevention, i.e., early diagnosis via awareness campaigns or screening, can only be successful if appropriate treatment is available and patients are willing, or can afford, to accept it. Without access to care, sensitisation campaigns and sometimes ill-conceived screening programs may raise inappropriate expectations and squander valuable resources. It doesn't help individuals to know that their cancer is curable if they have no access to effective treatment.

... and research?

We need to build evidence in the low and middle income countries themselves in order to provide a more relevant platform on which to base action. Evidence accumulated in rich countries may not necessarily be relevant to poor countries. Imaging, modern radiotherapy techniques and drugs may all differ in availability, and the quality of supportive care is usually much lower. For example, in Europe and the US, more than 90% of patients with Burkitt's lymphoma are cured but the standard regime would be far too

intensive for patients in sub-Saharan Africa. Patterns of cancers can also be very different, due partly to differences in lifestyle and environment and partly to the age structure of the populations such that there are relatively few elderly people and a greater percentage of cancer is paediatric. Cancer in these settings needs to be approached in a scientific way so that the lower income countries develop feasible approaches relevant to their own situation.

This is a huge undertaking.

INCTR is a small organisation, and, alone, will make only a tiny difference. For example, we've helped our African colleagues to treat about 350 children with Burkitt's lymphoma, and by expanding the network of participating centres hope to get up to 1000. But it's a small contribution in the scheme of things and one of the reasons why the Partnership Programme, which we are in the process of expanding, is so important. We're building up a large core of health professionals willing to help; and will be maximising our use of the Web for education, training and consultation.

How has partnership worked to date?

The best example is in palliative care. Our palliative care specialists, including nurses, social workers and paediatric oncologists – are mostly based in the developed world and largely volunteer their time. They have helped build programs in Nepal, India, Tanzania and Brazil. Our experts go to assess the existing situation and develop a plan to expand services. They see patients, and hold discussion groups and workshops in order to teach the basic elements of palliative care. Their aim is to establish palliative care centres that help people while training nurses and doctors from the institute, region, or even other countries.

Our coordinator for India is Dr Gayatri Palat who has developed a program of this kind at the MNJ cancer centre, in Hyderabad, India, the Director of which has been very supportive. Our palliative care specialists visit Hyderabad at intervals and help with

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training courses and workshops for various health professionals. Plans to develop community palliative care programmes in surrounding areas are underway. Dr Palat also spearheaded a campaign to lobby the state government, and was successful in getting legislation changed to make opioids more accessible. This will encourage other states to follow suite and help overcome barriers to prescribing these drugs that often exist in the medical and nursing professions.

How are you using the Web?

It's critically important to us and will become increasingly so. We use a system called iPath, for example, that is basically a website to which digital images and text pertaining to specific cases can be uploaded. We have a team of pathologists, again, mostly volunteers, who comment on the images and use them for training purposes. We are in the process of expanding this to oncology cases for which diagnostic imaging and clinical photographs can also be used. We have also worked with Merlot and others to develop a portal called Open Education Resources for Cancer, which we are populating with a broad range of educational materials relating to cancer and providing links to other sources of information on the Web.

Dr Anil Srivastava heads our Open Health Systems Laboratory at Johns Hopkins Montgomery County Campus, in Maryland, USA, which is fully equipped for e-learning. It is early days, but we plan to use this both for live videoconferencing and for courses that can be recorded and used later for training, either online, or as a DVD. We also have access to a similar *Telesynergy* system here in Brussels that was provided by the US National Cancer Institute and has been used widely in Ireland. The objective is to utilise the expertise that exists in some parts of the world and bring it to people who can benefit from it in others.

How will a partnership with an institution work?

We want to encourage this. We already have links with a number of universities including Lund, Bonn, Sienna

and Georgetown (US). This will give us access to a broad range of expertise and, even, in the context of the Web, to experts who might be willing, but have limited time available. The Web-based tools make it possible, for example, for an individual to commit one hour a week to commenting on cases on iPath, or submitting materials to OERC. Others may be willing to spend time visiting other countries, making assessments, identifying problems and developing solutions. Some visits are essential, because specialists have to know what resources are available. Recommending a PET scan is not much help when no scanner is available!

We want to encourage individual departments in richer countries (some may be in middle income countries) to join the partnership programme with a view to helping build and develop centres of excellence in institutions with more limited resources. This will improve patient services while providing training and education, including outreach to others working in the same country. In addition, the program will help support ongoing scientific studies that will expand the evidence base.

Can the 'rich' institutions expect to benefit from the partnership?

There's a lot to be learnt on both sides. Some aspects of care which have become routine in the west are probably superfluous. Studies could be done to determine whether the similar results can be obtained with fewer tests or less intensive or expensive therapy. Very often, much can be accomplished without sophisticated tests and sometimes the latter add nothing except cost and even delay. This information is equally valuable everywhere in the world.

In our model, everyone is considered equal. The people from wealthier countries should be humble enough to be willing to learn from their less privileged colleagues, who may have developed innovative ways of overcoming severe shortages. In addition, there are new research opportunities in developing countries which, again, could often be of universal value.

How much impact will INCTR have?

We are limited in what we can achieve directly but we've had encouraging signs of a 'ripple out' effect from our work on leukaemia. In the early 1980's (actually, prior to INCTR's existence) we developed, with our Indian colleagues, a protocol for the treatment of acute lymphoblastic leukaemia that was used in several major cancer centres. As young physicians finished their training and moved to smaller medical colleges, many continued to use the protocol; it's now widely used in India, for the most part in centres we have never visited. If we can more positively stimulate the dissemination of information, it will increase our impact. Critically important is to have offices and branches in many countries which can coordinate studies and be involved in training and education locally, or in the case of wealthy countries, help to build the Partnership program, develop funding, and possibly focus on a particular area of endeavour. At present, we have offices or branches in Brazil, Egypt, Nepal, Tanzania, Cameroon, India, USA, UK, and France.

How does INCTR relate to other international organisations?

We have working relationships with many organisations, including the National Cancer Institute, USA, the European School of Oncology, the Program of Action Against Cancer of the International Atomic Energy Agency, the American Cancer Society, the International Union Against Cancer and several non-governmental organisations (NGOs). We have just become an NGO in Official Relations with the World Health Organization (WHO) and will increasingly work with WHO regional and country offices.

2010 is the 10th anniversary of our office in Brussels and I think our work is increasingly recognised by major institutions and organisations. We're bringing together interested and involved people in March, 2010, to examine our ongoing programs, identify strengths and weaknesses and decide how best to build the organisation in the coming years.

Helen Saul