

Poor countries stretched on infection and cancer treatment

Developing countries' problems tend to push cancer treatment for children down priority list

Andrew Jack JUNE 2, 2016

Ghana may be a thriving nation of 26m people with a fledgling health insurance system and an economy classified as “middle income” but Lorna Renner sees large gaps in its capacity to help local children diagnosed with cancer.

Based in a hospital in Accra, the capital, she is one of just three paediatric oncologists in one of only two centres in the country. She sees big disparities in the access to treatment compared with adult cancers and, yet more so, with infectious diseases.

“There’s still a lot of focus of resources on infections — on malaria, HIV and tuberculosis,” says Dr Renner. “I sit on the national technical committee for non-communicable diseases. But it’s not really functioning as it should. Our national health insurance doesn’t even cover childhood cancers. Families have to pay for everything, from labs to treatment.”

Just a few years ago, she estimates that the parents of up to half of the children’s cases she saw had abandoned therapy before it was completed. “They had to pay for drugs, diagnostics, travelling and staying for six months or more for treatment. It affects their income, their children’s schooling, family life and cohesion.”

Such a pattern is familiar to doctors and patients in many other lower and middle income countries around the world. While relatively simple medicines could treat and cure far more widely, prolonging children’s lives for many decades into adulthood, an estimated 100,000 still die each year.

Professor Tim Eden, founding medical trustee of World Child Cancer, a UK-based charity, says one widespread problem is the lack of availability of drugs. While simple treatments often exist in richer countries, many are not part of the “essential medicines list” of the World Health Organisation, an inventory which helps ensure they are recognised and adopted more widely.

There has been some significant progress in adding drugs in recent months to that global list. Yet inclusion alone is not enough. It does not necessarily mean the medicines are then automatically added to countries’ national formularies, imported or made available and reimbursed by local health systems.

“We are making some progress, but it’s been very slow,” Prof Eden says. “Children’s cancer is a ‘best buy’ with very high cure rates if they get therapy and a long life afterwards — meaning they can pay back through their labour and taxes far more than it costs. But they are dying because of lack of access, including to medicines.”



'Best buy': cure rates for children can be very high if therapy is available © Getty

Erwinase, to treat acute lymphoblastic leukaemia, was once supplied very cheaply but its price has soared since control over production and commercialisation was sold on to companies not originally involved in its development or manufacture.

Yet for most of the drugs needed to treat children's cancers, the problem is more one of availability of high quality medicines. Many of the large research-based pharmaceutical companies have pulled out of production of the established cancer medicines on which there are no longer patents. Instead, most are made by lower cost generic manufacturers, primarily in India and China.

That has raised a different sort of concern about prices: that the charges are too low to be viable and that the pool of suppliers is diminishing to the point where some drugs may no longer be available.

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Dr Lorna Renner

In any case, there are growing worries over the quality of production. “We have drugs available but you can’t tell how good they are,” says Dr Renner in Ghana. “We have been questioning their quality because children don’t seem to do so well on them,” she adds. “Is that the biology of the cancer or is it substandard drugs? It’s difficult to know.”

Some work done elsewhere to analyse batches of cancer drugs has suggested that they are substandard and risk having little curative effect. “There is strong evidence that essential medicines are frequently sub optimal, or totally ineffective,” argues Prof Eden. Yet so far there has been little willingness by producers or regulators to intervene and push for improvements.

Even efforts to make existing drugs available, affordable and accessible will not be sufficient to tackle unnecessary deaths. Medical personnel and access to diagnostics are also required.

So, too, is a more balanced perspective that gives a higher priority to cancers suffered by children. These have been long overshadowed by cancers that afflict adults and require different approaches.

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Prof Eden says health officials often erroneously lump the two together. Many adult cancers can be prevented — such as lung cancer, caused by smoking, and HPV, or human papilloma virus that affects the skin and moist membranes lining the body, around, for example, the mouth and genitals and against which a vaccine exists. By contrast, many children’s cancers cannot be prevented and early diagnosis coupled with treatment remains central.

There are some exceptions. The reduction in malaria across Africa in recent years — which is the result of widespread use of insecticides, bed nets and more effective drugs — may help reduce the incidence of Burkitt’s lymphoma; so, too, improved nutrition and sanitation.

At present, in most children’s cancers, however, cure remains a far more important and neglected priority than prevention.

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