FACT-FINDING TOUR OF THE ONCOLOGY SERVICES AT THE KENYATTA NATIONAL HOSPITAL

Present:.

Dr. J. Gesami	-	MOH Representative
Dr. H.O. Abwao	-	Dept. Radiotherapy
Dr. O.W. Mwanda	-	Haematology and Blood Transfusion Services
Dr. W. Njuguna	-	Department of Radiotherapy
Dr. M. Musau	-	Administration, KNH
Mrs. J. Nzinzi	-	Adult Oncology Ward
Mrs. R. Mutua	-	Paediatric Oncology Ward
Mrs. M. Munyinyi	-	Department of Radiotherapy
Mrs. Githenji	-	Department of Gynaecology
Mrs. E. Gakuo	-	Nurse Counsellor
Mrs. M. Mburu	-	KECANSA
Mr. B. Mutava	-	Department of Radiotherapy
Dr. K. Muhombe	-	KECANSA

Apologies:

Dr. K. Rogo
Dr. R. Chauhan
Prof.A. Nyong'o

1.0 Introduction

The prevalence of cancer in the emerging countries is higher than in developed countries.

Mortality from cancer in emerging countries is currently at 2.5 million and is predicted to rise to 6.5 million by the year 2015 (W.H.O.). More than 50% of the world's cancer load is in the emerging countries.

Cancer accounts for 20% of all deaths at KNH. This rises to 40% in the older age groups. The overall cancer burden is now increasing due to the HIV/AIDS phenomenon. This means there will be an increase in demand for cancer services in the next 10-15 years. The social costs of early deaths to care-givers and family income earners also make it prudent to invest in cancer services.

2.0 Background Information

Information was obtained through the following:

- interviews with healthcare providers, administration and recipients of care.
- Visit to the Radiotherapy Unit, Adult Oncology and Paediatric Oncology wards.

Kenyatta National Hospital serves as a referral and University teaching Hospital.

The University of Nairobi does not have Radiotherapy Oncology as a discipline in its teaching curricula.

There is a very basic introductory course to Medical Oncology in the third year clinical teaching programme. This is still inadequate in terms of exposure and time allocation to cover the topic of cancer.

The Radiotherapy Department of KNH is a purely service unit. It is the only fully functional Radiotherapy Oncology service in the country. It serves the rest of the East African region to include Uganda, Tanzania, Rwanda, Burundi and Ethiopia. KNH also serves as the sole referral hospital for all cancers (including leukaemias). Other patients are admitted in Medical wards, Surgical wards including Paediatric, Surgery, Ophthalmology, Head and Neck Units, the Cardiothoracic Unit, the Paediatric Oncology ward and the Acute and cold Gynaecologic wards.

3.0 Rationale for concern on Quality of Oncology services

1. The growing prevalence of cancer in the region.
2. The absence of an integrated comprehensive cancer service or institute in Kenya.
3. The absence of common guidelines, treatment protocols and audit procedures for the management of cancer.
4. The lack of synchrony of common pathways for training, education and Service delivery for professionals involved in cancer care.
5. The need to promote the ethic of multi-disciplinary teamwork in the medical profession especially in cancer management.
6. The absence of reliable information systems on cancers in Kenya, and the inability to collect common data across all categories of care providers.
7. Many health care providers and patients are unaware where specialist cancer service are available.
8. Policy guidelines on cancer at MOH level are still not adequate in the current National Health Policy 1999-2002.

4.0 Objective

To discuss with all the groups involved in cancer care so as to define the shortcomings and the ideal service to provide the best care throughout the "patient journey". Patients who receive care at community level should have access to the full range of specialist services at higher levels of uniformly high quality while respecting the informed choice of the patient. Service providers should also take into account cost-effectiveness and quality of life indicators.

5.0 Current Oncology Services at KNH

5.1 GFC Ward (Adult Oncology Ward)

Capacity 30 beds, 24 female and 6 male units.
These serve the whole of Kenya and other referrals from within the East African Region i.e., Uganda, Tanzania, Ethiopia, Rwanda and Burundi.
Patient treatment delays occur due to the inadequate bed capacity.
Initially, KNH had 60 beds for adult cancer patients. These were reduced to 12 (Ward 17) before the creation of the GFC Ward.
The current bed shortage has resulted in patients undergoing Radiotherapy being scattered all over the 10 floors in the tower block where they do not get appropriate supportive care.

5.2 Radiotherapy facilities

KNH Radiotherapy department has the following:

- Two Cobalt–60 Gamma Radiation teletherapy machines - both functional with lasers.
- One HDR Selection Brachytherapy machine.
- One Superficial X-ray Therapy machine
- Simulator
- One Treatment planning machine
- Equipment for patient immobilisation
- A suite for Radio Iodine therapy accommodates two patients at a time.
- One Diagnostic X-ray machine.
- A fully equipped theatre for E..U.A. and Staging of Cancer of the Cervix cases and insertion of intracavitary after loading system applicators.

The current equipment and facilities are adequate for the patient load at KNH. The machines treat 100-150 fields daily from 7.00 a.m. – 7.00 p.m. in two shifts. Machine maintenance is currently adequate. A large number of patients are treated on out-patient basis daily.

5.3 Clinics

For follow up and reviews. These are well organised according to routine time-table from Monday to Friday. Chemotherapy is also administered on out-patient basis.

5.4 Staff

Three trained Consultants
Three Junior doctors
No nurse with specialist training in Oncology nursing
One trained radiographer out of a total of 6.

5.5 Requirements

(a) More operational space for out-patient clinics with six doctors and an average of 80 out-patients (with relatives as escorts) the current clinic space is grossly inadequate. Patient privacy and confidentiality is non-existent when being reviewed by the medical staff. This is in reference to the waiting area and examination cubicles.

(b) More bed capacity is required so as to treat more patients and reduce the treatment waiting list from two months to at least two weeks.

(c) Training: There are currently only three trained doctors in Radiotherapy. Two are due for training in the year 2000. There are no trained Oncology nurses. They also require more trained radiographers for all the shifts. At the moment they currently have only one trained Radiographer out of a staff of six. The radiophysicists require in-service training updates.

(d) Drug shortgages
A hospital policy is required on acquisition of cytotoxic drugs as some of them are very costly.

(e) Comprehensive patient management structures should be encouraged with interaction between all the interested teams, that is, surgeons, oncologists, physicians, pharmacy and counsellors. This would be very beneficial to both staff and the patient using the multi-disciplinary approach. Eventually this working structure could evolve into a comprehensive Oncology centre or Unit that could have some measure of autonomy.

(f) Decentralisation of Oncology services.

Decentralisation of services to regional hospitals should be lobbied for to reduce the patient load at Kenyatta National Hospital and make compliance with follow up easier for the patient. The Ministry of Health should consider this proposition.

5.6 Dr. Gesami explained the financial constraints the Ministry of Health was undergoing. Kenyatta National Hospital had the autonomy to run its own services while the Ministry had to cater for health services countrywide. It was the mandate of the Ministry to furnish resources to establish more cancer treatment centres and manpower development. The Ministry does not have any personnel trained in Oncological services to start other centres.

5.7 Oncology was in competition with other specialties in medicine and it has been left to each specialty to lobby for its resources for expansion and service provision. The Head of Radiotherapy Unit should lobby the Kenyatta National Hospital administration to be allocated more space.

6.0 Since the Ministry of Health does not forsee itself establishing other cancer treatment centres soon, KECANSA should strongly follow up and lobby the Ministry and WHO office to resume the proceedings initiated in 1993 towards establishing a National Cancer Control Programme. He will do his best to assist this issue move forward. The minutes or a notice of the proceedings of this fact finding mission should be forwarded to Dr. Chatora at the WHO office.

6.1 Dr. O.W. Mwanda mentioned that certain sections of Kenyatta National Hospital fit the purposes of its role as a National Hospital as seen with the medical and surgical services provided. Patients should however not be referred to Kenyatta National Hospital for mastectomy which can be done by surgeons in District and Provincial Hospitals.

6.2 There is no guideline or policy on the extent of Oncological services Kenyatta National Hospital should provide. The Ministry of Health should share in the management of patients if they present at KNH on *ad hoc* basis for preliminary sergery, blood transfusion or staging.

6.3 For the way forward in improving Oncology services in this country, the MOH should take the issue of staff development seriously. The University of Nairobi College of Health Sciences and MTC do not have any departments teaching Oncology as a discipline. The MOH should seek to have the subject included in the syllabi, especially at the basic and undergraduate level. KNH at the moment is developing its own staff for a Cancer Management Centre.

7.0 Dr. H.O. Abwao proposed that since there is no known policy on cancer management, the working group on the National Cancer Control Group should be reactivated. Resources in Oncology are limited. Most of the surgical referrals coming to KNH should be managed at Provincial Hospital level which are now staffed by surgical and gynaecological specialists. This will allow more resources at KNH to be directed where there is most need.

7.1 Dr. Gesami mentioned that KNH has the autonomy to allocate its resources as it deems fit. The M.O.H should deal with issues on service provision policies.

7.2 Dr. K. Muhombe talked about the current National Development Plan for Kenya Year 1999-2002 which is now available. In the Health Policy component, the only mention cancer has received is as one of the other causes of death, after the five main causes (Infectious Diseases). Why is there this limitation?

7.3 Dr. Gesami advised the group that for cancer to be considered a serious issue, all interested parties such as KECANSA and Oncologists should lobby and involve the various other Ministries and groups involved in decision making and Policy Planning. More trasparency and goodwill and less bureaucracy is required from the M.O.H in planning. Accurate definition of interests is required when giving information for inclusion of policy. This is best achieved through "Working Groups" rather than individual parties.

8.0 Dr. Mwanda stated that though most governments or Ministries of Health do not like comparison, we should establish an autonomous institution dealing with cancer similar to the Uganda Cancer Institute with the blessings of the M.O.H.

8.1 Composition of staff in the Oncology units at KNH:

Nurses	100% KNH staff
Doctors	50% KNH staff
Support services	40% KNH staff
Ward 45	40% KNH staff. It is independent to the tune of 60% of its services and is able to lobby for resources from "Friends of Ward 45".

8.2 Mr. B. Mutava stated that a cancer policy structure in place has priority over service delivery, training and expansion of facilities.

8.3 Dr. J. Gesami stressed the revival of the Working group on the National Cancer Control Programme (Policy). The M.O.H jointly with KECANSA should form a working group whose members will be drawn from all medical specialists and other interested groups.

9.0 Sr. J. Nzinzi expressed concern over the quality of some of the medical care and supportive care given to cancer patients referred from district and Provincial General Hospitals, such as, patients requiring blood transfusion due to anemia prior to commencing definitive treatment, such as, Radiotherapy. Health professionals also need to be educated on general cancer management to fulfil their roles adequately.

9.1 Dr. J. Gesami informed the group that the laxity in patient management occurs due to three components:

(i) Doctors attitudes towards cancer patients.
(ii) The cost-sharing system and relevant poverty of patients making the required treatment unaffordable. Most patients will not go for the necessary treatment in time due to this.
(iii) Blood for transfusion is scarce since the onset of the AIDS epidemic. Suitable donors are

few so hospitals have to rely on patients relatives who generally are not compliant. This has caused problems with trasfusions countrywide.

9.2 IEC

Health professionals require re-education which can be achieved through the following:

(i) Curriculum in medical schools and M.T.C's .
(ii) More continuing Medical Education through the Kenya Medical Association and other professional societies and associations.
(iii) There is to be a Clause included in the Medical Practitioners and Dentist Act by the MD & PD where doctors will not be relicenced unless they have attended a particular number of CME sessions that include cancer issues.

10.0 Dr. O. W. Mwanda invited the group to visit ward 45 – Paediatric Oncology Unit and see how the Ward is run. It has a large degree of autonomy from KNH.

10.1 He also stated that current events have revealed a Policy is required on the handling of Radioactive materials for all categories of staff. There should be liaison with the Radiation Protection Board over this issue.

10.2 Dr. H.O. Abwao informed the group there was a Radiation Protection Board based in the MOH headquarters of which he is a member. It has guidelines on the handling of all Radioactive materials in Kenya. They should do more to acquaint health professionals with the rules.

11.0 Dr. J. Gesami expressed the need for controls and audits in Oncology i.e the management of cancer patients. The Medical and Dental Practitioners Board exists to regulate doctors. The Act should be reviewed to see if it covers Oncology Practice adequately.

12.0 Mrs. Githenji expressed appreciation for the manner in which health workers expressed their concern for provision of services through a multi-disciplinary approach. This could be an innovative way in which health professionals could audit their services and establish policy or guidelines on patient management.

12.1 Dr. J. Gesami expressed his appreciation for the concern and initiative taken by all those concerned with the care of Oncology patients. The M.O.H is receptive to ideas that could improve service delivery and will facilitate action where it can.

13.0 After visiting Ward 45, Dr. H.O. Abwao gave a vote of thanks to the MOH and personnel present and closed the meeting.

OTHER AVAILABLE SERVICES AT KNH

Therapeutic: various other medical and surgical specialties and super specialties.

Diagnostic: Xrays

Radiological Ultra Sonography
Mammography
CT Scan

Laboratory Services:

Chemical pathology
Immunology
Microbiology
Histo and Cytopathology
Parasitology
Blood Transfusion services

Other support services:

Physiotherapy
Occupational therapy
Counselling services
Pastoral Care
Hospice (Palliative) Care
Medical Social Workers

Services required but unavailable:

Rehabilitative services e.g. Breast or Limb prosthesis, Corrective Surgery.

Reach to Recovery groups for patient rehabilitation

Magnetic Resonance Imaging (MRI)

Nuclear Medicine Dept with a Gamma Camera

Computerized linkage between Raidotherapy Unit treatment Planning and diagnostic Imaging devices.

SUMMARY OF FINDINGS

1. Prevention and early detection service need to be initiated and augmented at primary Health Care level. These must be of good quality.
2. Diagnositic and therapeutic services at KNH are of fair quality, especially for haematological childhood

and gynaecological malignancies.

3. Patient Support Services.

   Access to professional services and in-patient palliative care still needs to be improved.

4. Human Resources

   Most of the cancer patients in Kenya are looked after by non-cancer specialists. Specialist multi-disciplinary teams should bring together all categories of health care givers who could fill the gaps between the super specialists and secondary level.

   There is a dire need for increase in manpower resources for all cadres in Oncology.

5. Information

   There is a necessity for establishment of a Data base. KNH should resume its Pathology based hospital Cancer Registry. All hospitals with Pathologists should be encouraged to do the same. A Cancer Registry in the National Cancer Control Programme is mandatory. Standardised data collection should embrace Primary(Community) as well as secondary care.

6. The need to network between Primary health care levels, hospitals/institutions and the Ministry of Health. Role of M.O.H should be in Policy formulation. Oncology must be given the right priority.

7. The need for a comprehensive high quality Oncology unit. This should be a model for the ethic of multi-disciplinary teamwork that is able to integrate Primary and Secondary Care and provide appropriate rapid referral services.

8. The need for standardised guidelines, protocols and audit procedures for cancer management.

9. Research
   Development of local treatment protocols, collaboration with other researchers and pharmaceutical firms is more cost-effective when carried out in an established service delivery set up.

10. I.E.C for health professionals and the lay public screening, promotion and preventive activities, follow up and outreach services – all these can be carried out using multi-disciplinary teams.

11. The integrated approach will result in improvement and advancement of other support services e.g technological services like laboratory medicine and surgery.