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## Challenges for cancer care during COVID-19 pandemic in Kenya: Policy implications



Cancer accounts for roughly 7 percent of Kenyan mortality, making it the country's third leading cause of death [1]. Available statistics indicate that 70–80 percent of cancer cases in Kenya are first diagnosed only in later stages [2]. Despite its high prevalence and the care needed to treat late-stage cancer, Kenya has few facilities and qualified healthcare workers (HCWs) that are dedicated to cancer treatment. In periods of a pandemic like COVID-19, both patients and HCWs may be at an additional risk of contracting the disease if tailored measures and strategies are not implemented for continuity of services.

Studies conducted in China [3]; Italy [4], U.S.A., Canada, and Spain [5] and the United Kingdom [6] confirm a higher risk for contracting and dying from COVID-19 in vulnerable individuals particularly those with such underlying health issues as chronic respiratory, cardiovascular, diabetes; or active cancer. These findings indicate the urgent need to institute measures known to reduce the risk of contracting COVID-19 while ensuring that there is continuity of care for cancer patients.

In Kenya, the few cancer facilities are located in urban centers. Few Kenyan rural hospitals, where 72 % of the Kenyan population live, have no dedicated cancer facilities. Rural cancer patients are, therefore, obliged to travel to urban centers for treatment, which can be intermittent and delivered over an extensive period. Poverty, lack of transport, poor roads, packed cancer wards, and lack of a place to stay in the city all combine to deprive many very ill cancer patients timely and appropriate medical treatment [7]. Additionally, those that do get treated may have trouble with complex drug regimens. Side effects that lower their immunity make already ill cancer patients still more vulnerable to infections pathogens, and now, SARS-CoV-2.

Seeking to contain the spread of COVID -19, Kenya's Ministry of Health (MOH) enacted measures at the end of March 2020 to enforce social distancing. From April through July 2020, the government has imposed a strict curfew prohibiting Kenyans from leaving their houses from 7 P.M. to 5 A.M. in the first two months, and later from 9 P.M. to 4:00 A.M [8]. Additional measures include a ban on travel from all rural areas and county cities to the capital Nairobi, which contains the vast majority of cancer services. The government's one-size-fits-all COVID-19 containment strategy fails to factor in the special needs of citizens made vulnerable by compromised immunity who need continuous and intensive medical care. As a result, the country's few cancer facilities are open for only a few hours in a day; fewer patients are seen each day, and specialized cancer health care workers are even more scarce. Likewise, a total lockdown contains no provisions for patients who need to travel to care facilities and live away from home to continue their treatment.

In Kenya, COVID-19 has become a highly stigmatized disease. People have little information about what to do to protect themselves, and police regularly beat up citizens found outside during curfew. Local newspapers report those deceased are being buried hurriedly under cover of night, and those close to an infected person are stigmatized and

likely to be victimized. Moreover, cancer, like COVID-19, is highly stigmatized. Along with the fear that they will catch COVID-19 on the way to a medical facility, in hospital, in their lodgings away from home, Kenya's cancer patients also have to fear ostracism in the communities where they live. As the growing number of COVID-19 cases swamps Kenya's already inadequate health care system, these attitudes, added to cancer patients' elevated risk for COVID infection, may cause the country's few oncology nurses to fear to treat their patients.

Oncology specialists are faced with questions around how best to take care of cancer patients, ensuring they get timely antitumor treatment as well as alleviating side effects and other distressing symptoms while preventing exposure to COVID – 19. The Kenya government in the interim guidelines developed by the Ministry of Health (MOH) recommend postponement of elective surgeries where COVID-19 demands on personnel and supplies strain service provision. The directive also gave vague guidance on the treatment of gynecological cancers and the interim guidelines developed by the Ministry of Health (MOH) does not advise on the management of cancer patients [9]. In contrast to the government guidelines, the Kenya Society of Hematology and Oncology issued a position statement calling for the resumption of cancer surgery for both new and ongoing patients [10]. Lack of clear messages from the Ministry of Health has confused cancer providers prompting treatment centers to develop their guidelines. For instance, private hospitals in the cities have developed their protocols and initiated patients' teleconsultations, which primarily attend to the middle-class patient. The lack of guidelines has left impoverished patients at a heightened risk, particularly in patients currently receiving or recently having received chemo- or radiation therapy and those requiring bone marrow or cell transplants.

In this unprecedented pandemic, we must strategically approach cancer care to ensure that COVID-19 does not further exacerbate inequalities within the health system. Lack of nationally standardized guidelines for the treatment and management of cancer will fail cancer patients. Therefore, local context research on the status of cancer patients and mitigation strategies is urgently needed to reduce COVID-19 adverse outcomes and to inform policy. This crisis may also be the opportune time to integrate cancer care services as part of existing primary care services, particularly at the county level. Longterm, the Kenyan government needs to implement the National Cancer Control Strategy 2017–2022, which plans to decentralize services and improve cancer surveillance.

### Authors' contribution

DK conceptualized the manuscript. All authors wrote, reviewed and approved the final manuscript

<https://doi.org/10.1016/j.jcpc.2020.100247>

Received 18 June 2020; Received in revised form 14 July 2020; Accepted 23 July 2020

Available online 28 July 2020

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**Funding**

None.

**Transparency document**

The [Transparency document](#) associated with this article can be found in the online version.

**Declaration of Competing Interest**

No competing interest declared.

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