



# From Distance to Access

How a **"Wonder Pill"**  
Changed the Story  
of CML in Rural  
Tanzania

by Oliver Henke

When I began working at the Kilimanjaro Christian Medical Centre (KCMC) in Moshi, Tanzania, in 2016, I quickly learned a central reality of oncology in sub-Saharan Africa: most patients arrive too late.

Disease is advanced, treatment options are limited, and outcomes are often poor. In many cases, our role is not to cure, but to relieve suffering. This makes every exception deeply meaningful.

Chronic myeloid leukemia (CML) should be one of those exceptions. Globally, it has become a model disease transformed by tyrosine kinase inhibitors (TKIs) from a fatal condition into a chronic, manageable one. But at that time in northern Tanzania, this transformation had not yet reached our patients.

## When **Treatment** Exists, But Patients Cannot Reach It

We were able to diagnose CML with reasonable confidence. Many patients presented with massive splenomegaly and characteristic blood count abnormalities. *The clinical picture was often clear. What was missing was not knowledge, it was access.*

TKIs were not available in our hospital. Occasionally, they could be found in private pharmacies, but at a cost far beyond what most patients could afford. *We were diagnosing a disease, we knew how to treat it, but with no means to do so.*

Through a colleague in Berlin, I learned about The Max Foundation and its access programs, which provided imatinib free of charge to eligible patients. At that time, however, there was only one partnering institution in Tanzania: the Ocean Road Cancer Institute in Dar es Salaam.

For our patients, this meant traveling an entire day one way just to receive their medication. And this was not a one-time journey, but a monthly requirement. For many, even the cost of transportation was a barrier. Some patients made the journey once or twice, then stopped coming. Others never attempted it at all.

*Access existed, but it was out of reach for most patients, especially from rural areas.*

As more patients presented to our clinic, this situation

became increasingly difficult to accept. The idea that a simple oral therapy could transform their prognosis, yet remain out of reach due to geography and cost, was deeply frustrating.

## Bringing Treatment Closer to Patients

We decided to act.

After persistent communication and preparation, KCMC became a partnering site of The Max Foundation. We were the first such centre outside a capital city in Africa. This marked the beginning of a different approach—*bringing treatment closer to patients, rather than expecting patients to travel to treatment.*

At the same time, we worked to improve diagnostic capacity. With support, we established RT-PCR testing for BCR-ABL within our own laboratory, making both diagnosis and monitoring more affordable and locally available.

The impact was immediate. Today, more than 200 patients have been enrolled in the program at KCMC. Many are in deep molecular remission. For a disease that once carried a poor prognosis in this setting, this represents a fundamental shift.

What has changed most, however, is not only the clinical outcome. It is the nature of care. In a context, where many cancers remain incurable, CML has become something different. We see patients regularly over years. We follow their progress. The disease becomes part of a long-term relationship, rather than a short and often terminal encounter.

**For us - clinicians, this is powerful. It provides a sense of continuity and purpose that is often missing in oncology in low-resource settings.**

## From **Late** Diagnosis to **Earlier** Action

At the same time, significant challenges remain. One of the most striking is how late many patients are still present. We continue to see complications that should be avoidable, including permanent visual and hearing impairment caused by extreme and longstanding



Cytology Course for Primary Health Care Workers, left side: Mr Priscus Mapendo, Head of Laboratory Cancer Care Centre at KCMC

leukocytosis.

What is particularly frustrating is that many of these patients had already sought care earlier, often at primary healthcare facilities. The issue is not a lack of contact with the health system, but a gap in recognition and referral.

To address this, we launched the *Online Outreach Cancer Clinic* in 2025. The goal was to strengthen early detection at the primary care level using simple, low-cost tools. Healthcare workers were trained to prepare and interpret manual blood smears, and weekly online case discussions were established with specialists at KCMC.

*This approach does not rely on advanced technology. It builds on existing structures and focuses on practical skills. Since its introduction, we have already identified three patients with suspected CML in rural settings and initiated treatment within one to two weeks.*

This is a remarkable achievement. It demonstrates that timely diagnosis and treatment are possible even in resource-limited environments when systems are adapted to local realities.

Looking back, the story of CML in this setting is not only about a drug. It is about access, infrastructure, and persistence. Imatinib is often described as a “wonder drug,” and in many ways it is. But its true impact depends on the systems that deliver it to patients.

*What we have learned is that access is not fixed. It can be expanded beyond major cities. It can be adapted to local needs. And it can be improved through collaboration between clinicians, organizations, and communities.*

There is still much work to be done. Patients continue to present late, and infrastructure remains fragile. But the progress achieved over the past years shows what is possible.

