EDITORIAL

Practical Cancer Prevention - Where is it Going to Occur and Who is Going to be Responsible?

Increasingly the issues of the APJCP over the last two years have featured papers on cancer registration data for incidence and mortality and in this first issue of Volume 7 we have again some half dozen examples. Clearly we know a great deal about the burden. We also know that the socieconomic background is important in determining risk and that there is a need for greater emphasis on education about risk factors, for example regarding betel/tobacco use in Asia. In addition, our awareness of the potential for use of natural chemopreventive agents is growing. However, despite our gigantic body of information regarding risk and beneficial factors, practical cancer prevention as envisaged by ourselves four years ago (Tajima and Moore, 2002, see Figure 1) remains largely a dream.

The Union Internationale Contra Cancrum (UICC) is now stressing such practical aspects in its four strategic directions (Tajima and Moore, 2003) but for obvious reasons of geography and financial contraints has only scratched the surface here in the Asian Pacific. This is the rationale for present attempts to set up a UICC Asian office and for Kazuo Tajima to take on responsibilities as a Strategic Leader for cancer prevention in this region of the world. If this plan does come to fruition we need to consider how to best contribute to information transfer and other forms of intervention at the community level.

Conducting research in rural areas of Asian countries requires major efforts on the part of academics to build up rapport with local people and develop participatory approaches, as well exemplified by the paper by Senarucket al in this issue (2006). We have to be aware of the impact of various socioeconomic factors on the local populace, whether adolescents, young adults, the middle-aged or the elderly, but there is generally a relatively tight community spirit at the village level which facilitates two-way information transfer. There are also generally village halls or medical centres/stations which could be employed for this purpose and for interventions to improve diet or levels of physical activity. There is also very little movement of non-indigenous people into the communities although partial loss to big cities does occur, even if only for part of the year.

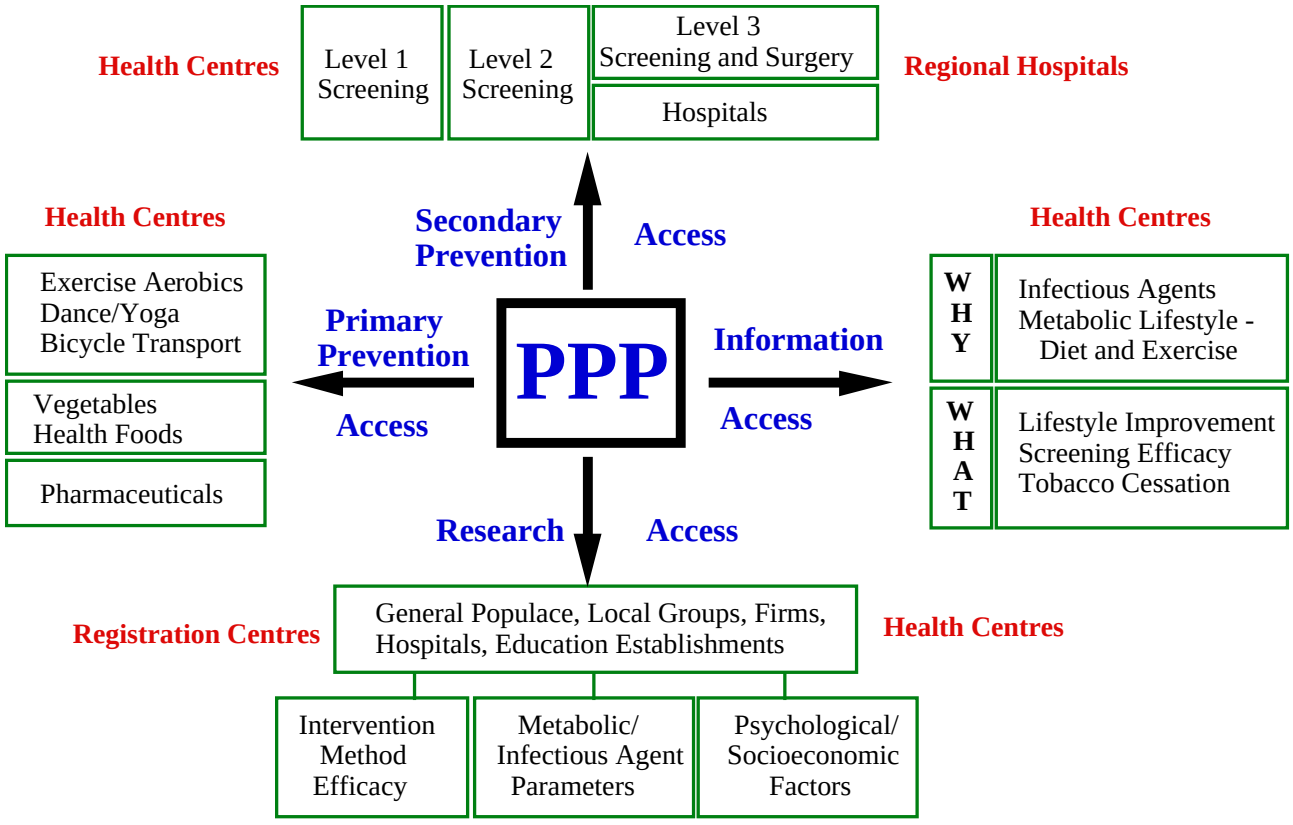

Figure 1. A Practical Prevention Program for Use at the Community Level in Health and Registration Centres

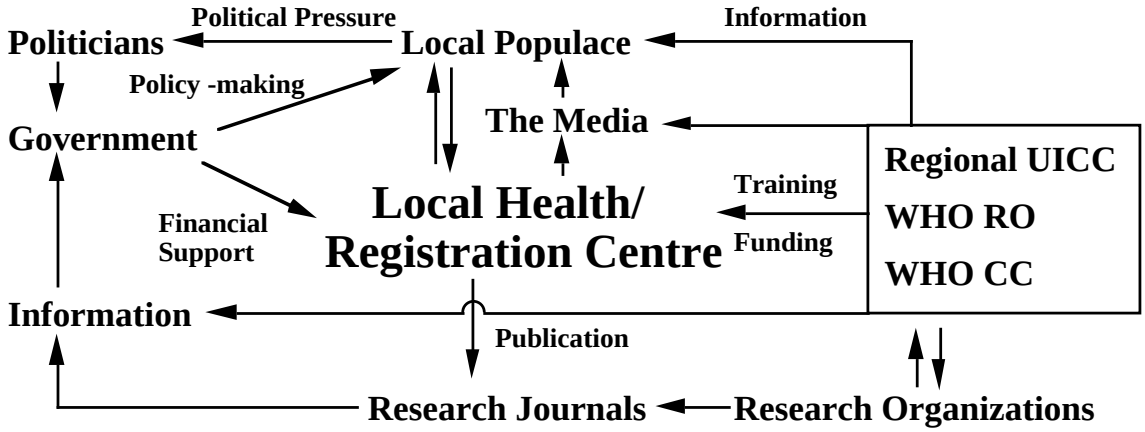

Figure 2. Actors in Facilitating Health/Registation Centre Ability to Conduct Practical Prevention Programs

In urban communities on the other hand, there is a great deal of movement in and out and the community cohesion is necessary lower, with far greater densities of population. However, there are facilities which could be used. At the community level there are schools which have sports halls where population-based aerobic exercise could be organized, along with opportunities for speakers to give talks on health issues. Clearly more could be achieved by the Universities and Colleges offering courses and seminars open to interested people in the local communities. Thus there are roles for academics in providing readily comprehensible information - perhaps more attention should be devoted to writing for the lay public rather than just trying to get published in the most prestigious journal with the highest impact factor. The impact that we are all ostensibly working towards is cancer prevention in the community.

The physician seeing patients on a daily basis can obviously make a strong contribution, particularly in efforts to persuade people to quit smoking (Hamajima et al., 2006). However, the real backbone for practical cancer prevention will be the community nurse and other paramedical staff. Whether working with adolescents (Kanato and Saranrittichai, 2006) or with middle-aged women (Senaruck et al., 2006), whether in a village hall, a health centre or a local school, the nurse fulfils social roles which are entirely consistent with preventive activity.

The question is therefore how we can best engineer support for this activity. Figure 2 illustrates one concrete scenario for interactions between organizations that we could work towards for Asia, and wherever else in the globe given like-minded colleagues.The central place allotted to the local health/disease registration centre is in line with the fact that a large proportion of scientific papers produced by epidemiologists in Asia are in fact by cancer registry staff. If appropriate training and financial support were provided through registration centres to nurses and other paramedical staff they would better be able to conduct practical prevention programs. We believe they, and all the other actors included in the figure, like a regional UICC and WHO regional offices (WHO RO) and collaborating centres (WHO CC) (as well as those others like the World Bank), acting together with the public and government can achieve a great deal in not only cancer but also all chronic disease prevention. The same measures that we have always been advocated for cancer prevention, like increased exercise, optimal nutrition, avoidance of tobacco and other risk factors, and informed self-choice for lifestyle and screening decisions with adequate information available are efficacious for all the non-communicable diseases. Whether they will be effectively applied depend on ourselves - or are we going to be holding the conversation recently portrayed by Ogilvie and Hamlet (2005) in a society incapable of making the right decisions.

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