EDITION 3

CONFERENCE NEWSLETTER

AORTIC 2007—6TH INTERNATIONAL CANCER CONFERENCE
CANCER IN AFRICA: CHALLENGES AND OPPORTUNITIES





National Cancer Control

IMPROVING PARTNERSHIPS, NETWORKING AND ADVOCACY

The formation of prioritised national cancer control programmes is essential in the fight against cancer in Africa. This was the conclusion of a panel that sought to address the challenges posed by government policies that do not accurately reflect the impact of cancer on the continent. Even more important than the lack of resources in understanding the burden of cancer in Africa, is the lack of education, particularly in impoverished rural areas. The regional disparities of awareness and treatment of the disease is huge. Dr Twalib Ngoma of Tanzania highlighted the cases of two patients in his country and their very different experiences of cancer care. The one, a woman living in a rural area, found a lump in her breast and went to her local clinic. No diagnosis was made and she was told to go home. A year later, still undiagnosed, and with the lump worsening, she was unable to access proper health care facilities and diagnosis due to lack of funds. She was eventually diagnosed, but at this point was at an advanced stage of breast cancer and died soon after. The other case, a lawyer in an urban region, received an appointment on the same day and after diagnosis opted to travel to London where she received radiotherapy and chemotherapy and is still alive today. These cases serve to illustrate the importance of national cancer programmes that highlight education and awareness for the benefit of all.

Non-existing, or badly organised cancer registries and fragmented and under-financed national health care systems mean that African countries struggle under the burden of diseases that can be effectively prevented, treated and cured. Not only struggling with cancers caused by infections, Africa is also becoming increasingly influenced by globalisation and the consequent effects of the marketing strategies of alcohol and tobacco companies. The increased targeting of developing economies by tobacco and alcohol companies means increased risks with regard to tobacco and alcohol related cancers. Tobacco related cancers are a growing epidemic in the developing world and one that can only be effectively controlled by getting young people to stop using tobacco in any form. Dr Carl Albrecht spoke energetically, advocating the using of tax excised from tobacco companies in funding cancer initiatives in Africa. Although other countries in the world have successfully tapped tobacco tax for use in health-care, Africa has yet to see even one country do the same.

Palliative care is another area where the foundation of an effective NCCP is essential to ensure that all involved parties are properly co-ordinated and are aware of each other's need rather than competing for funds. Dr Anne Merriman of Hospice Uganda, spoke about the importance of palliative care and the need for implementation from the moment of diagnosis. Africans in advanced stages of chronic illness prefer to die at home, both because of financial constraints and cultural and spiritual reasons. Merriman spoke of her work in Uganda to effectively deliver morphine to patients to alleviate suffering and 'life to days" and not merely "days to life".

Partnership, networking and advocacy emerged as the key principles by which national cancer control programmes could successfully emerge with implementation focused on realistic and achievable goals which will bring results to those experiencing the very real suffering caused by these diseases.

By Charles Human

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Healthy eating:

A HUGE PORTION OF THE FIGHT AGAINST CANCER

Friday morning's discussion of *Nutrition and Cancer* saw speakers highlight forms of nutrition related cancer control such as maize meal and herbal teas. The connection between diet and cancer control is a hot topic in the medical field. Many vehemently advocate the benefits of foods with 'pro-drug' or 'anti-carcinogenic' properties whilst others deny that there is concrete evidence for such findings.

In her presentation entitled *Nutrition and Breast Cancer: A focus on Body Mass Index,* Dr Lucile Adams-Campbell strongly emphasised idea of the importance of a healthy diet as a means of preventing cancer. Adams-Campbell reported that "30 percent of all cancers can be explained by nutrition" and that the concept of energy balance was an important one in terms of cancer prevention. Her presentation stressed the vital role that leading a healthy lifestyle can play. "How you start and lead your life is important," Adams-Campbell said of preventative cancer measures, "it is important to develop continuity in terms of eating habits." She highlighted healthy natural foods, such as fruit and vegetables, as an important alternative to unhealthy processed foods which could possibly lead to an increased cancer risk. "Diets rich in fruits and vegetables are protective of breast cancer risk," Adams-Campbell reiterated.

However Dr Carl Albrecht (pictured above) contended these ideas: stating that the idea that low-fat foods can reduce the risk of cancer is questionable. In his presentation, *Prevention of Colon Cancer by Maize Meal Staple Diet: an Hypothesis*, he urged the audience not to rest on their laurels but rather to question the data presented to them. He continued by posing the question of whether there are in fact molecules present in food with the ability to increase our risk of cancer and conversely whether molecules exist in food which decrease our risk in cancer. According to Albrecht, DNA is the fundamental component in cancer with the environment merely "putting the cherry on top." According his findings, "the long-term eating of maize meal as a staple diet can prevent colon cancer." This is due to maize meal's low GI qualities and its ability to be less completely absorbed in the gut. Albrecht concluded that this resistance to digestion could make maize meal a natural cancer preventing 'pro-drug.'

Speakers suggested that despite the significant evidence to support the findings presented in the session there still existed a lack of significant acknowledgement of the data. "It is not clear what further evidence is required before this concept can be translated into a cancer prevention strategy," said Albrecht, "to counter the urbanisation-induced choice of white bread, rice, pasta, and processed cereals."

By Crystal Espin

The way forward for Cancer Advocacy in Africa

Breast Cancer advocacy has emerged as a powerful and well-organised force from which other groups can learn. "It is not business, it is not government, it is the social sector that may yet save society." Using this quote from Peter Drucker, American Cancer Society's Anne McMikel spoke about the importance of civil society in winning the fight against cancer.

But what are the essential components of successful advocacy? A relationship with the media is essential. Not only do the media play a watchdog role and help to keep governments and corporations in check, but also are the primary way in which information is disseminated in a society. The AORTIC conference, focusing on research, treatment and policy, had no science communication component. This is something that should be looked at in future. A journalist commented that doctors, the scientific community and NGOs had to meet the media halfway by learning to communicate in ways that accessible to the public at large. The public may not understand complex medical terms but they can certainly understand and empathise with stories of suffering and triumph. Putting a human face on the disease is thus essential.

Linda Greef presented on the importance of advocacy development in the context of cancer care in South Africa. Rather than see advocates of other diseases as competitors for funding it is essential that partnership and knowledge sharing be considered. The good work done by breast cancer advocacy was reviewed and delegates were encouraged to learn from their lessons, challenges and successes. Breast cancer advocacy has achieved the level of worldwide awareness it currently has through the tenacity and courage of advocacy groups and by simply "not allowing anyone not to hear them". There is no reason why cervical cancer or stomach cancer advocates cannot do the same.

Engaging civil society and the public sphere in debate is essential in making group decisions that will ultimately benefit us all. It is important to realise that it is not only doctors who will win the fight against cancer: it is everybody who is willing to engage in debateabout issues which affect them. The telling of stories public figures, politicians and even celebrities who have had personal experiences with cancer will help people to empathise with the humanity of cancer patients, something that statistics and pie-charts will never do.

By Charles Human

Multidisciplinary approaches:

STILL OUT OF REACH FOR AFRICAN CANCER CARE

Innovative methods are needed to make a multidisciplinary approach viable for African healthcare. This was the consensus of the panel discussion which played to a near-empty room yesterday morning. Yet while nobody disputed the merits of a multidisciplinary approach, there were several different theories on the best way of tackling it.

The three chairs, Dr Chirenje (Harare), Dr Kiel (Chicago) and Dr Holland (New York), each offered their own perspective. Dr Chirenje, working mainly in cervical cancer, pointed out that the healthcare situation in Zimbabwe does allow some degree of multidisciplinary approach, in that he partners with a counsellor. Counselling skills were vital, he said, because about 80 percent of rural woman screened have inoperable cervical cancer, and patients need counselling to cope with the diagnosis. However, he also stressed that in such resource-poor settings, a comprehensive multidisciplinary team is not feasible.

Dr Kiel offered an excellent model for an efficient multidisciplinary taskforce in cancer care, while conceding that such a model was out-of-reach for the developing-world.

Because late diagnosis is one major logistic challenge to cancer treatment in Africa, Dr Holland proposed a community volunteer scheme. He premised that most preventable cancers present their symptoms at surface level. Therefore, doctors can train senior women (such as midwives or local community leaders) to "seek the limits of normality" in their own community. It would be the job of these women to perform the majority of the screenings and diagnoses in areas the health workers cannot reach, and to refer patients to the nearest centre. "CT scans, mammograms -- they're out of the question," Holland said. "But we can do this."

He also stressed the need for training in the emotional and psychological fear of cancer, wherein community and family members could play a key role where under-staffed medical workers are not always able to. Dr Holland's suggestion stimulated both interest and debate among his African counterparts about its potential merits and pitfalls. Several doctors who work in resource-poor settings treated it as an innovative approach to the need for multidisciplinary teams in cancer care. Whether or not it would work remains to be seen.

By Murray Hunter

African Cancer Registries: more than a body-count

"There is no substitute for fact". These words from Dr. Donald Parkin encapsulated the sentiments of delegates involved in cancer registries throughout Africa and the world. This highlighted the importance of local African cancer registries in obtaining accurate and timely data for use in planning cancer programmes, rather than relying on statistical estimates and extrapolations from outside sources.

Problems facing Africa cancer registries are many and varied. Often they operate in a limbo state, and are never fully integrated into a national ministry of health. Funding is thus a huge problem. Joe Harford noticed that governments were eager to receive results from registries but were consistently unwilling to fund cancer registry projects. Contrary to presumptions that ad hoc cancer registries were desirable, Harford urged delegates to carefully consider the sustainability of a national cancer registry before attempting to start one. "A cancer registry has a beginning, but it never has an end", he said, referring to the fact that registration is an ongoing process. "Starting something without knowing how much it costs or how to fund it, is the definition of foolishness." Hard data is essential for the conducting of effective evidence-based medicine, unfortunately in countries where governments have to deal with numerous medical, social and political problems, data collection and research is often sidelined.

Furthermore, as has been emphasised throughout the conference, some patients may never enter into the health system and hence never be diagnosed. This is particularly true in rural areas and something which creates a problem for accurate data gathering.

It is important that a culture of accurate record taking is encouraged in hospitals and clinics. Nods and smiles of recognition greeted a delegate who described being given a biopsy report which contained neither the age nor sex of the patient. Inadequate filing of reports, lack of disease indexes and comprehensive mortality registration are massive stumbling blocks in African medicine. Information systems such computerised hospital records are highly desirable in creating an institutional knowledge culture that can be used to benefit the population at large.

These problems, however, are not insurmountable. Several speakers were able to give impressive information of the work of cancer registries in their own countries. Delegates from Algeria, Libya, Nigeria, Malawi, Mauritius and Egypt were able to use to session to compare and contrast their findings. This is important because comparisons of the data of registries can lead to important studies based on similarities and differences and regional fluctuation of the incidence of various cancers.

By Charles Human

CONFERENCE NEWSLETTER

THANK YOU TO OUR SPONSERS:

HPV VACCINATION AND CERVICAL CANCER:

What you need to know

What is the Human Papillomavirus (HPV)?

HPV is a widespread DNA-based virus that affects the skin and mucous membranes. There are over 120 different types of HPV, and they are numbered according to the order in which they were discovered. The most common infecting the genital tract are 6, 11, 16, and 18. The former two are associated with anal and genital warts, and are considered 'low-risk' because they are not associated with cancer. The latter two types are oncogenic (oncogenesis is the process of malignant tumour growth), considered 'high-risk' and along with 13 other types, are associated with almost 100% of cases of cervical cancer worldwide. Types 16 and 18 alone, however, account for approximately 70% of all cases of cervical cancer.

It is the persistence of infection by oncogenic HPV that causes cervical cancer. The virus is spread through sexual contact, and both men and women can be infected with HPV throughout their lives without presenting with symptoms. This is because the immune system is capable of fighting off infections without carriers ever knowing that they have contracted a virus. Repeated infection with one or more types of HPV, however, can lead to the onset both of precancerous lesions, and ultimately, cervical cancer. The most effective way for women to prevent this is to go for regular pap smears – screenings which detect pre-cancerous cell abnormalities in the cervix.

HPV Vaccine – how does it work?

At the 9th international conference of the African Organisation for Research and Training in Cancer (AORTIC), the pharmaceutical company GlaxoSmithKline (GSK) presented data on a bivalent HPV vaccine – currently under development - a drug which immunises against HPV types 16 and 18, which are the cause of around 70% of cervical cancer cases. The launch of an HPV vaccine would be a landmark development in cancer research since this is only the second time that a cancer-controlling vaccine has ever been synthesised. The Hepatitis B (HBV) vaccine was the first ever to be developed for the prevention of cancer, and immunises against HBV-related cancer of the liver.

Because HPV is spread by skin-to-skin and genital-to-skin contact, everybody is at risk of contracting the virus from their very first sexual encounter. This means that, in order to ensure the efficacy of any HPV immunisation drive, the vaccine must be targeted to adolescent girls between the ages of 9 and 15 years, who have yet to make their sexual debut. This fact has caused no small amount of controversy amongst parental groups in countries such as the United States, where fears proliferate that the vaccination could be interpreted as a green light for their pre-adolescent daughters to start having sex.

Despite the concerns raised by this disturbance, the British National Health Service (NHS) has committed itself to an HPV immunisation drive aimed at girls aged 12 to 13 years, which it will begin rolling out in Autumn 2009 at a cost to the health service of up to £100 million per year.

'Cervical cancer is a disease of inequity.'

Every 10 minutes a woman in Sub-Saharan Africa dies of cervical cancer. While the government and the public health service in the UK have both the financial means and the political will to launch a comprehensive HPV immunisation drive, and attempt to lighten the burden of the disease on British girls and women, the countries of the developing world (particularly those in Africa) have a long way to go before they can gather together the funds and establish the infrastructure necessary to mount similar immunisation drives. If, however, pharmaceutical companies such as GlaxoSmithKline agree to sell the vaccine on to countries of the developing world by employing a tiered system of pricing according to the income-levels of each country, as has been mooted, then relief from the burden of cancer deaths might yet come to Africa sooner than we think.

By Lindiwe Mazibuko

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