Attachment #5

Canadian Strategy for Cancer Control

The Revised Strategic Plan of the Primary Prevention Action Group of the Canadian Strategy for Cancer Control 2006-2010

November 17, 2006

CANADIAN STRATEGY FOR CANCER CONTROL
Primary Prevention Action Group (PP-AG)

Revised Strategic Plan (2006-2010)

A. MANDATE of PP-AG

- Reduce the incidence of preventable cancers in Canada, and ultimately reduce morbidity and mortality from this disease.
- Play a leadership role in promoting major change in the cancer control and health care paradigms, whereby primary prevention/health promotion obtains the appropriate increased priority and resource allocation, and this increase is sustained in the future.

B. BACKGROUND

1. What is Primary Prevention of Cancer?

The primary prevention of cancer means removing the exposure or risk factors that give rise to cancer or improving the ability of the body to resist cancer. This includes activities designed to eliminate/reduce environmental, occupational, and lifestyle causes of cancer (such as environmental or occupational exposure to classified carcinogens and smoking) and actions to strengthen resistance against cancer (such as improved nutrition).

Cancer primary prevention is directed to individual behaviour change, implementation of health-promoting public policy, and mobilization of communities so as to create environments where healthy choices become easier choices.

The underlying social determinants of health also need to be addressed, emphasizing the importance of considering areas beyond the traditional health sector. (Note that our action group is focused on primary prevention. Another CSCC action group is addressing screening – the testing and early detection of disease among apparently healthy individuals in the population).

2. Why is Primary Prevention a Priority in the CSCC?

- **Cancer is growing** – In 2006, some 153,100 Canadians will be diagnosed with cancer, and about 70,400 will die as a result of the disease. Two in five of us will be diagnosed with cancer at some point in our lives. One in two diagnosed will die of cancer, making it the most dreaded disease in the country. While cancer *rates* are not changing dramatically from year to year, the *number* of people being diagnosed and dying from cancer continues to rise inexorably, due in part to an increasing population, but mostly due to an aging population. If current rates continue, over the next 30 years more than 2.4 million Canadians will be diagnosed with cancer, and some 872,000 will die. *Direct* costs to the health care system will exceed $175 billion.

  Cancer is currently the largest cause of PYLL (potential years of life lost), and, by 2010, will be the greatest cause of deaths in the country (overtaking heart disease). In 1997, cancer was responsible for more Canadian deaths than strokes, chronic obstructive pulmonary disease, respiratory disease, pneumonia, diabetes, suicides, unintentional injuries, liver disease and HIV/AIDS *combined*.

- **At least 50% of cancer is due to preventable factors** – It comes as a surprise to many people to learn that only about 10 percent of cancers are due to heredity. Behaviours such as smoking, poor diet, inactivity, and obesity have the greatest bearing – not only on cancer – but on a number of other 'chronic' diseases. Other risk factors/behaviours are cancer-specific, including sun/UV exposure and occupational and environmental exposure to carcinogens. The recent development of a vaccine to prevent HPV (and in turn, prevent cervical cancer) opens up further opportunities for prevention. As noted in *The Strategic Framework for the CSCC* (2005), "primary prevention has the potential to have the greatest beneficial impact on the burden of cancer in Canada."

- **Cancer primary prevention has not had the priority it deserves** – Provincial cancer agencies have focused on diagnosis and treatment, with primary prevention typically receiving only approximately 1% in budget allocations. The Canadian Cancer Society has been assuming a heightened role in this area, but there are limits to what can be expected of NGOs and donor dollars. The concept that primary prevention is a wise investment, rather than an incremental expense, has been slow to take hold. The CSCC, however, has demonstrated its commitment to this area by allocating some 16% of its budget (more than $41 million) to prevention efforts over five years.

3. How do we need to approach primary prevention?

- **Primary prevention of cancer cannot happen in isolation** – No one cancer organization can address the full scope of primary prevention needs, and cancer primary prevention cannot be done in isolation. Both a common risk factor approach (addressing smoking, poor diet, inactivity, and obesity) and a cancer-specific approach (addressing UV, occupational and environmental exposure and certain infectious agents) are necessary.

- **Partnerships are key** – Partnerships increase both the opportunity for collaboration between different stakeholders in the world of prevention and health promotion, and the possibility of focusing limited resources to achieve the greatest benefit. The fact that a remarkably short list of major risk factors relates to an array of serious chronic diseases multiplies the potential for such initiatives.

- **There is no 'magic bullet'** – A focus on one risk factor, and one intervention will not do the job required. Change agency at both individual and population levels are needed on multiple fronts. Most risk factors do not exist in isolation in an individual; further, each risk tends to have a significant *independent* effect on mortality and morbidity. Thus to make the most population health gains, sometimes the factors need to be addressed in combination. The synergistic benefits of reducing multiple risk factors are potentially enormous. As well, a combination of effective approaches is needed to address each risk factor.

- **We need to enhance the evidence base in primary prevention** – A basic principle of the CSCC is that we continue to build a platform of knowledge in cancer control, such that evidence/best practices will inform policy and practice. There is a need for improved surveillance, program evaluation, data collection and analysis to identify and disseminate existing and emerging information.

- **But cancer can't wait for full evidence** – While we have a responsibility to be evidence-based, we also need to act before all the evidence is in. For example, lessons learned in tobacco control should be adaptable to other risk factors. Also, the CSCC has approved the precautionary principle – whenever reliable scientific evidence is available that a substance may have an adverse impact on human health and the environment, but there is still scientific uncertainty about the precise nature or magnitude of the potential effect, decision-making must be based on precaution.

- **The importance of "early primary" or exposure prevention** – Exposure prevention involves the adoption of strategies to enable people to avoid getting risk factors in the first place. It is seen to be superior to later forms of prevention because it is often easier, for example, to never gain a kilogram of weight than it is to lose that same kilogram after it has been gained. This example underscores the clear strategic value of targeting prevention efforts early in life, before risk factors develop.

- **Small changes can make a big difference** – Generally speaking, our focus is on "shifting the curve" – helping large numbers of people make relatively small changes that eventually have a significant impact at the population health level.

- **Primary prevention should not be positioned to 'blame the victim"** – Focusing on lifestyle "choices" alone demonstrates a lack of understanding of the social determinants of health. Healthy choices are not easy choices for all groups of people. We must strive to create environments where more people make such choices. Ultimately, the personal and the environmental perspective on health change must be seen as complementary 'dancing partners' rather than forces that are ideologically opposed.

- **Health inequities must be addressed** – Traditionally, public health/prevention programs have assisted those who are *already* quite healthy to remain so, or even to increase their wellness. Hence, health inequities between the advantaged and the disadvantaged can inadvertently be exacerbated by universal programs, underlining the importance of targeting specific populations. Thus, the CSCC has recognized the need to develop a distinct approach for First Nations/Aboriginal/Inuit people. Other groups will also require special attention.

- **A long-term perspective is essential** – A sustained campaign is crucial. The war on tobacco has made substantial gains in developed nations, but it took a concerted effort over a 40-year period. The famous North Karelia project in Finland saw dietary changes and reduced cardiovascular disease after a 30-year program. A general societal attitude shift often needs to precede individual behavioural improvements; such shifts usually take a great deal of time and effort.

C. ACCOMPLISHMENTS TO DATE

Despite a modest amount of funding to date, the PP-AG has worked hard since 2003 and seen a number of accomplishments. These accomplishments are outlined below.

1. Risk Factors or Conditions Common to a number of "Chronic" Diseases

These risk factors include smoking, poor diet, inactivity and overweight/obesity.

PP-AG has accomplished the following:

- **Two surveys of provincial cancer agencies and divisions of the Canadian Cancer Society.** These surveys provided an environmental scan, offered ideas for further development, and implicitly advanced the primary prevention agenda in both organizations in a complementary manner.

- **A national symposium on cancer prevention.** This served to clarify issues regarding the primary prevention of cancer and its relationship with chronic diseases, and was the launch for formalizing the PP-AG.

- **A pilot project on cancer primary prevention.** The BC Cancer Agency and the BC/Yukon Division of the Canadian Cancer Society developed a report on the effectiveness of risk factor interventions and combined this with an economic analysis, culminating in recommendations for a province-wide program aimed at reducing risk factors and preventing chronic disease. The BC government has embraced this "Winning Legacy" and some $25 million has been granted to the BC Healthy Living Alliance to begin the implementation of these recommendations.

- **Family Physician Chronic Disease Prevention Survey.** This survey has been distributed to 4500 physicians throughout the country. The purpose of the survey is to identify

  a) what primary prevention practices family care physicians are involved in,

  b) what kinds of information they need or would be helpful to have when counselling patients about prevention, and

  c) what their perceived role in cancer prevention is.

- **A Synthesis Paper on national and international nutrition strategies and initiatives and the Strategic Framework for a pan-Canadian nutrition strategy.** With support from the PP-AG, in 2004 an inter-sectoral Nutrition Planning Group (NPG) was struck to oversee the development of a comprehensive evidence-based nutrition framework for policies and programs at the national, provincial and local levels. The report will assist those already active, and those who can potentially be active, for further areas of collaboration, coordination and new developmental efforts within Canada. The framework and report were validated at a follow-up meeting held in March 2005 with the same nutrition stakeholders who participated in the initial planning meeting. Next steps for the NPG include developing a mobilization plan for national action on nutrition and chronic disease prevention in Canada.

- **Linkages with the prevention research community and with CDPAC.** Membership on PP-AG from these constituencies facilitated communication and coordination.

2. Sun Exposure

This cancer specific risk factor was one of the "incubated" areas in PP-AG.

There have been two specific deliverables in this area under the oversight of the National Sun Safety Committee of the PP-AG:

i. **A report on strategic directions for the primary prevention of skin cancer in Canada.** Building on a comparable report from Australia, the NSSC has identified the following four strategic directions for the primary prevention of skin cancer in Canada:

   a. Improving knowledge, attitudes and behaviours of individuals about skin cancer and ultraviolet (UV) protection;

   b. Achieving healthy settings, organizations, products, policies and practices that promote sun protection;

   c. Strengthening the community's capacity for effective action on skin cancer prevention; and

   d. Strengthening informed decision making to the design, implementation and evaluation of skin prevention cancer strategies.

   The directions, along with the specific objectives and recommended strategies identified for each in the report, have been reviewed by 32 national and international skin cancer control stakeholders (governments, non-governmental organizations,

public health, dermatologists, etc.) at all levels (national, provincial/territorial, regional and local) and by the members of the NSSC.

ii. **Second National Sun Survey.** Funds to conduct a sun behaviour, knowledge, attitude and beliefs survey were secured from NCIC and Ontario Division of the Canadian Cancer Society, with a top-up from the Canadian Strategy for Cancer Control. This survey will permit comparison with a previous survey conducted in 1996, and provide improved information for planning and evaluation of cancer control strategies. Some 2000 adults (aged 16+) across Canada will be interviewed by telephone, using selected questions from the 1996 survey to permit direct comparison. An additional 6,700 adults will be selected according to region of residence (4 provinces and 2 groups of provinces), and with sufficient sample size for each region. These adults will be interviewed using a more detailed questionnaire, which includes questions about 1 randomly selected child aged 1-12 in households with children (about 1500 children expected). The survey is being conducted during the summer of 2006 with a report by 2008.

3. Environmental/Occupational Exposure to Carcinogens

Another cancer-specific risk factor, this too was incubated by PP-AG.

With increasing public and media interest in this area, the following was accomplished under the oversight of the National Committee on Environmental and Occupational Exposures (NCEOE):

i. **A report entitled, "Prevention of Occupational and Environmental Cancers in Canada: A Best practices Review".** An extensive internet review and consultation with experts in Canada, the United States and Europe identified the current status and opportunities for improvement in this country regarding:

- Pollution prevention programs
- Public policy (including legislation and regulation)
- Surveillance
- Stakeholder actions

Based on this review a number of priority recommendations were made, targeted towards government, industry, labour and NGOs.

As a result of the development of the "Best Practices" Report, various provinces are taking action on prevention of environmental and occupational carcinogens. For example, the BC Cancer Agency and BC/Yukon Division of the Canadian Cancer Society have identified occupational and environmental carcinogens an