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## Editorial

# The 3<sup>rd</sup> International Cancer Control Congress: international collaboration in an era of cancer as a global concern

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In 2002, there were 10.9 million new cancer cases in the world; 6.7 million deaths were due to cancer<sup>1</sup>. Cancer incidence (new cases) rises each year due to population growth and aging. Overall, five year survival rates vary from less than 15% to greater than 60% across nations<sup>2</sup>. Although improvements in mortality from cancer are taking place, they do not offset the increase in incidence. Hence, each year, more people will develop cancer, more will die of cancer, and more will be survivors of cancer – the burden (personnel, community and socio-economic) will continue, inexorably, to increase. If the cancer issue is to be addressed, the interventions must be directed at the process of cancer, not solely to the disease. Thus, cancer control must address incidence through primordial and primary prevention, detection of curable, asymptomatic, early stage disease, effective treatment programs for established disease, and palliative, supportive and end-of-life care to meet the needs of those cured and those whose death requires dignity, symptom control and compassion. To be effective, cancer control plans must be directed to the entire population (the healthy, high-risk, ill, cured and dying), recognizing that disparities of access, circumstances, gender, ethnicity and social well-being exist in all populations.

Population-based cancer control plans require a vision of what is to be achieved, principles that will characterize the intents and expectations, and a process for adapting plans to align with the contextual realities of the nation/country from cultural, political and resource perspectives. Consideration must be given to the extent that cancer control plans are specific to cancer, or whether they are integrated into strategies that address many non-communicable diseases [NCDs], given the common risk factors across NCDs and the overlap of principles underlying disease control plans. Finally, all plans must consider the content, the implementation process, the 'stakeholders' (government, non-government organizations [NGOs], foundations, professionals, patients, public and the private sector) and their roles and relationships, and the timeframe over which plans will be enacted. To control the process of NCDs, including cancer, requires collaboration, relationships and 'partnerships' – it cannot be achieved solely by discrete organizations, institutions, or disciplines. Given the diversity and disparity across populations and the rising cancer/NCD burden that will face all, common purpose, collaboration, knowledge transfer and rational action must characterize the way forward. The purpose of the 3<sup>rd</sup> International Cancer Control Congress (ICCC-3) was to promote and foster a global community of practice through enabling extensive participation and dialogue between countries and societies with wide and varying experiences in cancer control; building on and synergizing ongoing work by governments, NGOs, international organizations and patient and public groups to make sustainable cancer control an important global priority. The ICCC-3 was held in Cernobbio, Italy in November 2009, and was built upon the achievements of the ICCC-1 (Vancouver, 2005) and ICCC-2 (Rio de Janeiro, 2007) by ensuring an agenda that focused on: international collaboration; establishment of sustainable national/large population cancer control strategies; promoting broad cross-sectoral participation (e.g., governments, cancer organizations, foundations, non-govern-

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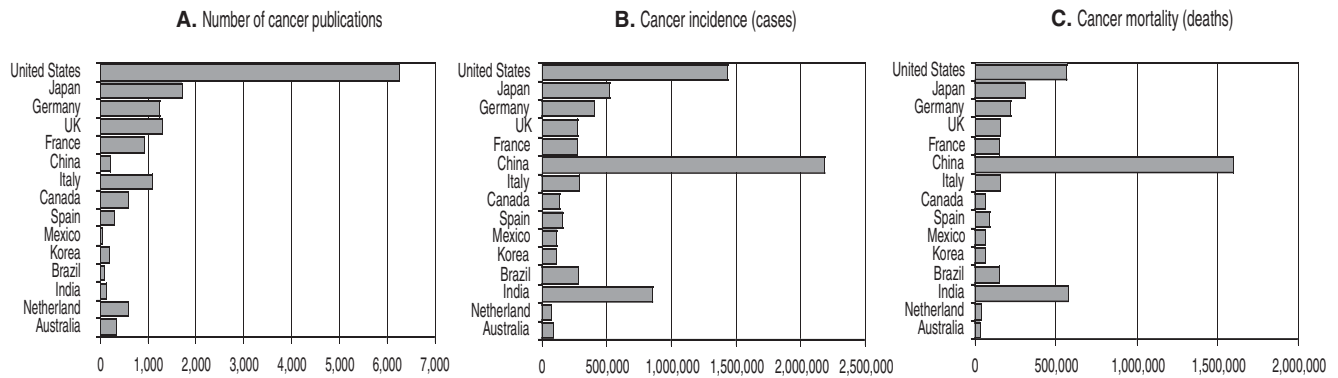


Figure 1 - Number of cancer publications (A)\*, cancer incidence - number of cases (B)<sup>°</sup>, and cancer mortality - number of deaths (C)<sup>°</sup> in the 15 richest countries by GDP<sup>§</sup> in 2002.

\*Number of cancer publications in 2002, source: SCOPUS database<sup>13</sup>; <sup>°</sup>source: GLOBOCAN<sup>1</sup> 2002; <sup>§</sup>Gross Domestic Product in 2002, source: World Economic Outlook (WEO) report 2009<sup>14</sup>.

Note The number of publications (i.e. articles, editorials, letters and reviews) refers to the scientific journals indexed as “oncology” journals in the Journal Citation Reports<sup>15</sup>. To identify these we used the Scopus online database<sup>13</sup>. Each publication, published in 2002, was assigned to a country according to the institute to which each author was affiliated<sup>12</sup> (see reference for methodology). Incidence, as the number of tumor cases, and mortality, as the number of deaths, are an estimation presented by GLOBOCAN 2002 for the year 2002. Countries are ordered by decreasing GDP in 2002.

ment organizations, stakeholders and publics); and promotion and fostering of a global community of practice in cancer control. ICCC-3 was designed to promote international cooperation and collaboration at a global level, including collaboration between countries on different continents\* with different socio-cultural contexts and resource settings, with the intent to increase global outreach and collaboration at all levels to deal with new knowledge and opportunities. Strengthening a strategic alliance between the European Union and African Union, and defining “pilot” projects or “proof of principle” projects and collaborative assistance to enable development and implementation of cancer control action plans through virtual (electronic) and/or face-to-face approaches were specific Congress goals.

Delegates from 47 countries participated in ICCC-3 and six papers are included in the present issue of *Tumori*<sup>3</sup> to provide a picture of cancer control in the first decade of 2000. Harford and colleagues<sup>4</sup> discussed emerging problems in planning and monitoring population-based systems and how many of the challenges faced by low-and middle-income countries have been at least partially addressed by higher income countries, thereby illustrating how experiences from around the world may suggest possible solutions for local problems. Micheli and colleagues<sup>5</sup> presented some global initiatives to promote international/intercontinental collaborations, particularly between countries in the Eastern Mediterranean, Africa, and the countries of Lat-

in-America and the Caribbean. Principles and practices of the UICC World Cancer Declaration were presented<sup>6</sup> and the importance of putting cancer in the political agendas of the international treaties of cooperation was stressed. Ongoing political cooperation in support of the European Union-African Union Alliance was highlighted with identification of domains for initial activity (cancer registration, education with particular focus on prevention, and palliative and end-of-life care)<sup>7</sup>. Luciani and colleagues<sup>8</sup> considered cancer prevention and population-based screening, drawing attention to the worldwide consensus on the major cancer risk factors and the cancer sites amenable to control through screening and early detection. Kerner and colleagues<sup>9</sup> highlighted research and development as a vehicle to promote cancer control in a given country, stressing the importance of public health sector (historically the sector devoted to cancer prevention and control programs), non-governmental organizations, academia, and the private sector (historically the sector involved in clinical research and practice issues) sharing their skills, knowledge, and resources to reduce the burden of cancer. Otter and colleagues<sup>10</sup> discussed the organization of population-based control programs, highlighting the promotion of collaboration between stakeholders and the role of leadership in the cancer control process. The prioritization of effective interventions and programs that benefit the majority of the population, the comprehensiveness of activities to control cancer (prevention, screening and early detection, treatment, palliation and end-of-life care) was recognized. Finally, Trapido and colleagues<sup>11</sup> discussed the critical factors that influence sustainability of population-based cancer control pro-

\*ICCC-3 logo included the colours of five continents: black for Africa, red for America, yellow for Asia, blue for Europe, and green for Oceania

grammes, including the integration of initiatives and efforts across risk factors; control; diseases (cancer and NCDs); technologies; public, private and advocacy groups; and communication and managing strategies.

The six manuscripts prepared for the ICC3-3 illustrate the gap between the present and emerging global burden of cancer and the availability and distribution of resources to control cancer.

Figure 1 presents the number of national publications in oncology (see the footnote in the Figure 1 for the definition)<sup>12</sup>, and compares these data with the cancer burden for the 15 richest countries in the world in terms of Gross Domestic Product (GDP). This group of countries account for 76% of all cancer publications. Cancer burden is presented as the annual estimated number of incident cancer cases, and the annual number of deaths for cancer (the 15 countries considered account for 66% of global cancer incidence and 63% of the global cancer deaths). For five countries (US, Japan, Germany, UK and France), there is a clear correlation between publication output (a proxy for scientific and clinical capability and capacity) and cancer burden. This is not the case for Brazil, India and China (three countries of BRIC group). The discrepancy between publication output and burden of cancer is illustrative of the mismatch between the impacts of rapid economic development on incidence and mortality and the 'level of preparedness' for effective cancer control solutions. Whilst these crude macro data may be subject to several biases, they highlight two relevant considerations: the necessity to link the burden of cancer to the level of cancer control response required, and the necessity for all countries to share knowledge, learning and experience to maximize effective context-appropriate solutions to control cancer.

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