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ACTIVITIES OF THE SOUTH PACIFIC COMMISSION CANCER REGISTRY

The SPC Cancer Registry created in 1979 is a world unique example of a regional collaborative effort in cancer surveillance.

The reporting of cases of cancer to a registry is one of the basic surveillance tools for the study and the prevention of cancer. The use of a cancer registry not only provides cancer mortality statistics, but also important demographic and medical variables. This allows health professionals to determine the magnitude of cancer in different areas and ethnic groups as well as possible causes and risk-factors.

The first cancer registries in the Pacific were established in Papua New Guinea in 1958 and Fiji in 1965. Since the 1970s, several other registries have been developed which cover the countries and territories of American Samoa, Fiji, French Polynesia, Guam, New Caledonia, and Papua New Guinea. Other countries plan to begin permanent cancer registries in the near future. Cancer registries, like infectious disease surveillance programmes, have been shown to be a cost-effective way to track trends and risk factors of diseases.

Most cancer registry reports in the Pacific are based on laboratory findings. While this type of reporting will prevent reporting of cases that are not in fact cancer cases (false positives), cancer cases that are only clinically diagnosed or only reported by death certificate will not be included (false negatives). As a result, the cancer registry will be incomplete. Another reason for incomplete cancer registration is the uneven reporting of cases of cancer from health facilities that see cancer patients.

Many of the Pacific Island countries do not have a local cancer registry. It was therefore recommended at the Eighth Regional Conference of Permanent Heads of Health Services in 1979 that a uniform cancer reporting system for the region be developed. The establishment of a cancer registry at the South Pacific Commission was approved by the South Pacific Conference in 1980 and included in the 1981 South Pacific Commission work programme.

Through the collaboration of the University of Southern California and the University of Hawaii, a traveling cancer registrar project was implemented for the Pacific. A cancer registrar visited countries to collect retrospective data on cases of cancer. Retrospective data were also collected from registries in countries where patients were referred for diagnosis and treatment and where laboratory specimens were processed, including the United States, New Zealand and Australia.

Cancer registration data are processed at the SPC in New Caledonia and forwarded to the University of Southern California for complete analysis. Though the completeness and accuracy of these data vary, it is possible to draw some general conclusions about cancer problems in the Pacific Islands.

Several cancer problems are apparent from the data. Lung cancer is widespread and accounts for approximately 30 per cent of all cancers in Polynesian and Micronesian males and 25 per cent of cancers in Melanesian males of New Caledonia. Oral cancer from betel nut chewing accounts for 33 per cent of all cancer in males and 20 per cent of cancer in females in areas of Papua New Guinea where betel nut is readily available. Liver cancer accounts for about

10 per cent of all cancers in the Pacific Islanders and most of this cancer is believed to be caused from Hepatitis B infection. Elevated oesophageal cancer rates were found in Melanesian males of New Caledonia and Polynesian males in French Polynesia where the consumption of alcoholic beverage is reported to be high.

Cancer prevention programmes focussing on a reduction in smoking, betel nut chewing, and alcohol consumption, along with hepatitis B immunisation, are strongly encouraged by these fundings.

To encourage continued improvement of cancer registries throughout the Pacific, SPC recommends that a cancer registrar visit the participating island countries on a yearly basis in close collaboration with registries from countries where Pacific Islanders are referred for cancer diagnosis and treatment or where laboratory specimens processed. Extra-budgetary funds will be secured to conduct these activities. Processing and analysis of the data will be provided routinely to participating countries and in periodic regional SPC publications.

1986 NUTRITION SURVEY OF THE KINGDOM OF TONGA

The National Food and Nutrition Committee of the Kingdom of Tonga, with technical assistance from SPC, carried out a National Nutrition Survey in Tonga in 1986. This survey is summarised below and can be used as a reference for developing nutrition policy in the Pacific.

Design of the Survey

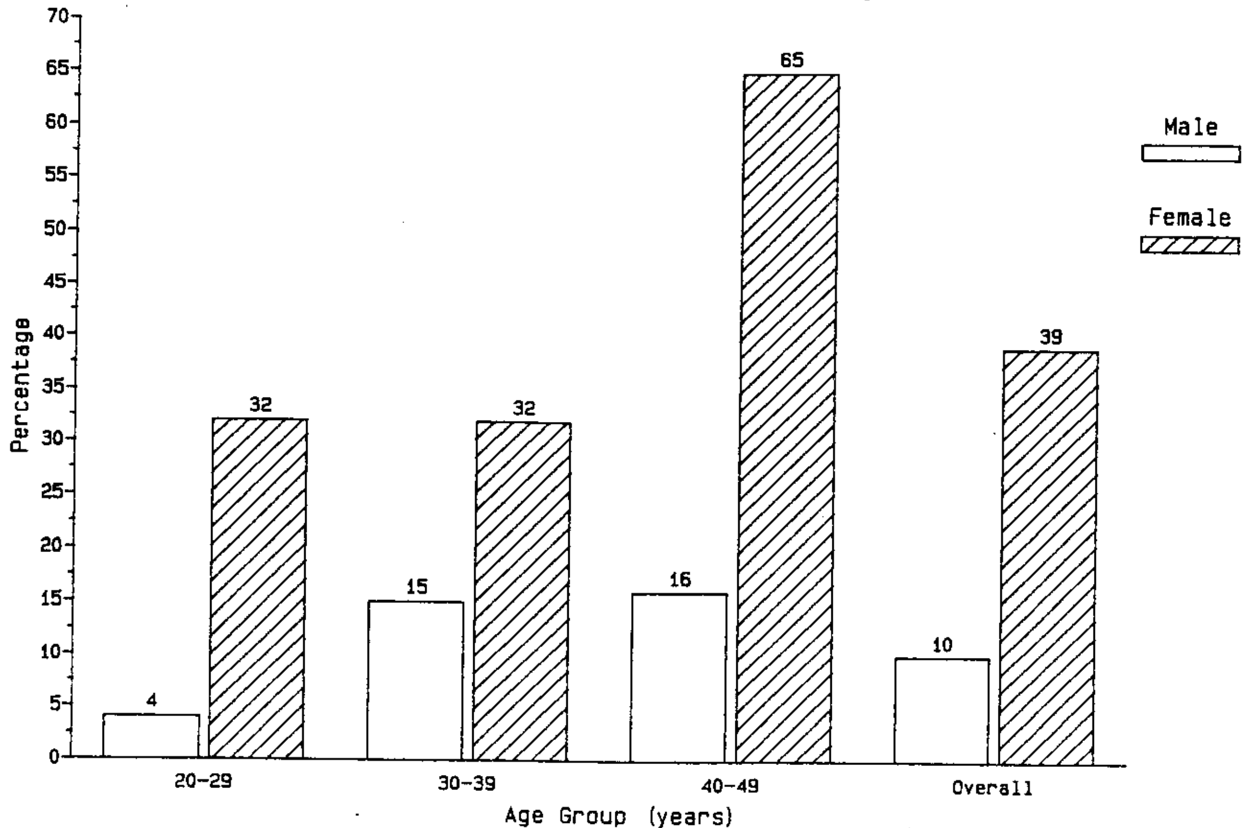
The survey was performed from May to December 1986 with funding from the United Nations Children's Fund (UNICEF) and the Australian Government. Data were obtained from men aged 20-49 years, women aged 15-49 and children up to 4 years old, through the use of a questionnaire completed by interviewers. The survey sample was randomly selected and covered 8 per cent of the total population of the Kingdom of Tonga. Information requested on the questionnaire included dietary habits, infant feeding patterns, maternal and child health care practices, nutrition knowledge, and anthropometric indicators (weight and height/length).

The results of the survey indicate that:

a) There is a high incidence of overweight among adults (especially women) that increases with age (see Figure 1). Adults were classified as severely overweight (obese) if their weight was 40 per cent over their desirable weight as derived from Caucasian standards. These standards are used for comparison purposes only, and may not reflect desirable weights in other cultures. Obesity is a primary risk factor in diabetes, hypertension, and heart disease and its treatment and prevention should be a priority for future public health programmes.

b) The good nutritional status among Tongan children is encouraging. The almost universal breastfeeding and the early introduction of solids are thought to have contributed to this, along with the good health status of mothers. But the consumption of fruits and vegetables by children is low,

which suggests that vitamin and mineral deficiencies could occur. Nutrition programmes should emphasise the current good infant feeding and childhood nutritional practices, while encouraging the increased consumption of local fruits and vegetables.



c) Consumption of sugar and sugar snacks is particularly high among children and is likely to be harmful to their teeth.

d) There is high attendance at maternal and child clinics which probably contributes greatly to good maternal and nutritional status. These clinics are good resources for nutrition education programmes.

Overweight problems among adults are common in many areas of the Pacific and nutritional policy should include an emphasis on lowering the prevalence of obesity in adults where this occurs. To achieve this end, nutrition education programmes should use guidelines that include:

o controlling weight,

o using less sugar and fat,

o eating a variety of fresh foods,

o limiting alcohol intake, and

o promoting exercise.

These programmes should focus on educating the general adult population on weight control and educating school children on the prevention of obesity and dental caries through good nutritional habits. The SPC has a series of health education posters available upon request.

Successful nutritional programmes should be regularly evaluated to determine their effectiveness. This includes (regular) monitoring of nutritional status of adults and children and assessing their knowledge of good nutrition practices and principles.

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