INFLUENCING ALCOHOL POLICY WHEN THE DOOR IS SHUT

Dr Jyotsna Vohra
WCC 2018
GLOBAL ALCOHOL PROBLEM

Population Average of Drinks consumed by males

(Lancet August 2018)
ALCOHOL AND CANCER

ALCOHOL CAN CAUSE 7 TYPES OF CANCER

- Mouth & Upper throat
- Larynx
- Oesophagus
- Breast in women
- Liver
- Bowel

Larger circles indicate cancers with more UK cancer cases linked to drinking alcohol.

WE WILL BEAT CANCER SOONER

cruk.org
“......findings strongly suggest that alcohol control policies should aim to reduce total – population level consumption ...............a need for countries to revisit their alcohol control policies.....”

(Lancet 2018)
GOVERNMENT CLOSED DOORS
WHAT CAN WE DO?

IMPACT OF ALCOHOL ON CANCER IN ENGLAND (2015-2035)

If current trends in alcohol consumption continue over the next 20 years, it is estimated it will cause...

Alcohol trends were modelled using a scenario that incorporates both the recent shifts in consumption alongside longer-term trends.


LET'S BEAT CANCER SOONER
cr.uk.org

£2BN IN CANCER COSTS TO THE NHS
135,000 CANCER DEATHS
1.2M HOSPITAL ADMISSIONS
## BUILDING THE EVIDENCE

<table>
<thead>
<tr>
<th>Scenario</th>
<th>In 20 years with no change (baseline)</th>
<th>Effect of decrease in alcohol consumption in 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1%</td>
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<tr>
<td>Health outcomes: mortality</td>
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<tr>
<td>All deaths from alcohol-related conditions</td>
<td>Absolute</td>
<td>12,778</td>
</tr>
<tr>
<td></td>
<td>Relative</td>
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<tr>
<td>All deaths from alcohol-related cancers</td>
<td>Absolute</td>
<td>7,097</td>
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<td></td>
<td>Relative</td>
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<tr>
<td>All admissions for alcohol-related cancers</td>
<td>Absolute</td>
<td>65,005</td>
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<td></td>
<td>Relative</td>
<td></td>
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</tbody>
</table>
“That’s appealing to me because, it’s like bright, and the packaging is nice”

“Also yeah, you see it everywhere [American lager] is heavily advertised, so that’s probably why I grabbed it”.

“They taste really nice; taste like sour sweets”
135,000 alcohol-related cancer deaths predicted by 2035
WORKING TOGETHER
MOVEMENT FROM GOVERNMENT

• Minimum Unit Pricing in Wales –
• England – want to understand unintended harm + Evaluation
• Public Health England – campaign (but with Drinkaware)
• Alcohol strategy discussions have begun
CONCLUSIONS

AS THE WORLD’S LARGEST INDEPENDENT FUNDER OF CANCER RESEARCH, WE ARE COMMITTED TO ACCELERATING PROGRESS IN CANCER OUTCOMES

COME AND JOIN US IN THE GLOBAL FIGHT AGAINST CANCER

THANK YOU

JYOTSNA.VOHRA@CANCER.ORG.UK

TO LEARN MORE ABOUT OUR WORK GLOBALLY AND EXPLORE NEXT STEPS, PLEASE EMAIL INTERNATIONAL@CANCER.ORG.UK
Obesity Prevention Policy in Australia:
Tipping the Scales

Jane Martin
Executive Manager
JaneMartinOPC

Implementation Science to Prevent Cancer
World Cancer Congress, Kuala Lumpur
2 October, 2018
Role of Research
• Utilising and synthesising existing research
• Filling in the gaps, particularly in relation to policy orientated research
• Orientation should be focussed on the question “What would it take?” from decision maker’s perspective
THE CASE FOR A HEALTH LEVY ON SUGAR-SWEETENED BEVERAGES

SUMMARY

A health levy on sugar-sweetened beverages (SSBs) to increase their retail price and reduce consumption has been advanced as a potentially powerful policy intervention to improve diets and reduce the burden of chronic disease in Australia. Revenue raised by such a levy could be used to support healthy eating initiatives and subsidies on healthy foods, particularly for low socioeconomic position (SEP) households.

A health levy on SSBs is proposed here as a viable and recommended policy initiative, forming part of a comprehensive suite of measures to address diet-related disease. This is because there is evidence that a levy on SSBs has the potential to:

1. Effectively discourage consumption of a product that contributes substantially to the poor diets and chronic disease risk of Australians;¹
2. Decrease sales of unhealthy beverages and influence demand for healthier alternatives, such as water and low fat milk;
3. Encourage beverage manufacturers to reformulate their beverages to reduce sugar content;
4. Convey the message that the government recognises that these products are a matter of concern for public health; and
5. Raise considerable revenue which may contribute to health promotion initiatives.

is argued that consideration of a health levy on SSBs should be a priority for the Australian Government as an effective intervention to reduce obesity and chronic disease.

BACKGROUND

Australians consume large volumes of SSBs, and suffer high rates of overweight, obesity and chronic disease. The Australian Government has acknowledged the need to improve the diets and health of Australians; however few economic policies have been implemented in pursuit of that objective.

The need to consider economic and pricing strategies to reduce consumption of unhealthy products was underscored in 2013 by Australia’s endorsement of the World Health Organization (WHO) Global Action Plan for the Prevention and Control of Non-communicable Diseases 2013–2020 (GAP). The GAP recommends that member states consider economic tools justified by evidence, including taxes and subsidies, to promote the consumption of healthier food products and discourage the consumption of less healthy options.²³

The introduction of a healthy levy on SSBs is vigorously opposed by the beverage industry, which argues that a levy on SSBs will not improve health, will unfairly single-out the SSBs sector, will cost jobs, will disadvantage Australians on lower incomes and will curtail personal freedoms.⁴ However there is strong evidence of the potential efficacy of an SSB health levy, particularly for lower income groups, and growing international policy impetus to include this policy as part of a comprehensive strategy to improve dietary health and reduce chronic disease.
RESEARCH ARTICLE

The Impact of a Tax on Sugar-Sweetened Beverages on Health and Health Care Costs: A Modelling Study

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1 School of Public Health, The University of Queensland, Brisbane, Australia, 2 WHO Collaborating Centre for Obesity Prevention, Deakin University, Melbourne, Australia, 3 Obesity Policy Coalition/Cancer Council Victoria, Melbourne, Australia

* jveerman@uq.edu.au

Abstract

This paper aims to estimate the consequences of an additional 20% tax on sugar-sweetened beverages (SSBs) on health and health care expenditure. Participants were adults (aged ≥ 20) Australians alive in 2010, who were modelled over their remaining lifetime. We used life-table based epidemiological modelling to examine the potential impact of a 20% excise tax on SSBs on total lifetime disability-adjusted life years (DALYs), incidence, prevalence, and mortality of obesity-related disease, and health care expenditure. Over the lifetime of adult Australian alive in 2010, seemingly modest estimated changes in average body mass as a result of the SSB tax translated to gains of 112,000 health-adjusted life years for men (95% uncertainty interval [UI]: 73,000–155,000) and 56,000 (95% UI: 36,000–76,000) for women; and a reduction in overall health care expenditure of AUD609 million (95% UI: 368 million–870 million). The tax is estimated to reduce the number of new type 2 diabetes cases by approximately 800 per year. Twenty-five years after the introduction of the tax, there would be 4,400 fewer prevalent cases of heart disease and 1,100 fewer persons living with the consequences of stroke, and an estimated 1606 extra people would be alive as a result of the tax. The tax would generate an estimated AUD400 million in revenue each year. Governments should consider increasing the tax on sugared drinks. This would improve population health, reduce health care costs, as well as bring in direct revenue.

Introduction

Unhealthy diets (11%) and high body mass index (9%) are the risk factors that contribute most to the burden of disease in Australia [1]. In order to reduce diet-related diseases, overweight, and obesity, focus should be placed on creating healthy food environments, whereby foods and beverages that contribute to a healthy diet are more readily available, affordable, and physically accessible, compared to unhealthy foods [2]. Food taxes have been frequently identified as a powerful tool to improve population diets [3], with evidence indicating that taxes are an effective intervention to improve the healthiness of consumption patterns [4]. The World Health Organization (WHO) recommends that country-level programs to combat obesity should
Australian sugary drinks tax could prevent thousands of heart attacks and strokes and save 1,600 lives

April 14, 2016 6:15am AEST

Sugary drinks are high in energy and lead to weight gain and obesity. Credit: AP/CC BY-NC-ND

Last month the United Kingdom announced a sugar tax on soft drinks. The tax will come into effect in 2018, with the funds to be used to address childhood obesity.

The move has been applauded by public health groups internationally. Unsurprisingly, the tax is strongly opposed by powerful groups in the food industry, and the announcement resulted in shares in Coca-Cola temporarily plunging.

In our new research published today in PLOS ONE, for the first time we have modelled the impact of such a tax in Australia. Over 23 years, a 20% rise in the price of soft drinks and flavoured mineral waters would save 1,600 lives. It would also prevent 4,400 heart attacks and 1,100 strokes.

Overall, the savings to the health-care system would add up to A$609 million.
A 20% sugary drinks tax in Australia could save 1,600+ lives

The impact of a tax on sugar-sweetened beverages on health and health care costs: a modelling study. Published in PLOS ONE on 14 April 2016.
Find key evidence on obesity trends, impacts & prevention in Australia

**Trends**
Trends in Australia and globally non mollis. Vivamus mattis ipsum at ex hendrerit, vel ultrices nisi porta.

**Impacts**
Impacts in Australia and globally non mollis. Vivamus mattis ipsum at ex hendrerit, vel ultrices nisi porta.

**Prevention**
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**Treatment**
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**Environmental**
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Environmental

Role of Partnerships
TIPPING THE SCALES

8 critical actions Australia must take to tackle obesity

1. **Toughen restrictions on TV junk food advertising to kids**
   ![TV with crossed-out food icons]

2. **Set food reformulation targets**
   ![Target with checkmark]

3. **Make Health Star Ratings mandatory**
   ![Rating system]

4. **Develop an active transport strategy**
   ![Shoe with upward arrow]

5. **Fund public health education campaigns**
   ![Phone and bicycle with apple]

6. **Add a 20% health levy to sugary drinks**
   ![Can with dollar sign]

7. **Establish a national obesity taskforce**
   ![Checklist]

8. **Monitor diet, physical activity, weight guidelines**
   ![Scale with feet]

opc.org.au/tippingthescales
#TippingTheScales
Partnerships to oppose a sugary drink tax

The Australian retail, farming, grocery and beverage sectors contribute more than $311bn to the economy each year, and account for approximately 15% of the total workforce in Australia.

Our industries understand that obesity is a public health problem in Australia, and that it is appropriate for calls to be made for Australians to modify and improve their dietary intake.

However, it is not beneficial to blame or tax a single component of the diet.

Obesity is a serious and complex public issue with no single cause or quick-fix solution. A new tax is not the way to make our nation healthier.

The McKinsey Global Institute, for instance, classifies taxation as one of the least effective obesity interventions, with 'No direct evidence for change in weight or change in consumption or physical activity levels.'[1]

- In fact, consumption trends show that the change such a tax seeks to effect is already happening.
- Recent Australian Bureau of Statistics (ABS) data indicates a decline in added sugar intake over time, yet obesity rates continue to climb.[2]

As a food supply sector, we recognise that we have a role to play in improving the food choices available for the Australian consumer.

We will continue to:

- Promote and support healthy balanced lifestyles that involve responsible eating habits and
Diet and Nutrition – a global Perspective

International Agency for Research on Cancer
World Cancer Research Fund

Dr Inge Huybrechts
Nutrition and Metabolism Section, IARC, Lyon
Outline

• Global cancer incidence & the nutrition transition
• Evidence based cancer prevention recommendations from WCRF
• Nutrient profiling to help consumers make healthier food choices
• Need of capacity building in LMIC
• Summary
Estimated age-standardized incidence rates (World) in 2018, all cancers, both sexes, all ages

ASR (World) per 100 000

- ≥ 253.9
- 183.8–253.9
- 138.3–183.8
- 106.5–138.3
- < 106.5

Not applicable
No data

All rights reserved. The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization / International Agency for Research on Cancer concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate borderlines for which there may not yet be full agreement.

Data source: GLOBOCAN 2018
Graph production: IARC
World Health Organization
Global cancer incidence & the nutrition transition

Estimated number of incident cases from 2018 to 2040, all cancers, both sexes, all ages

- **Asia**: 2018 baseline (blue) and increase by 2040 (red)
- **Europe**: 2018 baseline (blue) and increase by 2040 (red)
- **North America**: 2018 baseline (blue) and increase by 2040 (red)
- **Latin America and the Caribbean**: 2018 baseline (blue) and increase by 2040 (red)
- **Africa**: 2018 baseline (blue) and increase by 2040 (red)
- **Oceania**: 2018 baseline (blue) and increase by 2040 (red)

Number of incident cases

Data source: Globocan 2018
Graph production: Global Cancer Observatory (http://gco.iarc.fr/)
© International Agency for Research on Cancer 2018

https://gco.iarc.fr/tomorrow/
Based on the latest science available
Only evidence that strongly links a risk factor to cancer is used
10 Recommendations for cancer prevention & cancer survivors
<table>
<thead>
<tr>
<th>Adherence to WCRF/AICR recommendations and CRC risk in Morocco</th>
<th>Colon cancer ORa (95%IC); N=729</th>
<th>Rectal cancer ORa (95%IC); N=724</th>
<th>CRC overall ORa (95%IC); N=1453</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Body fatness</strong></td>
<td>&lt;0.5</td>
<td>1</td>
<td>1</td>
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<tr>
<td></td>
<td>0.5-&lt;1</td>
<td>0.74 (0.50-1.09)</td>
<td>0.46 (0.30-0.69)</td>
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<td></td>
<td>1</td>
<td>0.51 (0.34-0.75)</td>
<td>0.45 (0.29-0.68)</td>
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<tr>
<td>p-trend</td>
<td>0.001</td>
<td>&lt;0.001</td>
<td>&lt;0.001</td>
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<tr>
<td><strong>Physical activity</strong></td>
<td>&lt;0.5</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>0.5-&lt;1</td>
<td>0.56 (0.38-0.81)</td>
<td>0.34 (0.23-0.50)</td>
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<tr>
<td></td>
<td>1</td>
<td>0.45 (0.28-0.70)</td>
<td>0.24 (0.15-0.37)</td>
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<td>p-trend</td>
<td>0.002</td>
<td>&lt;0.001</td>
<td>&lt;0.001</td>
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<tr>
<td><strong>Food and drinks that promote weight again</strong></td>
<td>&lt;0.5</td>
<td>1</td>
<td>1</td>
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<td></td>
<td>0.5-&lt;1</td>
<td>0.72 (0.54-0.96)</td>
<td>0.91 (0.67-1.22)</td>
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<td>1</td>
<td>0.71 (0.45-1.13)</td>
<td>0.51 (0.32-0.82)</td>
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<tr>
<td>p-trend</td>
<td>0.076</td>
<td>0.018</td>
<td>0.004</td>
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<tr>
<td><strong>Plant foods</strong></td>
<td>&lt;0.5</td>
<td>1</td>
<td>1</td>
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<td>0.5-&lt;1</td>
<td>0.47 (0.21-1.04)</td>
<td>0.34 (0.13-0.88)</td>
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<td></td>
<td>1</td>
<td>0.27 (0.11-0.63)</td>
<td>0.15 (0.05-0.43)</td>
</tr>
<tr>
<td>p-trend</td>
<td>&lt;0.001</td>
<td>&lt;0.001</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td><strong>Animal foods (red/processed meat)</strong></td>
<td>&lt;0.5</td>
<td>1</td>
<td>1</td>
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<tr>
<td></td>
<td>0.5-&lt;1</td>
<td>2.00 (0.93-4.30)</td>
<td>3.55 (1.51-8.38)</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>0.42 (0.29-0.61)</td>
<td>0.54 (0.36-0.81)</td>
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<tr>
<td>p-trend</td>
<td>&lt;0.001</td>
<td>&lt;0.001</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td><strong>Alcoholic drinks</strong></td>
<td>&lt;0.5</td>
<td>1</td>
<td>1</td>
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<tr>
<td></td>
<td>0.5-&lt;1</td>
<td>-</td>
<td>0.81 (0.08-8.39)</td>
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<td></td>
<td>1</td>
<td>0.66 (0.20-2.17)</td>
<td>1.07 (0.35-3.26)</td>
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<tr>
<td>p-trend</td>
<td>0.794</td>
<td>0.968</td>
<td>0.556</td>
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</tbody>
</table>
**Nutrient profiling**

Helping consumers make **healthier food choices** → key to prevention of cancer

Political authorities consider the implementation of a **simplified labelling system** to reflect the nutritional quality of food products

**Nutrient profiling** is a scientific method for assessing the nutritional quality of foods & beverages → can be used to promote public health dietary goals
# Associations between Nutri-Score & cancer risk

**Multivariable Cox proportional hazards models, EPIC 1992-2014**

<table>
<thead>
<tr>
<th>Nutri-Score range* (men/women) (n=471,495)</th>
<th>Per 2-point increment</th>
<th>Q5 vs. Q1</th>
<th>P-trend</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total cancer</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All (cases/person-years)</td>
<td>49,794/6,635,062</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex-adjusted model - HR (95% CI)</td>
<td>1.04 (1.03-1.05)</td>
<td>1.12 (1.08-1.15)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Multi-adjusted model - HR (95% CI)</td>
<td>1.02 (1.01-1.03)</td>
<td>1.07 (1.03-1.10)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td><strong>Colorectal cancer</strong></td>
<td></td>
<td></td>
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<tr>
<td>All (cases/person-years)</td>
<td>5,806/6,639,343</td>
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</tr>
<tr>
<td>Sex-adjusted model - HR (95% CI)</td>
<td>1.03 (1.00-1.06)</td>
<td>1.11 (1.01-1.21)</td>
<td>0.03</td>
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<tr>
<td>Multi-adjusted model - HR (95% CI)</td>
<td>1.03 (1.00-1.06)</td>
<td>1.11 (1.01-1.22)</td>
<td>0.03</td>
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<tr>
<td><strong>Breast cancer</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Women (cases/person-years)</td>
<td>12,063/4,659,777</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unadjusted model - HR (95% CI)</td>
<td>1.03 (1.01-1.05)</td>
<td>1.08 (1.01-1.15)</td>
<td>0.01</td>
</tr>
<tr>
<td>Multi-adjusted model - HR (95% CI)</td>
<td>1.02 (1.00-1.04)</td>
<td>1.06 (0.99-1.14)</td>
<td>0.05</td>
</tr>
</tbody>
</table>

*Higher score → lower nutritional quality*
Associations between Nutri-Score & health
Results derived from cohort studies in France

**Weight gain** in men (SU.VI.MAX)
- +16% risk for becoming obese for 1 point increase in Nutri-score
- +91% risk for becoming obese (Q4 vs. Q1)

**Metabolic syndrome** (SU.VI.MAX)
- +43% risk of developing MetS (Q4 vs. Q1)

**Cardiovascular disease** (NutriNet-Sante & SU.VI.MAX)
- +40 to +61% risk of CVD (Q4 vs. Q1)

**Cancer** (SU.VI.MAX & NutriNet-Sante)
- Overall cancer: +7 to +34% risk (Q5 vs. Q1)
- Breast cancer: +52% risk (Q5 vs. Q1)

- Julia, Kesse-Guyot et al., J Nutr, 2015;145(10):2355-61
- Deschasaux, Touvier et al., BMJ Open. 2017;7(6):e013718
- Adriouch, Fezeu, Touvier et al., Int J Cardiol. 2017;234:22-27
- Donnenfeld, Touvier et al, Br J Nutr 2015;1-9
WHO Nutrient profiling project

Development of an internationally recognized method for nutrient profiling?

- beneficial for a number of applications
- criteria might not be applicable to all cultures, settings and applications

A procedure for systematic validation & comparison of different approaches required

WHO developed a Guiding Principles and Framework Manual to assist member states globally in developing & adapting NP models

http://www.who.int/nutrition/topics/profiling/en/
Need for capacity building in LMIC
UICC-IARC-WCRF fellowship

To help answering the need for capacity building in LMIC to boost the generation of good quality evidence in LMIC

Dr Francis Zotor from the University of Health and Allied Sciences, Ghana, joined IARC (2016) to receive training in the area of nutrition and cancer:

• how to set-up studies on nutrition & cancer in Ghana, & the wider African region

• discuss gaps & needs (e.g. obesity & cancer)

Words from Dr Francis Zotor “My experience with the team at IARC was an honour for me as it opened my eyes to the need for research on cancer studies in LMIC”
Summary

Cancer incidence increasing in LMIC → partly due to nutrition transition

Need for preventive actions:

• WCRF → evidence based cancer prevention recommendations

• Political authorities → encouraged to implement simplified labelling system to reflect the nutritional quality of food products

Need for capacity building → UICC-IARC-WCRF fellowship for capacity building in Africa
Acknowledgements

Nutritional Epidemiology Research Team (EREN), Paris
  Mélanie Deschasaux  Serge Hercberg
  Chantal Julia  Mathilde Touvier

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  Marc Gunter  Joseph Rothwell
  Pietro Ferrari

University of Health and Allied Sciences, Ghana
  Francis Zotor

Faculty of Medicine, Sidi Mohamed Ben Abdillah University
  Fez, Morocco
  Karima El Rhazi

https://www.wcrf.org/int/research-we-fund/wcrf-academy
IUNS International Task Force on Nutrition and Cancer

WCRF & UICC stands
IMPLEMENTATION SCIENCE TO PREVENT CANCER – THE GLOBAL PICTURE

INFLUENCING TOBACCO CONTROL IN AN LMIC

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ICMR-National Institute of Cancer Prevention and Research (NICPR)
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Track 1 - Motivating prevention and healthy behaviour

Disclosure of interest: None declared
Prevalence & Burden of Tobacco use

- More than 7 million people die every year due to tobacco use related illness
- More than 80% of these deaths occur in LMICs
- LMICs also bear the double burden of both smoking and smokeless tobacco
- LMICs also have high rates of adolescent smoking, particularly among boys where rates in some countries is as high as 46%
- Even SLT use among adolescents are high in LMICs
- There is a clear shift in the product preference from smoking to smokeless tobacco products
Use of Non-combustible tobacco products

1. Smokeless tobacco is used in several ways in different parts of the world
2. Its use is highest in the Southeast Asia region
3. Nearly 360 million people use SLT products in 140 countries with more than 90% of the burden in LMICs
4. In SEAR and African region, SLT use is higher in rural areas and poorest communities
5. India alone is home to more than 60% of the global SLT users
6. SLT use is responsible for the 90% of oral cancers in India
7. SLT is also responsible for several other cancers, heart diseases and other chronic diseases and kills more than 0.65 million people every year.
8. Several efforts have been taken to curb SLT use in the region
9. Implementation science have been effectively used to influence SLT control in LMIC
Use of Areca Nut

- More than 600 million people use areca nut globally.
- It has been classified as group-1 carcinogen.
- Majority of the users are in the Asia-Pacific region.
- It is the fourth-most-used stimulant after caffeine, alcohol and tobacco.
- Aggressive marketing and advertisement of areca nut based products and their sale with attractive and appealing taste, scents, additives, flavourings besides attractive packaging have further increased its use globally, especially among young and vulnerable.
FCTC an evidence based treaty

1. FCTC provides for both demand and supply reduction measures to curb tobacco use.

2. About 4.7 billion people – 63% of the world’s population – are covered by at least one comprehensive tobacco control measure, which has quadrupled since 2007 when only 1 billion people, and 15% of the world’s population, were covered.

3. The Global Progress Report on implementation of the WHO FCTC & the WHO report on the global tobacco epidemic provide the global update on implementation of effective tobacco control measures.
All FCTC Provisions apply to SLT Products

- Article 6: Republic of Korea have highest taxes on SLT products.
- Article 11: Larger 85% mouth cancer warnings in India.
- Article 12: Mukesh and Sunita mass media campaigns in India and betel nut campaign in Myanmar.
- Article 13: complete ban on direct and indirect advertisement
- Article 14: cessation services
- Article 15: prohibit illicit trade - governmental licensing including of retail sale
- Article 16: Prevent minor access - Age of sale increased to 21 years
- Article 20: collect data on SLT under GTSS and other national and international surveillance systems
Status Report 2016

MPOWER Report 2017
Global Progress Report on SLT Control

- Governmental sale licenses: 26 countries require license for sale of SLT products.
- Several countries regulate the production, distribution, and sale of cottage industry manufactured SLT products as well.
- Age restrictions: Several countries have raised age of access to 21 years.
- Reduce the appeal of SLT products by banning or regulating sweeteners and flavouring substances.

Publications from the KH-SLT


### KH-SLT Session on 3-4th October on Areca Nut

**15:20 TO 16:50**

**WEDNESDAY 3 OCTOBER 2018**

<table>
<thead>
<tr>
<th>Topic</th>
<th>Room</th>
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<tbody>
<tr>
<td>Prioritizing research and policy interventions to prevent oral cancers – Targeting the Betel Quid &amp; Areca Nut Users</td>
<td>301</td>
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<tr>
<td>Track 1 - Motivating prevention and healthy behaviours</td>
<td></td>
</tr>
<tr>
<td>Organised by ICMR - National Institute of Cancer Prevention and Research (NICPR) (India) and National Cancer Institute (United States)</td>
<td></td>
</tr>
</tbody>
</table>

### KH-SLT Session on SLT and FCTC on 4th October

**13:50 TO 14:50**

**THURSDAY 4 OCTOBER 2018**

<table>
<thead>
<tr>
<th>Topic</th>
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<td>Full Implementation of the WHO FCTC Demand and Supply Reduction Measures to Mitigate the Global Smokeless Tobacco Burden</td>
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<tr>
<td>Track 1 - Motivating prevention and healthy behaviours</td>
<td></td>
</tr>
<tr>
<td>Organised by National Institute of Cancer Prevention and Research (India)</td>
<td></td>
</tr>
</tbody>
</table>
Q & A!

THANK YOU

Prof. Ravi Mehrotra
ICMR-National Institute of Cancer Prevention and Research (NICPR)
Noida, Uttar Pradesh 201301
directornicpr@gmail.com
Behavioural Science Research for Cancer Prevention: The NCI Story

2018 World Cancer Congress

William Klein, PhD
Associate Director
Behavioral Research Program
Division of Cancer Control and Population Sciences
National Cancer Institute
Behaviors account for a large proportion of cancer risk.

- Tobacco & Smoke Exposure: 29%
- Nutrition, Diet & Obesity: 25%
- Viruses: 8%
- Sedentary Lifestyle: 5%
- Alcohol: 4%
- UV Radiation: 2%

Adapted from Wolin, Carson, and Colditz, 2010
Public health policy examples

- Taxes on products that contribute to cancer risk
- Regulation of tobacco products and messaging
- Smoke-free air laws
- Menu labeling and ingredient restrictions
- School nutrition and activity policies
- Tanning bed regulations
- Institutionalized HPV vaccinations
Evidence-based research to inform tobacco control

- Tobacco Control Monograph 21 (produced in collaboration with WHO)
  - Examined evidence of use, growth, manufacturing, and trade; tax and price; and policies and interventions to reduce use and health consequences of tobacco.

- Tobacco Control Monograph 22
  - Examined health disparities in initiation, secondhand smoke exposure, frequency and intensity, cessation, morbidity, and mortality.

Experimental study to evaluate corrective statements

- The tobacco industry was ordered to issue corrective statements on:
  - Adverse health effects of cigarette smoking
  - Addictiveness of cigarette smoking & nicotine
  - No health benefit from smoking “low tar,” “light,” “ultra light,” “mild,” and “natural” cigarettes
  - Tobacco companies’ manipulation of cigarette design and composition to enhance nicotine delivery

- Study involved empirical message testing for corrective statements, with specific audience segmentation to reflect subpopulations disproportionately targeted by tobacco industry advertising.
Research resulting from the TCORS initiative has informed FDA’s regulatory activities in several ways.

- FDA cites TCORS studies in rulemaking activities, including the recent Advance Notices of Proposed Rulemaking on:
  - Regulating flavors in tobacco products
- TCORS researchers formally submit their research to FDA calls for public comment on their proposed regulations.
Smoke-free housing

- Without interventions, smoke exposure can be high in public housing (Levy, 2013)

- Households in buildings with smoke-free policies have better air quality than those in buildings without (regardless of whether the household has a smoker) (Russo, 2015)

- Common areas also see fewer particulates, less nicotine (MacNaughton, 2016)

- Smoke-free policies in public housing are found to be acceptable (Rokicki, 2015)
Welcome to the Tobacco Control Policy tool

This website provides decision-makers and health professionals with estimates of the projected impact of four specific tobacco control policies on public health in the United States.

The estimates were derived from simulations of over 2,200 policy scenarios, with 30 million people per scenario, and calibrated for each state and Washington, DC.

Read more about the tool or go directly to one of the policy pages below and explore the results.

Updates
3/24/2018: A detailed study protocol describing the methods behind the TCP tool is now freely available. Find out more at BMJ Open.
12/18/2017: Smoke-free air law coverage in restaurants, bars, and workplaces have been updated to reflect recent data compiled by the CDC & NCI State Cancer Profiles and American Nonsmokers’ Rights Foundation (as of October 2, 2017). The percent of the population in non-smoking work environments now reflects survey data from the 2014-2015 Tobacco Use Supplement to the Current Population Survey (TUS-CPS)
Time-sensitive obesity policy evaluation – Evidence for policy makers about behavior

- Evaluation of policy and programs outside investigator control (e.g. transportation, taxation, retail, labeling)
- “Rapid” funding mechanism launched in 2012 to allow pre-test–post-test study designs
- Cooperative across multiple NIH institutes
- $25M in grants over 7 years

Lessons learned

- Requires flexibility – sometimes policies don’t happen
- Key challenge: adequate efforts to create “as-if-randomized” comparisons across time and space

Sugar Alert - Evaluating San Francisco’s Sugar-Sweetened Beverage Advertising Warning Label Ordinance

PHRESH: Pittsburgh Hill/Homewood Research on Neighborhood Change and Health
Classification of Laws Associated with School Students (CLASS)

This CLASS brief summarizes a study asking:

Are state laws regulating competitive foods in schools associated with lower adolescent weight gain?
ALCOHOL CAN CAUSE 7 TYPES OF CANCER
INCLUDING BREAST CANCER.

The more you drink, the more you increase your risk. Reduce your risk of developing breast cancer.

Go to reducemyrisk.tv for the facts.
Concerned about your drinking? Call Drinkerline: 0300 123 1110

breast cancer now

NATIONAL CANCER INSTITUTE
Relevant research tools

cancercontrol.cancer.gov/brp

Family Life, Activity, Sun, Health, and Eating (FLASHE) Study
https://cancercontrol.cancer.gov/flashe

Health Information National Trends Survey (HINTS)
https://hints.cancer.gov

Classification of Laws Associated with School Students (CLASS)
https://class.cancer.gov
Stay connected

Website
www.cancer.gov
www.cancer.gov/espanol
https://cancercontrol.cancer.gov/brp

Twitter
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@NCIbehaviors

Facebook
www.facebook.com/cancer.gov
Meet the Experts
National Cancer Institute

Wednesday, 3 Oct
Exhibit Booth #E17-18

Behavioral Research
10:00 - 11:00

Implementation Science Research
11:00 - 11:30

Susan Czajkowski  Bill Klein  Sudha Sivaram
ADDITIONAL SLIDES
# The Cancer Control Continuum

## FOCUS

### CROSS-CUTTING AREAS

- **Communications**
- **Surveillance**
- **Health Disparities**
- **Decision-Making**
- **Dissemination of Evidence-Based Interventions**
- **Health Care Delivery**
- **Epidemiology**
- **Measurement**

### Etiology
- Environmental factors
- Genetic factors
- Gene-environment interactions
- Medication (or pharmaceutical exposure)
- Infectious agents
- Health behaviors

### Prevention
- Tobacco control
- Diet
- Physical activity
- Sun protection
- HPV vaccine
- Limited alcohol use
- Chemoprevention

### Detection
- Pap/HPV testing
- Mammography
- Fecal occult blood test
- Colonoscopy
- Lung cancer screening

### Diagnosis
- Shared and informed decision-making

### Treatment
- Curative treatment
- Non-curative treatment
- Adherence
- Symptom management

### Survivorship
- Coping
- Health promotion for survivors

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Adapted from David B. Abrams, Brown University School of Medicine
Epidemiologic model of tobacco use

Source: Orleans & Slade, 1993; Giovino, 2002