Cancer Prevention Awareness Program: Targeting Black Americans

In 1984, the National Cancer Institute announced its national goal: to reduce the 1980 cancer death rate in this country by one-half by the year 2000. This is a reasonable and reachable objective, but it will require the dedication and cooperation of all of us in the field of health care. Health professionals, particularly those at State and local health agencies, play a key role in achieving this goal.

The National Cancer Institute now has evidence that some cancers are preventable and that individuals can modify their lifestyles to reduce their cancer risk. Nearly 80 percent of cancers are related to lifestyle factors, many associated with personal choices like cigarette smoking and eating habits. Providing accurate up-to-date information to the public about cancer and its prevention is the first step in promoting behavioral change.

Data documented from the National Cancer Institute's Surveillance, Epidemiology and End Results Program indicate that certain segments of the population are at a higher cancer risk than the general public. Data collected over the past several decades show that the cancer incidence rates have increased 27 percent among blacks and only 12 percent among whites. Mortality rates for blacks have increased 34 percent but only 9 percent for whites. National Cancer Institute researchers believe that differences in lifestyle contribute to the different cancer incidence rates. Access to and use of medical care for screening tests, early diagnosis, and prompt treatment may also contribute to differences in cancer death rates.

Recent studies by the American Cancer Society and the National Cancer Institute reveal that blacks, along with many other Americans, have misconceptions and deeply rooted fears about the cause and cure of cancer. The outlook many blacks have on cancer can be summarized briefly:

1. Blacks underestimate the prevalence of cancer. Blacks believe cancer is a disease that chiefly affects whites.
2. Blacks are less knowledgeable than whites about cancer's warning signals, treatment options, and information available to them about cancer.
3. Blacks are pessimistic about the curability of cancer and are less likely to see a physician if they are experiencing symptoms.
4. Blacks are not informed about those cancers that have sharply increased in mortality: prostate, esophageal, and colorectal.

These studies indicate that, as we endeavor to improve treatment and care for all persons, we must also inform and educate those at high risk. If we are going to make significant progress toward achieving our year 2000 goal, then we must speak directly to those in special need of cancer information.

In 1984, when we announced the year 2000 goal, we also launched the Cancer Prevention Awareness Program, which is designed to inform and educate the public about cancer prevention. This program has adopted a "good news" theme to counteract and dispel the negative myths and misconceptions about cancer. Since blacks perceive cancer as "inevitable" and "caused by everything," the "good news" message is particularly appropriate when communicated to the black population.

To reach the black population, we are bringing together health professionals, media, churches, and businesses representing black interests for a national meeting to be held May 30, 1985, in Detroit, MI. These individuals and groups will participate in a "Joint Health Venture" to inform and educate blacks and other high-risk populations about cancer and methods of cancer prevention. The Joint Health Venture is envisioned by the National Cancer Institute as a coalition of organizations whose unifying objective is to improve the overall health and well-being of the American population.

We hope our efforts will extend beyond the Federal level to State and local health agencies where education, training, screening, and early detection programs are provided. The National Cancer Institute is available as a resource for the materials needed to disseminate information and implement these programs. This year's effort extends to all citizens and focuses on black Americans. It requires your involvement as health professionals to be successful. The National Cancer Institute views the Cancer Prevention Awareness Program as a collaborative effort in changing the public perception of cancer and, more important, in teaching people

what they can do every day to control their own cancer risks.

Vincent T. DeVita, Jr., MD
Director
National Cancer Institute

PHS Task Force Seeks Volunteers To Cope with Famine in Africa

The Public Health Service is being called on for assistance in coping with the drought-related disaster unfolding in Sub-Saharan Africa. Millions of people are starving. Thousands have lost their homes and become refugees. U.S. officials decided that the Government should make a humanitarian response to the international emergency. The Agency for International Development asked Secretary Margaret M. Heckler for Public Health Service personnel to provide stopgap aid to private voluntary organizations in the field. To fulfill this request, I formed the Public Health Service Working Group on the Famine Emergency in Africa and named as its director, Dr. Robert Graham, Administrator of the Health Resources and Services Administration. The group, which consists of representatives of all Public Health Service agencies, will select appropriate volunteers. The group is looking for physicians, nurses, nutritionists, sanitarians, public health advisers, transportation specialists, camp administrators—anyone with skills needed in providing emergency health services.

Volunteers will be asked to serve for up to 90 days. Most will work with voluntary agencies such as Save the Children, International Rescue Committee, or United Nations International Childrens Education Fund (UNICEF). Some will work with host governments. The first volunteer, Dr. Gershon Bergeisen, an Indian Health Service medical officer stationed in Bemidji, MN, left April 8 for Chad. Assistance also is needed in Sudan. Neighboring countries with similar problems are Burkina Faso, Ethiopia, Mali, Mauritania, Niger, and Somalia. Up to 20 more volunteers may be needed. Further calls may be expected.

Applicants must complete a 4-page form with questions about their health, ability to work under adverse conditions, skills, language proficiency, and work experience in the United States and foreign countries. Interested Public Health Service personnel should contact Kay Strawder at (301) 443-6152, Rm 14–18, Parklawn Bldg. 5600 Fishers Lane, Rockville, MD, 20857.

James O. Mason, MD, DrPH
Acting Assistant Secretary for Health

LETTER TO THE EDITOR

Fighting Malaria in Texas, 1949–51

The article in your November-December 1984 issue, "Fighting Smallpox on the Texas Border: an Episode from PHS's Proud Past," was especially meaningful to me as a former PHS officer. I commend Dr. Michael and Dr. Bender for reminding your readers of the professional way PHS assignees have traditionally served State health departments when called upon.

In the fall of 1949 I was transferred to the malaria surveillance program in Texas at the request of Dr. George W. Cox, the State health officer, whose approval was necessary before any move could be made (as in 1895 with the assignment of Dr. George M. Magruder). My prime objective during that period of 1949–51 was to investigate each reported case of malaria in Texas by interviewing both physician and patient, reviewing the malaria smears (sometimes my own), discussing with engineers and entomologists the possibilities for transmission in that particular area, and making a final report to my superiors at CDC.

Texas, Arkansas, and South Carolina were the last strongholds of malaria in those days, but it was often wrongly diagnosed. This had certainly been the case in Mississippi, where I had collaborated with (and learned from) Dr. Archie Lee Gray in exorcising the "ghost of malaria" by offering $5 for each laboratory-proven case.

Dr. Alexander D. Langmuir, CDC's Chief Epidemiologist and an invaluable "father figure" to those of us assigned to the States, supported my efforts in the malaria surveillance program and encouraged an interest in other fields such as a study of health problems of migrant workers and the whole subject of public health on the border.

The so-called wetback (as opposed to "bracero," or legally admitted agricultural worker) was both misunderstood and unfairly maligned at this time. I was occasionally able to speak with and examine those "wetbacks" who had been recently rounded up. Eventually there was a regular program of health screening that included an interview, a cursory physical, a malaria smear, and a smallpox vaccination. When I was working in Cameron and Hidalgo Counties, the branch lab at San Benito, run by Dr. Eddie Klaboch, proved invaluable.

In an attempt to relate this to the article by Michael and Bender, I might observe that smallpox was a constant concern to us, although I never actually saw a case in the Lower Valley. The "wetbacks" used to oblige us by describing outbreaks of the disease, usually down in the vicinity of Guadalajara. In many ways, I am grateful that I did not have the same problems as Dr. Magruder in 1895, and was able to move on to malaria control in Thailand at the conclusion of my work in Texas.

—Maynard H. Mires, MD, MPH, Deputy State Health Officer, Sussex County Health Unit, Delaware Department of Health and Social Services