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The Benefits of International Student Perspectives in a Global Cancer Workshop

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ABSTRACT

A recent opportunity to facilitate a faculty and student workshop in Global Health and Cancer Prevention allowed us, an international group of graduate students, to reflect on cancer disparities in our home countries as well as our understanding of these differences. This included discussing the complexity of achieving equitable cancer prevention globally, and learning from our shared and disparate experiences of public health systems across the world. It became clear through this process that being an international student, and working with other international students with distinct backgrounds, can result in an enriched learning environment. Our discussions highlighted gaps in our knowledge regarding other cultures, and gave each of us a new perspective on aspects of our own cultures, related to cancer, cancer-related risk factors, and more broadly. This forum demonstrated to us the benefits of the diversity international students can bring to the learning space.

Keywords: cancer prevention, diversity, global health, shared-learning, workshop

REFLECTION

Cancer is the second leading cause of death worldwide (Global Burden of Disease Cancer Collaboration, 2015) and approximately 14 million people are diagnosed with cancer every year (Ferlay et al., 2015). While it was once considered a disease primarily of middle and high-income countries, cancer is increasingly prevalent in developing countries (Ferlay et al., 2015). Current projections suggest that the number of cancer cases globally will increase by 68 percent by 2030 (Bray, Jemal, Grey, Ferlay, & Forman, 2012). This will largely be due to a growing population and an ageing population in developed countries, but it is likely to be compounded by a rise in cancer diagnoses in developing countries.

Recently, we were presented with a unique opportunity to consider the meaning of these changes for cancer prevention on a global scale. We are members of the Centre for Excellence in Cancer Prevention at the University of British Columbia (UBC), and have travelled from a diverse set of countries to pursue post-graduate education in Canada. In collaboration with our supervisor, we organized a workshop in Global Health and Cancer

Prevention as part of a student-led symposium in March 2016. During this workshop, we presented an overview of the cancer landscape in our home countries: Ireland, Iran, Canada, and Mexico.

The primary aim of the workshop was to open a dialogue on global cancer disparities. To do so, we felt it was important to first present the differing patterns of cancer incidence and mortality across these four countries. Through the use of World Health Organization (WHO) data (WHO, 2014) we were able to identify both the commonalities across countries (e.g., breast cancer was uniformly the most common cancer in women) and the differences (e.g., stomach cancer was in the top three cancers in Mexico and Iran but was rare in Ireland and Canada). We also presented information on the challenges in cancer prevention unique to each country. A benefit of having each of us speak about this information was the depth of informal knowledge about our own countries we could present to workshop participants. This was particularly true with regard to the barriers for improving cancer prevention. While all four countries had cancer prevention policies in place to a greater or lesser extent, we were able to discuss the potential systemic barriers to the implementation of these policies. For example, traditional cooking methods in Iranian cuisine emphasize the cooking of vegetables for long periods of time, a practice that decreases the nutritional value of these foods (Farahmand, Tehrani, Amiri, & Azizi, 2012). These traditions may inhibit the effectiveness of healthy eating campaigns in Iran.

In researching and facilitating this workshop, it became clear just how intertwined cancer risk factors are with differences in cultural beliefs, socioeconomic status, health care, and political systems. Discussion both prior to, and during the workshop also highlighted the importance of avoiding simple comparisons between these four countries, in terms of risk factors. We felt this would be reductionist given the vast differences in the histories, climate and cultures of these four countries. In addition, health risks are in transition globally, and it is likely that the cancer related risks in Iran, Mexico, Ireland and Canada are changing in different ways and at different rates.

A key challenge in preparing for this workshop was harmonizing the information we presented and discussed across each of our home countries. We found that accessing reliable information for some countries (e.g. Iran) was more challenging than for others (e.g. Canada). We found the WHO (2014) cancer country profiles a good source for informational overviews of cancer morbidity and mortality and some cancer-risk factors for each country we considered. However, identifying more detailed information for Mexico and Iran was challenging. Again, being able to draw on the first-hand experience of students from these countries of having dealing with these data limitations in the past was highly beneficial. Local knowledge about local data sources was invaluable, in particular the familiarity in knowing which were the most up to date and reliable sources.

Contributions during the workshop also highlighted the importance of considering the feasibility of cancer prevention and treatment efforts in countries with limited resources. For example, in Iran the delay between seeking help for cancer symptoms and cancer diagnosis is up to five months (Taghipour, 2016). This delay is associated with lower survival and higher mortality among patients (Taghipour, 2016). While this suggests improved cancer detection and diagnostic systems are required, the reality is more complex, as we discovered during our research and discussion. Screening programs developed in high-resource countries may be not be possible in contexts with resource constraints such as limited infrastructure or equipment (Brown, Goldie, Draisma, Harford, & Lipscomb, 2006). More importantly, these types of interventions are only beneficial if there are facilities for appropriate follow up (e.g. it is only useful to administer a mammogram if there is treatment available for those with a positive

indication for breast cancer). Qualitative work has also suggested that the delay in medical help seeking may be due to a complex set of culturally related beliefs including inhibited emotional expression and the prioritization of family responsibilities over one's own health (Khakbazan, Taghipour, Roudsari, Mohammadi, & Omranipour, 2014)

A final topic of discussion, both before and during the workshop, was the importance of considering the exportation of cancer-related risk factors from high to low-income countries. Tobacco, for example, has fallen out of favor in Western countries and smoking rates have dropped steadily (Lee & Hashibe, 2014). Tobacco companies have turned their attention to emerging markets in developing countries where large populations coupled with lax tobacco policies allow for freer trade and higher profits. In considering our home countries, it was interesting to discuss how cultural norms could act either as a protector or hazard to exposure to cancer-related risk factors. In Iran, for example, cigarette smoking rates amongst women are very low (see Table 1), largely due to the social unacceptability of women smoking (Moosazadeh, Ziaaddini, Mirzazadeh, Ashrafi-Asgarabad, & Haghdoost, 2013). This is reflected in the low age standardized lung cancer incidence rates for women in the country: 5 per 100,000, relative to 27.4 per 100,000 in Irish women, for example (Jemal et al., 2011). In contrast, Mexico provided an example of the impact of the exportation of Western junk food; soda consumption per capita in Mexico was the second highest in the world in 2014 (Popkin & Hawkes, 2016). This new trend may be reflected in obesity-related cancer rates in Mexico in the future.

Table 1. Prevalence of smoking any tobacco product among persons aged ≥15 years in 2015.*

Country	Male [95% CI]**	Female [95% CI]**
Canada	17.7% [14.5, 21.1]	12.2% [10.2, 14.5]
Iran	21.5% [15.5, 28.8]	0.7% [0.4, 1.1]
Ireland	22.4% [15.0, 29.7]	21.9% [15.7, 30.1]
Mexico	20.8% [16.4, 25.3]	6.6% [5.2, 8.2]

*Information taken from Global Health Observatory Data Repository (World Health Organization, 2018).

**CI: confidence interval around the estimate.

Overall, this workshop provided a useful introduction to the global disparities in cancer for both participants and presenters. The presentations and discussion led by us, as international students, helped lend an engaged and participatory aspect to the workshop. Presenting cancer-related information from our countries side by side helped emphasize the differences in cancer policies, cancer risks, and the inequities in cancer care globally. As a result of the breadth of discussion topics, we put together a blog series to look at global cancer risk factors in greater detail (available at cancerprevent.ca).

Reflecting on this workshop led us to conclude that there are two primary benefits to this type of learning experience from an international student perspective. Firstly, discussing the differences between our countries in terms of cancer risk factors, rates, and mortality highlighted the gaps in our knowledge regarding other cultures, and the danger of making generalizations across countries. For example, the two of us from "developed" countries held beliefs that lung cancer is a disease that is on the rise in "developing" countries. While we could have learned that this is not always the case from online research (see Table 1), the opportunity to discuss why smoking is so low amongst Iranian women with our co-author—an Iranian woman herself, was invaluable. This highlighted to us how the sharing of experiences

and knowledge by international students can increase the level of contextual detail, and reveal important subtleties related to established facts in the learning environment.

Secondly, this workshop also encouraged us to reflect on our own heritage. Discussing our own individual countries' cancer risk factors, as well as the societal determinants of these factors, gave each of us a new perspective on aspects of our own cultures that we had taken for granted/seen as the norm. For example, Ireland has higher smoking rates than Canada, despite being at a similar level of socioeconomic development. This led our Irish co-author to consider possible explanations for this difference, and to reflect that despite Irish smoking policies often being described as successful, there is actually improvement needed when smoking rates are considered in the international context.

These cultural subtleties in cancer risk factors are essential knowledge for us, as people with an ambition to work in cancer prevention in the future. Whether we return to our home countries, or stay where we are now, increasing global migration coupled with a growing emphasis on behavioral interventions for cancer prevention will increase the importance of these types of skills when working in the field of public health. This workshop provided us, as students, with a valuable working example of how sharing varied international perspectives can open up new avenues of discussion for these types of inequities. Student-led workshops and symposia can provide useful demonstrations of how global concerns in health and other fields will need to be addressed in the future. In particular, our workshop demonstrated how important international student representation at these events is in encouraging cross-cultural engagement, enhancing student appreciation for the interplay between culture and disease risk factors, and more generally, improving student knowledge of different countries.

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