Progress report in implementing WHA 70.12 on Cancer Control

Member State Information Session

25 April 2023

World Health Organization

Objectives of MS Briefing

- Present WHO's programme of work in cancer including WHO cancer initiatives through an integrated approach
- Progress in cancer control planning – nationally, regionally and globally – tracking progress and impact of programmes
- Proposal for mapping, expected output and strengthening cancer control mandate, in line with the request from Slovak Republic and other EB members (EB 143)
- Next steps including reporting on progress to Governing Bodies

Time	Agenda Item
11:30	Welcome addresses
11:40	**Item 1**: WHO programme of work in cancer control: Progress in the implementation of initiatives in childhood, cervical and breast cancers
12:05	**Item 2**: Reporting on progress in cancer control: Mapping current status and data gaps
12:20	**Item 3**: Methodology for stock-take and setting a strategic direction for 2025 and beyond Review of proposed approach, sharing of best practices and results
12:30	**Item 4**: Moderated discussion with Member States
12:50	Wrap up and end of session

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Opening Remarks

Prof Dr Jérôme Salomon

Assistant Director-General,

Division of Universal Health Coverage, Communicable and Noncommunicable Diseases

Dr Maria Neira

Assistant Director-General (a.i.),

Division of Universal Health Coverage/Healthier Populations

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Agenda item 1:

WHO programme of work in cancer control

Progress in the implementation of initiatives in childhood, cervical and breast cancers

Time	Topic	Speaker
11.40 – 11.50	Current status of strategic priorities in cancer control	Dr Bente Mikkelsen, Director, Noncommunicable Diseases Department/HQ
11.50 – 11.55	WHO cancer initiatives and inclusion of communities with lived experience	
11.55 – 12.00	Cancer control link to health system strengthening with focus on access to medicines	Dr Rogério Pinto de Sa Gaspar, Director, Regulation and Prequalification Department/HQ
12.00 – 12.05	Integrated approach to cancer management with co-morbid conditions	Dr Meg Doherty, Director, Global HIV, Hepatitis and STI Programmes/HQ

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Current status of cancer control: *major burden, marked by inequalities*

20 mil

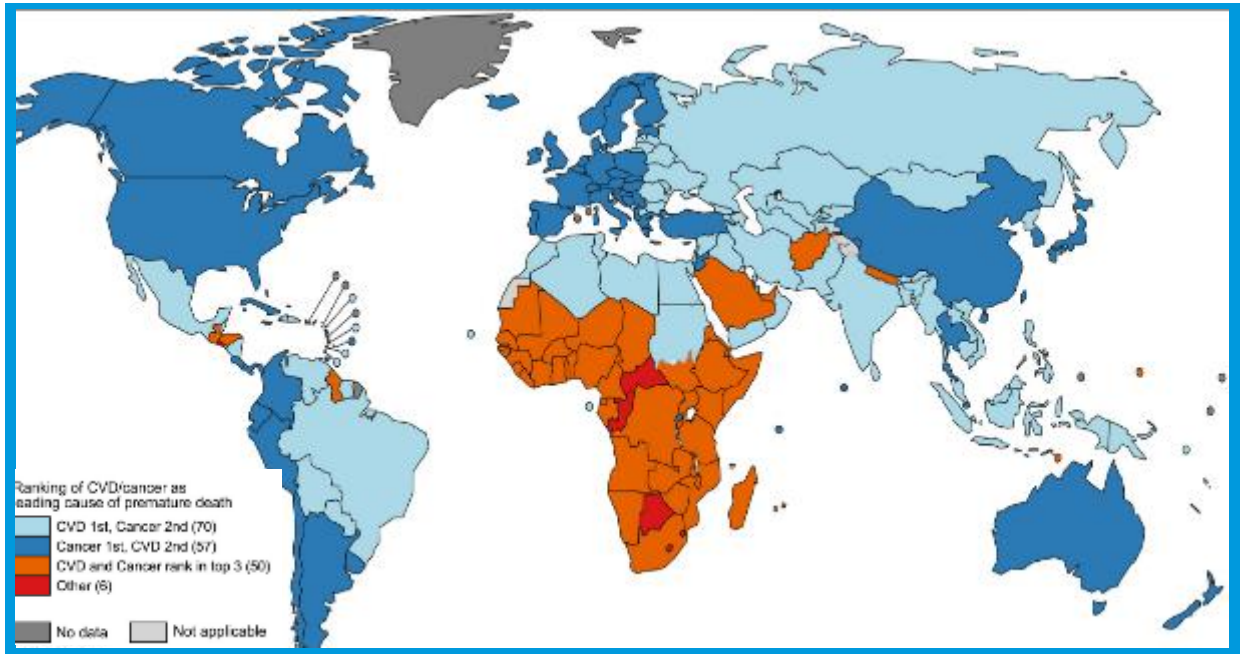
Diagnosed with cancer per year;
1 in 3 lifetime risk of being diagnosed with cancer in HIC;
Lifetime risk in LMIC is 1 in 6

14 (of 196)

Countries on track to reduce premature mortality from cancer by one-third by 2030

1 in 3

Cancer deaths in men in Europe associated with educational inequalities;
1 in 6 deaths in women in Europe



Cancer & CVD ranks as the two leading causes of premature death in **127 countries** (2019).
Cancer may be the leading cause of premature death this century.

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Generational harm: *premature deaths & impoverishment*

>60%

People with cancer experience anxiety or depression

>70%

Experience financial distress or hardship

GDP loss

0.5-2%

2.1

Maternal orphans per cancer death. Cancer affects women 2.7 million women aged 25-54 years old

>30%

People affected by cancer and caregivers experience unemployment after diagnosis.

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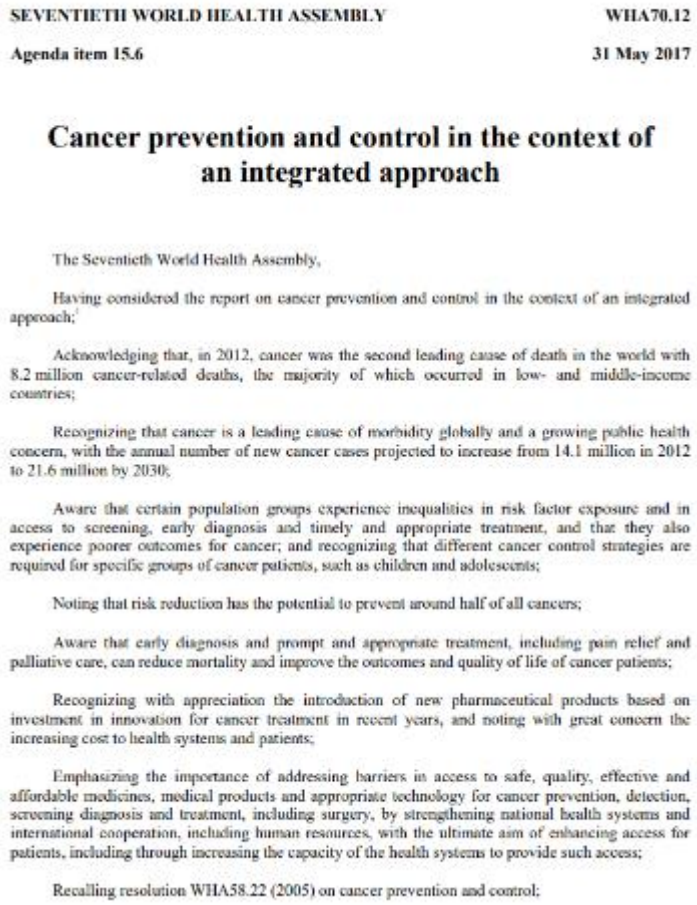
Tracking Progress in WHA 70.12 Implementation

Secretariat activity along strategic shifts	Output (2017 – 2023)
Overview	Launched 3 integrated cancer initiatives (cervical, childhood and breast cancers)
Technical guidance	Produced 10 strategic guidance documents and 2 implementation tools
Country support	Increased country support from 5 (2017) to 75 (ongoing)
Leadership & advocacy	Increased partner networks including 10 MoUs, 300 implementing partners; Launched network for people affected by cancer
Implementation capacity	Increased WHO capacity in RO and CO to >40 new staff & consultants Voluntary contribution – mainly, non-state actor



SEVENTIETH WORLD HEALTH ASSEMBLY WHA70.12

Agenda item 15.6 31 May 2017

Cancer prevention and control in the context of an integrated approach

The Seventieth World Health Assembly,

Having considered the report on cancer prevention and control in the context of an integrated approach;

Acknowledging that, in 2012, cancer was the second leading cause of death in the world with 8.2 million cancer-related deaths, the majority of which occurred in low- and middle-income countries;

Recognizing that cancer is a leading cause of morbidity globally and a growing public health concern, with the annual number of new cancer cases projected to increase from 14.1 million in 2012 to 21.6 million by 2030;

Aware that certain population groups experience inequalities in risk factor exposure and in access to screening, early diagnosis and timely and appropriate treatment, and that they also experience poorer outcomes for cancer; and recognizing that different cancer control strategies are required for specific groups of cancer patients, such as children and adolescents;

Noting that risk reduction has the potential to prevent around half of all cancers;

Aware that early diagnosis and prompt and appropriate treatment, including pain relief and palliative care, can reduce mortality and improve the outcomes and quality of life of cancer patients;

Recognizing with appreciation the introduction of new pharmaceutical products based on investment in innovation for cancer treatment in recent years, and noting with great concern the increasing cost to health systems and patients;

Emphasizing the importance of addressing barriers in access to safe, quality, effective and affordable medicines, medical products and appropriate technology for cancer prevention, detection, screening diagnosis and treatment, including surgery, by strengthening national health systems and international cooperation, including human resources, with the ultimate aim of enhancing access for patients, including through increasing the capacity of the health systems to provide such access;

Recalling resolution WHA58.22 (2005) on cancer prevention and control;

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Overview of major milestones by MS request

2018

DG announces call for Cervical Cancer Elimination

Launch of WHO **Global Initiative for Childhood Cancer**

Pricing of cancer medicines and its impacts

2019

Guidelines for pain management

Monitoring system for cervical cancer

2020

Launch of WHO Global Report on Cancer

Launch of **Global strategy to accelerate elimination of cervical cancer** with technical guidance

2021

WHO guidelines for screening and treatment of cervical cancer; AI evidence

Cure*All* Framework for GICC

Launch of GBCI using resource-stratified approach

Announce Global Platform for access to childhood cancer medicines

2022

Cancer centre document with IAEA

Amplifying the lived experience of people affected by cancer

Community of practice established

Partner and donor network expanded

2023

Launch of implementation guidance for **Global Breast Cancer Initiative**

Position paper on breast cancer & alcohol use – integrated RF and management

WHO-IARC workplan established

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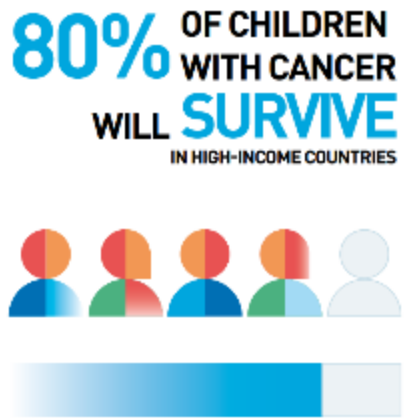
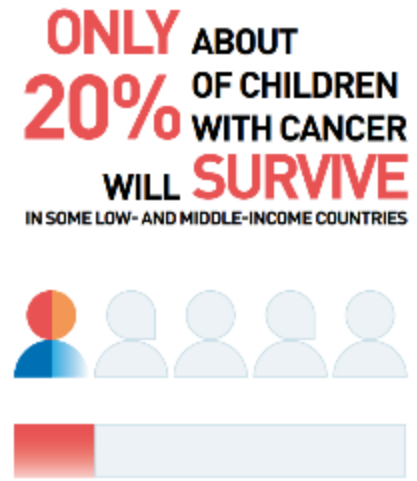
Global Initiative for Childhood Cancer

>80% children with cancer in **HIC** survive



<20-30% children with cancer in LMIC survive



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Cure*All* Country Showcase: GICC Milestones

$ 12,000,000

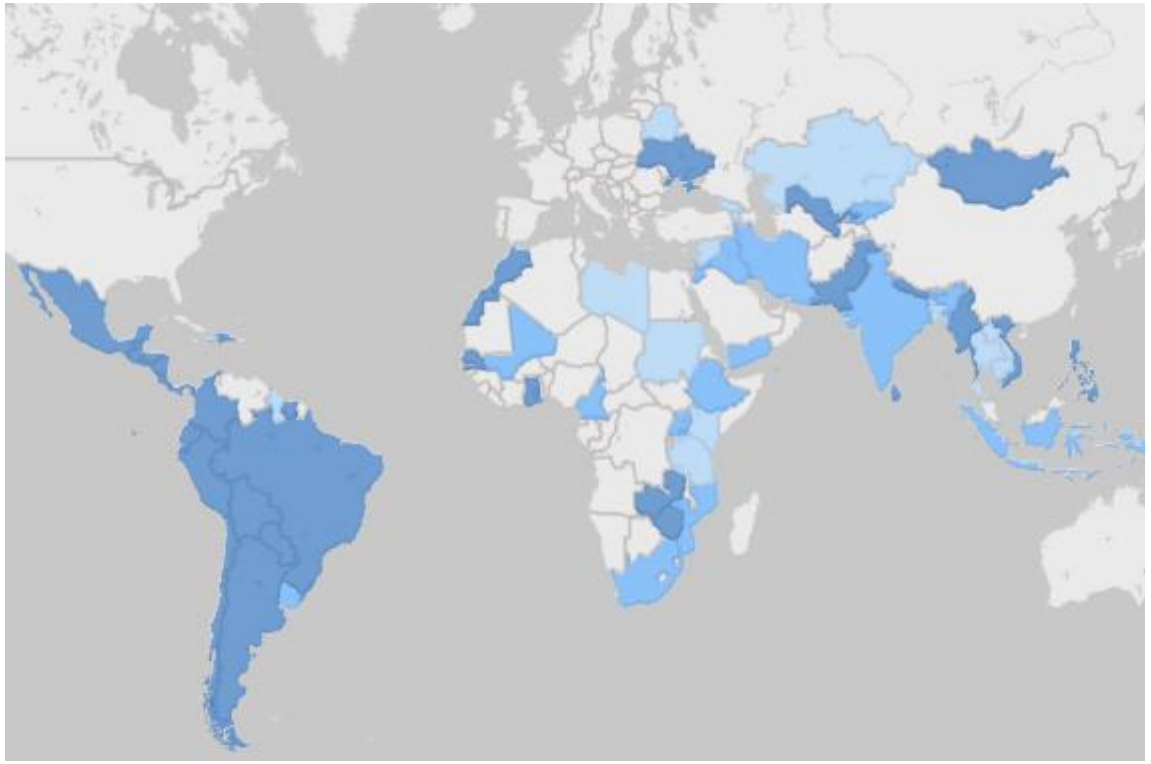
Funding support distributed to major WHO Budget Centres, Years 1-4

150+

Childhood cancer centres supported in providing care across 6 WHO Regions

35,000+

Children newly diagnosed with cancer accessing care improved care in **70+ countries**



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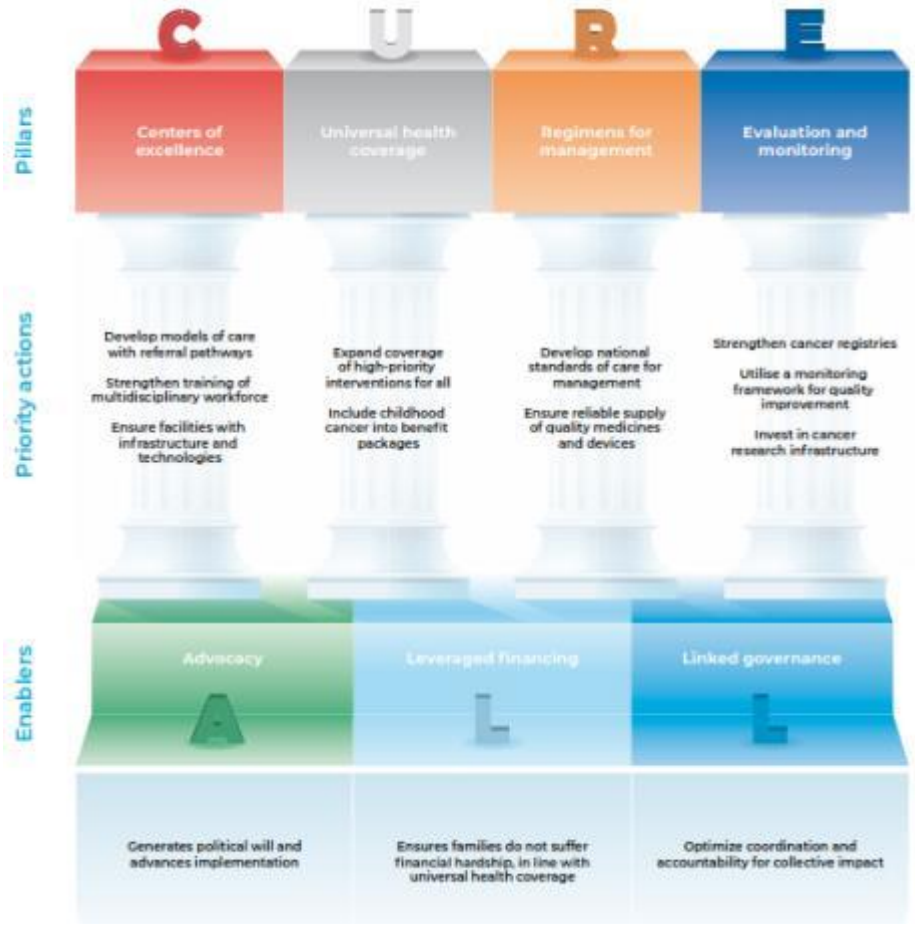
Cure*All* Country Showcase: GICC Milestones



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Global Platform for Access to Childhood Cancer Medicines

Platform vision: a **comprehensive** solution engaging **global partners** to provide an **uninterrupted** supply of **quality** childhood cancer medicines

		Initial Phase		Growth Phase		
	2022	**2023**	**2024**	**2025**	**2026**	**2027**
Countries		6	12	30	40	50
Children		5,000	12,000	25,000	35,000	50,000
Budget (USD)	2 mil	11 mil	21 mil	39 mil	50 mil	65 mil

*** 50,000 children per year by 2027 represents approximately**:

- 25% of all children with cancer in the world
- 60% to 70% of children with cancer in low- & lower-middle income countries

By 2027, the Global Platform will have provided medications for > 120,000 children

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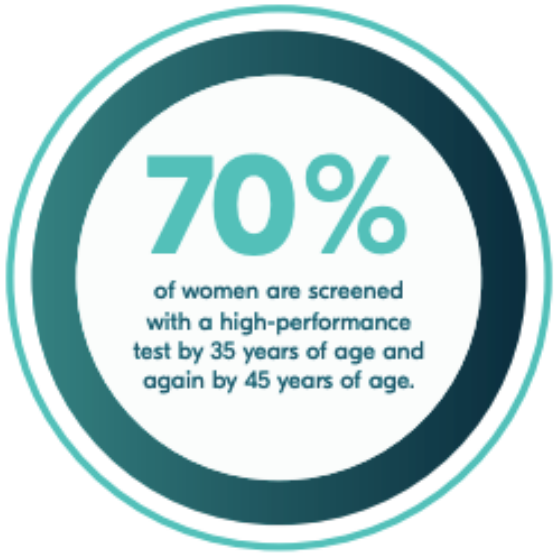
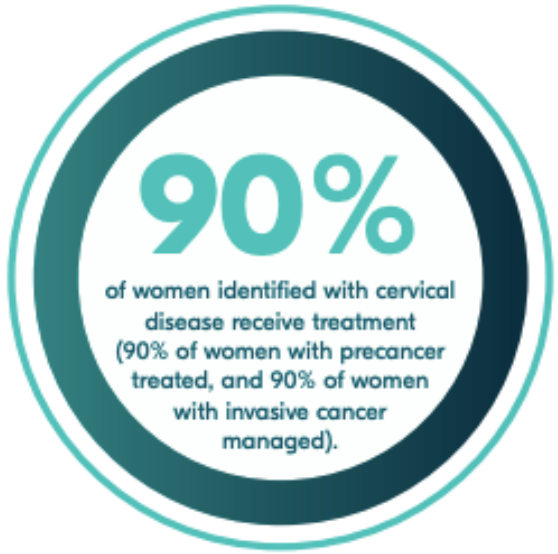
The Global Strategy

THRESHOLD: < 4 cases per 100 000 women per year

2030 Control Targets





LIFE-COURSE APPROACH:

Three pillars provide a **comprehensive strategy** to ensure lifetime benefits are maximized.

Cervical Cancer Elimination Initiative: timeline & progress

Flagship launched by WHO Director-General (2018)

"One woman dies of cervical cancer every two minutes...Each one is a tragedy, and we can prevent it."

Partnership, advocacy, and monitoring and evaluation

Adoption & Launch of Global strategy	Guidance updated & expanded	Regional implementation / action plan	**Implementation guidance & support**
2020	2021-2022	2022	**Strengthened leadership & accelerated impact**

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CCEI Implementation

COORDINATION

Building on existing UN coordination mechanism – dialogues with UNFPA, UNICEF, GAVI, Unitaid and others

Partner networks
Developing WHO implementation network with South-South engagement

Expanding stakeholder dialogue
For example, African Union Commonwealth, Union for Mediterranean, cancer institutes

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ADVOCACY

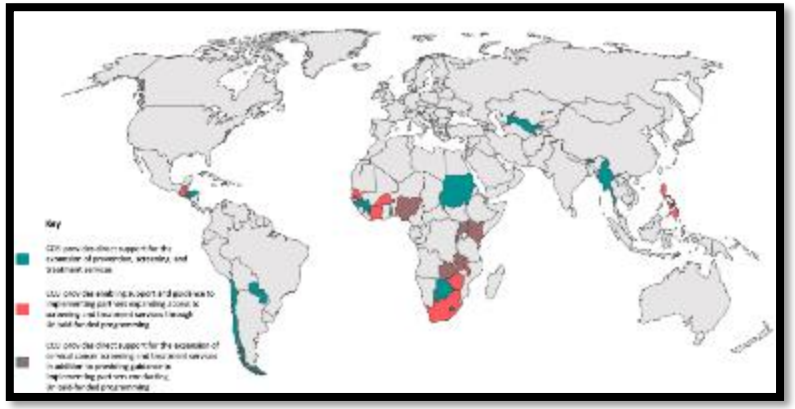
17 November: day of action

Uzbekistan: Great Silk Road

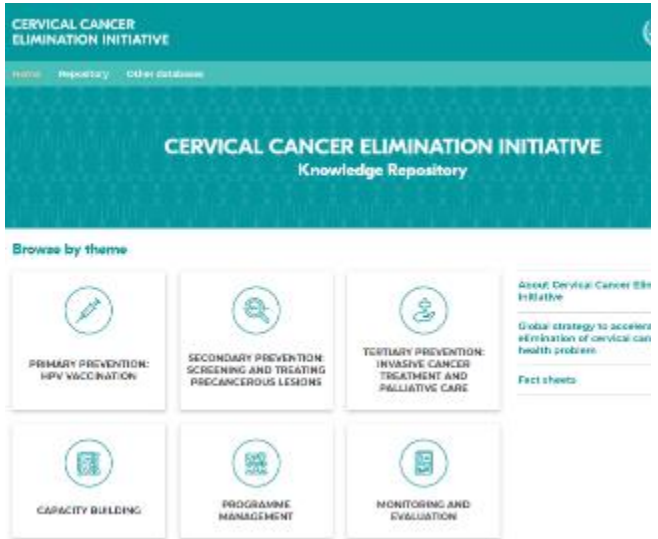
WHO Ambassador
CCEI led a history-making endeavour to **honor Henrietta Lacks**

First Spouse Network
>10 First Spouses engaging with CCEI

CCEI direct support to 20 Member States, leveraging implementation partners for impact.



Knowledge repository & exchange
including communities of practice



Global Breast Cancer Initiative

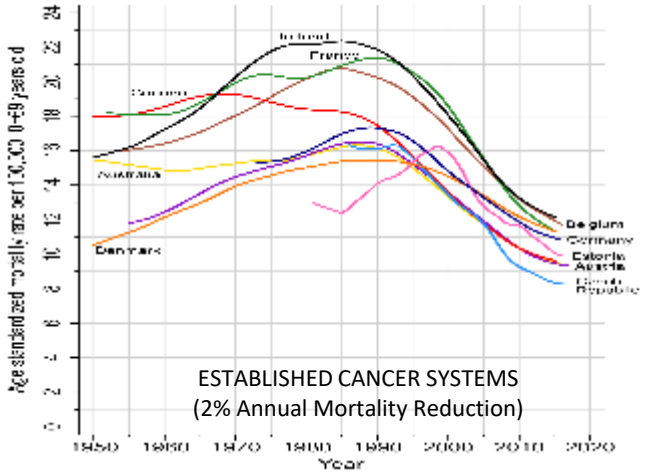
OBJECTIVE: reduce breast cancer mortality by 2.5% per year, to avert **2.5 million breast cancer deaths** globally by 2040.

Pillar 1
Pre-diagnostic interval
Early detection

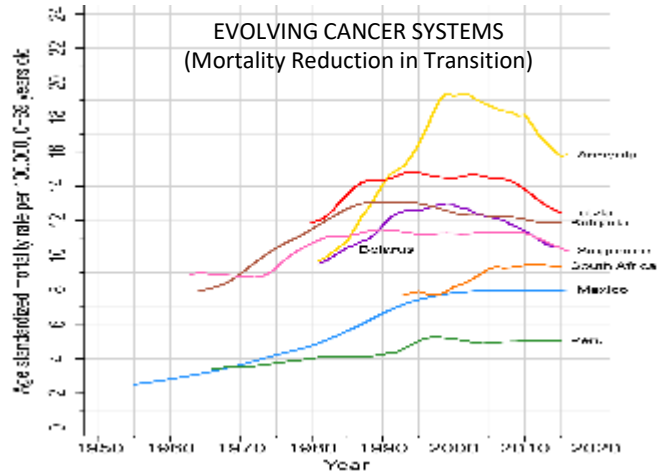
Pillar 2
Diagnostic interval
Definitive diagnosis

Pillar 3
Treatment interval
Integrated care

AGE-STANDARDIZED BREAST CANCER MORTALITY RATES



ESTABLISHED CANCER SYSTEMS
(2% Annual Mortality Reduction)



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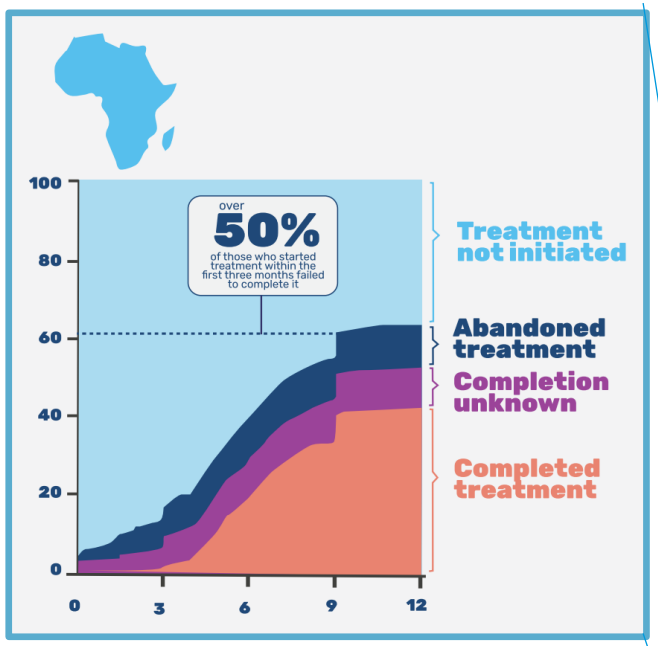
Global Breast Cancer Initiative

3 pillars



Pillar 1

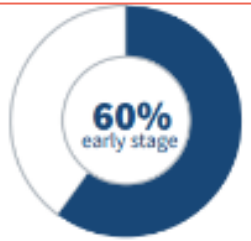
Heath promotion for early detection (pre-diagnostic interval)

Pillar 2

Timely breast diagnostics (diagnostic interval)

Pillar 3

Comprehensive breast-cancer management (treatment interval)



Achieve diagnosis of at least 60% of invasive breast cancers at stage I or II

Evaluation, imaging, tissue sampling and pathology completed within 60 days

80% undergo full courses of multimodality treatment and successfully return home

3 implementation strategies

Convene multi-sectoral stakeholders

Develop operational guidance

Accelerate & monitor implementation

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Launch of campaign to engage communities affected by cancer

Primary objective:

- to **<u>understand and support</u>** impact of cancer in the medium to long-term, in a diversity of settings

Secondary objectives:

- to **define and innovate** ways stakeholders support people facing a cancer diagnosis and their families.

SURVEY (ENGLISH)

SURVEY (FRANÇAIS)

SURVEY (ESPAÑOL)

73% BUT **30%**

Wanted to speak with their health professional about their emotional health

Had any discussion on emotional well being

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Levers in access to oncology medicines

Policy, including National Essential Medicines Lists (nEML) and treatment guidelines, reflect oncology medicines, including biosimilars.

Procurement, pricing and financing strategies are in place to ensure sustainable access.

Regulatory affairs are enabled, including pharmacovigilance, to ensure safe distribution and use of medicines.

- Normal levers along the value chain for access to medicines may not be well developed for oncology medicines if treatment options have been limited to private institutions.
- All of these areas will need to be assured. In some cases, regulators require support, which can be available from WHO Prequalification Programme for many situations.

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Access to medicines: prequalification & regulatory pathway

- The regulatory environment can be complex, particularly for oncology medicines and especially in LMIC markets.
- To stabilize markets, it will be critical to ensure products have market authorization from National Medicines Regulatory Authority.
- If the products have been imported through informal means, or if they are being used “off label”, availability and quality are often unstable.
- In some cases, regulators require support, which can be available from WHO Prequalification of Medicines Programme for many situation.

PQ pilot for biosimilar oncology medicines ongoing

- Trastuzumab (breast cancer): 4 manufacturers
- Rituximab (non-Hodgkin’s lymphoma & leukemia): 3 manufacturers

PQ will expand to include additional oncology medicines

- Identification and prioritization for products included into the WHO Prequalification Programme is based on ongoing recommendations from technical department.
- Work is in progress

Support is available for the best regulatory pathway

- WHO Collaborative Registration Procedure is an option for products prequalified by WHO
- Other reliance mechanisms may be used, where available, for other products

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Cervical cancer and HIV are intricately linked

Women and girls living with HIV have:

- Higher risk of getting HPV infection
- Lower chances of clearing the infection
- Faster progression from infection to cancer
- Lower regression of pre-cancer lesions
- Higher recurrence following treatment
- Younger age at presentation

Our goals are to:

- Better understand this relationship & prioritize resources
- Develop guidance relating to cervical cancer & HIV
- Support woman-centred program integration and expansion of coverage

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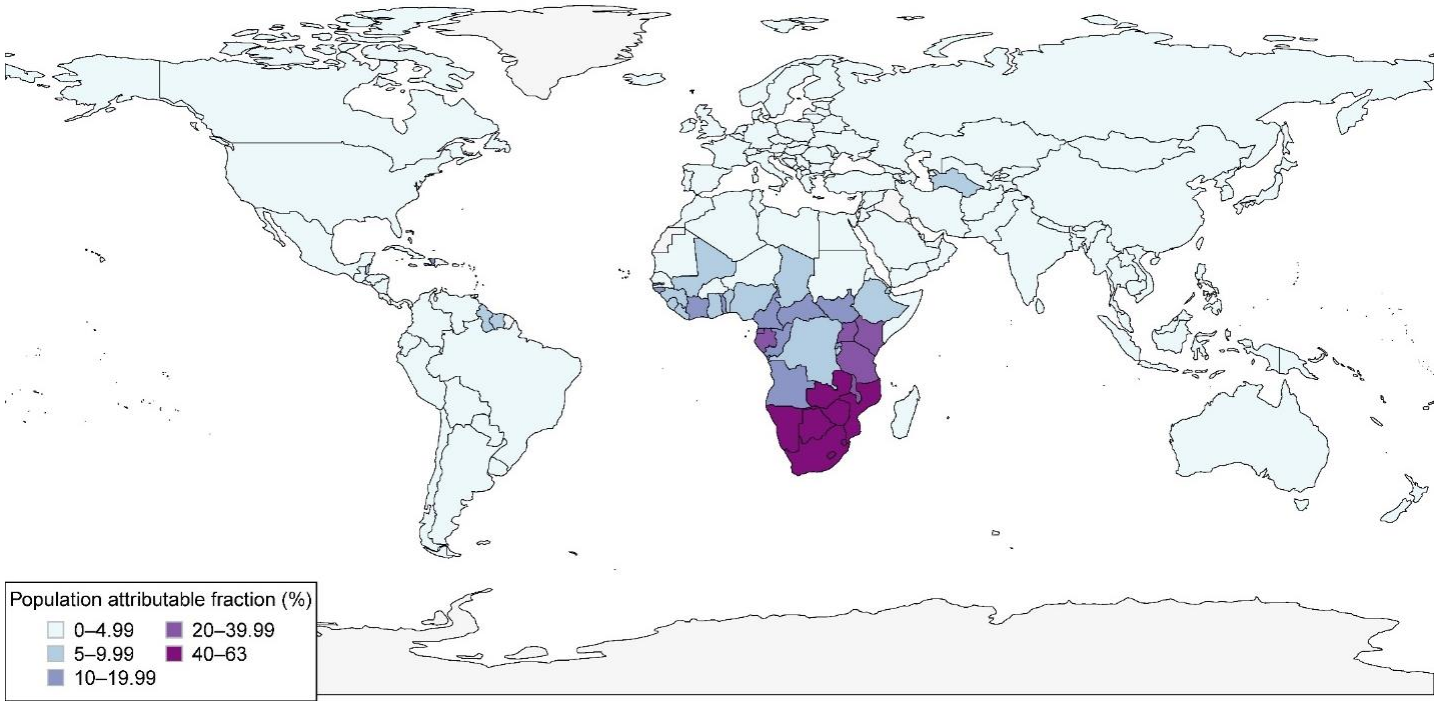
Risk for cervical cancer among women living with HIV is 6x higher (RR = 6.07)

Population attributable fraction of women with cervical cancer living with HIV, 2018



Source: Stelzle D, Tanaka LF, Lee KK, et al. Estimates of the global burden of cervical cancer associated with HIV. Lancet Glob Health 2020; published online Nov 16.

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Over 15 million women on ARVs provide an opportunity for screening and treatment.

Two Important WHO Guidelines

Screening and treatment to prevent cervical cancer

- Age of screening initiation
- Interval of cervical cancer screening
- Optimal algorithm for screening and treatment
  - Limited data for multiple test/treatment algorithms in WLHIV
  - Modeling of ~30 scenarios with differing screening tests and treatment options

Consolidated HIV Guidelines

- Clinical services
- Service delivery
  - Focus on people-centered care
  - Integration and linking services
    - Section on cervical cancer screening for women living with HIV

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Summary Cervical Cancer Screening & Treatment Recommendations

Summary Recommendation for the general population of women

WHO suggests using either of the following strategies for cervical cancer prevention among the general population of women:

- HPV DNA detection in a screen-and-treat approach starting at the age of 30 years with regular screening every 5 to 10 years.
- HPV DNA detection in a screen, triage and treat approach starting at the age of 30 years with regular screening every 5 to 10 years.

Summary Recommendation for **women living with HIV**

WHO suggests using the following strategy for cervical cancer prevention among women living with HIV:

- HPV DNA detection in a **screen, triage and treat approach** starting at the **age of 25 years** with **regular screening every 3 to 5 years**.

Awareness of cervical cancer prevention

Low levels of knowledge on cervical cancer, its association with HPV and the ability to prevent it

High acceptability (70% or higher, several with 90%) across studies for self-sampling, VIA, HPV DNA tests or triage-based methods

Clear and strong preference for immediate treatment following a diagnosis of a cervical intraepithelial lesion among all women

Single-visit based approach and multi-visit approach feasible across multiple intervention types – self-sampling, HPV test, VIA, cryotherapy, LEEP and thermocoagulation

- An online survey found that women stated they were likely to have difficulties returning for follow-up

Clear request from the community for better counselling, patient education, availability of choices of treatment and screening tests

Policy & Program Implementation

Support ministries of health in adopting guidelines

- Increase country-level impact
- Improve awareness in communities

Bi-directional integration of HIV and cervical cancer services

- Improve service provision in settings with high HIV prevalence
- Facilitate referrals between programs
- Early identification of STIs

Further strengthen links with the community

- Advocate for better counselling, patient education, availability of treatment and screening tests
- Involve community of women in all aspects of programme development

Address knowledge gaps with implementation science

Agenda item 2:

Monitoring progress in cancer control

Current reporting on core indicators and data gaps

Time	Topic	Speaker
12.05 – 12.10	Mandate to report on programme of work in cancer	Dr Bente Mikkelsen, Director, Noncommunicable Diseases Department/HQ
12.10 – 12.15	IARC Global cancer observatory	Dr Freddie Bray, Head, Cancer Surveillance Branch
12.15 – 12.20	Reporting social and economic impact of cancer	Dr Tessa Edejer, Director (a.i.), Health Financing and Governance Department/HQ
12.20 – 12.25	Using data to shape innovation in cancer control	Dr John Reeder, Director, Research for Health Department/HQ

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Reporting to WHA on progress in cancer control: current mandate

	Monitoring framework	Cancer indicators	Frequency & End Date
SIXTY-SIXTH WORLD HEALTH ASSEMBLY WHA66.10 Agenda item 13.1 Agenda item 13.2 27 May 2013 **Follow-up to the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases**		(1) Cancer incidence (2) Proportion screened for cervical cancer (3) HPV vaccination availability (4) Hep B vaccination coverage	(1) Yearly Progress Monitor to WHA until 2031 (2) 2024 Progress report to UN SG, preparation for 4th HLM on NCDs
		No cancer targets among 9 NCD voluntary targets	
SEVENTIETH WORLD HEALTH ASSEMBLY WHA70.12 Agenda item 15.6 31 May 2017 **Cancer prevention and control in the context of an integrated approach**	**None requested**	**None**	(1) Narrative reporting in line with WHA 66.12 (yearly) (2) "Periodic" global report on cancer
SEVENTY-THIRD WORLD HEALTH ASSEMBLY WHA73.2 Agenda item 11.4 3 August 2020 **Global strategy to accelerate the elimination of cervical cancer as a public health problem and its associated goals and targets for the period 2020–2030**	*In development* "MS adopt strategy with associated goals and target"	(1) HPV vaccination coverage (2) Proportion screened for cervical cancer (3) Proportion with cervical disease receiving treatment ***Two indicators related to GMF for NCDs***	(1) Narrative reporting in line with WHA 66.12 (yearly) (2) Implementation progress in 2022 and 2025 (3) Final report in 2030

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Core indicators for WHO Cancer initiative: data gaps

Cervical cancer incidence <4 per 100,000

MS adopted targets

Childhood cancer survival >60%

(collected by 30-50 MS)

(1) Number of children completing treatment

(2) Inclusion of childhood cancer in benefit packages/policies

(3) Number of public childhood cancer centres

Annual ↓breast cancer mortality (2.5%/yr)

(1) Stage of diagnosis

(collected by 70-90 MS)

(2) Time to diagnosis

(3) Treatment completion rate

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Current guidance & capacity building in NCDs

	C1 Clinical breast evaluation for early diagnosis of breast cancer among women aged 30–49 years with signs and/or symptoms associated with breast cancer
Indicator name	Clinical breast evaluation for early diagnosis of breast cancer among women aged 30–49 years with signs and/or symptoms associated with breast cancer
Purpose	To measure level of breast health services
Definition	Proportion of women aged 30–49 years with signs and/or symptoms associated with breast cancer who underwent an appropriate clinical breast evaluation for early diagnosis of signs and symptoms associated with breast cancer based on WHO or national guidelines Clinical breast evaluation consists of: • Taking a health history including a breast health history, and • Performing a physical examination including a clinical breast examination to identify persons with signs and/or symptoms of breast cancer Common signs and symptoms of breast cancer include: • A breast lump or thickening confirmed on clinical breast examination • Newly developed whole breast asymmetry • Skin retraction, increasing nipple retraction • Spontaneous clear or bloody nipple discharge Early breast cancer symptoms include: • The women's sense of a discrete lump • Thickening or localized non-migratory pain in the breast Advanced breast cancers may exhibit skin changes with redness that over time evolves into ulceration
Numerator	Number of women aged 30–49 years with signs and/or symptoms associated with breast cancer who underwent a clinical breast evaluation for breast cancer early diagnosis in the last year
Denominator	Total number of women aged 30–49 years with signs and/or symptoms associated with breast cancer who attended the facility in the last year
Method of calculation	Numerator ÷ denominator × 100
Aggregation	District, province, state, country
Disaggregation	Where possible and applicable, stratify by health facility, provider ownership type (public/private), and patient characteristics such as age, sex, race/ethnicity, comorbidity status, high risk groups, socio-economic status, residence type (urban/rural), and health insurance type
Sources of data	Health facility patient registers, patient records
Key data elements	Sex, age, presence of breast cancer signs and/or symptoms, clinical breast evaluation status
Frequency of reporting	Annually
Users of data	Facility-level managers to assess the proportion of women in the target age group who have been evaluated for breast abnormalities District-, province-, state-, and national-level managers to assess the overall quality of breast cancer diagnostic and screening services, and to identify poorly performing facilities and rectify problems at an early stage

- ***1st phase:*** Meta-data provided for 20 facility-based (primary care) indicators
- ***2nd phase:*** selection and finalization of facility-based data for cancer centres

- Implementation approach (sample):
  - Integration of indicators into DHIS-2
  - Pilot testing planned; broad engagement of implementation partners

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NCD Data Portal & visualization platform

- ***1st phase:*** NCD indicators routinely collected and reported to WHO including RF and disease burden

- ***2nd phase:*** data visualization platform to support adoption of “NCD best buys” and to demonstrate the value (impact and cost-effectiveness) of implementation

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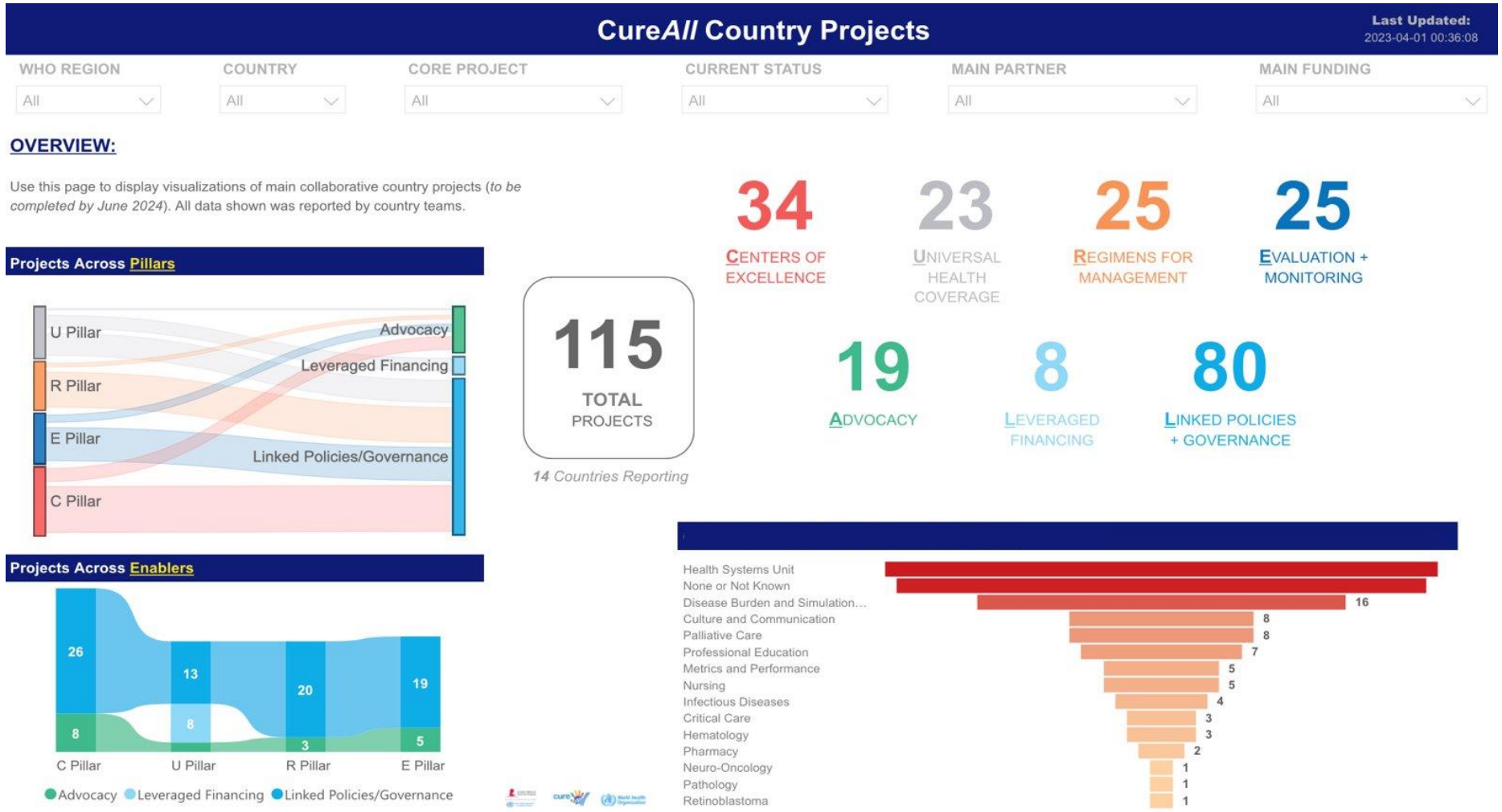
Sample implementation monitoring: draft approach from GICC



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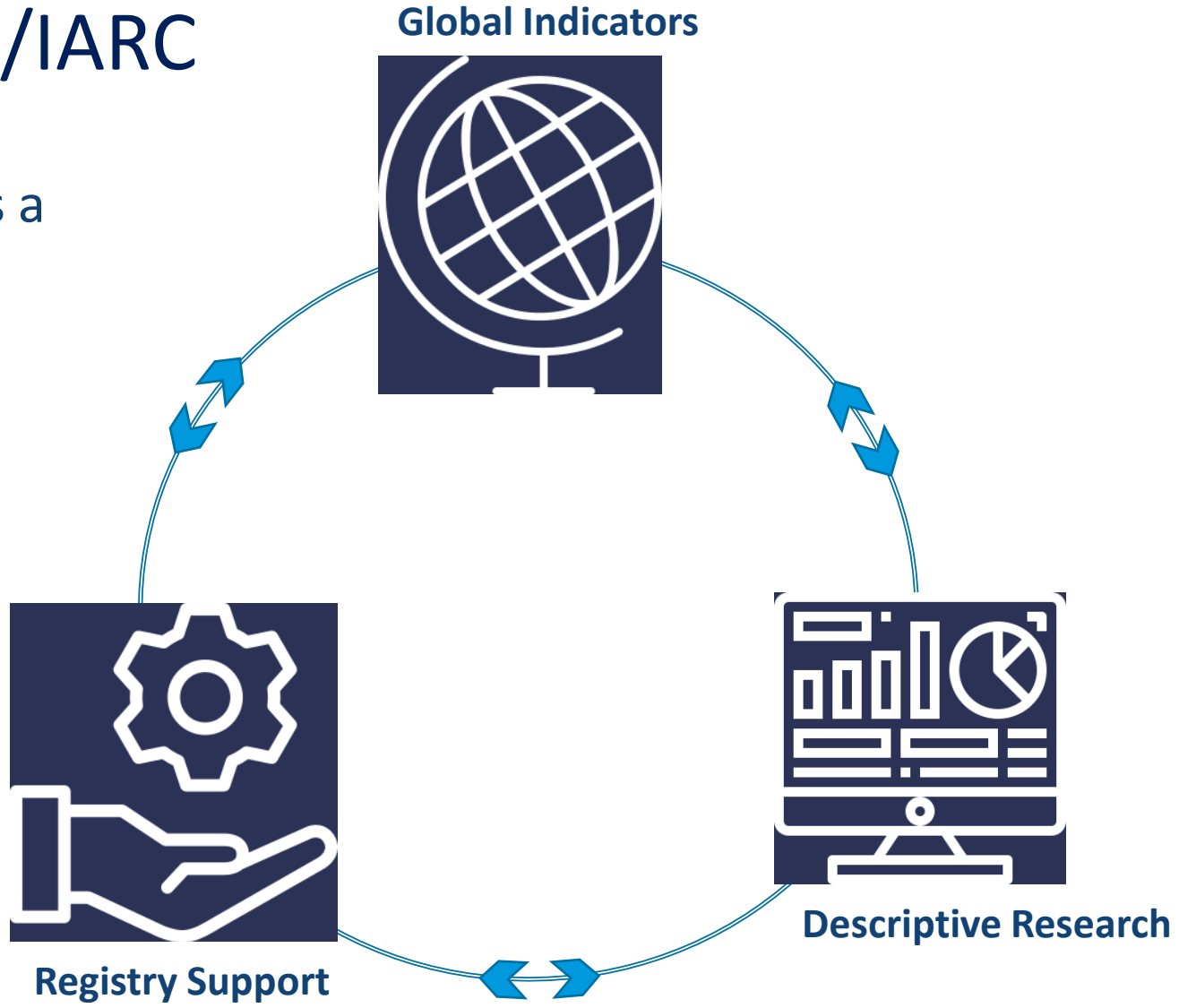
Draft content with credit to Dr Catherine Lam, St Jude Children's Research Hospital

Cancer Surveillance at WHO/IARC

- consolidate and expand IARC's role as a global reference for cancer data
- ensure locally recorded data are of high quality available for cancer control and research
- conduct research that illustrates the transitional nature of cancer and the benefits of interventions



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Cancer Surveillance Framework

Core Surveillance Measures	Risk Factors	Risk factor reduction	Screening programme	Incidence	· By cancer type · By stage	Survival	Mortality
Surveillance Strategy	Population Surveys	Vaccine registry	Screening registry	PBCRs		PBCRs	Vital Statistics
Extended Surveillance Measures				Attributable Risk		Prevalence	DALYs
				Associated Economic Costs			
Population	Healthy			New Diagnosis		Living With Cancer	Dying From Cancer
Cancer control continuum	**Prevention**			**Early Detection**		**Treatment Care**	**Palliative End-of-Life Care**

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Global Initiative for Cancer Registration (GICR) – data for action

VISION

SAVING LIVES THROUGH RELIABLE DATA

OUTCOMES

Long-Term:
- 50 new high quality cancer registries by 2030
- Evidence base for cancer control planning
- Greater understanding of the cancer burden

Medium-Term:
- First cancer registry reports in 50 countries
- Regional and national cancer registry networks
- Accelerate the development of new free and open-sourced electronic tools

Short-Term:
- 50 country led plans to implement population-based cancer registries
- Training for over 700 professionals
- Development of mentorship programme

STRATEGIC GOALS

1. Country Leadership
- ✓ Increase qualified staff through training, educational resources, and access to experts
- ✓ Support improvements in the quality and use of sustainable population-based cancer registry data
- ✓ Enhance the use of reporting tools
- ✓ Contribute to the integration of cancer data in health care planning

2. Regional Focus
- ✓ Equip six IARC Regional Hubs as local providers to PBCRs
- ✓ Develop regional networks to promote peer-to-peer country interactions
- ✓ Accelerate the scale up new solutions by documenting and sharing proven strategies
- ✓ Inspire innovation with emerging electronic technologies

3. Global Coordination
- ✓ Engage partners to develop strategic directions and operational plans
- ✓ Provide support to Regional Hubs and countries
- ✓ Raise awareness of the role of PBCRs in national cancer control strategies
- ✓ Coordinate and provide oversight for projects through collaborative agreements with IARC

FOUNDATION

PRINCIPLES
- Country led cancer action
- Focused on low– and middle– income countries
- Collaborative, flexible model
- Scientific integrity
- Results-based management and accountability

CORE FUNCTIONS
- Training
- Directed Support
- Networks
- Cancer Control

- A global partnership to improve the quality, availability and use of data from population-based cancer registries (PBCR) worldwide
- Six IARC Hubs created with support of 13 IARC-GICR Centres of Expertise

GICR*Net*

- 'train the trainer' ++ model to form subject specific networks to deliver regional courses and provide support to registries
- Move towards greater responsibilities of regional trainers in courses and support
- Integration of learning materials to develop certification programme: in-person; E-learning modules; and technical reports

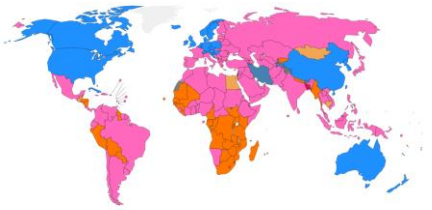
Electronic medical health data linkages

- District Health Information System v2 (DHIS2) cancer module to link data w CanReg5+
- Piloted in the Caribbean with the OECS and the IARC Caribbean Hub (11 countries)
- CanReg5+, enhanced to take advantage of modern technology using insights gained from users and the CanReg5 GICR*Net*

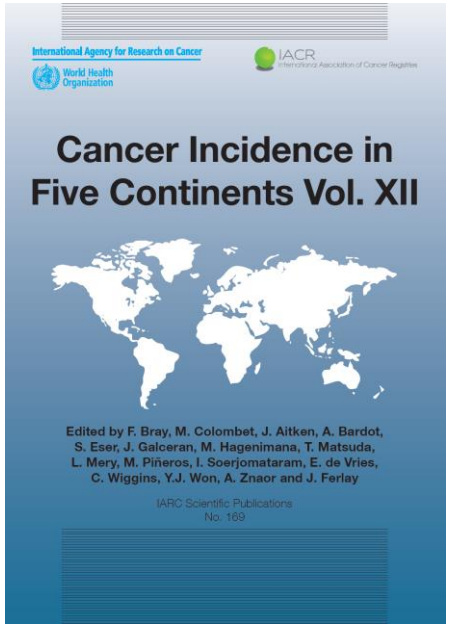
GICR Partner Countries

- Identify and develop joint work plans to improve the registry in selected countries; clear opportunity with commitment from the country and agreement to monitor progress towards goals
- Up to an additional 30 Partner Countries in next five years

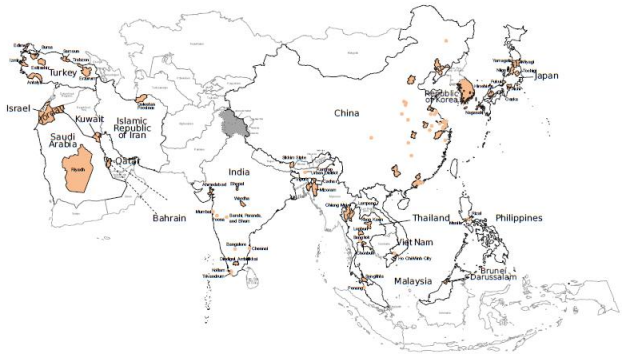
IARC global data launches 2023



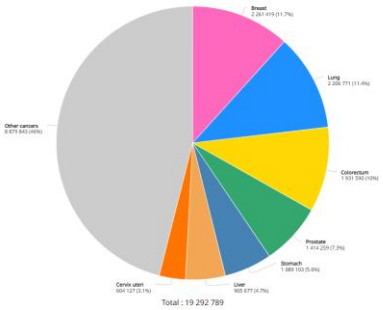
Cancer Incidence in Five Continents → GLOBOCAN

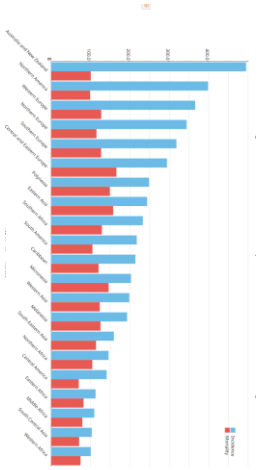


- Compendium of comparable data on cancer incidence in different subpopulations
- Reference source for studies exploring cancer variations
- Volume XII (2013-17) online end-June 2023



- Incidence, mortality and prevalence estimates in 185 countries, 36 cancers, by sex and age
- Estimates derived from best available information in each country
- GLOBOCAN 2022 launched end-May 2023 on the Global Cancer Observatory (GCO)





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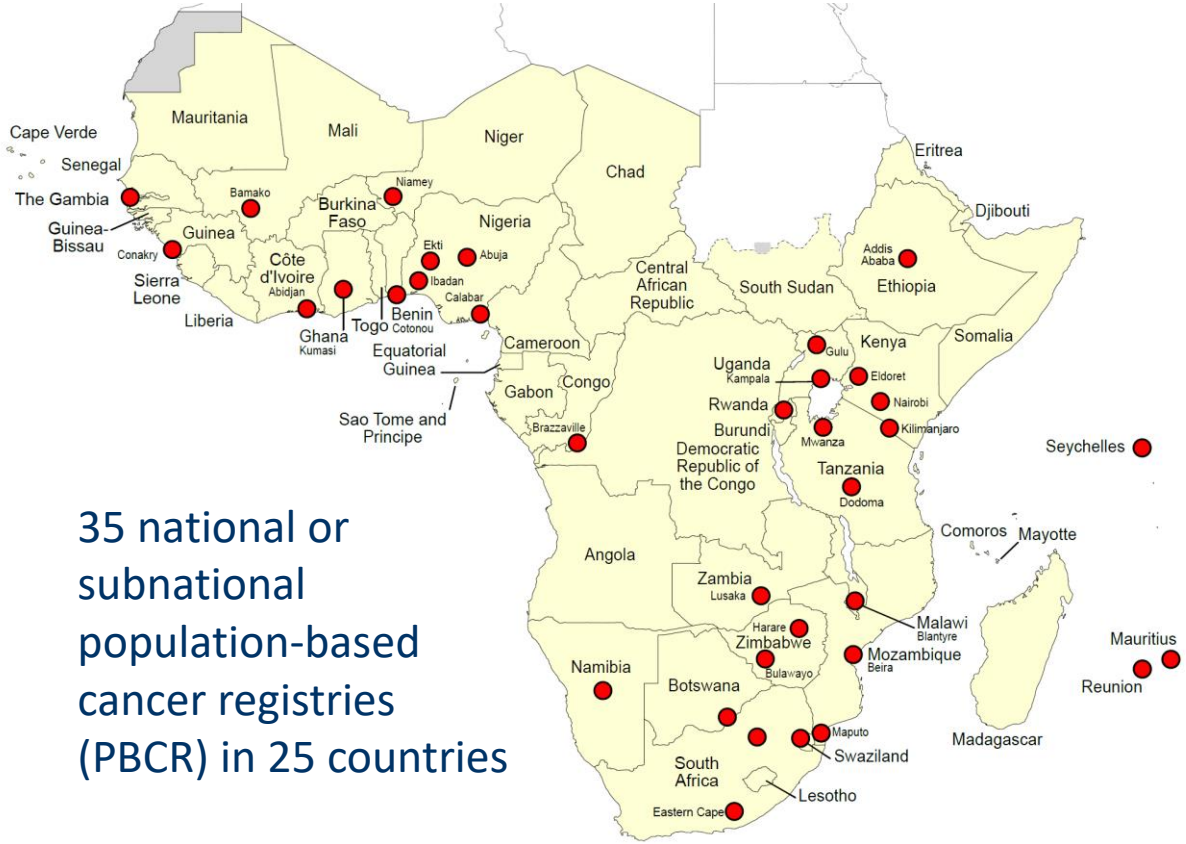
How do we get robust national estimates of the cancer burden?

PBCR in the African Cancer Registry Network (AFCRN)



35 national or subnational population-based cancer registries (PBCR) in 25 countries

Data source: GICR
Map production: IARC
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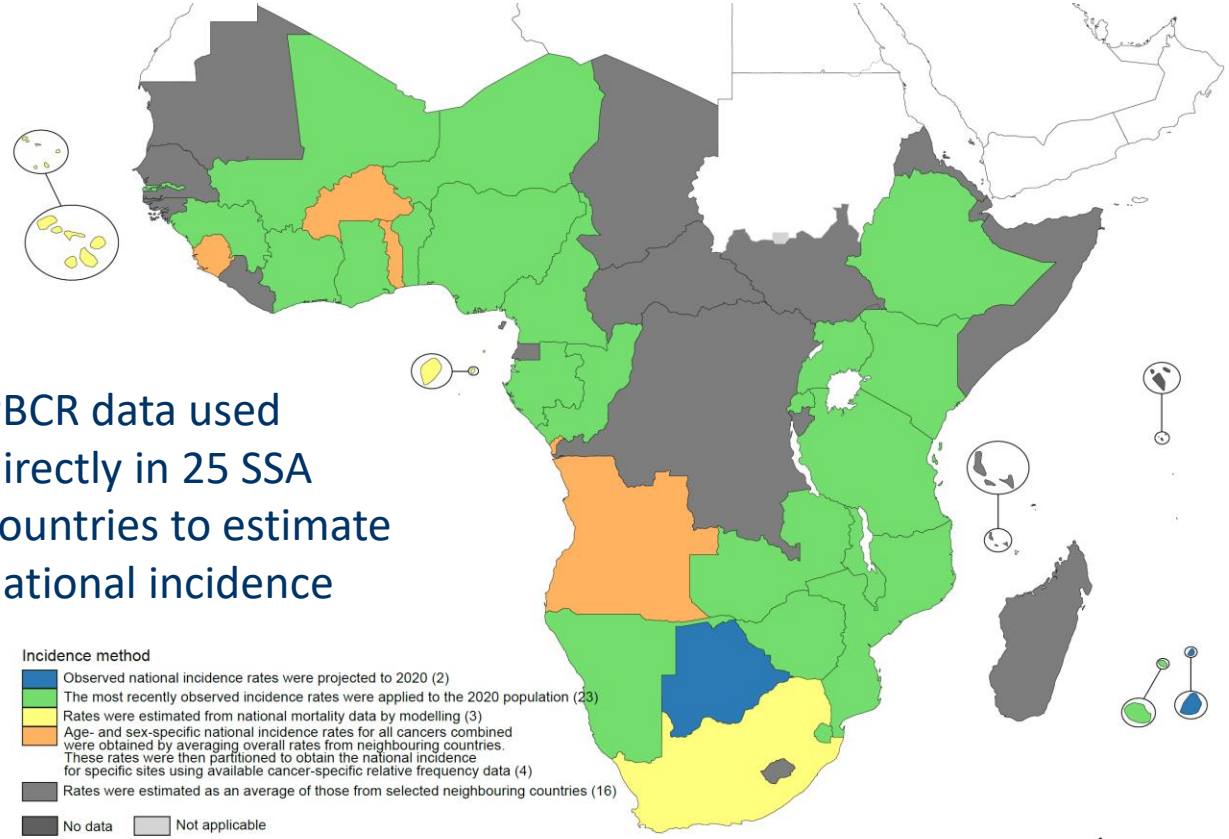
World Health Organization

Methods of national incidence estimation, GLOBOCAN 2020



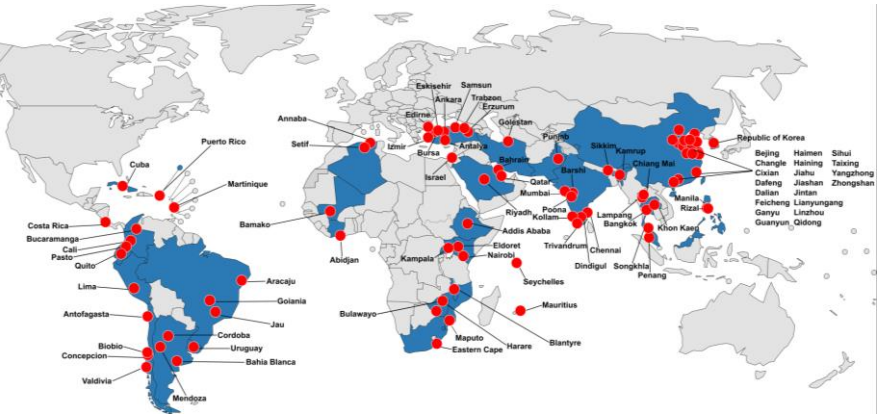
PBCR data used directly in 25 SSA countries to estimate national incidence

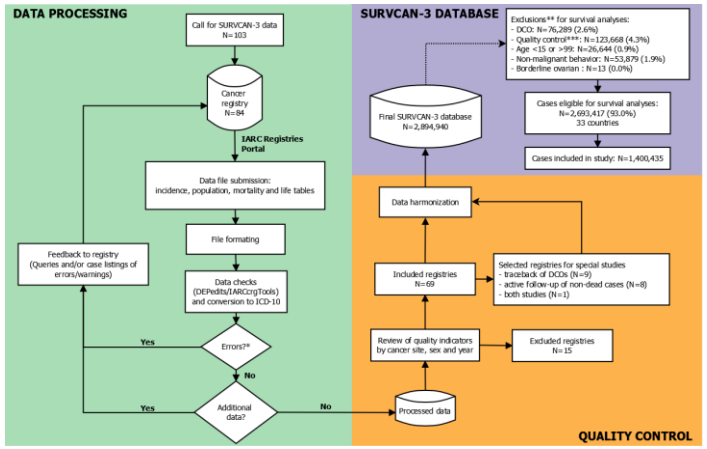
GLOBAL CANCER OBSERVATORY

Data source: Globocan 2020
Map production: IARC
World Health Organization

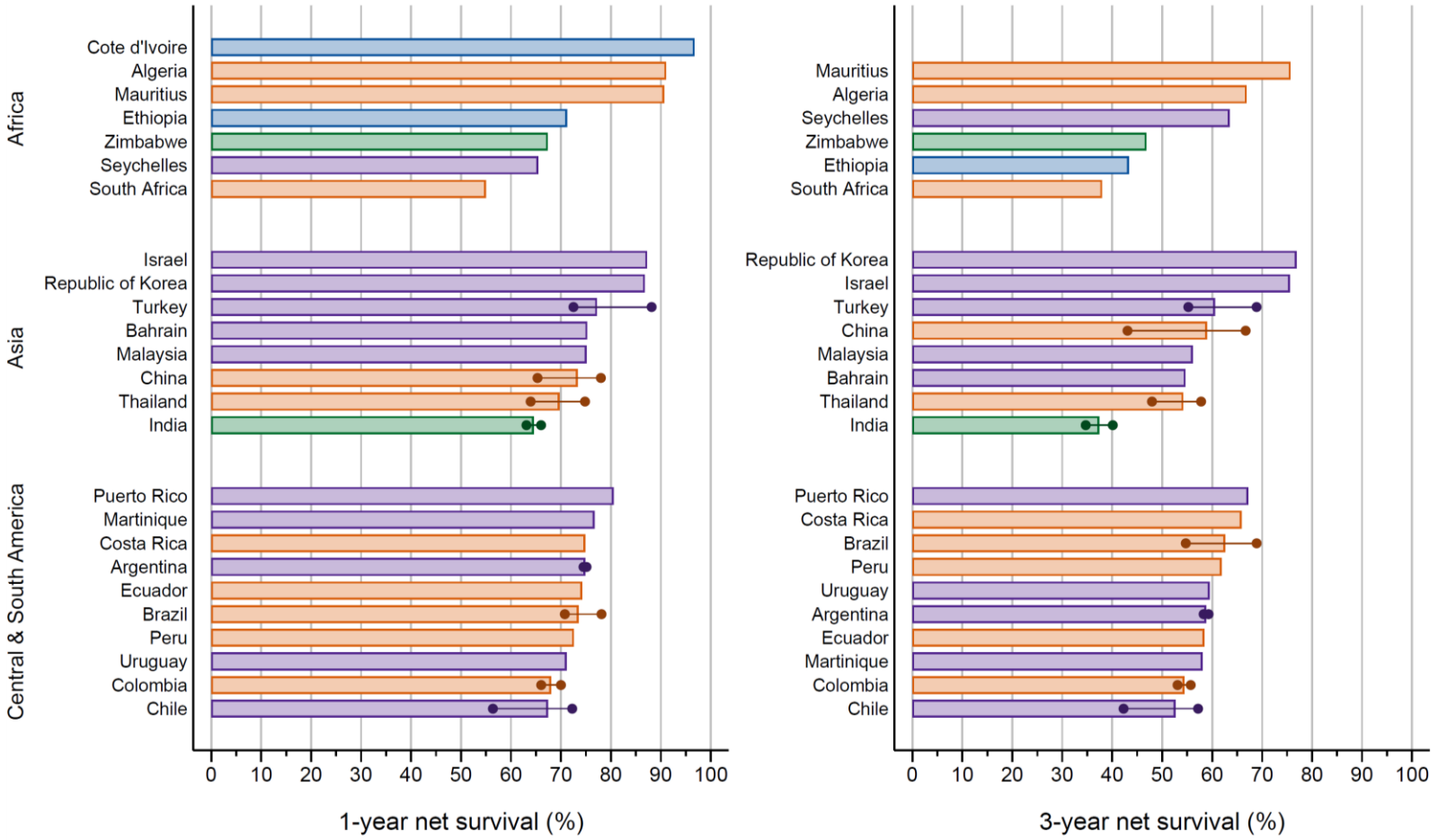
World Health Organization

How do we get robust national estimates of cancer survival?





1- and 3-year survival differences by region and HDI, colon cancer

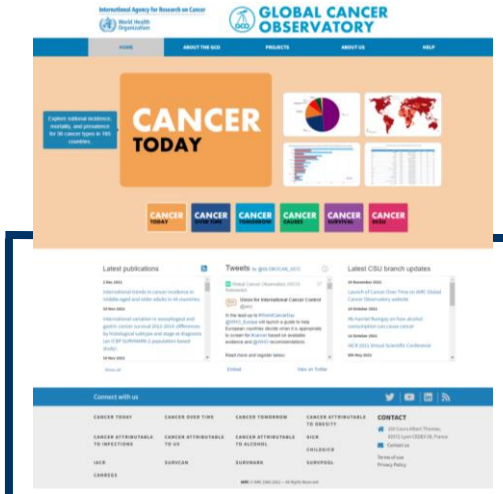


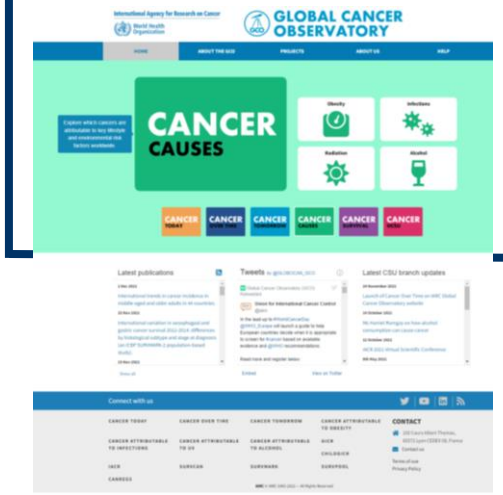
Soerjomataram et al. Cancer survival in Africa, Central and South America, and Asia (SURVCAN-3): a population-based benchmarking study in 32 countries. Lancet Oncol 2023;24(1).

GLOBAL CANCER OBSERVATORY

http://gco.iarc.who.int

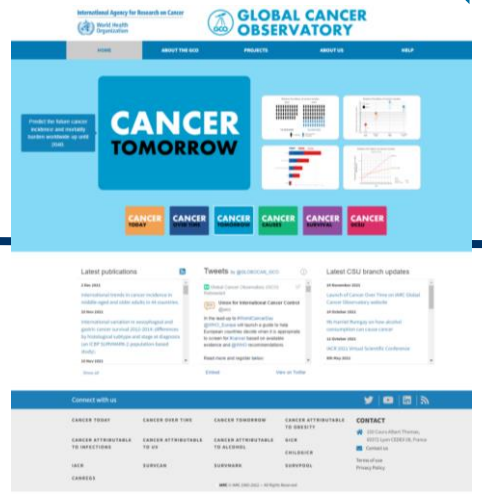
GLOBOCAN 2022
GLOBOCAN 2024





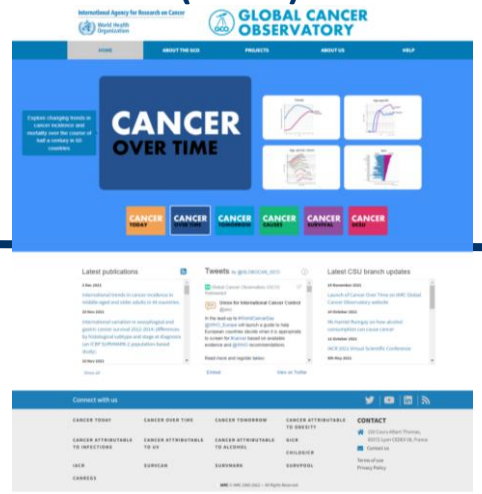
Update PAF
Tobacco PAF

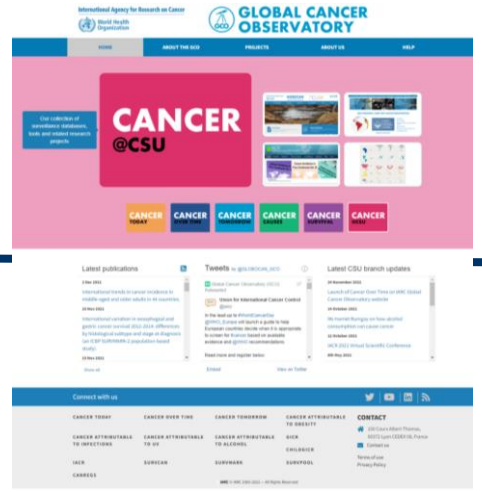
GLOBOCAN 2022
GLOBOCAN 2024



SURVCAN-3

APC modelling
EAPC (trend)





Work in progress

CHILDCAN

Cancer in Children

Cancer Economics

YPPLL, DALYs,
prevalence by phase of care

Collaborations

Cancer Impact and Resilience

1. Harmonisation of data processes / databases
2. Timeliness of recorded data

CSU internal process review

The social and economic impact of cancer: lack of prioritization

- In addition to being a leading cause of mortality and morbidity, cancer also negatively affects countries' economies and impose a heavy economic burden to patients and families
- The burden of cancer affects a country's economy because of premature mortality, absence from work and lost productivity.
- Cancer impacts patient and families due to out-of-pocket expenditures, in particular in settings with no or limited universal health coverage, but also due to psychological and subjective financial distress.
  - Worldwide, only 41% of national benefit packages include core childhood cancer services.
  - 50% of health benefit packages in low-income countries include screening, but only 20% cover treatment.

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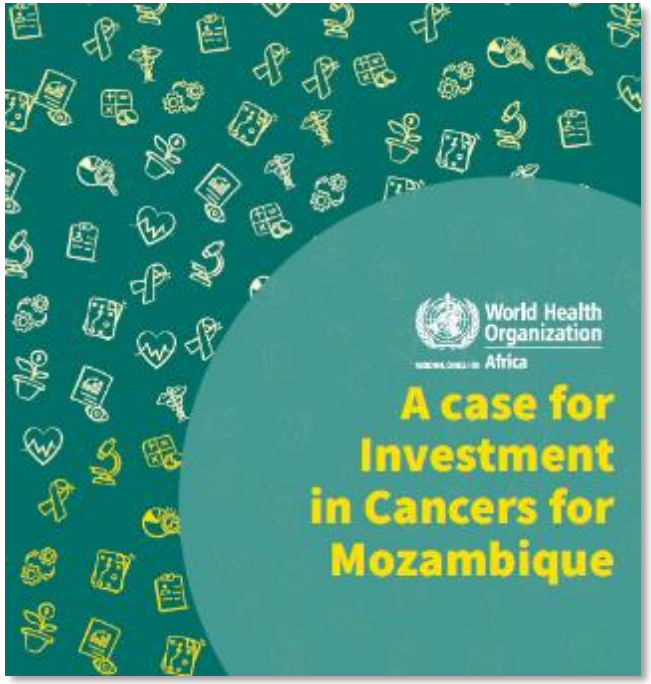
WHA mandate and response

- Development of a cancer priority setting and costing tool
- Use cases:
  - Support to Member States in costing the national cancer control plan
  - Development of investment cases (e.g. Mozambique, Kenya, Senegal, Palestine, Honduras, five in pipeline)
  - Update of appendix 3 of Global NCD Action Plan → 24% of all assessed interventions are related to cancer prevention and control.



  - A majority of these interventions represent *very good value for money* and should be a priority for inclusion in health benefit packages.

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Gaps and priorities

- Ensure optimal use of resources by prioritizing cost-effective and affordable interventions to promote universal access to comprehensive cancer care.
  - There is a need to expand the evidence-base on cost-effectiveness of cancer control interventions and consider additional criteria such as equity.
- There is limited evidence on the macro –and microeconomic impact of cancer.
  - Several systematic reviews on the economic burden of cancer are ongoing to better understand the determinants of financial hardship experienced by patients and families.
  - There is a need to estimate the global economic cost of cancer and to make an investment case for cancer prevention and control.
    - Initial analysis has shown that for each US$1 invested in cancer care, the direct productivity return is US$2.30
  - We are currently updating EPIC, a tool to estimate the burden of ill-health, to better capture the economic impact of cancer (e.g. loss of employment to caregivers)

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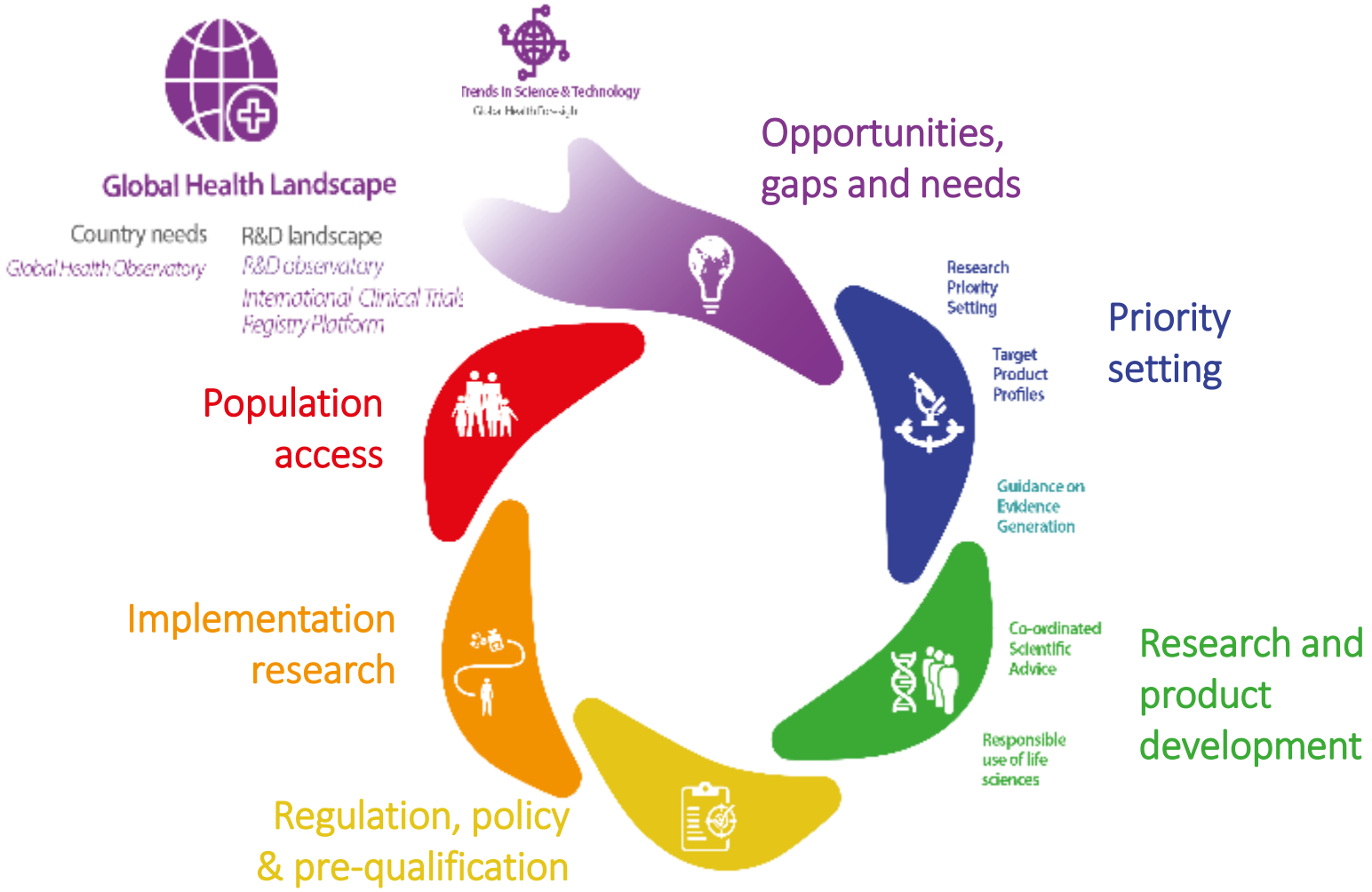
R&D processes at WHO



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Outcomes: development of health products that address global health needs and accelerated implementation and uptake in countries

What is the Global Observatory on Health R&D?

- **Established through resolution WHA66.22** (2013) “to consolidate, monitor and analyze relevant information on health research and development activities” to identify gaps and opportunities in health R&D and coordinate actions.
- **Supports evidence-informed decisions related to R&D gaps, funding and capacity.**
- **Scope: all health and health-related** fields and **all types of research**
- **Target users:** Governments, policy-makers, funders, researchers.

A comprehensive source for up-to-date global information and analysis on health R&D, including resources, processes and outputs.

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url: https://www.who.int/observatories/global-observatory-on-health-research-and-development

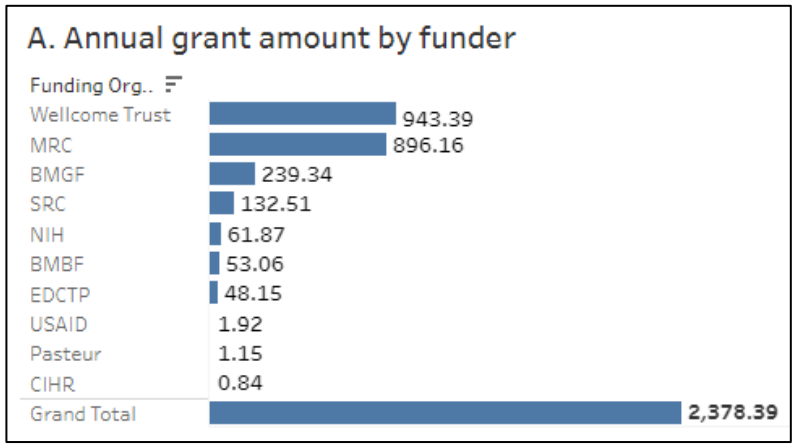
Analysis example – Research Investments

- Who is funding what and where?
- In Europe 8.37% of research funding spent on cancers,
- In Europe $USD 282 million spent on research for malaria, HIV and TB

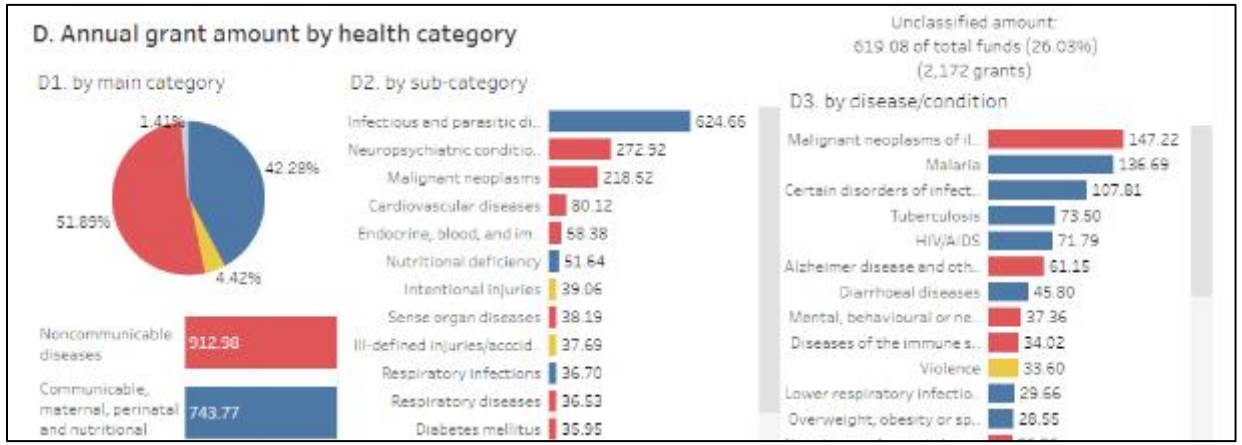
C. Annual grant amount by recipient's WHO region and income group

WHO region	High income	Upper middle income	Lower middle income	Low income	Grand Total
Africa		111.44	58.45	63.87	233.76
Americas	32,590.45	28.37	2.02		32,620.84
Eastern Medite..		0.46	5.41	1.08	6.96
Europe	2,377.20	0.61	0.58		2,378.39
South-East Asia		4.82	42.49		47.30
Western Pacific	79.93	11.60	2.78		94.31
Grand Total	35,047.58	157.30	111.73	64.95	35,381.55

A. Annual grant amount by funder



D. Annual grant amount by health category



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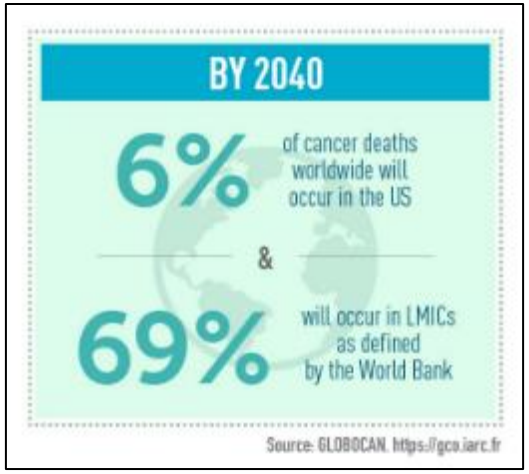
Investments on grants for biomedical research by funder, type of grant, health category and recipient in 2019 (who.int)

Analysis example – Research topics funded

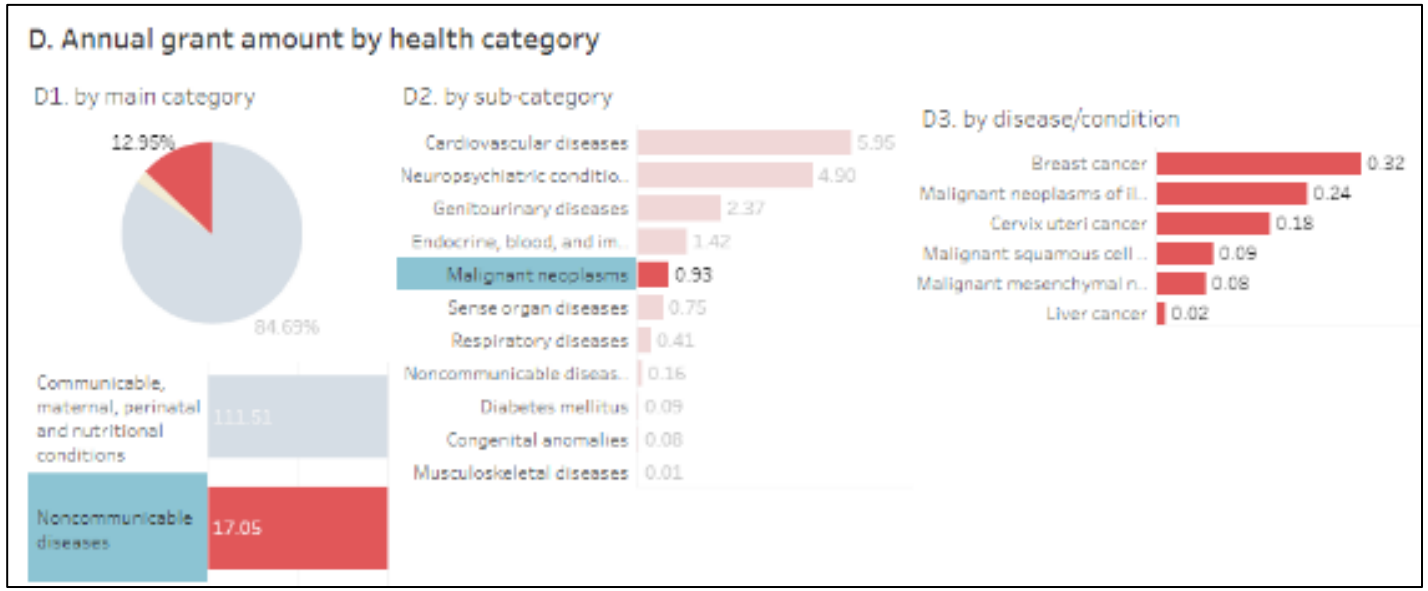
Grants on NCDs:
- 17 million USD to LMIC
- 19,673 million USD to USA

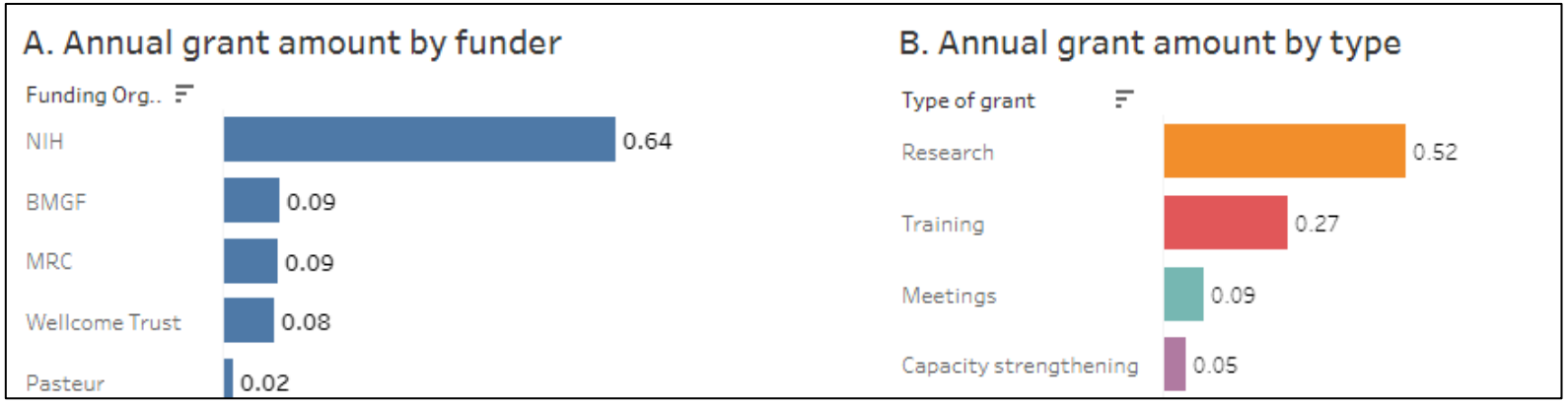
Cancer:
- In LMIC: < 1million USD in on cancers (in only 6 cancer topics)

Despite



Centre for global health strategic plan 2021-2025





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A concerted response across the product life-cycle

Prioritizing and Evaluating:

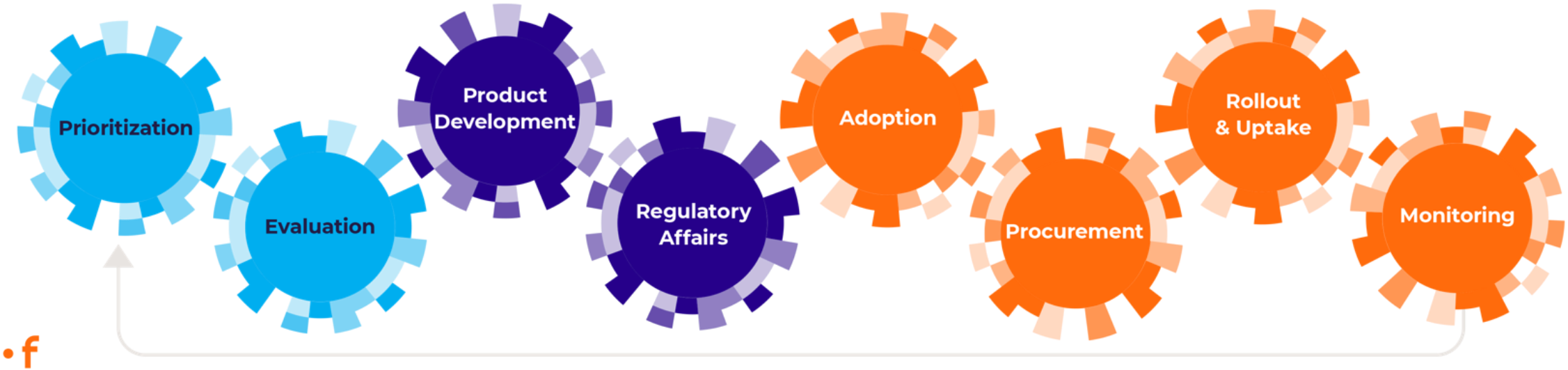
Developing a prioritized drug portfolio of the most needed formulations and assisting in the design and implementation of efficient, and high-quality clinical trials.

Developing:

Establishing and maintaining relationships to launch effective products and supporting regulatory submission activities to facilitate paediatric medicine approvals.

Delivering:

Supporting efforts to introduce new, adapted formulations in an equitable, accelerated, safe and coordinated manner.



GAP·f Global Accelerator for Paediatric formulations WHO Hosted Network

Agenda item 3:

Methodology for stock-take and setting strategic direction

Review of proposed approach, sharing of best practices

Time	Topic	Speaker
12.25 – 12.35	Current and planned reports, in response to Member State mandates Performing stock-take to inform strategic priorities in WHO's programme of work for cancer Childhood cancer as a tracer in NCD agenda to inform and contribution to current mandates (e.g., clinical trials, access to medicines, social determinants)	Dr Bente Mikkelsen, Director, Noncommunicable Diseases Department/HQ

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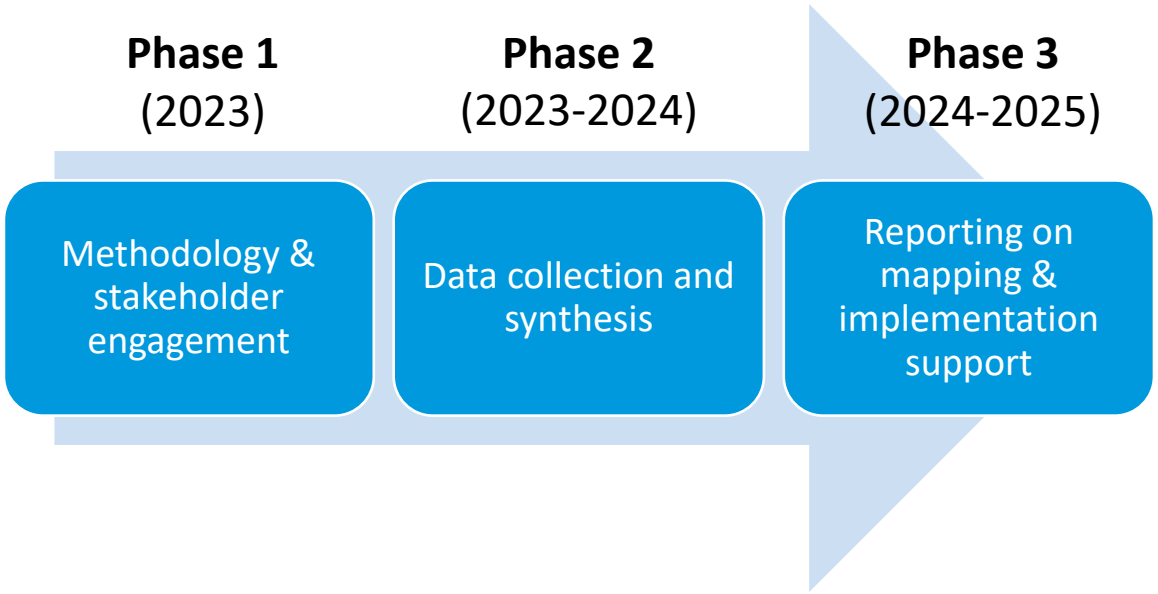
Next steps: stock-take methodology



Objectives:

(1) Present current best practices and gaps/inequalities in cancer control

(2) Gather and present MS with models and tools to improve outcomes through an integrated approach

(3) Promote incorporation of key indicators for WHO cancer initiatives into routine national NCD reporting

Anticipated Outputs:

(1) Stock takes for WHO cancer initiatives presented to EB 154 (2024) in annual NCD report
(cervical ca, May 2023; childhood ca Q3 2023; breast ca Q3 2024)

(2) WHO global status report (in line with WHA 70.12) to be presented to EB 156 (2025)

(3) Communication events (eg, WHA side events)

(4) Updated mandate / programme of work for 2024-2025

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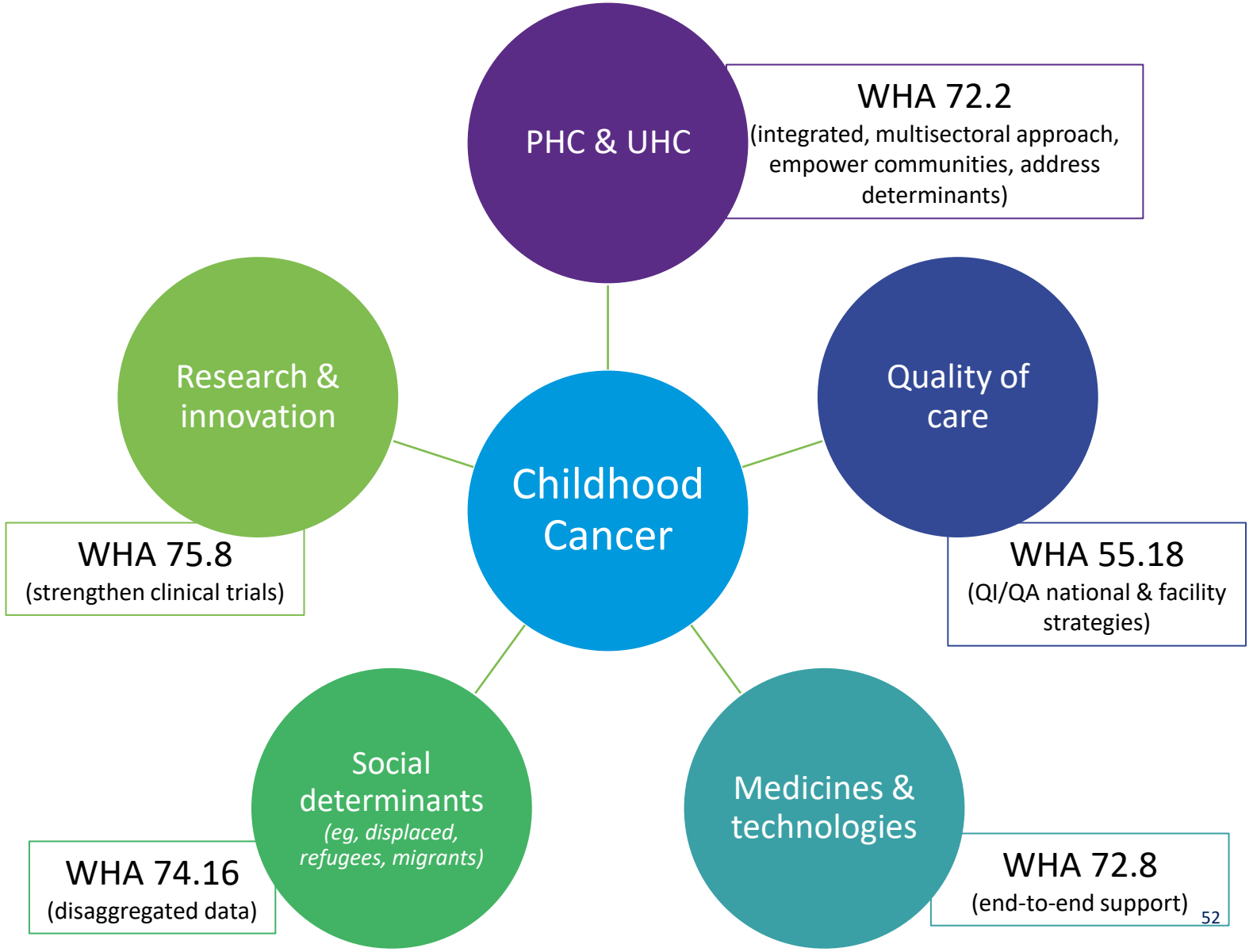
Cancer & broader health agenda: *Example of childhood cancer*

Mapping current strategies and gaps in cancer.

Objectives

1) Demonstrate how progress in and implementation of WHO Global Initiative for Childhood Cancer
   tracer for NCDs & strengthen health systems through an integrated approach
2) Track progress, drive innovation
3) Leverage recent commitments
   (eg, Global Platform for Access to Childhood Cancer Medicines to ↑programmatic investments)



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Stakeholder engagement: partners for stock-take/mapping

WHO, IARC

Responsible for full process of mapping to dissemination and implementation of recommendations

UN agencies

Close collaboration throughout process including data inputs, review and communication

Affected communities

Consultation on priority indicators, summaries of best practices and presentation of results

Civil society

Inputs on priority indicators, participation in communities of practice, dissemination of findings

Private sector

Dialogue as advised in WHA 70.12 (2017) and in line with FENSA

Professional society & academia

Including participation of WHO Collaborating Centres including data collection and dissemination of results

Philanthropic foundations

Participation in development of investment cases / business plans

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Horizon: Strategic opportunities in cancer

Advocacy & leadership

- Anticipate multiple **side events during World Health Assembly 2023** to further elevate cancer agenda
- **UN High-Level Meeting on UHC** including event(s) on childhood cancer **(Q3/4 2023)**: launch of Global Platform and stock-take of GICC
- **Global partners forum (Nov 2023)** with multi-sector engagement (provisionally 16-17 Nov), and Civil Society Dialogue

Capacity building & communities of practice

- WHO expanding **Knowledge Action Portal** for cancer control as community of practice to gather best practices & accelerate implementation
- Number of countries engaging in **WHO cancer initiatives continue to increase**, likely to reach 100 countries by 2024
- Additional **MoUs, partner engagement strategy**: WHO working with UN agencies and >300 implementing partners for coordinated support

Expanding mandate

- Dialogue on strategic priorities for 2024-2025 Programme of work ongoing with MS through **three-level WHO approach**
- **Align cancer mandate with relevant resolutions** including on research & innovation (clinical trial), access to medicines, quality of care, workforce optimization

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Next steps & conclusion

- Methodology on stock-take/mapping
  - Initiate consultative process in Q2/3 2023
  - Stock-take (narrative) – cervical cancer in May 2023; childhood cancer in Q3 2023
  - Progress toward global status report in 2024

- Communicate data gaps & priority targets
  - Increase and standardized reporting frequency
  - Expand reporting to include socioeconomic impact of cancer & horizon scanning

- Accelerate integration of cancer with other programmes, leveraging cervical cancer as entry point

Thank you for your commitment to cancer control

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Questions ?
Moderated discussion

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Wrap-up & Closing

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Thank you

Further information on cancer is available at: https://www.who.int/health-topics/cancer.

Should you require additional information please do not hesitate to contact

Dr Bente Mikkelsen, Director, Department of NCDs (mikkelsenb@who.int);

Dr Slim Slama, MND Unit Head, Department of NCDs (slamas@who.int);

Dr André Ilbawi, Technical lead, cancer control, Department of NCDs (ilbawia@who.int).

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Annex

Additional slides

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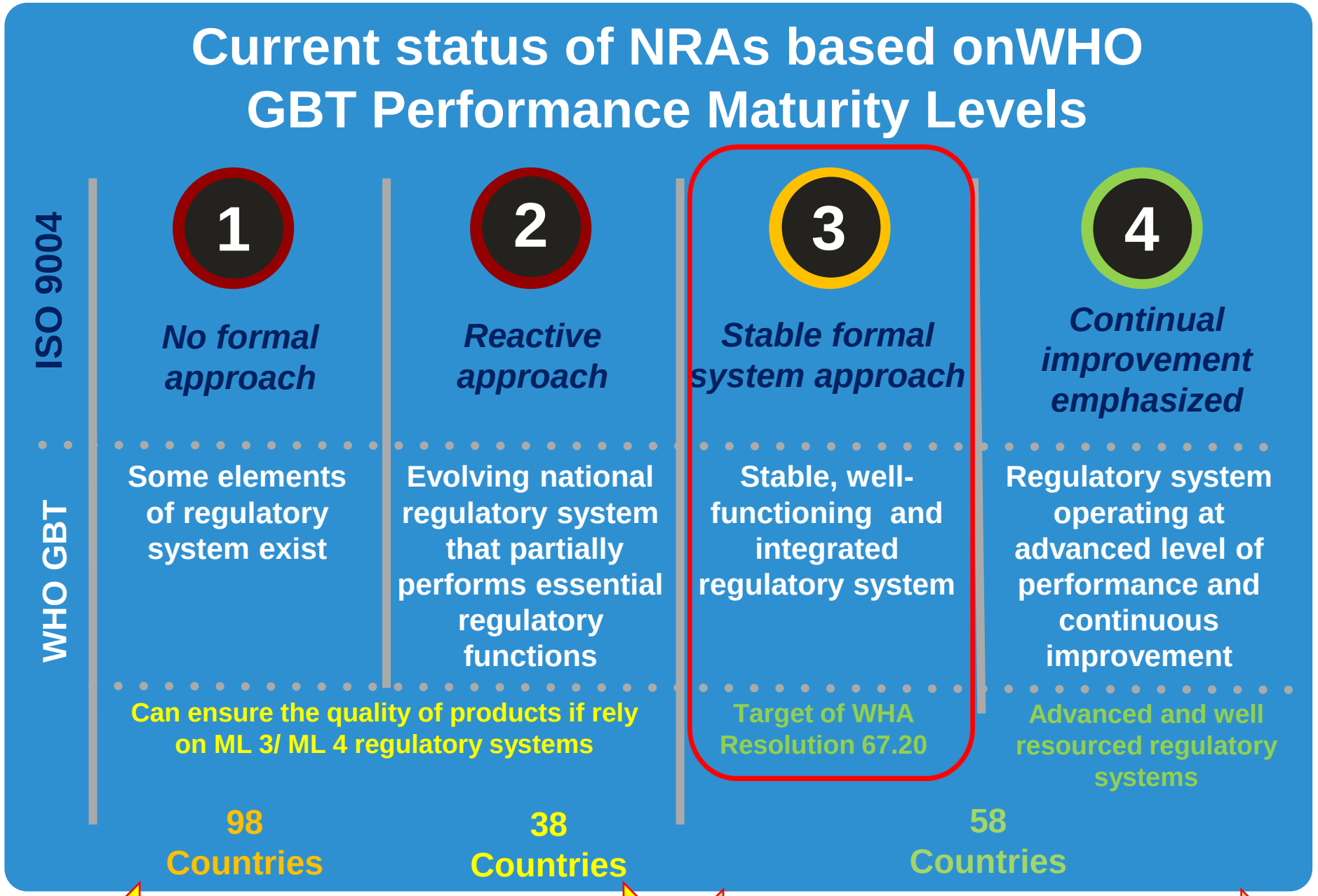
Current status of NRAs based onWHO GBT Performance Maturity Levels



What is WHO Prequalification?

- WHO prequalification aims to ensure access to key health products that meet global standards of quality, safety and efficacy/performance, in order to optimize use of health resources and improve health outcomes.

- Today, there are almost 1,500 WHO prequalified products — in vitro diagnostics (IVDs), male circumcision devices, medicines, vaccines, immunization devices and cold chain equipment, and vector control products — that have assisted in improving public health in low- and middle-income countries (LMIC).

- WHO prequalification has become a trusted and reputed symbol for *safety, quality and efficacy* across stakeholders.

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Cancer medicines in PQ

- EoIs are disease area-focused (except for trastuzumab/rituximab and insulin which are product-focused)

- There has never been an EoI in PQ focusing on cancer as a therapeutic area.

- Up to Nov 2010 certain medicines against cancers associated with HIV/AIDS were invited in the HIV/AIDS EoI (etoposide, bleomycin, vincristine, vinblastine) but these medicines were subsequently dropped from the EoI. Two products (vincristine and vinblastine) were prequalified in 2002 but were later withdrawn by the company. Palliative therapies continued to be invited for a while, but not any longer.

The prequalification of rituximab and trastuzumab
Background to pilot

BTP/SBPs quality, safety and efficacy, product handling and post-prequalification requirements differ greatly compared to small molecules. Trastuzumab and rituximab were selected as model biotherapeutics in the pilot for the below reasons.

- Disease prevalence, evidence of efficacy and safety, and comparative cost-effectiveness
- One of the first monoclonal antibody therapies listed in the WHO Model List of Essential Medicines
- Existence of established WHO technical guidance for evaluation of biotherapeutic protein products prepared by recombinant DNA technology and on evaluation of MAbs
- Some SRAs have extensive experience in evaluating these molecules.

Pilot for PQ of rituximab & trastuzumab and their corresponding SBPs**: EOI published on 5 July 2018** (first dossier received on 24 Oct 2018)

Access to medicines: prequalification & registration ***(provisional)***

After identification of supplier and product:
In-country Registration of the product

- All pharmaceutical products should be used in a country **only after approval** by the national or regional authority. (*WHA Resolutions: WHA 67.20 (2014); WHA 67.21 (2014); WHA63.12 (2010)*)

1. Tender process → 2. Identification of supplier and product → 3. **Registration of the product in the country by the NRA (National Regulatory Authority)**

- Depending on the nature of product and supplier, the **National Regulatory authority (NRA)** of each country may follow one of the following regulatory pathways to accept the introduction of the product in the country:

1. **One-time waiver or only Import Permit for the first allocations,** particularly if those are small allocations: Country to decide on the acceptability of this pathway. NRA to inform on the requirements for the supplier to meet and to issue the regulatory clearance – No product registration, regulatory clearance only
2. **Collaborative Registration Procedure (CRP)** - for full registration/approval or marketing authorization of the product: WHO supports the NRA to get access to the relevant product data to accelerate the assessment and registration of a product (within 90 working days)
   - **SRA CRP:** products approved by SRAs
   - **PQ CRP:** products prequalified by WHO
3. Mix of the 2 above - **Import waiver + CRP (in parallel):** NRA and WHO
4. **National registration pathway:** Accelerated or standard registration pathway following NRA timelines (sometimes above 250 days for product assessment and registration): NRA only

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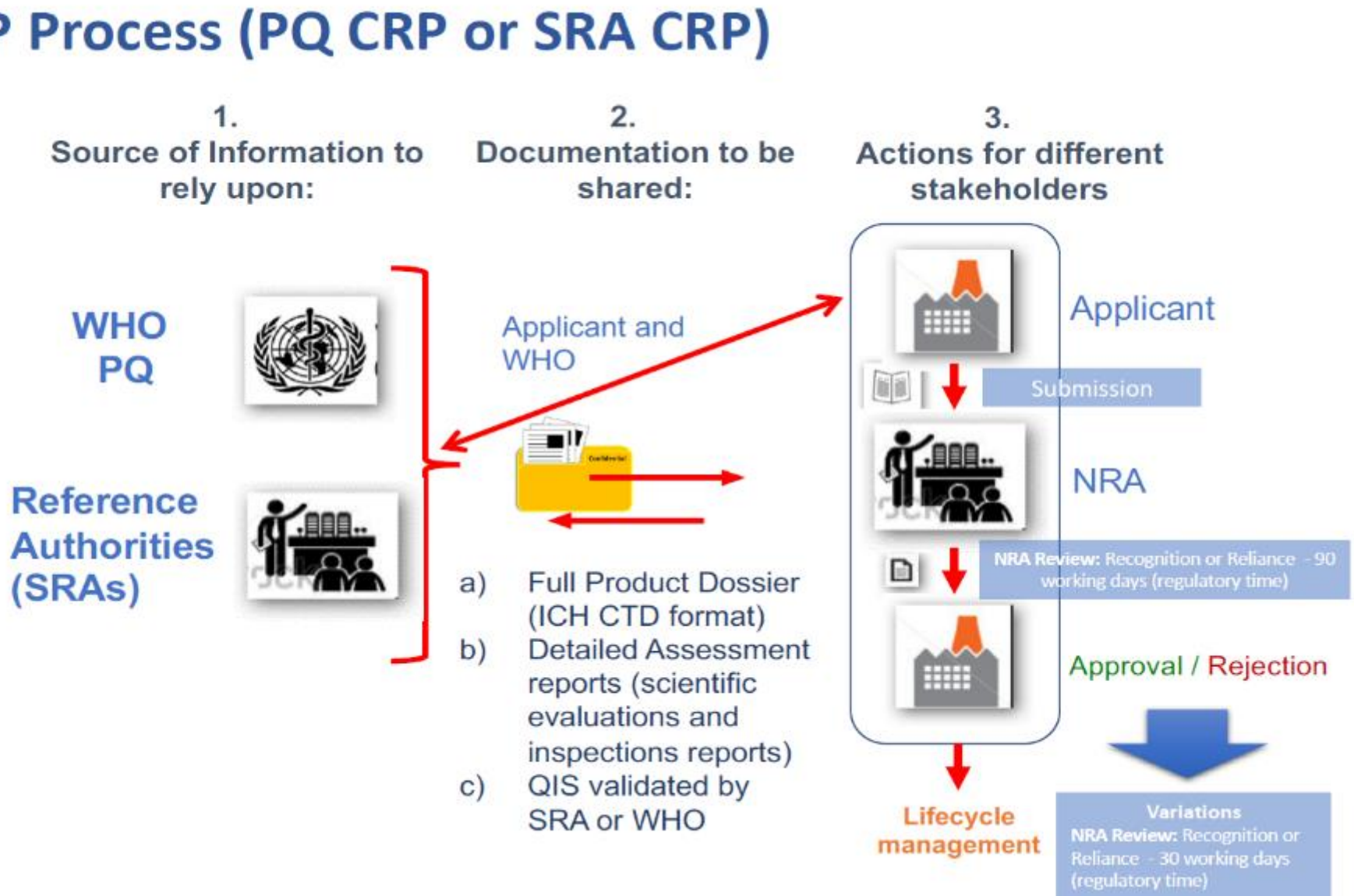
2

Access to medicines: prequalification & registration ***(provisional)***



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→ *PQ has been proven as an effective mechanism for facilitating access to quality assure health products*

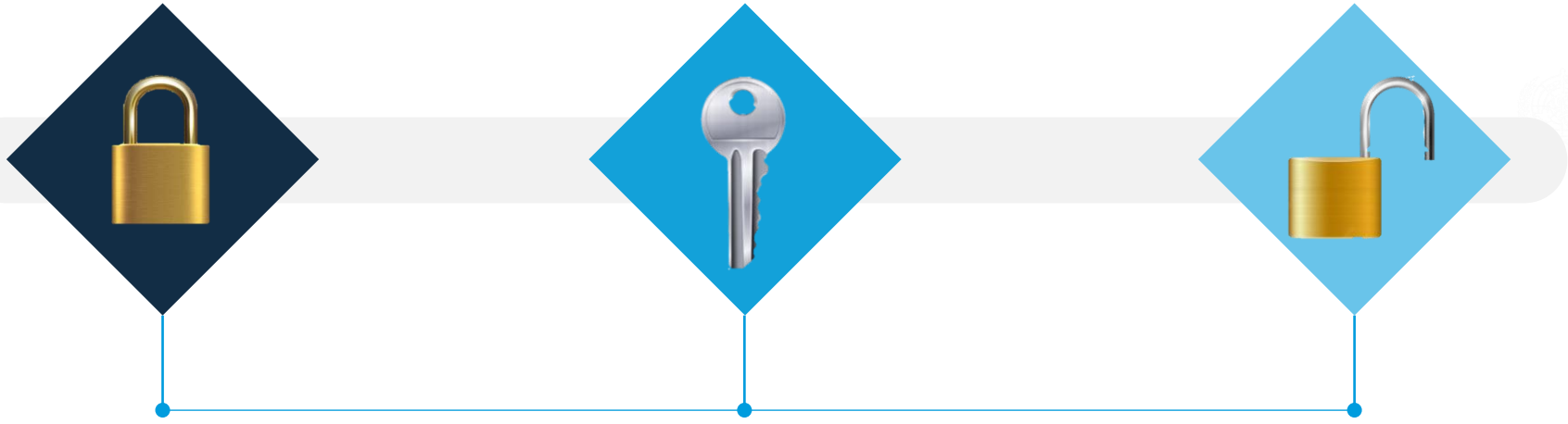
❑ **Key findings of the independent external impact assessment:**

(https://www.who.int/medicines/news/2019/report_Impact-assessment_WHO-PQ-Reg-systems.pdf?ua=1)

- ✓ WHO Prequalification (PQ) programme **enables a core market of approximately US$3.5 billion** with the majority coming from vaccines
- ✓ WHO PQ has a **Return on Investment of 30-40 to 1** for the PQ-enabled donor-funded market (US$ million)
- ✓ Most donors and procurers and implementing partners view **PQ approval as equivalent to approvals by stringent regulatory authorities**
- ✓ **340-400 million more patients have access** thanks to resources freed up by PQ
- ✓ National regulatory authorities (NRAs) relying on Collaborative Registration Procedure (CRP) have **achieved significant acceleration of approval timelines** vs pre-CRP registrations

WHO Listed Authorities

A new concept introduced to replace SRAs



Following ICH structural changes in 2015, need for replacing the term Stringent Regulatory Authority (SRA) and eligibility criteria based on the pre-reform membership to ICH

ICDRA 2016 & 2018 *Recommendations regarding SRAs*

Recommendations from 51st ECSPP in 2017 and 61st ECBS in 2018

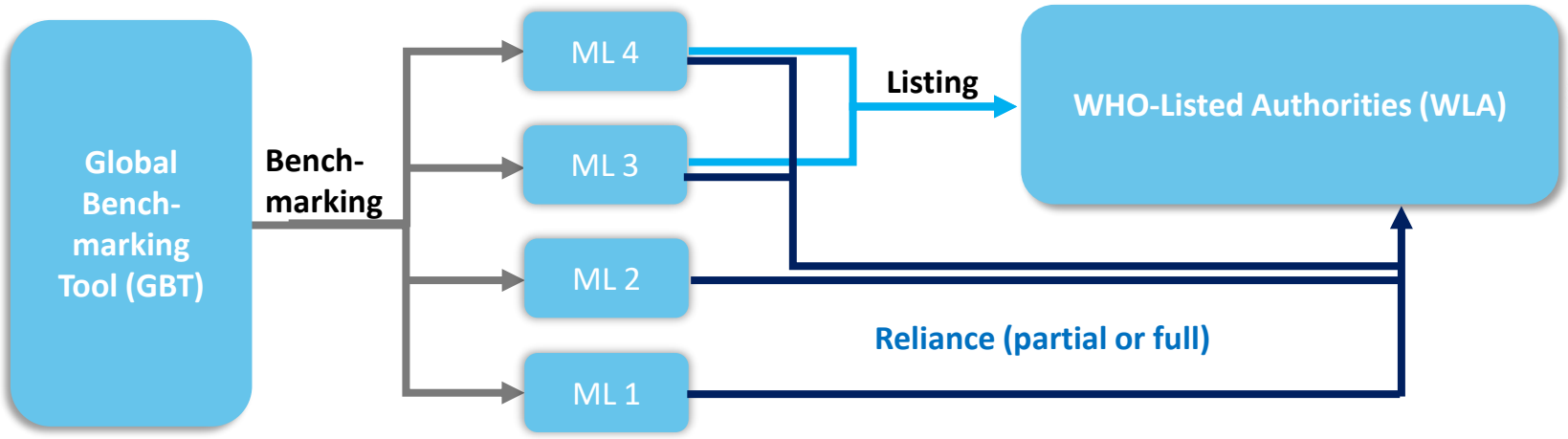
Feedback *from international consultations and virtual meetings on developing the GBT*

WLA

Authorities listed by WHO following a **consistent, documented, transparent and accountable** assessment

WHO Listed Authorities

…and to promote reliance



- **LISTING** can be achieved by ML3 and ML4 NRA/RRS and implies ADVANCED PERFORMANCE

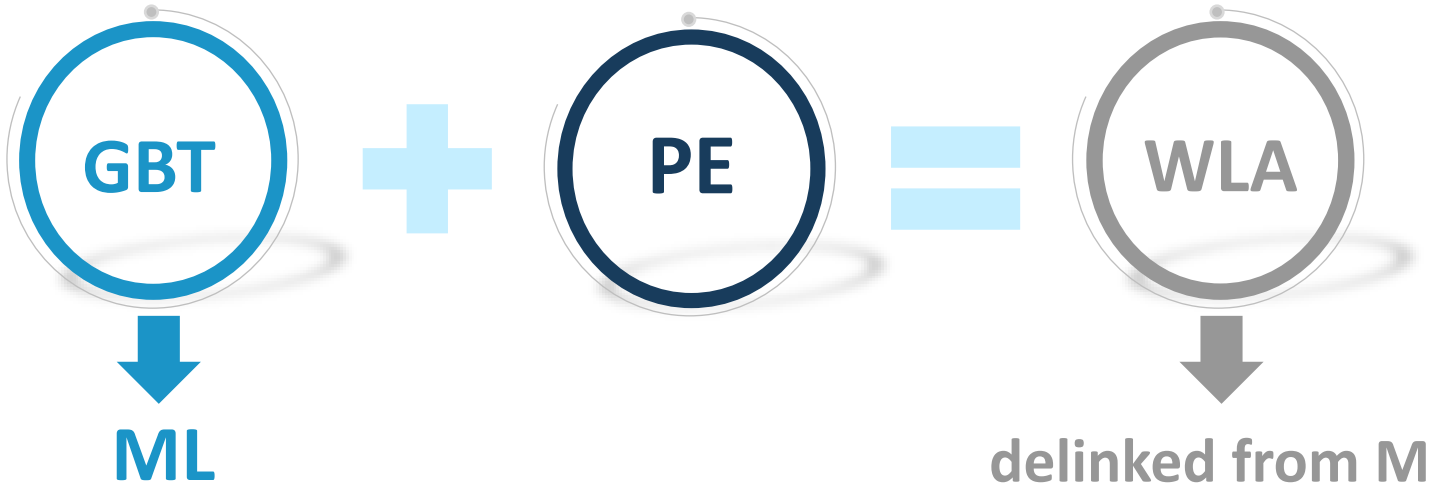
  i.e., **consistent** adherence to international standards and guidelines, as well as **good regulatory practices**, by ensuring the attainment of **key regulatory outputs** over time

Definition of a WHO Listed Authority

Adopted by the ECSPP in October 2020, TRS 1033

A WHO Listed Authority (WLA) is a regulatory authority or a regional regulatory system which has been documented to comply with all the relevant indicators and requirements specified by WHO for the requested scope of listing based on an

established benchmarking (GBT) **AND** a **Performance Evaluation process**



Objectives of WLA initiative

01 To provide a transparent and evidence-based pathway for RAs to be globally recognized

02 To promote access and the supply of safe, effective and quality medical products

03 To optimize use of limited resources by facilitating reliance

Policy document:

Describes the purpose, definitions and high-level operating principles related to the evaluation and public listing of authorities

Link: https://www.who.int/publications/i/item/9789240023444