



## **Implementation of resolutions: progress reports**

### **Report by the Secretariat**

#### **CONTENTS**

	<b>Page</b>
B. Commission on Social Determinants of Health: empowering local communities.....	2
F. Public health, innovation and intellectual property: towards a global strategy and plan of action.....	2
I. Cancer prevention and control (resolution WHA58.22): cervical cancer .....	4
J Reducing global measles mortality .....	5
Action by the Executive Board .....	7

**B. COMMISSION ON SOCIAL DETERMINANTS OF HEALTH: EMPOWERING LOCAL COMMUNITIES FOR ACHIEVING HEALTH GOALS, AND THE ROLE OF LOCAL LEADERS**

1. The Commission on Social Determinants of Health aims to provide support to countries in tackling health inequities among social groups through action on the social determinants of health. The engagement of local communities and leaders is vital for this process. It will help to advance the goals of civil society related to social determinants; strengthen capacities among participating civil-society organizations; enhance learning at community level; promote action as shaped by knowledge from civil society; broaden the political uptake of the Commission's messages; and improve chances that the Commission's output will have a sustainable impact.

2. In order to develop collaboration with civil society, the Commission has encouraged their organizations to take an active role in its work. Known as civil society facilitators, leading civil-society networks in Africa, the Americas, Asia, and the Eastern Mediterranean have been asked to provide input in order to inform the Commission's recommendations.

3. The Commission's commitment to involving civil society reflects the importance that should be given not only to its final output but also to the processes by which these products are generated. In general, principles of ethics and human rights require not only that the outcomes of political and social policy promote human welfare, but also that people participate actively in shaping the political choices that affect their lives. Populations, including marginalized groups, should participate in the complex process of translating values of equity and human dignity into action, and not merely be recipients of benefits conferred by authorities or private bodies. The Commission is able to shape such an inclusive, participatory process by including representatives of civil society and communities actively in its mechanisms.

**F. PUBLIC HEALTH, INNOVATION, AND INTELLECTUAL PROPERTY: TOWARDS A GLOBAL STRATEGY AND PLAN OF ACTION**

4. The Intergovernmental Working Group on Public Health, Innovation and Intellectual Property established by resolution WHA59.24 held its first session from 4 to 8 December 2006 in Geneva. The Working Group elected Mr P. Oldham (Canada) as Chairman, and the following vice-chairmen: Mr B. Wijnberg (Netherlands), Dr H. Gashut (Libyan Arab Jamahiriya), Dr A.E.O. Ogwell (Kenya), Mr Jaya Ratnam (Singapore), and Mr N. Dayal (India). Dr Ogwell was also designated Rapporteur.

5. The task of the Working Group is to draw up a draft global strategy and plan of action in order to provide a medium-term framework based on the recommendations of the Commission on Intellectual Property Rights, Innovation and Public Health which would aim, inter alia, to secure an enhanced and sustainable basis for needs-driven, essential health research and development relevant to diseases that disproportionately affect developing countries. Resolution WHA59.24 called for the Working Group to submit the strategy and plan of action to the Sixty-first World Health Assembly, through the Executive Board.

6. In order to solicit inputs from a wide group of stakeholders, web-based public hearings were organized in November 2006. Thirty-two submissions were received from governments, academia, public/private partnerships, product-development partnerships and industry.<sup>1</sup>

7. Member States and regional economic integration organizations that had already taken steps towards implementing aspects of resolution WHA59.24 and the Secretariat reported their progress to the Group.

8. The Working Group considered six elements of a draft plan of action: prioritizing research and development needs; promoting research and development; building and improving innovative capacity; improving delivery and access; ensuring sustainable financing mechanisms; and establishing monitoring and reporting systems. In the ensuing discussion, Member States decided that transfer of technology, and management of intellectual property should be highlighted and should therefore be added as separate items. All eight elements were examined.

9. The Working Group also discussed elements of a global strategy based on WHO's Constitution, the report of the Commission on Intellectual Property Rights,<sup>2</sup> Innovation and Public Health, resolution WHA59.24 and other recent resolutions in relevant subject areas. It also took account of previous work, including Health Assembly resolutions and the work of the Commission.

10. An outcome document<sup>3</sup> detailing issues raised in the Working Group was prepared and circulated to participants for review and comment. It was agreed that additional submissions on the plan of action and global strategy should reach the Secretariat by the end of February 2007. The input received during and after the session will be presented in a working document, which will be made available in July 2007 and will provide the basis for negotiation.

11. The Working Group also recommended a process for enabling nongovernmental organizations which met the requirements for admission into official relations with WHO, but have not yet been so admitted, to participate in the second session of the Working Group. A proposal to this effect will be submitted to the Standing Committee on Nongovernmental Organizations at the 120th session of the Board.

12. In order to expand the pool of experts and entities invited to attend sessions of the Working Group by virtue of resolution WHA59.24, and ensure a balanced regional, gender and developing/developed country representation, Member States will be invited to submit proposals for the second session, for decision by the Director-General after consultation with the Officers of the Working Group.

13. In accordance with resolution WHA59.24, some Member States suggested potential areas for early implementation, taking into account the recommendations of the Commission on Intellectual Property Rights, Innovation and Public Health. Concern was expressed by some Member States that too little time had been devoted at the first session to identifying and discussing adequately such areas; it was agreed to submit to the Executive Board at its 120th session and to the Sixtieth World Health

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<sup>1</sup> See document A/PHI/IGWG/1/INF.DOC./2.

<sup>2</sup> Document CIPH/2006/1.

<sup>3</sup> Document A/PHI/IGWG/1/5.

Assembly, the suggestions made on areas for possible early implementation<sup>1</sup> indicating that these suggestions had not been endorsed by Member States.

14. The Working Group plans to hold its second and final session in October 2007 in order to finalize the draft global strategy and plan of action. Consultations at regional and subregional levels will continue in between the two sessions, and the Officers of the Working Group will continue to meet as necessary to consider other possible intersessional work and detailed arrangements for the second session.

## I. CANCER PREVENTION AND CONTROL: CERVICAL CANCER

15. Cervical cancer, a preventable but common cancer in women, was responsible in 2005 for up to 500 000 new cases and up to 257 000 deaths, more than 90% in low- and middle-income countries where access to cervical cancer screening and treatment and palliative-care services is often non-existent or insufficient. According to WHO's projections, deaths from cervical cancer will rise to 320 000 in 2015 and to 435 000 in 2030. Cervical cancer is caused by a common sexually transmitted infection with oncogenic types of human papillomavirus (HPV). The pathogenesis can evolve over a period of 10 to 20 years through precancerous lesions to invasive cancer and death.

16. Following resolution WHA57.12 on reproductive health and resolution WHA58.22, on cancer prevention and control, the Secretariat has drawn up an action plan against cervical cancer. That plan is based on a comprehensive approach that encompasses primary prevention, early detection and screening, treatment, and palliative care under the umbrella of national cancer control programmes,<sup>2</sup> to promote which WHO is working in partnership with major stakeholders including UNFPA and IAEA.

17. Also in response to resolution WHA58.22, prevention and control of cervical cancer are being recommended,<sup>3</sup> through the promotion of condom use and the implementation of systematic screening for detecting precancerous lesions and invasive cancer and determining appropriate management. Screening for cervical cancer by cytology has been shown to be effective in reducing incidence and mortality but this technique requires appropriate health-service infrastructure, technical resources and a well-defined system of referral to treatment services. Alternative screening techniques more suitable for low-resource countries, such as visual inspection with acetic acid, followed by cryotherapy, are currently under investigation,<sup>4</sup> and, in further response to the resolution WHA58.22, an operational research programme is introducing these techniques in various African countries.

18. As also requested in resolution WHA58.22, applied research on a vaccine against cervical cancer has been promoted. The newly available HPV vaccine has proven to be effective in preventing 65% to 76% of infections and lesions due to the viruses, depending on the local prevalence of oncogenic types of human papillomavirus.<sup>5</sup> The Secretariat has identified several obstacles to

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<sup>1</sup> See document EB120/INF.DOC./1.

<sup>2</sup> *Cancer control knowledge into action. WHO guide for effective programmes: Module 1 – Planning*. Geneva, World Health Organization, 2006.

<sup>3</sup> *Comprehensive cervical cancer control. A guide to essential practice*. Geneva, World Health Organization, 2006.

<sup>4</sup> *Cervix cancer screening*. IARC Handbooks of cancer prevention Vol. 10. Lyon, IARC Press, 2005.

<sup>5</sup> WHO, UNFPA. *Preparing for the introduction of HPV vaccines: policy and programme guidance for countries*. Geneva, World Health Organization, 2006.

implementation and research gaps.<sup>1,2</sup> New delivery strategies need to be developed and evaluated because WHO's current routine immunization programmes mainly target infants less than one year of age whereas the HPV vaccine is aimed at pre-adolescent girls and immunization coverage may be expanded in the future to boys. Delivery costs, therefore, are likely to be much higher, adding to the already high costs of the vaccine itself, although it is expected that the vaccine producers will practice differential pricing. Use of this vaccine, moreover, raises culturally sensitive issues, such as sexual behaviour, sexually transmitted infection and genital cancer, adding further obstacles to implementation. Finally, sustainable financing of future HPV vaccine programmes needs to be considered in the context of financing of screening programmes. A reduction in cancer incidence and mortality might not be measurable before 10 to 30 years after the vaccine is introduced.

19. The decision on whether and when to introduce HPV vaccine will depend on national policies based on the burden of cervical cancer, the level of risk for exposure to human papillomaviruses, the cost-effectiveness of interventions, and obstacles to implementation. An essential element of any cervical cancer control plan is monitoring and evaluation through cancer registries. Striving for universal and equitable access to cervical cancer prevention, screening, treatment and palliative-care services will be the key to reducing the burden of cervical cancer worldwide.

## **J. REDUCING GLOBAL MEASLES MORTALITY**

20. In resolution WHA56.20, the Health Assembly stressed the importance of achieving the goal to reduce deaths due to measles by half by 2005, compared with the 1999 level. Activities aimed at reducing measles mortality are concentrated in 47 priority countries that account for about 98% of measles deaths globally.

21. Global mortality from measles fell from an estimated 873 000 deaths in 1999 to 345 000 in 2005 – a 60% reduction (see Figure 1). Thus, the goal of halving deaths due to measles has been not only achieved but exceeded, and the figures show that 2.3 million deaths have been prevented through accelerated disease-control efforts. In Africa, the region with the highest burden of the disease, deaths due to measles fell by 75% from an estimated 506 000 in 1999 to 126 000 in 2005.

22. Over the same period 1999–2005, routine measles immunization coverage globally increased from 71% to 77%, although coverage rates varied significantly across geographical regions. Moreover, there was a marked increase in the proportion of countries providing children nationwide with a second opportunity for measles immunization: as of September 2006, 175 (91%) Member States have offered children a second opportunity, compared to 125 (65%) in 1999. Among the 47 priority countries, 37 (79%) had completed nationwide catch-up campaigns by this date.

23. This outstanding public health success is the direct result of:

- strong political commitment at country level and hard work by governments and their partners to provide better access to routine childhood immunization

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<sup>1</sup> *Human papillomavirus and HPV vaccine: key technical information*. Geneva, World Health Organization, in press.

<sup>2</sup> WHO, UNFPA. *Preparing for the introduction of HPV vaccines: policy and programme guidance for countries*. Geneva, World Health Organization, 2006.

- nationwide measles vaccination campaigns conducted by countries with a heavy burden of disease due to measles, in which more than 600 million children were vaccinated against measles over the period 2000–2005
- provision of technical and financial support by the Measles Initiative partnership<sup>1</sup>
- intensified surveillance, with laboratory confirmation, of suspected measles cases.

24. The goal now is to build on this achievement and reduce global measles mortality by 90% by 2010 as compared to the baseline of 2000.<sup>2</sup> In order to achieve this new goal, several challenges have to be overcome through the following measures:

- populous countries that continue to have large numbers of deaths due to measles should implement activities to reduce measles mortality
- efforts need to be intensified in order to ensure that at least 90% of infants are vaccinated against measles before their first birthday; based on WHO/UNICEF estimates, more than 29 million one-year-old children had not received a dose of measles vaccine through routine immunization services in 2005 (see Figure 2)
- high-priority countries must continue to conduct follow-up vaccination campaigns every three to four years until their routine immunization systems are able to provide all children with two opportunities for measles vaccination
- field surveillance with laboratory confirmation of suspected cases of measles will need to be extended to all prioritized countries in order to allow effective monitoring.

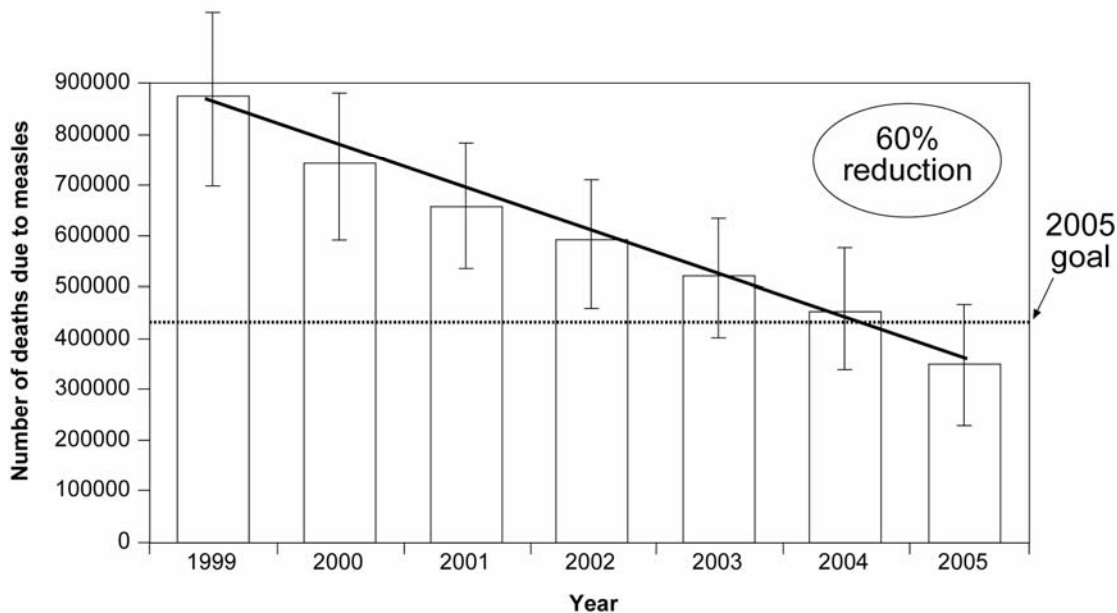
25. The successful reduction in global measles mortality by 90% by 2010 will depend on developing and maintaining strong political commitment in the countries with high disease burdens and continuing support from international partners. In addition to country contributions, an additional US\$ 479 million is required for attainment of the 2010 goal; of this sum, US\$ 147 million has been raised through the International Finance Facility for Immunisation Company and an additional US\$ 100 million have been pledged by partners in the Measles Initiative.

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<sup>1</sup> Lead partners in the Measles Initiative are WHO, UNICEF, the American Red Cross, Centers for Disease Control and Prevention (Atlanta, Georgia, United States of America) and the United Nations Foundation.

<sup>2</sup> The goal of reducing globally mortality due to measles by 90% by 2010 or earlier forms part of the Global Immunization Vision and Strategy 2006–2015, which was welcomed by the Health Assembly in resolution WHA58.15.

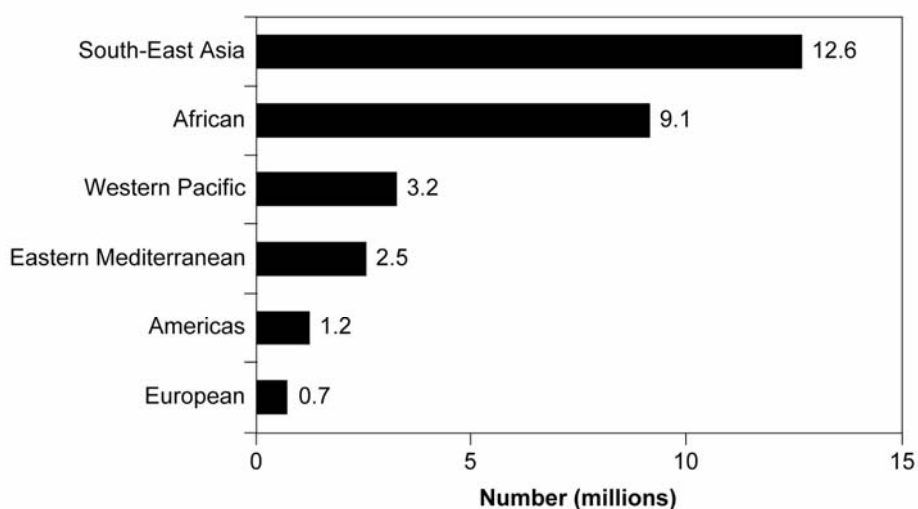
**Figure 1. Estimated reduction in global mortality due to measles, all ages, 1999–2005**



Columns show upper and lower uncertainty bounds.  
Source: WHO.

WHO 06.157

**Figure 2. Number of one-year-old children not vaccinated against measles in 2005, by WHO Region**



Source: WHO/UNICEF estimates 2005.

WHO 06.158

**ACTION BY THE EXECUTIVE BOARD**

- 26. The Executive Board is invited to note the above progress reports.