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## **Cancer prevention and control in the context of an integrated approach**

### **Report by the Secretariat**

1. In January 2017, the Executive Board, at its 140th session, considered an earlier version of this report that contained a draft resolution.<sup>1</sup> During the discussions,<sup>2</sup> an informal drafting group was set up so that consensus could be reached on the text of the draft resolution. Despite progress made by the drafting group, consensus was not achieved before closure of the Board's session and certain paragraphs of the draft resolution remained pending. The Board then agreed that the discussion of those outstanding paragraphs would be continued during the intersessional period.

#### **BURDEN AND TRENDS**

2. Cancer is a growing public health concern. In 2012, there were 14.1 million new cases and 8.2 million cancer-related deaths worldwide. The number of new cases is projected to increase to 21.6 million annually by 2030. The greatest impact is in low- and middle-income countries, many of which are ill-equipped to cope with the escalating burden of disease, and where 65% of cancer deaths occur.

3. In 2012, there were 4.3 million premature deaths from cancer worldwide, 75% of which were in low- and middle-income countries. In order to achieve Sustainable Development Goal 3 (Ensure healthy lives and promote well-being for all at all ages) and its target 3.4 to reduce, by 2030, premature mortality from noncommunicable diseases, including cancer, by one third, an urgent scale-up of actions is needed. This scale-up should include actions that apply also to other targets, such as target 3.a to strengthen the implementation of the WHO Framework Convention on Tobacco Control by all Parties to the Convention, as appropriate.

4. Progress in cancer control has been uneven. In spite of known effective interventions, the burden of cervical cancer, for example, remains greatest in low- and middle-income countries, where progress has been the slowest. While there have been moderate improvements in age-standardized cancer mortality rates in high-income countries, reaching a 25% reduction in some settings, overall declines in mortality from cancer have not been achieved globally.

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<sup>1</sup> Document EB140/31.

<sup>2</sup> See the summary records of the Executive Board at its 140th session, fourteenth meeting, fifteenth meeting, section 1 and eighteenth meeting, section 3.

5. Outcomes for childhood acute lymphoblastic leukaemia, a highly treatable cancer, reflect global inequities: five-year survival is less than 20% in some low- and middle-income countries, as compared to 90% in some high-income countries. In many countries, women, children, indigenous groups, ethnic minorities and socioeconomically disadvantaged groups are often inequitably exposed to risk factors and have limited access to diagnosis and care services, which may result in poorer outcomes for these vulnerable groups.
6. The economic impact of cancer is significant and is increasing. In 2010, the total annual economic cost of cancer was estimated at approximately US\$ 1.16 trillion, threatening health budgets and economies at all income levels as well as causing financial catastrophe for individuals and families.
7. Effective cancer control planning requires accurate data, including reliable cancer registries and monitoring and evaluation programmes for quality assurance. While most countries (84%) have reported having a cancer registry, only one in five low- and middle-income countries have the necessary data to drive policy.

## **DEVELOPING AND IMPLEMENTING NATIONAL CANCER CONTROL PLANS**

8. In the 2015 country capacity survey for noncommunicable diseases,<sup>1</sup> 87% of the 177 responding Member States reported having a policy, strategy or action plan for all or some cancers but only 68% reported that such a policy, strategy or action plan was operational. Implementing a national cancer control plan requires adequate resources, monitoring and accountability together with an effective health system, founded on the principles of universal health coverage and strong primary health care.
9. Orienting funding through domestic, bilateral and multilateral channels towards evidence-based, cost-effective interventions to reduce risk factors, including tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol, can reduce unnecessary expenditure on high-cost interventions, medicines and technologies. As recognized in the Addis Ababa Action Agenda,<sup>2</sup> resources for financing national cancer responses increasingly need to come from domestic budgets. According to some estimates, only 5% of global resources for cancer prevention and control are spent in low- and middle-income countries, despite the majority of preventable deaths occurring in these countries. Innovative financing is needed, including through increased taxes on tobacco and alcohol.

## **PREVENTION, EARLY DIAGNOSIS, SCREENING AND TREATMENT**

10. Based on current knowledge, between one third and one half of all cancers are potentially preventable; this proportion will rise as further understanding of cancer risk factors and the development of associated preventive interventions is gained. Cancer is caused by a wide range of risk factors, including the four shared noncommunicable disease risk factors (tobacco use; unhealthy diet; physical inactivity; and harmful use of alcohol), obesity, infections, indoor and outdoor air pollution, radiation, environmental chemicals and occupational exposures. Tobacco use directly contributes to 22% of global cancer deaths. Cancer-causing infections are responsible for over 20% of cancer deaths

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<sup>1</sup> Assessing national capacity for the prevention and control of noncommunicable diseases: global survey. Geneva: World Health Organization; 2016.

<sup>2</sup> United Nations General Assembly resolution 69/313 (2015).

in low- and middle-income countries. Vaccines are currently available for two of the most common oncogenic infectious agents, human papilloma virus and hepatitis B virus, and are very cost-effective strategies for cancer prevention.

11. Identifying cancer at the earliest possible stage means that treatment is less costly and cure is more likely. Late diagnosis of cancer is common in low- and middle-income countries, where many individuals present with advanced or metastatic cancer. Access to diagnostic, including pathology, and treatment services is limited in many low- and middle-income countries.

12. Cancer screening has had a limited impact in many low- and middle-income countries due to low participation, inadequate quality assurance measures and insufficient health infrastructure to deliver organized services. In 2015, only 20% of the countries that reported in the country capacity survey for noncommunicable diseases as having a screening programme achieved greater than 70% participation for cervical or breast cancer screening.

13. Of the estimated 20 million people who need palliative care each year, 6.6 million (33%) are cancer patients. Over half of cancer patients at all stages experience pain, even more so when undergoing treatment and when in advanced phases of disease, yet 83% of the global population live in countries with low or non-existent access to adequate pain management. In resolution WHA67.19 (2014) on the strengthening of palliative care as a component of comprehensive care throughout the life course, the Sixty-seventh World Health Assembly urged Member States to integrate palliative care services in the continuum of care, with emphasis on primary care, community and home-based care, and universal coverage schemes.

## **WHO'S RESPONSE**

14. The Secretariat is supporting the fulfilment of the commitments made by Heads of State and Government in the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases,<sup>1</sup> and the achievement of the Sustainable Development Goal targets pertaining to comprehensive cancer control. It is also supporting Member States in their efforts to develop, strengthen, implement and monitor national cancer control plans, and to prioritize cost-effective interventions in noncommunicable disease prevention and control.

15. The Secretariat has developed technical materials to support the planning and implementation of cancer prevention strategies by Member States. These include publications and activities to support the implementation of the WHO Framework Convention on Tobacco Control (2005) and provide guidance on interventions to promote healthy diet and physical activity (2014), reduce the harmful use of alcohol (2010) and implement vaccination programmes (2014). In addition, strategies have been developed on promoting cancer early diagnosis and screening (2007 and 2017), developing a comprehensive approach to cervical cancer control (2014), identifying priority medical devices (2016), strengthening palliative care services (2016) and analysing selected cost-effective cancer control interventions (2016). The 2015 update of the WHO Model List of Essential Medicines provides guidance on cancer medicines and treatment indications for 33 cancers and supports countries in negotiating lower medicine prices. Cancer control capacity is periodically assessed through the WHO global noncommunicable disease country capacity survey.

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<sup>1</sup> United Nations General Assembly resolution 66/2 (2011).

16. IARC, the specialized cancer research agency of WHO, has provided a global reference for cancer information through the Global Cancer Observatory, which is a web-based platform that uses data from several of IARC's key projects, including the GLOBOCAN project and the Cancer Incidence in Five Continents series of monographs. IARC leads the Global Initiative for Cancer Registry Development, which provides expertise, training and support to national authorities and cancer registries in low- and middle-income countries to address the lack of quality data. The IARC Monographs on the Evaluation of Carcinogenic Risks to Humans programme is the most comprehensive international approach to the evaluation and identification of carcinogenic agents. IARC conducts extensive research to evaluate screening methodologies with particular emphasis on technologies appropriate to low- and middle-income countries.

17. A global joint programme has been developed by the WHO-led United Nations Inter-agency Task Force on the Prevention and Control of Non-communicable Diseases, with seven organizations of the United Nations system (IAEA, IARC, UNAIDS, UNFPA, UNICEF, the United Nations Entity for Gender Equality and the Empowerment of Women, and WHO) providing support to governments to prevent and control cervical cancer. In addition, IAEA, IARC and WHO have been working together to provide support to countries in respect of comprehensive cancer control.

18. All WHO regional offices, and many country offices, have provided direct support to Member States in respect of cancer prevention and control by organizing regional workshops and training courses, convening meetings and passing resolutions. Some of the regional activities are described below.

(a) The Regional Office for Africa has been providing support for cancer prevention and control policies, strategies and plans in 19 Member States and has developed five normative documents on cancer prevention and control.

(b) The Regional Office for the Americas has developed five information products on cervical cancer to inform and provide direct in-country support for 11 Member States.

(c) The Regional Office for South-East Asia, in the light of the resolution on cancer prevention and control adopted by the Regional Committee for South-East Asia at its Sixty-eighth session (2015),<sup>1</sup> has been promoting activities to strengthen the early diagnosis, referral and management of cancers, focusing on primary care and on enhancing information systems and registries.

(d) The Regional Office for Europe has produced training materials for health professionals and in 2014 published a progress report for policy-makers on the prevention and control of noncommunicable diseases in the Region.

(e) The Regional Office for the Eastern Mediterranean has developed a regional framework (2016) and a regional strategy for cancer prevention and control (2009–2013).

(f) The Regional Office for the Western Pacific has supported workshops on leadership and capacity building for cancer control and, in partnership with a WHO collaborating centre in the Republic of Korea, has developed an e-learning course on the subject, based on WHO publications.

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<sup>1</sup> Resolution SEA/RC68/R5 (2015) on cancer prevention and control – the way forward.

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## RECOMMENDED ACTIONS FOR MEMBER STATES AT THE COUNTRY LEVEL

19. **As part of the national commitments to develop policies and plans for the prevention and control of noncommunicable diseases, develop and implement a national cancer control plan with a focus on equity and access.** Countries should develop and implement national cancer control plans with adequate resources and accountability to provide high-quality, resource-appropriate cancer prevention and control services for all and the targets of the 2030 Agenda for Sustainable Development.

20. **Reduce risk factors for cancer through policies and programmes.** In accordance with existing global strategies to reduce the shared risk factors for noncommunicable diseases and multisectoral implementation of the WHO Framework Convention on Tobacco Control, cost-effective policies must be implemented to reduce the cancer burden, such as policies to: impose higher taxes on tobacco and alcohol; eliminate exposure to tobacco smoke or tobacco marketing tactics; restrict the marketing of foods and non-alcoholic beverages to children; ensure a quality public open space and adequate infrastructure for physical activity; reduce air pollution; and promote access to human papillomavirus vaccination. Research on the causes of human cancer and carcinogenesis is needed. Preventing the tobacco industry's interference in public health policy is a cross-cutting intervention critical for the success of reducing the risk factors of noncommunicable diseases.

21. **Improve access to timely diagnosis and treatment.** Pursuant to commitments made at the United Nations General Assembly in 2011, 2014 and 2015,<sup>1</sup> Member States should increase efforts to strengthen health systems at the national and local levels to ensure early diagnosis and accessible, affordable and high-quality care for all cancer patients. The implementation of comprehensive packages for noncommunicable disease prevention and control, such as WHO's Package of essential noncommunicable disease interventions for primary health care in low-resource settings,<sup>2</sup> can improve service delivery by promoting early diagnosis.

22. **Optimize the use of existing human resources and anticipate future requirements for cancer prevention and control.** Countries should ensure that their workforce has the appropriate competencies and skills for comprehensive cancer control through education and training programmes and appropriate recruitment, deployment and retention strategies, including career-development opportunities.

23. **Improve data to inform policy decision-making.** Effective policies must be founded on accurate data. In that respect, there is a need for renewed commitment to: the development and maintenance of population-based cancer registries; the surveillance of risk factors and of the measures implemented to control them; strengthened civil registration and vital statistics systems; routine health information systems that assess both technical and experiential quality; facility assessments to determine readiness and the quality of the services provided; and a rigorous monitoring and evaluation framework at the national and subnational levels.

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<sup>1</sup> United Nations General Assembly resolutions 66/2 (2011), 68/300 (2014) and 69/313 (2015).

<sup>2</sup> Implementation tools: Package of essential noncommunicable (PEN) disease interventions for primary health care in low-resource settings. Geneva: World Health Organization; 2013.

## **ACTIONS FOR THE SECRETARIAT**

24. The Secretariat will develop technical tools for and provide support to Member States in the planning, implementation, monitoring and evaluation of cancer prevention and control strategies, in the context of integrated national responses to noncommunicable diseases. This will include help with the costing of national cancer control plans, the implementation of cost-effective interventions including “best buys” in the context of the global action plan for the prevention and control of noncommunicable diseases 2013–2020, strengthening the workforce, promoting access to essential medicines and technology and integrating cancer prevention and control into national health systems. The Secretariat will also help to implement national cancer control plans and will provide in-country technical assistance as needed.

25. The Secretariat will also support efforts to strengthen the policy environment including the efforts by Member States to scale-up tobacco control, reduce the harmful use of alcohol, address environmental and occupational carcinogens, promote healthy diet and physical activity and increase human papillomavirus and hepatitis B vaccination coverage.

26. In addition, the Secretariat will support data collection and analysis, including through cancer registries, and the development of a monitoring and evaluation framework to assist with cancer prevention and control planning and quality assurance.

## **ACTION BY THE HEALTH ASSEMBLY**

27. The Health Assembly is invited to note this report.

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