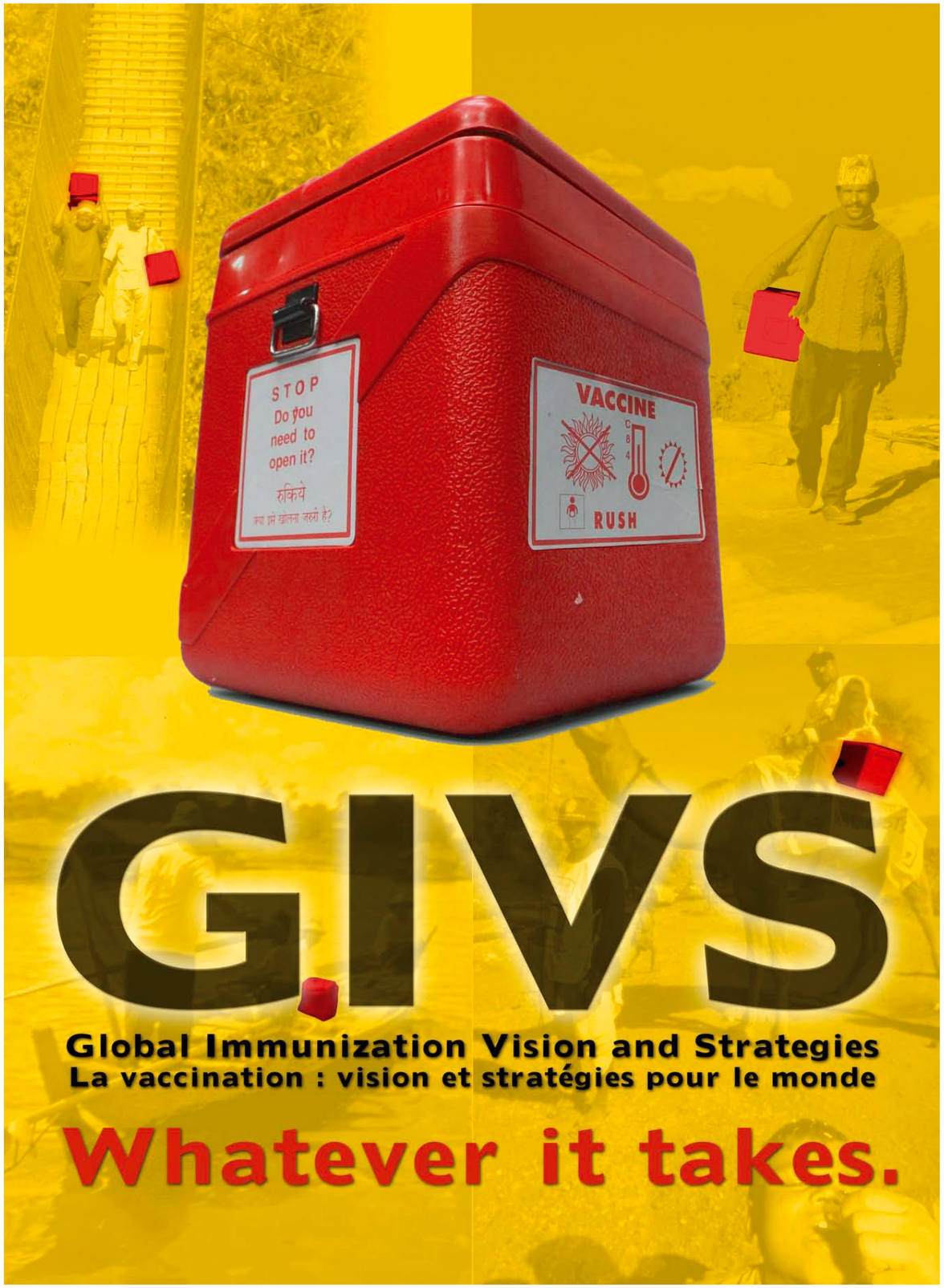
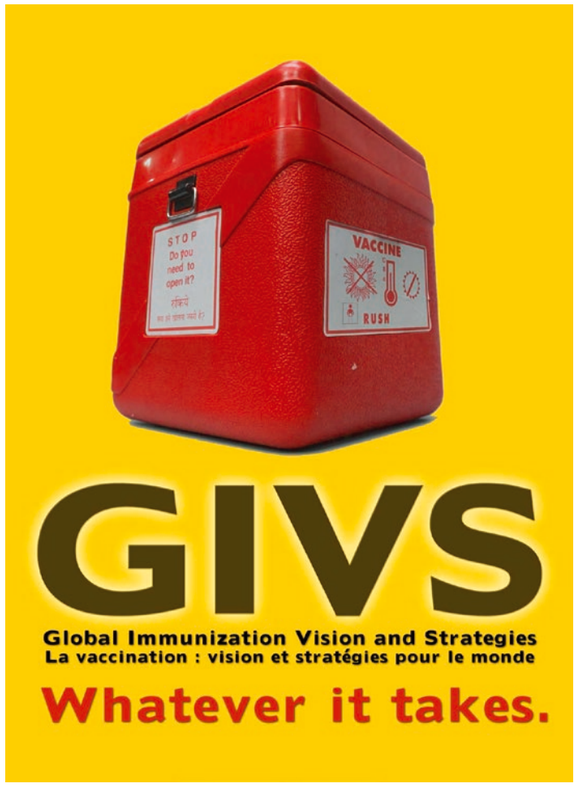
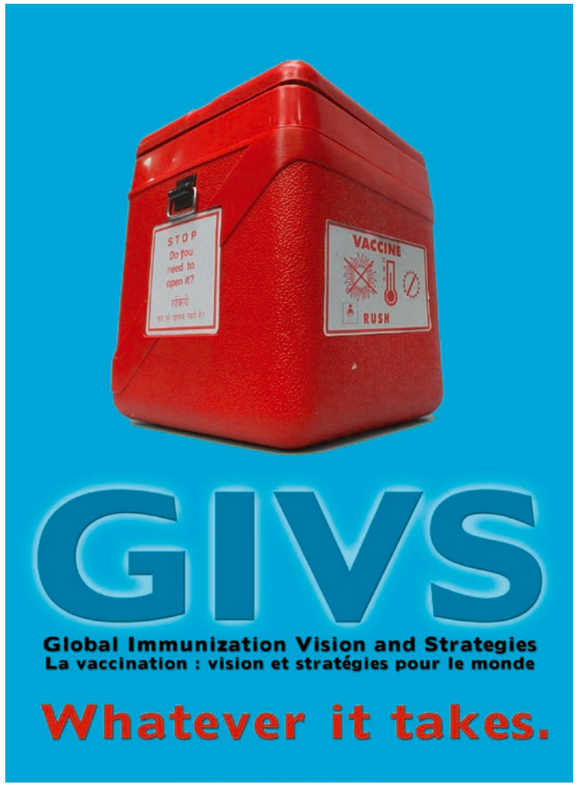
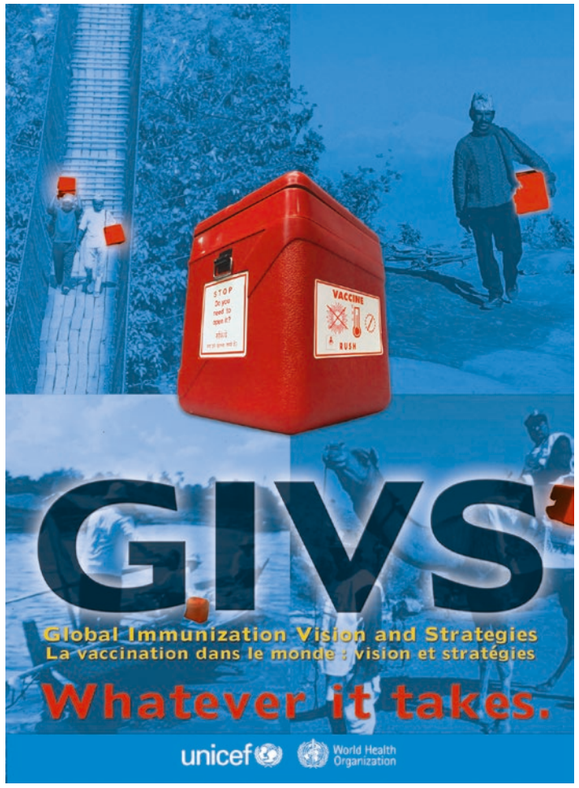




Poster design

Global Immunization Vision and Strategies,
poster proposal.





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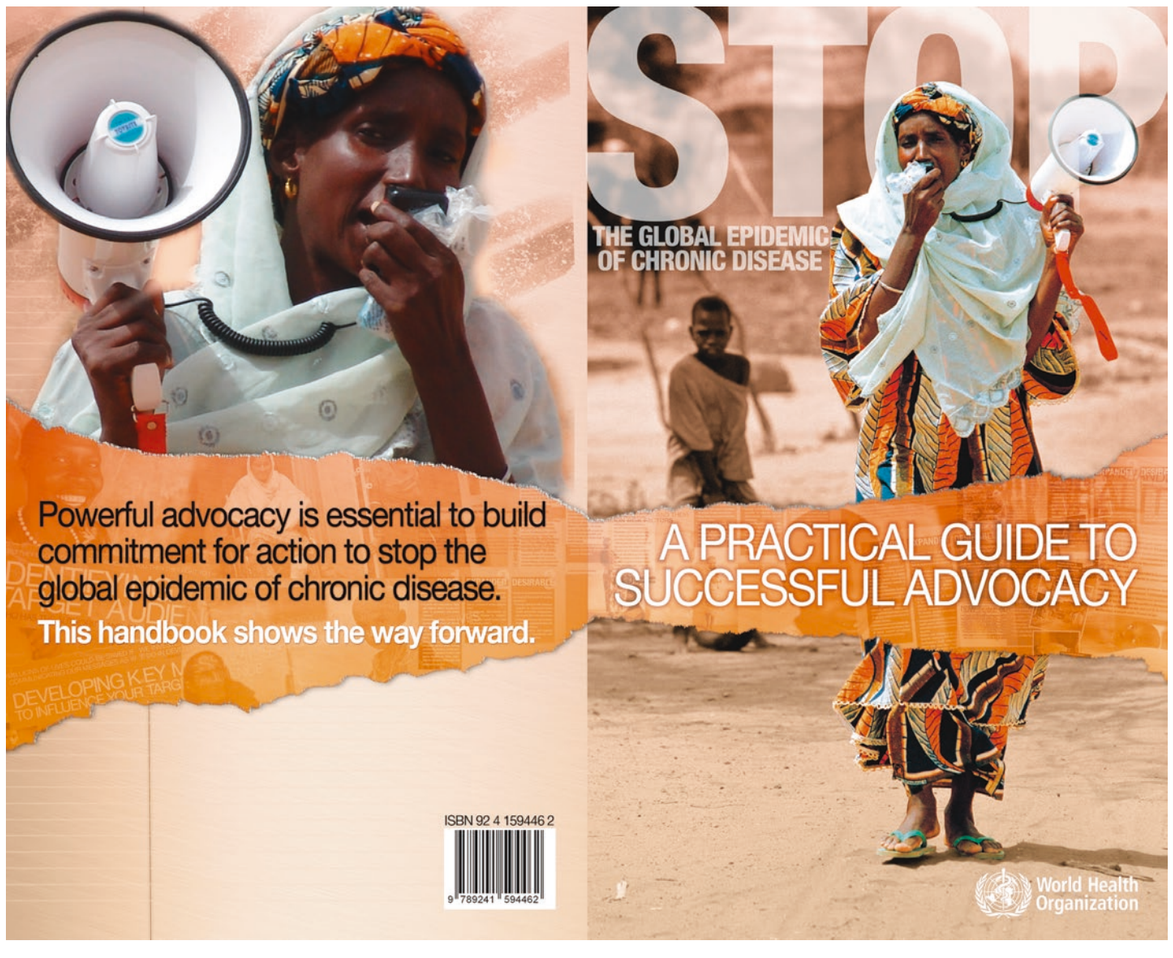
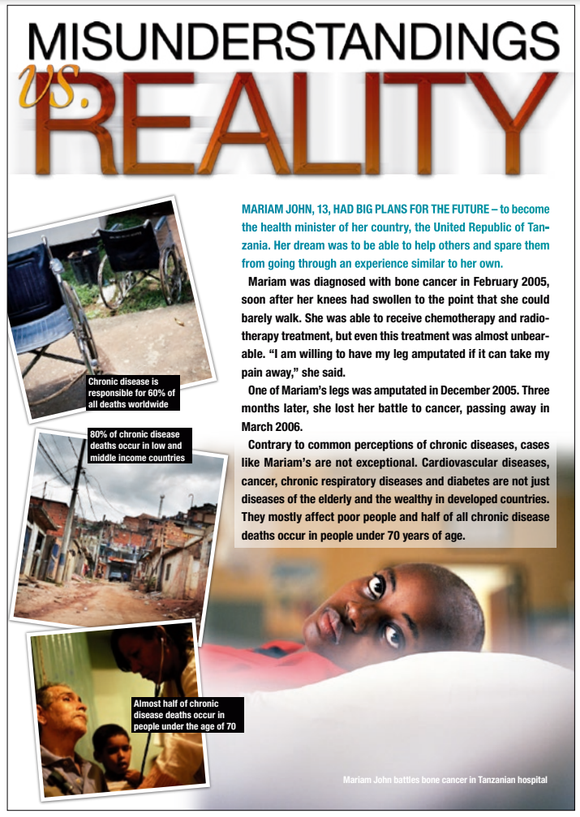
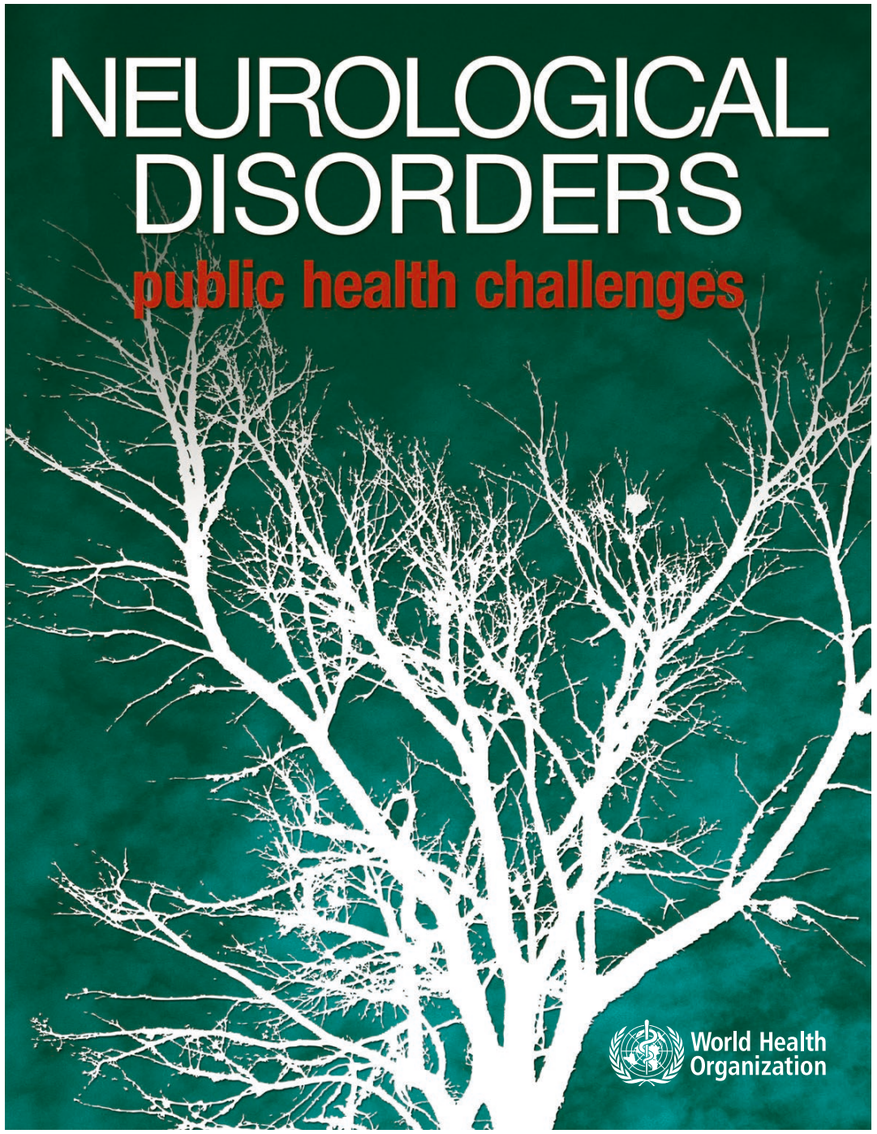
They are heuristic for what we can do for you.

Advocacy campaign
Visual identity system

Stop the Global Epidemic of Chronic Disease: A Practical Guide to Successful Advocacy.
Selected components of the Chronic diseases advocacy tool kit, in English and French.

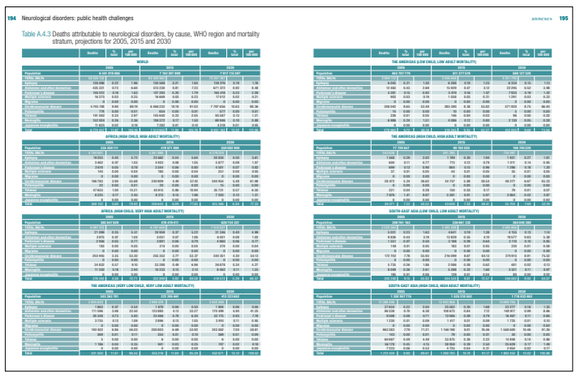






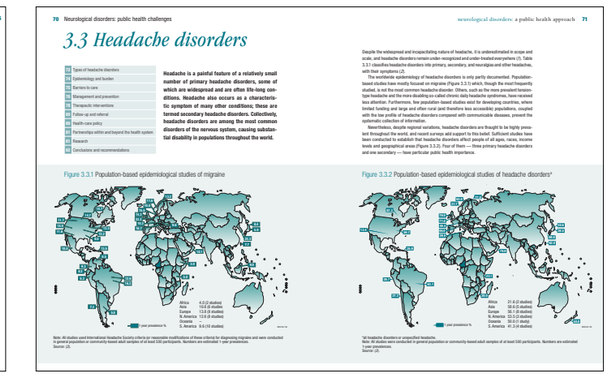
Book design
Table design
Graphs and Maps

Neurological Disorders:
Public Health Challenges,
228 pages.



194 Neurological disorders: public health challenges — ANNEXES 195

Table A.4.3 Deaths attributable to neurological disorders, by cause, WHO region and mortality stratum, projections for 2005, 2015 and 2030



70 Neurological disorders: public health challenges — neurological disorders: a public health approach 71

3.3 Headache disorders

Headache is a painful feature of a relatively small number of primary headache disorders, some of which are widespread and are often life-long conditions. Headache also occurs as a characteristic symptom of many other conditions; these are termed secondary headache disorders. Collectively, headache disorders are among the most common disorders of the nervous system, causing substantial disability in populations throughout the world.

Despite the widespread and incapacitating nature of headache, it is underestimated in scope and scale, and headache disorders remain under-recognized and under-treated everywhere (1). Table 3.3.1 classifies headache disorders into primary, secondary, and neuralgias and other headaches, with their symptoms (2).

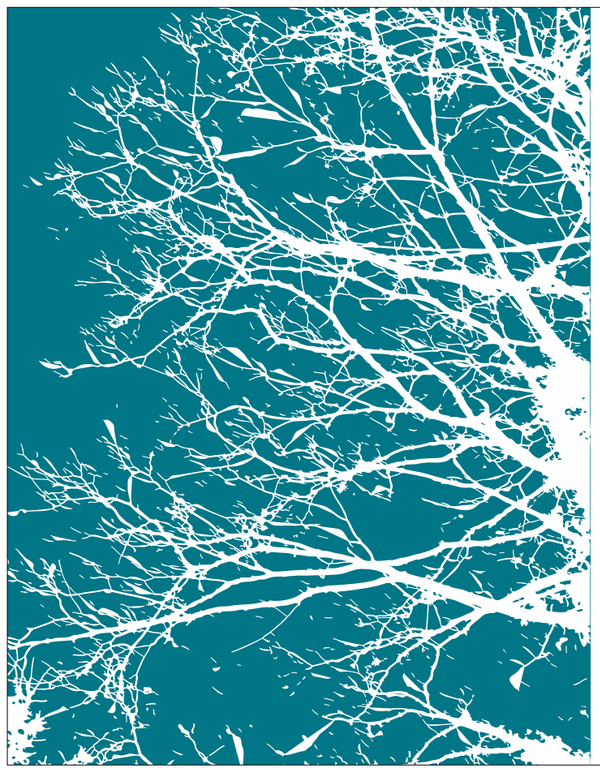
The epidemiology and burden of headache disorders is only partly documented. Population-based studies have mostly focused on migraine (Figure 3.3.1) which, though the most frequently studied, is not the most common headache disorder. Others, such as the more prevalent tension-type headache and the more disabling so-called chronic daily headache syndromes, have received less attention. Furthermore, few population-based studies exist for developing countries, where limited funding and large and often rural (and therefore less accessible) populations, coupled with the low profile of headache disorders compared with communicable diseases, prevent the systematic collection of information.

Nevertheless, despite regional variations, headache disorders are thought to be highly prevalent worldwide. Several population-based studies in developed countries have been conducted to establish that headache disorders affect people of all ages, races, income levels and geographical areas (Figure 3.3.2). Four of them — three primary headache disorders and one secondary — have particular public health importance.

Table of headache disorders
Epidemiology and burden
Barriers to care
Management and prevention
Therapeutic interventions
Follow-up and referral
Health-care policy
Partnerships within and beyond the health system
Research
Conclusions and recommendations

Figure 3.3.1 Population-based epidemiological studies of migraine

Figure 3.3.2 Population-based epidemiological studies of headache disorders*



CHAPTER 1

public health principles and neurological disorders

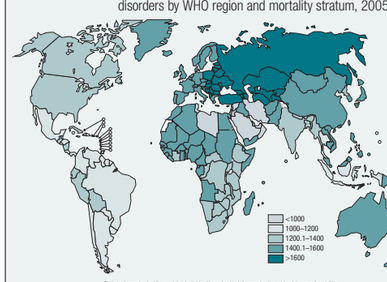
This chapter explains briefly the principles of public health, epidemiology and the burden of disease, and the ways in which health promotion and disease prevention are achieved. It looks at risks to health and prevention strategies, and explains what health policy means. It then describes the goals and functions of health systems and in particular considers service provision for neurological disorders. As many neurological disorders result in considerable morbidity, special attention is paid to disability and rehabilitation. The all-important part played by stigma in neurological disorders is assessed and, finally, education and training in neurology are discussed.

Many distinctions can be made between the practice of public health and that of clinical neurology. Public health professionals approach neurology more broadly than neurologists by monitoring neurological disorders and related health concerns of entire communities and promoting healthy practices and behaviours among them to ensure that populations stay healthy. Public health specialists focus on health and disease of entire populations rather than on individual patients, whereas neurologists usually treat one patient at a time for a specific neurological condition. These two approaches could be seen as being almost at the opposite ends of the health-care spectrum. What this chapter aims to do is to help build bridges between these two approaches and serve as a useful guide to the chapter that follows — on the public health aspects of specific neurological disorders.

34 Neurological disorders: public health challenges

Figure 2.4 DALYs per 100 000 population associated with neurological disorders by WHO region and mortality stratum, 2005

Region	Mortality stratum	DALYs per 100 000 population for neurological disorders
Africa (AFR)	Afr-D Afr-E	1 536.73 1 361.41
Americas (AMR)	Amr-A Amr-B Amr-D	1 214.18 1 135.56 1 251.09
South-East Asia (SEAR)	Sear-B Sear-D	750.50 1 480.39
Europe (EUR)	Eur-A Eur-B Eur-C	1 463.53 1 665.33 2 920.22
Eastern Mediterranean (EMR)	Emr-B Emr-D	1 089.68 1 377.09
Western Pacific (WPR)	Wpr-A Wpr-B	1 543.28 1 470.80



The designations employed and the presentation of material on this map do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dashed lines represent approximate border lines for which there may not yet be full agreement.

WHO GL 154

Table 2.6 Neurological disorders as percentage of total DALYs by WHO region, 2005

Cause category	World (%)	WHO region					
		AFR (%)	AMR (%)	SEAR (%)	EUR (%)	EMR (%)	WPR (%)
Epilepsy	0.50	0.46	0.73	0.46	0.40	0.54	0.44
Alzheimer and other dementias	0.75	0.10	1.47	0.26	2.04	0.42	1.32
Parkinson's disease	0.11	0.02	0.22	0.07	0.30	0.06	0.15
Multiple sclerosis	0.10	0.03	0.17	0.08	0.20	0.09	0.15
Migraine	0.52	0.13	0.97	0.41	0.80	0.51	0.73
Cerebrovascular disease	3.46	1.11	3.10	1.93	7.23	2.69	6.81
Poliomyelitis	0.01	0.00	0.00	0.01	0.00	0.01	0.01
Tetanus	0.44	0.77	0.01	0.81	0.00	0.54	0.10
Meningitis	0.36	0.24	0.39	0.81	0.24	0.43	0.24
Japanese encephalitis	0.04	0.00	0.00	0.05	0.00	0.06	0.09
Total	**6.29**	**2.86**	**7.06**	**4.90**	**11.23**	**5.34**	**10.04**

Estimates of deaths

Neurological disorders are an important cause of mortality and constitute 12% of total deaths globally (see Table 2.7). Within these, cerebrovascular diseases are responsible for 85% of the deaths due to neurological disorders (see Figure 2.5). Neurological disorders constitute 16.8% of the total deaths in lower middle income countries compared with 13.2% of the total deaths in high income countries (Figure 2.6). Among the neurological disorders, Alzheimer and other dementias are estimated to constitute 2.84% of the total deaths in high income countries in 2005. Cerebrovascular disease constitute 15.8%, 9.6%, 9.5% and 6.4% of the total deaths in lower middle, upper middle, high and low income countries respectively (Table 2.8).

Table 2.7 Deaths attributable to neurological disorders as percentage of total deaths, 2005, 2015 and 2030

Cause category	2005 (%)	2015 (%)	2030 (%)
Epilepsy	0.22	0.21	0.19
Alzheimer and other dementias	0.73	0.81	0.92
Parkinson's disease	0.18	0.20	0.23
Multiple sclerosis	0.03	0.03	0.02
Migraine	0.00	0.00	0.00
Cerebrovascular disease	9.90	10.19	10.63
Poliomyelitis	0.00	0.00	0.00
Tetanus	0.33	0.23	0.13
Meningitis	0.26	0.17	0.10
Japanese encephalitis	0.02	0.01	0.01
Total	**11.67**	**11.84**	**12.22**

Figure 2.5 Deaths from selected neurological disorders as percentage of total neurological disorders

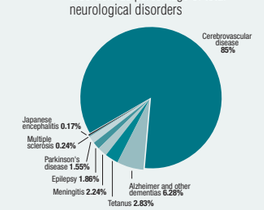
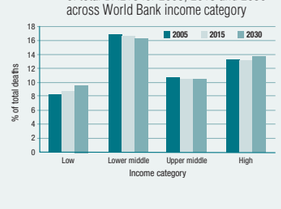


Figure 2.6 Neurological disorders as percentage of total DALYs for 2005, 2015 and 2030 across World Bank income category



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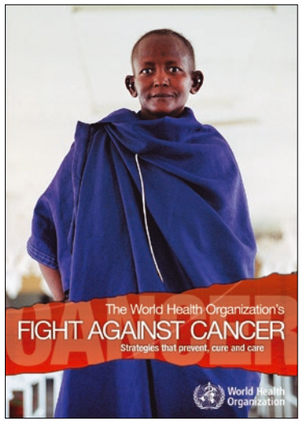
Brochure design

The World Health Organization's Fight Against Cancer: Strategies That Prevent, Cure and Care.
Cover and inside pages.



GLOBAL ACTION PLAN CAN SAVE MILLIONS

WHO knows how to stop millions of people dying needlessly from cancer. Our task is to support Member States to make this happen.

WHO's Global Action Plan Against Cancer combines the organization's existing strengths and strategies to increase its capacity to face this global public health problem.

It provides guidance to governments, health providers and other stakeholders on how to prevent and cure this chronic disease, as well as care for those for whom palliation is the only option.

"It is possible, even in very economically-constrained environments, to be effective in preventing cancer and improving access to quality services for patients who need such services," says Dr Catherine Le Galès-Camus, WHO's Assistant Director-General for Noncommunicable Diseases and Mental Health.

Every year, at least 7 million people die from cancer, more than HIV/AIDS, malaria and tuberculosis combined. And almost half of these deaths are avoidable. The high prevalence of cancer is ominously shifting from developed nations to poorer, less medically-equipped countries.

WHO CANCER FIGHTERS
Dr Catherine Le Galès-Camus, Assistant Director-General for Noncommunicable Diseases and Mental Health

Tobacco use and exposure causes 1.5 million cancer deaths annually.

Chronic hepatitis B infection kills 340 000 from liver cancer and cirrhosis. A quarter of a million women die from cervical cancer. Vaccines exist to prevent most of these deaths.

Occupational carcinogens kill at least 152 000 people. Some 274 000 people who are overweight, obese or physically inactive die from cancer. Harmful alcohol causes 351 000 cancer deaths. Indoor and outdoor air pollution leads to 71 000 cancer deaths, according to WHO's Comparative Risk Assessment publications (www.who.int/healthinfo/bodddiscrisk).

The human price is not the only loss caused by cancer. It is responsible for immense costs to health systems, insufferable economic and emotional burdens on families and irreplaceable losses for communities.

But WHO's many departments and experts have developed a wide range of strategies to end this needless suffering. These measures prevent and cure many cancers, provide palliative care for the terminally ill, and measure and manage the disease's impact and services to fight it. All these efforts are being consolidated in WHO's Global Action Plan Against Cancer.

This multi-faceted approach will ensure that these strategies are addressed at country levels within national cancer control programmes (NCCP), which are blueprints governments can use to frame legislation, design health services and raise awareness to fight cancer.

To ensure that these strategies succeed, WHO must keep working closely with global partners, ranging from collaborating centres (whocc.who.int) to governmental and nongovernmental organizations in cancer-related fields like tobacco and immunization.

We also work hand-in-hand with a host of UN bodies, like the International Atomic Energy Agency on the joint-Program of Action for Cancer Therapy (PACT) in Albania, Nicaragua, Sri Lanka and the United Republic of Tanzania.

WHO has also formed a Commission on Social Determinants of Health to promote equal access to preventive and curative health services for all people, irrespective of their social or economic backgrounds.

Dr Andreas Ullrich, a WHO cancer control medical officer within the Department of Chronic Diseases and Health Promotion, says the Action Plan can help governments prevent deaths from cancer by advocating prevention and control programmes at the highest political level.

"Every country, regardless of resource level, can confidently take steps to curb the cancer epidemic," Ullrich says. "They can save lives and prevent unnecessary suffering caused by cancer."

WHO CANCER FIGHTERS
Dr Andreas Ullrich, Medical Officer, Cancer Control

AGAINST CANCER OF LIVES

HOW **WHO** FIGHTS CANCER

Reading this brochure, you'll be given a dynamic glimpse of the many cancer control activities WHO performs. Each activity fits within the four broad approaches WHO takes to fight cancer: Prevention, Cure, Care and Manage. WHO's intensive efforts have produced dozens of strategies, recommendations and technical programmes to combat cancer, prevent needless deaths and provide appropriate care for the terminally ill. WHO has consolidated these tools for countries in a framework known as the national cancer control programme (NCCP), which focuses government attention and services on all facets of the fight against cancer.

PREVENT

WHO devotes vast amounts of effort to prevention activities, which can reduce cancer deaths by 40% and prevent untold suffering and cost to communities, increasingly in the developing world. This brochure examines each WHO programme dealing with cancer prevention and how they go about it. Reducing tobacco and alcohol use are key goals, as are improving diets and physical activity. Safeguarding workplaces against carcinogens, and advancing immunizations against the hepatitis B virus play enormous roles in reducing the cancer burden. They are all discussed in the Prevention section.

CARE

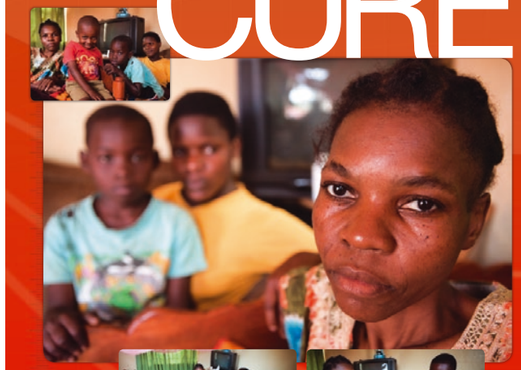
WHO provides vital support and guidance to care for cancer sufferers for whom cure is not an option. Guidelines, technical support and training are all offered to provide the best possible palliative care services. WHO's work in palliative care – from headquarters to the field – is reviewed in this brochure.

CURE

Through early detection, screening and adequate treatment, many cancers can be cured. WHO helps countries scale up these areas. WHO provides countries, particularly in the developing world, access to the most appropriate technologies, medicines and training to perform potentially life-saving treatment. This brochure looks at what different programmes are doing to build this cancer-fighting capacity in the field.

MANAGE

Providing information on cancer burdens for strengthening evidence-based policy is a core WHO function. We assist countries to plan, implement and measure the success of their NCCPs. Such work also helps identify challenges and direct resources towards effective cancer prevention and control activities. This brochure examines the different, yet coordinated, departments playing crucial clive in developing necessary data and providing policy options to ensure people benefit from NCCP.



CURE &CARE

WHO CANCER FIGHTERS
Prof. Charles Gilks, Coordinator, Antiretroviral Treatment and HIV Care

VICTORIES OVER AIDS BRING CANCER BURDEN INTO FOCUS

Success in scaling up access to HIV/AIDS treatment has set the world a new challenge: protecting people with the virus from succumbing to long-term chronic diseases like cancer.

Combination antiretroviral therapies work by suppressing the AIDS virus, in turn enabling people with the disease to enjoy longer and more productive lives.

"We are getting lots of people on treatment, thereby lengthening their lives," says Prof. Charles Gilks, Coordinator of Antiretroviral Treatment and HIV Care for WHO's HIV/AIDS Department. "But the consequence is that HIV-associated cancers become more and more important."

www.who.int/hiv

With this in mind, WHO is focusing more on chronic disease prevention for people living with HIV/AIDS.

Primary prevention measures like recommending people living with HIV/AIDS use condoms have led to a reduction in Kaposi sarcoma, a common form of cancer, in HIV-positive people linked with a sexually-transmitted herpes-like virus.

WHO supports Kaposi sarcoma treatment and is planning next steps for other HIV/AIDS-related cancers, says Gilks. Such measures could include scaling up cervical cancer screening as part of the HIV/AIDS treatment programme.

Other cancers linked to HIV/AIDS include lymphomas and cancers of the lung, skin and liver.

WHO's Department of HIV/AIDS promotes WHO's palliative care guidelines for general symptom relief for HIV/AIDS sufferers, particularly the terminally ill. These guidelines are being widely implemented through hospices.

"The success we have had in getting people onto treatment programmes has turned AIDS into a chronic disease, which means we will have a new pattern of morbidity and mortality and a lot of it will be from cancer," Gilks says.

Years of work have resulted in global strategies being crafted and implemented to improve health, and prevent and control cancer.

These strategies, requested by the World Health Organization's own Member States, provide a strong foundation for a determined fight against the disease. Jointly, they will form the basis of our Global Action Plan Against Cancer.

Despite these efforts, WHO and its Member States still face great challenges to defeat the global burden of cancer. Greater investment in prevention, cure and care, closer collaboration with international partners and stronger determination to defeat cancer are needed to fuel what must be a continuous, sustainable campaign.

Cancer is the world's second biggest killer after cardiovascular disease, but one of the most preventable noncommunicable chronic diseases. Cancer killed 7.6 million people in 2005, three quarters of whom were in low- and middle- income countries. By 2015, that number is expected to rise to 9 million and increase further to 11.5 million in 2030.

Up to 40% of all cancer deaths can be avoided by reducing tobacco use, improving diets and physical activity, lowering alcohol consumption, eliminating workplace carcinogens and immunizing against hepatitis B virus and the human papillomavirus.

A large proportion of cancer can be cured and all cancer patients deserve care. WHO provides support to strengthen health services to cure and care for cancer patients by improving primary and specialized health care. WHO makes essential medicines and technologies available for cancer treatment and palliative care. Our strategies and policy guidelines help governments in all countries to improve population health standards and reduce national cancer burdens.

Backed by World Health Assembly resolution 58.22 of 2005 on cancer prevention and control, WHO is committed to a Global Action Plan Against Cancer that will enhance synergies both across WHO and with our international partners to reduce the physical, social and economic burden of cancer worldwide.

Dr Margaret Chan
Director-General

40%
of all cancer deaths can be prevented

Cancer killed 7.6 million people in 2005, three quarters of whom were in low- and middle-income countries

www.who.int/cancer/en/

WHO REDUCES IONIZING RADIATION-RELATED CANCER

WHO's efforts to reduce harmful exposure to ionizing radiation, from radon to nuclear emergencies, are preventing cancer.

WHO CANCER FIGHTERS
Dr Jhanet Gar, Scientist, Radiation and Environmental Health

Ionizing radiation is a well-established cause for certain cancers, like lung, breast and thyroid cancer and most types of leukaemia.

"We look at all environments where radiation-related health risks may be found, including natural radiation, accidents, nuclear weapons and radiation use in occupational or medical settings," says Dr Jhanet Gar, a scientist with WHO's Radiation and Environmental Health Programme.

www.who.int/ionizing_radiation/

One of the world's largest natural radiation sources is radon, a gas produced from the uranium decay chain in rocks and soils. It accumulates in the basement of homes built in areas where radon is present naturally. It is the second most important risk factor for lung cancer after tobacco, causing tens of thousands of deaths annually.

WHO launched its International Radon Project to estimate radon-associated disease burdens, provide mitigation and approaches guidance and help Member States form evidence-based radon policies.

www.who.int/ionizing_radiation/env/radon

WHO also deals with the results of nuclear emergencies like the 1986 Chernobyl disaster, which released massive amounts of radiation into the fallout that affected many Belarus, Ukraine, and the Russian Federation.

Since 1989, WHO has been involved in programmes at Chernobyl providing assistance and assessing the health impacts of the explosion. By 2002, 4 000 cases of thyroid cancer had been diagnosed in people who were children at that time, most of whom were able to be treated successfully. Thousands of clean-up workers are also under medical and epidemiological surveillance in Belarus, the Russian Federation and Ukraine.

In 2006, WHO issued a report with findings of 20 years of health research into the Chernobyl explosion, which provided a basis for national policy recommendations.

www.who.int/ionizing_radiation/chernobyl

WHO works with its International Agency for Research on Cancer (IARC) to gather evidence on Chernobyl and develop strong radiation safety policies.

WHO SHEDS LIGHT ON RISKS OF SOLAR RAYS, SUNBEDS

No one can stop the sun shining, but WHO knows how to stop people suffering skin cancer from ultraviolet radiation.

WHO CANCER FIGHTERS
Dr Emilie van Deventer, Scientist, Radiation and Environmental Health

WHO is a key player in raising awareness to prevent cancer caused by exposure to sunlight and other non-ionizing, low-frequency forms of radiation, such as sunbeds.

www.who.int/uv/health

In 2006, WHO released its Global Burden of Disease of Solar Ultraviolet Radiation, estimating that 1.5 to 60 000 people die every year due to ever exposure to ultraviolet radiation. Of these, 48 000 are caused by malignant melanoma and 1.5 million by non-melanoma skin cancer.

"Ultraviolet radiation can have significant negative health consequences such as skin cancer, as well as a positive effect in terms of vitamin D production," says Dr Emilie van Deventer, a scientist specializing in electromagnetic radiation within WHO's Radiation and Environmental Health Programme.

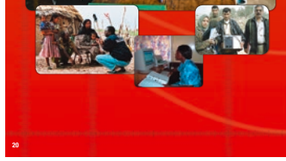
"Our task is to ensure we work to develop prevention-based approaches to help people live with the sun."

WHO's Sun Protection and Schools Module, *How to Make a Sun-wise School*, brings the issue of health and education to develop programmes promoting sun safety. WHO fact sheets raise awareness of dangers associated with sunbeds, tanning and ultraviolet light equipment.

The Radiation and Environmental Health Programme promotes and evaluates peer-reviewed studies on possible links between non-ionizing radiation and cancer.

It works closely with IARC to follow studies into possible overexposure to EMFs, which are produced by power lines and a variety of daily tools, like power lines and mobile telephony.

MANAGE



WHO NATIONAL CANCER CONTROL PROGRAMMES PROVIDE HOLISTIC CANCER GUIDANCE

Many countries are already putting WHO's cancer-fighting tools to use in their attempt to reduce the cancer burden.

National Cancer Control Programmes (NCCP) act as a public health framework for all strategies and plans dealing with cancer prevention, control, care and management for their health systems.

WHO's benchmark publication, *National Cancer Control Programmes: Policies and Managerial Guidelines*, has been used by 115 countries to address every stage of cancer care and is also used in courses developed by the Department of Chronic Diseases and Health Promotion (www.who.int/cancer/media/en/405.pdf).

According to this text, NCCP should be the country's most effective coordinator of public programmes and interventions adapted to specific country needs and resource levels.

Since 2000, WHO countries and policy-makers in managing their systems to ensure effective services are provided through optimal use of resources.

The Programmes have produced guidance through publications on best public health practices (http://www.who.int/cancer/modules/en) as well as hands-on assistance through WHO regional and country offices.

Canada, France, India and Viet Nam are among the many countries that have established NCCP since the mid-1990s. In 2006, WHO launched Ask to Achieve a target of cancer prevention and control. It was launched to increasing the number of countries with NCCPs.

WHO SUPPORTS ALBANIA IN LAUNCHING ITS OWN NCCP

Albania has embraced WHO best practice to develop its own nationwide pathogen to fight cancer. Albania's new National Cancer Control Programme aims to prevent still-rare cancer, the country's newest and highest cases of death, and comprehensively care for those with terminal conditions.

"WHO's evidence-based approach has helped us to develop a cancer control programme that will help us to reduce the cancer burden in our country," says Dr Ardiana Gjata, Albania's Director.

In 2005, 1000 Albanians died from cancer, the country's second highest cause of mortality after cardiovascular disease and responsible for 10% of all deaths for that year.

Tobacco use, childhood chronic conditions, changing sexual behaviours and unsafe exposure to solar radiation are all contributing to the increasing cancer burden.

If deaths were left to advance these patterns over-serious often no longer found but 60% of Albanians terminally ill from cancer prefer to be cared for at home rather than in hospital settings.

WHO and Albania have been working with Albanian experts and officials on the programme. This collaboration has included training in cancer epidemiology, cancer registration, improved training and needs assessments for radiotherapists, oncologists and pathology care doctors.

PREVENT

WHO TOBACCO CONVENTION CRUCIAL TO CANCER PREVENTION

Quitting tobacco is the best way to reduce cancer. To help make this happen, WHO develops and helps implement powerful tobacco controls.

WHO CANCER FIGHTERS
Dr Douglas Bettcher, Acting Director, Tobacco Free Initiative

Tobacco use is the world's leading preventable cause of premature death. It kills more than 5 million people annually, 25 every hour. More than one in two – left unchecked, global tobacco-related deaths could rise to over 8 million by 2030.

The landmark WHO Framework Convention on Tobacco Control (WHO FCTC) came into force in February 2005. It establishes evidence-based standards and sets countries in banding civil and criminal liability issues linked to tobacco use and manufacturers.

"We highlight the global problems of tobacco use and the many serious diseases it causes, cancer being the main one," says Dr Douglas Bettcher, Acting Director of the Tobacco Free Initiative (TFI), which drives the convention.

www.who.int/tobacco/framework

More than 140 countries have ratified the legally-binding WHO FCTC, which is the organization's principal tool to help countries implement its strategies to introduce effective tobacco control policies based on rigorous scientific evidence. Nongovernmental organizations, such as the International Union Against Cancer (UICC), play a significant role in helping WHO push ratification.

Of the 7 million annual cancer deaths, 90% are preventable. Of these deaths, about 30% are caused by risk factors for NCDs. Lung cancer is the leading form of tobacco-caused cancer, followed by tumours of the larynx, pancreas, kidney and bladder.

Tobacco is also a major risk factor for cervical cancer, currently prevalent and fuel tobacco advertising and smoking in public places.

Implementing the Convention's controls could cause a 10% reduction in tobacco uptake and consumption, saving up to 200 million lives by 2050.

TFI and WHO's Oral Health Programme have also worked together to address the tobacco-related burden of oral cancer, which can be fatal on oral cavity cancer. 75% of which is related to tobacco.

BRAZIL'S ANTI-TOBACCO CAMPAIGN CUTS CANCER DEATHS

Brazil's approach to tobacco control is causing smoking prevalence and cancer deaths to decrease rapidly.

Studies show that WHO-backed measures caused smoking rates in Brazil to fall from 32% in 1989 to 18% today, says Vera Luiza da Costa e Silva, Director of Brazil's National Cancer Institute.

"We can see fluid cancer mortality, particularly from lung cancer among men, is declining due to our programmes, which makes Brazil a true success story," says da Costa e Silva, now the senior advisor on tobacco to Brazil's Minister of Health.

Brazil was a key architect of the WHO FCTC and has passed a wide range of laws to fight tobacco use.

The WHO FCTC has banned tobacco product advertising, promotion and sponsorship, and requires countries to ensure that 30% of each cigarette package display clear pictorial health warnings on packaging, and removes misleading descriptive words like "mild" and "light" cigarettes.

Brazil now targets low prices for tobacco products, tobacco smuggling controls and the high rates of young girls smoking to further cut smoking rates and reduce future cancer burdens.

"WHO's support has been essential in this entire tobacco control process," says da Costa e Silva.

WHO DIET, PHYSICAL ACTIVITY AND HEALTH STRATEGY TACKLES CANCER

Eating well and staying active are keys to leading healthier lives and eliminating the risks of chronic conditions like cancer.

WHO CANCER FIGHTERS
Dr Timothy Armstrong, Acting Team Leader, Global Strategy on Diet, Physical Activity and Health

At just 5 years old, Brazil's Nadia is obese. Consuming health sectors is a key challenge for WHO's Global Strategy on Diet, Physical Activity and Health, which aims to help governments, like that of Brazil.

WHO works with countries to spread this simple message and craft straightforward approaches to prevent healthy diets and physical activity.

The Global Strategy on Diet, Physical Activity and Health (DPAS) sets a range of policy options for two major chronic diseases risk factors, unhealthy diet and physical inactivity.

DPAS implementation can save many cancer lives. Studies show that 30% of cancers are linked to levels of physical activity and improving dietary habits," says Dr Timothy Armstrong, Acting Team Leader, Global Strategy on Diet, Physical Activity and Health.

Poor diet, physical inactivity and being overweight or obese are linked to 30% of endometrial cancer, 25% of oesophageal cancer, 20% of colon cancer, 20% of kidney cancer and 20% of postmenopausal breast cancer deaths each year.

Studies show 10% of breast cancer deaths and 30% of colorectal cancer mortality are attributable to increased weight and physical inactivity.

DPAS is a tool for Member States to develop and implement policies, plans and programmes to reduce risk factors linked to unhealthy diets and physical inactivity in homes, schools and workplaces.

Numerous countries in all WHO regions plan to implement or have implemented DPAS independently or as part of existing programmes.

WHO has conducted its Fruit and Vegetable Promotion Initiative since 2003 to increase global fruit and vegetable consumption.

www.who.int/dietphysicalactivity

OMAN EMBRACES WHO APPROACH TO DIET AND EXERCISE

Oman has turned to WHO to defeat the growing burden of overweight and obesity, and in doing so reduce cancer.

WHO has helped Oman develop its Strategy on Diet, Physical Activity and Health. Oman health policymakers have nearly made guidelines to reduce risk factors that cause high rates of chronic disease.

"There is strong political will in Oman to implement DPAS because noncommunicable diseases like cancer are seen as this country's next major challenge," says Dr Ali Al-Rubkhi, Director of Noncommunicable Diseases for Oman's Ministry of Health.

"One of the avenues to address these issues is through DPAS."

About half of Omanis over 20 years of age are overweight or obese. This puts them at increased risk of suffering from oesophagus, colorectal, breast and endometrial cancer. Oman's Ministry of Health Rapid Development in the past 30 years has drastically changed Omani lifestyle, resulting in more people becoming sedentary, eating more fast-food and exercising less.

Omani health authorities will disseminate WHO's DPAS strategy and implementation plan to all health sectors and establish a national diet and physical activity goals. At Least says the strategy is feasible enough to be matched to Oman's cultural requirements.

WHO MEDICINAL ADVICE CURES, CARES FOR CANCER PATIENTS

If countries are to cure and care for cancer patients, access to essential medicines is vital.

WHO CANCER FIGHTERS
Dr Suzanne Hill, Secretary of the WHO Committee on the Selection and Use of Essential Medicines

WHO volunteers certain essential medicines to treat patients suffering from chronic diseases, including cancer, which are safe, cost-effective and efficacy. The same good for providing appropriate pain relief for those with terminal conditions.

For 30 years, WHO has published a Model List of Essential Medicines that includes medicines for cancer and palliative care," says Dr Suzanne Hill, Secretary of WHO's Committee on Selection and Use of Essential Medicines.

WHO is also working on a list of essential medicines for children, including those treating treatment in oncology centres.

Chemotherapy drugs in middle-income countries are becoming for cancer treatment, but are still unaffordable in many. Hill says WHO guidelines are costs and use can help in this area.

For cancer patients who cannot hope for cure, providing pain relief is crucial. Half of all cancer patients suffer severe pain and 50% have no access to opioids.

WHO's Pain Ladder programme use as part of tightly controlled palliative care programmes helps to prevent patient suffering. It collects with governments to balance drug control policies that block access to medically-required opioids.

WHO is updating existing guidelines and programmes to provide pain treatment for cancer patients, says Dr William Schutter, technical officer for quality assurance and Safety of Medicines within WHO's Department of Medicines Policy and Standards.

WHO CANCER FIGHTERS
Dr William Schutter, Technical Officer, Quality Assurance and Safety of Medicines

WHO PROMOTES PALLIATIVE CARE FOR CANCER PAIN RELIEF

While urging countries to do everything possible to prevent and control cancer, WHO demands equal effort to promote palliative care for people for whom cure is not possible.

Most cancer patients need palliative care and pain control, given appropriate strategy for advanced cancer patients to be able to address physical, psychological and social problems in line with optimal dignity.

But in many low-resource settings, capacities to process such care are often lacking. Tobacco opiate policies can be too restrictive, limiting availability of morphine and other pain relief drugs.

WHO advocates that governments ensure palliative care is institutionalized. Furthermore, WHO is developing and promoting palliative care services and pain relief protocols for national health systems.

Since 2002, WHO, health authorities in Barcelona have implemented the Catalan region's public health approach to make palliative care available to all people in a variety of settings.

WHO, through its headquarters and regional and country offices, has helped expand palliative care services in many developing countries, particularly in Africa, where chronic diseases are rising.

Throughout Africa, WHO has supported local services by giving palliative care to people with HIV/AIDS, who also need palliative care at advanced stages of the disease.

WHO has also worked with other analgesic and palliative care planning to reach as many people as possible. WHO's Ladder for Pain Relief is a key pain management strategy that can ease pain for about 80% of patients.

WHO TRAINING EASES PAIN FOR UGANDAN CANCER SUFFERERS

WHO guidelines have helped train 19000 Ugandan health professionals to care for patients suffering from HIV/AIDS-related conditions and other acute or chronic illnesses.

WHO advocacy and publications have also persuaded many governments in low- and middle-income countries to provide essential pain relief drugs, such as morphine, to replace the suffering of patients.

WHO publications chose from this health workers in Uganda to provide palliative care for people suffering from Kaposi sarcoma and other forms of cancer," says Dr Mubiana Inambao, a palliative care physician and Manager of HIV prevention and treatment in Uganda.

Kaposi sarcoma, particularly severe palliative care is institutionalized. Furthermore, WHO is developing and promoting palliative care and pain relief protocols for national health systems.

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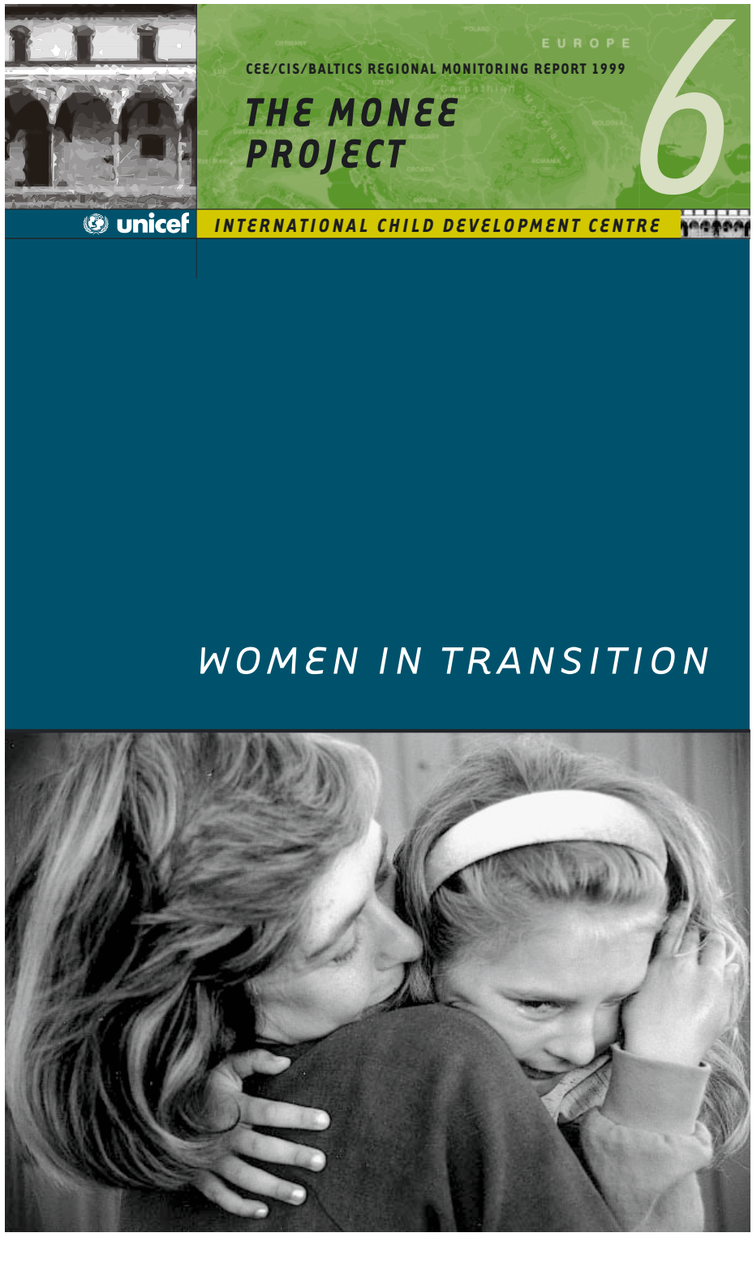
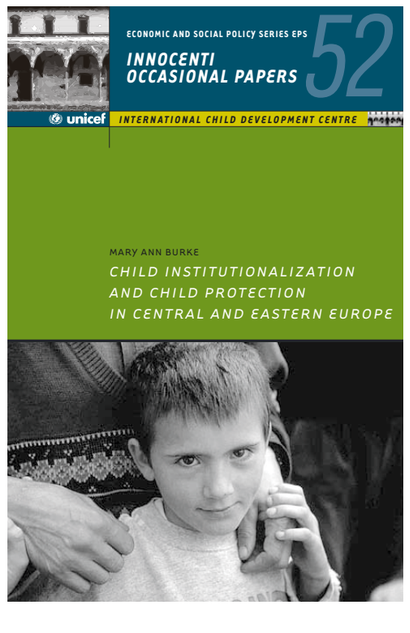
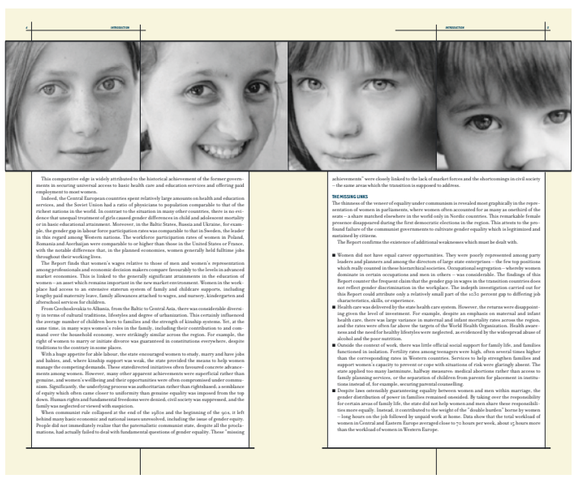
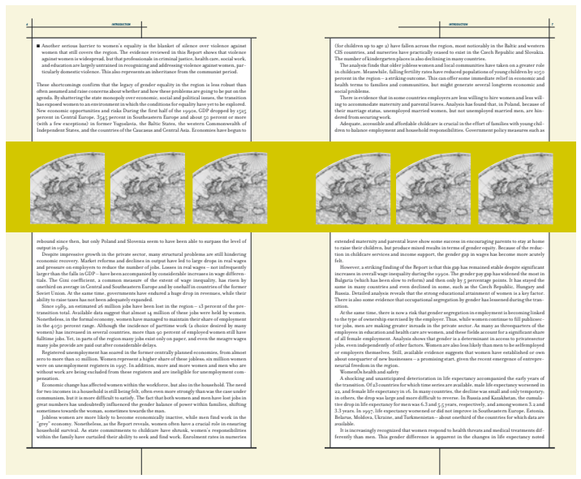
Visual identity system

UNICEF International Child Development Centre,
excerpts form a design proposal.









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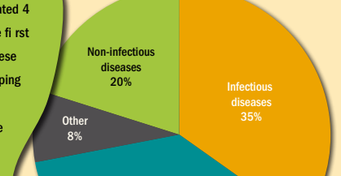
Color and tonal variations

Newborn Health

KEY AREAS OF WORK
Causes of death ■ Breast feeding ■ HIV and infant feeding ■ Millenium Development Goals ■ 10 years of IMCI strategy ■ Newborn guidelines

The first few days and weeks of life are among the most critical for child survival. Every year, an estimated 4 million children die during the fi rst month of life. Almost all of these deaths (98%) occur in developing countries.
Most neonatal deaths are due to low birth weight, asphyxia and infections such as sepsis, tetanus and pneumonia. An estimated two-thirds of these deaths could be prevented or treated with proven, cost-effective interventions that already exist. About half of these deaths occur at home, often among newborns who have had no contact with a health care provider.

Causes of deaths of newborns, developing countries, 2004–2007



Millenium Development Goals: How are we doing?

Tracking of global progress towards the MDGs reveals that seven of the 60 highest-mortality rate countries are on track to meet MDG4 (Bangladesh, Brazil, Egypt, Indonesia, Mexico, Nepal and the Philippines), 39 countries are making some progress but they need to accelerate, and 14 are cause for serious concern (see Figure).
Although rates of coverage for some interventions are improving, for many interventions it remains low, and coverage rates for the most part have no indication of the quality of the interventions.

HIV and infant feeding

In October 2006, on behalf of the Inter-agency Task Team (IATT) on Prevention of HIV Infections in Pregnant Women, Mothers and their Infants, WHO held a technical consultation in Geneva on HIV and infant feeding. Th e participants included researchers, programme managers, infant feeding experts, representatives of relevant UN agencies, AFRO, and six WHO departments. The aim was to review the substantial body of new evidence and most recent experience regarding HIV and infant feeding and to clarify and refi ne the existing UN recommendations.

Breastfeeding

While evidence of the short-term benefi ts of breastfeeding – a reduction in early childhood illness and deaths due to infectious diseases - is well-established, the jury was still out on the long-term protective health benefi ts. However, a new analysis carried out in 2006 suggests that adults who were breastfed as children may be healthier and more intelligent than adults who were not.

While evidence of the short-term benefi ts of breastfeeding – a reduction in early childhood illness and deaths due to infectious diseases – is well-established, the jury was still out.
While evidence of the short-term benefits of breastfeeding is still pending, we will move forward with the programme as planned.

10 years of IMCI Strategy

The Multi-Country Evaluation (MCE) of IMCI is designed to evaluate the impact, cost and eff ectiveness of the IMCI strategy. The results of MCE support planning and advocacy for child health interventions by ministries of health in developing countries, and by national and international partners in development. To date, MCE has been conducted in Brazil, Bangladesh, Peru, Uganda and the United Republic of Tanzania.

The results of MCE indicate that:
- IMCI improves health worker performance and their quality of care;
- IMCI can reduce under-fi ve mortality and improve nutritional status, if implemented well;
- IMCI is worth the investment, as it costs up to six times less per child correctly managed than current care;
- child survival programmes require more attention to activities that improve family and community behaviour;
- the implementation of child survival interventions needs to be complemented by activities that strengthen system support;
- a significant reduction in under-fi ve mortality will not be attained unless large-scale intervention coverage is achieved.

Guidelines for planning based on Newborn Health Framework

In 2006, WHO worked in collaboration with UNICEF and the Saving Newborn Lives initiative to develop tools to build the capacity of national programme managers to strengthen the newborn health component in maternal and child health programmes and in related programmes including family planning, nutrition, malaria and HIV. Th e tools – which are based on the steps outlined in the recently revised Newborn Health Framework and Guidelines for Planning – are used during a one-week workshop for programme managers.

This includes a focus on: situation analysis, prioritizing and packaging interventions; setting realistic coverage targets, and planning for implementation. During 2006, two capacity development workshops, involving 14 African countries, were held. During 2006, two capacity development workshops were held.

Brochure design
Visual identity system

Child and Adolescent Health and Development: Progress Report 2006–2007, 2008, design development for the Department's new visual identity.

ADOLESCENTS

In 2006–2007, the Department of Child and Adolescent Health and Development advocated for a comprehensive, multi-sectoral approach to improving adolescent health and development. Our particular focus was on supporting ministries of health to play a stewardship role to strengthen the contribution of the health sector in four key areas:

1. **Gathering and using strategic information;**
2. **Developing supportive, evidence-informed policies;**
3. **Scaling up the provision of health services and commodities; and**
4. **Strengthening action in other sectors and civil society.**

We used HIV and reproductive health as entry points to strengthen the health sector's response to adolescents' needs in these as well as other areas of public health importance such as nutrition, mental health, substance use and violence.
In 2006–2007 we have worked to generate evidence, to develop and test methods and tools to support programmatic action in countries, to build a common sense of purpose with key players within and outside the United Nations system, and to build capacity and to support and document country-level action. Highlights of this work are described below.

1 Strategic information

Gathering and using strategic information is central to ensure that programming efforts are focussed on the right issues, and that their effects are measured. One highlight of our work in 2006–2007 is described below.

Fact Sheets

In 2006–2007 we worked with partners to achieve global consensus on a set of 16 indicators to track progress on global goals and targets for young peoples' access to health services for preventing HIV and reproductive health problems. We then mined sources of internationally comparable data and compiled a package of fact sheets on each of the 16 indicators:

1. **Institutionalizing youth-friendly health services**
2. **Condom use by young people at last higher risk sex; condom use among young injecting drug users who had sex in the past one month**
3. **HIV testing behaviour among young people**
4. **Condom availability for young people**
5. **Knowledge of a formal source of condoms among young people**
6. **Access to HIV testing and counselling services by young people**
7. **Perception of access to condoms by young people**
8. **Use of specified health services by young people**
9. **Young people seeking treatment for sexually transmitted infections**
10. **Intervention sites with a minimum package of HIV prevention services in 'hotspots' where most-at-risk young people are present in greater numbers**
11. **Most-at-risk young people reached by HIV prevention services**
12. **Safe injecting practices among young injecting drug users**
13. **Contraceptive prevalence**
14. **Antenatal care coverage**
15. **Age-specific fertility rate for young women**
16. **Unmet need for family planning for young women**

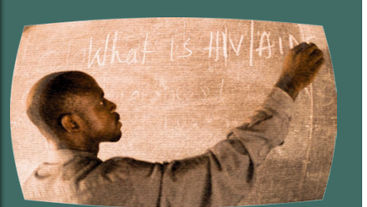
Supportive, evidence-informed policies 2

Steady, Ready, Go!

Forty per cent of all new HIV infections around the world in 2006 occurred among 15–24 year olds. Over a two year period, we conducted a systematic review of the evidence from developing countries on the effectiveness of interventions for preventing HIV/AIDS in young people which are delivered through schools, health services, mass media, communities, and to young people who are most vulnerable to HIV infection. In 2006 we published a report which classifies these interventions into three categories:

- ***Steady*** – don't implement yet, needs more work and evaluation;
- ***Ready*** – implement widely, but evaluate carefully;
- ***Go*** – implement on a large scale while monitoring coverage and quality.

In 2007, we followed-up with a series of policy briefs which synthesized the recommendations for policy-makers, programme managers and researchers to guide their efforts to increase access to information, skills and services in order to reduce the rate of HIV infection among young people.



UNICEF/HQ07-0976/Olivier Asselin

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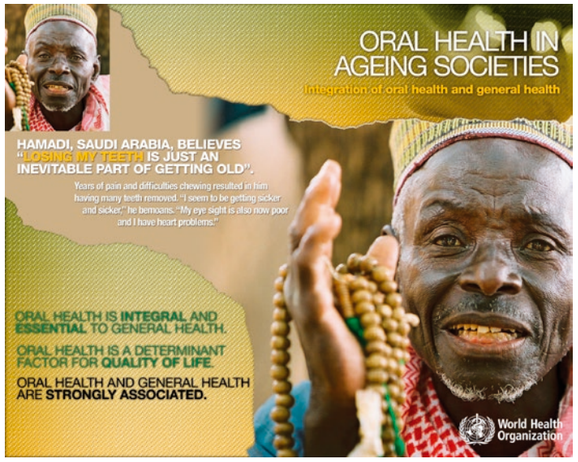
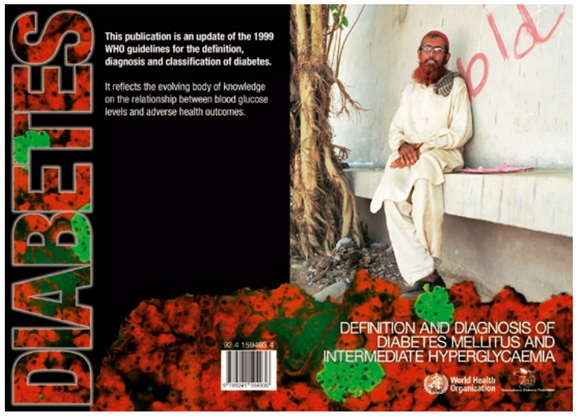
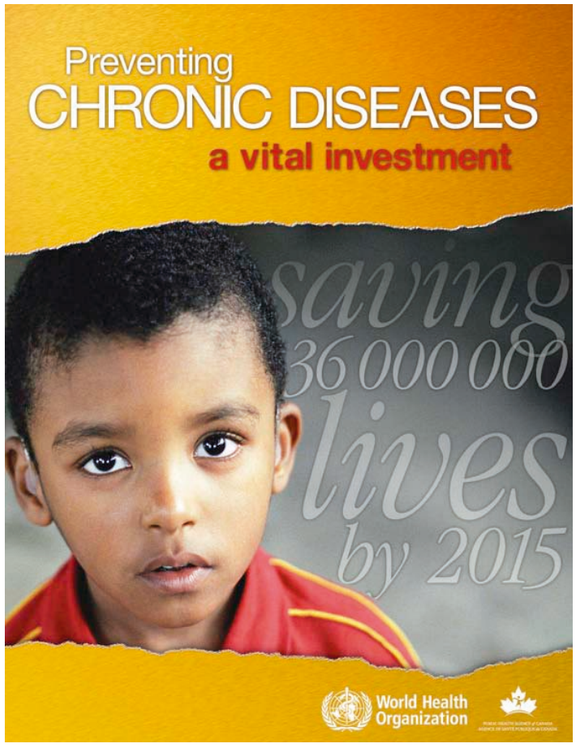
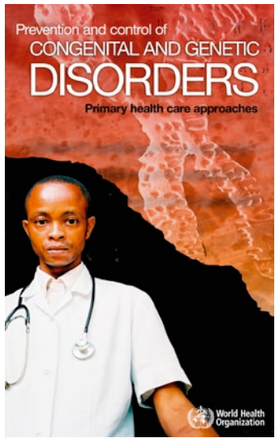
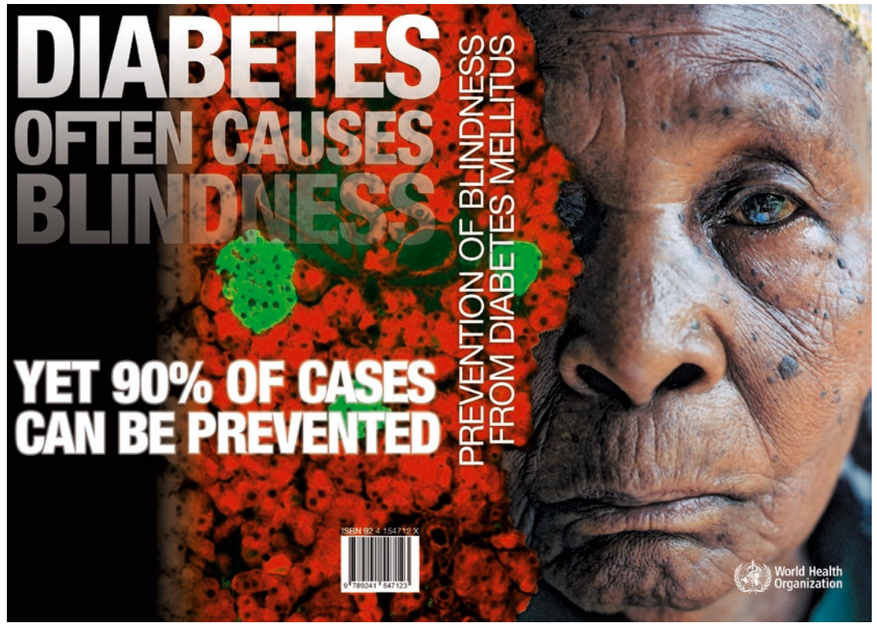


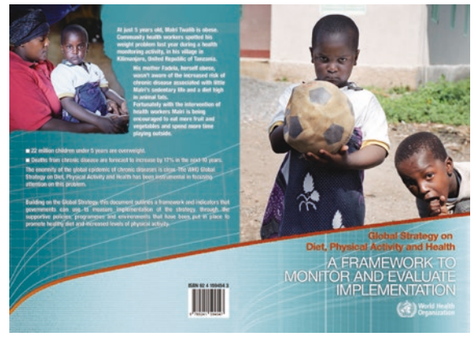


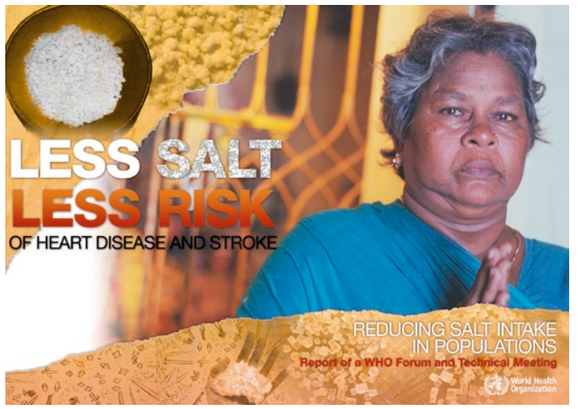
Cover series for the Department of Chronic diseases and health promotion (CHP).

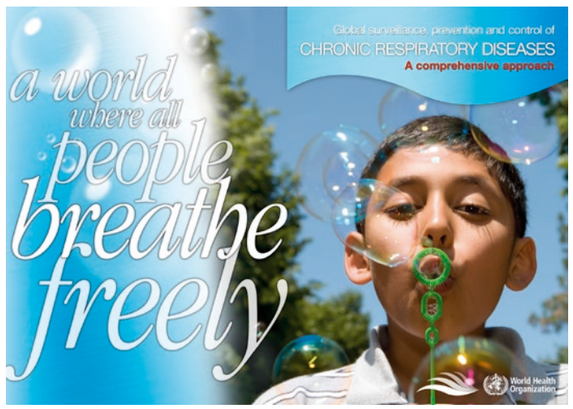












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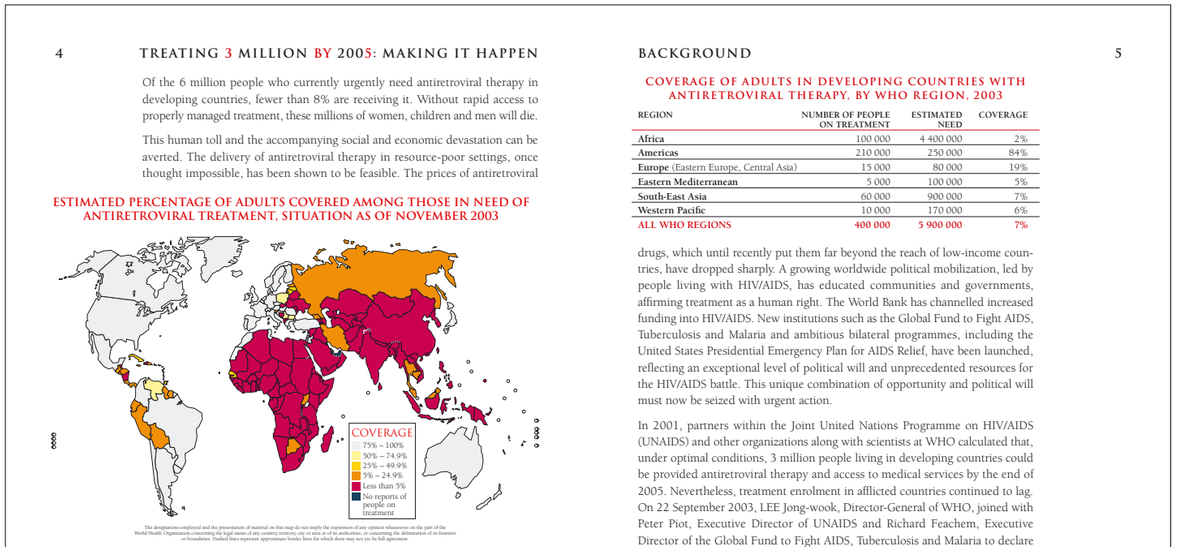
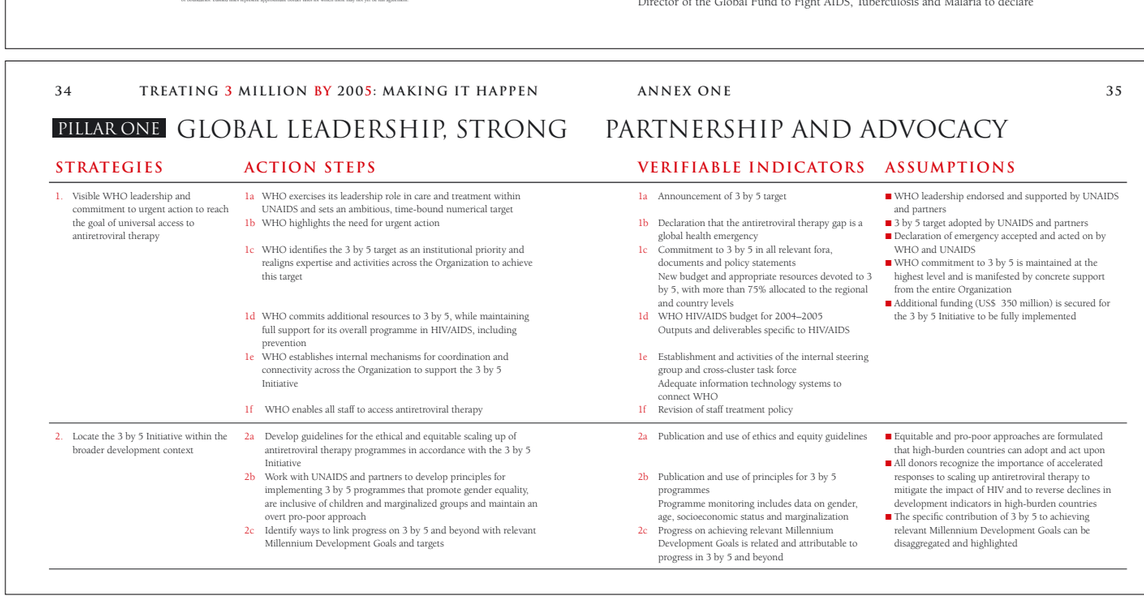
Brochure design

Milestones of a Global Campaign for Violence Prevention,
32 pages, in English and French.

Brochure design

Treating 3 Million by 2005, 2003, 32 pages,
in 6 official languages.





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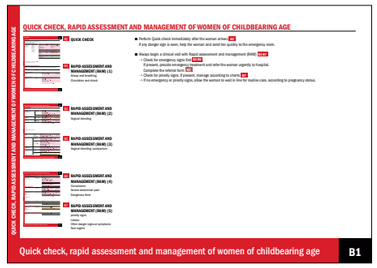
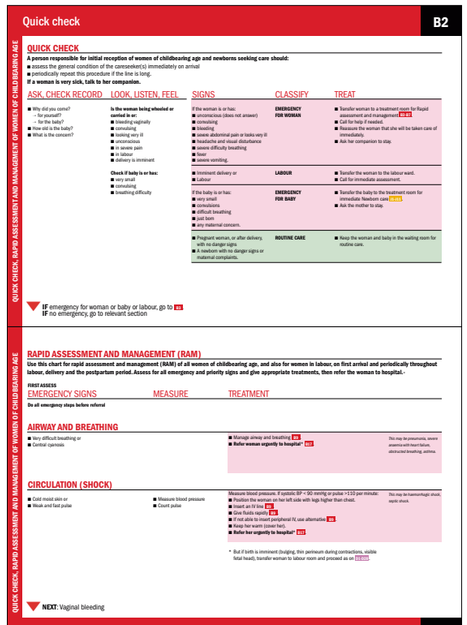
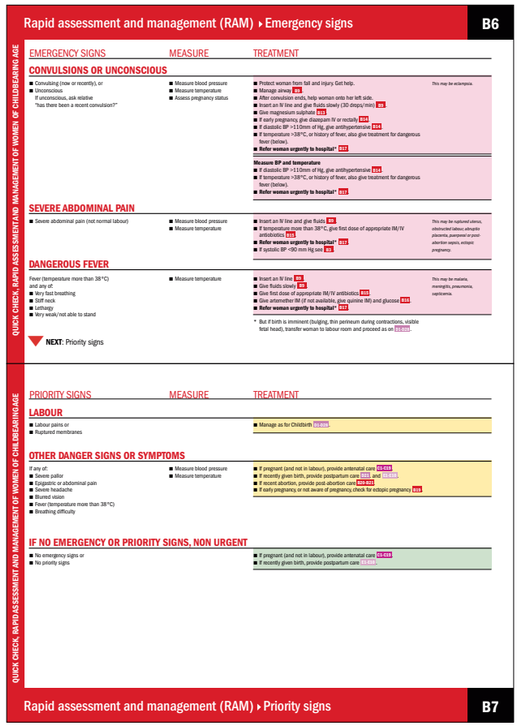
Technical report design and layout

Pregnancy, Childbirth, Postpartum and Newborn Care:
A guide for essential practice, 180 pages.

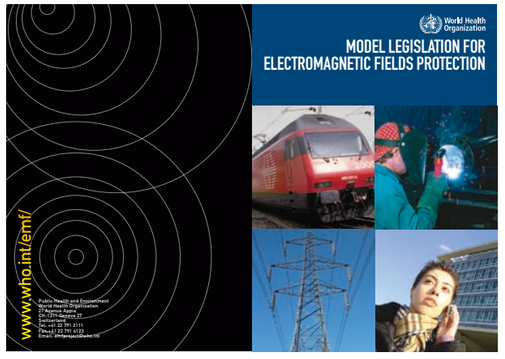


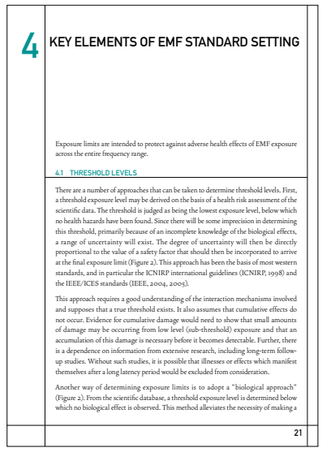


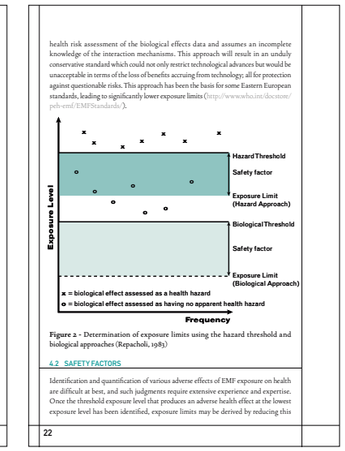


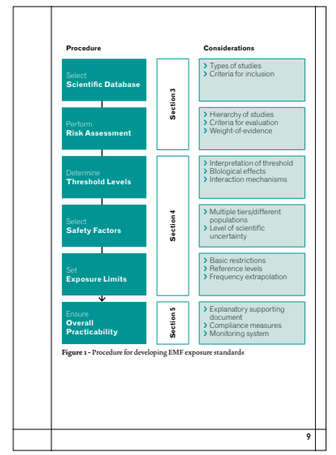
Technical report design and layout

Framework for developing health-based EMF standards









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Multilingual design

Corporate brochure. Working for Health, in six official languages, 32 pages.

Book design

World Health Report, design, 2004–2007.