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for Research on Cancer



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## **DIRECTOR'S REPORT**

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## ACRONYMS AND ABBREVIATIONS

BMS	Business Management System
BMI	Body Mass Index
CCGMC	COVID-19 and Cancer Global Modelling Consortium
ECVSS	Early Career and Visiting Scientists
EDAG	IARC Equity and Diversity Advisory Group
ERP	Enterprise Management System
FENSA	Framework of Engagement with Non-State Actors
GAC	WHO Global Advisory Committee on formal complaints of abusive conduct
GACD	Global Alliance for Chronic Diseases
GCO	Global Cancer Observatory
GICR	Global Initiative for Cancer Registry Development
GWAS	Genome-wide association studies
HDI	Human Development Index
HIV	Human Immunodeficiency Virus
HPV	Human Papillomavirus
IAC	The International Academy of Cytology
IAEA	International Atomic Energy Agency
IARC	International Agency for Research on Cancer
imPACT	Programme of Action for Cancer Therapy
JECFA	Joint WHO/FAO Expert Committee on Food Additives
KPIs	Key Performance Indicators
LMICs	Low- and middle-income countries
LXP	Learning Experience System
MoU	Memorandum of Understanding
MTS	Medium-Term Strategy
NCC	National Cancer Centre
NCCP	National Cancer Control Plan
NCDs	Noncommunicable Diseases
NSAs	Non-State Actors
ODA	Official Development Assistance
OECD	Organisation of Economic and Co-operation and Development
SAC	Staff Association Committee
SOP	Standard Operating Procedure
TAD	Tobacco and Arms Disclosure
UICC	Union for International Cancer Control
UNESCO	United Nations Educational, Scientific and Cultural Organization
WHO	World Health Organization

## EXECUTIVE SUMMARY

The Director's Report provides a comprehensive overview of the research endeavors, collaborative efforts, partnerships, strategic engagements, and managerial initiatives undertaken since the previous Governing Council session in May 2023. This report encompasses:

### Scientific highlights

The Director's Report starts with highlights of the Biennial Report 2022–2023 complemented with recent scientific highlights, followed by information about IARC publications and capacity building. Additional Key Performance Indicators (KPIs) are shown for 2023.

Highlights of IARC's research are reported across the four Pillars: i) data for action, ii) understanding the causes, iii) from understanding to prevention, and iv) knowledge mobilization (WHO Classification of Tumours, *IARC Monographs Programme*, *IARC Handbooks of Cancer Prevention*). Finally, IARC research at the intersection between COVID-19 and cancer is also underlined.

### Cooperation, Partnerships and Strategic Engagement

The strengthened cooperation between IARC and the World Health Organization (WHO) is underlined, as shown by the implementation of the IARC-WHO joint strategic workplan 2023–2025. Selected high-level partnerships and strategic engagements of the Agency are highlighted, as well as the specific actions taken last year to accelerate the Agency's resource mobilization efforts. Grants and contracts obtained over the past year are reported. The chapter ends with an update on IARC engagement under the Framework of Engagement with Non-State Actors (FENSA).

### Management

The evaluability assessment of Medium-Term Strategy (MTS) 2021–2025 and the preparation of the MTS 2026–2030 are briefly described. In its continued effort to modernize IARC's administrative management systems, IARC joined forces with WHO and embarked on the implementation of a new Business Management System (BMS). Concurrently, IARC has devised an administrative transformation roadmap in support of the MTS 2021–2025, inter alia to further strengthen IARC's data protection measures. Finally, information on IARC personnel is provided for the past year, as well as for IARC Working Groups and Programmes.

## 1. INTRODUCTION

1. The year 2023 was significant as we transitioned to our new building. The dedicated efforts of the entire IARC personnel to overcome the challenges of relocation and settling into our new environment have been truly commendable.
2. IARC/WHO held an official inauguration ceremony for the Nouveau Centre on 12 May 2023, which was attended by the French Minister of Health and Prevention, local government officials, members of the IARC Governing Council, dignitaries from IARC Participating States, representatives from the WHO, national and international collaborators, and the principal funders of the construction project.
3. With its iconic shape, the Nouveau Centre embodies the Agency's vision for Open Science and international collaboration in cancer research. Comprising six floors of ultra-modern laboratories, offices and collaborative working spaces, it can host up to 500 researchers. The internationally-renowned Biobank has the capacity to hold 10 million biological samples from all over the world. I am convinced that our new building will become a beacon for cancer research and a catalyst for strengthening collaboration between scientists, health professionals and the general public.
4. The Biennial Report 2022–2023 showcases a selection of the work conducted during this period by IARC in collaboration with its global network of partners. The publication is available for free download in Pdf format. The Biennial Report has an associated webpage that showcases key facts and figures on IARC and scientific highlights during the 2022–2023 biennium.
5. IARC released the 2022 estimates of the global burden of cancer. IARC estimates, based on the best sources of data available in countries in 2022, highlight the growing burden of cancer, the disproportionate impact on underserved populations, and the urgent need to address cancer inequities worldwide. In 2022, there were an estimated 20 million new cancer cases and 9.7 million deaths. The estimated number of people who were alive within five years following a cancer diagnosis was 53.5 million. About 1 in 5 people develop cancer in their lifetime, approximately 1 in 9 men and 1 in 12 women die from the disease.
6. The new estimates available on IARC's Global Cancer Observatory show that 10 types of cancer collectively comprised around two-thirds of new cases and deaths globally in 2022. Data covers 185 countries and 36 cancers. Lung cancer was the most commonly occurring cancer worldwide with 2.5 million new cases accounting for 12.4% of the total new cases. Female breast cancer ranked second (2.3 million cases, 11.6%), followed by colorectal cancer (1.9 million cases, 9.6%), prostate cancer (1.5 million cases, 7.3%), and stomach cancer (970 000 cases, 4.9%).
7. Lung cancer was the leading cause of cancer death (1.8 million deaths, 18.7% of the total cancer deaths) followed by colorectal cancer (900 000 deaths, 9.3%), liver cancer (760 000 deaths, 7.8%), breast cancer (670 000 deaths, 6.9%) and stomach cancer (660 000 deaths, 6.8%). Lung cancer's re-emergence as the most common cancer is likely related to persistent tobacco use in Asia.
8. IARC's global estimates revealed striking inequities in the cancer burden according to the human development index (HDI). This is particularly true for breast cancer. In countries with a very high HDI, one in 12 women will be diagnosed with breast cancer in their lifetime and one in 71 women die of it. By contrast, in countries with a low HDI, while only one in 27 women is diagnosed with breast cancer in their lifetime, one in 48 women will die from it.

9. Over 35 million new cancer cases are predicted in 2050, a 77% increase from the estimated 20 million cases in 2022. The rapidly growing global cancer burden reflects both population ageing and growth, as well as changes to people's exposure to risk factors, several of which are associated with socioeconomic development. Tobacco, alcohol and obesity are key factors behind the increasing incidence of cancer, with air pollution still a key driver of environmental risk factors.
10. HDI highlights the clear reality of increasing inequalities between countries. High HDI countries are expected to experience the greatest absolute increase in incidence, with an additional 4.8 million new cases predicted in 2050 compared with 2022 estimates. Yet the proportional increase in incidence is most striking in low HDI countries (142% increase) and in medium HDI countries (99%). Likewise, cancer mortality in these countries is projected to almost double in 2050. Such inequalities can only be expected to grow unless resource-dependent, effective, and cost-effective interventions are urgently implemented. Efforts to plan, implement and evaluate prevention programmes must be considered greater priorities in low-and middle-income countries (LMICs).
11. With these concerning statistics in mind, alongside projections indicating a significant rise in the cancer burden over the next 25 years, it is imperative to recognize the profound personal, societal, and economic impact. Given the potential to prevent up to half of all cancer cases through the effective implementation of preventive interventions, directing resources toward research on cancer prevention emerges as the pivotal strategy to bridge the significant scientific knowledge gap and combat the burgeoning cancer epidemic.
12. For the betterment of implementation of cancer prevention interventions globally, IARC strengthened coordination and collaboration with WHO. In the past year, IARC has implemented the joint strategic workplan for 2023–2025 and have intensified coordination of technical activities. As examples, IARC-led research on breast cancer survival in Sub-Saharan Africa has informed KPIs for the WHO Global Breast Cancer Initiative Framework. IARC supports the WHO Global Initiative on cervical cancer elimination and contributes to WHO guidance updates, best practices, and national programme implementation. IARC's pivotal research includes establishing the role of HPV in cervical cancer, evaluating HPV vaccine safety and efficacy, and finding simplified screening alternatives for LMICs.
13. The Sixty Session of the IARC Scientific Council, the first in-person session after the move to the new premises in Lyon-Gerland, was held on 7–9 February 2024. This session, chaired by Dr Manami Inoue (Japan), reviewed key areas of IARC's research programme over the last biennium.
14. The Scientific Council stressed that the global scale of IARC's research activities provides a truly unparalleled example of cancer research informing policies and practice related to cancer worldwide, and that continued progress against cancer globally depends on stronger financial support from Participating States. As an international public health organization, IARC is uniquely positioned and plays a critical role in supporting national and international efforts to reduce the global cancer burden, and is a vital resource for governments, researchers, trainees, and health professionals around the world.
15. I look forward to welcoming you all to IARC, Lyon, in May 2024.

## 2. SCIENTIFIC HIGHLIGHTS<sup>1</sup>: BIENNIAL REPORT 2022–2023

16. The scientific highlights of the Biennial Report 2022–2023, complemented with recent scientific highlights, are arranged according to the four IARC Pillars, as spelled out in the MTS priorities ([Document GC/63/6A](#)). An update of IARC research at the intersection between COVID-19 and cancer is also provided.

### 2.1 Pillar I. Data for action

17. IARC, in collaboration with the International Association of Cancer Registries, launched the latest volume (Volume XII) of **Cancer Incidence in Five Continents** (CI5) series online. Volume XII compiles cancer incidence data from 455 cancer registries, covering 588 populations in 70 countries.

18. The **GLOBOCAN estimates for 2022** have been launched online on IARC's Global Cancer Observatory, which includes online facilities for the tabulation and graphical visualization of the GLOBOCAN database **for 185 countries and 36 cancers by age and sex**. Data will be published in *CA Cancer J Clin* 2024.

19. IARC, in collaboration with partner institutions, found that 1.9 million lives are lost each year to cancers caused by four preventable risk factors (tobacco smoking, alcohol consumption, overweight or obesity, and human papillomavirus (HPV) infections) across the BRICS countries (Brazil, the Russian Federation, India, China, and South Africa), the United Kingdom, and the USA. Together, the seven countries analyzed represent more than half of the global burden of cancer deaths each year. IARC found that the four preventable risk factors result in more than 30 million years of life lost each year. Tobacco smoking had the biggest impact by far, leading to 20.8 million years of life lost. The results were published in *eClinicalMedicine*.

20. IARC quantified for the first time the global partition of stage at diagnosis of breast cancer in women across 81 countries worldwide. IARC showed that 40% of the countries included in the study did not meet the target as set out by the WHO global initiative on breast cancer, that advises that countries strive to increase the proportion of breast cancers diagnosed at an early stage (I or II) to at least 60%. A much higher proportion of women with breast cancer in sub-Saharan African countries – up to 30% – were diagnosed with late-stage distant metastatic tumours. In comparison, less than 10% of the women with breast cancer in most of the countries in North America, Europe, and Oceania were diagnosed with distant metastatic disease. The study was published in *JAMA Oncology*.

21. IARC and Guangdong Medical University (China) quantified for the first time the global burden of lung cancer incidence for the four main histological subtypes, documenting the substantial variations across world regions and their constituent countries. Globally, there were an estimated 2 206 771 new cases of lung cancer in 2020: 1 435 943 in males and 770 828 in females. Among males, an estimated 39% of all lung cancer cases were adenocarcinoma, 25% were squamous cell carcinoma, 11% were small-cell carcinoma, and 8% were large-cell carcinoma. Among females, an estimated 57% of all lung cancer cases were adenocarcinoma, 12% were squamous cell carcinoma, 9% were small-cell carcinoma, and 6% were large-cell carcinoma. With this more granular assessment of global lung cancer patterns, this study seeks to facilitate the implementation of tailored approaches to the reduction of the burden of this highly preventable disease. The study was published in *The Lancet Oncology*.

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<sup>1</sup> Please refer to the IARC Organizational Structure in [Figure 8](#) for list of acronyms.

22. According to a new *Lancet* Commission on Women, Power, and Cancer and an accompanying new analysis of data from IARC, published in *The Lancet Global Health*, the deaths of almost 7 in 10 women who died prematurely (i.e. at ages < 70 years) of cancer in 2020 could have been prevented. Two thirds of the deaths of these women – or 1.3 million deaths – could have been averted through prevention, by reducing exposure to four major risk factors: tobacco smoking, alcohol consumption, high body weight, and infections, and the remaining one third could have been avoided through timely and appropriate treatment. The proportion of premature deaths from cancer in women is much higher in countries with a low HDI (72%) than in countries with a high HDI (36%).

23. IARC found that approximately 1 in every 1000 Australians under the age of 50 years had been diagnosed with cancer before their 15<sup>th</sup> birthday. Scientists expect that childhood cancer prevalence in Australia will continue to increase and exert rising demands on the health system. Monitoring both short-term and long-term prevalence is essential to plan for the health services and infrastructure required to meet the needs of the growing population of survivors of childhood cancer. The results were published in *Pediatric Blood & Cancer*.

24. IARC and partner institutions reported that almost all families of children or adolescents with cancer experience financial hardship due to the cancer diagnosis, regardless of whether the family lives in a high-income country or a LMIC. Financial hardship experienced by affected families may hinder access to health care, can have long-term effects on the well-being of families, and is associated with poor health outcomes for both children with cancer and their family members. The results were published in *The Lancet Oncology*.

25. IARC provided an in-depth analysis of gains in life expectancy over the past quarter of a century that are attributable to progress in the control of cardiovascular disease (CVD) compared with common cancer types in each of 28 European countries and in Europe overall from 1995 to 2019. The results highlighted the continued existence of a divide in life expectancy between eastern Europe and western Europe. The results were published in the *European Journal of Epidemiology*.

26. IARC and partner institutions highlighted the critical role of socioeconomic factors in explaining cancer outcomes and cancer inequalities within and between countries. The authors argued that current efforts to address socioeconomic inequalities in cancer, including research funding and interventions, are insufficient. The report is published in the *Bulletin of the World Health Organization*.

27. IARC highlighted that, even total cancer mortality rates decreased, evidence is emerging of the rise in the incidence and mortality rates for some common cancer types among adults in younger (unscreened) age groups in the UK. The increasing rates of certain cancer types among recent generations may be linked to risk factors that act early in life or during young adulthood. The study underlines the urgent need for increased awareness of modifiable risk factors for cancer. The study is published in *BMJ*.



## 2.2 Pillar II. Understanding the causes

28. IARC showed that people who are living with excess weight, obesity, and cardiovascular diseases, such as a stroke, are more likely to develop cancer, particularly of the bowel, breast, and liver. Preventing obesity could lead to a greater reduction in cancer risk among people who also have cardiovascular diseases than among the general population. The study was published in *BMC Medicine*.
29. IARC and partner institutions provided new evidence that life-course adiposity-related exposures are associated with 18 types of cancer, including leukaemia, non-Hodgkin lymphoma, and, in never-smokers, head and neck cancer and bladder cancer, which are not yet considered as obesity-related cancers in the literature. The study was published in *Nature Communications*.
30. IARC, in collaboration with partner institutions, found that a higher consumption of ultra-processed foods is associated with a higher risk of cancer and cardiometabolic multimorbidity. These findings can inform preventive strategies for reducing the risk of multimorbidity from cancer and cardiometabolic diseases through dietary recommendations, health policies, and other interventions. The study was published in *The Lancet Regional Health – Europe*.
31. IARC reported that regular consumption of fruits and supplementation with folic acid during pregnancy are two factors that may offer protection against the development of acute leukaemia in children. Scientists noted a possible association of maternal consumption of coffee and/or caffeinated beverages with an increased risk of childhood acute leukaemia. The results were published in *Nutrients* and in the *International Journal of Environmental Research and Public Health*.
32. IARC provided new insights into inherited susceptibility to early-onset colorectal cancer, including target genes and functional pathways, and revealed key modifiable targets for primary prevention, such as excess adiposity, hyperinsulinemia, and alcohol consumption. These findings may help to prioritize individuals for personalized screening regimens or other intervention strategies. The study was published in *Annals of Oncology*.
33. IARC and partner institutions described the scientific scope, ongoing research, and future aims of the Mutographs biorepository in a new perspective article published in *Cell Genomics*. The Mutographs study is an example of the novel genomic initiatives being undertaken to further the understanding of the causes and processes related to cancer onset, which could later guide tailored prevention strategies and aid in the global reduction of the burden of cancer.
34. Research from the Mutographs project highlighted novel mutational signatures that correlates strongly with incidence of kidney cancer. The results included the presence of a signature in south-eastern Europe that is linked to the mutagen aristolochic acid, and a separate signature that was present in Japan. These results indicated that exposure to both known or unknown potent mutagens are widespread, affecting many millions of people, and can be detected by sequencing renal tissue. (*study accepted in Nature*).
35. IARC and partner institutions identified protein markers in blood samples that are associated with future lung cancer diagnosis, and developed an algorithm based on these markers to predict future lung cancer cases. These important complementary findings were published in *Nature Communications* and the *Journal of the National Cancer Institute*.

36. IARC and partners identified a panel of early epigenetic biomarkers of breast cancer risk. Such specific alterations in DNA methylation may provide useful markers for risk stratification and, ultimately, personalized cancer prevention. The study was published in *Clin Epigenetics*.

### 2.3 Pillar III. From understanding to prevention

*IARC scientific highlights listed below provided key indicators to support the implementation of the WHO Global Cervical Cancer Elimination Initiative:*

37. IARC showed that a new quadrivalent HPV vaccine, which targets HPV types 6, 11, 16, and 18, is safe and effective in provoking an immune response against these HPV types. Access to this new, effective vaccine could help meet the global demand for HPV vaccines and boost coverage for both girls and boys globally. The study was published in *The Lancet Oncology*.

38. IARC and partners showed that vaccination against HPV has more than halved the prevalence of high-risk HPV types in Rwanda in less than eight years. This study, which was published in *The Lancet Global Health*, is the first of its kind to evaluate HPV vaccination in Africa.

39. IARC released the 4<sup>th</sup> edition of the IARC Evidence Summary Brief "Protection from a single dose of HPV vaccine – A major public health impact from IARC studies of vaccine efficacy", 2023. Available from: <https://www.iarc.who.int/evidence-summary-briefs-series/>.

40. IARC and partner institutions completed the largest ever study on cervical cancer screening methods in Latin America. They found that testing for HPV was almost twice as likely to detect cervical precancers compared with cytology, which remains the main screening method used in countries in Latin America. The results were published in *The Lancet Regional Health – Americas*.

41. IARC found that HPV vaccines had a modest efficacy in treating grade 2 or 3 cervical lesions (CIN 2/3), and that the observed high HPV clearance rates should be studied further to determine whether therapeutic HPV vaccination may lead to a more rapid and durable elimination of the virus in HPV-positive women with no precancerous or cancerous lesions. The study was published in *BMJ Open*.

42. IARC and partners published the IARC Working Group Report No. 11: *Best practices in cervical screening programmes: audit of cancers, legal and ethical frameworks, communication, and workforce competencies*.

*IARC scientific highlights listed below provided key indicators to support the implementation of the WHO Global Breast Cancer Initiative:*

43. IARC showed that marked racial disparities in breast cancer survival were paralleled by inequities all along the breast cancer journey in Namibia. To improve breast cancer survival, interventions are needed to promote earlier diagnosis in black Namibian women and to increase multimodal treatment initiation and completion in all women.

44. IARC and partner institutions reported that the time interval to confirm a diagnosis of cancer (breast cancer is the main cancer site) for patients in Morocco was, on average, almost twice as long as recommended by WHO and several high-income countries. Interval targets should be defined to encourage health systems to be more equitable and effective and to ensure that cancer patients are treated within a defined timeframe. The results were published in *Public Health*.

45. IARC released the fifth [IARC Evidence Summary Brief](#), titled “Maternal Orphans due to Cancer: The intergenerational impact of cancer deaths in women”. This new report summarizes the findings from previous publications by IARC and partners that dealt with the theme of the intergenerational impact of cancer deaths in women. The report highlights the scale of maternal orphans due to cancer and calls for support to address the needs of the affected generation of children.

*Additional scientific highlights are listed below:*

46. IARC and partner institutions reported the main results on cancer mortality from a historical cohort study of workers employed in the world’s largest chrysotile (asbestos) mine and its enrichment factories located in the town of Asbest, Sverdlovsk Oblast, Russian Federation. The study confirmed that exposure to dust containing chrysotile mined increases the risk of developing mesothelioma and lung cancer in a dose-dependent manner. For lung cancer, it suggested an interplay with other lung carcinogens, especially tobacco smoking, and perhaps also with other occupational exposures. These results were published in the *Journal of the National Cancer Institute*.

47. IARC and partner institutions have found that co-exposures to some known lung carcinogens created a synergistic effect that increased workers’ risk of developing lung cancer by more than this combination. The results were published in *Environmental Health Perspectives*.

48. IARC and partner institutions found that workers in nuclear facilities who are persistently exposed to low doses of ionizing radiation experience an increase in deaths due to cancer. This major update of cancer risk in a large cohort of nuclear workers provides additional evidence to strengthen radiation protection measures for workers and the general public. The study was published in the *BMJ*.

49. In a second article reporting on the risk of cancers in the large international cohort of children and young adults who underwent computed tomography (CT) examinations, IARC confirmed a clear association between exposure to radiation from CT scans in young people and an increased risk of haematological malignancies. The study was published in *Nature Medicine*.

50. IARC reported the latest findings of the prospective cohort study COSMOS, indicating that people with the most total hours of mobile phone calls do not have a higher risk of developing a brain tumour compared with light users of mobile phones. The study was published in *Environ Int*.

#### **2.4 Pillar IV. Knowledge mobilization**

51. IARC published the 5<sup>th</sup> edition, volume 7, of the WHO Classification of Tumours: [Paediatric Tumours](#).

52. The following volumes were made available on the WHO Classification of Tumours Online website as beta versions: *Head and Neck Tumours, fifth edition*; *Endocrine Tumours, fifth edition*; *Haematolymphoid Tumours, fifth edition*; *Skin Tumours, fifth edition*; *Eye and Orbit Tumours, fifth edition*; *Genetic Tumour Syndromes, fifth edition*.

53. *IARC Monographs* classified perfluorooctanoic acid (PFOA) as *carcinogenic to humans* (Group 1) and perfluorooctanesulfonic acid (PFOS) as *possibly carcinogenic to humans* (Group 2B). PFOA is *carcinogenic to humans* on the basis of *sufficient evidence* for cancer in experimental animals and *strong* mechanistic evidence in exposed humans. There was also *limited evidence* for cancer in humans (renal cell carcinoma and testicular cancer) and *strong* mechanistic evidence in human primary cells and experimental systems. PFOS is *possibly carcinogenic to humans* on the basis of *strong* mechanistic evidence across test systems,

including in exposed humans. There was also *limited evidence* for cancer in experimental animals and *inadequate evidence* regarding cancer in humans.

54. *IARC Monographs* classified aspartame as *possibly carcinogenic to humans (Group 2B)* on the basis of *limited evidence* for cancer in humans (specifically, for hepatocellular carcinoma, which is a type of liver cancer). There was also *limited evidence* for cancer in experimental animals and *limited evidence* related to the possible mechanisms for causing cancer. Methyleugenol was classified as *probably carcinogenic to humans (Group 2A)* and isoeugenol as *possibly carcinogenic to humans (Group 2B)*.

55. *IARC Monographs* classified anthracene, butyl methacrylate, and dimethyl hydrogen phosphite as *possibly carcinogenic to humans (Group 2B)* on the basis of *sufficient evidence* for cancer in experimental animals and *limited or inadequate* mechanistic evidence. 2-Bromopropane was classified as *probably carcinogenic to humans (Group 2A)* on the basis of *sufficient evidence* for cancer in experimental animals (noting an unusually high degree of carcinogenic activity) and *strong* mechanistic evidence in experimental systems, supported by suggestive mechanistic evidence in exposed humans.

56. *IARC Handbooks of Cancer Prevention* Volume 20A, published in *The New England Journal of Medicine*, reviewed and summarized the available evidence on the effectiveness of reduction or cessation of alcohol consumption in reducing alcohol-related cancers. Based on the evidence reviewed, the experts concluded that there is *sufficient evidence* that reduction or cessation of alcohol consumption reduces the incidence of cancers of the oral cavity and the oesophagus, *limited evidence* for cancers of the larynx, colorectum, and breast, and *inadequate evidence* for cancers of the pharynx and liver.

57. IARC launched Volume 19: Oral Cancer Prevention of the *IARC Handbooks of Cancer Prevention* series. There was *sufficient evidence* that quitting tobacco smoking, quitting use of areca nut products with or without tobacco, and quitting alcohol consumption decreases the risk of oral cancer; in addition, behavioural interventions in adults are effective in inducing quitting smokeless tobacco use. It was also concluded that screening by clinical oral examination of high-risk people (those exposed to one or more risk factors) may reduce deaths resulting from oral cancer.

## 2.5 IARC research at the intersection between COVID-19 and cancer

58. The COVID-19 and cancer initiative or IARC-C19 led by IARC in collaboration with partner institutions aims to provide widespread and long-term impact of the pandemic on risk factors, cancer outcomes, and cancer services to improve the health system resilience of countries and provide guidance to help them to build back better.

59. A update on IARC C-19 is provided in [Document GC/66/12](#).

60. IARC highlighted the positive lessons learned during the COVID-19 pandemic for cancer care in the Metropole of Lyon region, including the lasting innovations that came out of the crisis. This work demonstrated clear adaptations and innovations in (i) new processes and resources to facilitate disciplinary and interdisciplinary work and (ii) the harmonization and streamlining of patient journeys. The study was published in *PLOS Global Public Health*.

## 2.6 Report on Key Performance Indicators (KPIs)

### 2.6.1 Publications

61. A broader range of KPIs began to be reported in 2020. In addition to the productivity (number of IARC articles in a given year), the current KPIs highlight the influence of IARC research (h-index), international collaboration, and visibility. These KPIs form the baseline for comparison going forward, and the evolution of these KPIs will be monitored during the period of the MTS 2021–2025.

62. **Productivity.** In 2023, IARC scientists published a total of **374 articles** in 178 journals, of which 293 (78%) were peer-reviewed papers\*. The total number of articles and the proportion of peer-reviewed papers were quite similar to recent years (see [Table 1](#)).

\*Records were retrieved via the Web of Science database, specifically from Science Citation Index and Emerging Sources Citation Index. Records were restricted to 2023 as the final publication year and records marked "Meeting Abstract" were removed prior to analysis.

63. **Influence of research: citation index (h-index).** [Table 2](#) shows an **h-index of 14** for IARC's 2023 output, meaning that 14 articles have been cited at least 14 times each, with an average citation count of 3.5 per article. The top 10 most cited articles published in 2023 are listed in [Table 3](#). Comparative data for the previous five years is also shown. The h-index for articles from 2019 to 2023 inclusive is 99, with an average citation rate of 41.0 per article.

64. **International collaboration.** Analysing the proportion of IARC's publications whose co-author affiliations include addresses in more than one country. Of the 374 total articles for 2023, 356 (95%) involved international collaboration, including a co-author affiliation from at least one other country. This percentage is in line with that of the last five years overall, 2019–2023, in which 1998 (95%) of 2107 total articles involved at least one other country affiliation.

65. **Visibility.** The Altmetric database tracks mentions of IARC research output in the news, social media, policy documents and other non-traditional sources of citation. It therefore complements traditional citation tracking from sources such as Web of Science and other databases in the scholarly ecosystem. [Figure 1](#) gives a snapshot of IARC's altmetrics profile for its 2023 output.

66. [Table 4](#) reported the number of visitors to the IARC websites in 2023. Among IARC research project websites, the Global Cancer Observatory (GCO) received the highest number of total visits in 2023.

67. **Figure 2** reported the number of visits to the IARC websites throughout 2023.
- The peak of 6646 visitors (30 June 2023) is after the publication of the news item "[Update on IARC Monographs Meeting 134: Aspartame, Methyleugenol, and Isoeugenol](#)".
  - The peak of 9678 visitors (14 July 2023) is after the publication of the news item and press release "[Aspartame hazard and risk assessment results released](#)".
68. **Figure 3** reported the number of visits to the Monographs website in 2023.
- The peak of 25 023 visitors (30 June 2023) is due to a large number of visits to the following webpages:  
<https://monographs.iarc.who.int/news-events/update-on-iarc-monographs-meeting-134/>,  
<https://monographs.iarc.who.int/agents-classified-by-the-iarc/>, and  
<https://monographs.iarc.who.int/list-of-classifications>
  - The peak of 14 231 users (14 July 2023) is due to a large number of visits to the following webpages:  
<https://monographs.iarc.who.int/>, <https://monographs.iarc.who.int/agents-classified-by-the-iarc/>, <https://monographs.iarc.who.int/list-of-classifications/>, and  
<https://monographs.iarc.who.int//iarc-monographs-volume-134/>
69. **Figure 4** reported the number of visitors to the GCO website in 2023. The reasons for the peaks on 23 February, 4 April, 14 April, and 1 June are unknown. On those dates, website visits originated from "direct search" to the GCO website (i.e. users typing in <https://gco.iarc.who.int/> directly).
70. The most popular downloads from the IARC Publications website are presented in **Table 5**.

### 2.6.2 Capacity building

71. In 2023, IARC hosted a total of **211 Early Career and Visiting Scientists** (ECVS) from 53 countries through its Research Training and Fellowship Programme, out of which 106 were new arrivals.
72. The call for applications and related selection process for IARC Postdoctoral Fellowships tenable in 2023–2025, targeting early career scientists from LMICs, was carried out between September 2022 and April 2023. The final decision on the number of awards funded on Regular Budget was made after the Governing Council in May 2023, based on the outcome of the budget 2024–2025 discussions. The latter led to a decrease of available fellowships (six instead of seven). In parallel, fund-raising efforts have led to the renewed support of Children with Cancer UK, which funded two additional two-year postdoctoral fellowships focusing on childhood cancer research. Awarded fellowships are reported in **Table 6**.
73. As per [Resolution GC/64/R4](#), authorizing the conversion of the 12-month Senior Visiting Scientist Award into shorter Mid-Career Visiting Scientist Awards, to be funded from the Special Account for Undesignated Contributions, the above-mentioned process included a call for two to three Mid-Career Visiting Scientist Awards. The aim of these new fellowships is to develop collaborative research projects with IARC and contribute to enhancing their career prospects and build the capacity of their instruction through longer term collaborations initiated/strengthened through the Fellowship. The call led to the award of three fellowships. The duration is of five, six and nine months, according to the specificities and needs of the project.



74. The IARC Courses Programme enhances research capacity of the global research community, in particular in LMICs, through lifelong learning opportunities in the areas of the Agency's expertise.

75. In 2023, and as shown in [Table 7](#), the Agency organized **45 training courses and webinars** targeting researchers and health professionals from many countries, in particular LMICs. It is to be noted that, because of the recent global health crisis and the move to the new building, several courses were organized online. When on-site options were not possible, courses were redesigned to combine live sessions with facilitated self-learning (blended learning). The IARC online teaching and learning infrastructure developed over previous years continued to provide flexibility and offer tools for IARC Branches and their collaborators.

76. The IARC Summer School in Cancer Epidemiology aims to improve the methodological and practical skills of cancer researchers and health professionals. In 2023, both modules – Introduction to Cancer Epidemiology, and Implementing Cancer Prevention and Early Detection – were held in a blended format: Each module included a Part 1 (online) and a Part 2 when participants travelled to IARC to attend an intense 5-days in person session at IARC. A total of 70 cancer researchers and health professionals from 41 countries (most of which were LMICs) participated in the two modules, representing a wide variety of disciplines and nationalities, which is what makes the IARC Summer School so unique. Recorded sessions are publicly available from the IARC Learning Portal. In addition, a brand-new Public Events Series was part of the programme, with 12 live public events successfully organized throughout the period (<https://www.youtube.com/@iarclearning5527/streams>) and attracted 260 to 1100 viewers per event.

77. As a key complement to live events, IARC continued to produce self-learning resources, including the two following examples:

78. The series of modules on the European Code Against Cancer 4<sup>th</sup> edition, developed during the previous years by the Environment and Lifestyle Epidemiology (ENV) and the Learning and Capacity Building (LCB) Branches in the frame of the Cancer Prevention Europe programme (CPE), was translated into five languages (French, Spanish, Hungarian, Polish and German) and deployed as an online learning programme on primary and secondary prevention of cancer, targeting cancer prevention advocates, health practitioners and promoters (<https://learning.iarc.fr/edp/courses/cpe/>). A comprehensive evaluation framework was designed and is being implemented. The programme is also currently being accredited from the European Accreditation Council for Continuing Medical Education (EACCME).

79. The first module of a self-paced e-learning programme on Pollution and Cancer was designed/developed and released as part of the collaboration with the European Society for Medical Oncology (ESMO) (<https://learning.iarc.fr/wcr/courses/module-1-pollution/>). This "Introduction to Research on Pollution and Cancer" module includes 2 learning sequences, a final quiz to test the new knowledge, and a certificate of completion. A particular attention was given to create an immersive and interactive environment, with professional graphic design tailored to the topic, animated images, as well as several quizzes, exercises, and case studies throughout each learning sequence. The second module of the programme, on "Ambient and Household Air Pollution and Cancer" is being developed and will be released in 2024.

80. The above-described resources are available through the IARC Learning Portal, which attracts a growingly increasing audience (<https://learning.iarc.fr/>). In 2023 (January–October), 1316 new accounts were created on the portal. These new users registered from 123 countries. On 30 October 2023, the IARC Learning portal counted 4473 users from 168 countries. As described in section **3.1.3** of this report, IARC and the WHO Academy have developed a collaboration within the development of the Academy's Learning Experience System, which will progressively replace the current IARC Learning infrastructure.

81. Regional learning centres are a powerful way to leverage the impact of an institution's courses and learning resources. Based on the recommendation provided by China during the 64<sup>th</sup> IARC GC in May 2022, the Agency and the National Cancer Centre China have collaborated to set up a first regional centre, the IARC-NCC China Learning Centre. As formalised through a Memorandum of Understanding (MoU) in May 2023, this joint centre, funded and sustained by NCC China will include: i) the organization of the IARC Summer School's modules in China, targeting researchers and health professionals from China and South- Eastern Asian countries, ii) the joint development of new learning modules, and iii) the organization of train the trainers courses in the framework of initiatives such as GICR, CanScreen5 or primary prevention programmes. The first course of the IARC-NCC China Learning Centre (Introduction to Cancer Epidemiology) is planned in Summer 2024. The course will follow the same structure as the course in Lyon, i.e. a blending learning format using the IARC learning infrastructure and contents for the online part, followed by a face-to-face session in China focused on practice, group work and networking. Sessions will be based on IARC open teaching resources as described above, adapted, and translated into Chinese. The evaluation of the course will be carried out by the LCB Branch. A similar partnership is being developed with the INCA Brazil and the University of Sao Paulo, in collaboration with other national entities. The first course (Introduction to Cancer Epidemiology) is planned for 2025, targeting health professionals from Brazil, as well as from Asian and African Lusophone countries. In this instance, it is planned that online material will also be translated into Portuguese. The set up of other similar regional partnerships will be considered, subject to availability of financial resources in LCB to launch and coordinate activities implemented with partners.



### 3. COOPERATION, PARTNERSHIPS AND STRATEGIC ENGAGEMENTS

#### 3.1 Cooperation with WHO

##### 3.1.1 IARC-WHO thematic cooperation

82. Close collaboration between IARC and WHO is critical to successful delivery of respective mandates and has been strategically identified as a priority in IARC's MTS 2021–2025 as well as in the [World Health Assembly Resolution 70.12](#) (2017). IARC and WHO have complementary functions and mandates to advance cancer control globally. In that regard, and as part of broader strategic activities, the IARC Statute places emphasis on cancer research, while WHO has the mandate in cancer control to support policy formulation and implementing programmes towards effective global cancer control. This pathway of research into policies and programmes is the basis for the complementary relationship between IARC and WHO.

83. IARC research informs the goals of the WHO Global initiatives (Global Cervical Cancer Elimination Initiative, Global Breast Cancer Initiative, Global Childhood Cancer Initiative, Global Initiative for Cancer Registry Development) and is vital for monitoring progress towards attaining the targets. The findings of scientists from IARC and partner institutions also provide the evidence base for WHO recommendations. For example, the Framework for the WHO Global Breast Cancer Initiative Framework has KPIs informed by the IARC-led research in Sub-Saharan Africa. In cervical cancer, examples are the recent update to WHO recommendations on HPV vaccination schedule and the updated *WHO guideline for screening and treatment of cervical pre-cancer lesions for cervical cancer prevention*.

84. Coordination and collaboration between IARC and WHO has been further strengthened in 2023, resulting in the implementation of the joint strategic workplan 2023–2025. The strategic workplan proposes three core elements to further strengthen collaboration:

(i) Implementation of IARC Teams related to each WHO Global Initiative (Global Cervical Cancer Elimination Initiative, Global Breast Cancer Initiative, Global Childhood Cancer Initiative) to improve sharing of information and knowledge.

(ii) Identification of a set of priority projects co-designed between WHO and IARC to be implemented in the next two years.

- As a priority project, IARC's Global Initiative for Cancer Registry Development (GICR) is being adapted by IARC and WHO as GICR+, upon consensus, to optimally support the provision of relevant indicators to inform and evaluate progress in scaling-up the three WHO Cancer Initiatives and more broadly in the support of the implementation of NCCP.
- Handbook volume 19 on the prevention of cancer of the oral cavity has considered the development of a Supplement. This Supplement is a set of "products" which aims to deepen the results of the Handbook and present data and knowledge that can be directly useful to governments and other decision-making bodies in the implementation of prevention strategies.

(iii) Creation of governance mechanisms with the setting up of committees to support implementation of the strategic workplan and to strengthen broader engagement. In 2023, the IARC Director hosted the yearly leadership Committee and welcomed WHO Assistant Director-General (ADG) Communicable Diseases and Noncommunicable Diseases, ADG Universal Health Coverage,

ADG Healthier Populations and Chief scientist to establish strategic directions for increased cooperation and impact.

### 3.1.2 IARC-WHO joint communication/events

85. IARC and WHO jointly released the latest estimates of the global burden of cancer on 1 February 2024. WHO also published survey results from 115 countries, showing a majority of countries do not adequately finance priority cancer and palliative care services, as part of universal health coverage (UHC).

86. IARC Director participated in the leadership meeting held in January 2024 regarding the Presidential initiative on women health in Egypt in collaboration with the WHO Regional Office for Eastern Mediterranean (EMRO) in Cairo.

87. The International Atomic Energy Agency (IAEA) hosted the 2023 tri-partite IARC-WHO-IAEA annual consultation on cancer control in December. The overall meeting goal of the 2023 Trilateral Meeting was to present and accelerate workplan deliverables, to review and demonstrate relevant cancer control tools that have been developed by linking them to established joint workplan objectives, and to identify strategic collaborations for coordinated country support in line with recent UN initiatives (e.g., WHO three cancer initiatives, Global Platform for Access to Childhood Cancer medicines, Rays of Hope, Global Initiative for Cancer Registries).

88. Joint estimates by WHO, the International Labour Organization (ILO) and IARC in November 2023 indicated that nearly 1 in 3 deaths from non-melanoma skin cancer is caused by working under the sun. The study found that outdoor workers carry a large and increasing burden of non-melanoma skin cancer and calls for action to prevent this serious workplace hazard and the loss of workers' lives it causes. The results were published in *Environment International*.

89. IARC launched Volume 19: Oral Cancer Prevention of the *IARC Handbooks of Cancer Prevention* series in a webinar co-organized with WHO in November 2023. The webinar brought together health experts, researchers, clinicians, and survivors to raise awareness of oral cancer, its risk factors, and best strategies to prevent the disease. The event was available online and aimed to promote dialogue between survivors, clinicians, and policy-makers.

90. IARC and the Pan American Health Organization (PAHO) launched the 1<sup>st</sup> edition of the Latin America and the Caribbean Code Against Cancer in October 2023. This new Code, which forms part of the World Code Against Cancer Framework, aims to help reduce the burden of cancer in the region by providing recommendations based on the most recent scientific evidence. The development of this Code represents a collaborative effort between IARC and PAHO, working with a large group of scientific experts from the region, to review the evidence and make recommendations on how best to prevent cancer.

91. IARC's hazard identifications are the first fundamental step to understand the carcinogenicity of an agent by identifying its specific properties and its potential to cause harm, i.e. cancer. IARC classifications reflect the strength of scientific evidence as to whether an agent can cause cancer in humans, but they do not reflect the risk of developing cancer at a given exposure level. As per our Standard Operating Procedure (SOP), carcinogenic hazard and health risk of the non-sugar sweetener aspartame were respectively assessed in June and July 2023 by IARC and WHO and the Food and Agriculture Organization (FAO) Joint Expert Committee on Food Additives (JECFA). Aspartame hazard and risk assessment results were jointly released by IARC and WHO/JECFA on 14 July 2023. Citing *limited evidence* for carcinogenicity in humans,

IARC classified aspartame as possibly carcinogenic to humans (IARC Group 2B) and JECFA reaffirmed the acceptable daily intake of 40 mg/kg body weight.

92. As per our SOP, results, including infographics and Q&A of *Monographs* evaluation volume 135 on carcinogenicity of perfluorooctanoic acid (PFOA) and perfluorooctanesulfonic acid (PFOS), were communicated to WHO before publication in *The Lancet Oncology*.

93. As per our SOP, the announcement for the Advisory Group Meeting to Recommend Priorities for the *IARC Monographs* during 2025–2029 was posted on the IARC website one year prior to the scheduled meeting (19–22 March 2024). An invitation to WHO/HQ to assign one or more WHO/HQ staff to be part of the IARC-WHO/HQ secretariat of the Advisory Group was issued six months prior to the scheduled meeting.

94. IARC hosted the meeting of the Advisory Group to Recommend Priorities for the *IARC Monographs* during 2025–2029 on 19–22 March 2024 in Lyon, France. An Advisory Group of 28 scientists from 22 countries met to recommend priorities for the *IARC Monographs* programme from a list of agents nominated by the general public, the scientific community, national health agencies, and other organizations. The recommendations of the Advisory Group will be published in *The Lancet Oncology* in April 2024.

95. As per our SOP, the list of agents proposed to be evaluated by the Working Groups in 2024 has been cleared by WHO for the upcoming *Monographs* meetings: talc, acrylonitrile (volume 136; 11–18 June); and hydrochlorothiazide, voriconazole and tacrolimus (volume 137; 5–12 November).

96. Following discussions between the Director and the Scientific Council and Governing Council Chairs in 2023, it was agreed that the SOP be updated through 2023–2024 based on the six-year experience gained in its application, on consultation with WHO/HQ. At the request of WHO and in agreement with the Director of IARC, the updated draft SOP will be submitted at the 67<sup>th</sup> Session of the Governing Council in May 2025.

97. IARC marked Cervical Cancer Awareness Month 2023 (and 2024, January) by highlighting the work that remains to be done for the world to eliminate this disease by the end of this century, and by promoting the tools that are available to achieve this goal. Countries have only six years left, until 2030, to meet the WHO targets that will help make cervical cancer elimination a reality within this ambitious timeframe. Recent research by IARC and partner institutions suggests that these targets will be missed unless countries scale up screening programmes, improve coverage of HPV vaccination, and expand access to affordable treatment.

98. To mark three years of the Global Initiative on cervical cancer elimination, IARC launched online learning resources on cervical cancer screening in additional languages: *Atlas of visual inspection of the cervix with acetic acid for screening, triage, and assessment for treatment*; *Using HPV tests for cervical cancer screening and managing HPV-positive women – a practical online guide*; and *Atlas of colposcopy: principles and practice*.

99. IARC marked Breast Cancer Awareness Month 2023 by highlighting recent and new results related to the global burden of breast cancer, risk factors for developing breast cancer, and initiatives to prevent breast cancer.

100. IARC marked Childhood Cancer Awareness Month 2023 with a series of posts highlighting some of the different research projects IARC is undertaking with the goals of better understanding how cancer develops in children and improving the measurement of the global burden of childhood cancer.

101. On World Hepatitis Day 2023, WHO hosted a global webinar to raise awareness about the epidemic of viral hepatitis. The theme for World Hepatitis Day 2023 was “One life, one liver”, to highlight the importance of the liver to the strategy to eliminate viral hepatitis. WHO aims to achieve elimination of viral hepatitis as a public health threat by 2030. IARC also promoted the “One life, one liver” message.

102. To mark World Cancer Research Day 2023 and promote the theme of “integrating diversity, advancing research, and achieving equity”, IARC highlighted some of the research projects that IARC scientists are conducting to ensure that diverse populations are represented and included in cancer research, so that underrepresented groups can benefit from advances in prevention and early detection.

103. IARC celebrated the 75<sup>th</sup> anniversary of WHO on World Health Day 2023.

104. Mrs Charu Mehta, Director of Administration and Finance, ad interim, is the IARC focal point for general management, business operations, and legal matters.

105. IARC is part of the WHO Global Advisory Committee on formal complaints of abusive conduct (GAC). The GAC's role is to review Internal Oversight Services investigation reports on allegations of abusive conduct (i.e. abuse of authority, discrimination, harassment, and sexual harassment) and to provide a recommendation to the Director-General/Regional Director/Executive Director concerning an appropriate course of action, in accordance with the options set out in the Policy on Preventing and Addressing Abusive Conduct (PAAC).

### *3.1.3 WHO Academy and the Global Health Hub in Lyon*

106. The WHO Academy will provide millions of people around the world with rapid access to the highest quality training courses in health. The Academy will be a key lifelong learning platform to accelerate the implementation of evidence-based health practice and policy, and an important future partner for IARC. The Agency therefore continued to contribute to the planning of the Academy through participation in its governance, as well as to relevant activities of the WHO Academy.

107. The IARC Director has been invited as a member of the WHO Academy internal steering committee, to provide guidance on strategy and activity roadmap.

108. On the administration side, discussions have been continued to share some services and related costs.

109. Regarding learning contents, the Comprehensive Learning Programme on Screening, Diagnosis and Management of Cervical Precancer has therefore been developed by a consortium of WHO/HQ and the six Regional Offices coordinated by the IARC Early Detection, Prevention and Infections (EPR) Branch. The Managing Infrastructure for Medical Research Learning Programme was also selected and is led by the Nutrition and Metabolism (NME)/Laboratory Support, Biobanking and Services (LSB) Branch. Modules of both programmes should be launched in 2024.

110. As far as learning infrastructure is concerned, IARC and the Academy set up a collaboration within the development of the Academy's Learning Experience System (LXP), which led to the signature of an agreement in 2023. In the frame of this collaboration, the IARC LCB Branch has provided training design expertise to support the development of the LXP, including through advises on key LXP functionalities and testing of demo versions. The Academy team has created a dedicated Learning Space on the LXP, which will be managed by IARC autonomously. A stable version of the LXP was released for testing end 2023. In 2024, IARC self-paced and facilitated courses will progressively be migrated to the LXP, which will eventually replace the current IARC Learning infrastructure.

### 3.2 Partnership highlights

111. Selected partnerships of the Agency are highlighted below. Strengthened partnerships will enable new projects to begin and add momentum to ongoing projects, and directly contribute to the IARC mission to promote international collaboration in cancer research.

112. In collaboration with the Brazilian National Cancer Institute (INCa), IARC played a pivotal role in guiding the Brazilian National Immunization Technical Advisory Groups (NITAG) by leveraging scientific evidence and IARC's model-based evaluations on single-dose, catch-up, and dose-reallocation policies. These factors were carefully considered in the ultimate decision to transition the local HPV vaccination program to a single-dose schedule and to initiate a catch-up campaign. Special emphasis was placed on Northern states with lower coverage to expedite the country's efforts towards cervical cancer elimination. This achievement reflects over two years of dedicated effort, meticulous planning, and the allocation of adequate resources.

113. In March 2024, IARC and NCKK celebrated the 10 years of the Effect of *Helicobacter pylori* Eradication on Gastric Cancer Prevention (HELPER) study in the Republic of Korea by holding meetings with research staff and investigators from 13 study centres throughout the country. The HELPER study, a major effort to reduce gastric cancer burden in the Republic of Korea and also globally, is a randomized controlled clinical trial conducted by NCKK in collaboration with IARC to evaluate the effect of *H. pylori* eradication for gastric cancer prevention among a study population of almost 12 000 healthy people.

114. IARC hosted the consortium meeting for the Prostate Cancer Awareness and Initiative for Screening in the European Union (PRAISE-U) project on 19–20 February 2024 in Lyon, France. The goal of the PRAISE- U project is to reduce morbidity and mortality caused by prostate cancer in the EU by providing concrete evidence on a risk-stratified approach to the early detection of prostate cancer. The project includes pilot studies of screening programmes to detect prostate cancer, and representatives of countries with pilot sites – Ireland, Lithuania, Poland, and Spain – were in attendance to present the study protocols.

115. IARC participated to the National Cancer Institute Global Health Interest Group (GHIG) meeting on 7 February 2024, focused on “Addressing Present, Emerging and Future Challenges in Global Cancer Care and Prevention”. The mission of GHIG is to unite and strengthen the NIH community and to foster collaborations among institutions in the field of global health.

116. IARC hosted the foundation meeting of the Expert Working Group of the European Commission (EC) Initiative on Cervical Cancer (EC-CvC) on 5–6 February 2024 in Lyon, France. The EC-CvC Expert Working Group consists of 22 multidisciplinary professionals with expertise covering the full patient pathway of primary, secondary, and tertiary care. By mid-2026, the EC-CvC Expert Working Group will develop

updated patient-centred, evidence-based guidelines on HPV vaccination, cervical cancer screening, and diagnosis and management of precancerous lesions. The group will also identify quality and safety indicators and performance measures for the European quality assurance scheme for cervical cancer care services. The quality assurance scheme will cover all processes of cervical cancer care, from screening to end-of-life care.

117. IARC hosted the launch event of the OECD overarching report, "Beating Cancer Inequalities in the EU: Spotlight on cancer prevention and early detection" on 5 February 2024. IARC contributed to this report through the European Code Against Cancer, which strengthened the field of prevention.

118. As part of the European Commission (EC) Initiative on EC-CvC and Europe's Beating Cancer Plan, the IARC and the EC Joint Research Centre (JRC) launched an open call for experts to develop screening guidelines and quality assurance schemes for Europe. IARC will draw on its experience in developing guidelines and its international networks in cancer screening to implement this initiative in collaboration with the JRC. This approach promotes a unified front in tackling cervical cancer at the European Union level and is modelled on similar EC initiatives on breast cancer (ECIBC) and colorectal cancer (ECICC).

119. To mark the end of the Improving Cancer Care Coordination and Screening in Latvia and Slovakia (ICCCS) project, IARC and partners are co-organized two virtual events on 10–11 January 2024 to showcase the project outcomes. These events specifically focused on Latvia and Slovakia and brought together experts in cancer screening and cancer registration, oncologists, policy-makers, patient advocates, and researchers. Experts presented recommendations for strengthening cancer control in the areas of cancer registration, cancer screening, comprehensive cancer-care networks, and communication for raising awareness about the importance of cancer screening.

120. IARC hosted a strategic meeting with the National Cancer Institute (INCA), Brazil, in September 2023 to strengthen further areas of collaboration.

121. IARC and partners held a meeting on 17 August 2023 in Zimbabwe to launch a new cervical cancer screening project, the EASTER project. More than 20 collaborators and seven international trainers participated in theoretical and hands-on training in study protocol, ethical considerations, and procedures.

122. IARC and partner institutions organized a two-day workshop on 1–2 June 2023 for cancer screening experts as part of the "Strengthening cancer screening data collection to update the European Cancer Information System and improve quality and coverage of cancer screening programmes in Europe" (CanScreen-ECIS) project. The workshop was attended by 64 experts from 32 European countries.

123. IARC, the Centre for Innovation in Medicine, and 14 European partner institutions launched the "Personalized CANcer Primary Prevention research through Citizen Participation and digitally enabled social innovation" (4P-CAN) project on 16–17 May 2023. The project will draw on the European Code Against Cancer, implementation research, social sciences, humanities, and behavioural sciences to create personalized tools to improve primary prevention of cancer over a period of four years. IARC will contribute a series of implementation research activities related to designing personalized interventions for primary prevention. In addition, results and knowledge from 4P-CAN will feed into the 5<sup>th</sup> edition of the European Code Against Cancer, which is currently being prepared.



124. IARC and partners from across Europe met on 15–16 May 2023 to discuss the progress and upcoming deliverables of the Discovering the Causes of Three Poorly Understood Cancers in Europe (DISCERN) project. The dedicated project website was launched to coincide with the event. The goal of the DISCERN project is to uncover novel causes for renal, pancreatic, and colorectal cancers and to provide the evidence base required to develop new prevention strategies for these cancer types in Europe.

125. IARC launched a new project focused on the implementation of gastric cancer prevention strategies in the EU on 30 March 2023. This major EU initiative, known as the Towards gastric cancer screening implementation in the European Union (TOGAS) project, aims to provide the missing evidence base for effective gastric cancer prevention in the EU by assessing the needs of EU Member States and target populations in gastric cancer prevention, evaluating various gastric cancer prevention strategies for implementation in the EU by conducting pilot studies in different countries, and ensuring the sustainability and scale-up of the TOGAS results by global dissemination of information.

126. IARC presented the World Code against Cancer Framework during the First China Primary Cancer Prevention Conference on 25 March 2023, where the China Code Against Cancer was announced.

### 3.3 Strategic engagement highlights

127. The Agency continued building a strong collaborative global network with strategic partners. In 2023, the Agency signed **seven Memoranda of Understanding** (MoU) with the World Cancer Research Fund (WCRF), UK; the Kenya Medical Research Institute (KEMRI), Kenya; the National Cancer Institute for Cancer Control (NCCICC), Japan; the National Cancer Centre (NCC), China; the European Organization for Nuclear research (CERN), Switzerland; the European Society of Pathology (ESP), Belgium; the National Cancer Institute (NCI), Brazil.

128. In 2023, IARC signed **74 Collaborative Research Agreements** (CRAs) with partners institutions on specific research projects aligned with the MTS.

129. IARC has continued to further solidify its data protection framework and data security measures over the last year, to ensure IARC's data protection framework remains in line with internationally recognized standards, inter alia through the following actions:

- The IARC Data Protection Policy, focusing on the processing of personal data for scientific purposes, that was published on our public website in 2021, has been widely shared with our collaborators and was well-received;
- The IARC Data Protection General Awareness training which is mandatory for all personnel and is followed on a yearly basis was updated to reflect new developments. Newcomers follow the training within their first month at IARC and receive a briefing from IARC's Data Protection Officer afterwards to further discuss this topic;
- IARC maintained the established comprehensive Register of Records of Data Processing Activities (ROPA) for all scientific and non-scientific data processed at IARC;
- IARC continued to actively work on finding practical solutions with its scientific collaborators for any arising data protection challenges within research projects, ensuring scientific collaborations can be implemented as planned;

- IARC continuously works, in collaboration with WHO, on strengthening our data protection framework taking into account new developments and internationally recognized standards;
- IARC has successfully implemented solutions (including a standard Data Use Agreement template) that enable us to share data with our collaborators remotely via our Scientific IT Platform. These solutions have been set up in accordance with internationally recognized standards;
- IARC continues to collaborate with its scientific collaborators, the European Commission, the European Data Protection Supervisor, several networks of International Organizations and data protection authorities to work on long-term solutions to simplify data sharing with IARC.

### 3.4 Resource Mobilization highlights

130. IARC's Resource Mobilization strategy highlights four main sources of funding for the Agency. The following targeted actions have been taken since the last Governing Council meeting on each of the four main focus areas: (i) Increase assessed contributions; (ii) Explore innovative resource mobilization; (iii) Enlarge direct and flexible funding; (iv) Strengthen competitive funding (under [3.4.1. Voluntary contributions to IARC – grants and contracts](#)).

#### (i) Increase assessed contributions

131. One of the ways to increase the statutory contributions for the Agency is to welcome new Participating States. The Secretariat created a priority list of potential countries and several actions have been put in place, as listed below:

- Identify a short list of potential countries. The IARC membership fees are quite expensive compared to the contribution made by most countries to WHO or other UN agencies. Countries are split into five different groups. With the entry of China as a Participating State in 2021, all countries from Groups 1, 2 and 3 are now joined IARC. Any new Participating States will thus come from Groups 4 or 5. The level of annual contribution is around €750 000 for a Group 4 country and €620 000 for a Group 5 country. There are 16 countries in Group 4 of which 8 are already IARC Participating States. Based on this classification, IARC has worked on a shortlist of 10 potential members, which includes:
  - Saudi Arabia
  - Egypt
  - Portugal
  - Greece
  - Poland
  - Kazakhstan
  - New Zealand
  - Indonesia
  - Mexico
  - South Africa
  - Czech Republic
  - United Arab Emirates
  - Kuwait



- Establish IARC investment case for countries to join. It is worth noting that the current economic environment is not very conducive for Ministries of Health to explore the possibility to become an IARC Participating State. Over the last three years, those Ministries have been at the fore front of the COVID-19 crisis and their budgets have been spent on health crisis relief activities. Moreover, the cost-benefit analysis done by the potential countries regarding their IARC membership does not seem, on face value, to favour IARC. Being part of the United Nations system, IARC was created on the principle of providing free and universal access to its research. That is why IARC's largest and most reputed programmes are completely open source. This is the case for the GCO, the *Monographs*, the *Handbooks of Cancer Prevention* and the World Cancer Report. Becoming one of IARC's Participating States provides the opportunity to help advance cancer research globally, with a focus on LMICs.

132. Countries that could become IARC Participating States want a tangible return on their investment for their contribution. As they already have access to open source IARC publications, they tend to believe that becoming an IARC Participating State is not worth the investment. The Secretariat has thus worked on an analysis of what countries can gain from being an IARC Participating State (e.g. internationalization of their research, shaping the world cancer prevention research agenda) to strengthen its argument when discussing with a potential new Participating State. Based on this analysis, the Secretariat has developed a strong investment case and has produced attractive communication materials to present to potential new countries.

- Specific background research on specific country needs. Based on the specific situation of the potential new countries, the Secretariat has also adapted its pitch to make it as relevant as possible to their needs and expectations. For example, understanding the willingness of Saudi Arabia to enhance its regional leadership in the Gulf area, the Secretariat has proposed the creation of a regional hub based in Riyadh for its CanScreen5 programme. This will help position Saudi Arabia as a strong regional leader in cancer research.
- Create and activate networks of advocates. Making sure the visibility and attractiveness of IARC could be enhanced in a specific country required the support of well-placed and renowned personalities to work in close collaboration with IARC, to introduce us to the right interlocutors within the different Ministries and advocate strongly for IARC membership. In some of the shortlisted countries, the Secretariat has developed networks of strong advocates who have been extremely helpful in communicating IARC's work and the benefits of becoming a Participating State. For example, Dr Samar Jaber Alhomoud, colorectal surgeon and researcher at the King Faisal hospital in Riyadh and current chairperson of IARC Ethics Committee, has been actively engaged and has helped the Secretariat navigate through the country's administration. Similarly, the Secretariat has also contacted the Saudi embassy in Paris and IARC Director has visited the Ambassador to ensure clear endorsement from the Ministry of Foreign Affairs.

133. The Secretariat has thus been able to overcome some of the faced challenges by developing more tailored and attractive pitches according to specific needs and expectations of the potential countries. Thanks to a strong network of advocates, the Secretariat has been able to navigate administrative systems.

134. The Secretariat is happy to report that the discussions with the Kingdom of Saudi Arabia have led to the formalization of the request from Saudi Arabia to become an IARC Participating State. The official letter of application has been received by the WHO Director General (WHO DG) Office on February 14<sup>th</sup>, 2024.

The formal process for membership is now in place and the GC sub-group on the admission of new Participating State will meet in April and produce a recommendation for the GC session in May 2024.

135. The Secretariat has also had very fruitful and promising discussions with Egypt, Greece and Indonesia. There is a high probability than one or more of these countries will send their application letter to WHO DG office in the next few weeks.

*(ii) Explore innovative resource mobilization*

136. In 2023, the Secretariat has launched a more structured legacy programme which could become an important source of funds in the years to come. A new brochure has been designed and contacts made with notary offices.

137. The Secretariat also continues to identify and reach out to potential high-level donors. These Ultra-High Net-Worth Individuals (UHNWI) have the possibility to make substantial donation to the organization. However, they are very difficult to approach and tend to live in their own secluded world. Through different connections, the Secretariat has been able to approach one of those UHNWI and discussions should reach a positive conclusion in 2024.

*(iii) Enlarge direct and flexible funding*

138. The third objective of the Resource Mobilization strategy is to increase the proportion of direct funding received by the Agency. As explained in the last Director's Report, important steps have been taken in this regard: the Secretariat has designed new and improved communication materials and has conducted match-making exercises to find out the most relevant donors for IARC.

139. The Secretariat reached out to its current Participating States for possible investment in some 100% ODA-compliant LMIC focused projects that could help them fulfil their objective of development.

140. The Secretariat is very thankful to the Netherlands for their generous contribution. Indeed, the Secretariat has worked in close collaboration with the Dutch Ministry of Health and Sport to design a research project focusing on childhood cancer in Africa. The government of Netherlands has agreed on providing a direct grant of almost €2 million for this specific project that will be implemented in close collaboration with the Princess Maxima Centre.

141. The Secretariat would also like to thank the German government for their generous contribution of €450 000 towards some equipment of the IARC new headquarters. The funds were used to acquire a new state-of-the art platform for metabolomics, consisting of two liquid chromatography-mass spectrometry (LC-MS) instruments from Agilent Technologies: a time-of-flight system Revident, and a triple quadrupole system 6495. With this combination, IARC will have instrumentation that meets the demands of modern metabolomics research applied to large-scale cancer epidemiologic studies, a field where the Agency has already become a globally recognized expert. Metabolomics is a powerful discovery method, allowing simultaneous measurement of thousands of molecules in clinical samples. This enables identification of metabolites associated with different exposures, phenotypes, or other factors, without limiting the research questions to preselected target metabolites. Once operational, the first study where the new platform will be employed is a recent European Commission-funded study DISCERN, which aims to understand the causes of three poorly understood cancers in Europe; renal, pancreatic and colorectal cancer, and help to explain their geographical distribution. This study involves metabolomics analysis of close to 10 000 blood samples and will be followed up by other studies on molecular risk factor of different cancers.

142. The Secretariat has also secured funding from the Gulf Centre for Disease Control (CDC) to strengthen cancer registry and screening activities in the Gulf region. With the Kingdom of Saudi Arabia soon becoming an IARC Participating State, this project with the Gulf CDC will without any doubt help reinforcing IARC presence in the Gulf region.

143. The Secretariat was also able to finalize the agreement with the government of Uzbekistan and the Islamic development bank for the project that will be implemented in close collaboration with WHO Regional office for Europe and IAEA.

#### 3.4.1 Voluntary contributions to IARC (grants and contracts)

144. Voluntary contributions to IARC are obtained mainly through competitive research grants from national and international funding agencies and increasingly through direct funding requests. The success in obtaining peer-reviewed funding is an external indicator of the overall quality of the research at the Agency.

145. These contributions represent a substantial component of the Agency's overall funding to successfully implement its programmes and the MTS 2021–2025. This income supplements the investment made by Participating States through their assessed contributions.

146. As part of the objective to increase competitive funding, the Secretariat is screening permanently more than **200 funders** and has posted on its intranet Resource Mobilization pages **230 funding opportunities** in 2023 for IARC colleagues to consider.

147. The number of new grant applications and direct funding requests submitted in 2023 reached **a total of 207** (first stage and second stage applications) (**Table 8**). This reflects the commitment of the Agency's scientists to secure sufficient extrabudgetary funds to conduct the research defined within the MTS.

148. Funding opportunities available to IARC under the Horizon Europe, EU4Health and Cancer Mission programs have also been closely monitored throughout the year. IARC has been a successful applicant for these extremely competitive funding mechanisms. In 2023, **11 EC funded projects** with IARC participation or coordination have been selected, under the *EU4H programme* (2), the *Horizon Europe programme* (8) and the *European Social Fund + programme* (1).

149. The Agency signed extrabudgetary contracts amounting to a total value of **€72,86 million in 2023; of which €20,42 million was attributed to IARC**. The large proportion of the total value of signed contracts going to IARC collaborators indicates that IARC's participation in projects can bring benefits to a wide network of institutions and organizations at national levels. The very high level of funding allocated by donors to these consortia is a testimony of the high level of trust given to such research project ideas.

150. Overall, the figures on extrabudgetary contracts represent an outstanding achievement given the increasingly competitive nature of research funding, triggered by the decreasing number of funding opportunities available for cancer research.

151. As these sources of funding are unpredictable and unstable by nature, a stable and robust IARC Regular Budget is key to continue obtaining these strategic extrabudgetary contracts. Voluntary Contribution (grants and contracts) expenditure in 2023 was **€20.14 million**. This represented approximately 44% of the overall combined expenditure from Regular Budget and Voluntary Contributions ([Figure 5](#)).

152. About 80% of the contributions signed in 2023 came from the following **9 funders**, as shown in [Figure 6](#).

- Bill & Melinda Gates Foundation (BMGF, USA),
- National Institutes of Health/National Cancer Institute (NIH/NCI, USA),
- European Commission – Compilation of various agencies (EC, Belgium),
- Ministry of Health, Welfare and Sport of Netherlands (NL-MoH, NL)
- Gulf Center for Disease Prevention and Control (Gulf CDC, SA)
- World Cancer Research Fund International (WCRF, GB)
- Institut National du Cancer (INCa-FR, FR)
- Cancer Research UK (CRUK, GB)
- Islamic Development Bank (IDB, SA)

#### *3.4.2 Implementation of the Framework of Engagement with Non-State Actors (FENSA) at IARC*

153. During its 60<sup>th</sup> session in May 2018, the IARC Governing Council reviewed the “Recommendations from the Governing Council Working Group on the implementation of FENSA” ([Document GC/60/17](#)) and noted the “IARC-Specific Guide on Engagement with Non-State Actors” prepared by the Governing Council Working Group. Following [Resolution GC/60/R17](#), the Secretariat is requested to annually report on IARC engagement under FENSA as part of the Director's Report.

154. During the course of 2023, IARC has continued the implementation of the simplified procedure as the default procedure for the assessment of engagements with Non-State Actors (NSAs) to be conducted by IARC FENSA focal points, following the recommendation from the WHO Due Diligence and Non-State Actors Unit.

155. WHO and IARC are aligned in their approach of implementing FENSA, using two levels of due diligence and risk assessment, by distinguishing between low-risk simplified procedures and standard procedures prior to engaging with NSAs. The identification of risk factors does not automatically exclude the possibility of engaging with NSAs. Determination of whether a potential conflict of interest exists is made, taking into account the specificities of the project at stake. The risks are balanced against the expected benefits for IARC, also considering the probability of the risk.

156. Under the simplified procedure, due diligence and risk assessment are conducted by the Resource Mobilization and Management Office on potential donors and project partners related to resources (competitive grants and direct funding); and self-assessment or due diligence and risk assessment on NSAs under other types of engagement (technical collaboration, participation, evidence, and advocacy) is carried out by the Director of Administration and Finance with the support of the IARC Ethics and Compliance Officer.

157. Under the standard procedure, complex cases and those potentially presenting a higher reputational risk should be referred to WHO Due Diligence and Non-State Actors Unit for their assessment and recommendations.

158. In August 2023, IARC contributed to the report presented to the 154<sup>th</sup> session of the WHO Executive Board by providing information on the implementation of FENSA at IARC ([Document EB154/36](#)). IARC staff has also participated in two network meetings organized at WHO HQ for FENSA Focal Points.

159. In 2023, IARC applied the low-risk simplified procedure for **more than 400 NSAs** (unique values) with whom IARC engaged either through funding applications and contribution agreements (395 NSAs) or through other types of engagement (14 NSAs), noting that IARC has sometimes engaged several times with the same NSA partner throughout the year, i.e. through different projects. Internal due diligence evaluations and risk assessments were conducted to screen for potential reputational risks, by scrutinizing the NSAs' legal status, governance and sources of funding. Information is systematically gathered from the documentation submitted by the NSAs (ByLaws, Governance, financial reports) and complemented by various publicly available sources such as reports and media. Reference has been made to the WHO Register of NSAs when information on the entity was available.

160. IARC has not applied the standard procedure for complex engagement with NSAs in 2023.

161. IARC maintains its own Due diligence Register where it keeps profiles of all the NSAs it has engaged with since January 2017 (a total of **1,416 NSA profiles** had been prepared and archived by the end of 2023). IARC also maintains a NSA Register in which **271 NSAs** have a complete set of FENSA-relevant documentations, including Tobacco and Arms Disclosure (TAD) forms signed by the authorized representative of the NSA (IARC has collected **267 signed TADs** in 2023). This internal resource has allowed IARC colleagues to rely on already acquired documentation in the majority of our engagements in 2023 (on average, the documentation was already available in the NSA register in **74%** of the cases - analysis done in August 2023 on the first 8 months).

162. Despite its inherent challenges, FENSA provided the Agency with the opportunity to further expand its engagement with NSAs, including the private sector, and to increase transparency and accountability, inter alia towards WHO Member States and IARC Participating States.

## 4. MANAGEMENT

### 4.1 Evaluability assessment of the IARC Medium-Term Strategy (MTS) 2021–2025 and its Working Group membership

163. In May 2021, the Governing Council requested the Secretariat to evaluate the Medium-Term Strategy (MTS 2021–2025 ([Resolution GC/63/R4](#))). The evaluation of the MTS consists of the systematic and objective assessment of IARC's strategic programme for 2021–2025: its design, implementation, and results. The aim of this evaluation is to determine the relevance and the fulfilment of the objectives, as well as the efficiency, effectiveness, and impact of IARC's activities.

164. The methodology, the evaluation framework and the Key Performance Indicators (KPIs) to assess progress in the implementation of the MTS were approved by the Governing Council in May 2022 ([Resolution GC/64/R12](#)). This evaluation of the MTS implementation is complementary to the scientific reviews of individual Branches, which take place every five years through a peer-review process.

165. In 2023, an evaluability assessment was performed to determine the readiness of the MTS 2021–2025 for the evaluation and to prepare the MTS 2021–2025 evaluation to be conducted in 2024. The data and KPIs of the evaluability assessment also present a short mid-term overview of the implementation of the MTS 2021–2025. The evaluability assessment of the MTS 2021–2025 and its Working Group membership are detailed in [Document GC/66/8](#).

166. At the Sixtieth session of the Scientific Council in February 2024, Pål Richard Romundstad (Norway) and Luis Felipe Ribeiro Pinto (Brazil) were nominated to be part of the Working Group to prepare the MTS 2021–2025 evaluation.

167. The draft "Evaluation Report of IARC Medium-Term Strategy for 2021–2025" will be submitted for discussion at the 61<sup>st</sup> session of the Scientific Council in February 2025 and for approval at the 67<sup>th</sup> session of the Governing Council in May 2025.

### 4.2 Preparation of the IARC Medium-Term Strategy (MTS) 2026–2030 and its Advisory Group membership

168. The MTS 2026–2030 will define IARC's priorities and action plan over the five years. Its elaboration and the first years of implementation will be coordinated by the current Director of IARC, who will remain in office until the end of 2028.

169. The preparation of the MTS 2026–2030 will rely on a consultation beginning during the 66<sup>th</sup> Governing Council session in May 2024. The elaboration of the new MTS will run in parallel with the MTS 2021–2025 evaluation to better consider and integrate its conclusions and recommendations.

170. The preparation of the MTS 2026–2030 and its Advisory Group membership are detailed in [Document GC/66/9](#). The Advisory Group for the elaboration of the new MTS will guide and review the document of the MTS 2026–2030.

171. At the Sixtieth session of the Scientific Council in February 2024, Satish Gopal (USA) and Louisa Gordon (Australia) were nominated to be part of the Advisory Group for the development of the MTS 2026–2030.

172. The draft proposal of the MTS 2026–2030 will be submitted at the 62<sup>nd</sup> session of the Scientific Council in February 2026 and at the 68<sup>th</sup> session of the Governing Council in May 2026.



### 4.3 Modernizing IARC's administrative systems

173. After successfully moving to the new building, IARC continues its work on preparing for the implementation of the new Business Management System (BMS), in collaboration with WHO. IARC's current Enterprise Management System (ERP) needs to be replaced with a much more modern and efficient system. A system that can help replace several labor-intensive manual activities with other high-quality analytical functions. This will not only result in elimination of inefficiencies and risk of errors but will also lead to a motivated workforce focusing on creative thinking and innovation. In joining forces with WHO as the implementation lead of the BMS project, IARC derives best value for money as well as a better alignment of its policies and processes with those of WHO. The WHO go-live date for the BMS project has been moved from the previously anticipated date of 1 January 2024 to sometime in the second half of this year. It has been discussed and agreed with WHO that IARC will roll-out the system at least four to six months after the WHO go-live date. During the last 18 months, IARC administrative teams have worked closely with the WHO teams throughout the different phases of this project and will continue to do so in the coming months.

174. IARC continues to work on further strengthening its scientific IT capacity and data protection measures. Several IT initiatives to strengthen cybersecurity are underway, including multi-factor authentication for access to IARC systems both by internal and external users. IARC is aiming at implementing the smart building management system that will eventually make the new IARC building more energy efficient. IARC administration is working continuously to look for ways of making IARC a truly modern organization, as envisaged in the IARC MTS for 2021–2025. These efforts will be further strengthened as the Agency moves into the preparation phase of the next MTS 2026–2030.

175. The unbudgeted assessments of new Participating States allow the Director to invest in support of IARC activities. The Governing Council noted ([Resolution GC/64/R2](#)) the partial use of such funds to modernize IARC's administrative management system by joining WHO's new BMS project, to further strengthen IARC's data protection mechanism as well as scientific data management systems. The Director is pleased to report that, as of 27 March 2024, €580 243 have been used for this purpose (additional information can be found in [Document GC/66/7](#)). The Director will further report on the use of these funds in next year's Report.

### 4.4 Personnel.

176. As of **29 February 2024**, there were a total of **382** personnel, 237 staff members and 145 Early Career and Visiting Scientists (ECVS), contributing to the activities at the Agency. For comparison, the number of personnel at the Agency **in 2021 , 2022 and 2023 was 345, 373, and 351 respectively.**

177. On the pre-doctoral level, ECVSs include eight Master's students, four Continuing Professional Development Trainees, and 26 Doctoral students. On the post-doctoral level and above, ECVS include 30 Visiting Scientists, two Mid-Career Visiting Scientists (awardees covered by the regular Budget), 13 Senior Visiting Scientists, and 62 Postdoctoral Scientists (which include four Fellows covered by the Regular Budget, three Fellows funded by the external budget from the Mark Foundation for Cancer Research, and two from Children with Cancer UK, and five Fellows extended on the Scientific Branches' budget).

178. Of the 214 fixed-term staff, an *increase* of seven compared to 2023, 98 (**45.79%**) are Professional staff, an *increase* of **eight**, of which seven were women (39 men; 59 women) and 116 (**54.21%**) are General Service Staff, a *decrease* of **one** (30 men; 86 women); in addition, there are 23 temporary staff members, a *decrease* of **two**. Of the 98 Professional staff, 18 (*increase of two*) are in the support services.

179. The number of staff positions on the Regular Budget *has decreased*, with a total of 150.7 approved staff posts in 2024–2025 funded through the assessed contributions of Participating States, compared with 153.2 posts in 2023. While a number of regular budget positions were vacant, human resources were assured for the implementation of programmes through the hiring of temporary resources while recruitments are ongoing.

180. 31% of staff from the General Services and 26% of Professional staff are covered by the Regular Budget. In 2023, 32% of staff from the General Services and 24% of Professional staff were covered by the Regular Budget. The increase is due to higher levels of completed competitive recruitments during the year.

181. The total evolution of staff positions funded by the Regular Budget since 2015 to date is reported in [Table 9](#) and in [Figures 7](#) by types of position. Since 2015, the number of staff positions funded by the Regular Budget *has decreased* ([Figure 7a](#)), the number of temporary positions *has increased* ([Figure 7b](#)), and the number of Professional staff *has decreased* ([Figure 7c](#)).

182. As noted above, the Agency has more women than men in Professional staff positions (**59.2%** as of **29 February 2024**). At the senior level (P4 and P5 and above), the proportion of women is *lower in the P5 and above category* (50% P4, 20% P5 and above), noting that there are currently a number of positions at P4 level and above under recruitment, which affords the Agency an opportunity to further improve gender representation.

183. Overall, IARC staff members come from 41 different countries worldwide, as first nationality with a total of 44 nationalities represented at the Agency. Of the staff on fixed-term contracts, **87.9%** are from Participating states (**188 out of 214**).

184. The period since the last GC session has been characterized mostly by the departure and appointment of several staff members, as reported below.

#### *Resignations*

Dr Tamas Landes, D1, Director of Administration & Finance

Ms Elisabeth Françon, P4, Administrative Services Officer

Ms Laura Brispot, LY4, Project Assistant

Dr Nickolas Myles, P2, Systematic Reviewer

Dr Claire Renard, LY5, Senior Research Assistant (Data Management & Analysis)

Ms Dominique Meunier, LY5, Project Assistant (Biobank)

#### *Completion of Appointments*

Dr Jean-Damien Combes, P2, Scientist

Dr Catherine de Martel, P3, Scientist



*Retirements or pre-retirements*

Dr Véronique Bouvard, P2, Scientist

Dr Ian Cree, P5, Scientist

Dr Fatiha El Ghissassi, P2, Scientist

Mr Eric Masuyer, LY5, Senior Research Assistant (Data Management & Analysis)

Ms Agnès Meneghel, LY6, Assistant (Documents)

Ms Hélène Renard, LY5, Senior Research Assistant (Data Management & Analysis)

*Fixed-term appointments:*

Ms Natalia Alves de Oliveira Vaz, LY4, Project Assistant

Dr Shaymaa Alwaheidi, P1, Project Officer

Dr Ievgeniia Chicherova, P1, Project Officer

Ms Claudia Culierat, LY4, Administrative Assistant

Dr Caterina Facchin, P2, Scientist

Dr Agneta Kiss, LY4, Research Assistant (Lab Services)

Mr Robert Ligorred, LY3, Procurement Clerk

Dr Daniela Mariosa, P2, Scientist

Ms Sandra Moreno Ayala, LY4, Project Assistant

Mr Nickolas Myles, P2, Systematic Reviewer

Dr Luciana Neamtii, P2, Scientist

Dr Elisa Pasqual, P2, Scientist (Epidemiology)

Mr David Ritchie, P1, Project Officer

Mr Mathieu Rose, LY5, IT Database and Web Developer

Dr Harriet Rungay, P1, Epidemiologist

Dr Mehrnaz Shamalnasab, P1, Project Officer

Dr Arunah Chandran, P2, Public Health Officer

Dr Aline de Conti, P2, Scientist

Dr Aida Ferreiro-Iglesias, P2, Scientist

Dr Gabrielle Goldman-Levy, P3, Pathologist

Ms Niree Kraushaar, LY4, Information Assistant

Ms Catarina Nobre Marques, LY4, Information Assistant

Dr Mahdi Sheikh, P2, Scientist

Dr Shama Virani, P2, Scientist

Dr Roland Wedekind, P2, Scientist

Dr Ana Caroline de Carvalho Peters, P2, Scientist

#### 4.5 IARC Advisory Groups, awards and learning programmes

185. The IARC Equity and Diversity Advisory Group (EDAG) was established in 2020 to focus on institutional challenges of inclusion and diversity at IARC and to provide the Director with specific, concrete recommendations on how to implement equitable practices.

186. EDAG launched a call for nominations for the second annual IARC Award for Women in Cancer Research on 24 February 2023. Established in 2022, this award recognizes outstanding contributions in the field of cancer prevention research by scientists who identify as women. IARC welcomed Professor Neerja Bhatla, Head of the Department of Obstetrics and Gynaecology at the All India Institute of Medical Sciences in New Delhi, India, to the new IARC headquarters building in Lyon, France, to receive the 2023 IARC Award for Women in Cancer Research.

187. A Working Group on disability awareness was created in 2023. The inaugural meeting covered a range of topics, including the breadth of the disability inclusion agenda, maternity leave considerations, challenges in navigating information and procedures, the value of designated support personnel, and the accessibility of WHO resources for IARC staff (e.g. clarification on whether WHO funds could cover IARC staff accommodation requests). It was decided that the initial goal should be to collect information on resources that were available.

188. IARC participated in the WHO-wide launch seminar titled "PROUD TO BE WHO: Leaving no one behind through implementation of the UN Disability Inclusion Strategy." This participation demonstrates IARC's commitment to continuous learning and engagement with broader diversity, equity, and inclusion efforts.

189. To foster a culture of collaboration, the IARC Reward and Recognition programme aims to encourage all personnel to nominate their colleagues who make an outstanding contribution to the Agency's success by displaying behaviours aligned with the IARC/WHO Values Charter. The programme runs on a yearly basis. Four awards are given each year in the following categories: Champions of collaboration and teamwork, champions of caring about people, champions of commitment to excellence in health research, and champions of integrity who can be consistently trusted to serve public health.

190. Dr Freddie Bray, the Head of the IARC Cancer Surveillance Branch, received the Outstanding Contribution to Cancer Control Award in the Civil Society category at the Union for International Cancer Control (UICC) World Cancer Leaders' Summit 2023, held in Long Beach, California.

191. Dr Pauline Boucheron, a postdoctoral scientist in the Environment and Lifestyle Epidemiology Branch at IARC, was awarded one of five Quality of Life prizes by the Association Ruban Rose at a ceremony at the French National Assembly in Paris on 18 October 2023. The €150 000 award will fund research for Dr Boucheron's project Virtual RealITy and mUsic in the Oncology SETting (VRtuose), which aims to improve the quality of life of patients with breast cancer who are undergoing chemotherapy through a tool that combines virtual reality with music.

192. At the 31<sup>st</sup> Annual Meeting of the Korean College of *Helicobacter* and Upper Gastrointestinal Research and International Symposium on *Helicobacter* and Upper Gastrointestinal Diseases and the 19<sup>th</sup> Korea–Japan Joint Symposium on *Helicobacter* Infection, Dr Jin Young Park from the EPR Branch at IARC received the Best Oral Presentation Award for her presentation on IARC's role in the Accelerating Gastric Cancer Reduction in Europe through *H. pylori* Eradication (EUROHELICAN) project.

193. Call for Elections for the Staff Association Committee (SAC) were announced in April 2023. The new SAC includes eight staff members, elected by the IARC staff, that met regularly since April with management and with representatives from the other WHO Regional Staff Associations.

194. As part of the Learning and Development (L&D) Framework implementation, close to 70% of personnel engaged in recommended learning and development activities throughout 2023. In addition, to facilitate smooth adaptation to the new facility, a substantial number of institutional briefing sessions were attended by more than 200 participants focusing on fire safety protocols and the optimal utilization of IT and audio-visual resources. In alignment with the Agency's commitment to ensuring a safe work environment and promoting health consciousness and a culture of support/care, approximately one-third of IARC colleagues received training in essential first-aid techniques.

195. The transition to the new building facilitated a shift from online training to a blend of face-to-face and hybrid learning approaches, offering participants greater flexibility. Face-to-face interactions significantly enrich learning experience, HRO and LCB are committed to provide such opportunities whenever feasible. Throughout 2023, a total of 29 recommended training sessions—conducted in face-to-face, hybrid, or online instructor-led formats—were internally promoted and organized by HRO and LCB, attended by 358 participants, as detailed in [Tables 10](#).

196. The compliance rate for the two online mandatory trainings aimed at enhancing cybersecurity awareness and promoting proactive measures against cyber-attacks exceeded by 91% at the beginning of 2024. Similarly, the revised version of the mandatory data protection general awareness training achieved a compliance rate of 91%, reflecting significant efforts to align practices with current data protection standards. Additionally, a compliance rate of 94% was attained for mandatory trainings focusing on abusive conduct and sexual misconduct, aimed at equipping IARC personnel with guidance, tools, and techniques to prevent and address such behaviors. In line with the Agency's commitment to maintain the highest standards of integrity, ethics, and professionalism, a specific ethics empowerment mandatory training was launched. Furthermore, to enhance awareness of reporting mechanisms and procedures available to personnel when confronted with unethical behavior or wrongdoing, a comprehensive list of IARC specific guidance, policies, and focal points was promoted.

197. In the framework of the Quality of Work Life (QWL) work plan and in the light of the Respectful Workplace initiative, efforts were dedicated to promoting WHO colleague-led online sessions related to prevention and management of abusive behavior and sexual misconduct, emotional intelligence, career management, efficient team, and performance management. These online learning opportunities were completed by 219 participants. In addition, close to 70 participants engaged in a variety of team level exercises and/or coaching sessions. These sessions aimed at offering support to supervisors, managers, and their teams in strengthening interpersonal relationships, promoting teamwork, and ensuring each team member is aware of their role within the team and their contribution to the workplan.

198. The overall objective of Workplace Well-being (WWIn) Initiative, initially established in 2018, is to promote well-being and respectful work environment at IARC. The composition and functioning of WWIn team were revised in 2023, based on various feedback received through the QWL initiative. Greater emphasis was placed on harmonization of practices, continuous coordination and communication of processes used by various focal points engaged in the promotion of harmonious work environment. The team endeavours to propose solutions, initiatives, learning and development opportunities, and preventive measures to address systemic issues as well as specific situations. Additionally, IARC colleagues

are actively participating in WHO Respectful, Safe and Healthy Work Environment Steering Committee with specific focus on enhancing collaboration, coordination, and synergy in promoting positive workplace culture across all WHO regions and agencies.

#### **4.6 Update on Resource Mobilization : the Nouveau Centre**

199. A detailed update on “Working Group to examine IARC infrastructure projects – Update on resource mobilization efforts and Nouveau Centre building” is provided in [Document GC/66/13](#). This document records the end of the project on the Nouveau Centre and the dissolution of the sub-committee. The Secretariat warmly thanks the Governing Council for its guidance.

## ANNEXES

Tables and Figures are listed in order of appearance in the text.

**Table 1: Total article output and percentage of peer-reviewed papers**

Year	Peer-reviewed articles	Reviews	Other	Total
2019	292 (79%)	43	36	371
2020	387 (82%)	43	40	470
2021	350 (82%)	41	35	426
2022	319 (79%)	45	42	406
2023	293 (78%)	42	39	374

**Table 2: IARC h-index for 2023 and for five-year period (2019–2023)**

	2023 output	Five-year output (2019–2023)
<b>Number of articles</b>	374	2107
<b>Sum of the times cited</b>	1296	86460
<b>Average citations per item</b>	3.47	41.03
<b>h-index</b>	14	99

**Table 3: IARC top 10 most cited articles published in 2023**

Reference	Total times cited (as of 22 Feb 2024)
Morgan E, Arnold M, Gini A, Lorenzoni, Cabasag CJ, Laversanne M, et al. Global burden of colorectal cancer in 2020 and 2040: incidence and mortality estimates from GLOBOCAN. Gut. 2023;72(2):338-44.	190
Singh D, Vignat J, Lorenzoni V, Eslahi M, Ginsburg O, Lauby-Secretan B, et al. Global estimates of incidence and mortality of cervical cancer in 2020: a baseline analysis of the WHO Global Cervical Cancer Elimination Initiative. Lancet Glob Health. 2023;11(2):E197-E206.	140
Cui FQ, Blach S, Mingiedi CM, Gonzalez MA, Alaama AS, Mozalevskis A, et al. Global reporting of progress towards elimination of hepatitis B and hepatitis C. Lancet Gastroenterol Hepatol. 2023;8(4):332-42.	34
Hauptmann M, Byrnes G, Cardis E, Bernier MO, Blettner M, Dabin J, et al. Brain cancer after radiation exposure from CT examinations of children and young adults: results from the EPI-CT cohort study. Lancet Oncol. 2023;24(1):45-53.	33
Lawler M, Davis L, Oberst S, Oliver K, Eggermont A, Schmutz A, et al. European Groundshot-addressing Europe's cancer research challenges: a Lancet Oncology Commission. Lancet Oncol. 2023;24(1):E11-E56.	29
Sheikh M, Roshandel G, McCormack V, Malekzadeh R. Current Status and Future Prospects for Esophageal Cancer. Cancers. 2023;15(3):29.	23
Vaccarella S, Georges D, Bray F, Ginsburg O, Charvat H, Martikainen P, et al. Socioeconomic inequalities in cancer mortality between and within countries in Europe: a population-based study. Lancet Reg Health-Eur. 2023;25:13.	23
Luo GF, Zhang YT, Etxeberria J, Arnold M, Cai XY, Hao YT, et al. Projections of Lung Cancer Incidence by 2035 in 40 Countries Worldwide: Population-Based Study. JMIR Public Health Surveill. 2023;9(1):15.	23
Bergengren O, Pekala KR, Matsoukas K, Fainberg J, Mungovan SF, Bratt O, et al. 2022 Update on Prostate Cancer Epidemiology and Risk Factors-A Systematic Review. Eur Urol. 2023;84(2):191-206.	22
Jubber I, Ong S, Bukavina L, Black PC, Compeérat E, Kamat AM, et al. Epidemiology of Bladder Cancer in 2023: A Systematic Review of Risk Factors. Eur Urol. 2023;84(2):176-90.	22

**Figure 1: Altmetric database summary report of IARC 2023 output**



Report for **Attention highlights for articles** from the **full Altmetric database** sorted by **Altmetric Attention Score** published between **2023-01-31** and **2023-12-31** affiliated with **International Agency for Research on Cancer**

REPORT OVERVIEW



Total mentions

14,041

Total number of mentions for research outputs in this report



Research outputs

364

Total number of research outputs in this report, including those without mentions



Outputs with mentions

339

Total number of research outputs in this report that have Altmetric mentions



Sources of attention

11

Number of attention sources that mention research outputs in this report

ATTENTION SOURCE BREAKDOWN

The number of mentions from each source that Altmetric has tracked for the research outputs in this report.



News mentions

2,008



Blog mentions

101



Policy mentions

7



Patent mentions

29



X mentions

11,714



Peer review mentions

10



Facebook mentions

95



Wikipedia mentions

18



Reddit mentions

42



Faculty Opinions  
mentions

1



YouTube mentions

16

**Table 4: Visitors to IARC websites in 2023 (in brackets corresponding figures in 2022)**

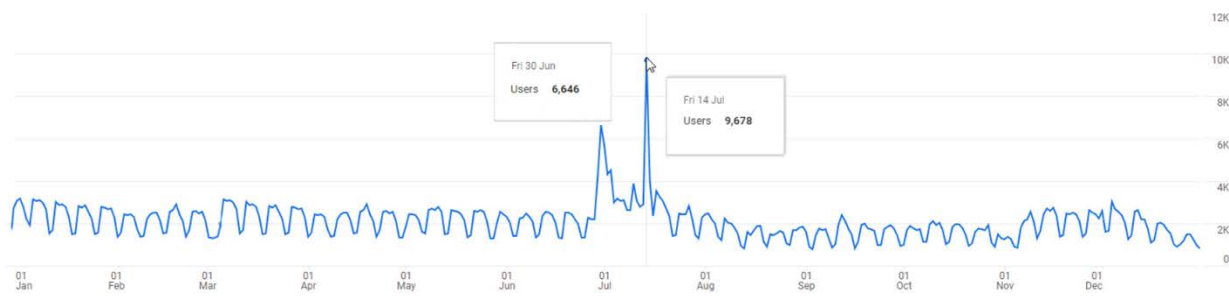
Website	Total visitors	Average visitors/day	Total visits	Average visits/day
<a href="http://www.iarc.who.int">www.iarc.who.int</a>	653 125 (616 267)	1789 (1688)	931 580 (807 489)	2552 (2212)
<a href="#">IARC Publications</a>	337 952 (298 090)	926 (816)	482 642 (387 914)	1322 (1062)
<a href="#">Monographs</a>	321 541 (226 442)	881 (620)	465 138 (361 191)	1274 (989)
<a href="#">Global Cancer Observatory</a>	597 998 (606 256)	1638 (1660)	1 207 423 (1 026 551)	3308 (2812)

*Visitor/User: A user that visits a given site. The initial session by an individual user during any given date range is considered to be an additional visit and an additional visitor. Any future sessions from the same user during the selected time period are counted as additional visits, but not as additional visitors.*

*Visit/Session: The number of times a visitor has been to the site (number of individual sessions initiated by all visitors).*

*If a user is inactive on the site for 30 minutes or more, any future activity will be attributed to a new session.*

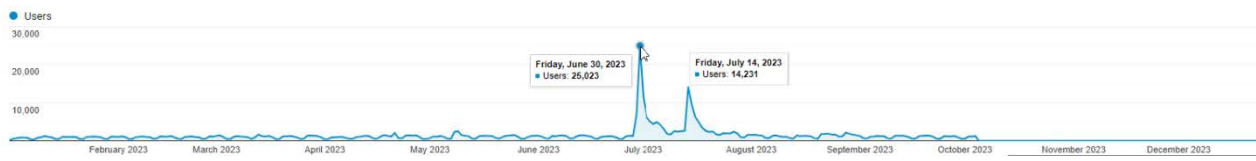
**Figure 2: Number of visitors to the IARC website in 2023**



- The peak of 6646 visitors (30 June 2023) is after the publication of the news item “[Update on IARC Monographs Meeting 134: Aspartame, Methyleugenol, and Isoeugenol](#)”
- The peak of 9678 visitors (14 July 2023) is after the publication of the news item and press release “[Aspartame hazard and risk assessment results released](#)”



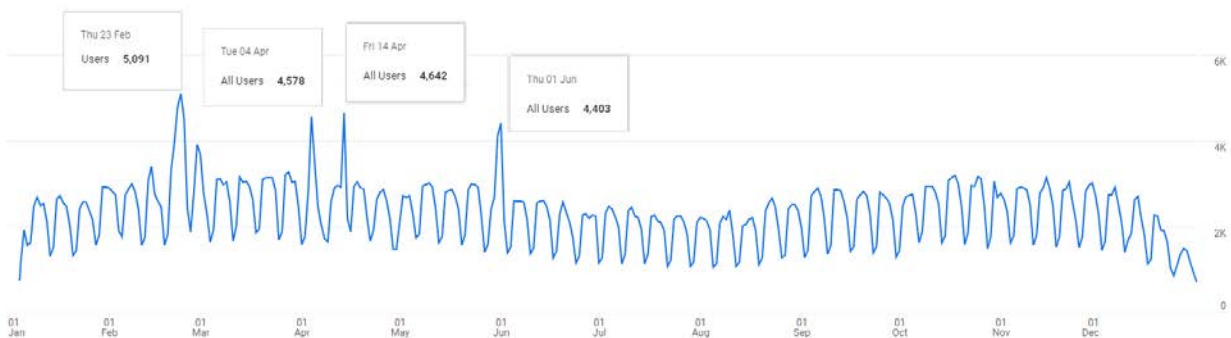
**Figure 3: Number of visitors to the IARC Monographs website in 2023**



- The peak of 25 023 visitors (30 June 2023) is due to a large number of visits to the following webpages:  
<https://monographs.iarc.who.int/news-events/update-on-iarc-monographs-meeting-134/>,  
<https://monographs.iarc.who.int/agents-classified-by-the-iarc/>, and  
<https://monographs.iarc.who.int/list-of-classifications>
- The peak of 14 231 users (14 July 2023) is due to a large number of visits to the following webpages:  
<https://monographs.iarc.who.int/>, <https://monographs.iarc.who.int/agents-classified-by-the-iarc/>, <https://monographs.iarc.who.int/list-of-classifications/>, and  
<https://monographs.iarc.who.int//iarc-monographs-volume-134/>

**Figure 4: Number of visitors to the Global Cancer Observatory (GCO) website in 2023**

- The reasons for the peaks on 23 February, 4 April, 14 April, and 1 June are unknown. On those dates, website visits originated from “direct search” to the GCO website (i.e. users typing in <https://gco.iarc.who.int/> directly).



**Table 5: Most popular downloads from the IARC Publications website ranked by 2023 data and corresponding figures in 2022**

Item	Number of downloads	
	2023	2022
Scientific Publication 163: Molecular Epidemiology: Principles and Practices	63 934	68 692
Monographs Volume 71: Re-evaluation of Some Organic Chemicals, Hydrazine and Hydrogen Peroxide (Part 1, Part 2, Part 3)	42 751	42 209
Cancer Epidemiology: Principles and Methods	35 927	35 962
Monographs Volume 82: Some Traditional Herbal Medicines, Some Mycotoxins, Naphthalene and Styrene	34 226	36 017
Monographs Supplement 7: Overall Evaluations of Carcinogenicity: An Updating of IARC Monographs Volumes 1–42	27 004	15 238
Technical Publication 45: Colposcopy and Treatment of Cervical Precancer	25 465	25 144
Monographs Volume 79: Some Thyrotropic Agents	20 178	20 048
Scientific Publication No. 165: Tumour Site Concordance and Mechanisms of Carcinogenesis	18 571	14 766
Cancer Registration: Principles and Methods	18 032	17 584
Le cancer dans le monde 2003	17 452	18 678
IARC Handbooks of Cancer Prevention Volume 8: Fruit and Vegetables	16 443	21 252
Monographs Volume 73: Some Chemicals that Cause Tumours of the Kidney or Urinary Bladder in Rodents and Some Other Substances	14 925	15 173

**Table 6: Education and Training – IARC Fellowships**

Year	No. of IARC Fellowships awarded <sup>a</sup>	No. of Fellows from LMICs
2014	21 (13 + 8)	12
2015	22 (10 + 12)	13
2016	17 (7 + 10)	10
2017	14 (7 + 7)	12
2018	7 (0 + 7)	6
2019*	7 (7 + 0)	7
2020	9 (2 + 7)	9
2021	9 (7 + 2)	9
2022	8 (1 + 7)	8
2023	9** (9 + 0)	9

*Post-doctoral fellowships (new + second year renewals), including IARC-Australia and IARC-Ireland Fellows in 2014–2015*

*\*Since 2019, only candidates from LMICs have been eligible to apply*

*\*\* Including two fellowships of one year each*

**Table 7: Education and Training – IARC Courses**

Year	No. courses organized	No. different countries	No. courses in LMICs	No. participants
2013	15	7	8	566
2014	17	14	12	576
2015	24	14	11	647
2016*	36	23	19	1410
2017	32	16	15	1324
2018	26	14	11	763
2019	28	18	15	1083
2020*	16	Online		868
2021	21	Online		1851
2022	26	Mostly online		1145
2023	45	Mostly online		2645

*\* Figures differ slightly from those presented in a previous Director's report to the Governing Council, as some additional data were received after its conclusion.*

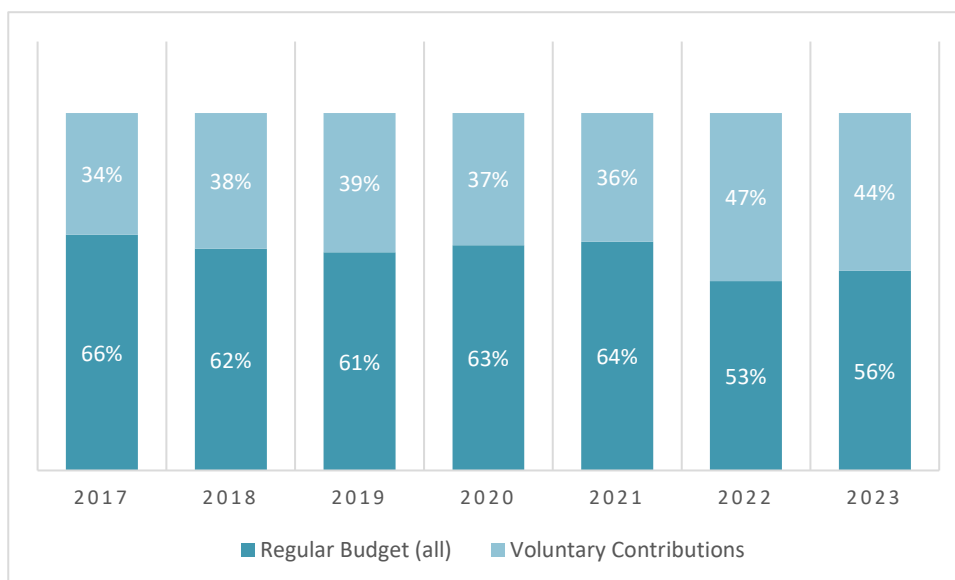
**Table 8: Extrabudgetary funding**

Year	Number of applications	Number of signed contracts	Total value of signed contracts <sup>a</sup> (in Euros)	Value attributed to IARC (in Euros)	Voluntary contribution expenditure <sup>b</sup> (in Euros)
2017	193	65	38 931 975	11 855 145	11 357 348
2018	204	68	20 987 750	9 183 834	13 362 692
2019	236	81	41 488 350	12 408 032	14 365 018
2020	236	94	20 072 571	12 337 370	13 017 438
2021	245	101	36 179 741	19 037 426	13 110 514
2022	203	123	70 342 245	24 378 699	18 776 046
2023	207	109	72 865 808	20 416 518	20 136 952

<sup>a</sup> The figures show total budgets of all grants signed irrespective of whether IARC is coordinating the studies or not.

<sup>b</sup> Voluntary contribution expenditure as reported in the IARC Financial Report and Financial Statements, which includes amount passed through to partners for IARC coordinated projects.

**Figure 5: Percentages of expenditure on Regular Budget and Voluntary Contributions**



**Figure 6: Value of contracts signed in 2023 and top 9 funders (amount in million euros)**

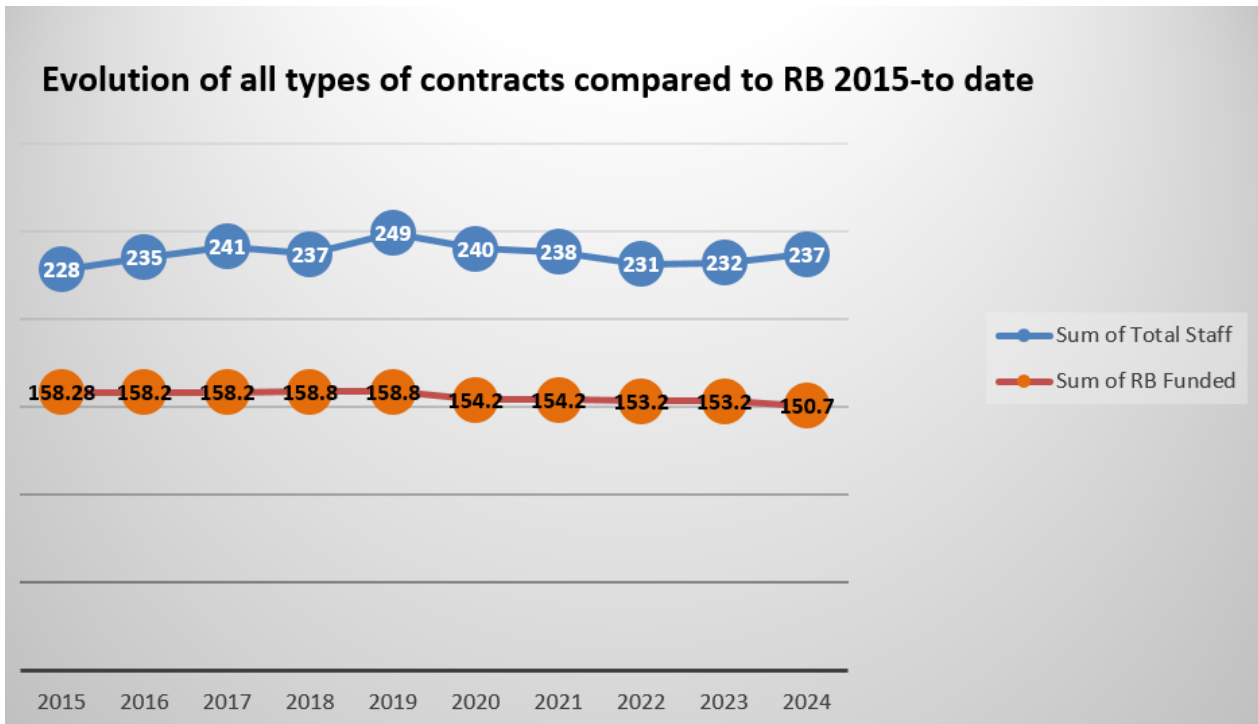


**Table 9: Evolution of staff positions since 2015 to date**

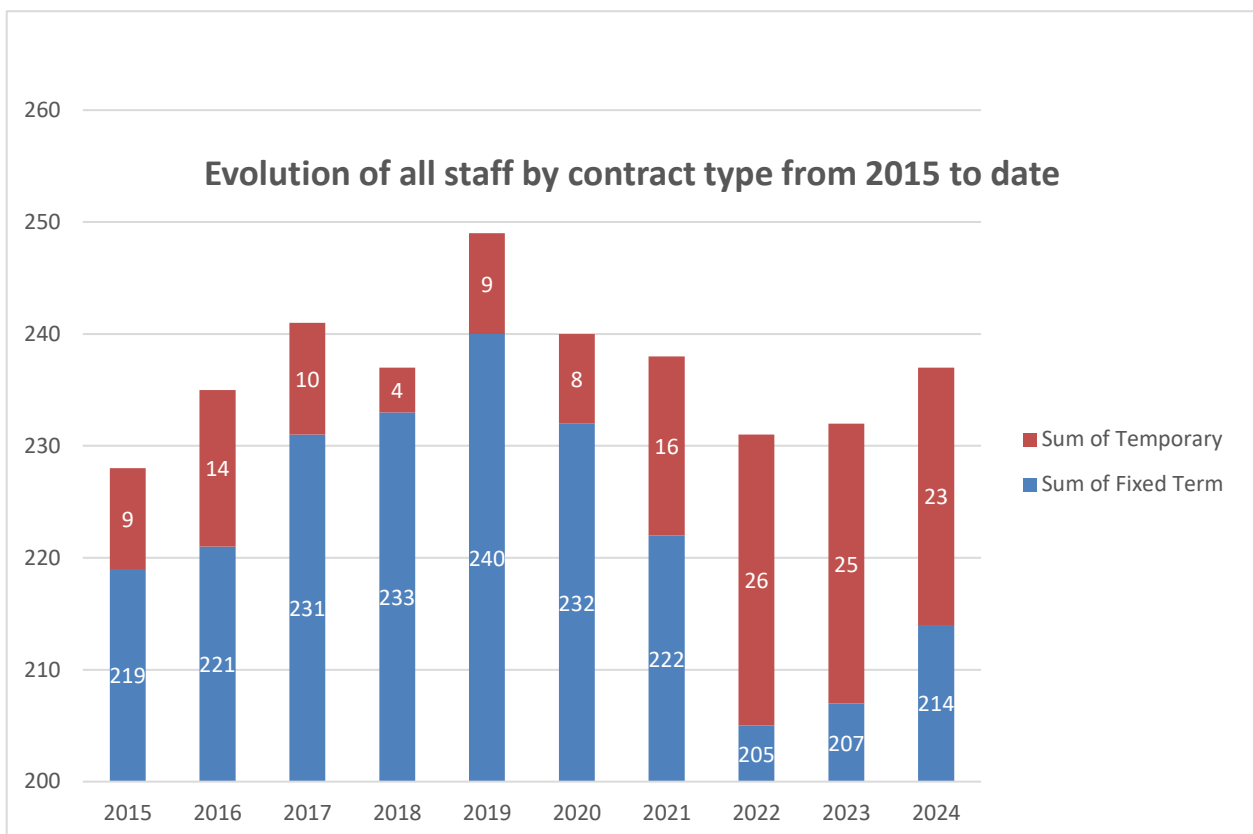
Year	Total Staff	P Total	P Male	P Female	GS Total	GS Male	GS Female	Fixed Term	Temporary	RB Funded
2015	228	99	45	54	120	30	90	219	9	158.28
2016	235	103	49	54	118	29	89	221	14	158.2
2017	241	106	48	58	125	32	93	231	10	158.2
2018	237	102	49	53	131	33	98	233	4	158.8
2019	249	106	50	56	134	38	96	240	9	158.8
2020	240	103	50	53	129	35	94	232	8	154.2
2021	238	98	47	51	124	34	90	222	16	154.2
2022	231	87	41	46	118	32	86	205	26	153.2
2023	232	90	38	52	117	30	87	207	25	153.2
2024	237	98	39	59	116	30	86	214	23	150.7

**Figure 7: Evolution of all staff types since 2015**

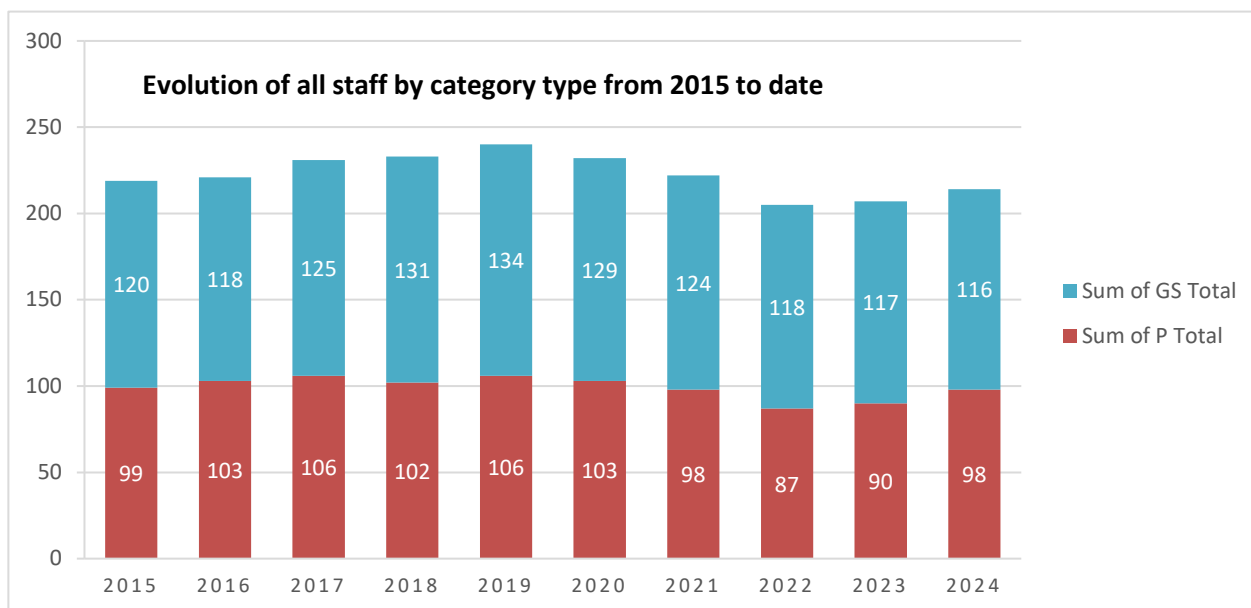
**Figure 7a: Staff funded on the Regular Budget**



**Figure 7b: Temporary versus Fixed-Term staff**



**Figure 7c: General Services (GS) versus Professional (P) staff**



**Table 10: Webinar sessions organized in 2022**

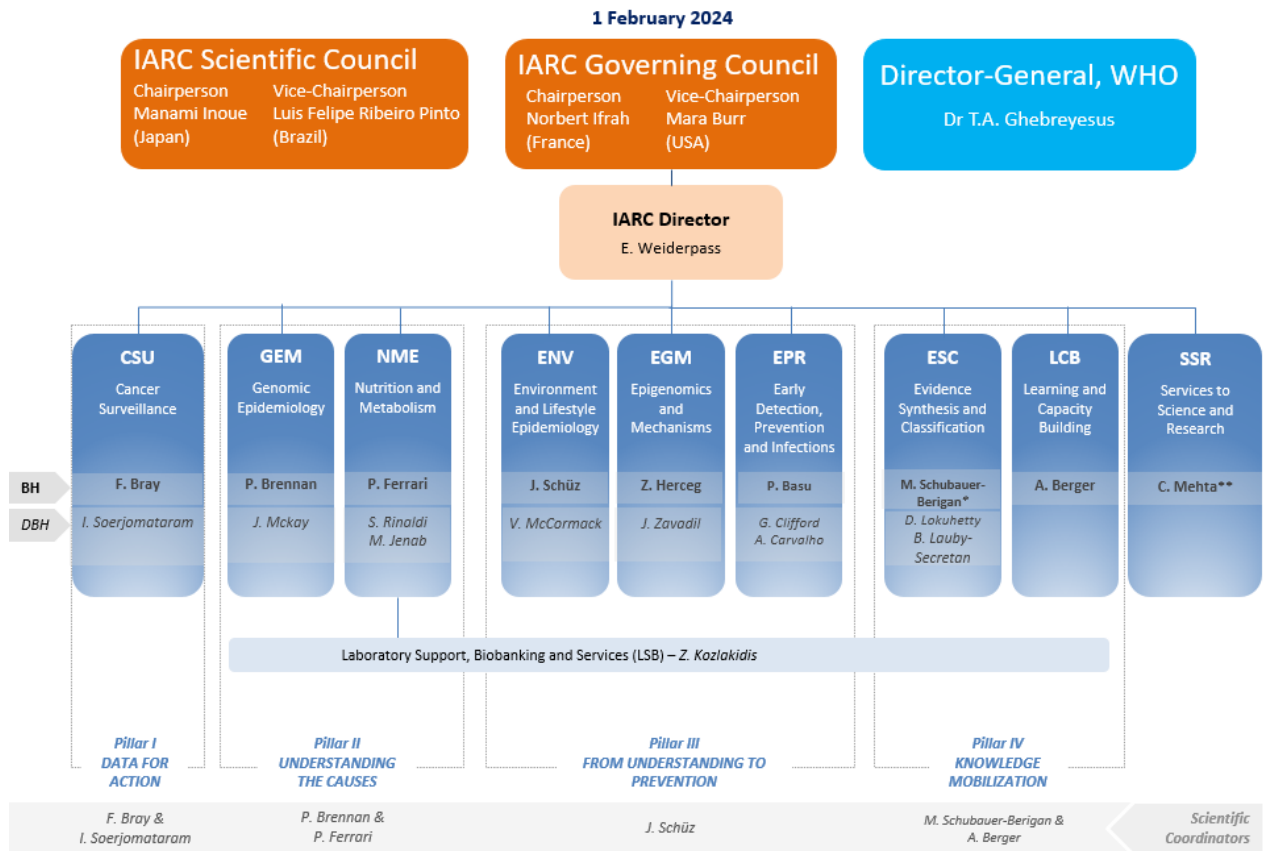
Type of training	No. of training session	No. of participants	
		Staff members	Early career and Visiting Scientists (ECVS)
Core competencies training	19 (19)	96 (185)	74 (72)
Job-specific training	12 (10)	70 (66)	171 (79)
Managerial and leadership training	5 (2)	69 (29)	1 (0)
<b>Total</b>	<b>36 (31)</b>	<b>235 (280)</b>	<b>246 (151)</b>



**Table 10: Trainer-led activities (face-to-face or online) organized in 2023 (in brackets corresponding webinars in 2022)**

Type of recommended training activity	No. of training session	No. of participants	
		Staff members	Early career and Visiting Scientists (ECVS)
Core competencies training	10 (19)	62 (96)	23 (74)
Job-specific training	18 (12)	161 (70)	97 (171)
Managerial and leadership training	1 (5)	13 (69)	2 (1)
<b>Total</b>	<b>29 (36)</b>	<b>236 (235)</b>	<b>122 (246)</b>

**Figure 8: IARC Organizational Structure**



BH = Branch Head (\*Acting / \*\* Ad interim)  
DBH = Deputy Branch Head