

## **Consultation of the World Health Organization on the draft updated Appendix 3 of the Global NCD Action Plan 2013-2020**

1 September 2016

The World Cancer Research Fund International welcomes the update of Appendix 3 of the Global Action Plan on the Prevention and Control of Noncommunicable Diseases 2013-2020 (GAP) and the opportunity to comment on the WHO discussion paper dated 25 July 2016.

### **About World Cancer Research Fund International**

World Cancer Research Fund International leads and unifies a network of cancer prevention charities with a global reach. We are the world's leading authority on cancer prevention research related to diet, weight and physical activity. We work collaboratively with organisations around the world to encourage governments to implement policies to prevent cancer and other noncommunicable diseases (NCDs). In April 2016, we obtained Official Relations status with WHO.

We advocate for the wider implementation of more effective policies that enable people to follow our Cancer Prevention Recommendations<sup>1</sup>. The evidence shows that effective policies will reduce the chances of people developing cancer and other NCDs.

Our NOURISHING policy framework and accompanying database of food policies from around the world contains implemented policies which aim to promote healthy diets to reduce overweight & obesity and nutrition-related NCDs.

More information on World Cancer Research Fund International can be found at:

[www.wcrf.org](http://www.wcrf.org)

[www.wcrf.org/NOURISHING](http://www.wcrf.org/NOURISHING)

### **Contact**

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### **Overview**

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<sup>1</sup> <http://www.wcrf.org/int/research-we-fund/our-cancer-prevention-recommendations> (accessed 30/08/2016).

## SUMMARY OF KEY POINTS

### Policy coherence and multisectoral interventions

- Enhanced policy coherence is necessary to ensure that policy commitments in other sectors such as agriculture, trade and education are developed in such a way that they align with commitments to protect and promote public health.
- We would welcome inclusion of more multisectoral interventions in Appendix 3, in particular for the risk factor of unhealthy diet in objective 3.
- A multisectoral approach calls for collaboration with the private sector, which provides many opportunities, but also an inherent risk of conflict of interest. We recommend expressly mentioning that Member States should develop mechanisms to identify, prevent and manage conflicts of interest when exploring partnerships with the private sector, or engaging with it to support the development and implementation of policies to tackle NCDs.

### Cost-effectiveness and non-financial considerations

- We are concerned by the bolding of a select number of interventions, and the terminology used to distinguish between "very cost-effective and affordable interventions (with WHO-CHOICE analysis)" and "other cost-effective interventions (without WHO-CHOICE analysis)". This could convey that certain interventions have priority over other interventions, in addition to suggesting that cost-effectiveness is the main criterion to use when prioritising among interventions, neglecting that other criteria are equally as important to reflect a Member State's situation (e.g. feasibility or affordability). We therefore recommend investigating how recommended interventions can be presented in a way which does not influence Member State's priority setting.
- We recommend that WHO emphasises more strongly that cost-effectiveness analysis has to be critically judged, and what its limitations are. While it is a useful tool, it is important to mention that other parameters have to be taken into account by Member States when prioritising interventions to account for contextual circumstances.
- The non-financial considerations should be more detailed to be useful to policy makers and health officers, giving greater clarity on the various dimensions of implementation to account for the contextual factors affecting health policy decision making and implementation (e.g. cultural acceptability; political, economic and legal feasibility; need; impact).
- In addition to capacity building in health, we would welcome the recognition that both legal and economic expertise – as well as the ability of citizens to exercise their political and civil rights – are necessary to strengthen the development and implementation of national NCD policies and action plans.

### Calls for research

- We suggest that WHO consider adding a "calls for research" section to the technical appendix to Appendix 3 or the interactive web tool to document and incentivise research needed to close the current gaps in cost-effectiveness data.
- We recommend expressly including implementation research (i.e. how and why health policies were successfully or unsuccessfully put on the political agenda, adopted and implemented) as well as research on the impact of existing policies to the overarching/enabling actions of objective 5 to overcome political barriers to policy development and adoption.

### Strengthening particular objectives

- The overarching/enabling actions under objective 2 need further clarification, in particular by including the necessary steps in the development of an NCD action plan and referencing WHO planning tools and guidance.
- To strengthen the section on unhealthy diet under objective 3:
  - We recommend adding the implementation of WHO's International Code of Marketing of Breast-milk Substitutes and Guidance on ending inappropriate promotion of foods for infants and young children, the WHO Guideline on free sugars intake for adults and children as well as the recommendations of the final report of the WHO Commission on Ending Childhood Obesity;
  - We suggest analysing a more comprehensive set of interventions using the WHO-CHOICE methodology during the next review cycle for interventions addressing overweight & obesity and nutrition-related NCDs;
  - We strongly urge WHO to focus more on mandatory regulation, or at least co-regulatory approaches rather than focusing on interventions which put no obligations on the food industry. More stringent approaches should be recommended for reformulation, limiting portion sizes and restrictions on food and non-alcoholic beverage marketing to children.
- To strengthen objective 6, we recommend explicitly calling for the development of robust monitoring and evaluation processes, including a process to revise national NCD action plans, in addition to providing sufficient financial resources.

### Future updates of Appendix 3

- We support the regular update of Appendix 3 beyond 2020 to accommodate new scientific evidence to reflect a comprehensive policy approach on prevention, treatment and care of NCDs, which can be tailored to national contexts and populations.
- For the next review cycle, we propose investigating how Appendix 3 can put an increased focus on the interaction between risk factors and synergies between the recommended interventions.

## GENERAL COMMENTS

### Selection of interventions

- We recommend that more multisectoral interventions are included in Appendix 3. While this area requires additional research, there are already a number of proven cost-effective interventions that could be included, such as providing healthier school meals and reducing agricultural subsidies for foods used to produce unhealthy ingredients for ultra-processed foods.
- While we welcome the explanation on the advisory, non-exhaustive nature of Appendix 3, we are concerned that without further clarification Member States might judge interventions not listed in Appendix 3 as unimportant. This might impact policy support and funding opportunities for policies which might, in a given country context, have a favourable effect on NCD prevention and control. For example, the section on unhealthy diet in objective 3 does not list nutritional guidelines for schools to ensure that school meals are healthy, and intervention no. D6 only includes preconception care, but not antenatal care.

### Presentation of Appendix 3

The presentation of Appendix 3 has been improved as compared to the original version. We like the distinction between interventions and enabling/overarching actions, as well as the numbering which allows for clear identification of interventions. However, the presentation of Appendix 3 could be further improved by addressing the following issues:

- Cross-referencing within the GAP continues to be necessary which makes using Appendix 3 laborious and inefficient. Appendix 3 still recommends the implementation of “other” policies for objectives 1, 2, 5 and 6. In order to determine these “other” policies, a reader needs to refer to the chapter detailing these policies, and compare them to the ones listed in Appendix 3. Some of these “other policies” either repeat what is in Appendix 3, or refer to WHO guidance documents. This is not practical. All recommended interventions should be contained in Appendix 3 in a logical and harmonised manner so as to enable fast and easy access without the need to cross-reference. At the very minimum, a clear reference should be included to help readers find the relevant page and paragraph in which the “other” policies can be found in the GAP. Ideally, each intervention which WHO deems cost-effective and useful to tackle NCDs should be included in Appendix 3, and not only referred to. The same should apply to relevant guidance.
- Cross-referencing between GAP and WHO guidance documents is still necessary as some interventions refer to WHO guidance (e.g. on diabetes treatment). This means that a reader would need to search for the guidance document and compare it to Appendix 3 to determine which other measures could be taken. Again, this is not practical and unnecessarily complicates the use of Appendix 3. Ideally, all interventions which WHO deems cost-effective and useful to tackle NCDs should be included in Appendix 3, and not only referred to. At a minimum, a clear reference, and ideally a link to the relevant website where the guidance document can be found, should be provided.
- The enabling/overarching actions can be classified into different stages of the policy cycle. Some are preparatory actions (e.g. raising political awareness), some target the development of a policy (e.g. setting targets and indicators) and others focus on implementation and enforcement. This complicates the task of developing a coherent NCD strategy. It would make the use of Appendix 3 easier if there was a clearer distinction between preparatory actions which lay the ground for an NCD action plan, actions supporting the development of a plan, interventions and implementation actions and, lastly, research and monitoring & evaluation (M&E).
- The enabling/overarching actions should also be assigned a number so they can easily be referred to.
- We are concerned by the bolding of a select number of interventions, and the terminology used to distinguish between “very cost-effective and affordable interventions (with WHO-CHOICE analysis)” and “other cost-effective interventions (without WHO-CHOICE analysis)”. This could be misleading by suggesting that the “very cost-effective and affordable” interventions, as well as the bolded ones, have priority over other interventions. Furthermore, it could be inferred that the “other cost-effective interventions” are not affordable.

In addition, this terminology and the bolding suggest that cost-effectiveness is the main criterion to use when prioritising among interventions, neglecting that other criteria are equally as important to reflect a Member State’s situation. This could lead to a dismissal of interventions which could be appropriate and impactful in a given country context, but which have not (yet) undergone a WHO-CHOICE analysis or which would be judged favourably using other criteria than cost-effectiveness (e.g. feasibility, cultural acceptability, affordability, equity and human rights considerations).

We therefore recommend investigating how recommended interventions can be presented in such a way that it does not influence prioritisation.

## Non-financial considerations

- We welcome the inclusion of non-financial considerations in Appendix 3 to reflect on issues around implementation as well as the importance to not solely rely on cost-effectiveness considerations.
- The non-financial considerations should be more detailed to be useful to policy makers and health officers. Greater clarity on the various dimensions of implementation could be included in the interactive web tool to account for the contextual factors affecting health policy decision making and implementation (e.g. cultural acceptability; political, economic and legal feasibility; need; impact; and ethical and human rights considerations).
- Additionally, consider including potential outside risks which Member States may face when trying to implement recommended interventions, and how to mitigate such risks (e.g. investor-state arbitration concerning health policies affecting food, tobacco and alcohol companies).
- We would like to see more language to the effect that cost-effectiveness analysis (CEA) is an important tool, but that it has its limitations. WHO should explain in greater detail that countries have to take into account other parameters when prioritising interventions. Each country is faced with its individual, specific context, challenges and opportunities within which interventions have to be implemented. Therefore, WHO should emphasise more strongly that CEA has to be critically judged, and what its limitations are.

## Additional guidance and tools

We support the proposal for WHO to develop an interactive web tool which could provide nationally adapted information. This tool could:

- expand on non-financial considerations in greater detail;
- include country specific information;
- help identify emerging research;
- link to literature beyond the four main NCDs;
- provide additional information and tools on how to develop and implement an NCD strategy and action plan, e.g. on costing, stakeholder mapping, conducting a situation analysis, priority-setting, and devising an implementation plan;
- feature specific calls for research in key areas to address the current gaps in cost-effectiveness data to help inform future iterations of Appendix 3.

## Methodology

- We welcome the separation of analyses for two income groups, i.e. low and lower-middle income, and upper-middle and high income countries, and the choice of countries.
- To strengthen the robustness of the criteria used to identify new interventions, we would recommend that one study in each of the two country income groups, and at least one strong study from the lower income country group, serve as basis for the analysis (instead of only one published study in a peer reviewed journal).
- Additionally, we would suggest to consider defining a minimum effect size which a new intervention would need to reach to be considered for inclusion. This could increase robustness and credibility of Appendix 3.
- We would welcome more clarity on the interventions under scrutiny for inclusion in Appendix 3. Having access to the list of interventions that have undergone WHO-

CHOICE analysis but failed to demonstrate their cost-effectiveness would also provide further guidance for countries when reassessing their own priority interventions against that list.

- We would also welcome more clarity on how the following two aspects are taken into account in the current methodology:
  - Multisectoral co-benefits of interventions which are likely to have broader social benefits outside the health system;
  - Legal costs incurred by Member States who implement NCD policies against which companies take legal action (e.g. against taxes on sugary drinks or plain-packaging laws for tobacco control).

### Future updates of Appendix 3

- We support the rationale to regularly update Appendix 3 as a continuously evolving section of the GAP to accommodate new scientific evidence as it emerges within the remaining period until 2020. As a vital implementation component of the GAP, Appendix 3 should continue to be strengthened to reflect a comprehensive policy approach on prevention, treatment and care of NCDs which can be tailored to national contexts and populations. To this end, specific calls for research in key areas could be made based on this cycle of updates to help inform future iterations of Appendix 3 in order to increase robustness.
- As the term of the GAP ends in 2020, we support consideration of future updates of Appendix 3 as part of the development of subsequent global strategies to address NCDs.
- We would recommend an update frequency of five years which would allow for sufficient time to gather experience with and evaluate included interventions, whilst giving Member States enough time to react to suggested changes.

## DETAILED COMMENTS ON INTERVENTIONS AND ACTIONS LISTED IN APPENDIX 3

### Objective 1: To raise the priority accorded to the prevention and control of NCDs in global, regional and national agendas and internationally agreed development goals, through strengthened international cooperation and advocacy

- The guidance in this section would need further clarification, in particular regarding how these actions should be carried out. Roles and responsibilities need to be clearly identified and relevant models and best practices should also be referenced.
- We would like to see health equity expressly mentioned as a goal towards which governments should work. We suggest adding "... to ensure health equity" to the overarching/enabling action on integrating NCDs into social and the development agenda (second bullet point).
- In addition to capacity building in health, we would welcome the recognition that both legal and economic expertise – as well as the ability of citizens to exercise their political and civil rights – are necessary alongside medical and public health capacity to strengthen the development and implementation of national NCD policies and action plans.
- We agree that civil society engagement is crucial to advance the NCD agenda. We suggest that the private sector and civil society should be dealt with separately, taking into account respective roles, responsibilities and relevant rules of engagement.

- We would welcome policy coherence to be explicitly mentioned, including agriculture and trade. Both these sectors are part of any development and poverty alleviation strategy, and given the importance of agriculture and trade in shaping the food environment (including alcohol) and the availability of tobacco, they should be expressly included in Appendix 3. It would lend political support to countries which try to work towards policy coherence but face industry opposition.
- “Health workforce training” should be followed by “and retention” (third bullet point).
- It is important to highlight that the private sector is by no means a homogenous group. This umbrella term includes a variety of different actors whose products and practices affect public health in different ways. While partnering with the private sector provides many opportunities, there is an inherent risk of conflict of interest. With respect to partnerships with the private sector, we support WHO’s efforts to ensure that health policy is protected from vested interests. Furthermore, we believe it would be important to expressly mention that Member States should develop mechanisms to identify, prevent and manage conflicts of interest when exploring partnerships with the private sector, or engaging with it to support the development and implementation of policies to tackle NCDs. The Ministry of Health and other government agencies who set health policy have to be protected from vested interests, in particular from those private sector companies producing and selling sugary drinks, infant formula, alcoholic beverages and foods high in fat, salt and sugar.

**Objective 2: To strengthen national capacity, leadership, governance, multisectoral action and partnerships to accelerate country response for the prevention and control of NCDs**

- The overarching/enabling actions in this section would need further clarification on how these actions should be carried out. In particular, the steps<sup>2</sup> necessary to develop an NCD policy and action plan should be laid out clearly. To reflect this, we recommend adding the following overarching/enabling actions:
  - “Conduct a situation analysis to determine the current NCD burden, including risk factors, and map existing NCD capacity, policies and programmes.”
  - “Based on the needs assessment, prioritise interventions to reflect the given national capacity and available budget.”

In addition, we suggest adding the following to the third bullet point on the development of an NCD policy and action plan: “... using WHO planning tools and guidance.” These planning tools<sup>3</sup> could be referenced in Appendix 3 or, alternatively, made available to Member States via the interactive web tool.

- While international cooperation should be strengthened with respect to NCD financing (objective 1), we are of the view that Member States should significantly increase their budget allocated to NCD prevention and control. Many countries still allocate only a small fraction of their health budget to NCDs, and mostly to treatment, not preventative measures. Therefore, we would prefer that “as needed” is deleted from the first bullet

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<sup>2</sup> 1. Situation analysis, including prevalence and incidence of the four main NCDs and risk factors, mapping of existing capacity, policies and programmes  
 2. Needs assessment based on situation analysis  
 3. Stakeholder identification and mapping  
 4. Target setting  
 5. Priority setting  
 6. Development of NCD policy and plan  
 7. Implementation of NCD policy and plan, including enforcement, M&E and revisions

<sup>3</sup> Existing planning tools, for example for assessing capacity such as the SARA (Service Availability and Readiness Assessment), and the forthcoming guidance documents on how to develop an NCD action plan (including a prioritisation tool, how to conduct a situation analysis and stakeholder mapping).

point as it unnecessarily weakens the prioritisation and increase of the budget allocated to NCDs.

- In addition, Appendix 3 only mentions the necessity to explore “viable and innovative” economic financing mechanisms under objective 4. We believe that sustainable and innovative financial solutions to stem the rise in NCDs are necessary for *both* prevention and treatment, and are one of the keys to successfully implementing any NCD strategy. Therefore, a focus on how to finance an increased budgetary allocation to health should be included in objective 2 as one of the overarching/enabling actions.
- We would welcome explicit mentioning that a “multisectoral” approach has to include all relevant ministries, not just academia and civil society alongside the Ministry of Health.
- Regarding our concerns on conflict of interest inherent in a multisectoral approach which calls for an engagement with the private sector, please refer to the last bullet point under objective 1 above.
- We would welcome if leadership was not mentioned under “other policy options”, but as an enabling/overarching action in its own right. A robust governance mechanism is essential to effectively devise and implement a national NCD action plan. It should include all ministries which are relevant in addressing NCDs, and should receive public support by the Head of State.

### **Objective 3: To reduce modifiable risk factors for NCDs and underlying social determinants through creation of health-promoting environments**

For the next review cycle, we propose investigating how Appendix 3 can draw attention to the interaction between risk factors. For example, urban design not only affects the ability of people to be physically active (intervention no. P2), but also determines what type of food is accessible to a population; and alcohol consumption contributes to excessive calorie intake in many countries<sup>4</sup>, thus aggravating unhealthy diets.

#### **Tobacco**

- As an additional overarching/enabling action, countries not party to the Framework Convention on Tobacco Control (FCTC) should be urged to become parties to the FCTC.
- In view of Article 4.7 of the FCTC, we suggest adding “... and participation of civil society” to the second overarching/enabling action.
- We welcome the non-financial consideration of necessary capacity to implement and enforce the FCTC.

#### **Harmful use of alcohol**

- Our research shows that alcohol is linked to an increased risk of developing six common cancers<sup>5</sup>, and WHO’s International Agency for Research on Cancer classified alcohol as a carcinogen<sup>6</sup>. The latest available evidence supports our cancer prevention recommendation that there is no safe level of alcohol consumption: a major literature

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<sup>4</sup> For example, the Centres for Disease Control, estimates that the US adult population consumed an average of almost 100 cal/day from alcoholic beverages between 2007 and 2010 (Centres for Disease Control, Calories Consumed from Alcoholic Beverages by U.S. Adults 2007-2010, [www.cdc.gov/nchs/data/databriefs/db110.pdf](http://www.cdc.gov/nchs/data/databriefs/db110.pdf) (accessed 31/08/2016) while the UK Royal Society of Public Health has called for mandatory calorie labelling on alcoholic drinks to help tackle obesity (Royal Society of Public Health, Alcohol Calorie Labelling, [www.rsph.org.uk/our-work/campaigns/alcohol-calorie-labelling-.html](http://www.rsph.org.uk/our-work/campaigns/alcohol-calorie-labelling-.html) (accessed 31/08/2016).

<sup>5</sup> <http://www.wcrf.org/int/cancer-facts-figures/link-between-lifestyle-cancer-risk/alcohol-cancer> (accessed 26/08/2016).

<sup>6</sup> WHO International Agency for Research on Cancer (2012), Consumption of Alcoholic Beverages, *IARC Monographs on the Evaluation of Carcinogenic Risks to Humans*, Volume 100E.

review published in 2016 concluded that regular moderate drinking had no net health benefits compared to abstinence or occasional drinking.<sup>7</sup> According to the 2014 Global Status Report on Alcohol and Health<sup>8</sup>, alcohol is responsible for 5.1% of the global burden of disease and injury, and 3.3 million deaths per year are attributable to alcohol, representing 5.9% of all deaths.<sup>9</sup> Therefore, we would prefer that WHO refer to “alcohol” or “alcohol use” as a lifestyle risk instead of “harmful use of alcohol”. Speaking of “harmful use” implies that moderate consumption of alcohol is not detrimental to health, or may even yield health benefits. WHO should not inadvertently promote the consumption of alcohol in any way, even if it is just by implication.

- The presentation of the overarching/enabling actions and the specific interventions is confusing and not in line with the other NCD risk factors. We recommend that as an overarching/enabling action, this section includes only “Implement the Global strategy to reduce harmful use of alcohol”. The specific interventions could then be listed in two tables below under the existing “Specific interventions with WHO-CHOICE analysis” and a new “Other interventions from WHO Guidance (without WHO-CHOICE analysis)”. This would not only make the use of this section easier by graphically demonstrating the cost effectiveness hierarchy of the recommended interventions, but also align it with the presentation of overarching/enabling actions and interventions for the three other NCD risk factors.
- *Intervention no. A1*: The list of fiscal measures should include minimum pricing policies alongside increased alcohol taxes, as already recommended in the WHO European action plan to reduce the harmful use of alcohol<sup>10</sup>, to account for latest evidence on their effectiveness in tackling alcohol mortality, morbidity and health inequalities.

*Evidence to include minimum pricing policies in intervention no. A1*: A study of minimum pricing of alcoholic beverages in Saskatchewan, Canada led to an overall reduction of consumption of 8.4%, with the highest impact on higher-strength beer (-22%).<sup>11</sup> The same 10% increase in minimum prices in British Columbia, Canada found an overall reduction of consumption of 3%, with the highest reduction for alcoholic sodas and ciders (-13.9%) and wine (-8.9%).<sup>12</sup> This reduced consumption resulted in 9% less hospital admissions due to alcohol consumption<sup>13</sup> and a 32% reduction in alcohol attributable deaths<sup>14</sup> in British Columbia. In the UK, modelling studies have suggested that a minimum unit price for alcohol would significantly reduce hospitalisations and deaths.<sup>15,16</sup> The most recent study showed that a minimum unit price of 50p/unit in Scotland would cut both by 7%.<sup>17</sup> Research indicates that 80% of the lives potentially

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<sup>7</sup> Stockwell T. et al (2016), Do “moderate” drinkers have reduced mortality risk? A systematic review and meta-analysis of alcohol consumption and all-cause mortality, *Journal of Studies on Alcohol and Drugs* 77:2, pp186-98.

<sup>8</sup> [http://www.who.int/substance\\_abuse/publications/global\\_alcohol\\_report/en/](http://www.who.int/substance_abuse/publications/global_alcohol_report/en/) (accessed 26/08/2016).

<sup>9</sup> WHO (2016), Global status report on alcohol and health 2014.

<sup>10</sup> <http://www.euro.who.int/en/health-topics/disease-prevention/alcohol-use/publications/2012/european-action-plan-to-reduce-the-harmful-use-of-alcohol-20122021> (accessed 26/08/2016).

<sup>11</sup> Stockwell T. et al (2012), The Raising of Minimum Alcohol Prices in Saskatchewan, Canada: impacts on consumption and implications for public health, *American Journal of Public Health* 102:12, pp103-10.

<sup>12</sup> Stockwell T. et al (2012), Does minimum pricing reduce alcohol consumption? The experience of a Canadian province, *Addiction* 107:5, pp912-20.

<sup>13</sup> Stockwell T. et al (2013), Minimum alcohol prices and outlet densities in British Columbia, Canada: Estimated impacts on alcohol-attributable hospital admissions, *American Journal of Public Health* 103:11, pp2014-20.

<sup>14</sup> Zhao J. et al (2013), The relationship between minimum alcohol prices, outlet densities and alcohol-attributable deaths in British Columbia, 2002-09, *Addiction* 108:6, 1059-69.

<sup>15</sup> Holmes J. et al (2014), Effects of minimum unit pricing for alcohol on different income and socioeconomic groups: a modelling study, *Lancet* 383, pp1655-64.

<sup>16</sup> Meier P. et al (2016), Estimated effects of different alcohol taxation and price policies on health inequalities: a mathematical modelling study, *PLOS Medicine* 13:2.

<sup>17</sup> Angus C. et al (2016), Model-based appraisal of the comparative impact of Minimum Unit Pricing and taxation policies in Scotland: An adaptation of the Sheffield Alcohol Policy Model version 3, Sheffield Alcohol Research Group, School of Health and Related Research (SchARR), University of Sheffield.

saved by introducing minimum pricing in England would be from lower income groups, suggesting that the policy would contribute to reducing health inequalities.<sup>18</sup>

- *Intervention no. A5:* With respect to non-financial considerations for psychosocial interventions, we would welcome mentioning of social acceptability of psychosocial treatment.

## Unhealthy diet

- Examples of implemented government policies from around the world promoting healthy diets can be found on [www.wcrf.org/NOURISHING](http://www.wcrf.org/NOURISHING).
- We welcome the separation of the risk factors of unhealthy diet and physical inactivity, and commend the addition and further clarification of interventions listed in this section.
- For the next review cycle, we suggest investigating how Appendix 3 can put an increased focus on synergies between the recommended interventions. An NCD policy which includes a comprehensive package of interventions not only results in larger health gains, but would likely have a positive cost-effectiveness profile.<sup>19</sup>
- We note that interventions with WHO-CHOICE analysis seem to mostly address cardiovascular disease (CVD) rather than all three main nutrition-related NCDs (cancer, CVD, type 2 diabetes) or overweight & obesity more broadly. In light of the high prevalence and increasing incidence of overweight & obesity<sup>20</sup> and nutrition-related NCDs, this seems inadequate.
- We therefore recommend to analyse a more comprehensive set of interventions using the WHO-CHOICE methodology during the next review cycle as more cost-effectiveness data becomes available for interventions addressing overweight & obesity and nutrition-related NCDs.
- We recommend adding the following three overarching/enabling actions:
  - “Implement the WHO Guideline on free sugars intake for adults and children.”<sup>21</sup>
  - “Implement the recommendations of the final report of the WHO Commission on Ending Childhood Obesity.”<sup>22</sup>
  - “Implement the WHO’s International Code of Marketing of Breast-milk Substitutes<sup>23</sup> and the WHO Guidance on Ending inappropriate promotion of foods for infants and young children<sup>24</sup>.”
- We strongly urge the WHO to focus more on mandatory regulation, or at least co-regulatory approaches rather than focusing on interventions which put no obligations on the food industry. Voluntary actions, e.g. on food marketing to children or reformulation, have generally shown to be effective only when incentivised through an underlying “threat” of legislation. More stringent approaches would be recommended for:

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<sup>18</sup> Meier, P. et al (2016), Estimated effects of different alcohol taxation and price policies on health inequalities: a mathematical modelling study, *PLOS Medicine* 13:2.

<sup>19</sup> Cecchini M. et al (2010), Tackling of unhealthy diets, physical inactivity, and obesity: health effects and cost-effectiveness, *Lancet* 376, pp1775-84.

<sup>20</sup> Overweight & obesity increase not only the risk for cardiovascular disease and type 2 diabetes, but also 11 common cancers: <http://www.wcrf.org/int/cancer-facts-figures/link-between-lifestyle-cancer-risk/weight-cancer> (accessed 26/08/2016).

<sup>21</sup> WHO (2015), Guideline: Sugars intake for adults and children ([http://apps.who.int/iris/bitstream/10665/149782/1/9789241549028\\_eng.pdf?ua=1](http://apps.who.int/iris/bitstream/10665/149782/1/9789241549028_eng.pdf?ua=1)) (accessed 01/09/2016).

<sup>22</sup> <http://www.who.int/end-childhood-obesity/final-report/en/> (accessed 31/08/2016).

<sup>23</sup> [http://www.who.int/nutrition/publications/code\\_english.pdf](http://www.who.int/nutrition/publications/code_english.pdf) (accessed 30/08/2016).

<sup>24</sup> [http://apps.who.int/gb/ebwha/pdf\\_files/WHA69/A69\\_R9-en.pdf](http://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_R9-en.pdf) (accessed 30/08/2016).

- reformulation, not just with respect to salt, trans fat and saturated fat, but also sugar (interventions no. U1 and no. U8);
  - limiting portion sizes (intervention no. U10);
  - restriction on food and non-alcoholic beverage marketing to children<sup>25</sup>.
- Consider including the development of nutrition guidelines and a nutrient profile, or adoption of a WHO-developed nutrient profile, as an overarching/enabling action or as non-financial considerations. This is important given that some of the included interventions require a nutrient profile or nutrition guidelines as a necessary precursor (e.g. nutrient profiling is necessary to guide restrictions on food marketing to children and nutrition guidelines as basis of public awareness campaigns on healthy eating).
  - We suggest considering the inclusion of a new intervention on banning TV advertisement of foods and non-alcoholic beverages high in salt, fat and sugar to children in addition to the overarching/enabling action to implement the WHO recommendations on the marketing of foods and non-alcoholic beverages to children.

*Evidence to include a television food advertisement ban:* Ample evidence exists that food advertising on television has an effect on children's food preferences, purchase behaviour and consumption.<sup>26</sup> A US modelling study<sup>27</sup> estimated that between 14% and 30% of children in the US would not be obese in the absence of television promotion of unhealthy foods. An Australian modelling study<sup>28</sup> on the cost-effectiveness of removing television advertising of foods and beverages high in fat and/or sugar estimated that such a ban would result in 37,000 disability-adjusted life-years (DALY) saved, and in an incremental cost-effectiveness ratio (ICER) of AUD 3.70/DALY.

- However, less research exists on food and non-alcoholic beverage marketing using other channels and techniques than television commercials. Therefore, we would welcome additional research on the cost-effectiveness of interventions targeting specific marketing techniques and channels, in particular sponsorship, use of brand equity characters and licensed characters, commercial messaging on social media and in places where many children might be exposed to marketing, such as sports events. This is an example of the type of research that could be highlighted in a "calls for research" section in Appendix 3 or the interactive web tool.
- *Intervention no. U7:* in addition to subsidies to increase the intake of fruit and vegetables, we would welcome more research on the cost-effectiveness of removing subsidies for agricultural products which are used in ultra-processed foods, such as subsidies for corn that is transformed into very cheap high fructose corn syrup used in both savoury and sweet processed foods.
- *Intervention no. U9:* we welcome the inclusion of taxes on sugar-sweetened beverages. We urge WHO to refer to "sugary drinks" rather than "sugar-sweetened beverages" to reflect WHO's "Guideline: Sugars intake for adults and children<sup>29</sup>" which recommends the reduction of free sugars which includes both added and naturally occurring sugars in honey, syrup, fruit juices and juice concentrates. In addition, introducing taxes on sugar-sweetened beverages would need to be supported by adequate measures such as social marketing campaigns and bans on advertising.

<sup>25</sup> Galbraith-Emami S. and Lobstein T. (2013), The impact of initiatives to limit the advertising of food and beverage products to children: a systematic review, *obesity reviews* 14(12), pp960-74.

<sup>26</sup> Hastings G. et al (2003), Review of research on the effects of food promotion to children, University of Strathclyde (<http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.134.1856&rep=rep1&type=pdf>) (accessed 31/08/2016).

<sup>27</sup> Lennert Veerman J. et al (2009), By how much would limiting TV food advertising reduce childhood obesity?, *European Journal of Public Health* 19 (4), pp365-69.

<sup>28</sup> Magnus A. et al (2009), The cost-effectiveness of removing television advertising of high-fat and/or high-sugar food and beverages to Australian children, *International Journal of Obesity* 33(10), pp1094-102.

<sup>29</sup> [http://apps.who.int/iris/bitstream/10665/149782/1/9789241549028\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/149782/1/9789241549028_eng.pdf) (accessed 31/08/2016).

- *Interventions no. U11 and no. U14:* we recommend adding “to reduce consumption of ultra-processed foods” and “to increase intake of whole foods such as fruit and vegetable” as aims of these two interventions.
- *Intervention no. U14:* we are not sure why WHO recommends the reduction of fibre intake. Fibre forms part of a healthy diet, and is a main component of fruits and vegetables whose increased intake is recommended in the same intervention. We assume this is a mistake which will be corrected in the final version of the updated Appendix 3.

### Physical inactivity

- We welcome the separation of unhealthy diet and physical inactivity, giving physical activity the appropriate attention: physical inactivity is the 4th leading cause of death in the world, causing an estimated 3.2 million deaths/year<sup>30</sup>, while physical activity has been shown to have protective effects against NCDs (e.g. strong evidence exists that physical activity decreases the risk of three cancers<sup>31,32</sup>). However, we regret that only one cost-effective intervention has been identified.
- The non-financial considerations for all interventions should include considerations around cultural and religious acceptability – and gender equality - of physical activity, especially in public spaces.
- *Intervention no. P2:* The non-financial considerations should include ensuring public security (e.g. sufficient policing of streets, sufficient lighting); otherwise, people will not use public space for physical activity.
- *Intervention no. P4:* We would welcome the inclusion of physical exercise in the mandatory school curriculum, and not just as a recreational activity for children. Exercise supports the prevention of overweight & obesity and the subsequent development of nutrition-related NCDs; in addition, a child used to exercise will find it easier to maintain physical activity in adulthood, promoting health throughout the life-course. Including regular physical activity would reflect the whole school approach to promote physical activity as recommended by the WHO Health Promoting Schools policy<sup>33</sup> and the recent 2016 International Charter for Physical Education, Physical Activity and Sports by UNESCO<sup>34</sup>.

### Objective 4: To strengthen and orient health systems to address the prevention and control of NCDs and the underlying social determinants through people-centred primary health care and universal health coverage

- We welcome the overarching/enabling action in the fourth bullet point, “Train health workforce and strengthen capacity of health system particularly at primary care level to address NCDs”. The role of front line health workers is instrumental both in educating the population on NCD prevention, and in delivering integrated care for people with NCDs.
- The overarching/enabling action in the second bullet point, “Explore viable health financing mechanisms and innovative economic tools supported by evidence”, is vague

<sup>30</sup> [http://www.who.int/topics/physical\\_activity/en/](http://www.who.int/topics/physical_activity/en/) (accessed 31/08/2016).

<sup>31</sup> <http://www.wcrf.org/sites/default/files/Obesity-physical-activity-and-cancer-infographic.pdf> (accessed 31/08/2016).

<sup>32</sup> <http://www.wcrf.org/int/cancer-facts-figures/link-between-lifestyle-cancer-risk/physical-activity> (accessed 31/08/2016).

<sup>33</sup> [http://www.who.int/school\\_youth\\_health/media/en/92.pdf](http://www.who.int/school_youth_health/media/en/92.pdf) (accessed 31/08/2016).

<sup>34</sup> <http://www.unesco.org/new/en/social-and-human-sciences/themes/physical-education-and-sport/sport-charter> (accessed 31/08/2016).

and could be strengthened by including concrete examples. Alternatively, consider including more detailed information in the interactive web tool.

- *Intervention no. D6:* We would welcome further research on the cost-effectiveness of antenatal care, as well as counselling on healthy diet and weight for women of reproductive age in addition to preconception care. Furthermore, glucose and weight management prior to conception and during pregnancy should be added.

### **Objective 5: To promote and support national capacity for high-quality research and development for the prevention and control of NCDs**

We welcome a focus on research and development. However, research shouldn't only focus on medical prevention and treatment but also include policy research, both with respect to implementation research (i.e. how and why health policies were successfully or unsuccessfully put on the political agenda, adopted and implemented) and research on the impact of implemented policies on health outcomes. A sufficient evidence base is necessary to overcome political barriers to policy development and adoption, especially in an environment of financial constraints, "nanny state" concerns and private sector opposition. Therefore, policy research should be expressly included in objective 5 as an important part of both national and international research agendas.

### **Objective 6: To monitor the trends and determinants of NCDs and evaluate progress in their prevention and control**

- A situation analysis is a necessary precursor for M&E, as it serves as a baseline against which government activities and progress towards targets can be measured. Without clear knowledge of the current NCD burden (incl. prevalence of risk factors), existing capacity, policies and programmes, Member States cannot track if resources are effectively invested. Therefore, we recommend including the necessity to conduct a situation analysis as an enabling measure. Alternatively, this could be mentioned under objective 2; please refer to our respective comment in the first bullet point under objective 2 above.
- Objective 6 only mentions the inclusion of M&E into national health information systems. However, NCD action plans should include a defined process on how M&E will be conducted, underpinned by earmarked financial resources. We recommend including the strengthening of financial resources, not only human resources, in the second bullet point, and including an additional enabling action on M&E: "Develop robust monitoring and evaluation processes, including a process to revise the NCD action plan."
- Regarding the third bullet point on establishing an NCD surveillance system, we recommend including the necessity that population-based cancer registries should align with the GAP indicators on surveillance.
- We would welcome an additional bullet point on disaggregating data by sex and age to improve morbidity and mortality monitoring.

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