World Cancer Research Fund International response to WHO 3rd discussion paper on a Global Monitoring Framework and Voluntary Global Targets for the Prevention and Control of Non-Communicable Diseases

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Response to 3rd WHO Discussion Paper on a Global Monitoring Framework and Voluntary Global Targets for the Prevention and Control of NCDs

About WCRF International

WCRF International and its four cancer charities[a,b] are dedicated to the prevention of cancer through *food*[2]*, nutrition, physical activity,* and *prevention and control of body fatness.* Our mission is to empower people to make choices today to prevent cancer tomorrow by:

1. Bringing together the scientific research on the relationship between food[c], nutrition, physical activity, body fatness and cancer into recommendations for people and populations to reduce their cancer risk. This involves a continually updated rigorous review process which builds on the WCRF International's *Second Expert Report, Food, Nutrition, Physical Activity, and the Prevention of Cancer: a Global Perspective* (2007), and an expert panel of leading academics.[d]
2. Awarding funding to cutting-edge research on food, nutrition, physical activity, body fatness and cancer. Since 1982, the WCRF network has funded over £85 million worth of research, including research by the WHO Agency, IARC – the International Agency for Research on Cancer.
3. Communicating the evidence and recommendations to scientists, health professionals, policymakers and individuals around the world.
4. Through the four charities[a,] providing science-based information about healthy eating and physical activity. This information is targeted at the supporters of the charities, health professionals, children and their families. The WCRF International Academy also educates young scientists and decision-makers about the relationship between diet, physical activity and cancer.
5. Conducting activities to advance policy at all levels of society. This includes communicating its set of evidence-based policy recommendations for the prevention of cancer.[e]
6. Raising funds through the network of four cancer charities as a means of financing the above activities.

Unique in its focus on prevention, WCRF International works in collaboration with the Union for International Cancer Control (UICC) and other NGOs, as well as the scientific community, in advancing the goal of preventing and controlling non-communicable diseases (NCDs).

a. American Institute of Cancer Research (AICR); World Cancer Research Fund UK (WCRF UK); Wereld Kanker Onderzoek Fonds (WCRF NL); World Cancer Research Fund Hong Kong (WCRF HK).
b. WCRF International and the four charities are collectively referred to as the WCRF global network. WCRF International leads and directs the science and policy activities of the network.
c. Includes alcohol
d. The 'Continuous Update Project' is an ongoing review of cancer prevention research that builds on the WCRF/AICR report Food, Nutrition, Physical Activity, and the Prevention of Cancer: a Global Perspective (2007), a comprehensive analysis of the literature on food, nutrition, physical activity and cancer. Available at: http://www.dietandcancerreport.org
e. WCRF/AICR. Policy and Action for Cancer Prevention (2009): http://www.dietandcancerreport.org/

Summary of the key points in this response

- **We support the inclusion of indicators to collect valuable data on cancer incidence by type and premature mortality from cancer.**

- **The target on obesity and related indicators, including on marketing to children, are a priority for cancer prevention given the strong evidence on the relationship between body fatness and several cancers.**

- **The targets and indicators that relate to unhealthy diet should be strengthened, as the latest draft of the monitoring framework fails to adequately address dietary risk factors for cancer and other NCDs.**

- **The framework needs to clarify and signpost the concrete linkages between each of the targets and indicators, and their importance in addressing risk factors for NCD prevention. This would better enable the indicators to monitor progress towards the targets.**

- **We support the following targets (and related indicators) for unhealthy diet and physical activity as risk factors for cancer and other NCDs:**
    - **TARGET Adult obesity *(proposed by WHO)* and infant obesity *(cross-referenced to maternal, infant and child nutrition action plan)***
        - **INDICATOR Child obesity (aged 5-18) *(new)***
        - **INDICATOR Policies on marketing of HFSS foods to children *(proposed by WHO)***
        - **INDICATOR Total fat intake and added sugar as % of energy intake *(new)***
        - **INDICATOR Inadequate fruit and vegetable consumption *(proposed by WHO)***
        - **INDICATOR Breastfeeding *(new)***
    - **TARGET Harmful use of alcohol *(proposed by WHO)***
        - **INDICATOR Policies on marketing of alcohol to young people *(new)***
    - **TARGET Physical inactivity *(proposed by WHO)***
    - **TARGET Salt intake *(proposed by WHO)***
    - **TARGET Saturated fat intake[*] *(proposed by WHO)***
    - **TARGET Trans fat intake[*] *(new)***

- **The framework should be more explicitly linked with the Global Action Plan on NCDs currently being drafted for 2013-2020. Clearer signposting and referencing to the Global Action Plan is needed to clarify how the targets can be met through specific policy actions and interventions.**

[*]The current evidence does not show that saturated and trans fats are of direct importance for cancer prevention. However we support its inclusion as an important dietary risk factor for other NCDs.

ABOUT THIS RESPONSE

WCRF International welcomes this opportunity to comment on the latest draft of the monitoring framework and voluntary global targets.

Our comments aim to ensure that the monitoring framework is a valuable tool in setting the ambition for, and monitoring progress towards, the target of reducing premature mortality from NCDs by 25% by 2025.

As an organisation, WCRF International has a specific focus on the prevention of cancer through eating a healthy diet, being physically active as part of everyday life, maintaining a healthy bodyweight and limiting the consumption of alcohol. Most of these risk factors are shared with other leading NCDs. Three of the main risk factors for NCDs are directly relevant to our work – unhealthy diet, physical inactivity and alcohol consumption – and the fourth, tobacco, is directly relevant to cancer prevention.

Given WCRF International's mission and expertise, this response focuses on the targets and indicators that are necessary and most relevant to the prevention of cancer through food[1], nutrition and physical activity and, therefore, other NCDs. Following some overarching comments, we set out the targets and indicators we would like to see for cancer prevention, while considering the need for a manageable number. We have based our comments on our scientific and policy reports, which constitute the best available evidence on the relationship between food, nutrition, physical activity, body fatness and cancer[2].

WCRF International has also contributed to the development of the responses from **UICC** and the **NCD Alliance**, and supports those responses.

OVERARCHING COMMENTS ON THE MONITORING FRAMEWORK

We fully support the WHO in its efforts to develop a comprehensive monitoring framework for the prevention and control of NCDs. We congratulate the WHO on securing the target for a 25% reduction in premature NCD mortality by 2025. We see this as an overarching target and anticipate that the full set of targets and indicators will deliver on this ambitious global *goal*. Targets to reduce the most important risk factors for cancer (tobacco, alcohol, unhealthy diet and physical inactivity) are a key component in this effort.

The political importance of targets should not be underestimated in galvanising action across Member States. It is also important that targets are aspirational. The targets should aim to support Member States, NGOs and others to develop and implement policy level actions aimed at reducing risk factors, as called for in paragraph 43 of the UN Political Declaration. Scaled up efforts will provide significant population health benefits and will contribute to the reduction in morbidity and mortality from NCDs and in achieving the overall reduction target of a 25% decrease in premature mortality by 2025.

[1] Includes alcohol

[2] WCRF/AICR (2007) Food, Nutrition, Physical Activity and the Prevention of Cancer: A Global Perspective; WCRF/AICR (2009) Policy and Action for Cancer Prevention

As the WHO notes, comprehensive monitoring and surveillance are important in mapping emerging disease patterns and identifying underlying social, economic and political determinants. We see the monitoring framework as a core pillar of the next Global Action Plan on NCDs (2013-2020), which will also allow Member States to monitor *progress* towards targets and encourage the implementation of policy actions and interventions. For this reason Member States will need technical support in establishing systems for in-country reporting on indicators and progress towards meeting the targets.

We would like to see a monitoring framework that is coherent, with targets that are linked to supporting indicators. There should also be explicit signposting that illustrates the relationship between each target and indicator and the specific policy actions and interventions recommended as part of the Global Action Plan.

WCRF International understands that the priority for WHO is to develop a monitoring framework that is comprehensive and coherent, yet still sensitive to the limited resources and capacity of the Member States. The monitoring framework must also strike a balance in its focus on both the prevention of NCDs and the delivery of health care services and treatment. This is why we have worked constructively with colleagues in other organisations to develop our thinking on this issue and produce carefully considered responses.

The Global Strategy on Non-Communicable Diseases (2000), the Global Action Plan (2008-2013) and the UN Political Declaration on the Prevention and Control of Non-Communicable Diseases (2011) all recognise the need to address the main risk factors for NCDs. WHO has a strong mandate to work in this area and the monitoring framework with targets and indicators is an innovative way to galvanise action by Member States to reduce risk factors.

We have several specific recommendations to the WHO to improve the structure of the monitoring framework:

(a) Explicit linkages between each of the targets and the indicators

WCRF International agrees with WHO that robust indicators should form the foundation of any monitoring framework and that the set of indicators can be more comprehensive than a shorter list of targets. However, we feel that the relationship between the set of voluntary targets and the wider set of indicators needs to be as clear as possible for Member States. Targets – particularly those linked to risk factors – highlight the importance of indicators in helping to monitor progress and can act as an incentive to collect high quality and relevant data. We therefore recommend that each indicator is explicitly linked to a related target, and that each risk factor is covered.

With regards to risk factors for cancer there are several instances where there are no clear linkages between key indicators and targets in the current draft.
For example, the indicator on inadequate fruit and vegetable intake does not have a counterpart target to increase consumption of fruit and vegetables, and nor is it explicitly linked to another target. Similarly, the indicator on policies to reduce the impact of marketing of foods to children does not have a target to reduce the marketing of foods high in saturated fats, trans-fatty acids, free sugars, or salt. Such inconsistencies highlight the fact that the targets are not comprehensive, and that unhealthy diet is an

outstanding challenge to be addressed (see next section). We anticipate that the Global Action Plan (2013-2020) will set out the rationale for policy action and interventions linked to both these indicators, but it is important that the monitoring framework is consistent with the Action Plan. In the absence of additional targets these indicators might be attached to the targets on obesity, salt and saturated fats.

Although not directly relevant to cancer prevention, a similar argument also applies to the indicator on policies to virtually eliminate trans fats from the food supply chain, which no longer has a target to eliminate trans fats attached.

In this regard, we support recommendations by the NCD Alliance in their briefing on a comprehensive monitoring framework, where they suggest alternative ways to present the targets and indicators to highlight their inter-relationships[3].

(b) Adequate coverage of each of the main risk factors

From a cancer prevention perspective, WCRF International supports the targets and indicators on tobacco, alcohol and physical inactivity. However, we have further comments on the targets and indicators for unhealthy diets.

In the current draft, some of the dietary factors associated with reduced risk of cancer have not been included as targets, such as the increased consumption of vegetables, fruit, pulses and wholegrain cereals and the decreased consumption of red meat[4]. Where they have been included as indicators, as in the case of low fruit and vegetable consumption, they are not clearly linked to a target or policy action.

We strongly support the inclusion of a target on obesity, as body fatness has been shown to increase the risk of several cancers, including some common cancers[5]. Yet there is no wider set of indicators for factors associated with obesity and overweight.

(*c) Clear signposting and reference to policy actions and interventions in the Global Action Plan*

Surveillance and monitoring are necessary to track progress and build the case for action but alone will not contribute to achieving the targets. This will require policy action and interventions. As WCRF International stresses in its response to the Discussion Paper on the Global Action Plan (2013-2020), the Action Plan should provide more guidance to Member States on policy actions and interventions that can contribute to achieving the targets. This integration and cross-referencing of the monitoring framework is essential to its success.

SPECIFIC RECOMMENDATIONS ON THE TARGETS AND INDICATORS

Here, we provide recommendations on specific targets and indicators from a cancer prevention perspective. These recommendations are summarised in the Table (p11).

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[3] NCD Alliance Briefing on a Comprehensive Global Monitoring Framework, Indicators and Targets for the Prevention and Control of NCDs, August 2012

[4] WCRF/AICR (2007) Food, Nutrition, Physical Activity and the Prevention of Cancer: A Global Perspective; WHO/FAO (2003) Diet, Nutrition and the Prevention of Chronic Diseases

[5] *Ibid.*

We first make comments on the targets and indicators already proposed by WHO which are relative to cancer prevention, then on targets and indicators not currently proposed relevant to cancer prevention. Finally we have included brief comments on some specific targets and indicators relative to other NCDs.

Comments on proposed targets and indicators relevant to cancer prevention:

(i) Cancer incidence by cancer type and premature mortality from cancer

We support the inclusion of an indicator on cancer incidence by cancer type. Given the diversity of cancers, their different distribution globally, and amenability to primary prevention, early detection and treatment, such data are important to inform cancer control programmes globally. Efforts to improve data coverage will particularly benefit planning in low- and middle-income countries. Similarly, we support the inclusion of an indicator on premature mortality from NCDs (including cancer) so that we continue to have a picture of the global burden of cancer, other NCDs, and their importance relative to other diseases.

We support previous submissions by **UICC** in this regard[6].

(ii) Obesity

WCRF International strongly supports the inclusion of a target and indicators on obesity prevalence. Body fatness independently increases the risk of developing several types of cancers, including oesophageal, pancreatic, colorectal, breast (post-menopause), endometrial, gallbladder and kidney[7]. According to our Second Expert Report and Continuous Update Project (CUP), the evidence that greater body fatness is a cause of these cancers is convincingly or probable. Levels of overweight and obesity are also strongly associated with unhealthy diet and physical inactivity, two of the major risk factors for cancer and other NCDs[8].

Maintenance of a healthy body weight throughout life is one of the most important ways to protect against cancer, and the inclusion of a target on obesity is commensurate to its importance in contributing to the wider NCD epidemic[9]. Furthermore, overweight and obesity continue to be risk factors that Member States are having difficulty in controlling. A target and set of indicators should help mobilise action.

We recommend the inclusion of two further measures to ensure adequate monitoring of overweight and obesity by Member States, which are in line with the recommendations made by the **International Association for the Study of Obesity (IASO)** in their submission to the consultation:

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[6] UICC Submission to WHO Consultations on NCDs (http://www.uicc.org/advocacy/position-papers)

[7] WCRF/AICR (2007) Food, Nutrition, Physical Activity and the Prevention of Cancer: A Global Perspective; WCRF/AICR Continuous Update Project Reports on Breast Cancer (2008) and Colorectal Cancer (2010)

[8] *Ibid.*

[9] World Health Organization (2004) Global Strategy on Diet and Physical Activity

Overweight and obesity in infants (aged 0-5)

- We recommend the incorporation of the recently adopted global target for "no increase in childhood overweight by 2025 for infants and young children under the age of 5 (WHA65[6])", along with an accompanying indicator.

Overweight and obesity in children (aged 5-18)

- We recommend the inclusion of a new indicator on overweight and obesity in children aged 5-18. Further work is needed to determine how best to report on obesity in school-aged children and young people. We recommend that this work is taken forward.

The inclusion of these measures is important since overweight and obese infants, children and young people face many of the same health conditions as adults, and can be particularly sensitive to the effects on their self-esteem and peer-group relationships. Moreover, the most significant outcome of childhood obesity is the likelihood that these children will progress to being obese adults and suffer chronic diseases at a much younger age. Overweight and obesity have been accelerating among these groups (particularly in low- and middle-income countries), but recent data suggests that obesity prevalence is stabilising among certain age groups in some countries[10]. This indicates that a target is achievable.

There is also an increasing body of evidence available on how this target could be achieved by Member States[11]. Mounting modelled evidence also provides policy-relevant guidance, indicating that obesity prevention policies are likely to be highly effective and cost-effective (usually cost-saving)[12].

Analyses, including by the OECD, have shown that policy interventions such as restrictions on unhealthy food marketing to children, traffic light food labelling, and health-related taxes on certain foods are cost-effective for reducing obesity[13].

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[10] World Health Organization, Maternal, Infant and Young Child Nutrition: Comprehensive Implementation Plan, 2012

[11] Waters E, de Silva-Sanigorski A, Hall B, Brown T, KJ C, Gao G, et al. Interventions for preventing obesity in children, update to Cochrane Review. 2011; Millar L, Kremer P, de Silva-Sanigorski A, McCabe MP, Mavoa H, Moodie M, et al. Reduction in overweight and obesity from a 3-year community-based intervention in Australia: the 'It's Your Move!' project. Obes Rev 2011;12 Suppl 2:20-8; de Silva-Sanigorski AM, Bell AC, Kremer P, Nichols M, Crellin M, Smith M, et al. Reducing obesity in early childhood: results from Romp & Chomp, an Australian community-wide intervention program. Am J Clin Nutr 2010;91(4):831-40. Sanigorski AM, Bell AC, Kremer PJ, Cuttler R, Swinburn BA. Reducing unhealthy weight gain in children through community capacity-building: results of a quasi-experimental intervention program, Be Active Eat Well. Int J Obes (Lond) 2008;32(7):1060-7

[12] Sacks G, Veerman J, Moodie M, Swinburn B. 'Traffic-light' nutrition labelling and 'junk-food' tax: a modelled comparison of cost-effectiveness for obesity prevention. International Journal of Obesity (2011)

[13] Magnus A, Haby MM, Carter R, Swinburn B. The cost-effectiveness of removing television advertising of high-fat and/or high-sugar food and beverages to Australian children. Int J Obes (Lond) 2009;33(10):1094-102. Sacks G, Veerman JL, Moodie M, Swinburn B. 'Traffic-light' nutrition labelling and 'junk-food' tax: a modelled comparison of cost-effectiveness for obesity prevention. Int J Obes 2011;35(7):1001-9. Sassi F. Obesity and the economics of prevention. Fit not fat. OECD 2010

The WHO should direct efforts at further elaborating the specific actions it recommends to Member States based on the best available evidence. The Global Action Plan (2008-2013) should provide this guidance.

(iii) Alcohol

We support the reinstatement of the target on overall alcohol consumption, as also recommended by the **Global Alcohol Policy Alliance** in this regard[14]. The consumption of alcohol increases the risk of cancers of the mouth, pharynx and larynx, the oesophagus, colorectum (men) and breast cancer[15]. Alcohol has been identified as one of the leading risk factors for death and disability globally, accounting for 3.8% of death and 4.6% of disability adjusted life years (DALYs) lost in 2004.

We recommend that an indicator on policies to reduce the impact of alcohol marketing to young people and adolescents should also be added. There is a strong body of evidence on the effects of marketing on total alcohol consumption[16]. This proposed indicator would complement the target on total adult alcohol consumption.

Given the health harm and significant externalities associated with excessive consumption of alcohol, the indicator should monitor policy action to control the content and volume of exposure.

(iv) Physical Inactivity

We support the continued inclusion of a target to reduce physical inactivity, and we fully support the rationale and arguments produced by the Global Alliance for Physical Activity in this regard[17]. Being physically active has been shown to independently reduce the risk of some of the most common cancers, including colorectal, breast and endometrial cancer[18]. In addition, physical activity is associated with decreased levels of obesity. Physical inactivity has been identified as the fourth leading risk factor for global mortality causing an estimated 3.2 million deaths globally.

One recommendation would be to ensure that the target and indicator capture both vigorous and moderate physical activity. Our recommendation for cancer prevention is to ensure that people are moderately physically active for at least 30 minutes every day. As fitness improves, people should aim for 60 minutes or more of moderate activity or

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[14] Global Alcohol Policy Alliance (2012) Reply to second WHO consultation on monitoring framework and targets for the prevention and control of NCDs. http://www.globalgapa.org/news/news300312/gapa-who-300312.pdf

[15] WCRF/AICR (2007) Food, Nutrition, Physical Activity and the Prevention of Cancer: A Global Perspective

[16] Scientific Opinion of the Science Group of the European Alcohol and Health Forum (2009); Gordon, R, Cooke, E, Hastings, G, and Anderson, A (2004) 'The influence of marketing and advertising by the alcohol industry on young people's alcohol consumption', *prepared for the World Health Organization*

[17] Global Advocacy for Physical Activity (2012) Position Statement: Support for the Inclusion of a Global Target on Physical Activity. http://www.globalpa.org.uk/downloads/support-global-pa-target.pdf

[18] WCRF/AICR (2007) Food, Nutrition, Physical Activity and the Prevention of Cancer: A Global Perspective

for 30 minutes or more of vigorous physical activity every day[19]

(v) Dietary salt intake

We support the target to reduce population intake of salt with the aim of reaching the recommended level of less than 5g per day. Salt and salt-preserved foods can be a cause of stomach cancer. Infection with the bacterium Helicobacter pylori is established as a necessary cause of almost all cases of stomach cancer but the risk of developing stomach cancer is increased by salt consumption[20]. Cancer of the stomach is the fourth most common type of cancer worldwide. Around one million cases of stomach cancer were recorded in 2008, accounting for around 8 per cent of all new cancer cases. It is predicted that the number of cases will rise to 1.7 million by 2030[21].

(vi) Fruit and vegetable intake

We support the inclusion of an indicator on inadequate consumption (<400g per day) of fruit and vegetables. The consumption of fruit and non-starchy vegetables has been shown to decrease the risk of many cancers, principally of the mouth, pharynx and larynx, the oesophagus, lung and stomach[22].

(*vii) Policies to reduce marketing of foods to children*

We strongly support the inclusion of the indicator on marketing of foods high in saturated fats, trans-fatty acids, free sugars or salt. This is consistent with the evidence on obesity, which is an independent risk factor for many of the most common cancers including oesophagus, pancreas, gallbladder, colorectum, breast (post-menopause), endometrium and kidney[23].

We would like to see the explicit addition of “non-alcoholic beverages” along side food in order to align the indicator with the WHO Set of Recommendations on the Marketing of Foods and Non-Alcoholic Beverages to Children.[24].Sugar-sweetened beverages have been found to be associated with weight gain[25].

In line with our recommendation to improve the coherence and linkages of the monitoring framework, we would ideally see the inclusion of a target reduce both the exposure and power of marketing to children, with a wide definition of commercial communication (including online and new media) and the inclusion of commercial-free childhood settings. At the very least, this indicator should be linked to the target on obesity. As a policy indicator, guidance as set out in the Global Action Plan should be clearly signposted.

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[19] *Ibid.*
[20] *Ibid.*
[21] Globocan (2008), International Agency for Research on Cancer.
[22] WCRF/AICR(2007) Food, Nutrition, Physical Activity and the Prevention of Cancer: A Global Perspective
[23] WCRF/AICR (2007) Food, Nutrition, Physical Activity and the Prevention of Cancer: A Global Perspective
[24] http://www.who.int/dietphysicalactivity/publications/recsmarketing/en/
[25] *Ibid.*

Table: Targets and indicators for factors associated with cancer

Factor	Current WHO target?	Current WHO indicator?	WCRF International recommendation
Obesity	✓	✓	Support and retain. Integrate and cross-reference target and indicator on infant obesity (aged 0-5) and include indicator on child obesity (aged 5-18). Cross reference to indicators on total fat and sugar consumption, fruit and vegetable consumption, marketing to children, physical activity and breastfeeding.
Harmful Use of Alcohol	✓	✓	Support and retain. Include new indicator on policies to reduce the impact of marketing of alcohol to young people and adolescents. Link as a policy action to support the target on alcohol consumption.
Physical Inactivity	✓	✓	Support and retain. Consider the addition of vigorous activity to capture both moderate and vigorous physical activity. Cross reference to target on obesity.
Salt Intake	✓	✓	Support and retain
Inadequate Fruit & Vegetable Intake	✗	✓	Support and retain indicator on inadequate fruit and vegetable consumption.
Added Sugar Intake	✗	✗	Include new indicator on age-standardised mean population intake of added sugar as % of total energy intake. Link to obesity target.
Total Fat Intake	✗	✗	Include new indicator on age-standardised mean population intake of total fats as % of total energy intake. Link to obesity target
Marketing of HFSS Foods to Children	✗	✓	Support and retain. Include explicit reference to non-alcoholic beverages in line with the WHO set of recommendations so that indicator reads *"policies to reduce the impact on children of marketing of foods and non-alcoholic beverages high in saturated fats, trans-fatty acids, free sugars or salt."* Link as a policy action to support the targets on obesity, salt and saturated fats.
Breastfeeding	✗	✗	Cross-reference to targets and indicators from maternal, infant and child nutrition action plan.
*Saturated Fat Intake**	✓	✓	*Support and retain*
*Trans Fat Intake**	✗	✓	*Reinstate target*

* These targets and indicators are not of direct importance for cancer prevention. However we support their inclusion as important dietary risk factors for NCDs.

Recommendations for further targets and indicators associated with cancer prevention:

(viii) Energy dense foods, and sugar and total fat intake

Energy-dense diets have been associated with positive energy balance and weight gain, whereas low energy-dense diets are associated with a lower risk of overweight and obesity[26]. The effect of energy-dense foods on weight gain, overweight and obesity in turn influences the risk of some of the most common cancers[27]. Currently there are no indicators (or targets) in the monitoring framework to capture data on energy density. We therefore propose that the WHO consider including a measure of intake of energy dense foods or diets, such as sugar and/or total fat as proportion of total energy intake[28].

This would ensure that the monitoring framework is in line with recommendations from the joint WHO/FAO consultation on diet, nutrition and the prevention of chronic diseases concerning the consumption of free sugars and total fat[29].

Food Balance Sheets (or 'disappearance sheets') from the Food and Agriculture Organization of the United Nations (FAO) have previously been used in academic literature and by WHO to provide a picture of energy intake, sugar and/or total fat intake[30]. Using such an approach would limit the reporting burden on Member States.

(ix) Breastfeeding

In addition to the many nutritional benefits of breastfeeding, there are significant protective effects from breastfeeding for both the mother (reduced risk of breast cancer) and infant (reduced risk of being overweight or obese later in life, which in turn influences the risk of many cancers) that relate to NCDs[31].

We recommend that the targets and indicators for breastfeeding adopted as part of the Action Plan on Maternal, Infant and Child Nutrition (WHA65/6) are integrated and cross-referenced in this monitoring framework[32].

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[26] WCRF/AICR (2007) Food, Nutrition, Physical Activity and the Prevention of Cancer: A Global Perspective

[27] *Ibid.*

[28] Popkin B and Nielsen S. The Sweetening of the World's Diet. Obesity Research 2003, Vol. 11 No. 11; Prentice A and Jebb S. Fast Foods, Energy Density and Obesity: a possible mechanistic link. Obesity Reviews 2003, Vol. 4.

[29] WHO/FAO (2004) Technical Report Series 916: Diet, Nutrition and the Prevention of Chronic Diseases

[30] WHO (2011) Global Status Report on Non-Communicable Diseases 2010; Popkin B and Nielsen S. The Sweetening of the World's Diet. Obesity Research 2003, Vol. 11 No. 11

[31] WCRF/AICR (2007) Food, Nutrition, Physical Activity and the Prevention of Cancer: A Global Perspective

[32] http://www.who.int/nutrition/topics/wha_nutrition/en/index.html

Comments on targets and indicators associated with other NCDs:

(x) Saturated Fat and Trans Fat Intake

We support our colleagues working on cardiovascular diseases in their call for a target on reduced saturated fat intake[33]. While availability of saturated fat in low- and middle-income countries is currently below 10% of energy intake, the availability of dietary energy from total fat has been increasing across all world regions [34]. It is important that global targets and indicators for saturated fat are put in place to prevent high saturated fat intakes, particularly in low-income countries. WHO experts recommend a population saturated fat target of less than 10% total energy intake[35].

In order to ensure that interventions to reduce saturated fat are effective and without negative implications, we support the indicator on trans-fatty acids and would also like to see the policy target on the elimination of trans-fatty acids reinstated. This target has been strongly endorsed by WHO experts and by independent experts working in the field of cardiovascular diseases. Given that elimination of trans fats from the food supply requires policy action, it is likely that a target will be more effective than a stand-alone indicator.

Industrially produced trans fats are highly damaging to health, and consumption significantly increases the risk of cardiovascular disease and strokes in particular[36].

However, we would point out that it is somewhat misleading to refer to these targets as 'fat intake' as together they do not reflect total fat intake.

Our recommendations are in line with the response submitted by the **European Heart Network**.

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[33] European Heart Network, Diet, Physical Activity and Cardiovascular Disease Prevention (2011); European Heart Network, Oral Statement to the 62nd Session of WHO Regional Committee for Europe (http://www.ehnheart.org/publications/position-papers.html)
[34] WHO (2011) Global Status Report on Non-Communicable Diseases 2010.
[35] WHO (2003) Diet, Nutrition and the Prevention of Chronic Diseases. WHO Technical Report Series 916. Geneva: WHO.
[36] Mozaffarian D, Katan MB, Ascherio A et al. Trans fatty acids and cardiovascular disease. N Engl J Med 2006;354:1601-1613; Hu FB, Stampfer MJ, Rimm EB et al. Dietary fat intake and the risk of coronary heart disease in women. N Engl J Med 1997;337:1491-1499.