World Cancer Research Fund International and International Association for the Study of Obesity input to the consultation on the revised draft global action plan for the prevention and control of NCDs covering the period 2013 to 2020 (draft dated 15 March 2013)
Draft, March 27, 2013

WCRF International and IASO welcome the opportunity to comment on the Updated Revised Draft Global Action Plan (GAP) for the Prevention and Control of Non-Communicable Diseases (15 March 2013). We have closely followed the development of the GAP and have submitted comments on previous versions.

1. Aims and principles. We continue to support the inclusion of prevention through reducing exposure to modifiable risk factors. The new overarching principle on international cooperation and conflict of interest are welcome. The new approach to have a 'menu of policy options' can also be welcomed in principle; as WCRF International has previously highlighted, having a menu of actions provides both guidance and flexibility to Member States. We thus support the Member States in calling for this. However, we are very concerned that the current draft does not yet reflect the full spirit of the call for a 'menu' approach. A menu of policy actions should provide Member States with sufficient options *a la carte* to enable them to select what is appropriate and effective in their national contexts. In view of this, it is inappropriate to pre-define a brief list of actions available which may not apply to all national contexts and is counter to the evidence that a comprehensive, multi-component approach is the best option, even if implemented in a step-wise approach. The Action Plan should thus avoid giving, at any point, the impression that the menu consists solely of prioritised interventions that have been classed in the document as cost effective. This would, in essence, mean that none of the actions in Objectives 1,2,5, and 6 would be recommended since there is no cost-effectiveness evidence available. Rather, prioritised actions should be a subset clearly identified from, and within the context of, the broad menu on the basis of existing blueprints and the best available evidence. In this light, it is evident that Appendix 3 must be revised (see comments below). In addition, the terminology needs to be changed: the term "menu of policy options" is tautological since "menu" means "list of options." As an action plan, this should thus be rephrased "menu of policy actions."

2. Appendix 3. The new Appendix 3 is potentially a highly useful inclusion that clarifies the links between the objectives, the menu of policy actions, the voluntary targets and existing WHO tools. We thus supported the call by Member States to create Appendix 3 from two appendices in the previous version. We agree with the principle it should be a summary of actions, with priority actions highlighted (as they are currently done in green). However, in its current form, it is confusing at best. At worst it could undermine

effective action if it comes to serve as a summary reference for Member States. The title of the appendix and the reference to menu of actions in the table headings suggests that this is a summary of the policy actions to achieve the voluntary targets set out in the text in body of the GAP. This is not the case. At the moment, the notion it is a 'summary' is misleading. For example:

- There is internal inconsistency: for some objectives Appendix 3 provides supplementary information (including new additions not referenced in the main text), while for others (e.g. Objective 3) it represents a major cut to the actions listed in the main text. This suggests that the appendix is serving a different purpose for the different objectives rather than being a 'summary.'
- In places, the wording of the recommendations in Appendix 3 is inconsistent with the wording contained in the body of the GAP. For example, under Objective 3, there is inconsistency over what trans fats should be replaced with (unsaturated or polyunsaturated fats); under Objective 1 in Appendix 3, "workforce" is referred to, even though in the main text, this appears under Objective 2 (see further comments under Unhealthy Diet below).
- For some objectives there does not appear to be a logical rationale for prioritisation of actions, given that they are not listed in the same order in the main text. In addition, priority actions are set for Objectives 3 and 4 but not for the other actions.
- Throughout, there is a mix of the level of generality. Some options are what do to achieve the Objective in very general terms (e.g. "raise awareness" in Objective 1), and others are how to achieve the objective in a far more specific way (e.g. Implement the FCTC in Objective 3).

3. Promoting healthy diet and physical activity. We welcome the improvements to Paragraph 32 from the last draft, including the inclusion of actions on portion size, energy density and saturated fat; new language on targeting the availability, affordability and acceptability of healthy food; and action targeting the agricultural sector. But we would like to highlight that the recommendation on nutrition labelling is inaccurate. In May 2012, the Codex Committee on Food Labelling made a new recommendation to the Codex Alimentarius Commission to replace the guideline mandating nutrition labelling only when a claim is made with mandatory nutrient lists. In addition, there is convincing evidence that the nutrient lists of the type recommended by Codex primarily benefit more educated consumers, implying that interpretative forms of labelling are needed to be effective. In line with this development, the text should be changed to:

Provide nutrition labelling for all pre-packaged foods following the guidelines and standards of the Codex Alimentarius Commission, including mandatory labelling, and consider nutrition labels that promote healthier choices (including interpretative elements).

In addition, specific changes are needed in Appendix 3. This is for four reasons. First, there is no apparent link between Paragraph 32 and the list of actions on unhealthy diet and physical activity in Appendix 3. Moreover, there are inconsistencies between them. For example:

- As noted above, there is inconsistency on whether trans fats should be replaced with polyunsaturated or unsaturated fats

- The recommended action in Appendix 3 on salt combines two separate recommendations in Paragraph 32 (sub-paragraphs b and g);
- The inclusion of public awareness programmes in Appendix 3 concerns both diet and physical activity, whereas these are dealt with separately in the main text (Paragraphs 32 and 33).

Second, Appendix 3 states that the associated voluntary targets include "10% relative reduction in prevalence of insufficient physical activity" and "Halt the rise in diabetes and obesity." Yet there is only half a recommended policy action for physical activity and only half a one that is relevant to obesity (public awareness) – and the evidence suggests it should not be considered the top option. Member States will not achieve the obesity target if there is any suggestion (implied or perceived from a reading of Appendix 3) that there are no appropriate recommended policy actions on obesity.

Third, it makes sense to summarise all the existing policy actions from the main text in Appendix 3 in order to enable Member States to select what is appropriate to their national context. For example, in some Member States, saturated fat intake is a critical dietary issue, and yet this is not included.

Fourth, we fully agree with the note under the Appendix 3 title that "This appendix needs to be updated as evidence and cost-effectiveness of interventions evolve with time." Yet the three interventions do not reflect the increasing availability of evidence on effectiveness and cost-effectiveness of policy actions to promote a healthy diet. The most recent evidence suggests that:

- Salt reduction strategies have been shown to be effective and cost-effective (as included)
- At least five systematic reviews of the evidence show that policy actions in schools have a positive effect on fruit and vegetable intake and other aspects of diet. Although limited, there is also evidence that these measures can be cost-effective.
- Restrictions on marketing of food and beverages to children have been found to be workable and enforceable and effective in reducing advertising through the targeted communication channels. Evidence shows these measures are cost effective, especially in low- and middle-income countries where they may in fact be cost saving.
- The weight of evidence suggests that sustained and focused media and educational campaigns, using multiple channels to increase consumption of specific healthy foods are likely to be effective at changing knowledge, but there is no consistent evidence on behaviour and dietary patterns. Evidence shows they can be cost-effective provided implementation costs are very low, but health effects are smaller than other policy actions.

For the benefit of Member States, we would like to see the emergence of a revised Appendix 3 that serves as an accurate summary of the actions in the main text, and then provides supplementary guidance for prioritisation based on the best available evidence. Concretely, as detailed below and in line with the above evidence, the three priority actions should concern salt, school-based actions, and food marketing to children. Specific recommendations are made below.

5. International Partners. WCRF International has previously called for a definition of 'international partners': a definition is needed to clarify who is being called on to act, and what actions should be targeted at which 'partners'. In addition, including action for international partners solely under Objective 1 is inadequate. It fails to recognise the breadth of expertise, knowledge and capacity that different actors can contribute to driving progress against all objectives in the GAP. We also note the disclaimer at the end of the GAP that references international partners. There is a need to clarify and set out, in an open and transparent way, how WHO intends to identify and implement cross-sector work with international partners and they way in which it intends to secure endorsement by these actors (e.g. other UN agencies). This is particularly important given the inclusion of a proposed UN Taskforce on NCDs and the Global Coordination Mechanism in the GAP.

4. Global Coordinating Mechanism. We welcome the inclusion in this draft of clearer principles to guide the work of the Global Coordinating Mechanism (GCM), particularly the clarification of roles and responsibilities and the need to protect against conflicts of interest. However, the functions still require greater elaboration. We have previously recommended that the core functions should be fivefold: convening to promote dialogue; coordinating policy and action to promote coherence; identifying, articulating and creating incentives to stimulate action across sectors; advocating action; and developing mechanisms for monitoring to ensure progress and accountability. The proposed GCM is both multi-sectoral (i.e. cross-governmental) and multi-stakeholder (i.e. including NGOs and select private sector); while action is needed on both fronts, an explicit priority for inclusion in the GAP should be wording concerning the identification and communication of incentives for multi-sector action, as this is currently a major gap in the effort to address NCDs. There is clear evidence from research and practice that to be successful, multi-sectoral action requires clear incentives to drive participation and action in sectors beyond those with specific responsibility for health policy. The global voluntary targets are a set of agreed incentives that should provide a common policy and public health objective across sectors, but there is a need to think systematically about how actions (in different sectors and at different entry points) can provide mutual value and benefit, thereby creating incentives for participation. One of the priority functions of the GCM should thus be to identify, articulate and if necessary, create, such incentives for action across UN agencies, inter-governmental organisations and within Member States.

Specific changes

1. Aims and principles

Aim (Paragraph 3) Amend: "The action plan covering the period 2013-2020 provides a menu of policy actions for the prevention and control of non-communicable diseases, including a number cost-effective interventions, building on..."

Paragraph 14. Amend: "Using the best available evidence and knowledge, the action plan proposes a menu of policy actions for Member States for the prevention and control of non-communicable diseases, including examples of cost-effective interventions, to be adapted and integrated into existing health and social development plans..."
Delete: ~~"There is no blueprint action plan that fits all countries, as countries are at different points with respect to progress in the prevention and control of non-communicable diseases"~~
Delete: ~~"On a positive note, there are high-impact, very cost-effective interventions and policy actions across the six objectives, which, if implemented to scale, would enable even low-income countries to make significant progress in attaining the nine voluntary targets by 2025 (see Appendix 3)"~~

2. Appendix 3

The title of Appendix 3 should be changed to: "Policy actions for the prevention and control of major non-communicable diseases, which Member States are encouraged to implement, as appropriate, for national context, in order to achieve the 9 voluntary global targets"

The text of the physical activity component of Objective 3 should be added to reflect the main text of the GAP.

The unhealthy diet component of Objective 3 in Appendix 3 should be changed as follows, with green (and bold and underlined) actions being the priorities. Changes in red and underlined are amended wording.

Obj.	Menu of actions	Voluntary global targets	WHO tools
3	**Promote healthy diet** Promote and support exclusive breastfeeding for first six months **Reduce level of salt/sodium in food** Virtually eliminate trans-fatty acids in the food supply Reduce saturated fat in food Reduce content of free sugars in food and non-alcoholic beverages	As in current draft	As in current draft Add: International Code on the Marketing of Breast-milk Substitutes

	Policies targeted at food retailers and caterers to improve availability, affordability and acceptability of healthier food products **Provision and availability of healthy food in public institutions, including schools, other education institutions and workplaces** Economic tools including taxes and subsidies to encourage consumption of healthier food products and discourage the consumption of less healthy options Policy measures directed at agricultural sector Conduct public awareness campaigns and social marketing to encourage healthy diet Create health and nutrition promoting environment in schools and other educational institutions, work sites, clinics and hospitals, and other public and private institutions, including nutrition education Provide nutrition labelling for all pre-packaged foods following the guidelines and standards of the Codex Alimentarius Commission, including mandatory labelling, and consider nutrition labels that promote healthier choices (including interpretative elements). *(amended wording)* **Implement the WHO set of recommendations on the marketing of foods and non-alcoholic beverages to children**		

Contact:
Corinna Hawkes, Head of Policy and Public Affairs, WCRF International
c.hawkes@wcrf.org
Jo Jewell, Policy and Public Affairs Manager, WCRF International
j.jewell@wcrf.org
Tim Lobstein, Director of Policy and Programme, IASO - The International Association for the Study of Obesity
tlobstein@iaso.org