Union for International Cancer Control (UICC)

Submission to WHO Consultation on a Comprehensive Global Monitoring Framework, Indicators and Targets for the Prevention and Control of NCDs, October 2012

The Union for International Cancer Control (UICC) welcomes the opportunity extended to civil society organisations to contribute to this WHO consultation on a Comprehensive Global Monitoring Framework, Indicators and Targets for Non-Communicable Diseases (NCDs).

UICC is a membership organisation uniting over 760 organisations across more than 155 countries to help the global health community accelerate the fight against cancer. As a founding member of the NCD Alliance, UICC strongly supports the recommendations outlined in the NCD Alliance submission to this consultation process (Annex 1), and as such will focus on providing a cancer specific commentary in this paper.

In particular, UICC wishes to highlight the critical importance of **striking a balance between targets on prevention with those of detection, diagnosis, treatment and care for cancer and other NCDs.** In decision WHA 65 (8), Member States re-stated their commitment to a set of targets that cover exposure to the common risk factors for NCDs and health system responses recognising the importance for implementation of the UN Political Declaration on NCDs and achievement of the "25 by 25" mortality target. This is particularly pertinent for cancer –for which a comprehensive, multi-faceted approach that spans the entire care continuum is essential. Strengthened cancer management and care is also critical to address the profound equity challenges associated with NCD control, and to adequately ensure the health needs of the most vulnerable populations. We therefore encourage Member States to consider full articulation of the term "control" in the Global Monitoring Framework for NCDs to embrace vaccination services, screening and early detection, as well as access to diagnosis, treatment and care.

Exposure to the common risk factors for NCDs

- **Tobacco smoking and alcohol misuse**: In 2011 tobacco use killed almost 6 million people worldwide[1] and resulted in over 1.5 million cancer deaths. Alcohol misuse results in over 2.3 million deaths every year, 20% of which are related to cancer.
  UICC therefore strongly supports the proposed targets for the relative reduction of tobacco smoking by 30%, and 10% relative reduction in overall alcohol consumption.

- **Nutrition and physical inactivity:** In high-income countries, about a third of the most common cancers could be prevented through healthier patterns of diet and physical activity; in low- and middle income countries about a quarter could be prevented in this way[2]. Maintenance of a healthy body weight throughout life is one of the most important ways to protect against cancer. UICC

[1] The Tobacco Atlas

[2] World Cancer Research Fund/American Institute for Cancer Research. Policy and Action for Cancer Prevention: Food, Nutrition, and Physical Activity: A Global Perspective, Washington DC:AICR, 2009

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commends the inclusion of an obesity target for adults, and further recommends the inclusion of specific obesity targets and accompanying indicators for infants, young children under 5, and school-aged children. In this regard UICC wishes to highlight its support of the response submitted by member organisation WCRF International (Annex 2) which contains further detail on proposed targets and indicators on food and nutrition related exposures. Robust NCD targets and indicators on nutrition can also support broader health, nutritional, and food security goals that are priorities for the global development agenda.

Indicators for cancer-specific risk factors

Proposed strategies for the control of NCDs focus mainly on the shared risk factors of tobacco, harmful use of alcohol, physical inactivity, and unhealthy diet. However, for cancer, a broader response is required. Notably, the heterogeneity of cancer with respect to its geographical distribution, etiology, and pathology all demand a more nuanced, regional and national approach.

- **Cancer incidence, by type of cancer per 100,000 population (including stage where appropriate):** Improved surveillance of cancer morbidity and mortality and prevalence is essential to planning cancer services. Governments need to know not only how many people are dying but how many will develop the disease and how many will live with it as cancer survivors. An understanding of temporal trends in the population prevalence of major cancer risk factors complements cancer surveillance to improve long-term cancer projections and planning, and is provided by population-based cancer registries, which are also vital in assessing the outcome of prevention-associated interventions.
  UICC supports the proposed indicator, but strongly recommends that cancer staging at diagnosis be included where appropriate as downstaging of cancer will provide an early indication for success, particularly of secondary- prevention-associated interventions such as cancer screening.

It is important to recognise that cancer in low- and middle-income countries (LMICs) is not simply due to adoption of the social and behavioural conditions found in the higher income countries. Both the current cancer patterns and future projections reflect indigenous risk factors prevalent in LMICs; these may be joined by the future superimposition of risk factors from high-income countries, resulting in a "double burden" of exposures. Infections are estimated to explain 22.9% of cancers in developing countries[3]. Ignoring the substantial cancer burden related to infection would be a failure to address preventable causes of cancer in many parts of the world.

Consequently, the inclusion of vaccination against cancer-related infections in the UN Political Declaration was an important step. Such interventions against specific cancers could tackle several hundred thousand cancer cases per year, and represent highly achievable and measurable interventions.

- **Vaccination against infectious cancers – HBV immunisation:** Infant HBV vaccination, including a birth dose, is recommended by the WHO, given the global importance of liver cancer and chronic liver disease. A target prevalence of less than 1% hepatitis B surface antigen positive among children younger than 5 years is achievable; additional information on vaccine coverage is available from national immunisation programmes[4].

[3] de Martel C, Ferlay J, Franceschi S, et al. Global burden of cancers attributable to infections in 2008: a review and synthetic analysis. *The Lancet Oncology*. 2012;13:607–615.

- **Vaccination against infectious cancers – HPV immunisation:** By 2030, if not addressed, cervical cancer deaths each year are expected to grow by nearly 60 percent, to 430,000 – with most of these occurring in developing countries. HPV vaccination using the quadrivalent or bivalent vaccine is recommended by the WHO, targeting adolescent girls before the onset of sexual activity. The cost of the vaccine is falling, and evidence of the efficacy of fewer than the standard three doses of vaccine may lead to easier administration[5,4]. The decision to vaccinate or not depends on country-specific factors, including the prevalence of HPV, the incidence of cervical cancer, vaccine affordability, and the national immunisation programme infrastructure. As recommended by WHO, HPV vaccines are an important element of a comprehensive cervical cancer control strategy. The target for HPV immunisation should be to increase the number of high-risk, low-resource countries that can achieve good vaccine coverage (>80%), with a suggested indicator of: number of girls aged 15 in target population who have received three doses of the HPV vaccine / Total number of 15 year old girls in target population x 100. (Please refer to UICC's position paper submitted in April 2012 for further details: http://www.uicc.org/advocacy/position-papers).

  UICC therefore welcomes the inclusion of indicators for vaccination against infectious cancers – HPV and HBV.

The relatively long latency of the majority of cancers offers opportunities for the early detection of precancerous lesions or malignancy. Different cancers (by organ and cell type) have different disease trajectories, but for most, their early detection makes treatment more effective. The best current examples of common cancers for which screening makes treatment more effective are cervical and breast cancers: even in low-income countries with limited therapeutic means, early detection is linked to improvements in survival[5,6]. Screening methods should be tailored to the setting concerned. In breast cancer for example, this will be in some countries mammographic screening programmes whereas for others, breast awareness and clinical breast examination[7,8]. The evidence to date suggests that the best results are obtained with population-based, high-coverage approaches and rigorous quality-control procedures. However, high-risk groups of individuals can benefit from targeted surveillance.

- **Early detection of cervical cancer:** Cervical cancer kills approximately 275,000 women each year, over 80% of which are living in low and middle-income countries. Effective early screening and treatment, mainly using cytology-based (Pap) testing, has resulted in a steady drop in cervical cancer incidence and mortality in high-resource settings like the US and Europe. These practical interventions can be tailored to the resource setting and population-based need. For instance, - as set out by the WHO - screening (by VIA) and treatment of cervical pre cancer has been found to be very cost effective, and feasible in primary care.[8] UICC strongly supports the inclusion of an

[4] WHO hepatitis B vaccine position paper 2009 http://www.who.int/wer/2009/wer8440.pdf

[5] Kreimer AR, Rodriguez AC, Hildesheim A, et al. Proof-of-principle evaluation of the efficacy of fewer than three doses of a bivalent HPV16/18 vaccine. *J Natl Cancer Inst*. 2011;103(19):1444–1451.

[6] Sankaranarayanan R, Swaminathan R, Brenner H, et al. Cancer survival in Africa, Asia, and Central America: a population-based study. *Lancet Oncol*. 2010;11(2):165–173.

[7] Farmer P, Frenk J, Knaul FM, et al. Expansion of cancer care and control in countries of low and middle income: a call to action. *Lancet*.2010;376(9747):1186–1193.

[8] Sankaranarayanan R, Ramadas K, Thara S, et al. Clinical breast examination: preliminary results from a cluster randomized controlled trial in India. *J Natl Cancer Inst*. 2011;103(19):1476–1480.

[9] Yip, C.-H., Smith, R. A., Anderson, B. O., Miller, A. B., Thomas, D. B., Ang, E.-S., et al. (2008). Guideline Implementation for Breast Healthcare in Low- and Middle-Income Countries Early Detection Resource Allocation. Cancer , 113 (8 suppl), pp. 2244-56.

[8] First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control

indicator for the prevalence of women screened for cervical cancer between ages 30-49 at least once.

- **Early detection of breast cancer:** Breast cancer is the most frequent cause of female cancer deaths in both developing and developed countries and is one of the leading causes of mortality in women in reproductive age in developing countries. UICC and its member organisations feel it is essential to recognise prior commitments in the Political Declaration on NCDs (article 43k) and the extent of breast cancer screening that has been reported globally and therefore recommends the addition of an indicator which monitors the population-based approach to breast screening as follows: % districts with breast cancer early detection services for women aged 40-64.

Health system responses

Expanding sustainable access to inexpensive, effective quality, essential medicines is one of the keys to achieving improved outcomes for people with cancer in all countries. A number of cancer medicines can substantially reduce the mortality rate for some cancer patients, and greatly extend the life of others. The delivery of these medicines, as part of a team-based approach to cancer care, is achievable in both high- and low- income settings if delivered according to guidelines that are appropriate for the level of resources.

- **80% Availability of essential NCD medicines and technologies to treat major NCDs:** UICC therefore supports the health systems response targets on drug therapy and on the availability of essential NCD medicines/technologies in line with the 80% availability already agreed as a target in the WHO Medium-Term Strategy. We recommend alignment with the well-established and comprehensive WHO model essential medicines list (EML and EMLc) which are selected against globally agreed criteria, updated every two years and adopted at national level. The international community is still falling short on providing treatment and care to millions of people with NCDs. Acknowledging that this recommendation falls short of the WHO criteria for selection of targets and indicators, the importance of this target should lead to further consultation to define a baseline and future monitoring mechanism with balance across the four major NCDs.

- **Availability of morphine for palliative care services:** One of the most unacceptable gaps in cancer care is the lack of adequate palliative care for much of the world's population. A small number of medications, none of which are limited by patent, can control pain for almost 90% of all people with cancer pain, including children.
  UICC strongly welcomes the proposal to include the indicator on morphine-equivalent consumption of strong opioid analgesics (excluding methadone) per death from cancer (or alternative - please refer to the joint position paper submitted in April 2012 http://www.uicc.org/advocacy/position-papers). This indicator would, for the first time, set up routine monitoring of a core component of palliative care, allowing for the tracking of progress on pain treatment over time; facilitating cross-country comparison; and raising awareness around this often neglected health service. Pain control is an issue critical not only for NCDs but also other health priorities such as HIV/AIDS.

(Moscow, 28-29 April 2011) DISCUSSION PAPER PREVENTION AND CONTROL OF NCDS: PRIORITIES FOR INVESTMENT, http://www.who.int/nmh/publications/who_bestbuys_to_prevent_ncds.pdf

In Summary, UICC calls on UN Member States to:

- *Ensure a balance between targets on prevention, treatment and care for cancer and other NCDs;*
- *Support exposure targets for the common risk factors for NCDs tobacco use, misuse of alcohol, physical inactivity and obesity with additional recommendations for childhood obesity;*
- *Support target for availability of essential medicines and technologies;*
- *Support inclusion of cancer specific indicators on cancer incidence, HBV and HPV vaccination and screening for women's cancers;*
- *Support the inclusion of the cross-cutting indicator on morphine availability.*

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The NCD Alliance

Putting non-communicable diseases on the global agenda

Annex 1

Submission to WHO Consultation on a Comprehensive Global Monitoring Framework, Indicators and Targets for the Prevention and Control of NCDs, October 2012

The NCD Alliance welcomes the opportunity to contribute to this World Health Organization consultation on a global monitoring framework, indicators and targets for non-communicable diseases (NCDs).

At the UN High-Level Meeting on the Prevention and Control of NCDs last year, Member States emphasised the importance of surveillance and monitoring of progress on NCDs and mandated WHO to develop a ***"comprehensive global monitoring framework****, including a* ***set of indicators*** *... to monitor trends and assess progress on NCDs"* and a *"****set of voluntary global targets***" by the end of 2012.

Over the past year, the consultative process has highlighted that **all stakeholders are in consensus of the importance of a robust global monitoring framework (GMF)** for the global NCD response. It will ensure that results and resources are identified, recognised, reviewed and reported in order to accelerate global progress on NCDs.

It will be the first time all UN Member States adopt a global set of NCD targets, signalling a new era of accountability for NCDs. The GMF will encourage governments to honour their commitments, improve data collection and surveillance on NCDs, and demonstrate how actions and investments translate into **tangible results and better long-term outcomes for people with NCDs.**

Significant progress has already been made in scoping the GMF, including the landmark decision at the World Health Assembly (WHA 65 (8)) to **adopt the global target of a 25% reduction in premature NCD mortality by 2025.** All 193 UN Member States have committed to this **bold and ambitious vision** of millions fewer people suffering avoidable illness, disability and death from these diseases.

Now, Member States need to agree a **comprehensive set of targets and indicators that will drive progress towards the "25 by 25" goal**. As WHO Director General Margaret Chan previously stated, "**what gets measured, gets done."**

In summary, **the NCD Alliance has five key recommendations:**

1. **Establish and resource a robust global monitoring framework**
2. **Adopt a comprehensive set of bold targets to drive progress towards "25 by 25"**
3. **Strike a balance between targets on prevention, treatment and care**
4. **Agree a rigorous reporting system, including national reporting every two years to WHA and UNGA**
5. **Support the application of global targets to regional and national levels**

In addition, the NCD Alliance recommends **the GMF consultation be viewed in relation to other current global consultations.** These consultations – to define global NCD targets, arrangements for global multisectoral NCD partnerships, and the next Global NCD Action Plan (GAP) 2013-2020 – should be seen as the **building blocks of a comprehensive Global NCD Framework.** But only by overtly making the connections and explicitly integrating one to the other will the international community achieve a coherent Framework to drive and monitor a coordinated response for NCDs

The NCD Alliance was founded by:

International Diabetes Federation

International Union Against Tuberculosis and Lung Disease
Health solutions for the poor

UICC
global cancer control

WORLD HEART FEDERATION

Specifically, the NCD Alliance identifies the following synergies and areas for integration:

a. **The priorities** in the GAP 2013-2020, the GMF, and the evolving global partnership arrangements for NCDs are **consistent and reflect the commitments in the UN Political Declaration on NCDs;**

b. Elements of the **GMF are incorporated into the GAP 2013-2020** to monitor progress, with "25 by 25" NCD mortality as the overarching goal of the Plan;

c. The global partnership arrangements for NCDs includes a multisectoral **global coordinating mechanism** to mobilise resources and partners and drive progress on the objectives of the GAP 2013-2020*;*

d. Elements of the GAP 2013-2020 and targets within the GMF are **integrated into the Post-2015 Development Framework.**

The NCD Alliance's Five Key Recommendations on the GMF, targets and indicators on NCDs:

1. Establish and resource a robust global monitoring framework

o The UN Political Declaration on NCDs calls upon WHO to develop a comprehensive GMF with the purpose of monitoring trends and assessing progress in NCDs. In order to serve this purpose, the GMF must be broad, and include the **three cyclical elements of accountability: monitoring results and resources; reviewing and reporting on progress; and action.**

p The principles that underlie the GMF must be **equity, national ownership, transparency and integration.** Due to the inequalities in the distribution of the global NCD epidemic and the major risk factors, indicators need to cover key equity dimensions including gender, age, and socio-economic status.

q The GMF should draw upon the **experience and lessons learnt of existing accountability mechanisms in other global health and development priorities,** particularly the Global AIDS Response Reporting, the Millennium Development Goals (MDGs) reporting mechanism, the Commission on Information and Accountability for Women's and Children's Health, and the Conference of the Parties to the Framework Convention on Tobacco Control (FCTC COP).

r The Political Declaration clearly recognises the leading role of WHO in the development of the GMF. But due to the multisectoral nature of NCDs, the **implementation of the GMF should be supported by an interagency group and advised by an independent technical advisory group**, modelled on the Independent Expert Review Group (IERG) for the Commission on Information and Accountability for Women's and Children's Health.

s **The GMF must be central to the next GAP 2013-2020, related to the evolving global partnership arrangements for NCDs, and integrated into the post-2015 global development framework.**

t **A critical element of accountability that is neglected in the GMF is the tracking and reporting of resources for NCDs**. Tracking resources is important for transparency, credibility, and being able to link funds to results, outcomes and impact. Currently both the level of global expenditure on NCDs, particularly through Official Development Assistance (ODA), and the means by which global resource flows on NCDs are reported and monitored (e.g. by WHO and OECD) is wholly inadequate. The GMF must therefore **aim to improve tracking of global NCD resources**, with the **long-term goal of securing sustainable financing for NCDs.**

2. Adopt a comprehensive set of bold targets to drive progress towards "25 by 25"

- The NCD Alliance welcomes the **adoption of the global target to reduce premature NCD mortality by 25% by 2025**. All 193 UN Member States have now committed to a vision of millions fewer people suffering avoidable illness, disability and death from these diabetes. This vision of "25 by 25" needs to be framed, not as one of a number of targets but rather, as **the overarching goal within the GMF**.

- Member States now need to **agree a comprehensive and bold set of targets and indicators to drive progress towards this "25 by 25" goal**. Decision WHA 65 (8) outlines ten potential targets with varying levels of support. Due to the complexity of this epidemic – spanning four major diseases, four common risk factors, and a web of underlying social determinants – **the NCD Alliance strongly recommends the adoption of these ten targets, with some revisions (see Annexes 1 and 2).**

- ***Ten targets is not too many* for what is one of the most complex public health issues the world has ever had to deal with.** Governments are currently being monitored on 10 targets for the global AIDS response. Member States need to signal their leadership and commitment to NCDs by adopting a comparable number for NCDs.

- In its 3rd Discussion Paper, WHO proposes that **interim targets for 2015 and 2020** will be set once the 2025 global targets are agreed.**The NCD Alliance fully supports this** as it will be important for countries to check they are on track to achieve the longer-term 2025 goals.

- In addition to this set of ten global NCD targets**, the GMF should incorporate other NCD-related targets that have already been adopted by Member States**. These include the UN Political Declaration on NCDs target to **develop or strengthen national NCD plans and policies by 2013**. In relation to this target, WHO needs to clearly define the criteria for what constitutes a national NCD plan, including taking into account whether the plan is operational and adequately resourced.

3. Strike a balance between targets on prevention, treatment and care

- In decision WHA 65 (8), Member States re-stated their commitment to a **set of targets that cover outcomes, exposure to risk factors and health system responses**. Both implementation of the UN Political Declaration on NCDs and achievement of the "25 by 25" goal **require a balance of prevention and disease management targets,** including early diagnosis, treatment and care.

- The NCD Alliance specifically requests Member States to **support targets on *all four major risk factors, including the harmful use of alcohol*.** The set of targets will not be credible or comprehensive without all four risk factors, and will not reflect the WHO official definition of NCDs. Member States expressed strong support for reaching consensus on targets relating to the four main NCD risk factors in decision WHA 65 (8).

- The NCD Alliance commends the ambition of other prevention targets, including the target to "halt the rise in obesity prevalence". This target is a major political statement and could have great impact in catalysing political leadership on an issue that is of significant concern to the general population in most countries.

- The NCD Alliance specifically **requests Member States to *support the health systems response targets on drug therapy and on the availability of essential NCD medicines/technologies*** (80% availability already agreed as a target in the WHO Medium-Term Strategy to 2013). The international community is still falling short on providing treatment and care to millions of people with NCDs. If Member States are serious about achieving the "25 by 25" goal, targets to drive progress on the **availability of effective medicines and technologies to diagnose, treat and monitor NCDs are critical**.

4. Adopt a rigorous reporting system, including national reporting every two years to WHA and UNGA

- The frequency of reporting by countries to the GMF is important. Drawing from the lessons of the HIV/AIDS global reporting system, the NCD Alliance **recommends national governments report on progress every two years.** This can be done and will elevate NCDs to the appropriate level of priority on national and global agendas. This will be in line with the reporting requirements of the FCTC and the GMF should explicitly recognise the FCTC COP as the global forum for tobacco control monitoring and accountability. To minimise the reporting burden and facilitate the reporting process, the role of WHO in providing operational guidelines and technical advice will be critical.

- As WHO Discussion Paper 2 states, due to the multisectoral nature of NCD prevention and control, **global and national progress should be reviewed and discussed at both the World Health Assembly *and* the UN General Assembly.**

- Both follow-up steps mandated in the UN Political Declaration - the UN Secretary General's Progress Report on the UN Political Declaration due in 2013 and the comprehensive review and assessment in 2014 – should be **leveraged to take stock on the GMF**.

- Similar to the HIV/AIDS review process, **the NCD Alliance strongly recommends that the comprehensive review and assessment in 2014 take the format of a High-Level Meeting of the General Assembly** and that it receives the first biennial progress report on the GMF and targets.

5. Support the application of global targets to regional and national levels

- In parallel to the development of the GMF, the UN Political Declaration on NCDs commits UN Member States to "*consider the development of national targets and indicators based on national situations".* **National targets are essential for the NCD response**, as it is countries themselves that are the foundations of accountability.

- **The set of global NCD targets and indicators should provide a template and guidance for countries to develop their own national targets.** National targets need to be consistent with the global targets, but be **adapted to specific national contexts including relative burden and etiology of NCDs**. Adaptations should be based on criteria similar to those used by WHO for the global targets – measurability, achievability, and feasibility.

- **Regional targets on NCDs will also be important in ensuring harmonisation and coordination within regions.** A good example of regional NCD targets can be seen in the recently adopted PAHO Regional NCD Strategy, which includes a comprehensive set of regional targets and indicators.

- There is a **clear leadership role for WHO in providing guidance to governments and strengthening capacity in countries** to facilitate the translation of global NCD targets and indicators to the national level. This was explicitly referenced in the UN Political Declaration on NCDs and WHO Discussion Paper 2.

- The more successful global monitoring efforts have been accompanied by **investments in country-level surveillance and institutional capacity strengthening**, including developing the health workforce. As mandated in the UN Political Declaration, international collaboration is required to strengthen country-level NCD surveillance and monitoring, including the development of population-based registries and the integration of NCD surveillance into national health information systems.

- **Civil society has a key role in the accountability process**, particularly at the national level. National monitoring and reporting requires the **active engagement of governments with communities and civil society, including NGOs, academics and people with NCDs**. Drawing from the HIV/AIDS response, the establishment of **national NCD commissions** could facilitate this.

Annexes

- **Annex 1: NCD Alliance proposed set of global NCD targets and indicators**

  The NCD Alliance's proposed set of global NCD targets and indicators for adoption by Member States, based upon the WHO Discussion Papers.

- **Annex 2: NCD Alliance detailed comments on the WHO proposed global NCD targets and indicators**

  The NCD Alliance's detailed comments and recommendations on the WHO proposed set of global NCD targets and indicators.

Annex 1: NCD Alliance Proposed Set of Global NCD Targets and Indicators

Targets		Indicators
GOAL	**Premature mortality from NCDs** *25% relative reduction in overall mortality from cardiovascular disease, cancer, diabetes, or chronic respiratory disease*	*Unconditional probability of death between ages 30 and 70 years from cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases.*
		Cancer incidence, by type of cancer per 100,000 population
1	**Tobacco smoking** *30% relative reduction in prevalence of current tobacco smoking*	*Age-standardized prevalence of current tobacco smoking among persons aged 15+ years*
		Average price of 100 cigarettes, expressed as a percentage of GDP per capita.
2	**Dietary salt intake** *30% relative reduction in mean adult (aged 18+) population intake of salt, with aim of achieving recommended level of less than 5 grams per day*	*Age-standardized mean population intake of salt (sodium chloride) per day in grams in adults aged 18+ years*
3	**Raised blood pressure** *25% relative reduction in prevalence of raised blood pressure*	*Age-standardized prevalence of raised blood pressure among adults aged 18+ years (defined as mean systolic blood pressure ≥140 mmHg and/or diastolic blood pressure ≥90 mmHg.)*
4	**Physical inactivity** *10% relative reduction in prevalence of insufficient physical activity in adults aged 18+ years*	*Age-standardized prevalence of insufficiently active adults aged 18+ years (defined as less than 150 minutes of moderate intensity activity per week, or equivalent)*
5	**Alcohol** *10% relative reduction in overall alcohol consumption (including hazardous and harmful drinking)*	*Total (recorded and unrecorded) alcohol per capita (15+ years old) consumption within a calendar year in litres of pure alcohol*
		Recommend an additional indicator is developed to monitor children/youth exposure to marketing of alcohol.
6	**Obesity** *Halt the rise in obesity prevalence.*	*Age-standardized prevalence of obesity (defined as BMI equal or greater than 30 kg/m2) in adults aged 18+ years.*
	Refer to existing target No increase in childhood overweight by 2025 for infants and young children under the age of 5 (WHA65[6])	*Age-standardized prevalence of overweight in adults aged 18+ years and adolescents (defined as body mass index equal or greater than 25 kg/m² for adults and according to the WHO Growth Reference for adolescents)*
		Recommend an additional indicator is developed to capture obesity and overweight in school-aged children aged 5-18, using WHO Growth Reference Standards
		Age-standardized prevalence of adult (aged 18+ years) population consuming less than five total servings (400 grams) of fruit and vegetables per day
		National policies that virtually eliminate partially hydrogenated vegetable oils (PHVO) in the food supply and replace with polyunsaturated fatty acids (PUFA)
		Policies to reduce the impact on children of marketing of foods and non-alcoholic beverages high in saturated fats, trans-fatty acids, added sugars, or salt.
		Recommend two additional indicators are developed to capture data on energy density: *Age-standardised mean population intake of added sugar per day as a percentage of total energy.* *Age-standardised mean population intake of total fats per day as a percentage of total energy.*

5

7	**Fat intake** *15% relative reduction in mean proportion of total energy intake from saturated fatty acids (SFA), with aim of achieving recommended level of less than 10% of total energy intake*	*Age-standardized mean proportion of total energy intake from saturated fatty acids (SFA) in adults aged 18+ years.*
		Age-standardized mean proportion of total energy intake from polyunsaturated fatty acids in adults aged 18+ years.
8	**Raised cholesterol** *20% relative reduction in prevalence of raised total cholesterol*	*Age-standardized prevalence of raised total cholesterol among adults aged 18+ years (defined as total cholesterol ≥5.0 mmol/L or 190 mg/dl)*
9	**Drug therapy to prevent heart attacks and stroke** *50% of eligible people receive drug therapy and to prevent heart attacks and strokes, and counselling*	*Drug therapy to prevent heart attacks and strokes (includes glycemic control), and counselling for people aged 40 years and over with a 10 year cardiovascular risk≥30 per cent (includes those with existing cardiovascular disease).*
		Age-standardized prevalence of raised blood glucose/diabetes among adults (defined as mean fasting plasma glucose value ≥ 7.0 mmol/L (126 mg/ dl) or on medication for raised blood glucose)
10	**Availability of essential NCD medicines and technologies to treat major NCDs** *80% availability of essential medicines and technologies required to treat major NCDs in both public and private facilities.*	*Availability of essential medicines and technologies required to treat major NCDs in public and private sector facilities, including primary care facilities.*
		Access to palliative care assessed by morphine-equivalent consumption of strong opioid analgesics (excluding methadone) per death from cancer.
Indicators not attached to specific targets		
		Recommend more detail is provided: *Vaccination against infectious cancers: Human Papillomavirus (HPV) and Hepatitis B virus (HBV)*
		Prevalence of women between ages 30-49 screened for cervical cancer at least once
		Additional indicator recommended to monitor commitment made in para 43k of Political Declaration to "Promote increased access to cost-effective cancer screening programmes, as determined by national situations": *% districts with breast cancer early detection services for women aged 40-64*

Annex 2: NCD Alliance Detailed Comments on the WHO Proposed Global NCD Targets and Indicators

WHO proposed target		WHO proposed indicators	NCD Alliance comments and recommendations
G O A L	**Premature mortality from NCDs** *25% relative reduction in overall mortality from cardiovascular disease, cancer, diabetes, or chronic respiratory disease*	*Unconditional probability of death between ages 30 and 70 years from cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases.*	**Recommend describing this adopted target as the 'goal' of the Global Monitoring Framework (GMF).** This proposed indicator relates to the combined mortality risk of the four major NCDs and so progress across all four will be critical to achieve this target.
		Cancer incidence, by type of cancer per 100,000 population	**Recommend edit (in bold) to indicator** to align with globally accepted practice: *Cancer incidence, by type of cancer per 100,000 population **and stage (as appropriate)**"*
1	**Tobacco smoking** *30% relative reduction in prevalence of current tobacco smoking*	*Age-standardized prevalence of current tobacco smoking among persons aged 15+ years*	**Recommend additional indicator**on affordability of tobacco, sourcing data on price through country reports on FCTC implementation (or national CPI): *Average price of 100 cigarettes, expressed as a percentage of GDP per capita*. **Rationale:** In order to see whether a country is making progress (or moving backward) on tobacco taxation, it is important to measure changes in affordability. To compare countries with vastly different levels of income, prices need to be compared to income levels; GDP per capita is the most easily available measure. Most countries collect tobacco price information as part of routine data-gathering for Consumer Price Index. In the minority of countries where cigarettes are not the dominant product, some alternative approach might be required. **The GMF should explicitly recognize the role of the FCTC Conference of the Parties** as the primary global forum for discussions on tobacco control implementation and accountability. **Targets to reduce oral tobacco use** should be developed by WHO for adaptation and adoption at national levels, as appropriate.
2	**Dietary salt intake** *30% relative reduction in mean adult (aged 18+) population intake of salt, with aim of achieving recommended level of less than 5 grams per day*	*Age-standardized mean population intake of salt (sodium chloride) per day in grams in adults aged 18+ years*	**Recommend support as is.**
3	**Raised blood pressure** *25% relative reduction in prevalence of raised blood pressure*	*Age-standardized prevalence of raised blood pressure among adults aged 18+ years (defined as systolic blood pressure ≥140 mmHg and/or diastolic blood pressure ≥90 mmHg.)*	**Recommend edit (in bold) to indicator:** *Age-standardized prevalence of raised blood pressure among adults aged 18+ years (defined as **mean** systolic blood pressure ≥140 mmHg and/or diastolic blood pressure ≥90 mmHg.)*

4	**Physical inactivity** *10% relative reduction in prevalence of insufficient physical activity in adults aged 18+ years*	*Age-standardized prevalence of insufficiently active adults aged 18+ years (defined as less than 150 minutes of moderate intensity activity per week, or equivalent)*	**Recommend support as is.**
5	**Alcohol** *10% relative reduction in overall alcohol consumption (including hazardous and harmful drinking)*	*Total (recorded and unrecorded) alcohol per capita (15+ years old) consumption within a calendar year in litres of pure alcohol*	**Recommend an additional indicator**be developed to monitor children's exposure to marketing of alcohol.
6	**Obesity** *Halt the rise in obesity prevalence.*	*Age-standardized prevalence of obesity (defined as BMI equal or greater than 30 kg/m2) in adults aged 18+ years.*	**Recommendthe recently adopted global target for "no increase in childhood overweight by 2025 for infants and young children under the age of 5 (WHA65[6])"** is integrated into this GMF, along with an indicator to capture obesity and overweight in school-aged children aged 5-18, using WHO Growth Reference Standards. **Rationale:** Overweight and obese children 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. There is also evidence that a target on childhood obesity is achievable, given recent data suggested that obesity prevalence is stabilising among certain age groups in some countries.
		Age-standardized prevalence of overweight in adults aged 18+ years and adolescents (defined as body mass index equal or greater than 25 kg/m² for adults and according to the WHO Growth Reference for adolescents)	
		Age-standardized prevalence of adult (aged 18+ years) population consuming less than five total servings (400 grams) of fruit and vegetables per day	**Recommend support as is.**
		National policies that virtually eliminate partially hydrogenated vegetable oils (PHVO) in the food supply and replace with polyunsaturated fatty acids (PUFA)	**Recommend support as is.**
		Policies to reduce the impact on children of marketing of foods high in saturated fats, trans-fatty acids, free sugars, or salt	**Recommend edits (in bold) to indicator:** *Policies to reduce the impact on children of marketing of foods **and non-alcoholic beverages** high in saturated fats, trans-fatty acids, ~~free~~ **added** sugars, or salt.*

			Recommend two additional indicators to capture data on energy density: *Age-standardised mean population intake of added sugar per day as a percentage of total energy.* *Age-standardised mean population intake of total fats per day as a percentage of total energy.* **Rationale:** Low energy-dense diets are associated with a lower risk of overweight and obesity. Currently there are no indicators (or targets) to capture data on energy density. Thesetwo additional indicatorswill ensure this GMF is in line with recommendations from the joint WHO/FAO consultation on diet, nutrition and the prevention of chronic diseases. Food Balance Sheets (or 'disappearance sheets') from the FAO have previously been used by WHO to provide a picture of energy intake, sugar and/or total fat intake. Using such an approach would limit the reporting burden on Member States.
7	**Fat intake** *15% relative reduction in mean proportion of total energy intake from saturated fatty acids (SFA), with aim of achieving recommended level of less than 10% of total energy intake*	*Age-standardized mean proportion of total energy intake from saturated fatty acids (SFA) in adults aged 18+ years.*	**Recommend support as is.**
		Age-standardized mean proportion of total energy intake frompolyunsaturated fatty acids in adults aged 18+ years.	**Recommend support as is.**
8	**Raised cholesterol** *20% relative reduction in prevalence of raised total cholesterol*	*Age-standardized prevalence of raised total cholesterol among adults aged 18+ years (defined as total cholesterol ≥5.0 mmol/L or 190 mg/dl)*	**Recommend support as is.**
9	**Drug therapy to prevent heart attacks and stroke** *50% of eligible people receive drug therapy and to prevent heart attacks and strokes, and counselling*	*Drug therapy to prevent heart attacks and strokes (includes glycemic control), and counselling for people aged 40 years and over with a 10 year cardiovascular risk≥30 per cent (includes those with existing cardiovascular disease).*	**Recommend support as is.**
		Age-standardized prevalence of raised blood glucose/diabetes among adults (defined as fasting plasma glucose value ≥ 7.0 mmol/L (126 mg/ dl) or on medication for raised blood glucose)	**Recommend edit (in bold) to indicator:** *Age-standardized prevalence of raised blood glucose/diabetes among adults (defined as **mean** fasting plasma glucose value ≥ 7.0 mmol/L (126 mg/ dl) or on medication for raised blood glucose)*

10	**Availability of genericessential NCD medicines and basic technologies to treat major NCDs** *80% availability of basic technologies and generic essential medicines required to treat major NCDs in both public and private facilities*	*Availability of basic technologies and generic essential medicines required to treat major NCDs in public and private sector facilities, including primary care facilities.* *The minimum list would include: Medicines - at least aspirin, a statin, an angiotensin converting enzyme inhibitor, thiazide diuretic, a long acting calcium channel blocker, metformin, insulin, a bronchodilator and a steroid inhalant. Technologies - at least a blood pressure measurement device, a weighing scale, blood sugar and blood cholesterol measurement devices with strips and urine strips for albumin assay.*	**Recommend edits (in bold) to both target and indicator:** Availability of ~~**generic**~~essential NCD medicines and ~~**basic**~~ technologies to treat major NCDs**.** **We also recommend <u>deleting</u> the minimum list.** **Rationale:** The focus should be on the availability of essential, affordable and quality-assured medicines and technologies, whether or not they are generic or basic. We recommendalignment with the well-established and comprehensive WHO Model Essential Medicines Lists (EML and EMLc) which are selected against globally agreed criteria, updated every two years and adopted at national level. Definition of a baseline for future monitoring and/or a sub-set of the essential medicines and technologies will require further consultation to ensure a balance across the four major NCDs, as well as reflecting the WHO criteria for selection of indicators.
		Access to palliative care assessed by morphine-equivalent consumption of strong opioid analgesics (excluding methadone) per death from cancer.	**Recommend support as is.**
Additional indicators		**WHO proposed indicators**	**NCD Alliance comments and recommendations**
		Vaccination against infectious cancers: Human Papillomavirus (HPV) and Hepatitis B virus (HBV)	**Recommend support but this indicator requires more detail.** Suggestions include: delivery of Hepatitis B vaccine within 24 hours of birth; prevalence of HBsAg carriers in children aged ≤ 1 year; number of girls aged 15 in target population who have received three doses of the HPV vaccine / Total number of 15 year old girls in target population x 100
		Prevalence of women between ages 30-49 screened for cervical cancer at least once	**Recommend support as is.**
			Recommend an additional indicator to monitor commitment made in para 43k of Political Declaration to "Promote increased access to cost-effective cancer screening programmes, as determined by national situations": *% districts with breast cancer early detection services for women aged 40-64*

Annex 2

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

Submitted to: World Health Organization

Date: 18 October 2012

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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:

[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].

[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

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

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prevention. Int J Obes 2011;35(7):1001-9. Sassi F. Obesity and the economics of prevention. Fit not fat. OECD 2010

[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

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 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

[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.*

obesity. As a policy indicator, guidance as set out in the Global Action Plan should be clearly signposted.

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 <u>and non-alcoholic beverages</u> 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].

[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.