World Obesity Federation

Response to WHO consultation on updating Appendix 3 to the NCD Global Action Plan

We welcome the initiative to update and extend Appendix 3 of the Global NCD Action Plan. We are pleased to submit the following general comments and some particular points.

General comments

We are particularly pleased to see that WHO has extended its list of interventions and indicated their cost-effectiveness.

We support the inclusion of a new column indicating non-financial considerations arising from some of the interventions.

However we are sorry to see the loss of the original columns specifying the relevant voluntary global targets and, especially, the tools available for supporting and guiding the suggested interventions. These tools are a valuable pool of experience and should be reinserted into the Appendix.

There needs to be a clearer statement that the interventions listed here are not the only ones which may work and be cost-effective. Other, perhaps untested interventions could be worthwhile. And some listed are not well-supported in the literature.

We would welcome more clarification on how interventions have been selected and assessed. The methodology given in the Technical annex does not really explain this, so we suggest that the document should provide links to more detailed descriptions of the process for identifying and including or rejecting interventions in Appendix 3, as one might expect from a UK NICE-type assessment. This is no small point: as the authors of Appendix 3 will be aware, the nature of evidence in the public health field is fraught with difficulty. RCT evidence is hard to obtain and tends to be limited to 'controllable' settings such as schools. Other forms of evidence showing effectiveness have to be considered, including modelling studies, in vivo case studies of voluntary and regulatory actions, and expert consensus.

There is overlap between Objective 3 (reducing risk factors), and Objective 4 (which includes health system prevention of NCDs) as the latter includes risk-factor reduction. Hence the rather anomalous intervention D4 "Lifestyle intervention for preventing type 2 diabetes" in Objective 4 Diabetes. It begs the question of what lifestyle interventions are intended here? And surely this would apply to CVD and Cancer, and perhaps COPD as well?

We welcome the emphasis on the need to “implement the WHO recommendations on the marketing of foods and non-alcoholic beverages to children” and trust that this will be retained as an overarching measure for promoting healthy diets.

Comments on specific interventions:

- U6 on breastfeeding support: this can be strengthened with interventions that provide Baby Friendly Hospitals, and social measures that provide adequate maternity leave.

- U9 on taxing sugar-sweetened beverages: these need to be implemented with social marketing campaigns and bans on advertising - a comprehensive approach. And surely taxation is strongly cost-effective as it is a net gain to the public treasury, and should be in bold?
- U11 and U12 have only weak evidence of effect, so are these as highly recommended as taxation, breastfeeding promotion and fruit and vegetable subsidies? Perhaps a 'strength of evidence of effectiveness' rating needs to be provided.
- U14 mass media campaign is only weakly effective and may increase health inequalities, so again a rating would be helpful. (And a rating for health equity impact raises some interesting questions).
- P2 (urban design for physical activity) could add that there would be a good case for subsidising public transport (or increased taxation of private transport such as congestion charging) to encourage greater use.
- P4 which suggests providing school playground facilities, means nothing if there is no time to use these, so the recommendation should be bolstered with ensuring adequate play-time and activity times are included in the curriculum.

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August 31 2016