NCD Alliance / UICC
NCD Risk Factor Webinar

12 July 2016

uicc
global cancer control
A MEMBERSHIP ORGANISATION
FIGHTING CANCER TOGETHER

NCD Alliance
PUTTING NON-COMMUNICABLE DISEASES
ON THE GLOBAL AGENDA

Agenda

Chair

- Katie Dain, NCD Alliance

Alcohol & Cancer Risk

- Terry Slevin, Cancer Council Western Australia

Physical Activity – the Global Movement

- Trevor Shilton, International Society for Physical Activity & Health

Nutrition – SMART Commitments

- Alena Matzke, NCDA & Simone Bösch, WCRF Int

Tobacco Control & COP7

- Francis Thompson, FCA

Alcohol consumption increases cancer risk: What should Cancer organisations do about it ?

Terry Slevin,
Cancer Council Western Australia

Alcohol consumption increases cancer risk: What should Cancer organisations do about it ?

Terry Slevin
Cancer Council Western Australia

Terry@cancerwa.asn.au

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Action on alcohol and cancer Summary

1. What does the evidence say ?
2. What action should we take about it ?
    1. Get our house in order
    2. Tell people what the evidence says
    3. Find like minded collaborators and work with them
    4. Focus on policy reform and apply advocacy strategies – this is political and Industry will not give up without a fight
    5. Persistence and hard work

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1. WHAT DOES THE EVIDENCE SAY? ALCOHOL AND CANCER

Alcohol and cancer

THE POSSIBLE ASSOCIATION OF THE CONSUMPTION OF ALCOHOL WITH EXCESSIVE MORTALITY FROM CANCER.

BY ARTHUR NEWSHOLME, M.D., F.R.C.P.LOND.,
Medical Officer of Health of Brighton.

PART II of Dr. Tatham's decennial supplement to the 55th report of the Registrar-General, published in 1897, contained extremely valuable statistics relating to the relative death-rates and what are known as the "comparative mortality figures" of men engaged in different occupations. These statistics dealt not only with deaths from all causes in conjunction, but also from certain diseases; and the latter figures throw important light upon the influence of occupation on the mortality, for instance, from tuberculosis and cancer.

The death-rate from all causes in the three years 1891, 1896, and 1901 was 17.13 among the abstainers and 23.52 per 1,000 lives at risk among the non-abstainers; while the death-rate from malignant disease was 0.95 among the former and 1.32 per 1,000 among the latter. In other words, if the death-rate among non-abstainers in each instance be stated as 100, that of abstainers from all causes was 72.8, and from cancer was 72.0.

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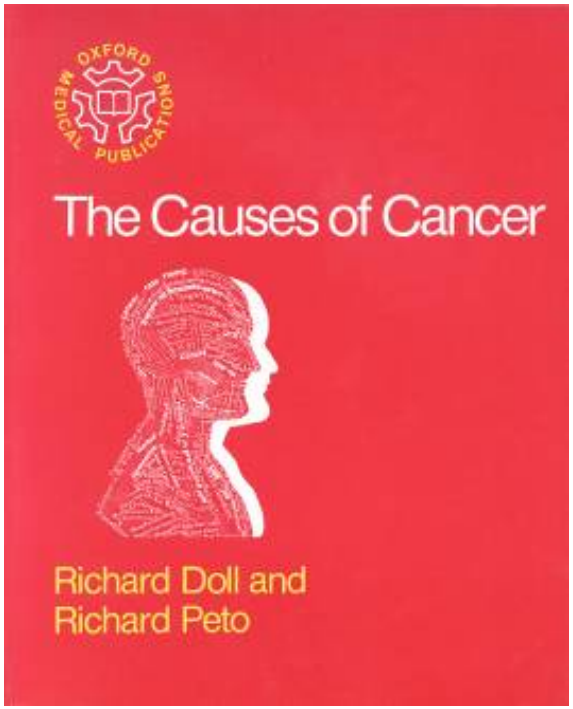
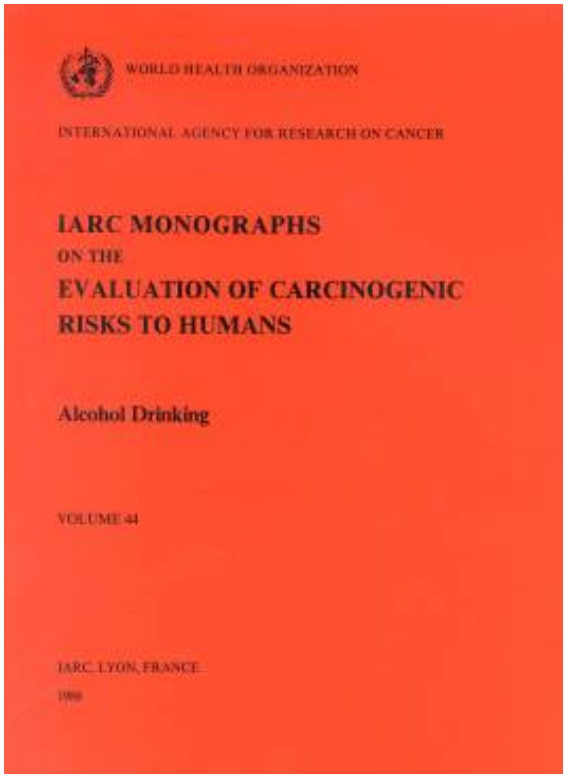
Alcohol and cancer



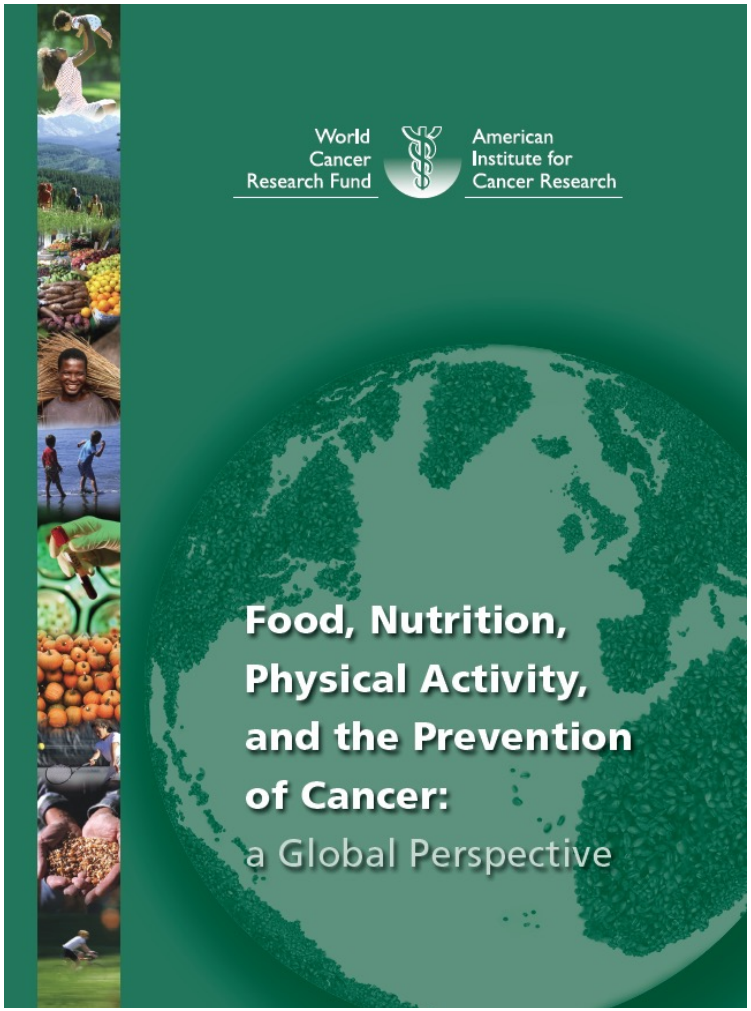
- Doll and Peto (1980)
  - "That alcohol is involved in the production of cancer has been suspected for 60 years…"
  - Sites:
    - Mouth
    - Pharynx
    - Larynx
    - Esophagus
    - Liver
  - Attributable fraction:
    - 3% (2-4%) of all deaths of both sexes

Alcohol and cancer



- IARC (1988)
  - "Alcoholic beverages are *carcinogenic to humans (Group 1)*."
  - Sites:
    (same as Doll and Peto)
    - Oral cavity
    - Pharynx
    - Larynx
    - Esophagus
    - Liver

Alcohol and cancer



- WCRF (2007)
  - "…the evidence is that alcoholic drinks are a cause of cancers…"
  - Sites:
    - Mouth
    - Pharynx
    - Larynx
    - Esophagus
    - Liver
    - Female breast
    - Colorectum

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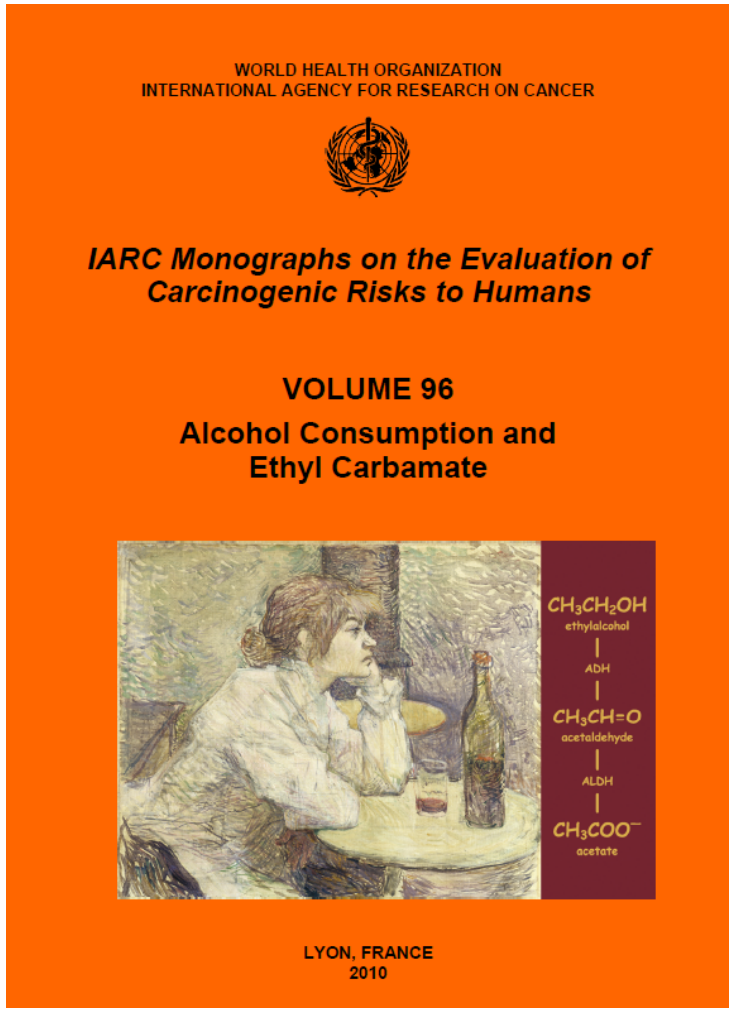
Alcohol and cancer



- IARC (2010)
  - There is sufficient evidence in humans for the carcinogenicity of alcoholic beverages.
  - Sites:
    - Oral cavity
    - Pharynx
    - Larynx
    - Oesophagus
    - Liver
    - Colorectum (bowel)
    - Female

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How much cancer does alcohol cause ? Australian estimates

Table 1. Cancers in Australia linked to alcohol use

Type of cancer	Population attributable fraction			Total incidence (2009)[1]	Incidence attributed to alcohol use
	WCRF AICR[4]	EPIC[5]	Parkin[5]		
Cancers linked to alcohol use by convincing evidence					
Mouth, pharynx	41%	25–44%	16.9–37.3%	3,005	508–1,322
Larynx in men		44%	27.3%	537	147–236
Larynx in women		25%	12.2%	69	8–28
Oesophagus in men	51%	44%	25.3%	917	232–468
Oesophagus in women		25%	11.3%	397	45–202
Bowel in men	7%	17%	15.5%	7,982	559–1,357
Breast in women	22%	5%	6.4%	13,668	683–3,007
Subtotal					**2,182–6,620**
% of all cancers					**1.9 – 5.8%**
Cancers linked to alcohol use by probable evidence					
Bowel in women	7%	4%	6.9%	6,428	257–450
Liver in men	17%	33%	11.4%	936	107–309
Liver in women		18%	5.0%	368	18–66
Subtotal					**382–825**
Percentage of all cancers					**0.3–0.7%**
Total cancers linked to alcohol use by convincing and probable evidence					
Total					**2,564–7,445**
Percentage of all cancers					**2.2–6.5%**

http://wiki.cancer.org.au/prevention/Alcohol

Abstract

Objective: To estimate the proportion and numbers of cancers occurring in Australia in 2010 that are attributable to alcohol consumption.

Methods: We estimated the population attributable fraction (PAF) of cancers causally associated with alcohol consumption using standard formulae incorporating prevalence of alcohol consumption and relative risks associated with consumption and cancer. We also estimated the proportion change in cancer incidence (potential impact fraction [PIF]) that might have occurred under the hypothetical scenario that an intervention reduced alcohol consumption, so that no-one drank >2 drinks/day.

Results: An estimated 3,208 cancers (2.8% of all cancers) occurring in Australian adults in 2010 could be attributed to alcohol consumption. The greatest numbers were for cancers of the colon (868) and female breast cancer (830). The highest PAFs were for squamous cell carcinomas of the oral cavity/pharynx (31%) and oesophagus (25%). The incidence of alcohol-associated cancer types could have been reduced by 1,442 cases (4.3%) – from 33,537 to 32,083 – if no Australian adult consumed >2 drinks/day.

Conclusions: More than 3,000 cancers were attributable to alcohol consumption and thus were potentially preventable.

Implications: Strategies that limit alcohol consumption to guideline levels could prevent a large number of cancers in Australian adults.

Key words: population attributable fraction, cancer, risk factor, alcohol, potential impact fraction

Pandeya N, Wilson LF, Webb PM, Neale RE, Bain CJ, Whiteman DC
Aust N Z J Public Health 2015 Oct;39(5):408-13.

Cancers in Australia in 2010 attributable to the consumption of alcohol

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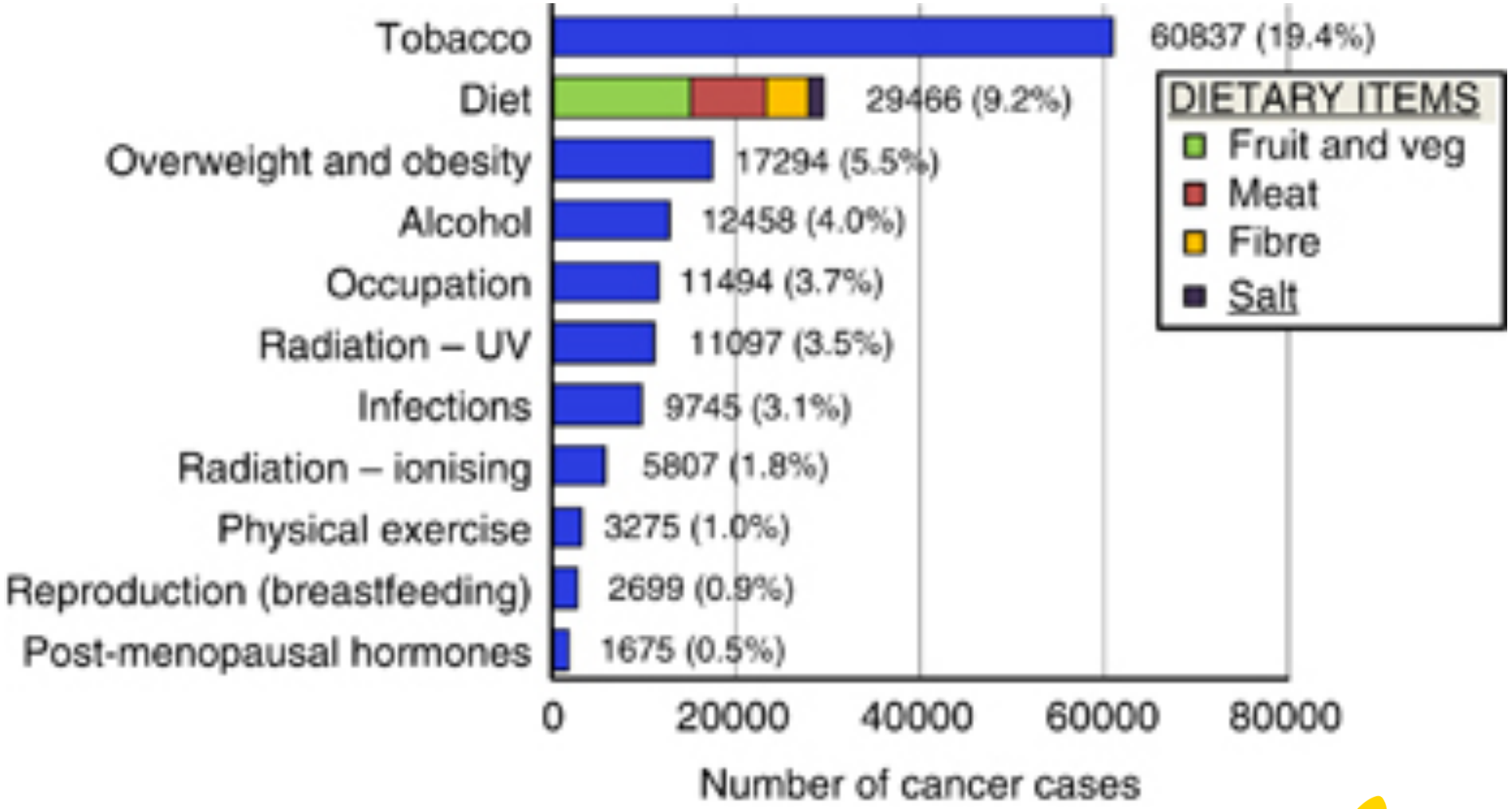
The fraction of cancer attributable to lifestyle and environmental factors in the UK in 2010



D M Parkin, L Boyd & L C Walker *British Journal of Cancer* (2011) **105**, S77–S81

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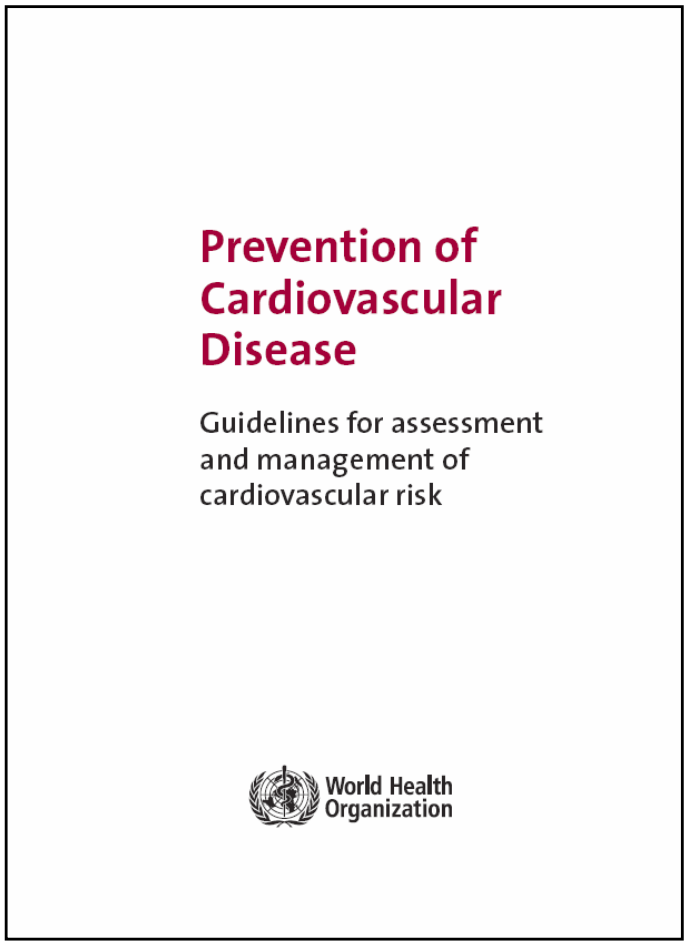
Alcohol and CVD



- WHO 2007
  - "Consequently, from both the public health and clinical viewpoints, there is no merit in promoting alcohol consumption as a preventive strategy.

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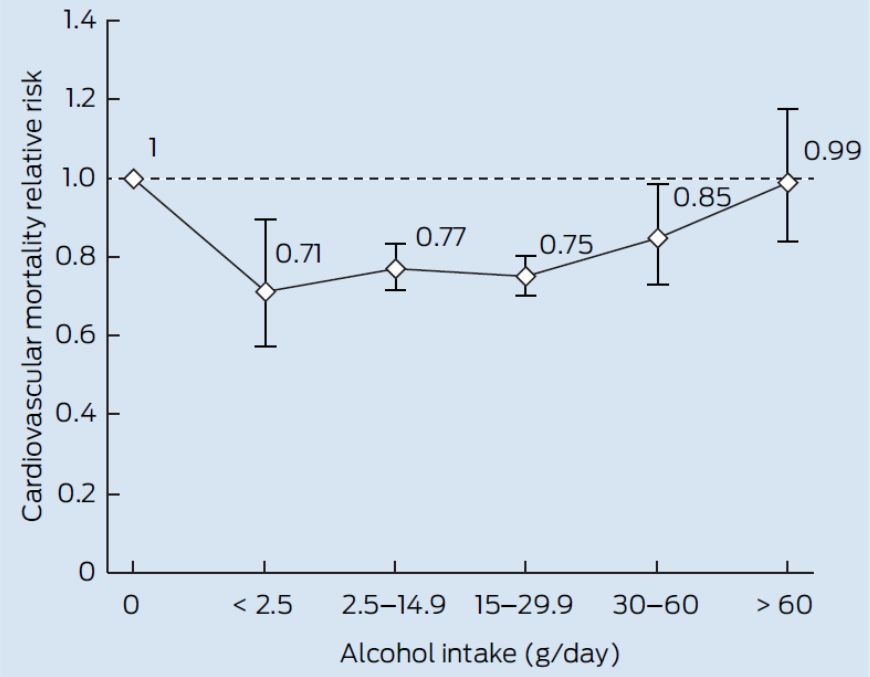
"But red wine prevents heart disease?"

For

2 Meta-analysis showing the J-shaped relationship between cardiovascular mortality and alcohol intake based on 84 studies involving over a million people



Redrawn from data in Ronksley et al.[22] ◆

Against

1. Misclassification error
2. Confounding
3. Self-report, recall bias and drinker 'drift'
4. Drinking patterns

Drug and Alcohol Review (July 2009), 28, 441–444
DOI: 10.1111/j.1465-3362.2009.00052.x

COMMENTARY

A healthy dose of scepticism: Four good reasons to think again about protective effects of alcohol on coronary heart disease

TANYA CHIKRITZHS[1], KAYE FILLMORE[2] & TIM STOCKWELL[3]

[1]*National Drug Research Institute, Curtin University of Technology, Perth, Australia,* [2]*Department of Social and Behavioral Sciences, University of California, San Francisco, USA, and* [3]*Center for Addictions Research of British Columbia, University of Victoria, Victoria BC, Canada*

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2. WHAT DO WE DO ABOUT IT ?
2.1 GETTING OUR OWN HOUSE IN ORDER

Alcohol and cancer

POSITION STATEMENT

Alcohol and cancer: a position statement from Cancer Council Australia

Margaret H Winstanley, Iain S Pratt, Kathryn Chapman, Hayley J Griffin, Emma J Croager, Ian N Olver, Craig Sinclair and Terry J Slevin

ABSTRACT

- The Cancer Council Australia (CCA) Alcohol Working Group has prepared a position statement on alcohol use and cancer. The statement has been reviewed by external experts and endorsed by the CCA Board.
- Alcohol use is a cause of cancer. Any level of alcohol consumption increases the risk of developing an alcohol-related cancer; the level of risk increases in line with the level of consumption.
- It is estimated that 5070 cases of cancer (or 5% of all cancers) are attributable to long-term chronic use of alcohol each year in Australia.
- Together, smoking and alcohol have a synergistic effect on cancer risk, meaning the combined effects of use are significantly greater than the sum of individual risks.
- Alcohol use may contribute to weight (fat) gain, and greater body fatness is a convincing cause of cancers of the oesophagus, pancreas, bowel, endometrium, kidney and breast (in postmenopausal women).
- The existing evidence does not justify the promotion of alcohol use to prevent coronary heart disease, as the previously reported role of alcohol in reducing heart disease risk in light-to-moderate drinkers appears to have been overestimated.
- CCA recommends that to reduce their risk of cancer, people limit their consumption of alcohol, or better still avoid alcohol altogether.
- For individuals who choose to drink alcohol, CCA recommends that they drink only within the National Health and Medical Research Council guidelines for alcohol consumption.

MJA 2011; 194: 479–482

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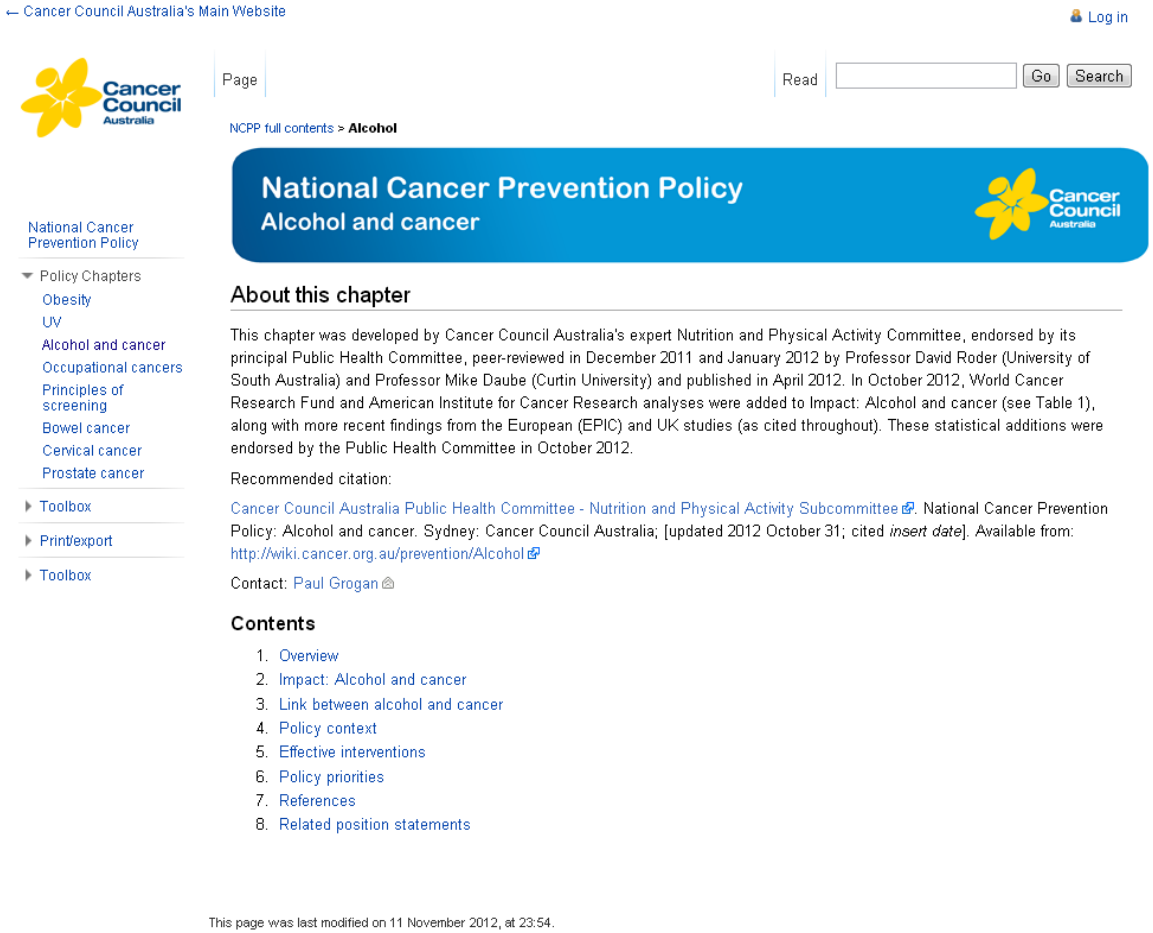
Alcohol and cancer



← Cancer Council Australia's Main Website

Log in

Page | Read | Go | Search

NCPP full contents > **Alcohol**

National Cancer Prevention Policy
Alcohol and cancer

National Cancer Prevention Policy

- Policy Chapters
  - Obesity
  - UV
  - Alcohol and cancer
  - Occupational cancers
  - Principles of screening
  - Bowel cancer
  - Cervical cancer
  - Prostate cancer
- Toolbox
- Print/export
- Toolbox

About this chapter

This chapter was developed by Cancer Council Australia's expert Nutrition and Physical Activity Committee, endorsed by its principal Public Health Committee, peer-reviewed in December 2011 and January 2012 by Professor David Roder (University of South Australia) and Professor Mike Daube (Curtin University) and published in April 2012. In October 2012, World Cancer Research Fund and American Institute for Cancer Research analyses were added to Impact: Alcohol and cancer (see Table 1), along with more recent findings from the European (EPIC) and UK studies (as cited throughout). These statistical additions were endorsed by the Public Health Committee in October 2012.

Recommended citation:

Cancer Council Australia Public Health Committee - Nutrition and Physical Activity Subcommittee. National Cancer Prevention Policy: Alcohol and cancer. Sydney: Cancer Council Australia; [updated 2012 October 31; cited *insert date*]. Available from: http://wiki.cancer.org.au/prevention/Alcohol

Contact: Paul Grogan

Contents

1. Overview
2. Impact: Alcohol and cancer
3. Link between alcohol and cancer
4. Policy context
5. Effective interventions
6. Policy priorities
7. References
8. Related position statements

This page was last modified on 11 November 2012, at 23:54.

Privacy policy | About National Cancer Prevention Policy | Disclaimers

Drug and alcohol policy.

"Practice what you preach"

Cancer Council WA

4.6. Public Health -

- **4.6.1.** Under *usual circumstances*, anyone on official Cancer Council business should not consume alcohol;
- **4.6.2.** Cancer Council does not accept funds from companies that produce alcohol;
- **4.6.3.** Alcohol must not be given as a corporate gift or prize;
- **4.6.4.** Alcohol must not be served or consumed on Cancer Council premises or at activities under the control of Cancer Council, unless written approval has been sought from the CEO. Approval must include the following:
  - **4.6.4.1.** Cancer Council will not hold the liquor license; and
  - **4.6.4.2.** Alcohol will be available for purchase under the conditions of the licence of the venue, in accordance with the *Liquor Licensing Act 1988* (WA).

But what about fund raising ?

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2.2 TELL PEOPLE WHAT THE SCIENCE SAYS

Alcohol and cancer campaign:
A partnership with WA Drug & Alcohol Office

Spread

Stains

[To see more campaigns on the health effects of alcohol

http://alcoholthinkagain.com.au/Campaigns](http://alcoholthinkagain.com.au/Campaigns)

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BMJ Open

Using a mass media campaign to raise women's awareness of the link between alcohol and cancer: cross-sectional pre-intervention and post-intervention evaluation surveys

Helen G Dixon,[1] Iain S Pratt,[2] Maree L Scully,[1] Jessica R Miller,[3] Carla Patterson,[3] Rebecca Hood,[3] Terry J Slevin[2]

To cite: Dixon HG, Pratt IS, Scully ML, *et al*. Using a mass media campaign to raise women's awareness of the link between alcohol and cancer: cross-sectional pre-intervention and post-intervention evaluation surveys. *BMJ Open* 2015;**5**: e006511. doi:10.1136/bmjopen-2014-006511

► Prepublication history for this paper is available online. To view these files please visit the journal online (http://dx.doi.org/10.1136/bmjopen-2014-006511).

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[3]Drug and Alcohol Office, Government of Western Australia, Mount Lawley, Western Australia, Australia

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SPratt@cancerwa.asn.au

ABSTRACT

Objectives: To evaluate the effectiveness of a population-based, statewide public health intervention designed to improve women's awareness and knowledge of the link between alcohol and cancer.

Design: Cross-sectional tracking surveys conducted pre-intervention and post-intervention (waves I and III of campaign).

Setting: Western Australia.

Participants: Cross-sectional samples of Western Australian women aged 25–54 years before the campaign (n=136) and immediately after wave I (n=206) and wave III (n=155) of the campaign.

Intervention: The 'Alcohol and Cancer' mass media campaign ran from May 2010 to May 2011 and consisted of three waves of paid television advertising with supporting print advertisements.

Main outcome measures: Campaign awareness; knowledge of drinking guidelines and the link between alcohol and cancer; intentions towards drinking.

Results: Prompted recognition of the campaign increased from 67% following wave I to 81% following wave III (adjusted OR (adj OR)=2.31, 95% CI 1.33 to 4.00, p=0.003). Improvements in women's knowledge that drinking alcohol on a regular basis increases cancer risk were found following wave I (adj OR=2.60, 95% CI 1.57 to 4.30, p<0.001) and wave III (adj OR=4.88, 95% CI 2.55 to 9.36, p<0.001) compared with baseline. Knowledge of the recommended number of standard drinks for low risk in the long term increased between baseline and wave I (adj OR=1.68, 95% CI 1.02 to 2.76, p=0.041), but not baseline and wave III (adj OR=1.42, 95% CI 0.84 to 2.39, p=0.191). Among women who drink alcohol, the proportion expressing intentions to reduce alcohol consumption increased significantly between baseline and wave III (adj OR=2.38, 95% CI 1.11 to 5.12, p=0.026). However, no significant reductions in recent drinking behaviour were found following the campaign.

Conclusions: Results indicate a population-based mass media campaign can reach the target audience and raise awareness of links between alcohol and cancer, and knowledge of drinking guidelines. However, a single campaign may be insufficient to measurably curb drinking behaviour in a culture where pro-alcohol social norms and product marketing are pervasive.

Strengths and limitations of this study

- This is the first published evaluation of a mass media campaign highlighting the link between alcohol and cancer.
- Results indicate this innovative mass media intervention produced medium to large effects on improving women's awareness and knowledge regarding alcohol and cancer.
- A strength of the evaluation design was the inclusion of a baseline survey assessing women's knowledge and intentions concerning alcohol and cancer prior to the intervention.
- The use of cross-sectional tracking surveys without a control group did not allow for the contribution of secular trends to the results to be measured.
- The campaign advertisements have potential to be adapted for use and evaluation in other settings.

INTRODUCTION

Globally, alcohol consumption is a major risk factor contributing to the burden of ill health and premature death. An estimated 3.8% of deaths and 4.6% of disability adjusted life-years are attributable to alcohol use, and alcohol imposes economic costs equivalent to about 1% of gross national product in high-income countries.[1] Alcohol is a known carcinogen, with current epidemiological data providing convincing evidence that alcohol is a cause of cancer of the mouth, pharynx, larynx, oesophagus, bowel (in men) and

Conclusions

Results indicate a population-based mass media campaign can reach the target audience and raise awareness of links between alcohol and cancer, and knowledge of drinking guidelines. However, a single campaign may be insufficient to measurably curb drinking behaviour in a culture where pro-alcohol social norms and product marketing are pervasive.

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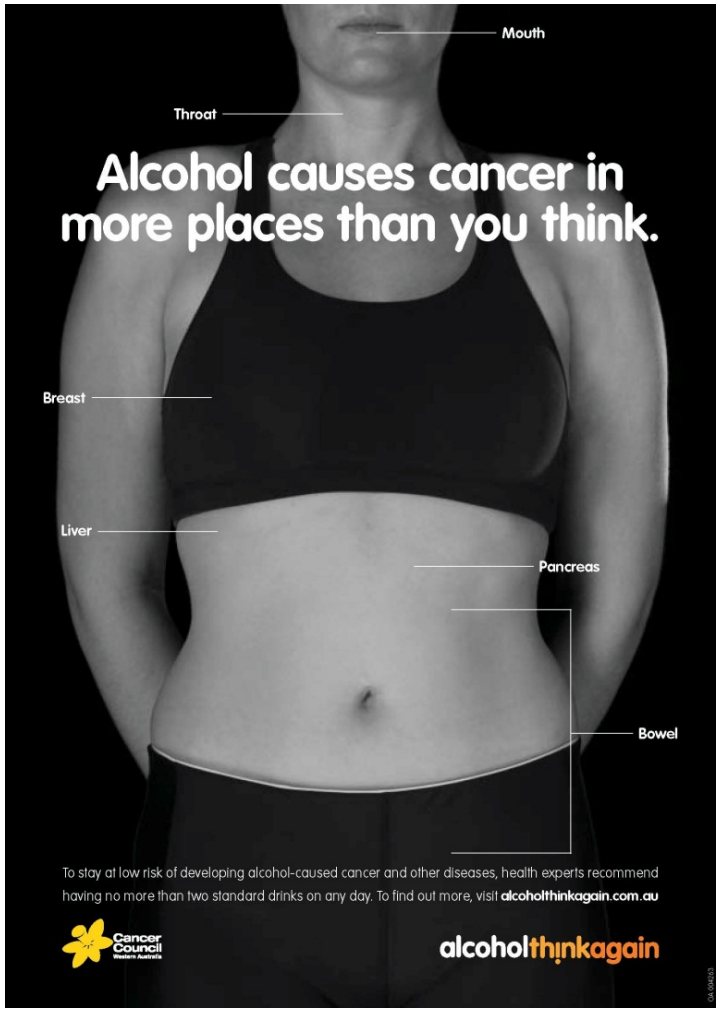
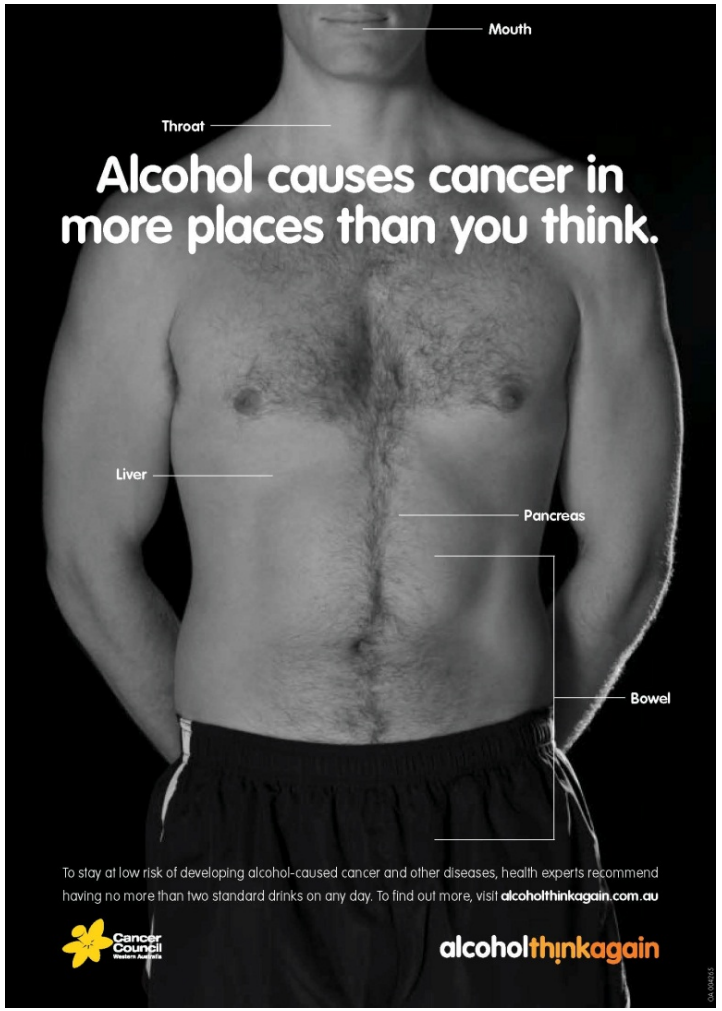
Phase one posters





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Alcohol and cancer information

Cancer Council Western Australia

What can I do?

- Stop smoking
- Move your body
- Stay in shape
- Eat for health
- Be SunSmart
- Avoid alcohol
- Talk to your doctor about cancer

Cancer Council Helpline
13 11 20
www.cancerwa.asn.au

For support and information on cancer and cancer-related issues, call Cancer Council Helpline. This is a confidential service. Available Statewide for the cost of a local call Monday to Friday 8 am – 6 pm

Funded by Community Donations

03/12

Alcohol and cancer

Reduce your risk of cancer

NCD Alliance

Cancer Council Western Australia

2.3 FIND COLLABORATORS AND WORK WITH THEM

Alcohol Action Alliances

- Organisations with an interest in
- Public Health (Public Health Association, Medical Association, Health Promotion Association, Emergency Physicians etc
- Disease Specific Heart, Diabetes, kidney,
- Drug and Alcohol organisation
- Social Welfare organisations (Salvation Army,
- Injury Prevention
- Law and order groups (policy, Crime prevention)

National Alliance for Action on Alcohol Australia: NAAAA

Home

National Alliance for Action on Alcohol is a national coalition of over 70 health and community organisations from across Australia that has been formed with the goal of reducing alcohol-related harm.

The National Alliance for Action on Alcohol is a national coalition of health and community organisations from across Australia that has been formed with the goal of reducing alcohol-related harm.

Currently comprising major organisations with an interest in alcohol and public health, the formation of the National Alliance for Action on Alcohol represents the first time such a broad-based alliance has come together to pool their collective expertise around what needs to be done to address Australia's drinking problems.

The National Alliance for Action on Alcohol aims to put forward evidence-based solutions with a strong emphasis on action.

This site is currently undergoing redevelopment, and some pages may be temporarily unavailable. We apologise for any inconvenience.

News Update

Time for all political parties to ban alcohol advertising to kids

29/06/2016

29 June 2016: There is still time for all major parties to commit to closing

Latest Tweets

ACTIONonALCOHOL Retweeted

The RACP
@TheRACP

#Alcohol-related harm now #1 public health issue in Canberra's emergency departments bit.ly/29EjQPq

http://actiononalcohol.org.au/

2.4 POLICY AND ADVOCACY

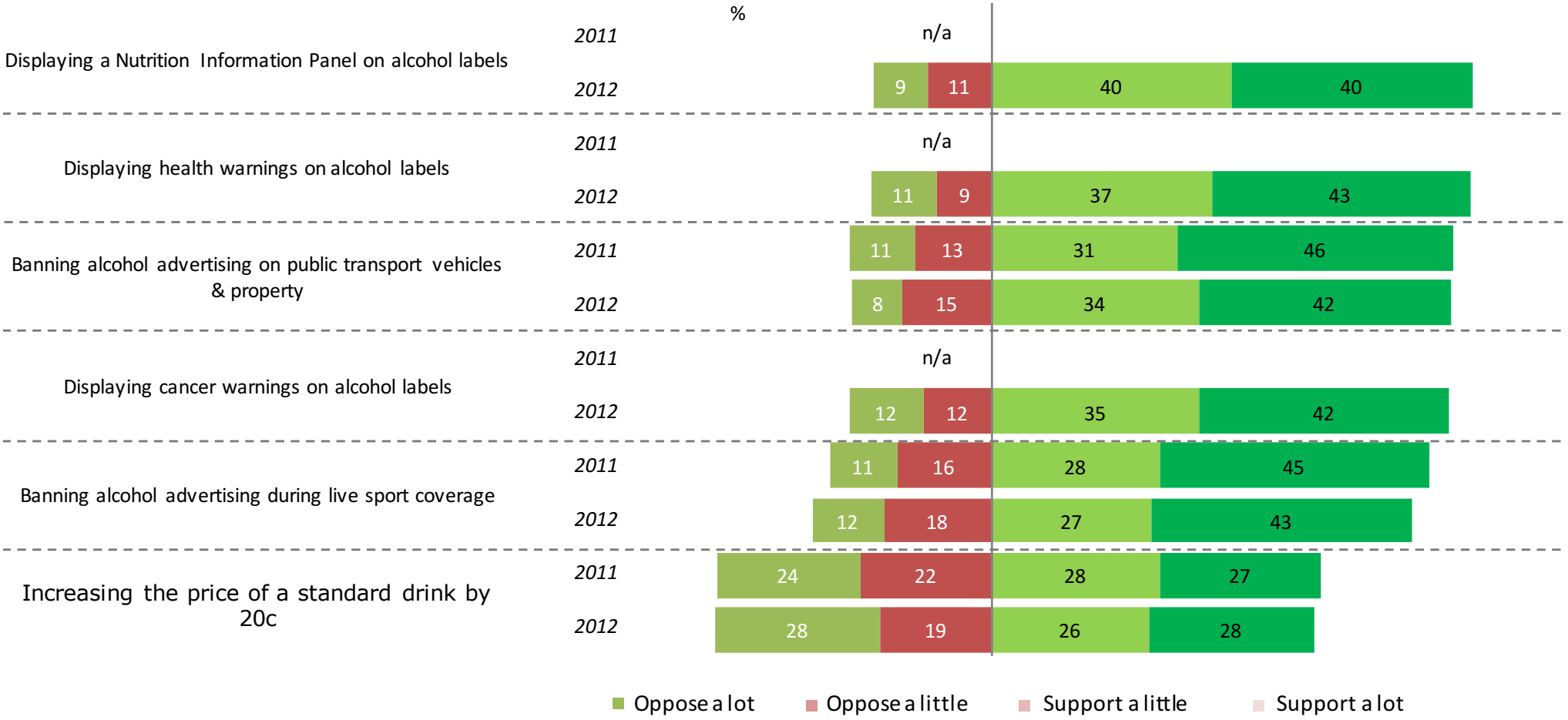
WHAT DO WE WANT TO CHANGE WHEN IT COMES TO ALCOHOL ?

What works to reduce alcohol consumption in populations ?

- Reduce promotion - Controls on marketing – firstly aimed at children, but more widely
- Control access. Liquor licencing laws restrict access to alcohol to certain people (e.g. children) at certain times (e.g. mandatory closing times).
- Drink driving laws also control when people can drink alcohol (not while in charge of cars or heavy machinery)
- Tax – increasing alcohol taxes increases price and reduces consumption
- Community education - This is important to drive all of the above

Support for Legislation

- The strongest level of support exists amongst the community for displaying a Nutrition Information panel or a health warning on alcohol labels. Increasing price remains the least supported proposed measure.



- Q25. Would you support or oppose the following measures to reduce alcohol-related issues in the community?
- Base: Total respondent 2011,n=419; 2012,n=400

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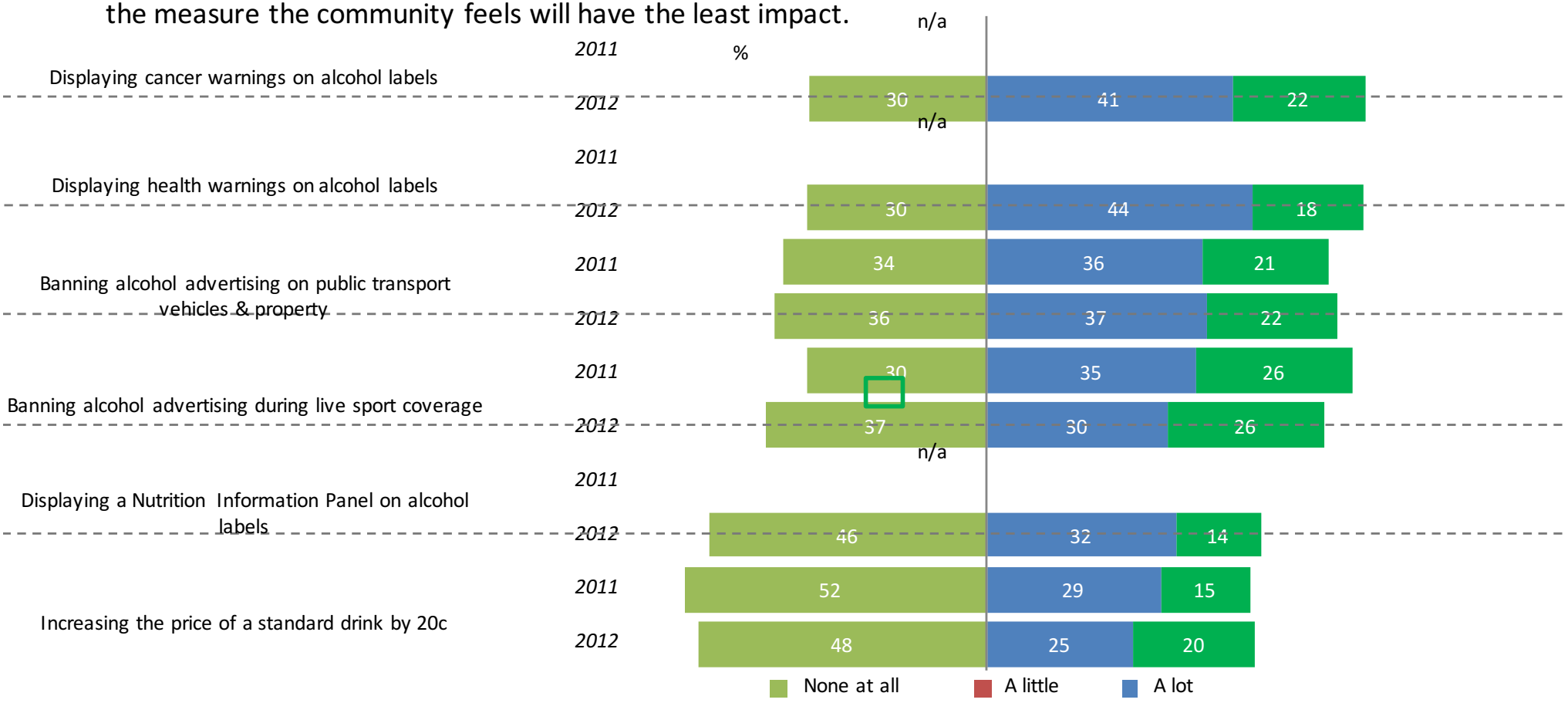
Potential Impact of Legislation

- Displaying a Nutrition Information Panel or a health warning on alcohol labels are perceived to be the measures which will have the greatest impact on reducing alcohol-related issues. Increasing price remains the measure the community feels will have the least impact.



- Q26. How much impact would each of these have on reducing alcohol-related issues in the community?
- Base: Total sample 2011,n=419; 2012,n=400

Alternative alcohol advertising code

ALCOHOL ADVERTISING REVIEW BOARD

MCAAY McCusker Centre for Action on Alcohol and Youth

Cancer Council Western Australia

Alcohol Advertising Review Board Content and Placement Code

Preamble

Alcohol is no ordinary commodity. It is associated with harm to health, violence, crime, social disruption and economic cost. Per capita alcohol consumption in Australia has been rising over the past two decades and alcohol-related harm has reached critical levels, with especial concerns about drinking patterns among young people.[1,2] Alcohol companies spend hundreds of millions of dollars promoting their products, and their advertising is highly effective. Alcohol and advertising industry involvement in the regulation of their advertising is seen as both biased and ineffective.[3] Current definitions of advertising used in Australia exclude major forms of advertising, including sports sponsorship. Current definitions of advertising used in Australia exclude major forms of advertising, including sports sponsorship. Recognising the compelling need for responsible regulation of alcohol advertising and promotion in Australia, the Alcohol Advertising Review Board reviews complaints from the community about alcohol advertising.

Alcohol and harm:

There is an urgent need for action to challenge Australia's harmful drinking culture. The social costs of alcohol-related harm to Australians are high. One in five Australians aged 14 years and above drinks at short-term risky/high-risk levels at least once a month.[4] This equates to more than 42 million occasions of binge drinking in Australia each year. The cost to the Australian community from alcohol-related harm is estimated to be more than $36 billion a year.[5] An estimated 40% of all people detained by police attribute their offence to alcohol consumption.[6] Alcohol is associated with violence, injury, crime and car crashes.

Alcohol also causes considerable harm to health. Heavy drinking at a young age can adversely affect brain development and is linked to alcohol-related problems in later life.[7] On average, one in four hospitalisations of young people aged 15-24 years occurs because of alcohol.[4] Alcohol ingested by the mother is associated with harm to unborn babies and breastfeeding infants.[4] Excessive alcohol consumption is a major risk factor for a variety of health problems such as stroke, coronary heart disease and high blood pressure.[8] Alcohol is a risk factor for cancer of the mouth, pharynx, larynx, oesophagus, bowel and breast, with 5% of all cancers in Australia linked to long-term alcohol consumption.[9]

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[1] Chikritzhs T, Allsop S, Moodie R, Hall W. Per capita alcohol consumption in Australia: will the real trend please step forward? Medical Journal of Australia. 2010; 193(10):1-4.
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[4] Australian Institute of Health and Welfare (AIHW) 2007 National Drug Strategy Household Survey: Detailed findings. Drugs Statistics Series 22. Canberra: AIHW, 2008.
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[7] National Health and Medical Research Council (NHMRC). Australian guidelines to reduce health risks from drinking alcohol. Canberra: NHMRC, 2009.
[8] National Health and Medical Research Council. Alcohol and Health in Australia: http://www.nhmrc.gov.au/your-health/alcohol-guidelines/alcohol-and-health-australia (August 2011)
[9] Winstanley M, Pratt I, Chapman K, Griffin H, Croager E, Oliver I, et al. Alcohol and cancer: a position statement from Cancer Council Australia. Medical Journal of Australia. 2011; 194(9):479-482.

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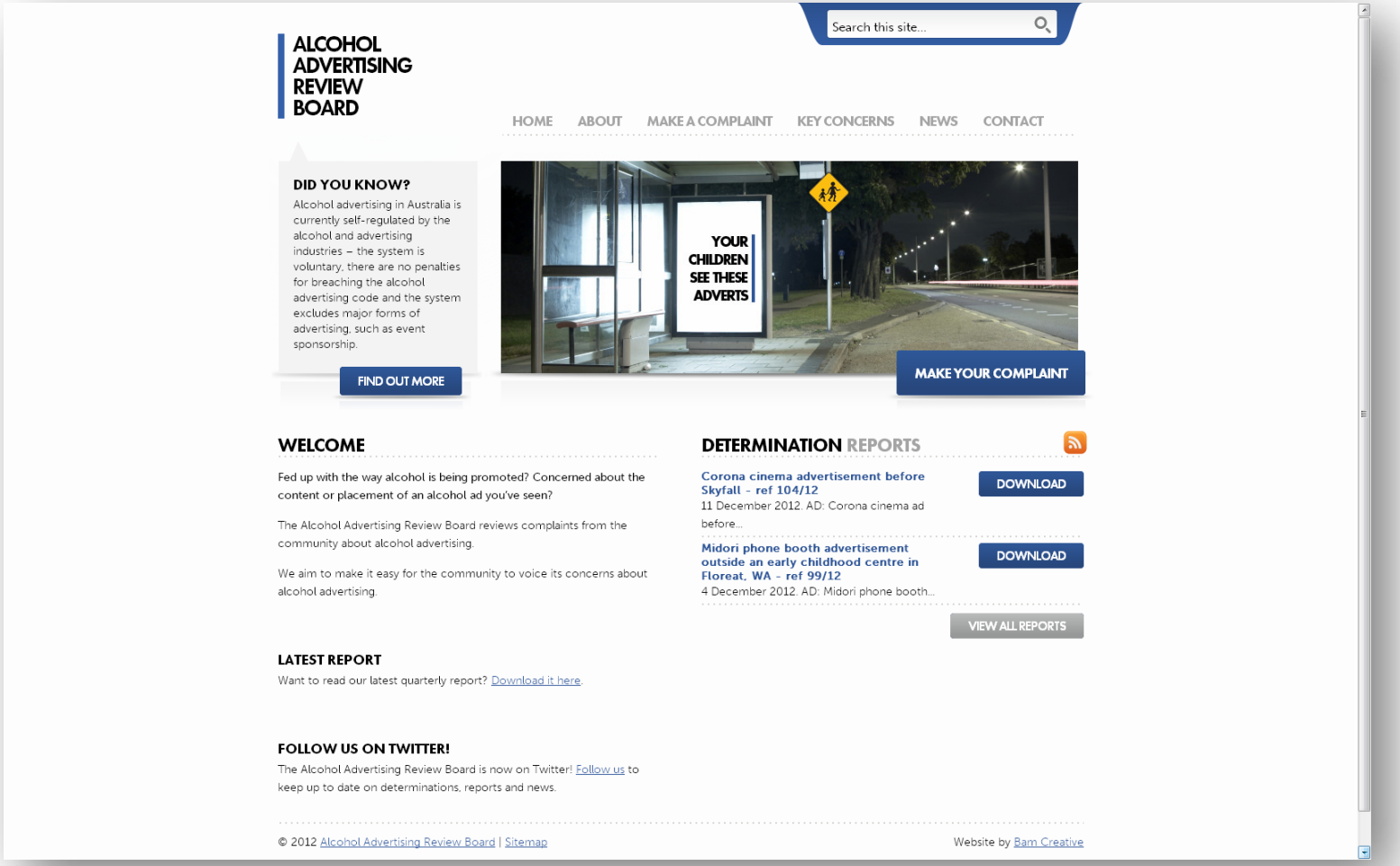
Cancer Council Western Australia

Alcohol Advertising Review Board



http://www.alcoholadreview.com.au/

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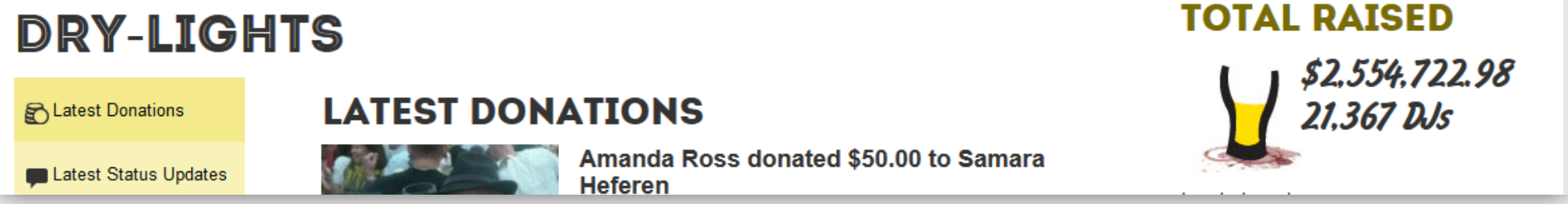
Cancer Council Western Australia



+ FebFast

+ Hello Sunday Morning

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Cancer Council Western Australia

Dionysos

Greek God of Wine

"Three kraters [cups] do I mix for the temperate: one to health, which they empty first, the second to love and pleasure, the third to sleep. When this bowl is drunk up wise guests go home. The fourth bowl is ours no longer but belongs to hubris, the fifth to uproar, the sixth to prancing about, the seventh to black eyes, the eighth brings the police, the ninth belongs to vomiting, and the tenth to insanity and the hurling of furniture."

Source: http://www.physics.uq.edu.au/people/nieminen/alcliterature.html

Finish

Q & A

Global Advocacy for Physical Activity 2016-2017

Trevor Shilton, ISPAH
Fiona Bull, ISPAH

ISPAH
International Society for Physical Activity and Health

GAPA
GLOBAL ADVOCACY
FOR PHYSICAL ACTIVITY
Advocacy Council of ISPAH

Global Advocacy for Physical Activity 2016-2017

Trevor Shilton

Chairman, GAPA

Fiona Bull

President, ISPAH

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Adj. Prof. Trevor Shilton

- **Director Cardiovascular Health, National Heart Foundation of Australia (WA)**
  - **National Lead, Active Living**
- **Adjunct Professor,** School of Public Health, Curtin University.
- **Adjunct Associate Professor**, School of Population Health, University of **Global Vice President for Advocacy**, International Union for Health Promotion and Education (IUHPE)
- Western Australia
- **Board Member**, International Society for Physical Activity and Health (ISPAH)
  - **Chairman**, Global Advocacy for Physical Activity (GAPA)
- **Life Member,** Australian Health Promotion Association.

Prof. Fiona Bull

- **Director of the Centre for Built Environment and Health at The University of Western Australia.**
- **President of the International Society for Physical Activity and Health.**
- Prior to this she worked at Loughborough University in the UK, the Division of Nutrition and Physical Activity at the Centers for Disease Control and Prevention in Atlanta, USA, and at the World Health Organization, Geneva.
- Fiona has a strong focus on application and she seeks to translate research into practical solutions and policy
- In 2014 her contribution to research and policy was recognised with the award of an MBE.

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GAPA GLOBAL ADVOCACY FOR PHYSICAL ACTIVITY Advocacy Council of ISPAH

ISPAH International Society for Physical Activity and Health

About ISPAH

International Society for Physical Activity and Health

- Founded in 2009
- **Vision**

  A healthy active world where the opportunities for *physcial activity and active living* are available to all.

- **Mission**

  To advance and promote physical activity as a global health priority through excellence in research, education, capacity building and advocacy

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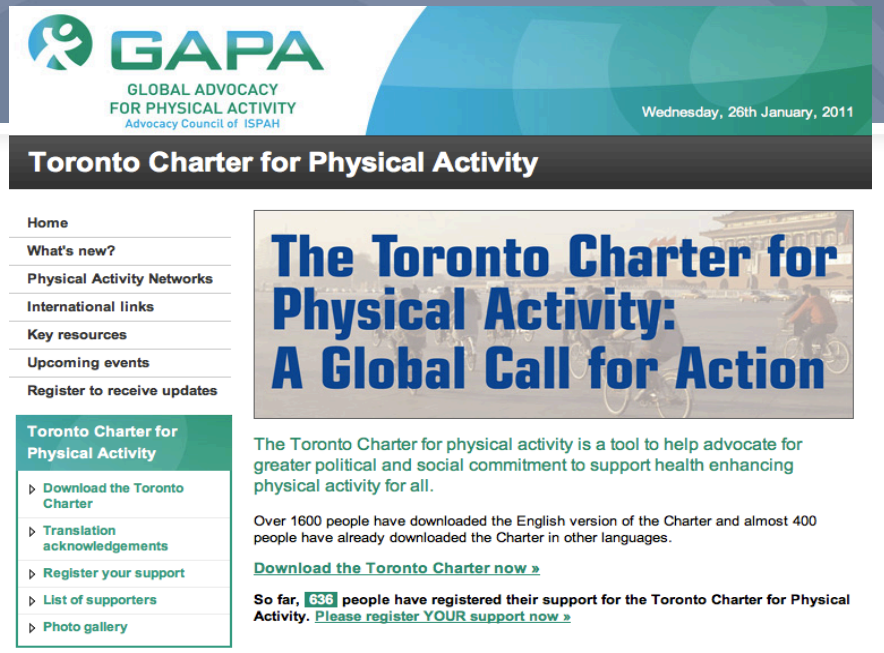
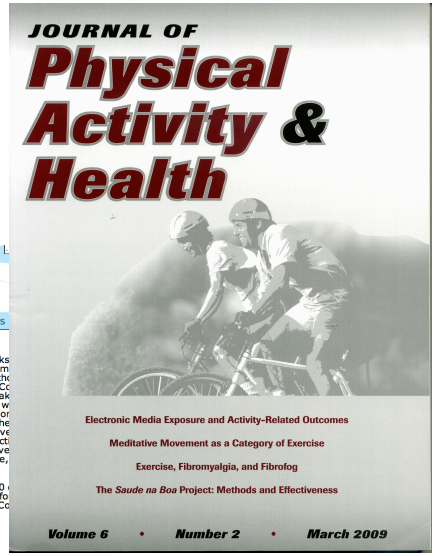
ISPAH

ISPAH – Five goals

1. Support **communication** of and excellence in research and practice on physical activity and public health
2. Develop **capacity** in research and practice on physical activity and public health world wide
3. Lead **advocacy** actions to advance research and knowledge dissemination into policy and practice
4. Partner in global **collaborations** to advance physical activity and public health research and practice
5. Be a world leading global **professional society** for researchers and practitioners in physical activity and public health





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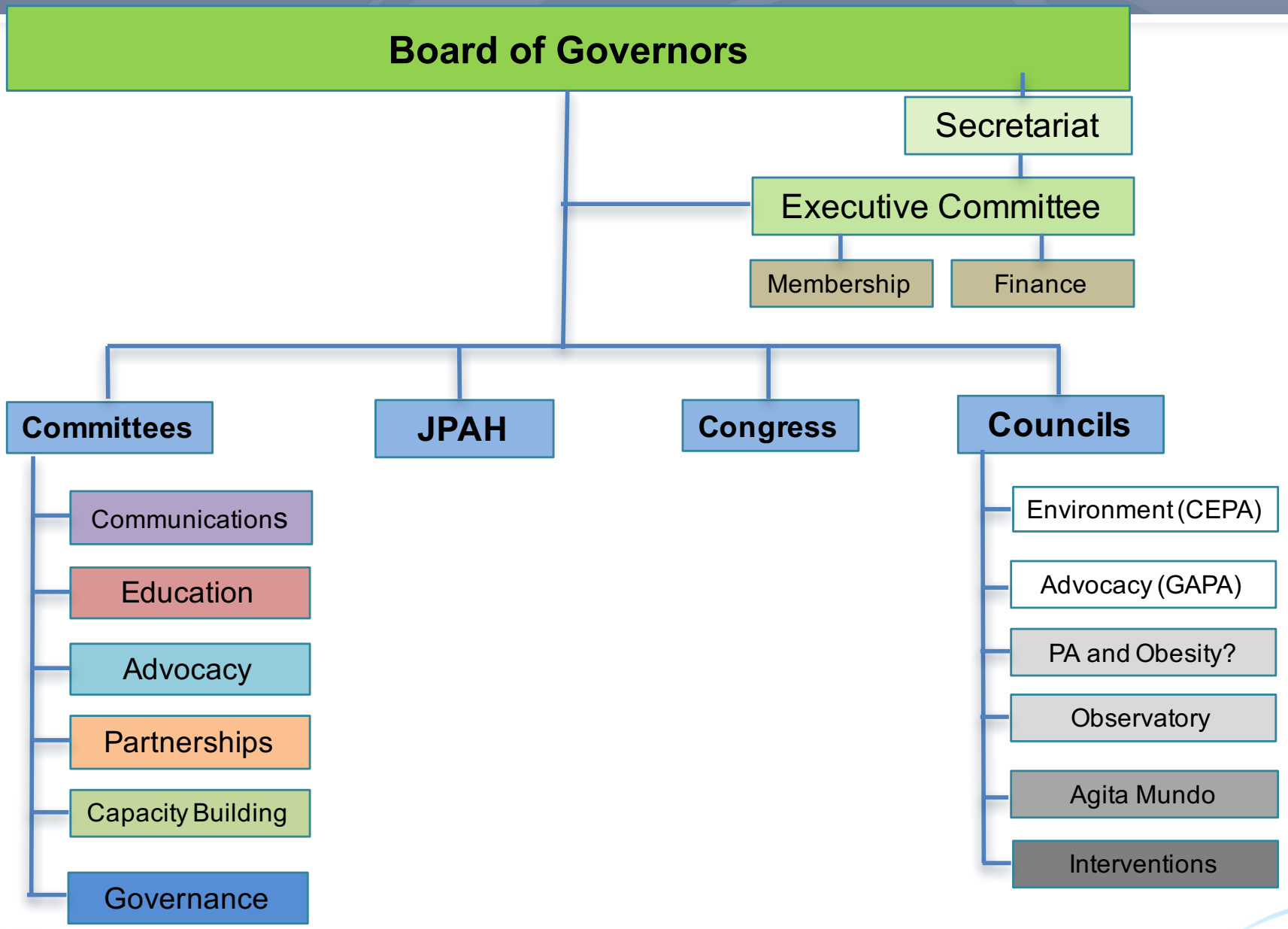
ISPAH – Organisational Structure



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ISPAH

Global Advocacy for Physical Activity
The Advocacy Council of ISPAH

GAPA
GLOBAL ADVOCACY FOR PHYSICAL ACTIVITY
Advocacy Council of ISPAH

Priority advocacy strategies 2016-2017:

1. **Advocate** for the development and funding of **National Physical Activity Action Plans and scaling up their implementation**
2. **Develop global consensus documents**, advocacy tools and products to support global advocacy for physical activity
3. Use the occasion of the biennial ISPAH conference to promote and extend the **Global Physical Activity Movement** and proactive roles for conference partners (e.g. 2016 – ThaiHealth, Thai Ministry of Health).
4. **Maximise effective coalitions** and partnerships with like-minded global, regional and national agencies to advance physical activity
5. **Continue to support and expand GlobalPAnet** as a primary communication to the physical activity workforce and to ISPAH members
6. **Advance evidence dissemination and translation** as a mechanism to support advocacy objectives.

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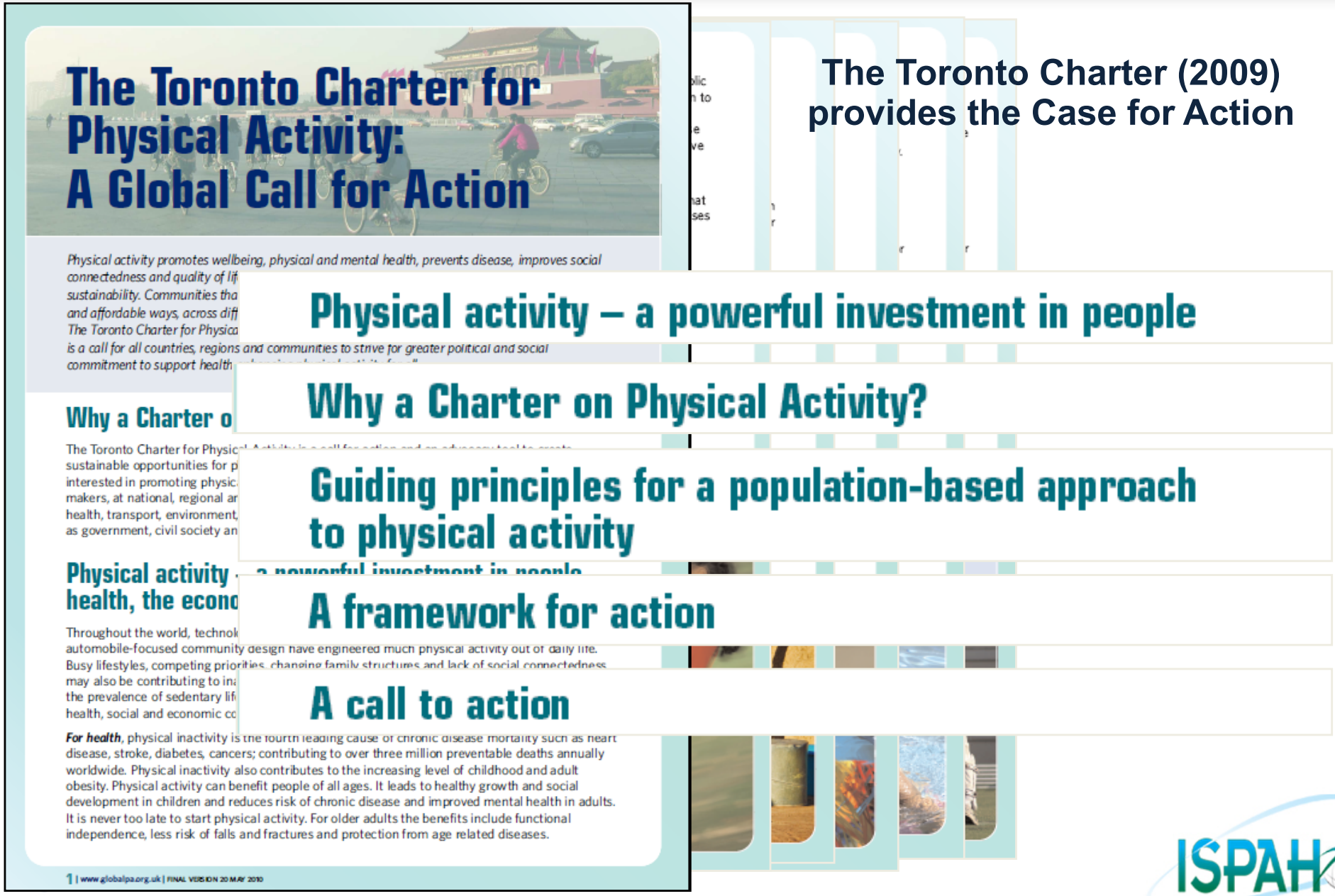
Advocacy

- A combination of individual and social actions designed to gain political commitment, policy support, social acceptance and systems support for a particular health goal or programme.

(*Health Promotion Glossary*. WHO, 1998)

Figure: Six imperatives for effective advocacy.
Modified from: Shilton TR (2006). *IUHPE:* and Shilton TR (2008). *JPAH:5(6);765-777*

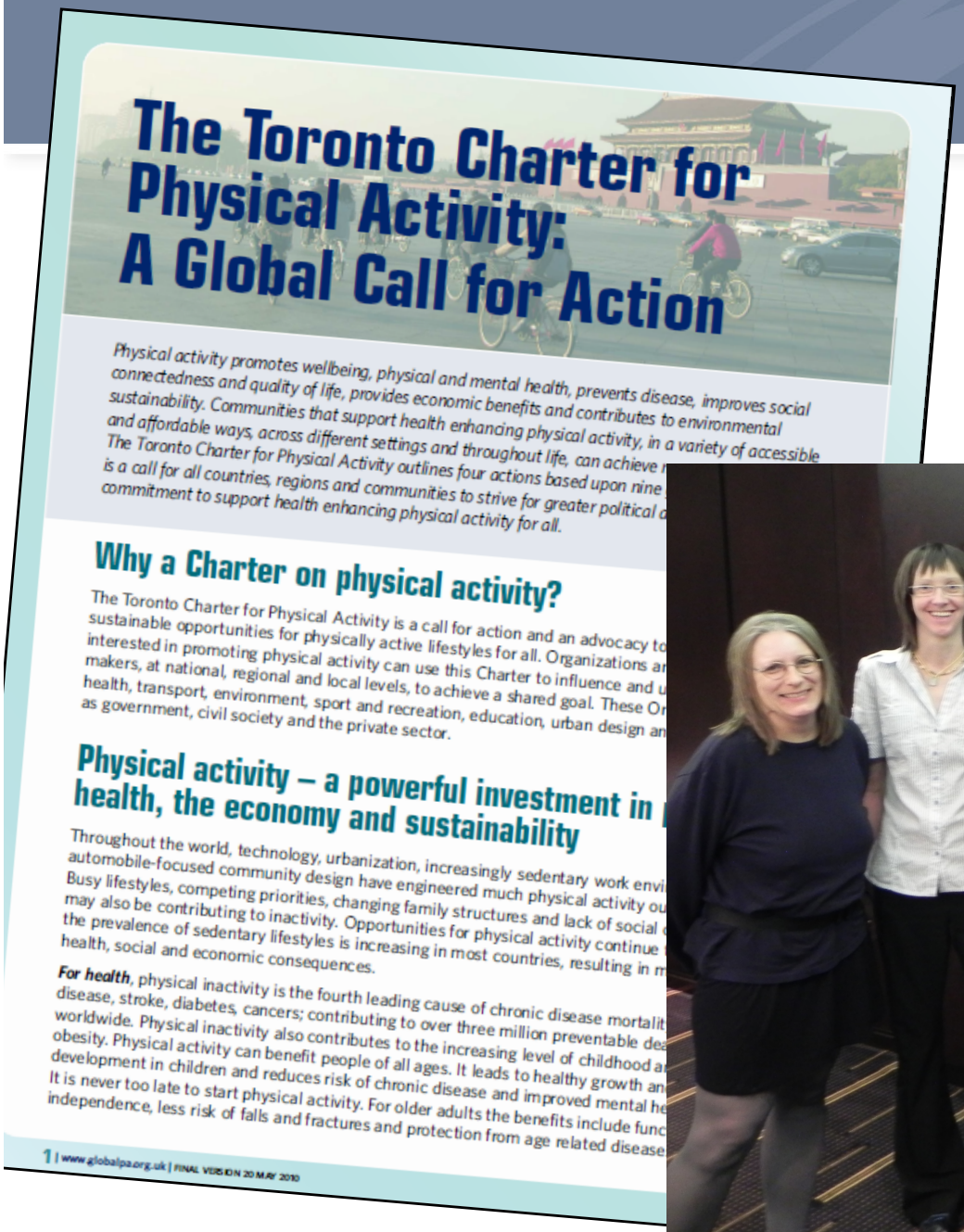
Goal 2: **Develop global consensus documents**, advocacy tools and products to support global advocacy for physical activity



The Toronto Charter (2009) provides the Case for Action

ISPAH

The Writing Team



The Toronto Charter for Physical Activity: A Global Call for Action

Physical activity promotes wellbeing, physical and mental health, prevents disease, improves social connectedness and quality of life, provides economic benefits and contributes to environmental sustainability. Communities that support health enhancing physical activity, in a variety of accessible and affordable ways, across different settings and throughout life, can achieve
The Toronto Charter for Physical Activity outlines four actions based upon nine
is a call for all countries, regions and communities to strive for greater political
commitment to support health enhancing physical activity for all.

Why a Charter on physical activity?

The Toronto Charter for Physical Activity is a call for action and an advocacy to
sustainable opportunities for physically active lifestyles for all. Organizations ar
interested in promoting physical activity can use this Charter to influence and u
makers, at national, regional and local levels, to achieve a shared goal. These Or
health, transport, environment, sport and recreation, education, urban design an
as government, civil society and the private sector.

Physical activity – a powerful investment in health, the economy and sustainability

Throughout the world, technology, urbanization, increasingly sedentary work envi
automobile-focused community design have engineered much physical activity ou
Busy lifestyles, competing priorities, changing family structures and lack of social
may also be contributing to inactivity. Opportunities for physical activity continue
the prevalence of sedentary lifestyles is increasing in most countries, resulting in m
health, social and economic consequences.

For health, physical inactivity is the fourth leading cause of chronic disease mortalit
disease, stroke, diabetes, cancers; contributing to over three million preventable dea
worldwide. Physical inactivity also contributes to the increasing level of childhood a
obesity. Physical activity can benefit people of all ages. It leads to healthy growth an
development in children and reduces risk of chronic disease and improved mental he
It is never too late to start physical activity. For older adults the benefits include func
independence, less risk of falls and fractures and protection from age related disease

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Translations:

undertaken through volunteer networks

Available in 23 languages:

- Arabic
- Castilion
- Catalan
- *Chinese*
- Czech
- Dutch
- English
- Finnish
- French
- German
- Greek
- Italian
- Japanese
- *Korean*
- Norwegian
- Persian
- Polish
- Portuguese (2)
- Russian
- Spanish
- Thai
- Turkish

Evidence on Actions

7 investments for physical activity and NCDS

- ISPAH guide for countries on where to invest in actions aimed at increasing physical activity
- Based on the best available evidence

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How we see physical activity

1. **Whole-of-school**' programs
2. **Transport policies** and systems that prioritise walking, cycling and public transport
3. **Urban design** regulations and infrastructure that provides for equitable and safe access for recreational physical activity, and recreational and transport-related walking and cycling across the life course
4. Physical activity and NCD prevention integrated into **primary health care** systems

5. **Public education**, including mass media to raise awareness and change social norms on physical activity
6. **Community-wide programs** involving multiple settings and sectors & that mobilize and integrate community engagement and resources
7. Sports systems and programs that promote '***sport for all***' and encourage participation across the life span

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ISPAH Advocacy tools

Taken to the 2011 UN High Level meeting on NCDs

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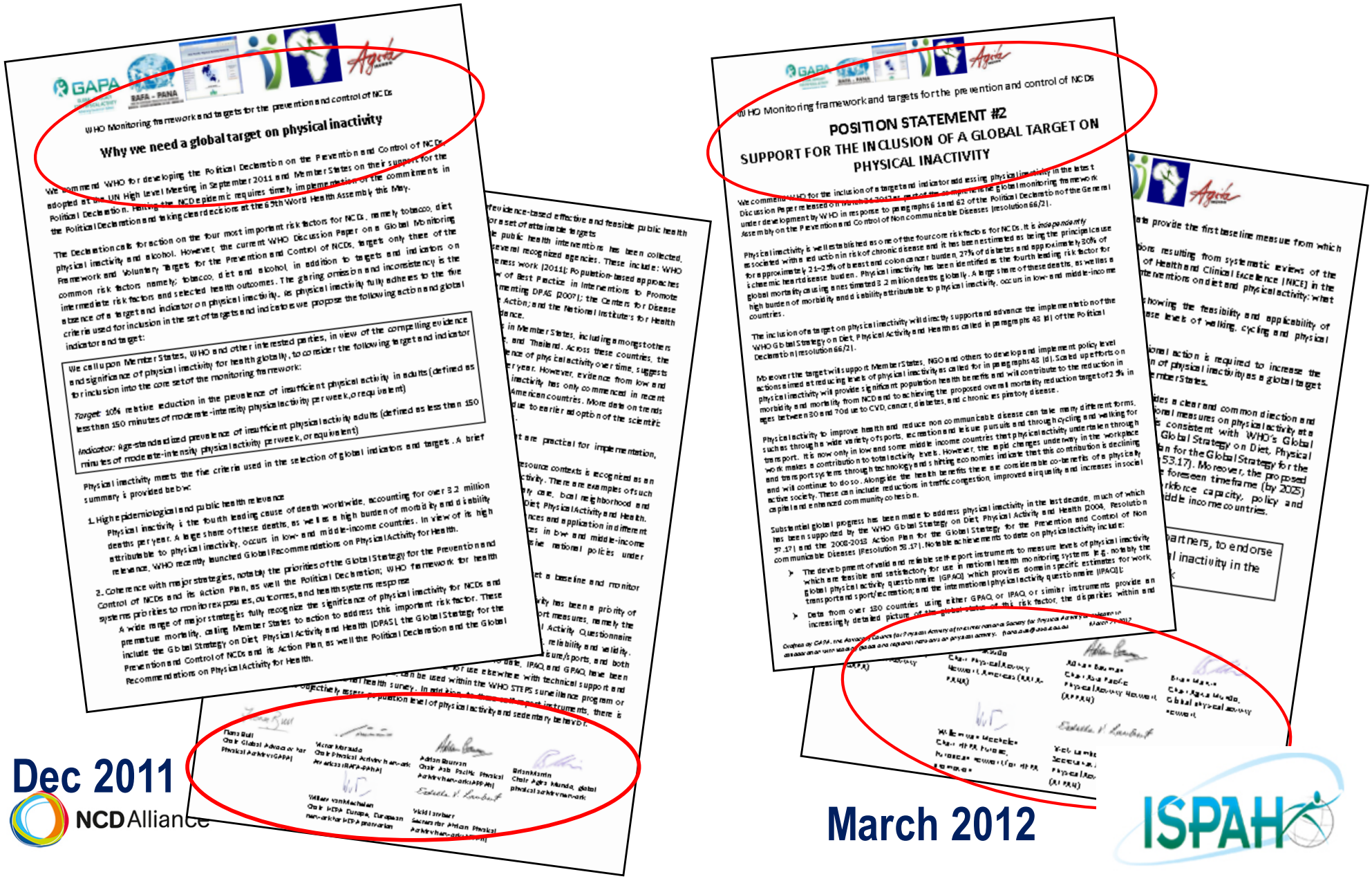
Post the 2011 NCD High Level Meeting

GAPA's advocacy work continues



Goal 5: Continue to support and expand GlobalPAnet as a primary communication to the physical activity workforce & to ISPAH members

GlobalPANet ISPAH

www.globalpanet.com

- Initiated and led by **Adrian Bauman** and **Trevor Shilton**
- Core Team: Rona MacNiven, Beth Goodall
- Global Editorial Board and "*Regional Correspondents*"

- **A free e-News every two weeks that includes**:
  - Latest key research findings summarized
  - News on PA policies and programs
  - Updates and introductions to people in PA
  - Job opportunities
  - Conferences and events calendar
  - Searchable database *'The Knowledge Base'*
- Good subscription: n=1,600 in 3 yrs but could be much higher

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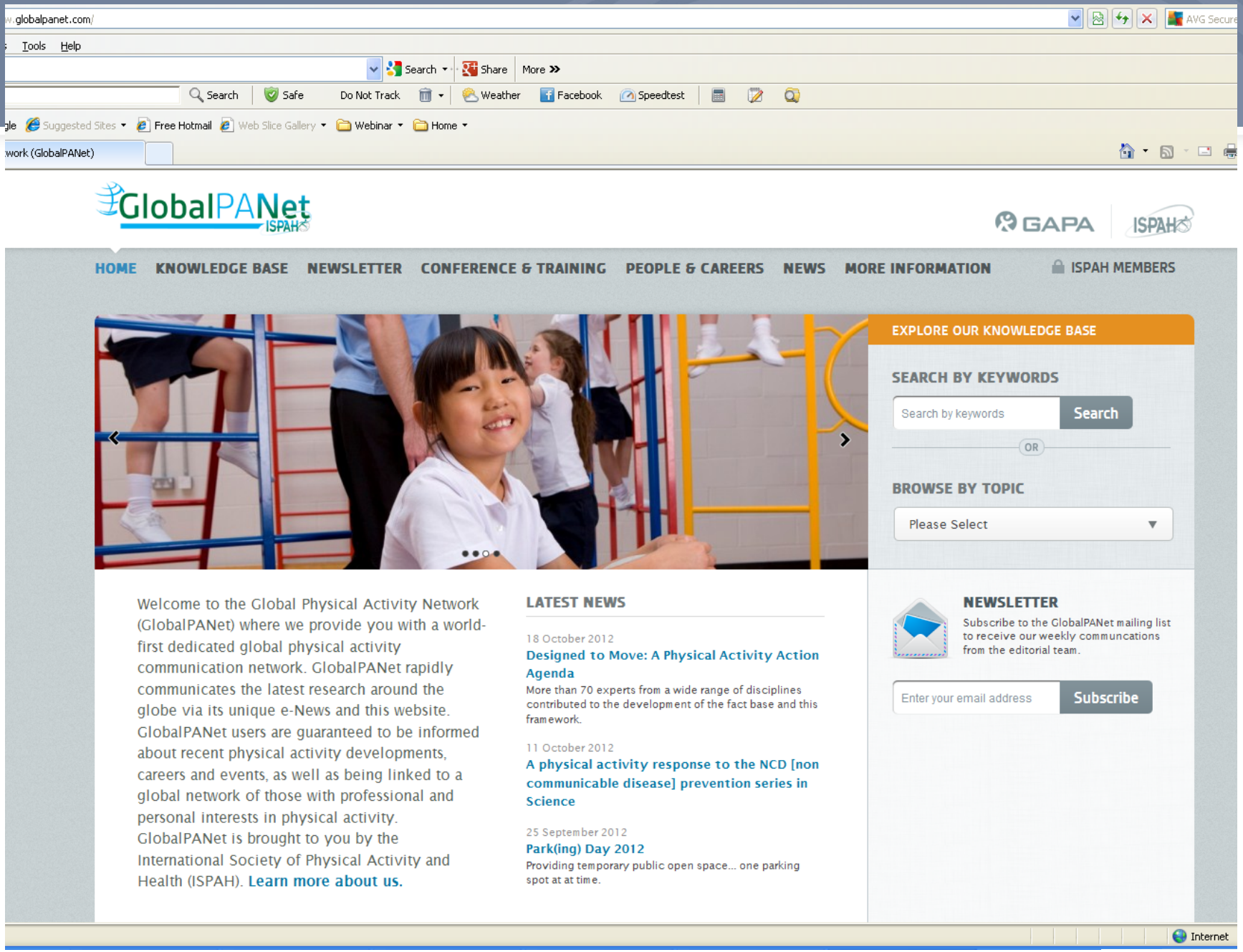
ISPAH



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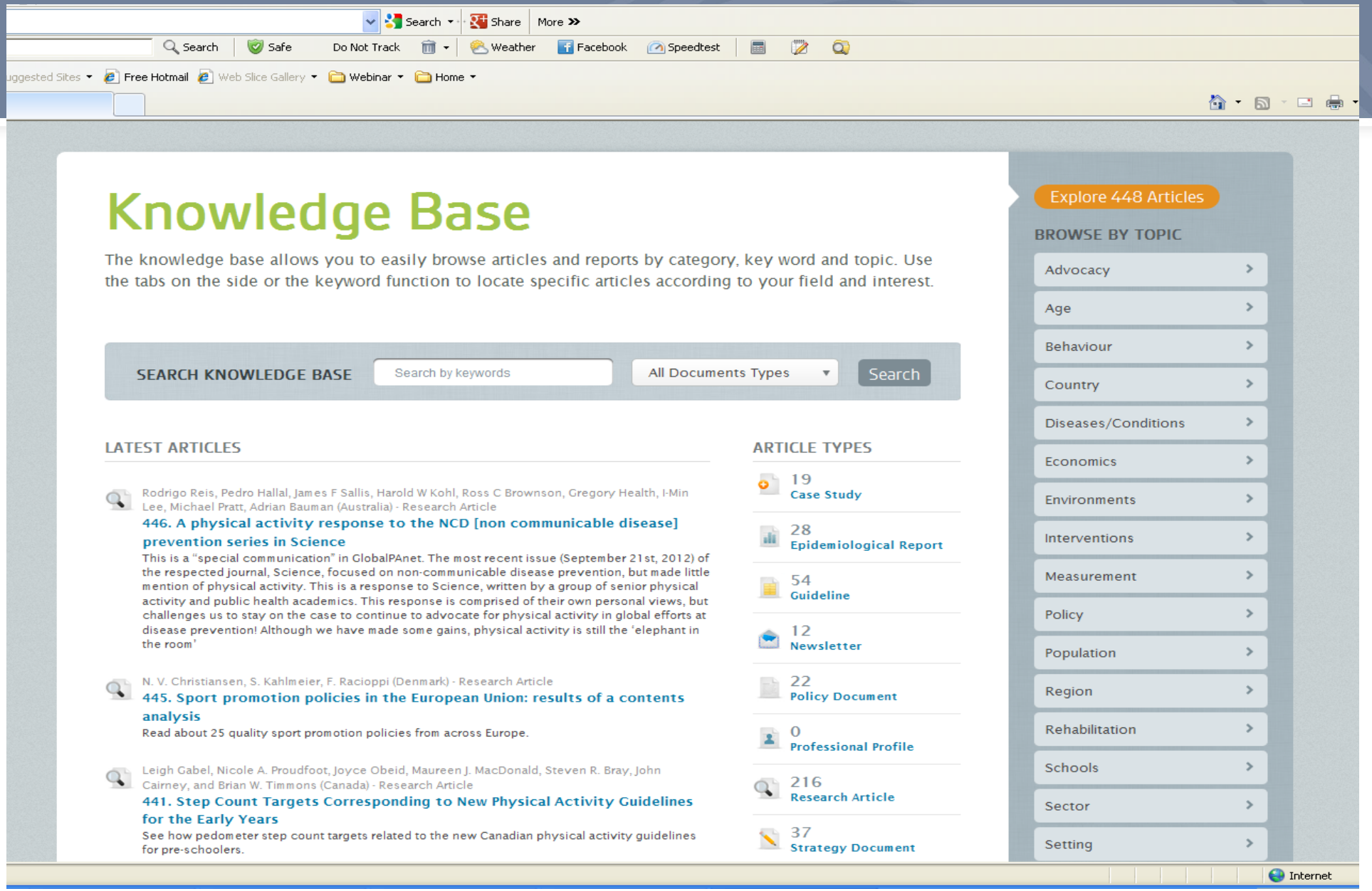

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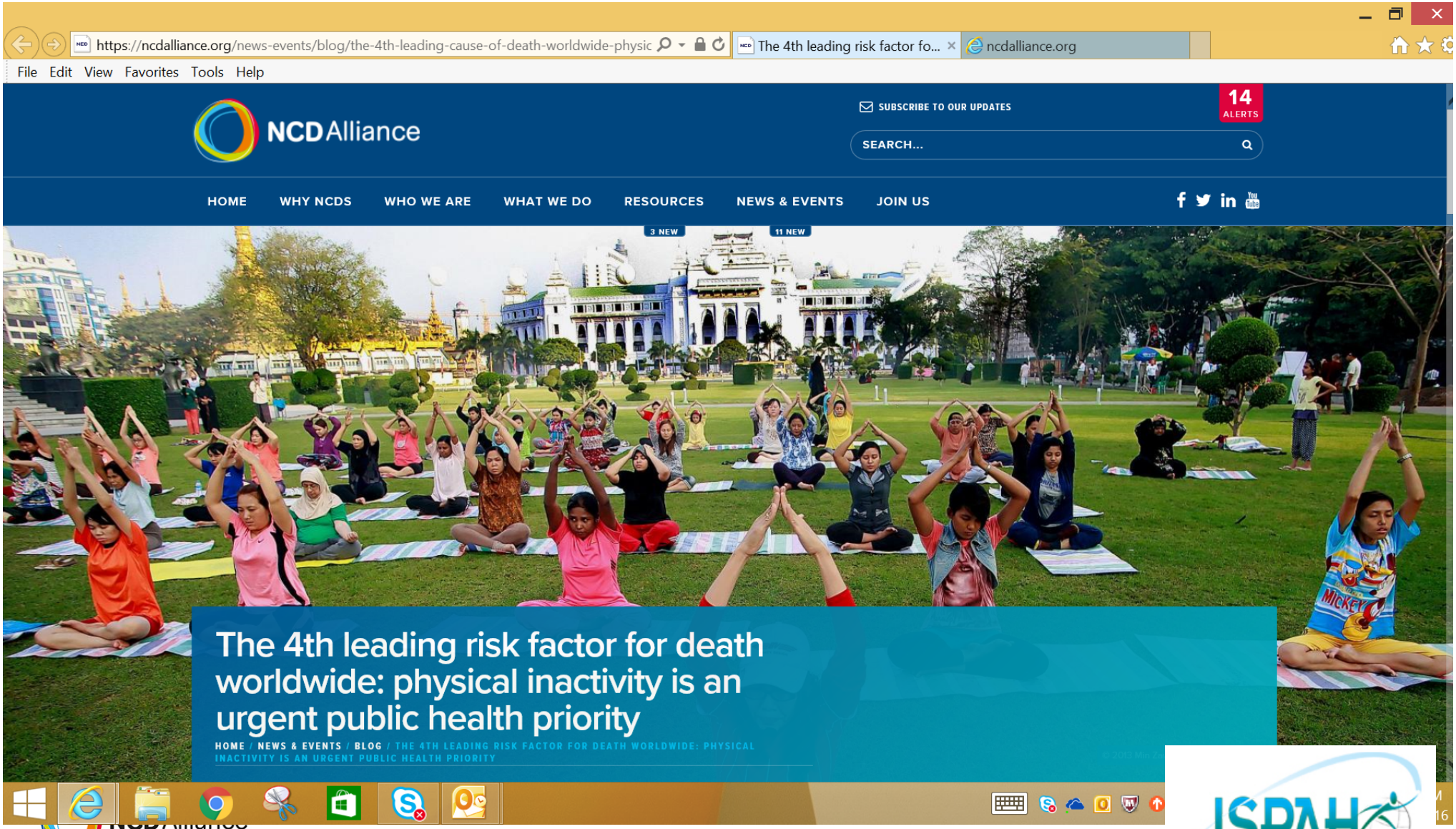
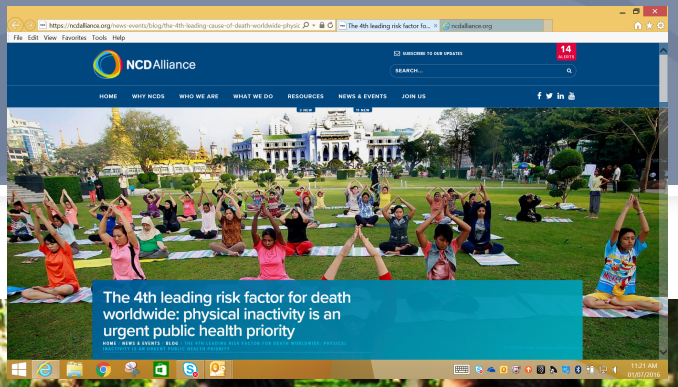
Goal 4: Maximise effective coalitions & partnerships with like-minded global, regional & national agencies to advance physical activity



Key message:

Trevor Shilton and Laurent Huber



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Goal 1: **Advocate** for the development and funding of **National Physical Activity Action Plans &scaling up their implementation**

- **Advocacy**
- **Implementation**
- **Scaling up**
- **Professional development**
- **Support**

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2016-2017 Advocacy strategy

Global Physical Activity Movement

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ISPAH
International Society for Physical Activity and Health

Global PA movement key milestones

There are 4 key milestones of PA movement (2016-2017)

I **PA Side Event @WHA 69th:** to set tone for PA and gain the support from member states to mainstream PA agenda

II **The 6th ISPAH Congress (16-19 Nov 2016 in Bangkok):** serve as a platform to elevate PA scientific knowledge and mobilize PA network.

III **PA Framework Report:** serve as supplement of the resolution and to urge the countries to support WHO data use for producing PA regular report

IV **Resolution:** to accelerate PA implementation in all countries

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World Health Assembly 2016, Geneva
Physical Activity side event (25 May, 2016)

Towards Achieving
the Physical Activity Target 2025 (10x25):
Are We Walking the Talk?

10x25

Technical Side Event at WHA69
Wednesday 25 May 2016,
12.30-14.00 hrs
Room 7, Building A

ISPAH

131 delegates from 46 member states

Physical Activity side event program & speakers
ISPAH and Member States

- **ISPAH:** scientific evidence of PA and global PA movement
- **Canada:** strong children PA program
- **USA:** integrate program on diet and PA

- **Finland:** multi-sectoral national policy
- **Iran:** leaders as example and innovative financing for PA
- **WHO:** show by example, healthy cities linkage

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Key Results:

Consensus was reached on the need to encourage PA champions at all levels, fostering country actions, and regular country and global monitoring on PA.

*"We plan to **table an agenda item and a draft resolution** for a revitalized and energized Global Strategy and action plan on **PA in the next (World Health) Assembly** through the EB. But we will start of act now, not to wait for the plan."*

-- Closing Remark by: Prof. Dr. Piyasakol Sakolsatayadorn, Minister of Public Health, Thailand

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Proposal for a 2017 WHA Resolution on Physical activity

- Proposed by Thailand
- Calling for two things:
  - A physical activity implementation plan
  - Reporting on physical activity implementation
    - over and above current reporting already in place by WHO
    - more detailed reporting (periodically) such as the global atlas

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6th ISPAH Congress

16 -19 November 2016 Bangkok Thailand

The International Congress on Physical Activity and Public Health

Goal 3: Use the occasion of the biennial ISPAH conference to promote and extend the **Global Physical Activity Movement** and proactive roles for conference partners (e.g. 2016 – ThaiHealth, Thai Ministry of Health).

Early-bird date 31 July 2016

Active People
Active Place
Active Policy

NCD Alliance

ISPAH
International Society for Physical Activity and Health

6th ISPAH Congress

16-19 November 2016 Bangkok Thailand

International Congress on Physical Activity and Public Health

16-19 November 2016 Bangkok

Active People
Active Place
Active Policy

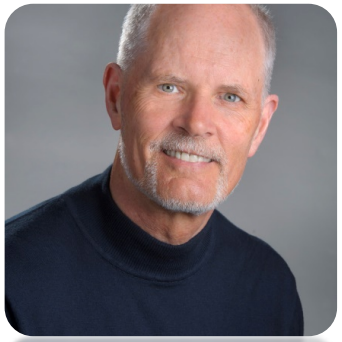
Dr.Suwit Wibulpolprasert Policy

Dr.Poonam Singh Policy

Dr.Oleg Chestnov Policy (TBC)

Prof. Billie Giles-Corti. Environment

Mr Gordon Price Environment



Mr Lloyd Wright Economics

Dr. Eric Finkelstein Economics

Prof. Kevin Patrick Technology

ISPAH

ISPAH2016 Conference output

The Bangkok Declaration on Physical Activity for Sustainable Development

- A conference output document providing a lasting contribution to the PA field post congress
- A landmark document that provides a consensus statement on a selected key issue
- An advocacy tool to assist countries in their work on PA
- A document that can inform / be cited in the PA Resolution proposed for 2017

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Proposed focus of Bangkok Declaration

The Bangkok Declaration on Physical Activity for Sustainable Development

- **to inform on the "co benefits" of investing in actions on PA**

– meaning the multiple positive outcomes and benefits to society of implementation of actions to create the supportive policies, places and programs* that can increase physical activity (particularly walking - cycling, public transport use)

- These benefits extend the established benefits in the health sector (NCD) to areas outside health sector
  - Reducing traffic congestion
  - Improving air quality
  - Creating safer streets
  - Revitalising / Supporting local economies
  - Reducing urban sprawl
- To highlight these actions and interventions that support increased PA also align with and support efforts to achieve other agreed goals and targets set for achieving SUSTAINABLE DEVELOPMENT - the SDG's
  - > 6 SDG targets

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2030 Sustainable Development Goals

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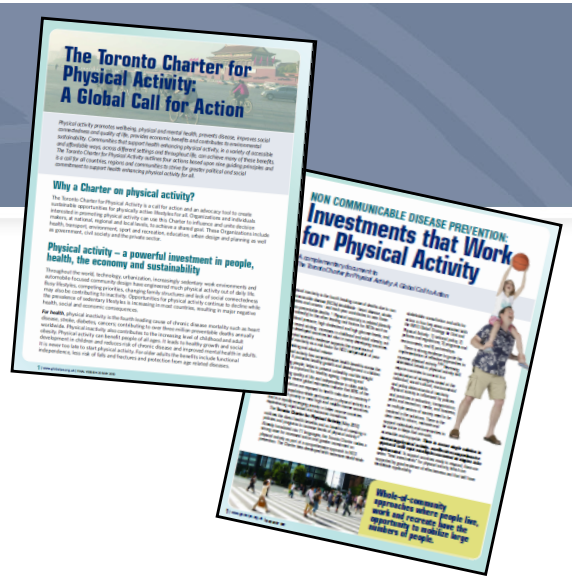
Our challenge

How do we continue to use our capacity and influence as a professional society and NGO to support and scale up implementation of National Physical Activity Policies and Action Plans?



- Advocacy
  - Political. Media, professional and community mobilization
- More tools?
  - Help to use existing tools?
- Case studies as examples?
- Technical advice "in practice"
- Conferences and training (Including advocacy training)
- Partnerships
- Other?

GlobalPANet ISPAH

6th ISPAH Congress
16 -19 November 2016 Bangkok Thailand
The International Congress on Physical Activity and Public Health

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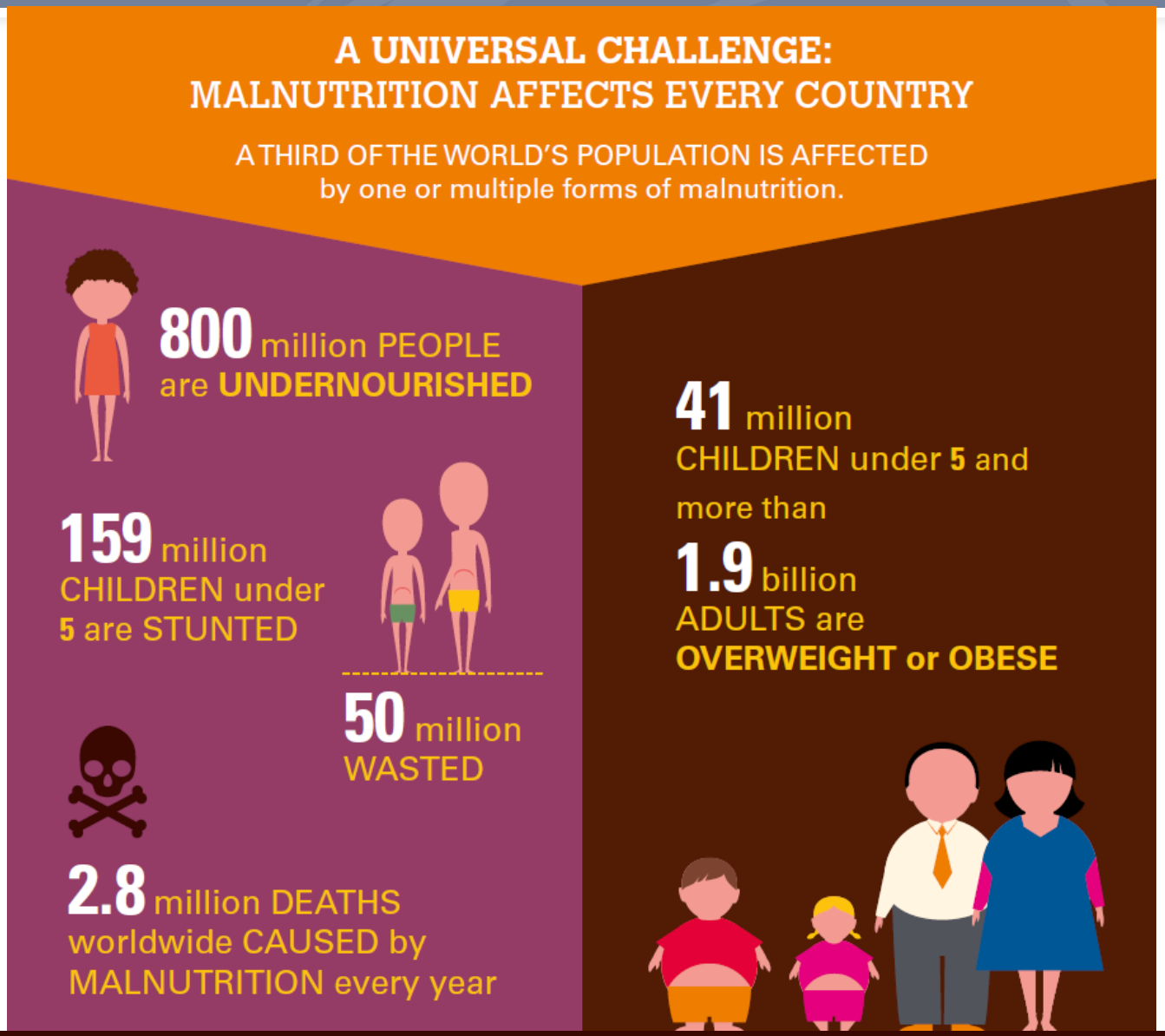
International Society for Physical Activity and Health

Q & A

SMART commitments to address NCDs, overweight & obesity

Alena Matzke, NCD Alliance &
Simone Bösch, WCRF International

The challenge: Malnutrition in all its forms



Annual global economic impact of obesity is estimated at $2 trillion, and of undernutrition at $2.1 trillion.

The opportunity: UN Decade of Action 2016-2025

A global effort to set, track and achieve SMART policy commitments to end all forms of malnutrition worldwide:

- **Policy-focused and Member States driven**, builds on existing national, regional and global plans
- Based on agreed **ICN2 Rome Declaration and Framework for Action** and within the SDGs
- Encompasses **all countries in all regions**
- Addresses all forms of malnutrition, incl. **NCDs / overweight & obesity**
- **UN-wide**: FAO and WHO-led, in collaboration with WFP, IFAD, UNICEF
- Open to involvement of all relevant stakeholders

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The opportunity: UN Decade of Action 2016-2025

The six pillars of the UN Decade of Action on Nutrition

Food systems for healthy, sustainable diets

Trade and investment for improved nutrition

Aligned health systems providing universal coverage of Essential Nutrition Actions

Enabling food and breastfeeding environments

Social protection and nutrition education

Review, strengthen and promote nutrition governance and accountability

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NCDA/WCRFI Policy Brief

Ambitious, SMART commitments to address NCDs, overweight & obesity

www.wcrf.org/SMART

World Cancer Research Fund International

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Ambitious, **SMART commitments** to address **NCDs, overweight & obesity**

Make the **UN Decade of Action on Nutrition** count for all forms of malnutrition

This brief illustrates how recommendations in the **Second International Conference on Nutrition (ICN2) Framework for Action** can be translated into policy commitments which are SMART (Specific, Measurable, Achievable, Relevant and Time-bound). The ICN2 Framework for Action contains a set of policy actions that governments pledged to implement as part of the ICN2 Rome Declaration to address malnutrition in all its forms (overweight & obesity, stunting, wasting, micronutrient deficiencies).[1]

The brief focuses on SMART commitments which target overweight & obesity and nutrition-related non-communicable diseases (NCDs); where possible, policy actions are identified which reduce undernutrition at the same time (so-called double-duty actions). **Double-duty actions** have the potential to impact undernutrition, NCDs, overweight & obesity at the same time, as opposed to addressing specific types of malnutrition in isolation.

SMART commitments to address malnutrition in all its forms

Governments are currently off-track to meet **global nutrition and NCD targets**, namely the 2025 nutrition targets of the World Health Organization (WHO)[2], the global WHO NCD targets[3], and the nutrition and food security related targets in the United Nations 2030 Agenda for Sustainable Development. Action to implement multi-sector policies and to increase policy coherence[4] across different government ministries is urgently needed to achieve these global targets. Recognising this need for sustained and coordinated action, the UN General Assembly has proclaimed a **Decade of Action on Nutrition 2016-2025** (Decade of Action) reinforcing the commitments of the ICN2 Rome Declaration and Framework for Action.

Against the background of the Decade of Action, we call on governments to:

- **Set ambitious national food and nutrition targets aligned with the ICN2 Rome Declaration and Framework for Action** to ensure bold action to end all forms of malnutrition.
- **Make SMART financial and political commitments** to implement the ICN2 Framework for Action.
- **Develop robust accountability mechanisms** to review, report on and monitor SMART commitments with the involvement of civil society.
- **Align national agriculture, nutrition, and NCD strategies and related policies** to ensure policy coherence.
- **Prioritise double-duty actions** to address stunting, wasting and micronutrient deficiencies while simultaneously protecting against overweight & obesity.[5]

[1] Specific policy recommendations to address overweight & obesity and nutrition-related NCDs are also set out in the WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013-2020, and the Final Report of the WHO Commission on Ending Childhood Obesity (2015).
[2] World Health Assembly Res. 65.6: Comprehensive implementation plan on maternal, infant and young child nutrition (2012).
[3] World Health Assembly Res. 66.8: WHO Global Monitoring Framework for the Prevention and Control of Non-Communicable Diseases (2013).
[4] Policy coherence is the "systematic promotion of mutually reinforcing policy actions across government departments and agencies creating synergies towards achieving the agreed objectives" (OECD Observer, Policy coherence: Vital for global development, Policy Brief, July 2003).
[5] More research is required in the area of double-duty actions. WHO, FAO, governments and donors need to invest in research to expand the evidence base in this area.

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NCDA/WCRFI Policy Brief

Calls on governments to make SMART commitments:

- Set ambitious **national food & nutrition targets**
- Align national agriculture, nutrition, & NCD strategies for greater **policy coherence**
- Make **SMART financial and political commitments**
- Develop **robust accountability mechanisms** to review, report on and monitor SMART commitments with the involvement of civil society
- Prioritise **double-duty actions**

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How to use the brief?

Structure

Background and call for action

What are SMART commitments?

Example SMART commitments / case studies

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How to use the brief?

Structure

ICN2 Framework for Action Recommendation	Example SMART Commitment	Case studies
16: *Establish food or nutrient-based standards to make healthy diets and safe drinking water accessible in public facilities such as hospitals, childcare facilities, workplaces, universities, schools, food and catering services, government offices and prisons, and encourage the establishment of facilities for breastfeeding.*	**(Double-duty action)** The Ministries of Education and Health develop nutrition standards for public schools adhering to WHO recommendations by June 2017, and ensure implementation in schools by December 2018.	**Iran**: the "Guideline for healthy diet and school buffets" includes a list of healthy and unhealthy foods based on their content of sugar, salt, fat, and harmful additives, and guidance on proper food preparation and catering as well as maintenance of the physical environment in which food is prepared.[48] **Jordan**: the Ministry of Health has set food standards regulating which foods may be sold to students in school canteens as part of the National School Health Strategy 2013-2017.[48] **Mauritius**: unhealthy snacks and soft drinks, including diet soft drinks, are banned from canteens of pre-elementary, elementary and secondary schools.[56] **Slovenia**: school meals must follow dietary guidelines as set out by Slovenia's School Nutrition Law, complemented by a list of foods that are not recommended, and recipe books.[57]
20: *Build nutrition skills and capacity to undertake nutrition education activities, particularly for front line workers, social workers, agricultural extension personnel, teachers and health professionals.*	**(Double-duty action)** The Ministries of Education and Health incorporate food and nutrition literacy, including on nutrition-related NCDs, in the mandatory school curriculum by developing (or revising) and disseminating course materials by June 2018.	**Japan**: the Basic Law on Shokuiku (Shoku = diet, iku = growth and education) promotes dietary education, including in schools and nursery schools.[58] **Slovenia**: mandated by the national nutrition policy, nutrition education in primary schools is mainly delivered through science subjects, but also in home economics, and is designed to both aid knowledge and skills acquisition.[59] **Vietnam**: the Ministry of Education and Training is responsible for incorporating nutrition education into the school curriculum at all levels and provides capacity building for teachers as part of the Vietnam National Nutrition Strategy 2011-2020.[60]

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How to use the brief?

Food and nutrition-based standards in public schools

Example SMART commitment:

The Ministries of Education and Health develop nutrition standards for public schools adhering to WHO recommendations by June 2017, and ensure implementation in schools by December 2018.

✓Double-duty action: potential to address undernutrition/overweight & obesity
✓SMART: commitment is **Specific, Measurable, Achievable, Relevant, Time-bound***

✓**Specific:**	Actors and action are identified
✓**Measurable:**	Action can be tracked and content of standards measured against WHO recommendations
✓**Achievable:**	Various countries have demonstrated that nutrition standards can be successfully implemented
✓**Relevant:**	Nutrition standards improve the quality of school food
✓**Time-bound:**	Concrete timeframe is included

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*based on: SMART Guidance Note 2016 Global Nutrition Report

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How to use the brief?

Food and nutrition-based standards in public schools

Case studies

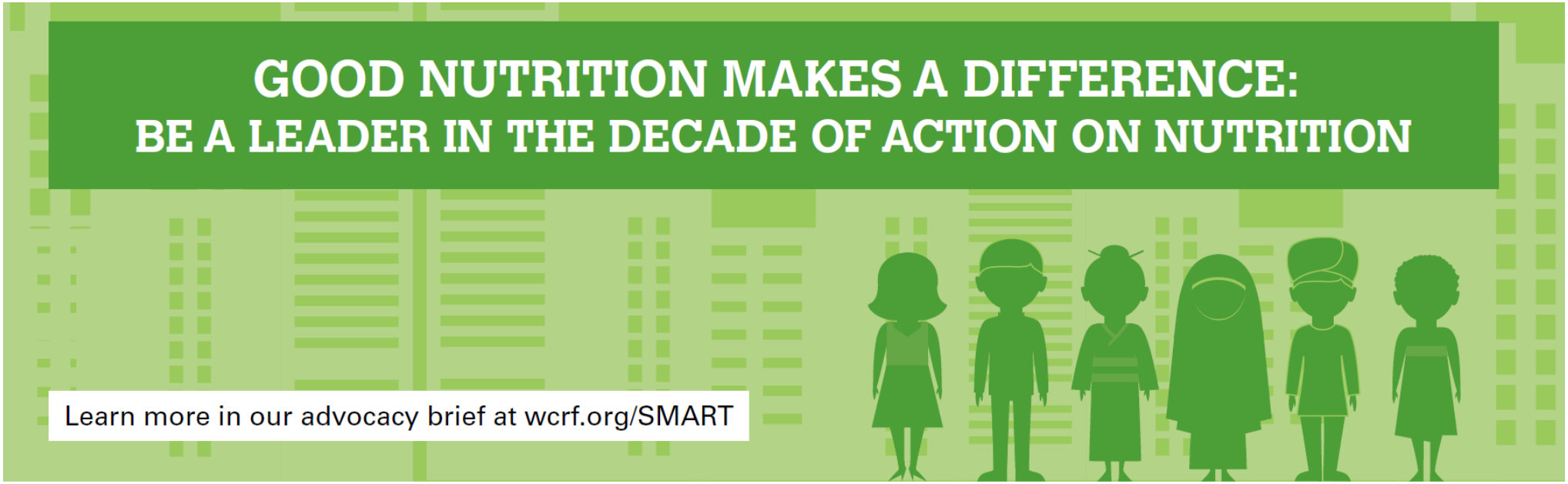
- **Brazil:** Emphasis on the availability of fresh, traditional and minimally processed foods – weekly minimum of fruits and vegetables, limits to sodium content and restriction on available sweets in school meals. A school food procurement law limits the amount of processed foods purchased by schools to 30%, and bans the procurement of drinks with low nutritional value, such as sugary drinks.
- **Iran:** The "Guideline for healthy diet and school buffets" includes a list of healthy and unhealthy foods based on their content of sugar, salt, fat, and harmful additives, and guidance on proper food preparation and catering as well as maintenance of the physical environment in which food is prepared.
- **Mauritius:** A 2009 regulation banned soft drinks, including diet soft drinks, and unhealthy snacks from canteens of pre-elementary, elementary and secondary schools.
- **Slovenia:** School meals must follow dietary guidelines as set out by Slovenia's School Nutrition Law, complemented by a list of foods that are not recommended. Recipe books are provided to support the implementation of the guidelines by schools.

How to use the brief?

Advocate for SMART commitments on NCDs, overweight & obesity

- **Identify commitments** most relevant to your national context based on (but not limited to) our example SMART commitments
- **Lobby your government to make public commitments** to ensure accountability – *at Nutrition for Growth, WHO/FAO commitment conference etc.*
- **Ensure commitments are SMART** (use Global Nutrition Report guidance)
- **Focus on policy coherence**: advocate for alignment of agriculture, food, trade, education and health/NCDs policies and plans
- **Promote double-duty actions:** actions to address stunting, wasting and micronutrient deficiencies while simultaneously protecting against overweight & obesity (e.g. Breastfeeding promotion/protection, school-feeding programmes etc.)
- **Monitor** government performance, advocate for keeping commitments

THANK YOU!



...or contact us directly at amatzke@ncdalliance.org or s.bosch@wcrf.org

NCD Alliance

World Cancer Research Fund International

Q & A

FRAMEWORK CONVENTION ALLIANCE

Action on Tobacco Control, 2016

Francis Thompson
Executive Director
11 July 2016

A bit of good news

- Decision announced Friday in trade/investment case between Philip Morris (manufacturer of Marlboro etc.) and Uruguay.
- Total victory for Uruguay, both on large warnings on cigarette packs and requirements for a single version of each brand.
- So even a trade arbitration panel says public health more important than private profits.
- Read the whole thing at: http://www.presidencia.gub.uy/comunicacion/comunicacionnoticias/laudo-ciadi-uruguay-phillip-morris-vazquez

What tobacco has: a treaty

- Framework Convention on Tobacco Control (FCTC) adopted in 2003, in force since 2005; now up to 180 Parties.
- Convention itself includes quite a number of detailed obligations (e.g. health warnings have to occupy at least 30% of both front and back of cigarette packs, ban on “light”, “mild”, other deceptive terms and devices).
- Guidelines on individual articles provide lots more detail – and we now have guidelines on all the demand-side articles (tax, smoke-free spaces, product regulation, packaging and labelling, advertising and promotion, education/communication, cessation).
- The question is now what to do, now that guidelines are largely finished.

Tobacco also has a dedicated forum

- As you know, World Health Assembly in 2013 adopted voluntary global targets for NCDs – including one for tobacco (30% relative reduction in tobacco use prevalence by 2025).
- You may not know: FCTC Conference of the Parties adopted the 30% target as its own *and will discuss progress every two years until 2025.*
- COP brings together most governments of the world, solely to discuss tobacco.

COP7 is being held in India (New Delhi)

KEY DATES

- 8 September: all official COP documents must be made available
- September/October: official pre-COP regional meetings
- 7-12 November: COP7

Treating the 30% target as a real objective

- There are a limited number of population-level interventions in tobacco control with a track record of impact – and we know fairly well how large the impact is, particularly for tax/price.
- Thus, it is possible to calculate what is needed to achieve a 30% reduction in a given country/region, *even if you don't know the baseline prevalence.*

Treating the 30% target as a real objective (2)

- For COP7, we want to focus governments' minds on the need to *take the target seriously* as a planning tool and a political commitment.

- That means not just boasting about progress achieved on individual FCTC articles, but taking a realistic look at overall progress, and what it would mean to take the tobacco epidemic seriously.

Related initiative: reporting / implementation review

- Under the FCTC (as with many other treaties), Parties are obliged to file individual reports on implementation – in the case of the FCTC, every two years.

- At the moment, nothing much happens with these reports, except that they are posted online. (See http://www.who.int/fctc/reporting/en/ .)

- We need a system under which Parties review each others' reports and seek action to correct problems, as exists under many human rights and environmental treaties.

Not resolved: lack of money

- In the NCD arena, tobacco is seen as the “successful” risk factor, because we have a treaty and a whole apparatus to deal with it.
- But in terms of funding, tobacco control is almost entirely dependent on domestic resources and private philanthropy (Bloomberg and Gates).
- This issue will come up again at COP7 – hope to have a more productive discussion than in the past.

Not resolved: lack of money (2)

Past discussions ran more or less as follows:

- *Some poor countries:* "We need a global fund for FCTC implementation! We want to do the right thing, but we don't have the money or the technical expertise."

- *Most rich countries*: "No way will we agree to a global fund. There's lots of development money available for health – you just need to include tobacco control in your national development priorities, and ask for it along with everything else." (i.e. take the money away from communicable diseases…)

Not resolved: lack of money (3)

This time round, things may be different:

- NCDs in general, and FCTC in particular, are part of the Sustainable Development Goals
- FCTC COP has had a working group on “sustainable measures” for several years.
- FCA hopes the COP will give the FCTC Secretariat the mandate to advocate systematically for increased resources for implementation.

How would Secretariat/FCTC COP advocate for more resources?

- Prioritize needs, and relate to outcomes ("top three kinds of assistance countries need to get to the target we've all agreed on").
- Emphasize the *evidence base* and the *legal underpinnings* for the priority interventions.
- Point to private/public imbalance: why should Bloomberg and Gates pay for implementation of an international treaty while rich governments pay next to nothing?

A successful COP7

- Will focus on implementation, accountability and results: we know in great detail *what* works at the country level, the question is how to scale up.
- Should make the case for greater public-sector involvement in funding tobacco control

Q & A

Thank you!

Please visit our websites:

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