NCD Alliance's submission to the first WHO consultation on the updated Appendix 3 of the Global action plan for the prevention and control of NCDs 2013–2030

24 June 2022

1. The NCD Alliance thanks and commends the World Health Organization (WHO) for preparing the **first draft** of the 2022 updated Appendix 3 of WHO's *Global action plan for the prevention and control of noncommunicable diseases (NCDs) 2013–2030* (hereinafter 'Appendix 3'). This is an important step to strengthen and inform the development of WHO's *Implementation road map 2023–2030 for the global action plan on NCDs*, the outline for which was recently approved at the World Health Assembly.

2. **Since its update in 2017, Appendix 3 became known as WHO's *NCD 'best buys' and other recommended interventions*** given that the policy options were divided into the *NCD 'best buys'* (those most cost-effective and implementable according to WHO's cost-effectiveness analysis); *NCD 'good buys'* (those having lower but still significant cost-effectiveness), *other recommended interventions* based on WHO policy and guidelines without a cost-effectiveness analysis, and *overarching/enabling actions*.

3. **The concept of NCD 'best buys' and 'good buys' has been key for advocating towards countries for the implementation of NCD policies** by making a strong investment case given their cost-effectiveness, and by always highlighting the need to consider epidemiological profiles and other national contexts when deciding on the most impactful package of policies. As highlighted by WHO's 2021 edition of ***Saving lives, spending less***, the implementation of the NCD 'best buys' can boost national economies, generating US$ 230 billion in economic gains by 2030 (by reducing health costs and increasing productivity). This especially applies in low and middle-income countries (LMICs) where the NCD burden is highest.

4. **Appendix 3 must therefore be seen as a valuable knowledge product for governments**, allowing them to assess what would be the most impactful and effective package of NCD interventions for their country, based on the cost-effectiveness analyses provided by the document and other national and regional factors. The document must support Member States' understanding of, and investment in a set of NCD services (across prevention, diagnosis, treatment and palliative care) and population-wide policies, that will have benefits for a wide range of NCDs and help reduce health inequalities. **It is therefore crucial that the interventions included within Appendix 3 remain comprehensive and specific, and that WHO provides more guidance and examples on the synergistic benefits of combining specific interventions.**

5. The NCD Alliance appreciates the consultation opportunity and wishes to contribute with the comments below for your consideration.

NCD Alliance
31-33 Avenue Giuseppe Motta
1202 Geneva | Switzerland
info@ncdalliance.org | ncdalliance.org

Current strengths

6. We particularly commend the following points of the discussion paper as they strengthen the scope, purpose and evidence base of Appendix 3.

7. **Additional interventions include information on their cost-effectiveness.** The 2022 updated Appendix 3 includes seven interventions (H5, CV6-7, D4, CA8-10), that did not have a cost-effectiveness analysis in the 2017 version, proving their effectiveness and "upgrading" these interventions as part of the menu of cost-effective policy options. This reinforces the need to continue performing generalized cost-effectiveness analyses (GCEA) on the other recommendations as data and evidence becomes available.

8. **Several interventions have been rephrased or revised to reflect updates to WHO policy, guidelines, or scientific evidence.** For instance, under physical inactivity, although the nature of the interventions has remained the same, the wording of most interventions has been updated to align with the latest WHO tools on physical activity. Moreover, this provides a valuable opportunity to align and support Member States' prioritsation and planning for implementation.

9. **New interventions were added based on the latest WHO guidance and tools.** For instance, in addition to nicotine replacement therapy (NRT), the new cost-effective intervention T7 *(provision of cost-covered effective pharmacological interventions to all tobacco users who want to quit)* includes Bupropion and Varenicline as pharmacotherapy options, given their recent addition (2021) on WHO's Essential Medicines List. More generally, under overarching/ enabling actions, we welcome additions such as the recently adopted WHO's *Action plan (2022–2030) to effectively implement the global strategy to reduce the harmful use of alcohol as a public health priority* or WHO's *Global action plan on physical activity 2018–2030*.

10. **GCEA results are based on data from 62 low and middle-income countries (LMICs)**, compared to 20 LMICs for the 2017 update. This means that key parameters for interventions with a GCEA were updated across three times more countries and were still shown to be highly cost-effective, which reinforces the investment case for these interventions. That should be emphasized.

11. **Different GCEA results have been presented for three country income groups**: low-income, lower middle-income, and upper middle-income. This allows countries to assess the potential cost-effectiveness of these interventions according to their specific income level. To note, interventions are usually more cost-effective in lower income countries (due to the lower economic cost for their implementation), while the health impact is often greater in higher-income countries when looking at the GCEA results. This reiterates the point made in the discussion paper about the need for countries to consider factors other than just cost-effectiveness, encouraging them to select the most impactful package of NCD interventions.

NCD Alliance
31-33 Avenue Giuseppe Motta
1202 Geneva | Switzerland
info@ncdalliance.org | ncdalliance.org

General comments on the methodology

More information on the methodology of this update is needed

12. **The technical annex to Appendix 3 needs to provide more information on the measures and formulas used.** For instance, there is little information on how the health impact (healthy-life years gained per million in one year) is calculated using the population and effect size of interventions, beyond simple reference to the WHO-CHOICE methodology and modelling platform.

13. **It is unclear how the health impact is calculated for some interventions**. For example, how is the health impact calculated for an intervention that includes several therapies or channels with different effect sizes, as for intervention T6 *(provision of cost-covered effective population-wide support [including brief advice, national toll-free quit line services and mCessation] for tobacco cessation to all tobacco users)*. Is it based on a weight of the effect size of the three different channels assuming they are implemented in equal proportions? Are there any overlaps assumed? Similar concerns could be raised from broad interventions such as H1 *(reformulation policies for healthier food and beverage products)*, which targets a reduction in sodium and sugars, and the elimination of trans-fats from the food supply.

14. **There is no information on why the set of countries analysed may differ**. We would appreciate more background from WHO on why a smaller subset of countries was analysed for the GCEA of some interventions (e.g., on alcohol use), and whether this subset of countries also aims to provide an equal regional and country income representation to cover a significant proportion of the world's population.

More information on the use of healthy-life year (HLY) unit is needed

15. **There is no background on why the 2017 version and 2022 update uses different units to measure cost-effectiveness.** While the 2017 version uses *I$ per disability-adjusted life year (DALY) adverted*, following the WHO-CHOICE methodology approved by the World Health Assembly in 2016, the 2022 update uses *I$ per healthy-life year (HLY) gained*. This is explained in the IJHPM's Special Issue on WHO-CHOICE Update (2021),[1] but it would also be important that the reasoning behind this change is clarified in the next discussion paper.

16. **The concept of HLY needs to be defined and Appendix 3 should explain how HLYs are calculated across the document**. For instance, the technical briefs on risk factors provide information about which NCDs (and which relative risks) have been considered to measure the health impact of specific interventions, but it is unclear whether, for instance, multi-morbidity was factored into the relative risk analyses, etc.

More information on the limitations is needed

17. **The updated Appendix 3 should also mention the current methodological limitations and gaps.** For example, some interventions, such as on physical activity, are solely focused on the data we have for adults, which highlights the data gap on young people. These limitations must

[1] https://www.ijhpm.com/issue_694_705.html

NCD Alliance
31-33 Avenue Giuseppe Motta
1202 Geneva | Switzerland
info@ncdalliance.org | ncdalliance.org

be noted, and future monitoring, research, and analyses should aim to include data on all age groups. This is essential as, for instance, 60% of the population in Africa is under 25 years-old,[2] and data on younger populations is key to inform policies spanning the full life-course. Also, NCDs do not affect women and men in the same way. It seems gender-disaggregated data was only used for the prevalence and relative risks of the NCDs analysed for each risk factor, while it is unclear if the analysis of the interventions' effect size and other parameters was disaggregated, and the same applies to the analyses done for each disease area.

18. **The real health impact of Appendix 3 interventions is higher than the indicated, and this needs to be clearly recognized within the document**. As clarified in the technical brief on tobacco use, the health impacts of interventions are calculated on the basis of the relative risk they have for a series of NCDs, but the impact of tobacco use is not limited to the analysed conditions. This means that the real health impact of tobacco control measures might be much higher, and this is also the case for other risk factors. For the prevention interventions, the calculated health impact is limited to specific NCDs (e.g., excluding mental health conditions) and the real impact might therefore be larger. This must be highlighted within the core draft of Appendix 3. This is also the case for breastfeeding, for which the health impact has been calculated on the basis of HLY gained by reducing the NCD burden – but breastfeeding is a double-duty action and its health impact is much larger, because it also reduces undernutrition. Moreover, given the high prevalence of NCD co-morbidities, enhancing the management of certain NCDs can also have additional health impacts by reducing the prevalence of other NCDs. It is therefore important to note that if co-morbidities had been considered, these would have positively impacted the cost-effectiveness calculations for treatment options.

19. **Importantly, for Appendix 3 to be a true guide for Member States on how to implement the most impactful set of NCD interventions, the document must provide more guidance and examples on the synergistic benefits of combining specific interventions.** The WHO-CHOICE and GCEA approaches use a comparator that features a hypothetical "null" scenario, where the impacts of all currently implemented interventions are removed, allowing existing and new interventions to be analysed at the same time, and assesses the combined impact of implementing a set of interventions. The upcoming simulation tool for Member States will aim to facilitate this, and it would be important for WHO to clarify within Appendix 3 how this will support prioritization processes.

General reservations and recommendations

<u>It is important to name Appendix 3 and retain the concept of NCD 'best buys'</u>

20. **We urge WHO to reconsider retaining the concept of NCD 'best buys' in the 2022 updated Appendix 3.** In the discussion paper, the distinction between NCD 'best buys' and 'good buys' has been omitted merging all the interventions with a GCEA into one category: *Specific interventions with WHO-CHOICE analysis*. We appreciate that the cost-effectiveness of an intervention can be different across the country income groups analysed, making it difficult to classify an intervention as either a 'best buy' or 'good buy' (≤ I$ 100 or >I$ 100 per DALY averted

[2] https://mo.ibrahim.foundation/sites/default/files/2020-08/international-youth-day-research-brief.pdf

NCD Alliance
31-33 Avenue Giuseppe Motta
1202 Geneva | Switzerland
info@ncdalliance.org | ncdalliance.org

in LMICs, in the 2017 version), and also to encourage governments to consider all interventions with different bands of cost-effectiveness, as countries must assess other factors than just cost-effectiveness when selecting a package of NCD interventions. That said, the *NCD 'best buys' and other recommended interventions* have grown into a reference for the health community, being the term through which we refer to Appendix 3 for dissemination. This term flags the high return on investment of these interventions, is a basis for WHO's support on NCDs to countries, and has become instrumental to advocacy.

NCD cost-effective interventions should be recognized as key elements for the resilience and recovery agenda

21. **We urge WHO to link essential NCD prevention and care to the resilience and recovery agenda**, outlining lessons learnt from the COVID-19 pandemic, particularly the importance of focusing on health equity and maintaining essential NCD prevention and care services during all-hazards emergency preparedness and responses. This was outlined at the World Health Assembly in 2021 through the approval of WHO's *Recommendations on how to strengthen the design and implementation of policies, including those for resilient health systems and health services and infrastructure, to treat people living with NCDs and to prevent and control their risk factors in humanitarian emergencies*. We are suggesting highlighting this as part of the overarching/enabling actions under Objective 1.

Recommended interventions should reflect the scope of their analyses

22. **The technical briefs provide a lot of relevant information on each intervention that needs to be reflected within Appendix 3. The interventions should guide country implementation as much as possible and reflect interventions' full scope based on their analyses.** For instance, the intervention T7 *(provision of cost-covered effective pharmacological interventions to all tobacco uses who want to quit)* should specify in the intervention heading which pharmacotherapy options this intervention should include based on the options analysed: NRT, Bupropion, Varenicline.

23. **We welcome the fact that many of the most cost-effective interventions to address unhealthy diets have been formulated to address other unhealthy nutrients beyond salt (sugars, trans-fats, saturated fats). To ensure Appendix 3 provides enough guidance to Member States, it would be useful that the nutrients analysed under each intervention are specified.** For instance, the intervention H1 *(reformulation policies for healthier food and beverage products)* should refer to the reduction of salt and sugars and the elimination of trans-fats not just in the technical brief but also within Appendix 3, as the GCEA results of this intervention were obtained on the basis of those unhealthy nutrients being targeted.

The role of public regulation in reformulation and trans-fat elimination must be clearly stated in the updated Appendix 3

24. **Of great concern is the fact that under H1 *(reformulation policies for healthier food and beverage products)* the technical brief refers to the fact that H1 can be implemented as a mandatory or voluntary measure.** However, the health impact of trans-fat elimination is measured based on the case of Denmark (through public regulation). The case of New York is

NCD Alliance
31-33 Avenue Giuseppe Motta
1202 Geneva | Switzerland
info@ncdalliance.org | ncdalliance.org

also referenced (also public regulation),[3] and therefore this needs to be reflected on the intervention heading for accuracy, fully reflecting the scope of the intervention as analysed and providing specific guidance to Member States. For the reformulation to reduce the content of salt and sugars, it seems WHO used studies assessing mandatory and voluntary approaches, although these studies and the latest WHO recommendations[4] highlight that mandatory approaches are more effective.

25. **We urge WHO to divide H1 into two interventions** to accurately reflect the scope and evidence of these interventions, providing Member States with specific guidance as follows:

- *H1a: Reformulation policies for healthier food and beverage products, including by setting target levels for the amount of salt and sugars, noting that public health regulations rather than voluntary targets have been shown to be more effective.*
- *H1b: Elimination of industrially-produced trans-fats through the development of public regulations that ban their use in the food supply.*

26. **We ask WHO to consider performing two GCEAs for H1a** comparing the cost-effectiveness of mandatory versus voluntary reformulation approaches, and to also **include and assess the effect size of reformulation of saturated fats**.

Appendix 3 needs to be consistent across sections

27. **We also urge WHO to be more consistent across each section, including in detailing the overarching/enabling actions.** For instance, the need to strengthen leadership against tobacco use and unhealthy diets, and to increase awareness and knowledge about the magnitude of these problems should be also mentioned. Moreover, under the physical inactivity section, there is one point on the ACTIVE technical package. Technical packages are key tools to inform the implementation of the recommended interventions within Appendix 3. It is therefore important that all the WHO technical packages on NCDs are included under their relevant overarching/enabling actions. These technical packages include: MPOWER (tobacco control), SAFER (alcohol control), SHAKE (salt reduction, to be included under unhealthy diet), REPLACE (trans-fat elimination, to be included under unhealthy diet), HEARTS (cardiovascular disease control). More specifically, intervention T9 (*Ban cross-border tobacco advertising, promotion and sponsorship, including through modern means of communication)* is also relevant for other risk factors, especially alcohol following WHO's *Action plan (2022–2030) to effectively implement the global strategy to reduce the harmful use of alcohol as a public health priority*, and unhealthy diets and breastmilk substitutes following the WHA75(21) decision (2022).

Appendix 3 needs to reflect the evolving NCD agenda

28. **Policy options on mental health, oral health, and air pollution should not be seen as separate from Appendix 3**. The WHA75.4 resolution (2021) asked for the development of 'best buys' on oral health to be included within Appendix 3, and the WHA72(11) decision (2019) requested the development of a menu of policy options on mental health and air pollution in response to the expansion of the NCD agenda to a '5x5' approach and in line with the 'best

[3] https://ncdalliance.org/sites/default/files/resource_files/NCDA_Trans%20Fat%20Free%20by%202023_Double%20Pages.pdf
[4] https://apps.who.int/iris/bitstream/handle/10665/355755/9789240039919-eng.pdf?fbclid=IwAR0dgIqrxQlUGPcm7XhoyeD307bKqM0bdXdlixcvVg2ChFrnkrtQpaO7Tjk

NCD Alliance
31-33 Avenue Giuseppe Motta
1202 Geneva | Switzerland
info@ncdalliance.org | ncdalliance.org

buys' approach. We ask WHO to clarify whether the 2020 *WHO menu of cost-effective interventions for mental health*, the future cost-effective interventions on air pollution (to be based on the 2022 *Compendium of WHO's and other United Nations' guidance on health and environment* and 2021 WHO's *Global air quality guidelines*), and the upcoming 'best buys' on oral health, will be fully integrated within Appendix 3 at some stage – this is a crucial step to achieve the ALIGN pillar of the upcoming WHO's *Implementation road map 2023–2030 for the global action plan on NCDs*.

29. **We urge WHO to also apply a phased approach to update the menu of cost-effective interventions for mental health in order to analyse and include in it, interventions related to neurological disorders**. The fifth NCD prioritized within the '5x5' approach encompasses mental health and neurological disorders: the 2018 NCD Political Declaration recognized that "mental disorders and other mental health conditions, as well as neurological disorders, contribute to the global burden of non-communicable diseases" and called for "integrating them into national responses for non-communicable diseases". Given the recent approval of WHO's *Global action plan on epilepsy and other neurological disorders 2022–2031*, such an update could be based on the cost-effectiveness analysis of its recommended interventions.

The consultation and updating processes need to be strengthened

30. **The update of Appendix 3 is a highly technical and important process that requires an inclusive consultation process.** WHO must provide sufficient information and allow enough time for civil society to consult their networks and comment on both the methodology and content. Also, the discussion papers should be made available in all UN languages at least.

31. **We urge WHO to establish a mechanism for the regular update of Appendix 3.** New cost-effectiveness estimates for interventions with a GCEA can be generated with countries' latest data on a regular basis, and key parameters can be updated as new evidence emerges on the effect size of specific interventions. GCEA should be developed for other recommended interventions as sufficient information for this analysis becomes available. This way, countries will always have access to an updated overview of the most implementable and cost-effective interventions for guidance.

32. **These update processes should be protected from the undue influence of health-harming industries**, including organizations involved in tobacco, alcohol, ultra-processed foods and beverages, breastmilk substitutes, and fossil fuels. This includes ensuring that the studies used for the GCEA do not have any conflicts of interest and that health-harming industries are not part of the consultation process. It is crucial for WHO to add a note clarifying how this is addressed. Moreover, we suggest referring to the implementation of conflict-of-interest policies as part of the overarching/enabling actions under Objective 1.

NCD Alliance
31-33 Avenue Giuseppe Motta
1202 Geneva | Switzerland
info@ncdalliance.org | ncdalliance.org

Comments per section

Objective / Area	Intervention	Comment
Objective 1	*Overarching/ enabling actions*	We suggest amending the following action point to highlight the importance of the NCD response for the resilience and recovery agenda: • ***"Integrate NCDs into public health agendas, including the pandemic preparedness and response, alongside the social and development agendas and poverty alleviation strategies."*** To highlight the relevance of addressing conflicts of interest with health-harming industries, we suggest adding the following action point: • ***"Implement conflict-of-interest policies to protect the development and implementation of interventions from industry interference."***
Objective 2	*Overarching/ enabling actions*	To highlight the relevance of public regulation and whole-of-government approach at national level, we suggest adding the following action point: • ***"Plan for implementation and enforcement of legislative and regulatory interventions and involve relevant government sectors in the planning process."*** Under this objective, it is relevant to reference the upcoming WHO's *Implementation road map 2023–2030 for the global action plan on* NCDs, and the need to adopt key enabling tools for the NCD response, such as updating national essential medicines, technologies and diagnostic lists in line with national epidemiological profiles and national policies.
Objective 3: Tobacco use	*Overarching/ enabling actions*	We **recommend adding reference to the MPOWER technical package**, due to its guidance for the implementation of tobacco control measures. Under this section, it would also be important to highlight that **tobacco use interventions should target all tobacco products**, including smoking

NCD Alliance
31-33 Avenue Giuseppe Motta
1202 Geneva | Switzerland
info@ncdalliance.org | ncdalliance.org

		(cigarettes) but also smokeless tobacco (such as betel quid and areca nut). Smokeless tobacco is also associated with high prevalence of NCDs (oral diseases and cancer in particular) and Appendix 3 should remind and stress that interventions for tobacco control should target all tobacco products.
	T2 (packaging and health warnings)	We urge WHO to amend this intervention to: ***"Implement plain/standardized packaging and large graphic health warnings on all tobacco packages"***, as plain packaging is a complementary intervention to graphic health warnings and should be implemented together according to the implementation guidelines for article 11 of the WHO Framework Convention on Tobacco Control (FCTC).
	T6 (cessation support)	We welcome GCEA and **integration of mCessation** as part of the cost-effective intervention on tobacco cessation support (it used to be an "other recommendation" in the 2017 version). We **would appreciate more information on how the different effect sizes of the different channels for support have been weighted** for the final GCEA, or whether these are meant to be combined.
	T7 (pharmacological therapies)	We welcome this **new intervention**, although the intervention heading needs to specify the therapies that were used for the GCEA as these are only specified in the technical brief that is not part of Appendix 3; for instance: • ***"Provision of cost-covered effective pharmacological interventions to all tobacco users who want to quit, through the use of nicotine replacement therapy (NRT), Bupropion and Varenicline."*** We would also appreciate more information on how the different effect sizes of the different therapies have been weighted for the final GCEA, or whether these are meant to be combined. Also, it is **unclear how the population of "all tobacco users who want to quit" has been estimated** for the GCEA.
	T9 (cross-border marketing)	We **welcome reference** to not just cross-border marketing of tobacco, but also its **wider promotion and sponsorship**, in line with WHO

NCD Alliance
31-33 Avenue Giuseppe Motta
1202 Geneva | Switzerland
info@ncdalliance.org | ncdalliance.org

		guidance. Article 13(2) of the FCTC obliges Parties to comprehensively ban tobacco advertising, promotion, and sponsorship, and Article 13 implementation guidelines includes cross-border advertising, promotion, and sponsorship.
Objective 3: Alcohol use	*Overarching/ enabling actions*	We **recommend adding reference to the SAFER technical package**, due to the guidance it provides for the implementation of the 'best buys' and 'good buys' on alcohol control. We also wish to reiterate under this section that as **there is no healthy nor safe level of alcohol use, it would be more accurate to entitle this section under objective 3: 'alcohol use'**, removing reference to 'harmful' in use of alcohol as technically all use of alcohol carries a degree of risk of harm.
	A1 (excise taxes)	We **urge WHO to perform the GCEA of A1 based on a specific tax rate (or different tax rates) for the update of Appendix 3**, in order to understand how a specific rate (or rates) will translate into gains in HLYs.
	A5 (brief psychosocial interventions for persons with hazardous or harmful alcohol use)	It is important to note that this intervention can be considered a 'best buy' for low-income countries, as it used to be classified as a 'good buy' based on 2017 data. We **would appreciate more information on why this intervention was modelled at a 50% coverage rate**, and how the number/proportion of persons with hazardous or harmful alcohol use has been defined and estimated.
	A11 (provide consumer information and labelling)	Front-of-package / plain labelling has been a very effective measure to reduce tobacco use and intake of unhealthy foods and beverages. Moreover, it is not only a relevant measure in connection with people's right to health, but also their right to information. We **urge WHO to prioritize performing a GCEA for this intervention next**, because by raising awareness about the cost-effectiveness that alcohol labelling can also have, countries can use

NCD Alliance
31-33 Avenue Giuseppe Motta
1202 Geneva | Switzerland
info@ncdalliance.org | ncdalliance.org

		lessons learnt from labelling other unhealthy commodities for alcohol control.
Objective 3: Unhealthy diet	*Overarching/ enabling actions*	We **recommend adding reference to the SHAKE and REPLACE technical packages**, and the following point: • ***"Ensure nutrition and food policies are informed by the Guideline on sugars intake for adult and children"*** as this resource provides solid evidence and guidance to keep intake of free sugars to less than 10% of total energy intake, significantly reducing the risk of overweight, obesity and tooth decay. Under this objective, it is also relevant to reference the recently approved WHO's *Recommendations for the prevention and management of obesity over the life course, including considering the potential development of targets in this regard* – as it includes recommendations for the improvement of food systems.
	Non-financial considerations	Multisectoral action is indeed crucial to build healthy food systems, and public regulation is key to **ensure public health interests prevail over the commercial interests of the unhealthy food and beverage industry**. It is therefore essential that multisectoral action includes mechanisms to avoid undue influence. We suggest the following language: • ***"Regulatory capacity along with multisectoral action, including the establishment of mechanisms to manage conflicts of interests with the food and beverage industry."***
	H1 (reformulation)	Based on earlier comments, we **ask WHO to consider mentioning the nutrients that are being targeted and separate this intervention into two**, as there is strong evidence on the cost-effectiveness of banning trans-fats through public regulation. The two interventions could be: • H1a: ***"Reformulation policies for healthier food and beverage products, including by setting target levels for the amount of salt and sugars, noting that public health***

NCDAlliance
31-33 Avenue Giuseppe Motta
1202 Geneva | Switzerland
info@ncdalliance.org | ncdalliance.org

		regulations rather than voluntary targets have been shown to be more effective." • H1b: ***"Elimination of industrially-produced trans-fats through the development of public regulations that ban their use in the food supply."*** We **urge WHO to also include and assess the effect size of reformulation of saturated fats**.
	H2 (front-of-package labelling)	We ask WHO to consider mentioning the nutrients that are being targeted and have been assessed for the GCEA, and **urge WHO to also include and assess the effect size of including information on sugars in front-of-package labelling**.
	H3 (public food procurement)	We **ask WHO to consider specifying the products** that are being targeted and have been assessed for the GCEA: • ***"Public food procurement and service policies for healthy diets (including reduction of salt, saturated fats, and sugar-sweetened beverages, and increase of fruit intake)."***
	H4 (behaviour change communciations)	The GCEA of this intervention should be calculated **taking also into account the effect size of campaigns on other unhealthy ultra-processed foods, and fruit and vegetable intake**.
	H5 (optimal breastfeeding)	We **welcome the new availability of a GCEA for the protection, promotion and support of optimal breastfeeding practices**. The health impact and therefore its cost-effectiveness is likely to be higher given its double duty to also reduce undernutrition, and this should be mentioned. Moreover, it would be important, to make the intervention more specific, possibly by adding the following reference, ***"including through the implementation of the International Code of Marketing for Breast Milk Substitutes."***
	H7 (marketing to children)	We have noticed that WHO's set of recommendations on the marketing of foods and non-alcoholic beverages to children has moved from an enabling action to *other* interventions. We welcome this change as it highlights the need to implement measures to regulate marketing targeted to children; however, **we recommend the**

NCD Alliance
31-33 Avenue Giuseppe Motta
1202 Geneva | Switzerland
info@ncdalliance.org | ncdalliance.org

		intervention be reformulated in line with the style of other interventions, for instance: • ***"Marketing restrictions for unhealthy foods and beverages to which children and youth are exposed, including through the implementation of WHO's set of recommendations on the marketing of foods and non-alcoholic beverages to children."*** We **urge WHO to prioritize performing a GCEA for this intervention next**, as unhealthy marketing to children and youth is increasing, especially through new modern channels, and governments need to understand the health impact and cost-effectiveness that marketing restrictions can have.
	H9 (menu labelling in food services)	We welcome the inclusion of this **new intervention**, as clear information on the nutritional value of the food served in restaurants and other food services is also part of efforts to increase consumer awareness.
Objective 3: Physical inactivity	*Overarching/ enabling actions*	We welcome the update of this section with the **latest WHO tools on physical activity**, including the global action plan and the ACTIVE technical package. Under this objective, it is also relevant to reference the recently approved WHO's *Recommendations for the prevention and management of obesity over the life course, including considering the potential development of targets in this regard* – as it includes recommendations for the promotion of physical activity.
	P3 (urban and transport planning) / P5 (walking and cycling infrastructure)	Under these interventions, we **ask WHO to also highlight the cost-benefits of improving urban planning and active mobility by also contributing to air pollution reduction**. We **urge WHO to prioritize performing a GCEA for these interventions next**, given their multiple co-benefits, but also because there are lesser GCEAs performed under this section and physical activity needs to be truly prioritised as one of the main NCD risk factors.

NCD Alliance
31-33 Avenue Giuseppe Motta
1202 Geneva | Switzerland
info@ncdalliance.org | ncdalliance.org

Objective 4 [Diseases control]	*Overarching/ enabling actions*	We **recommend adding reference to the HEARTS technical package**, which also has a 'HEARTS-D' module on the diagnosis and management of type 2 diabetes. This section should add **reference to the burden of co-morbidity** among these conditions and therefore the cross benefits of these interventions, which WHO should explicitly recognize to encourage integrated care. Enabling actions should also **refer to resilience**, and the importance of enhancing continuity of essential NCD services in times of emergencies.
Objective 4: Cardiovascular disease (CVD)	*General / Non-financial considerations*	Stand-alone guidance for CVD could be seen as an improvement, but we **ask WHO to clarify under non-financial considerations for CV2a and CV2b** that instead of "Glucose control not included in this intervention" it stays ***"Glucose control not included in this intervention, although a joint intervention can be implemented to maximize the health impact on people at high risk of CVD"***.
	CV1 (pharmacological treatment of hypertension)	We welcome the inclusion of this **new intervention** given only one in five adults living with hypertension have it under control.[5]
	CV2a/CV2b (drug therapy/counselling for people at high risk)	We **welcome widening the inclusion criteria for drug therapy/counselling coverage** of individuals with high risk of a fatal and non-fatal cardiovascular event in the next 10 years by using the updated WHO CVD risk charts.
	CV3 (treatment of new cases of acute myocardial infarction)	We **welcome the inclusion of clopidogrel** within the treatment options.
	CV4a/b (treatment of acute ischemic stroke)	We **welcome the inclusion of mechanical thrombectomy** as a treatment option where an experienced facility is available.
Objective 4: Diabetes	*D5 (blood pressure control in people living with diabetes)*	We welcome this **new intervention** with a GCEA, recognizing the increased risk of hypertension in some populations (e.g., people living with diabetes) and the need for integrated care.

[5] https://ncdalliance.org/sites/default/files/resource_files/Pressure%20Points_Diabetes%20Brief_FINAL.pdf

NCD Alliance
31-33 Avenue Giuseppe Motta
1202 Geneva | Switzerland
info@ncdalliance.org | ncdalliance.org

	Removed interventions	We note with concern that the following interventions have been removed and **request further information as to why** this is the case: • Influenza vaccination for patients with diabetes. • Preconception care among women of reproductive age who have diabetes including patient education and intensive glucose management.
Objective 4: Cancer	*CA2 (Cervical cancer screening)*	We **welcome the shift to encouraging that all cervical screenings include HPV DNA screening** (instead of just visual inspection), and the suggested frequency of screening strongly aligns with WHO's *Global strategy to accelerate the elimination of cervical cancer as a public health problem and its associated goals and targets for the period 2020–2030*. This frequency should be seen as the minimum screening women should receive.
	CA8-CA10	We welcome the **availability of GCEA results** for the interventions that used to be classified as *other* interventions, showing the cost-effectiveness of screening for oral and collateral cancers, and preventing liver cancer through hepatitis B vaccination.
	CA11 (early diagnosis for childhood cancer)	We welcome this **new intervention**, aligning with the six index cancers of the WHO Global Initiative for Childhood Cancer.
	CA12 (early diagnosis for head and neck cancers)	We welcome this **new intervention** with a GCEA, given the high prevalence of head and neck cancers.
	CA13 (early diagnosis for prostate cancer)	We welcome this **new intervention** with a GCEA, given the high prevalence of prostate cancer.
	CA14 (cancer services for people living with HIV)	We welcome this **new intervention** with a GCEA, recognizing the increased risk of cancer in some populations; e.g., people living with HIV.
Objective 4: Chronic respiratory disease	*CR1-CR4*	We **welcome the update of language to acute and long-term management** of asthma and COPD in alignment with latest PEN recommendations.
	CR6 (reduction of indoor air pollution via cleaner stoves and fuels)	We **urge WHO to prioritize performing a GCEA for this intervention as an urgent next step**, to understand the health impact and cost-effectiveness of this intervention for its addition in

NCD Alliance
31-33 Avenue Giuseppe Motta
1202 Geneva | Switzerland
info@ncdalliance.org | ncdalliance.org

		the future recommended interventions on air pollution (ambient and household).

Final comment

33. The **most recent NCD Countdown 2030 article** in The Lancet explains how a model package of 21 interventions, combining both intersectoral policies (such as taxation and regulation on unhealthy commodities) and clinical interventions, would ensure that LMICs achieve SDG target 3.4 on NCD mortality by 2030. **The 21 interventions are aligned with WHO's NCD 'best buys'** and would require an investment of US$18 billion annually over 2023-2030, averting 39 million deaths and generating an average net economic benefit of $2.7 trillion.

34. **We strongly urge WHO to retain the concept of NCD 'best buys' and to consider our comments and recommendations in order to strengthen the 2022 updated Appendix 3.** This is an initial response put together within the first consultation time given, we stand ready to continue supporting the updating process, and look forward to the second draft for discussion.

About this submission

35. **The NCD Alliance is a registered non-governmental organisation based in Geneva, Switzerland**, dedicated to supporting a world free from preventable suffering, disability and death caused by NCDs. Founded in 2009, NCDA brings together a unique network of over 300 members in more than 80 countries into a respected, united and credible global civil society movement. The movement is unified by the cross-cutting nature of common NCD risk factors including unhealthy diets, tobacco and alcohol use, physical inactivity and air pollution, and the system solutions for chronic NCDs such as cancer, cardiovascular disease, chronic respiratory disease, diabetes, and mental health and neurological disorders.

36. **This submission was prepared by NCD Alliance's policy and advocacy team, also informed by members of the NCD Alliance network**, including but not limited to:

- **European Federation of Neurological Associations (EFNA)**
- **Framework Convention Alliance (FCA)**
- **Global Alcohol Policy Alliance (GAPA)**
- **International Diabetes Federation (IDF)**
- **McCabe Centre for Law & Cancer**
- **The George Institute for Global Health**
- **Union for International Cancer Control (UICC)**
- **World Cancer Research Fund International (WCRFI)**

NCD Alliance
31-33 Avenue Giuseppe Motta
1202 Geneva | Switzerland
info@ncdalliance.org | ncdalliance.org