NCD Alliance

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

26 August 2022

1. This submission was prepared by the NCD Alliance, and the following civil society organisations are co-signatories: ACT Health Promotion, Africa NCDs Network, Alianza ENT Chile, Alzheimer's Disease International, ANAQ Foundation Ghana, Burundi NCD Alliance, Cameroon Civil Society NCD Alliance, Cancer Research UK, Coalicion America Saludable (CLAS), Ghana NCD Alliance, Healthy Caribbean Coalition, Healthy India Alliance, International Association for Dental Research, International Society of Nephrology, Movendi International, NCD Child, Norwegian Cancer Society, Swedish Hear Lung Foundation, Tanzania NCD Alliance, The George Institute, Umane, Vital Strategies and World Cancer Research Fund International.

2. The NCD Alliance and co-signatories thank the World Health Organization (WHO) for reviewing and preparing the **second 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') – **also known as the *NCD 'best buys' and other recommended interventions***.

3. **In the NCD Alliance's response to the first draft, we commended the strengths of the update process**, such as the inclusion of cost-effectiveness results for more interventions, that results have been presented for three country income groups (low-income, lower middle-income, and upper-middle-income), and that most cost-effectiveness analyses are now based on the data from 62 low- and middle-income countries (LMICs), reinforcing the investment case for these interventions.

4. **In this initial response, we also shared some reservations and several recommendations on both the methodology and content of the first draft**. These included the need for more information on the methodology and its limitations; the importance of retaining the concept of NCD 'best buys'; that recommended interventions should reflect the scope of their analyses; and that Appendix 3 needs to be consistent across sections and reflect the evolving NCD agenda; among other recommendations.

5. The NCD Alliance and co-signatories welcome that the revised draft acknowledges that interventions without a generalised cost-effectiveness analysis (GCEA) can also be cost-effective, and such interventions will be considered for analysis in future updates as data becomes available. However, **the current draft is still unclear on some aspects of its methodology, the direction it intends to take, and the guidance it aims to provide to Member States**. We therefore appreciate this second consultation opportunity and wish to contribute with the comments below.

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

General reservations and recommendations

6. **<u>We urge WHO to reconsider the concept of NCD 'best buys' in the updated Appendix 3</u>.** The term *NCD 'best buys' and other recommended interventions* has grown into a reference for the health community, being the well-recognised term with which we refer to Appendix 3 for communication purposes. This term flags the high return on investment of these interventions, is a basis for WHO's country support on NCDs, and has become instrumental to advocacy. However, the concept of NCD 'best buys' – interventions that cost ≤ I$ 100 per disability-adjusted life year (DALY) averted in LMICs, in the 2017 version – has been omitted in the 2022 update drafts, merging all the interventions with a GCEA into one category: "Specific interventions with WHO-CHOICE analysis". Currently, this does not even imply that these interventions are cost-effective, but it only says they have a GCEA. The second draft continues not to use the concept of 'best buys'. However, it has added a table (Table 3) listing all the interventions per section, ordered by their GCEA results across LMICs, clearly featuring interventions that have a cost-effectiveness ratio of ≤ I$ 100 per HLY gained in LMICs. Also, a new figure (Figure 1) shows the proportion of interventions per country income group and cost-effectiveness ratio, mentioning that depending on each country's cost threshold for NCD interventions, the figure provides an overview of the percentage of interventions countries could implement. We appreciate that the definition of a *very good* value-for-money versus a *good* value-for-money intervention may differ from country to country depending on their national circumstances, but it would be **more useful for WHO to highlight which interventions they consider the most cost-effective ones. We also recommend retaining the term 'best buys' as a well-recognised and easily understood signal to policy makers, and potentially expanding its concept to, for instance, interventions that cost ≤ I$ 500 per healthy-life year (HLY) gained in LMICs. At minimum, we believe these interventions should not be presented only as interventions with a GCEA, as this could be misleading.**

7. **<u>We urge WHO to be as clear and precise as possible with the descriptions of interventions</u>.** Interventions within Appendix 3 should guide country implementation as much as possible and the interventions' description must reflect their full scope based on their analysis. This information is often provided by the technical briefs but not reflected within Appendix 3, posing the risk that interventions may not be implemented to a minimum standard to obtain the estimated return on investment. For instance, **intervention T7 ("Provision of cost-covered effective pharmacological interventions to all tobacco users who want to quit") should specify in its description which pharmacotherapy options this intervention should include based on the options analysed and noted in the technical brief: nicotine replacement therapy (NRT), Bupropion, Varenicline**. In this instance, a higher level of specification would help mitigate against tobacco industry efforts to blur lines on the continuum of novel products. These concerns also apply to the section on unhealthy diets. We welcome the fact that many of the most cost-effective interventions to promote healthy diets have been formulated to address other unhealthy nutrients beyond salt (sugars, trans-fats, saturated fats), compared to the 2017 version. But to ensure Appendix 3 provides enough guidance to Member States, we suggest that the nutrients and products analysed under each intervention are specified as "including". For instance, intervention H3 could be

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

rephrased to (new suggested text in bold and highlighted): "Public food procurement and service policies for healthy diets **(including reduction of salt, saturated fats, and sugar-sweetened beverages, and increased fruit intake)**." **This would be seen as the minimum scope of the intervention, ensuring interventions are implemented to a minimum standard based on the evidence available and analysed.**

8. **We urge WHO to provide guidance on the synergistic benefits of combining interventions to support Member States with the prioritisation exercise of Appendix 3 interventions.** Appendix 3 recommends the implementation of a wide range of population-wide policies and NCD services (across prevention, diagnosis, treatment and palliative care) to reduce health inequalities. The document must therefore be seen as a valuable knowledge product for governments that allows them to assess what would be the most impactful and effective package of NCD interventions for their country. This prioritisation should be based on the cost-effectiveness analyses, but also on non-economic considerations, such as scalability, equity and other circumstances of national and regional nature. Cost-effectiveness is only a part of the value of an intervention, and it may vary depending on the cost of an intervention in different contexts, but this should not be confused with variations in effectiveness. We appreciate the reference in the second draft to the potential development of an interactive web-based tool that would help countries see the impact of implementing a set of cost-effective interventions from Appendix 3 on NCD targets. However, **it would be of great value if Appendix 3 also provides guidance on how different interventions that may have synergies in terms of costs and outcomes could be combined (e.g., interventions that involve taxation on tobacco, alcohol and sugar-sweetened beverages). More information could be also provided on the non-economic criteria that Member States should consider for prioritisation in the context of Appendix 3.**

9. **We urge WHO to recognize within Appendix 3 that the real impact of interventions is higher, reinforcing their investment case.** As clarified in the technical brief on tobacco, the health impact of interventions is calculated based on the relative risk they have for a series of specific NCDs, but the impact of tobacco use is not limited to the NCDs analysed. This means that the real health impact of tobacco control measures might be much higher than indicated, and this is also the case for other NCD risk factors. This should be highlighted within Appendix 3. This is also the case for breastfeeding, for which the health impact has been calculated based on the HLY gained by reducing the NCD burden – but breastfeeding is a double-duty action and its health impact is much larger, since it also reduces all forms of malnutrition. Moreover, given the high prevalence of co-morbidities among people living with NCDs (PLWNCDs), 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. Furthermore, Appendix 3 interventions can have a great positive impact on communities beyond reducing the burden of NCDs, by improving health equity and advancing the broader Sustainable Development agenda. **These additional benefits are not currently reflected in Appendix 3 and should be acknowledged.**

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

10. **<u>We urge WHO to provide more information on the methodology of this update, including the unit used, how cost-effectiveness was measured for interventions that include several components, and clarification on the methodological limitations</u>.** There is no background on why the 2017 version and 2022 update use different units to measure cost-effectiveness: I$ per DALY averted versus I$ per HLY gained. The information available in the IJHPM's Special Issue on WHO-CHOICE Update (2021) is limited and it would be important that the reasoning behind this change is clarified in Appendix 3. Also, it is still unclear how the health impact is calculated for interventions that include several therapies or channels with different effect sizes. More information on the limitations and gaps of the methodology is needed. 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 be noted, and future monitoring, research, and analyses should aim to include data on all age groups, as 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. The same applies to the analyses done for each disease area. **These clarifications would strengthen Appendix 3, provide additional background to Member States, and guide future updates.**

Overall recommendations on overarching/enabling actions and non-financial considerations

11. **<u>We urge WHO to be more consistent across each section of Appendix 3, especially in detailing the overarching/enabling actions</u>.** We appreciate that in the second draft it is acknowledged the need to perform a comparison across the risk factor and disease sections to check consistency in terms of methodology, and we also urge WHO to ensure consistency across the different sections and their overarching/enabling actions. For instance:
    a. The physical inactivity section refers to ACTIVE. 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) including the HEARTS-D module on diagnosis and management of type 2 diabetes.
    b. The second draft refers to the role that Appendix 3 can have in supporting the implementation of the new WHO acceleration plan on obesity, but there is no reference of this under any section. It would be relevant to reference the obesity acceleration plan and the recently approved *Recommendations for the prevention and management of obesity over the life course*, under the unhealthy diets and physical inactivity sections, as their scope includes improving food systems and promoting physical activity.
    c. As already acknowledged in the alcohol use and physical inactivity sections, the need to strengthen leadership against tobacco use and unhealthy diets, and to increase

awareness and knowledge about the magnitude of these problems is also relevant and should be mentioned in the overarching/enabling actions of these risk factors.

12. **We urge WHO to be more consistent with the wording and presence of non-financial considerations across risk factor sections.** Currently, there are some inconsistencies in the non-financial considerations included in the different risk factor sections. For instance, the same considerations for taxation of different unhealthy commodities could be applied across sections. Therefore, **we suggest having a joint section of non-financial considerations across the risk factor sections (under Objective 3) as follows**, compiling the existing considerations with a few additions (in bold and highlighted) to strengthen their scope:
    a. "Multisectoral action with relevant ministries and support by civil society is critical for implementing interventions"
    b. "Interventions implemented through legislative or regulatory changes require regulatory capacity along with multisectoral action, as well as capacity and infrastructure for implementing and enforcing regulations and legislation, **and for managing conflicts of interests with industries with vested interests**"
    c. "Interventions implemented via the health system require health worker capacity"
    d. "Levying taxes should be combined with other price measures, such as bans on discounts or promotions"
    e. "**Interventions should be implemented as a package of complementary policies with those interventions requiring legal implementation complementing non-legal interventions**"

Specific comments per section

Objective 1: Raise the priority accorded to NCDs

13. We suggest amending the following overarching/enabling action point to highlight the importance of the NCD response for the resilience and recovery agenda (new suggested text in bold and highlighted): "Integrate NCDs **into public health agendas, including pandemic preparedness and response**, alongside the social and development agendas and poverty alleviation strategies."

14. We suggest highlighting the relevance of addressing conflicts of interest with health-harming industries, by adding the following overarching/enabling action point: **"Implement conflict-of-interest policies to protect the development and implementation of interventions from industry interference."**

Objective 2: Strengthen national capacity, leadership, governance, multisectoral action and partnerships

15. We suggest highlighting the relevance of public regulation and a whole-of-government approach at national level, by adding the following overarching/enabling action point: "Plan for implementation and enforcement of legislative and regulatory interventions and involve relevant government sectors in the planning process."

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

16. We also suggest referencing the need to adopt key enabling tools for the NCD response, such as ensuring the meaningful involvement of people living with NCDs (including care givers) in national NCD responses, by engaging them in policy planning, programme development, monitoring and evaluation, including budgetary allocations; and updating national essential medicines, technologies, and diagnostic lists in line with national epidemiological profiles and national policies.

Objective 3: Tobacco use

17. **Intervention 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).

18. **Intervention T4 (eliminate exposure to second-hand tobacco smoke).** We suggest expanding protection for outdoor workplaces and crowded public spaces.

19. **Intervention T5 (mass media campaigns).** We recommend clarification that "mass media" includes digital media or "modern means of communication" to clarify the benefit of leveraging campaigning.

20. **Intervention T7 (pharmacological interventions)**. We urge WHO to specify the intended therapies for this intervention, i.e.: "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**."

21. **Intervention T8 (establish a tracking and tracing system).** We suggest this recommendation be clarified to exclude such systems that are developed by the tobacco industry to prevent industry interference.

22. **Intervention T9 (cross-border marketing)**. We urge WHO to consider including this intervention also under other relevant risk factor sections, especially for 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).

    The guidelines should advise Member States to implement appropriate restrictions on e-cigarette marketing and vaping to reduce its harms among young people. We appreciate that evidence is lacking on the (cost-) effectiveness of interventions for vaping prevention, but some mention of vaping is warranted in this section to avoid Member States failing to appreciate the need to also implement strategies to minimise vaping, at least among non-smokers.

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

Objective 3: Alcohol use

23. We wish to reiterate under this section that as **there is no healthy nor safe level of alcohol use**, and therefore it would be more accurate to entitle the section under Objective 3 as 'Alcohol use', removing the word 'harmful', as all use of alcohol carries a degree of risk of harm.

24. **Intervention 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, to demonstrate how a specific rate (or rates) will translate into HLY gains.

25. **Intervention A11 (consumer information and labelling)**. We ask WHO to prioritise performing a GCEA for this intervention next, because by raising awareness about the cost-effectiveness that alcohol labelling can have, countries are more likely to use lessons learnt from labelling other unhealthy commodities for alcohol control. 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. It will also be useful to have information about the amount of servings or alcohol in each product, so consumers can better moderate their usage.

26. **Intervention A3 (restrictions on physical availability, via reduced hours of sale).** This intervention is closely linked to intervention A8 ("Enact and enforce an appropriate minimum age for purchase or consumption of alcoholic beverages and reduce density of retail outlets"). We urge WHO to consider performing a GCEA on the effect size of establishing a minimum age for purchase or consumption of alcoholic beverages and reduce density of retail outlets and also consider the recommendation to also restrict alcohol delivery. The COVID-19 pandemic has done much to increase the prevalence of alcohol home deliveries, particularly through online outlets and delivery services.

27. **Intervention A6 (regular review of prices).** Reviewing alcohol affordability is not an intervention in itself but part of broader taxation efforts. This point could be improved by indicating that this intervention is part of the regular adjustment of the alcohol taxes to reduce affordability. This is also a relevant exercise for other interventions involving taxations of unhealthy commodities (tobacco, sugar-sweetened beverages).

Objective 3: Unhealthy diets

28. As an overarching/ enabling action for Objective 3 (unhealthy diets) we recommend that WHO urge the adoption of guidance from global experts, and international experiences such as in Chile and Mexico, and recommend the use of a simple Nutrient Profile model with nutrient thresholds for food and beverages that enables the easy identification of unhealthy products and the presence of ultra-processing.

29. **Intervention H1 (reformulation)**. Of great concern is the fact that under this intervention, the technical brief says reformulation can be implemented as a mandatory or voluntary measure.

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

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 also referenced (also public regulation), and therefore this needs to be reflected on the intervention description or accuracy, fully reflecting the scope of the intervention as analysed and providing specific guidance to Member States. For 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 highlight that mandatory approaches are more effective. **We therefore urge WHO to divide H1 into two interventions** to accurately reflect their scope and evidence, providing Member States with specific guidance as follows:

a. **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."**
b. **H1b: "Elimination of industrially-produced trans-fats through the development of public regulations that ban their use in the food supply."**

30. **Intervention H4 (behaviour change communication)**. In line with the NCD Alliance's initial response, we welcome the update of the GCEA for this intervention to also analyse the effect size of adding campaigns to deter consumption of unhealthy foods and promote healthy foods, which has increased the health impact of the intervention considerably, improving its cost-effectiveness ratio as well.

31. **Intervention H5 (marketing restrictions for children)**. In line with the NCD Alliance's initial response, we welcome that a GCEA has been performed for this new intervention on *Policies to protect children from the harmful impact of food marketing*, showing the cost-effectiveness of restricting marketing of unhealthy food products to which children are exposed. For consistency with other interventions, we suggest it is rephrased to: "Restrictions on marketing of unhealthy food products to which children are exposed."

32. **Intervention H6 (optimal breastfeeding)**. We welcome the elements added to this intervention's major cost assumptions, including under human resources (by adding: "to form a team that will support the development, implementation and monitoring of effective supportive policies, as well as mechanisms for preventing and managing potential conflict of interest"). As part of its guidance, we urge WHO to consider adding at the end of this intervention the following text: "**including through the implementation of the International Code of Marketing for Breast Milk Substitutes**."

33. **Intervention H7 (taxation on sugar-sweetened beverages as part of comprehensive fiscal policies)**. We welcome the updated GCEA of this intervention, as it uses more conservative estimates and includes the intervention's impact on oral health (dental caries), maintaining a very strong cost-effective ratio (I$ 100-500 per HLY gained in LMICs).

34. **We urge that recommendations on the use of potassium-enriched salt substitutes for people who are not living with or at risk of kidney disease be added under this section, based on the WHO guidance when completed (currently under development).** Research

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

shows that replacing salt with a reduced-sodium, added-potassium salt substitute significantly lowers the risk of stroke, heart disease, and death, and reduces healthcare costs.

Objective 3: Physical inactivity

35. **Interventions P3 (urban and transport planning) / P5 (walking and cycling infrastructure)**. We urge WHO to highlight the cost-benefits of improving urban planning and active mobility such as air pollution reduction, and to prioritise performing a GCEA for these interventions next. Apart from their multiple co-benefits, there are lesser GCEAs performed under this section and physical inactivity needs to be truly prioritised as one of the main NCD risk factors. Intervention P3 should be also more specific about the role that public transport can have in promoting physical activity (this reference has been removed from the 2017 version), and the influence that perceived and real threats to personal safety on sidewalks can have in discouraging physical activity. For instance, evidence from high-income country cities has shown that urban speed limits of 30km/h increased walking and cycling.

Objective 4: Cardiovascular disease (CVD)

36. We welcome the two additional recommended interventions in line with WHO guidance: CV11 and CV12.

37. **Interventions CV2a and CV2b (drug therapies to control CVD risk)**. We noted that the non-financial considerations now say: "Glucose control not included in this intervention, but in D5-Control of blood pressure in people with diabetes". However, this requires further clarification. **D5 focuses on the control of blood pressure (not glucose) in people living with diabetes specifically**. Additionally, extensive evidence on the use of Aspirin/ Acetylsalicylic Acid for secondary prevention of coronary heart disease is available (for example, NCD Countdown 2030: efficient pathways and strategic investments to accelerate progress towards the Sustainable Development Goal target 3.4 in low-income and middle-income countries, and its supplementary appendix). While it seems that a WHO-CHOICE Analysis has not been performed on this recommendation, **it would be important to include it under CV2a, rather than in CV12**, to highlight its importance.

38. Future update: We are urge WHO to undertake a GCEA on "**Identification and treatment of albuminuria with inhibitors of the renin angiotensin system (ACE--- inhibitors and ARBs) in patients with hypertension, diabetes and cardiovascular disease in order to reduce cardiovascular risk**" to inform inclusion in future updates. Screening for albuminuria and early intervention with angiotensin---converting enzyme (ACE) inhibitors and angiotensin II receptor blockers (ARBs) has been demonstrated to be cost effective in Europe as a measure to reduce CVD. Furthermore, the use of ACE---inhibitors and ARBs to treat albuminuria has also been shown to reduce the risk of heart failure in patients with chronic kidney disease.

Objective 4: Chronic respiratory disease

39. **CR6 (reduction of indoor air pollution via cleaner stoves and fuels)**. We urge WHO to prioritise 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 the future

recommended interventions on air pollution (ambient and household). Further, while "interventions for chronic respiratory disease" lists "access to improved stoves" the principal outcomes for avoidable DALYs and mortality from air pollution are cardiovascular, not chronic respiratory disease.

Objective 4: Diabetes

40. 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. According to multiple observational studies, the influenza immunization intervention is low risk, low cost and has a moderate to substantial impact on the care of people with diabetes. Clinical narrative and case-control studies support the fact that vaccination against influenza is effective to reduce hospital admissions of people with diabetes during influenza epidemics.
    • Preconception care among women of reproductive age who have diabetes including patient education and intensive glucose management. This is an important intervention as preconception care is an important factor in alleviating gestational complications in women with diabetes.

41. We suggest that the intervention D4 "Screening of people with diabetes for proteinuria and treatment with angiotensin-converting enzyme-inhibitor for the prevention and delay of renal disease" is revised to **"Assessment for albuminuria in people with diabetes and treatment with angiotensin-converting enzyme-inhibitor for the prevention and delay of kidney disease".** Evidence demonstrates that albuminuria is an important tool to help guide the investigation and management of known chronic kidney disease (CKD), as well as identifying cases of CKD in people with diabetes or hypertension. The screening for albuminuria is detailed (and mentioned as preferred) in the WHO HEARTS D guideline. It should also be noted that laboratory assays for proteinuria are more difficult to standardize and have poorer analytical precision when compared with assays for albuminuria. Additionally, It is recognised that the approach of looking for disease in a population with identified risk factors is more accurately described as "case-finding" rather than "screening". As the term case-finding is not well understood by the healthcare community, alternative terminology such as "assessment" or "early detection" should therefore be considered.

Objective 5: promote and support national capacity

42. We suggest adding under the first overarching/enabling action ("Develop and implement a prioritized national research agenda for noncommunicable diseases") the need for research agendas to be inclusive of all age groups (below and above the 30-69 age range) to ensure the evidence base reflects the needs and impact of the NCD response across people's life course, and that research includes sex- and/or gender-disaggregated data collection, analysis and reporting.

Objective 6: Monitor the trends and determinants of NCDs

43. We suggest amending the following overarching/enabling action point to highlight the importance of aligning national targets with the global NCD monitoring frameworks and other

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

existing national strategies, ensuring all national efforts are coordinated and effective in the use of resources: "Develop national targets and indicators based on global monitoring framework **and national UHC, NCD and disease strategies**, and linked with a multisectoral policy and plan."

Areas that require further clarification

44. **We ask WHO to provide further information about how the regular updating process of Appendix 3 will work**. We welcome very much that the second draft mentions that evidence used for the cost-effectiveness modelling of interventions will be periodically revised and updated. It would be very useful to understand whether Member States, UN agencies and civil society will be able to submit and suggest new sets of data and studies with new potential parameters for WHO consideration, and what the criteria for studies should be. **It is important to the overall utility of these updating processes to have clear and sufficient timelines and mechanisms.**

45. **We ask WHO to clarify how the update processes are protected from the undue influence of health-harming industries**, including organisations 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.

46. **We ask WHO to clarify whether the policy options on mental health, oral health, and air pollution will be integrated as part of Appendix 3**. This would be a crucial step to achieve the ALIGN pillar of WHO's upcoming *Implementation road map 2023–2030 for the global action plan on NCDs*. Moreover, WHO should clarify whether it plans to update the menu of cost-effective interventions for mental health to analyse and include interventions related to neurological disorders as the fifth NCD prioritised within the '5x5' approach encompasses mental health and neurological disorders.

47. **We ask WHO to consider these further questions and suggestions regarding the methodology.** The listing of 'enabling actions' alongside cost-effectiveness is to be commended as it acknowledges the practical, institutional, and infrastructure constraints in mobilising the money and implementing relevant interventions on the ground. **We request clarification of whether and how the costs of these enabling actions are factored into the cost-effectiveness estimates of other interventions.** Consideration might also be given to including in the updated version: provision of guidance on developing context-specific budget estimates; and addressing policymakers' needs for information on the timescale for cost-effectiveness.

48. **The NCD Alliance and co-signatories stand ready to continue supporting this update**. We look forward to the revised Appendix 3 that will be submitted to WHO's Executive Board and any additional information that may be provided on the development process and further guidance for implementation.