Submission to consultation on the draft WHO Discussion Paper on updates to Appendix 3 of the WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases (2013-2030)

[26th June 2022] – The George Institute for Global Health welcomes this opportunity to respond to the proposed updates to Appendix 3 of the WHO's global NCD action plan, which sets out recommended interventions for the prevention and control of NCDs.

We applaud the efforts of the WHO Secretariat to ensure Appendix 3 reflects the latest scientific evidence, as well as new WHO recommendations. We strongly support the intention to assist countries selecting a combination of these interventions to define locally tailored packages of interventions to accelerate ongoing national NCD responses. We also appreciate the inclusion of country-level data for 62 low- and middle-income countries to inform this expanded list of 102 interventions.

We look forward to the integration in Appendix 3 of recommended interventions on oral and mental health, and on-air pollution as a key risk factor for NCDs. We also feel there are several ways in which the current update of Appendix 3 could be strengthened.

As a general point, we believe the revised appendix should do more to **highlight the importance of equity considerations**, and the need to consider the impacts of interventions on communities experiencing marginalisation because of historic power imbalances. As the paper states, there are limitations to considering cost-effectiveness in isolation; non-economic implementation considerations are essential, and we believe the revised Appendix 3 should provide further guidance on how Member States can use these recommendations within a priority-setting framework that considers national and community preferences.

We also believe the updated appendix would be strengthened with the **application of a sex and gender lens to the recommendations**.[1] Our research has found that several well-known modifiable risk factors, such as smoking, hypertension, and diabetes, exert a greater effect on the risk of certain NCDs in women as compared to men, potentially warranting gender-sensitive approaches to the prevention and management of these risk factors.[23] We, and others, have also shown that lack of awareness of sex- and gender-based differences in NCD risk and progression has led to unequal care, and ultimately preventable deaths, in women.[45] Furthermore, sex-based factors intersect with gendered attitudes, behaviours, and relations, as well as other characteristics, such as age and ethnicity. However, sex and gender are largely missing from NCD interventions, and – except for recommendations related to female-specific diseases – from the updated Appendix 3.

In addition, we believe there would be added value in providing guidance on how to **combine packages of interventions where there are synergies** in terms of costs and outcomes; for example, when considering tobacco and alcohol taxation. Interventions that raise revenue unsurprisingly rank highly for cost-effectiveness, but it is unlikely this will be the most crucial factor in influencing government decisions as to whether to implement such taxes. Despite this, the concept of NCD 'best buys' and 'good buys' has been helpful in enabling governments to assess what can be the most impactful and effective package of NCD interventions for their country, and we believe **the label 'best buys' should be retained**.

It would be helpful for the discussion paper to explain the reason for the **change in units to measure cost-effectiveness**, from I$ per disability-adjusted life year (DALY) averted to I$ per healthy-life year

(HLY) gained in the updated Appendix 3. The technical annex to Appendix 3 needs to provide **more information on the methodology** used for the update, including limitations and gaps. And finally, we would support others in urging WHO to **establish a mechanism for the regular update of Appendix 3.**

We also have several comments on specific objectives:

Objective 1: To raise the priority accorded to the prevention and control of noncommunicable diseases in global, regional, and national agendas and internationally agreed development goals, through strengthened international cooperation and advocacy

We support the overarching/enabling actions set out under this unchanged objective, and in particular the recognition of the value of engaging civil society to support the implementation of the action plan at the global, regional, and national levels. We would suggest this recommendation is further strengthened by outlining specific activities that can foster civil society engagement and social participation in decisions regarding policy interventions, and by highlighting the need for policies to manage potential conflicts of interest when engaging with health-harming industries.

Objective 2: Strengthen national capacity, leadership, governance, multisectoral action and partnerships to accelerate country response to the prevention and control of noncommunicable diseases

The meaningful involvement of people living with NCDs (including their carers) and communities is a critical element of an effective NCD response, including budgetary allocations, programme development, monitoring, and evaluation. We suggest this is explicitly recognised in the updated Appendix 3. We look forward to seeing the supplementary guidance WHO is developing on pursuing multi-stakeholder collaboration, including meaningful engagement with people living with NCDs and mental health conditions.

Objective 3: To reduce modifiable risk factors for noncommunicable diseases and underlying social determinants through the creation of health-promoting environments

- ***Tobacco use***

Overall, these are a strong set of recommendations. In 2021, for the first time, the WHO report on the global tobacco epidemic included data on electronic nicotine delivery systems (ENDS) and revealed that they must be further regulated.[6] However, interventions to support this are not acknowledged within the discussion paper. 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.

- ***Harmful use of alcohol***

We welcome these recommendations and applaud the decision of the World Health Assembly to adopt the Global Alcohol Action Plan.[7] However, we are concerned that the term 'harmful use' of alcohol is at odds with the evidence of alcohol toxicity and the lack of any 'safe dose'.[8] No such qualifier is applied to tobacco in the document. We recommend that this qualifier is removed from the alcohol section to bring the wording in line with the evidence and to be consistent with the tobacco section.

Restrictions on alcohol retailing hours and outlet density are mentioned, but restrictions on alcohol delivery are not, despite evidence that less than one-third of countries have regulations on outlet density and days of alcohol sale.[9] The COVID-19 pandemic has done much to increase the prevalence of alcohol home deliveries, particularly through online outlets and delivery services.[10] We would therefore suggest incorporating this element of alcohol availability into the document.

- ***Unhealthy diets***

We strongly recommend that the use of potassium-enriched salt substitutes for people who are not living with or at risk of kidney disease is added to the updated Appendix 3. Our research – including a five-year study in China, one of the largest dietary interventions ever conducted – 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.[11] A global switch from regular salt to potassium-enriched salt substitutes would avert hundreds of thousands of cardiovascular events and strokes and would reduce the risk of premature death.[12]

Salt substitutes are a particularly low-cost and effective intervention in countries where most sodium in the diet comes from the salt added during home cooking, which can be easily substituted.[13] This includes most low- and middle-income countries. In high-income countries, where most of the salt in diets comes from processed foods and meals, the food industry should use salt substitutes to replace sodium in their products.

- ***Physical inactivity***

We welcome the recommended actions to address physical inactivity here, including guidance to improve walking and cycling infrastructure and the implementation of urban and transport planning and urban design that promotes mobility.

We suggest a further recommendation be added that Member States address public concerns about exposure to air pollution, as well as perceived and real threats to personal safety through sidewalks and violence prevention measures. Where necessary, governments should enforce urban speed limits of 30km/h, as evidence from cities high-income countries shows that lower vehicle speeds are associated with increased walking and cycling activity in these areas. People living in 'walkable' environments are more likely to engage in active transport and higher levels of physical activity.[14] It is important to invest in and promote public transport as an alternative to private vehicles, to implement national policies that address the use of fossil fuels and prioritise walking and cycling, and to encourage planning of liveable urban spaces with a focus on communities experiencing marginalisation.

Objective 4: To strengthen and orient health systems to address the prevention and control of noncommunicable diseases and the underlying social determinants through people-centred primary health care and universal health coverage

Despite the wording of this objective, which we support, very few of the recommended interventions that follow relate to the integration of NCD prevention in primary health care settings. We believe this is an omission that should be addressed. For example, the recently published WHO recommendations on addressing obesity across the life course highlight the importance of integrating obesity management into primary care, particularly in low-and middle-income countries. Similarly, the use of potassium-enriched salt substitutes as a measure to prevent cardiovascular events should be promoted in primary health care settings.

- ***Diabetes***

We note with concern that the recommendation on preconception care among women of reproductive age who have diabetes, including patient education and intensive glucose management, has been removed, and request further information as to why this is the case. We suggest an additional recommendation here: that in high-prevalence areas, screening for diabetes in pregnant women be integrated with existing maternal and primary healthcare to identify and manage risk factors for type 2 diabetes (recognising that women who have diabetes in pregnancy are seven times more likely to develop type 2 diabetes after giving birth).

Objective 5: To promote and support national capacity for high-quality research and development for the prevention and control of noncommunicable diseases

We warmly welcome the recommended actions here that Member States develop, implement, and resource national NCD research agendas. As a global health and medical research institute with offices in India, China, Australia, and the UK, and working with partners on ongoing projects in 45 countries, we strongly support the recommendation that research capacity should be built through collaboration.

There is considerable evidence of women being undertreated or presenting diseases differently to men. However, not enough is being done to understand these differences, which is a critical first step in creating evidence-based policies, trainings, and interventions. We suggest that a recommendation be added calling for national NCD research agendas to require sex (and gender, where appropriate) to be central considerations in NCD research. As part of this, it will be important for sex- and/or gender-disaggregated data collection, analysis, and reporting to be commonplace, and for a gendered lens, specific to the context, to be applied to data interpretation. These analyses could reveal whether and how the pathways and quality of care differ for women and men within a healthcare system, and support evidence-based strategies to ensure both women and men receive the best available care.

We thank you for considering this submission, which is based on the knowledge and experience of a team of leading NCD researchers around the world. We look forward to following the discussions on Appendix 3 and stand ready to support with the update in whatever way may be useful.

About The George Institute:

The George Institute is a leading independent global medical research institute with major centres in Australia, China, India and the UK, and an international network of experts and collaborators.

Our mission is to improve the health of millions of people worldwide, particularly those living in disadvantaged circumstances, by challenging the status quo to find the best ways to prevent and treat non-communicable diseases (NCDs), injury and violence.

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