APPENDIX 3 COMMENTS MOVENDI INTERNATIONAL

Movendi International is the largest independent global social movement for development through alcohol prevention. We unite, strengthen, and empower civil society to tackle alcohol as a serious obstacle to development on personal, community, societal, and global level. We are 130+ member organizations from 56 countries and in 20201 together we reached more than 24,000,000 people. We stand for the most comprehensive response to alcohol harm, working with prevention and treatment and rehabilitation, as well as advocacy, awareness raising campaigns and to expose and counter-act the unethical business practices of the alcohol industry.

Introduction

Movendi International welcomes the opportunity to update our comments and share additional evidence to the WHO Discussion Paper (version dated August 01, 2022) for the update of Appendix 3 of the WHO Global NCDs action plan 2013-2030.

We have not seen that our comments on the discussion paper version from June have been taken into account for the improvement of the discussion paper version from August.

We are sharing our input under five different categories.

1) Summary of key issues,
2) Correct scientific terminology,
3) Alcohol policy interventions as best and good buys,
4) Include data from High-Income Countries (HICs),
5) Additional comments,
6) Comment on CHOICE economic analysis regarding alcohol policy interventions, and
7) Comparison of tobacco control effectiveness analysis with alcohol policy.

Main analysis and comments

1. Summary of key issues

- Clearly indicate the alcohol policy best and good buys.
- Include age limits as an evaluated alcohol policy measure, best or good buy.
- Include alcohol monopoly retail monopolies as an evaluated alcohol policy measure best buy.
- Include high-income countries
    - People are harmed by alcohol in all countries, HIC have responded to alcohol harm with WHO-recommended interventions and provide data on cost-effectiveness.
    - It's difficult to understand why HIC data on alcohol policy impact is not included in the data/evaluation. WHO is a membership-based organization for all countries.
- Rectify the differences in the assessment of the health effects of interventions between tobacco and alcohol.
    - Probably the difference is based on the GBD's estimate of the burden of disease from tobacco and alcohol respectively, but the differences are strikingly large.
- It is essential to take into account the secondary and social harm of alcohol in the WHO modelling of cost-effectiveness and best buys.
- The alcohol industry should be addressed as an overarching point, like in the case of tobacco.

2. Correct scientific terminology

Alcohol is a major risk factor for NCDs.
Since the last update of Appendix 3, new, strong, and growing evidence has emerged showing there is no safe or healthy amount of alcohol consumption concerning cancer, cardiovascular disease, and brain diseases.
Therefore, the updated Appendix 3 should reflect this new, strong, and growing evidence base and abandon the political concept of "harmful use of alcohol" in all instances where it is not necessary.

Examples and suggested corrections

Example	Correction
• Strengthen leadership and increase commitment and capacity to address the harmful use of alcohol	Strengthen the leadership and increase commitment and capacity to address harm due to alcohol
• Increase awareness and strengthen the knowledge base on the magnitude and nature of problems caused by harmful use of alcohol by awareness programmes, operational research, improved monitoring, and surveillance systems	Increase awareness and strengthen the knowledge base on the magnitude and nature of problems caused by alcohol by awareness programs, operational research, improved monitoring, and surveillance systems

3. Alcohol policy interventions as best and good buys

a. Clearly identify the alcohol policy best buys and good buys

A1-3 are the most cost-effective and high-impact alcohol policy solutions and should clearly be identified as the alcohol policy best buys.

A4-5 are less cost-effective and have a smaller impact on population health and should thus be clearly identified as good buys.
The difference matters for policy makers to find clarity in the most impactful interventions.

b. Add new best buys for alcohol policy

A7 and A8 should qualify to be added to the alcohol policy best buys interventions.

- A7: There is strong and growing data on the cost-effectiveness of minimum unit pricing that should be used to for updating Appendix 3
- A8: Age limits as part of reducing the physical availability of alcohol are evidence-based interventions that should be identified as best buys; most of the evidence comes from high-income countries, because low-income countries struggle to even implement a minimum age or to enforce it (according to the WHO Global Alcohol Status Report 2018). But countries like the United States (in the 1980s) and Lithuania (in the 2010s) clearly demonstrate the cost-effectiveness of alcohol age limits.

We note that these two additional best buys fit the description of criteria perfectly:

The following criteria used for identifying interventions in 2017 were applied for the 2022 update:

- An intervention must have a demonstrated and quantifiable effect size, from at least one published study in a peer reviewed journal.
- An intervention must have a clear link to one of the global NCD targets.

Additional interventions were considered using the same criteria as above. The intervention list for the 2022 updated Appendix 3 comprised (i) interventions which have been unchanged from the 2017 update, (ii) interventions from the 2017 update which have been re-worded or revised to reflect updates in WHO policy or scientific

evidence (iii) interventions included in the 2017 update that had no analysis carried out at the time and for which cost-effectiveness analysis was done in the 2022 update, and (iv) new interventions from new WHO guidance and tools (Table 1).

c. Further comments on the alcohol policy interventions

A6: use better wording

- The review of alcohol affordability in itself is not an intervention but part of it; the wording could be improved to indicate that the intervention is indexation/ regular adjustment of the alcohol tax to reduce affordability.

A12: Add an intervention: Government-run retail monopoly

- There is so strong evidence about the impact and cost-effectiveness of government-run alcohol retail monopolies that eliminate the profit motive from alcohol retail for the benefit of public health; that is why this should be added to the alcohol policy intervention list in the updated Appendix 3

4. Include data from High-income countries

One root problem underlying most of the issues identified above is that the country selection as explained on page 23. This country selection is problematic for showing alcohol policy cost-effectiveness because most countries with alcohol policy commitment on recent years are absent from the list.
This selection skews against the alcohol policy best buys and adding newer ones because LMICs are not taking these up, are not committing resources to alcohol policy development and are not accelerating action so far – as WHO has shown.

Comment on table 2, page 23
Out of the 62 countries considered: No low income country from the list has implemented alcohol policy best buys; only Kenya, Philippines, Sri Lanka, Vietnam, (Ecuador), Peru, Russia, and Thailand have implemented alcohol policy solutions in recent years

We note the recognition that “For some type of interventions (e.g., harmful use of alcohol), the analysis was based on a smaller subset of countries.” But this could have been avoided if best practice evidence from high-income countries would have been included: Lithuania, Scotland for example, and the Scandinavian countries.

Overall, HICs also stand to gain a lot from cost-effectiveness analysis regarding alcohol policy solutions. We encourage WHO to reconsider this approach. Misunderstanding the cost-effectiveness of alcohol policy solutions is one of the reasons why governments have failed so far to accelerate action on alcohol as public health priority.

5. Additional comments

Interventions	Overarching/ enabling actions	Interventions with WHO-CHOICE analysis	Interventions without WHO-CHOICE analysis
Alcohol policy	4	5	6

- Add an additional overarching action!
- Add two more best buys (see above).
- Add one more intervention without WHO-CHOICE analysis (see above).

The WHO SAFER blueprint contains a horizontal action that pertains to protecting alcohol policy making from conflicts of interest and interference by the alcohol industry. This should be added as overarching/ enabling action in the updated Appendix 3.

6. Comment on CHOICE economic analysis regarding alcohol policy interventions

In table 3 on page 27, we find concerning figures.

- The alcohol taxation impact is MUCH lower than tobacco taxation impact, concerning health impact per year.
- This is concerning because other modelling on return on investment and even healthy live years saved projects a bigger impact from alcohol tax increases than from tobacco taxation – largely because alcohol taxes are so low and thus have bigger potential for increases.
- We are concerned that the table does not seem to reflect this data.

We are also concerned comparing the impact of the different alcohol policy interventions among themselves:

- Alcohol taxation has a LOWER health impact per year than brief interventions (except for upper-middle income countries).
- But brief interventions have a lower population level impact, are most costly to design, and are more complex to introduce and scale.

We would welcome an explanation for both issues of concern. And we would welcome if this data could be revised.

7. Comparison of tobacco control effectiveness analysis with alcohol policy

It is interesting to compare the measures for tobacco control and alcohol policy respectively. Is there really any reason why measures that have been shown to be effective for tobacco should not be effective for alcohol?
The research is worse on the alcohol side. But it is important that WHO efforts to evaluate the effectiveness and cost-effectiveness of NCD best buys avoids replicating existing problems in the science (lack of studies in LMICs, alcohol industry bias in a host of studies, etc.) and helps overcome these problems to facilitate a really evidence-based approach to alcohol policy.
Clearly, some of the measures that have a population health effect in tobacco control should be mentioned as worth considering for alcohol, too, based on the tobacco research, even if no WHO CHOICE evaluation has been done.

For example:

- Implement plain/standardized packaging and/or large graphics health warnings on all tobacco packages,
- Implement effective mass media campaigns that educate the public about the harms of smoking/tobacco use and second hand smoke,
- Establish a tracking and tracing system to support the elimination of illicit trade in tobacco products (or something about control of trade across national borders), and
- Ban cross-border tobacco advertising, promotion and sponsorship, including through modern means of communication.