



WCRF International consultation response

Online consultation submission: Draft updated Appendix 3 of the WHO Global NCD action plan (2013-2020)

June 2022

World Cancer Research Fund International welcomes the World Health Organization's preparation of 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 ('Appendix 3').

The concept of NCD 'best buys' and 'good buys' has been an integral advocacy tool for making a strong investment case for NCD policy implementation, and key in driving effective action at national level. The 'best and good buys' are particularly important post-COVID 19 given the setbacks of numerous NCD prevention measures, early detection, diagnosis, treatment and care services.

We thank WHO for the opportunity to provide our feedback and present brief recommendations that we believe will enhance clarity, cohesion, and impact of the updated document.

We also support the submission prepared by the NCD Alliance.

1. Strengths of the draft update Appendix 3

We commend the points of the discussion paper that strengthen the evidence base of Appendix 3 and reinforce the investment case for interventions. In particular, we welcome:

- 1.1. Interventions with a Generalized Cost Effectiveness Analysis (GCEA) based on data from 62 low and middle-income countries (LMICs), (compared to 20 LMICs for the 2017 update) whose key parameters were updated across three times more countries. The results remained highly cost-effective and reinforce the investment case for these interventions. We believe this should be emphasized.
- 1.2. Presentation of GCEA results for 3 country income groups: low-income, lower middle-income, and upper middle-income), which allows countries to assess the potential cost-effectiveness of these interventions depending on their specific income level. 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, it is important countries are encouraged to select the most

impactful package of NCD interventions considering other factors than just cost-effectiveness, as reflected in the draft.

2. Need for clarifications in the methodology

We believe several clarifications are needed within the methodology.

- 2.1. The updated Appendix 3 should mention what the current methodological limitations and gaps are. Limitations must be noted, and future monitoring, research, and analyses should aim to include data on all age groups. For example, physical activity interventions are based on available data for adults, showing a data gap for young populations. This is essential as, for instance, 60% of the population in Africa is below 25 years-old, and data on younger populations is key to inform policies spanning the full life-course.
- 2.2. To leverage the document's purpose, the recognition that the real health impact of the Appendix 3 interventions is higher than what's reflected with each GCEA needs to be highlighted. This is well illustrated with the case of breastfeeding, where the health impact has been calculated on the basis of HLY gained by reducing the NCD burden. As breastfeeding is also a double duty action, the impact on reducing infant undernutrition should be accounted for also.

3. Recommendations for the draft update Appendix 3

We also provide a series of recommendations for consideration.

- 3.1. We strongly urge retaining the concept of NCD 'best buys' in the 2022 updated Appendix 3. We appreciate that the named *Specific interventions with WHO-CHOICE analysis* encourages governments to consider all interventions with different levels of cost-effectiveness, particularly when taking into account other factors than just cost-effectiveness when adopting a package of NCD interventions fit-to-context. However, we must stress that *NCD 'best buys' and other recommended interventions* have grown into a reference for the health community, being the 'short hand' term which we refer to Appendix 3 for dissemination, as it 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. A change in name will risk undermining the role and value of the interventions
- 3.2. While we welcome 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), these nutrients should be specified in the heading of each relevant intervention. 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. This also applies to interventions H2-H4.

- 3.3. Furthermore, cost-effectiveness sub-analyses should be performed to support governments in selecting the most effective policy within each relevant intervention. In line with our comments on methodology above, for interventions that offer a combination of action areas, such as H1 (*reformulation policies for healthier food and beverage products*), it is not clear how the overall health impact is calculated. It would therefore be important to break down what the impact would be if a single action was implemented (in this case, a single nutrient: sodium, sugars or trans-fat) – this will also showcase the greater impact of interventions that address several action areas/nutrients, and it could also help Member States to prioritise policy actions.
- 3.4. We recommend for future updates to provide sub-analysis of the cost-effectiveness of specific labelling systems, as the current GCEA is based on an effect size that weights different labelling systems. While differentiating labelling system's cost-effectiveness would support Member States assess which system they might want to prioritise, it should be acknowledged that effectiveness can be linked to context, as labelling schemes have shown to vary in effectiveness across regions (for example, black octagon warning front of pack labels have proved more effective in Latin American contexts than in European).
- 3.5. We remain concerned about the role of public regulation in reformulation and trans-fat elimination which must be more clearly stated in the updated Appendix 3. 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 evidence is based on public regulation and therefore this needs to be clearly reflected on the intervention (in the heading). For the reformulation to reduce the content of salt and sugars, assessment of mandatory and voluntary approaches were taken into account, yet it should be clearly emphasised - as latest WHO recommendations¹ highlight - that mandatory approaches are more effective.
- 3.6. We therefore suggest dividing H1 into two interventions to accurately reflect the scope and evidence of these interventions, providing Member States with specific guidance as follows:
- *H1a: Reduce salt and sugar intake through the reformulation of food products to contain less salt and sugar, including setting target levels for the amount of*

¹ <https://apps.who.int/iris/bitstream/handle/10665/355755/9789240039919-eng.pdf?fbclid=IwAR0dglqrXlUGPcm7XhoyeD307bKqM0bdXdlixcvVg2ChFmkrtQpaO7Tjk>

- salt and sugars in foods and beverages, noting public health regulations rather than voluntary targets have shown to be more effective.*
- *H1b: Eliminate industrially trans-fats through the development of public regulations that ban their use in the food supply.*

Optimally, GCEA would benefit - for H1a – to compare the cost-effectiveness of mandatory versus voluntary reformulation approaches.

4. General comments

- 4.1. To achieve a comprehensive and yet contextualised set of policy interventions, the updated document should align and be coherent with recent WHO documents and Governing Body Meeting Decisions as much as possible. As a key feature in *Strategic direction 2: Prioritize and scale up the implementation of most impactful and feasible interventions in the national context* in the Implementation Roadmap for the Global Action Plan, the document needs to refer to the GAP consistently to provide the most clarity for Member States. WHO technical packages on NCDs under the relevant overarching/enabling actions ought to 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). There should also be a pathway under the enabling actions for alcohol and unhealthy diets to link to the recent WHO's *Acceleration Plan to implement recommendations for obesity* and the *Action plan (2022–2030) to effectively implement the global strategy to reduce the harmful use of alcohol as a public health priority*.
- 4.2. Overall, specific references to health-harming industries, commercial determinants of health and conflict of interest must be made. To highlight the relevance of addressing conflicts of interest with health-harming industries, we suggest adding the following action point to Objective 1: *'Implement conflict-of-interest policies to protect the development and implementation of interventions from industry interference.'* Furthermore, we suggest amending wording of Objective 3 to include a reference to the commercial determinants of health: *'To reduce modifiable risk factors for noncommunicable diseases and underlying social and commercial determinants through creation of health-promoting environments.'*
- 4.3. We remain very concerned about the continued use of the term "harmful use of alcohol." Evidence clearly shows there is no safe level of alcohol consumption for cancer risk, and we consider this opportunity – updating of the 'Best Buys' - a key moment to begin referring to alcohol harms and move away from ambiguous language, used in the benefit of the alcohol industry.

5. Comments on the consultation process

5.1. To ensure participatory approaches that leverage inclusivity, WHO must provide sufficient information and allow enough time for civil society to consult their networks and comment on both the methodology and content. We also 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. These update processes should be protected from the undue influence of health-harming industries, including organisations involved in tobacco, alcohol, ultra-processed foods and beverages, breastmilk substitutes, fossil fuels. Studies used for the GCEA must not have any conflicts of interest and health-harming industries should not be part of the consultation process. It is crucial for WHO to add a note clarifying how this is addressed.

About World Cancer Research Fund International

World Cancer Research Fund International (**WCRF International**) leads and unifies a network of cancer prevention charities with a global reach. We are the world's leading authority on cancer prevention research related to diet, weight and physical activity. We work collaboratively with organisations around the world to encourage governments to implement policies to prevent cancer and other non-communicable diseases (NCDs). WCRF International has been in official relations with WHO since 2016.

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