The United States continues to engage actively on the commitments of the UNGA High-Level Meeting on Non-Communicable Disease (NCDs), appreciates WHO’s effort to update this Appendix to the NCDs Global Action Plan 2013-2020. When adopting the GAP in 2013, Member States agreed that Appendix 3 would require periodic updates to reflect the state of the art in NCD prevention and control.

The U.S. encourages a broad frame for evaluating potential policies and interventions for inclusion, recognizing that determining which options are most effective and suitable at a regional, national, or local level requires additional analysis, including local disease burdens and population dynamics. We look forward to receiving additional information on the Technical Annex, and on WHO’s work to develop additional tools such as program managers’ guides and online tools. Tools that allow users to explore interventions and policy options in more detail, and with flexibility to consider local factors, would be helpful.

**General Comments**

**Appendix 3 Introduction – What has changed?**

In addition to adding interventions, the format and layout of the Appendix has changed. It would be helpful to provide some information guiding the reader in understanding the Appendix format.

- We suggest formatting the document in a way to allow the reader to quickly identify new or edited interventions. (While this may not be necessary in the final document, it would be helpful for the version sent to the Executive Board.)
- The current GAP Appendix includes information linking the interventions to relevant WHO tools and resources. The draft should retain this useful information, including footnotes for specific documents named.
- This version first lists ‘overarching/enabling actions’, such as implementing specific WHO Strategies, then lists interventions/policy options analyzed using the WHO-CHOICE methodology and interventions/policy options drawn from other WHO Guidance. Some brief introductory language would help the reader understand the difference between these categories and how they relate to other WHO documents. How were interventions in the “other interventions” category selected?

**Appendix 3 Introduction - Technical Annex**

We look forward to receiving the planned Technical Annex, providing more information on the detailed economic analysis for each intervention included. In particular, we would like to better understand the methodological approach used to select and analyze interventions.

- The identification criteria state “an intervention must have a demonstrated and quantifiable effect size, from at least one published study in a peer-reviewed journal.” Will the Annex (or online tool) include information such as the number or type of studies informing the inclusion of each intervention?
The 2015 consultation report indicates that information should be provided on interventions modeled that did not reach the threshold for cost-effectiveness. How will WHO reflect this information in relation to the updated Appendix 3?

More information would be helpful to understand how WHO determined the economic cost of implementation for each intervention. The 2015 consultation report notes that some interventions are multi-sectoral; the costs and benefits of implementing interventions may not be borne by the health sector, national government, or public sector alone. Will the Technical Annex include more information on how WHO factored these issues into the analyses?

The 2015 consultation report notes that economic concerns are one element of decision making. It would be helpful to note the contextual factors in addition to cost-effectiveness affecting implementation in the Appendix 3 material, such as available resource levels, cultural aspects, population and patient characteristics, health system factors including available the health workforce, feasibility (including technical and legal constraints, legal and regulatory frameworks), and acceptability (e.g., public acceptance, political acceptance, alignment among stakeholders).

When developing and implementing regulations and other measures, governments must do so in a manner consistent with their domestic and international obligations. Including information on this issue in the planned program manager guides or other related documents could be helpful to countries considering implementing one or more of the Appendix interventions.

Include links/footnotes to the referenced WHO strategies and plans noted. (For example, “the action “implement the WHO recommendations on the marketing of foods and non-alcoholic beverages to children” refers to the “Set of recommendations on the marketing of foods and non-alcoholic beverages to children” found here: http://www.who.int/dietphysicalactivity/publications/recsmarketing/en/.)

Specific Comments on Annex (“Proposed updated Appendix 3 of the GAP”)

Objective 3:

Tobacco Use

• Did WHO consider specifically including interventions on (1) banning vending machines with tobacco products, (2) banning sales of tobacco products to children and youth or (3) enforcing smoke-free health facilities?

Harmful Alcohol Use

• [Interventions included here are the same as 2013 NCD Global Action Plan].

Unhealthy Diet

• U1: “Reduce salt intake by engaging the industry in a voluntary reformulation process”. More information would be helpful on how the WHO-CHOICE analysis relates to language in the SHAKE strategy. Did the WHO-CHOICE analysis include both voluntary and mandatory approaches to achieve reformulation? Did WHO consider using language consistent with SHAKE strategy, e.g., “Reduce salt intake by promoting the formulation of food products to contain less salt and setting target levels for the amount of salt in foods and meals”? 

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U2: “Reduce salt intake through establishment of a supportive environment in public institutions such as hospitals, schools and nursing homes to enable low sodium meals to be provided”. Suggest editing to read “Reduce salt intake through establishment of a supportive environment in public institutions such as hospitals, WORKSITES, schools and nursing homes TO INCREASE AVAILABILITY OF LOWER SODIUM OPTIONS. Note: in the United States and other countries, “low sodium” is a nutrient content claim with set criteria. Switching to lower sodium foods, rather than “low sodium” may be the broader aim.

U3: “Reduce salt intake through a behavior change communication mass media campaign”. No specific edit is suggested, but we would like more information on the evidence in the WHO-CHOICE analysis on this intervention.

U4: “Reduce salt intake through implementation of front-of-pack labeling”. Did the WHO-CHOICE analysis specifically assess front-of-pack labeling for salt reduction? Or label approaches? This could be generalized beyond only front-of-pack approaches to “Implement standards for effective and accurate labeling and marketing of food”.

U5: “Complete elimination of industrial trans fat through the development of legislation banning their use in the food chain.” Suggest changing to “complete elimination of industrially produced partially hydrogenated oil (PHO)”. Trans-fats are produced through certain cooking methods at very low doses and could still be present in deep fat-fried foods and foods cooked at high temperatures. Unless these cooking methods are eliminated, eliminating industrially produced PHOs or “virtually eliminate trans fats” (with a specified very low threshold) may be more accurate.

U9: “Reduce sugar consumption through taxation on sugar sweetened beverages.” Suggest editing to “Reduce sugar consumption through EFFECTIVE taxation on sugar sweetened beverages” to focus attention on the need for policies to be well designed and implemented to reach the intended goals. The ECHO report notes “effective taxes”.

Other interventions:
- Did WHO consider including an intervention on identifying sources of and reducing intake of foods contaminated with aflatoxins and other mycotoxins?
- Did WHO consider any interventions addressing sugar intake other than taxes on sugar sweetened beverages?

Physical Inactivity

P2: “Ensure macro-level urban design incorporates the core elements of residential density, connected street networks, easy access to a diversity of destinations and access to public transport.” Sidewalks are an important infrastructure element – consider specifying sidewalks in this intervention, for example, “connected street networks THAT INCLUDE SIDEWALKS”.

P4: “Ensure adequate facilities are available on school premises to support recreational physical activity for all children.” Consider also specifying, “include designated time for physical activity for children and youth during school”.

Other interventions:
Did WHO consider including health education on the importance of maintaining healthy body weight
Did WHO consider including programs to monitor and modify body weight for children and youth in schools (nursery, primary, secondary)

Objective 4: Cardiovascular Disease and Diabetes

- CV1a and CV1b “Drug therapy and counseling to individuals who have had a heart attack or stroke and to persons with high risk (≥30%) of a fatal or nonfatal CVD event in the next ten years” and “Drug therapy and counseling to individuals who have had a heart attack or stroke and to persons with a moderate to high risk (≥20%) of a fatal or nonfatal CVD event in the next ten years”. The “total risk approach” should be identified and explained somewhere in the text. Include information/links to the relevant risk estimation tools, noting that some upper middle income and high-income countries use different estimation tools. Some discussion on how the ISH/WHO tool relates to country-specific and other tools would also be helpful.

- CV4 “Treatment of congestive cardiac failure with ACE inhibitor, beta-blocker and diuretic”. Some national guidelines on heart failure include medications other than these listed; an explanation of this list would be helpful. In the detailed explanation of the intervention, some information on indications, contraindications, adverse effects, and drug-to-drug interactions may be needed. It would be helpful to reference how the indicator aligns with performance measures for managing heart failure currently in practice in some countries.

- CV7 “Low-dose acetylsalicylic acid for ischemic stroke”. This description needs to be clarified. It is not clear whether low-dose acetylsalicylic acid here refers to primary and/or secondary prevention of stroke. Why was low-dose acetylsalicylic acid for preventing heart attacks not included?

- Other interventions:
  - Did WHO consider including (1) early detection of hypertension and hyperlipidemia, with linkage to follow-up treatment?
  - Did WHO consider including an intervention for screening pregnant women for hypertension?
  - Did WHO consider including an intervention for chronic kidney disease screening among patients hypertension?

Diabetes

- [Consider including “other interventions” noted above]

Cancer

- CA8 “Prevention of liver cancer through hepatitis B immunization”. This intervention could further specify (1) ensuring birth dose HBV for all newborns and (2) HBV vaccination for health care workers and other high risk groups

- CA10 “Population-based colorectal cancer screening, including through a fecal occult blood test, as appropriate, at age >50, linked with timely treatment.”: can other colorectal cancer screening modalities, in addition to fecal occult blood tests, be included?
• **Other interventions:**
  - For countries with a high burden of hepatitis infection, did WHO consider including (1) screening for HBV and HCV infection (2) with linkage to treatment and (3) early detection for hepatocellular carcinoma?
  - Did WHO consider including HPV vaccination for boys among interventions to prevent cancers?

**Chronic Respiratory Diseases**

- Did WHO consider including (1) early detection for COPD with (2) linkage to follow up and (3) smoke cessation services?

**Objective 6: To monitor the trends and determinants of noncommunicable diseases and evaluate progress in their prevention and control**

**Overarching/enabling action: edit suggested below**

- Suggest the following edits to bullet 3: “Establish and or strengthen a comprehensive noncommunicable disease surveillance systems including reliable registration of deaths by cause, cancer registration, periodic data collection on risk factors and monitoring national response”.
  - This edit emphasizes that multiple systems are used and needed to capture the necessary data. No one comprehensive system can capture all of these because of differences in (1) the institution responsible for data collection, (2) methods used for surveillance, and (3) source populations from which data are captured. It could also be useful to include disaggregation of data in this action, for example by age, gender, disability or socioeconomic groups, as noted in the Global Action Plan.

- **Bullet 4:** “Integrate noncommunicable disease surveillance and monitoring into national health information systems. Many countries use HMIS as a national health information system, however this system of aggregated data is not useful for death, NCD, and cancer registration. Suggest revising to address this issue with language like “Include surveillance and monitoring systems to capture deaths with cause, cancers, and other NCDs as integral parts of national health surveillance systems”.”