DRAFT UPDATED APPENDIX 3 OF THE WHO GLOBAL NCD ACTION PLAN 2013-2030
DISCUSSION PAPER JUNE 2022
Comments from Canada

We wish to express our appreciation to the WHO Secretariat for developing and sharing this document with Member States for consultation. We would like to offer the following comments for consideration.

GENERAL COMMENTS

1. **Domestic context**: We welcome the WHO Secretariat's effort to update Appendix 3 in light of emerging evidence and recommendations. We understand that the updates are focused on Objectives 3 (reduce modifiable risk factors) and 4 (strengthen and orient health systems). However, Canada would like to stress the importance of retaining the language in the opening paragraph of Appendix 3:

   "Menu of policy options and cost-effective interventions for prevention and control of major noncommunicable diseases, to assist Member States in implementing, as appropriate, for national context, (without prejudice to the sovereign rights of nations to determine taxation among other policies), actions to achieve the nine voluntary global targets."

2. **Interventions:**

   - We commend the WHO for working toward providing countries with methods to assess the combined (cost) effectiveness of interventions. While the intention is to acknowledge that a suite of interventions will provide a better strategy than any one intervention, the practical application of this WHO-CHOICE approach still seems to be somewhat elusive. The presentation continues to focus on individual priority interventions (the "best buys"), presenting and assessing each of them separately, rather than assessing their collective impact. As an example, under unhealthy diet, reformulation of foods is a key intervention, which may gain better traction if complementary initiatives such as front of package labelling (also listed) are implemented.

   - The document does an admirable job at attempting to incorporate population health interventions in each of the risk factors, particularly in tobacco cessation (i.e. smoke free workplaces and increased taxation), along with individual-focused approaches like counselling and smoking cessation interventions and cost-free pharmacotherapy. Questions for consideration however, include whether the interventions are sustainable and whether, as a whole, they are the gold standard for their associated diseases.

- Our understanding is that interventions for this updated Appendix would be eventually assessed as "best buys" or "good buys." It may be also helpful to group the types of interventions (e.g. prevention vs. treatment), and to more clearly indicate whether the WHO-CHOICE analysis interventions are considered higher priority than the interventions that have not undergone this analysis.

3. **Non-economic considerations**:

   - WHO continues to build on the recognition that non-monetary issues are critically important to whether highly effective/cost-effective interventions are adopted. Nevertheless, the discussion paper is dominated by monetary and effectiveness rationales for interventions and much less on the readiness, acceptability, complexity, etc., of interventions (or how a country builds toward acceptance).

   - Additional context could be provided in the opening paragraphs of Appendix 3 on non-economic implementation considerations. This includes drawing attention to considerations related to health equity, which is referenced in the Global Action Plan's overarching principles and approaches.

   - Engagement with leadership and organizations of particular peoples and communities (for example, in Canada, Indigenous Peoples (First Nations, Inuit and Metis)) would help integrate cultural considerations into the recommended interventions, as well as identify potential barriers to some of the proposed recommendations (and potential solutions).

4. **Other risk factors**: We suggest incorporating other environmental risk factors beyond air pollution for future updates to the WHO NCD Global Action Plan. WHO estimates that 24% of the global burden of disease is attributable to environmental factors (e.g., air, water and soil pollution, hazardous chemicals, climate change and others), and is disproportionately borne by vulnerable and marginalized people and low- and middle-income countries, highlighting the need for equity approaches. While air pollution is recognized as the largest environmental health risk, other environmental risk factors are also significant. For example, exposure to hazardous chemicals accounts for 2 million deaths worldwide (not including chemical mixtures in air pollution). In addition, the health impacts of climate change are on the rise and the WHO has deemed climate change as the single biggest health threat facing humanity.

5. **Broader objectives**: Appendix 3 can help support progress toward achieving the 2025 NCD and 2030 SDG targets. It would be valuable, in the updated Appendix, to link each of the interventions to existing WHO tools (e.g. guidance, action plans), similar to what was done in the current Appendix 3, and to the specific WHO NCD voluntary global targets these interventions would help achieve.

6. **Technical briefings**: We are grateful for the accompanying technical briefings, which provide useful information on methodological assumptions and on main changes to the 2017 analysis. The technical briefings, including the tables, would benefit from more context and background information to help the reader understand the methodology used and results from the analysis. Evidence supporting policies are provided, but in certain cases, the counter-argument was lacking to provide a complete picture of the issue.

7. **Communicating updates**: We would appreciate additional clarity on how final updates to the Appendix will be integrated into existing information and plans on NCDs and communicated out, including whether changes to Appendix 3 will be incorporated into the existing Global Action Plan for the Prevention and Control of Noncommunicable Diseases and/or the implementation roadmap 2023-2030 for the Global Action Plan, to ensure that Member States and stakeholders have easy access to the most up-to-date list of interventions.

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

Tobacco use

Specific interventions with WHO-CHOICE analysis

8. For the identified interventions, and in particular T4 to T7, it is critical to support the self-determination of Indigenous Peoples (First Nations, Inuit and Metis in Canada) to identify needs and priorities of individuals, families, communities, and health systems, and support Indigenous control over culturally appropriate service design and delivery toward reducing commercial tobacco use. This includes recognizing and respecting traditional forms and ceremonial uses of tobacco within Indigenous communities where this is applicable.

Harmful use of alcohol

Overarching/enabling actions

9. Canada agrees with the overarching/enabling actions. Canada supports both the Global Strategy to Reduce the Harmful Use of Alcohol and the Global Alcohol Action Plan 2022-2030 (GAAP). Recommendations made by Canada during the GAAP consultation process were included in the final version of the Action Plan. They included the reduction and elimination of stigma as an overarching principle; recognition of the unique circumstances of Indigenous populations; consideration of contributions of those with lived and living experience; and monitoring of alcohol trends across vulnerable groups.

10. With respect to the last bullet of the overarching/enabling actions on increasing awareness and strengthening the knowledge base on the magnitude and nature of problems caused by harmful use of alcohol:

    - We would suggest mentioning "determinants": "Increase awareness and strengthen the knowledge base on the magnitude, **determinants**, and nature of problems caused by harmful use of alcohol by awareness programmes, operational research, improved monitoring and surveillance systems." This change would emphasize an intersectional approach and help align with the wording in the objectives of the Global strategy to reduce the harmful use of alcohol (referenced the WHO global alcohol action plan 2022-2030 page 12), which include: "(b) strengthened knowledge base on the magnitude and determinants of alcohol-related harm and on effective interventions to reduce and prevent such harm."

    - Canada recommends that this overarching/enabling action should not only focus on the magnitude and the nature of the harms but also on providing guidance on how to reduce those harms, such as information on standard drinks/low risk drinking guidelines.

11. Given the significant investments in understanding the potential disability of different diseases and injuries due to alcohol (refer to the technical briefing), consideration could be given to:

    - Describing the effects that alcohol use during pregnancy can have on fetal, infant and child development (i.e., disability associated with fetal alcohol spectrum disorder); and

    - Providing targeted messaging, policies and interventions to women of reproductive age that there is no safe alcohol use during pregnancy.

Specific interventions with WHO-CHOICE analysis

12. Canada acknowledges the importance of focusing on the measures recommended by the SAFER initiative. The consultation on the past 10 year implementation of the Global Strategy to Reduce the Harmful Use of Alcohol highlighted the slow progress for implementing these evidence-based policies.

Other interventions from WHO guidance (without WHO-CHOICE analysis)

13. The intervention A10 ("Provide prevention, treatment and care for alcohol use disorders and comorbid conditions in health and social services") could include care that is culturally responsive or culturally safe.

14. Canada recognizes the need for other policy interventions that could also contribute to protecting the public from the health and social harms caused by alcohol use.

15. When comparing the key interventions supported for tobacco to those listed for alcohol, one omission from the alcohol list of interventions that is included for tobacco is mass media campaigns to educate the public about harms. If mass media campaigns to increase the public's understanding of tobacco risks is still considered cost effective, it could be argued that the same type of campaign for alcohol would be as effective.

Unhealthy diet

Overarching/enabling actions

16. The WHO may wish to consider integrating a health equity lens in the interventions focused on addressing unhealthy diets as some population groups may have greater challenges in eating healthy diets due to a variety of determinants. Interventions should focus on reaching and supporting these population groups.

17. We are supportive of the overarching action and several individual interventions to enable the 2004 WHO Global Strategy on Diet, Physical Activity, and Health, recognizing that there may have been significant changes in the environment since this Strategy was adopted.

Specific interventions with WHO-CHOICE analysis

18. We appreciate the new updates to wording of the interventions, which we find reflective and consistent with current initiatives in Canada. Canada is implementing initiatives that align with several of the interventions identified, including: H1 ("reformulation policies for healthier food and beverage products") and H2 (front-of pack labelling), which align with Canada's Healthy Eating Strategy; H4 ("behaviour change communication and mass media campaign for healthy diets") with the Government of Canada conducting promotional activities to further the reach and use of the Canada Food Guide, relaunched in 2019; and H5 ("protection, promotion and support of optimal breastfeeding practices") thanks to different activities including guidelines on family-centered maternity and newborn care, community-based programming and work with stakeholders to support best practices.

19. We note that the listed interventions are focused on either regulation or influencing individual behaviours, rather than consideration for supporting the social determinants of health, including food security, and accessibility and affordability of healthy foods, which are critical issues for Indigenous Peoples in Canada as well as persons living in vulnerable conditions related to income, housing, and employment.

20. It is critical to support Indigenous self-determined and led approaches to communication to ensure they are culturally appropriate. This is particularly relevant for H4 ("Behaviour change communication and mass media campaign for healthy diets").

Other interventions from WHO guidance (without WHO-CHOICE analysis)

21. With respect to H8 ("subsidies on healthy foods and beverages (e.g. fruits and vegetables) as part of comprehensive fiscal policies for healthy diets"), Canada helps make nutritious food and some essential items more affordable and accessible through programs such as Nutrition North Canada, which subsidizes certain nutritious foods in eligible Northern communities, and the Harvesters Support Grant, which increases access to country foods by providing funding to support traditional hunting, harvesting and food sharing in isolated communities. Canada also supports improved access to healthy foods for equity-seeking populations through efforts such as partnership with the Community Food Centres of Canada as well as projects that increase access to healthy foods in school settings.

22. Intervention H11 ("Nutrition education and counselling in different settings (for example, in preschools, schools, workplaces and hospitals) to promote healthy diets") could mention counselling that incorporates cultural traditions and traditional foods.

Physical inactivity

Overarching/enabling actions

23. The WHO may want to consider integrating a more explicit health equity lens as part of its overarching/enabling actions objectives and in the interventions to address physical inactivity, as some population groups may have greater challenges in being physically active due to a variety of determinants. Interventions should focus on reaching and supporting these population groups.

24. We are supportive of the overarching action and several individual interventions to enable the *Global action plan on physical activity 2018–2030: more active people for a healthier world.* We are pleased to see the WHO guidelines on physical activity and sedentary behaviour included here, recognizing the importance of movement behaviours other than physical activity for health promotion. Canada now has 24-Hour Movement Guidelines (including recommendations on physical activity, sedentary behaviour and sleep) for all age groups.

Other interventions from WHO guidance (without WHO-CHOICE analysis)

25. Canada's efforts on physical activity align with several of the interventions identified, including P3 (implement urban and transport planning and urban design to provide compact neighbourhoods providing mixed-land use and connected networks), P5 (improve walking and cycling infrastructure), and P7 (promote physical activity through provision of community-based sport and recreation programmes) through initiatives such as: the National Active Transportation Strategy, which aims to make investments to build new and expanded active transportation networks and to create safe environments for more equitable, healthy, active and sustainable travel options; the Canada Healthy Communities

Initiative, which provides funding to help communities adapt public spaces and local services to meet people's needs during and following the COVID-19 pandemic; the Community Sport for All Initiative, which supports community sport initiatives for equity-deserving groups; and the Healthy Canadians and Communities Fund, which funds projects that target different chronic disease risk factors including physical inactivity.

26. With respect to P4 (implement whole-of-school programmes that include quality physical education), putting in place national in-school education programs can be challenging in some countries such as Canada where education falls to provincial/territorial jurisdiction.

27. Physical activity and reducing sedentary living are both important for improving health outcomes (as recognized in the WHO guidelines on physical activity and sedentary behaviour and Canada's Common Vision for increasing physical activity and reducing sedentary living in Canada: Let's Get Moving). WHO may wish to consider adding "reducing sedentary behaviour" in intervention P6 ("Implement multi-component workplace physical activity programmes").

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

Overarching/enabling actions

28. The overarching/enabling action to "address behavioural risk factors" could contribute to perpetuating stigmatizing individual responsibility as the only determinant leading to chronic disease, when significant contributing factors for chronic disease are systemic inequities in the social determinants of health – including income, food security and healthy foods affordability and accessibility, education, housing/built environment, and environmental conditions.

29. The recommendations outlined in this section are very focused on tertiary prevention (with some secondary prevention around early diagnosis and early medical intervention, particularly under the cancer section). Despite the objective mentioning underlying social determinants of health, few of these interventions seem to be aimed at addressing these.

Diabetes

Specific interventions with WHO-CHOICE analysis

30. It may be valuable to include targeted or increased screening opportunities for individuals who are considered to be at higher risk of diabetes, as has been recommended by the Canadian Task Force on Preventive Health Care (guidance from 2012).

Cancer

Specific interventions with WHO-CHOICE analysis

31. WHO may wish to add "care in community clinics" in addition to "home-based and hospital care" in intervention CA7 ("Basic palliative care for cancer: home-based and hospital care with multi-disciplinary team and access to opiates and essential supportive medicines"). Community care may be in clinics outside of hospitals, and not always in the form of home visits, especially palliative services prior to end-of-life care.

EDITORIAL COMMENTS

32. The discussion paper indicates that results of the cost-effectiveness analysis are presented for "3 income categories: low-income countries, lower-middle income countries and high-income countries" (p. 4 and 6). However, the technical annex of the document (p. 23 and p. 26) seems to provide analysis for low-income, lower-middle-income and upper-middle-income countries. Should "high-income" be replaced by "upper-middle-income" countries in the body of the discussion paper?

33. We would suggest using the full title and including a relevant link for all WHO documents/initiatives referenced. For instance, the "action plan on alcohol" (p. 10) would read "Action plan (2022-2030) to effectively implement the global strategy to reduce the harmful use of alcohol as a public health priority," and a footnote with a relevant link would be included for "mCessation" (p. 9), "WHO's set of recommendations on the marketing of foods and non-alcoholic beverages to children" (p. 11), and "latest WHO guidelines (2021)" (p. 14).

34. The tables in the technical briefing ("Impact sizes used in WHO-CHOICE analysis") might be easier to navigate if the interventions were explicitly noted (rather than using the intervention number) and if the 2017 interventions were mapped to the 2022 proposed interventions, wherever possible.