World Health Organization

SIXTY-FIFTH WORLD HEALTH ASSEMBLY
COMMITTEE A

A65/A/PSR/2
13 August 2012

PROVISIONAL SUMMARY RECORD OF THE SECOND MEETING

Palais des Nations, Geneva
Tuesday, 22 May 2012, scheduled at 09:15

Chairman: Dr L.Z. DUKPA (Bhutan)
later: Dr F. FERGUSON (Jamaica)

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SECOND MEETING

Tuesday, 22 May 2012, at 09:15

Chairman: Dr L.Z. DUKPA (Bhutan)
later: Dr F. FERGUSON (Jamaica)

TECHNICAL AND HEALTH MATTERS: Item 13 of the Agenda (continued)

Prevention and control of noncommunicable diseases: Item 13.1 of the Agenda (Documents A65/6, A65/6 Add.1, A65/7, A65/8, A65/9, and EB130/2012/REC/1, resolutions EB130.R6 and EB130.R7) (continued)

- **Outcomes of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases and the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control** (continued)

- **Implementation of the global strategy for the prevention and control of noncommunicable diseases and the action plan** (continued)

Dr AL-JALAHMA (Bahrain), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that the Organization should strengthen its capacity to create a comprehensive global monitoring framework for the prevention and control of noncommunicable diseases and follow up on the action plan for the global strategy for the prevention and control of noncommunicable diseases, ensuring that all Member States respected their commitments and streamlined their efforts. Effective partnerships between Member States, the Secretariat and all relevant stakeholders should be formed in order to deal with noncommunicable diseases. She supported the development and expeditious implementation of a set of indicators and global voluntary targets. Appropriate steps should be taken to prepare a set of targets before the end of 2012, pursuant to paragraph 62 of the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases.

Dr LARSEN (Norway) said that the development of a comprehensive global monitoring framework, including a set of voluntary global targets and indicators, must be completed by the end of 2012. The list of voluntary targets should be extended to cover harmful use of alcohol. With regard to health system responses, a target should be included reflecting general access to primary health services with the capacity to diagnose and treat common diseases, including noncommunicable diseases.

Dr CARBONE (Argentina) expressed support for the set of indicators and voluntary global targets outlined in document A65/6. Solid surveillance systems for noncommunicable diseases had to be established in all countries. Her Government had created a surveillance unit and had implemented a range of long-term strategies to tackle such diseases. A national multisectoral commission for the prevention and control of noncommunicable diseases had been established with the participation of several ministries, the food industry, civil society and relevant scientific societies.

Dr NANTHAPHAN CHINLUMPRASERT (Thailand), speaking on behalf of the Member States of the South-East Asia Region, welcomed the Secretariat's work on a global monitoring

framework and a set of voluntary global targets, but expressed concern that some of the proposed targets were too ambitious for many countries in the Region, in particular those relating to the reduction of dietary salt intake and the prevalence of hypertension. Also of concern was the omission of targets that were especially relevant to the Region, notably those relating to the harmful use of alcohol, childhood obesity, diabetes, air pollution and increased access to essential medicines for noncommunicable diseases. Limited national capacity to measure indicators together with a lack of baseline values could hinder the achievement of the voluntary global targets, and the Secretariat should take those concerns into consideration when developing and finalizing the set of targets. In general, she supported the draft decision, but it did not adequately reflect the results of the informal consultations that had taken place. She therefore proposed that paragraph 2 should be deleted and that, in paragraph 4, the words "regional technical working groups with approval from" should be inserted before "Regional Committees".

Professor ADITAMA (Indonesia), expressing support for WHO's work on noncommunicable diseases, said that responses needed to be tailored to country needs and capacities. Prevention and control measures implemented by Indonesia included strengthening health system capacity, developing multisectoral collaboration, community empowerment, and the implementation of a five-year strategic plan for the period 2010–2014. Multisectoral engagement was essential to preventing and controlling noncommunicable diseases, with the involvement of government sectors other than the health sector, as well as civil society and the private sector.

Mr URQUIDO VELÁSQUEZ (Colombia) said that governments should tackle the risk factors associated with noncommunicable diseases and promote healthy lifestyles, in particular by curbing tobacco use and promoting physical activity and the consumption of fruit and vegetables, especially among poor populations with low educational levels. He shared the concerns of previous speakers regarding the definition of indicators for monitoring noncommunicable diseases and the impact of the proposed actions, especially in relation to lifestyle changes. The Health Assembly should consider giving greater impetus to global public policies aimed at reducing harmful use of alcohol and consumption of sugary drinks and foods with high salt and *trans*-fat content, as with the tobacco policies established under the WHO Framework Convention on Tobacco Control. Welcoming the Secretariat's efforts to facilitate and improve the effectiveness of Member States' responses, he called for the identification of more evidence-based, cost-effective policies to prevent and control noncommunicable diseases and the development of cooperation strategies targeting least developed countries.

Mr BARBOSA (Brazil), noting that his country was a sponsor of the draft decision, said that developing countries were faced with increased prevalence of noncommunicable diseases. It was important to implement the recommendations of the High-level Meeting on the Prevention and Control of Non-communicable Diseases. His Government had launched a national strategic action plan on noncommunicable diseases for the period 2011–2022 and was making significant progress in reducing the risk factors for and the rates of such diseases.

A major challenge for WHO was monitoring and assessing the social and economic determinants of noncommunicable diseases and establishing effective forms of intersectoral action. Commitments must be translated into concrete action and clear goals and indicators must be adopted in line with the capacities of national health systems.

Dr EL MENZHI (Morocco) expressed satisfaction at progress made in preventing and controlling noncommunicable diseases. The Secretariat should provide technical and scientific support to enable countries to apply the proposed indicators. As sustainable financing was needed in order to implement the action plan for the global strategy for the prevention and control of noncommunicable

diseases, a global fund should be established, akin to that in place to fight AIDS, malaria and tuberculosis.

Dr PAUVADAY (Mauritius) said that the greatest contributors to noncommunicable diseases were lack of physical activity, tobacco use, consumption of junk food and harmful alcohol use. The section on global partnership options in the Secretariat's report (document A65/7) should have referred to the possibility of developing mechanisms similar to the WHO Framework Convention on Tobacco Control. The document should also have reflected the need for coordinated action among United Nations agencies to help countries to develop national frameworks for health literacy. Finally, proposals should be formulated for capacity building to remedy the limited expertise in surveillance of noncommunicable diseases.

Dr SA'IDI (Saudi Arabia) announced that an international conference on healthy lifestyles would be held in Riyadh, Saudi Arabia, in September 2012, in coordination with the Regional Office for the Eastern Mediterranean and with the support of the Arab League and other expert bodies, to discuss measures to prevent and control noncommunicable diseases. He asked all those involved in the prevention and control of noncommunicable diseases to share their successful experiences. He supported the implementation of the action plan for the prevention of avoidable blindness and visual impairment (document A65/9), and expressed concern at the increased prevalence of diabetes.

Dr GONÇALVES (Mozambique) said that, even though communicable diseases remained her country's main public health concern, the prevalence of noncommunicable diseases had increased in recent years. The Government had made significant efforts to meet the six objectives outlined in the global strategy for the prevention and control of noncommunicable diseases, but lack of funding to monitor risk factors and other constraints had hindered those efforts. The Government remained committed to overcoming those obstacles in order to implement proven cost-effective strategies and reverse rising rates of noncommunicable disease.

Mr McIFF (United States of America), acknowledging the amendments to the draft decision proposed in the previous meeting by the delegate of Denmark, suggested that the addition of the words "including cholesterol" after the words "other targets or indicators that may emerge" in paragraph 2 would more accurately reflect the current state of the discussion on voluntary global targets and indicators. Paragraph 2, which the delegate of Thailand proposed to delete, fulfilled the essential purpose of capturing the progress made by Member States and the Secretariat. Its language closely followed that of document A65/6 Add.1, for example with regard to the risk factors for harmful alcohol use and obesity. He agreed that further work was necessary in order to reach consensus on the targets and indicators. Although the main aim of the draft decision was to capture progress and provide a way forward, it was not intended to prejudge the outcome of the proposed meeting of Member States later in the year to conclude the work on those items.

Dr RODIN (Canada) said that the draft decision, of which Canada was a sponsor, recognized the significant progress made by Member States towards the global monitoring framework and set a path for the finalization of a set of indicators and voluntary global targets by the end of 2012. She agreed with the proposal to insert the word "including cholesterol" in paragraph 2 of the draft decision and suggested that the last part of the paragraph should read "along with any other targets or indicators emerging, including cholesterol, in the remainder of the process established by resolution EB130.R7". She asked the delegate of Thailand to clarify the reasons for the proposed deletion of paragraph 2. She needed additional time to consider the delegate of Thailand's proposed amendment to paragraph 4, but questioned the feasibility of an approach involving regional technical working groups, given the timing of the regional committee meetings and the aim to finalize the global monitoring framework by

the end of 2012; that goal could be achieved if Member States worked together to ensure that regional perspectives were highlighted during global consultations.

Mr KAZI (Bangladesh) welcomed the Secretariat's efforts to scale up global action on the prevention and control of noncommunicable diseases and commended the progress made thus far in developing a global monitoring framework and a set of voluntary global targets. The targets should be ambitious, but also feasible and achievable, taking into account varying regional and national circumstances and capacities, especially in low-income countries. Referring to the comments made by the delegate of Thailand, he agreed that further work was needed to define the targets, particularly those of regional importance, including reduction of the prevalence of diabetes and childhood obesity, as well as enhanced access to essential and generic medicines. In view of the aim to finalize the set of indicators and targets by the end of 2012, it would be advisable to include only those that enjoyed strong support and could feasibly be achieved. The main focus of the draft decision should be on the process rather than the substance of the Secretariat's further work. He urged the Secretariat to continue providing support to developing countries, especially the least developed, to strengthen their national health information systems and improve their monitoring capacities.

Dr MAHDI (Sudan) welcomed the efforts made by WHO to prevent and control noncommunicable diseases. He supported the proposed targets, which should be feasible and therefore achievable.

Dr Ferguson took the Chair.

Dr FORSTER (Namibia) expressed satisfaction at the progress made to date regarding the prevention and control of noncommunicable diseases and the increased momentum created through the Moscow Declaration on Healthy Lifestyles and Noncommunicable Disease Control and the Political Declaration of the High-level Meeting of the United Nations General Assembly. Expeditious finalization of the global monitoring framework would enable the swift integration of the set of indicators into national health systems. His Government recognized the need to establish a reliable and comprehensive baseline for targeted subsequent action. In order to address the double burden of communicable and noncommunicable diseases, a cohesive, well-integrated, holistic approach that took full account of the social determinants was needed. He therefore supported the resolution contained in resolution EB130.R7, which emphasized broad-based multisectoral action. Broad partnerships built on community participation would be crucial, together with strong stewardship of global health systems.

Dr AL DOWAIRI (Kuwait) said that his Government had adopted a multisectoral plan to tackle noncommunicable diseases. All sectors should be involved in the prevention and control of noncommunicable diseases. Health information systems in the Member States of the Region of the Eastern Mediterranean were being strengthened with a view to reducing morbidity caused by unhealthy lifestyles. The Regional Office was coordinating its activities with governments and consulting experts in an effort to develop joint strategies to combat noncommunicable diseases.

Mr GLASSIE (Cook Islands) said that his country was facing a crisis due to noncommunicable diseases, the prevalence of which had risen dramatically over recent years. As a result, the Government had stepped up its efforts, focusing on the risk factors and implementing a national strategy and action plan. The WHO global forum on addressing the challenge of noncommunicable diseases (Moscow, 27 April 2011) and the High-level Meeting of the General Assembly had spurred his country to increase its efforts; the Government aimed to replicate and implement the action taken at the global level to the extent possible and in accordance with national needs, including multisectoral engagement.

Mr SAMO (Federated States of Micronesia) thanked the Secretariat for incorporating the outcomes of the High-level Meeting on the Prevention and Control of Non-communicable Diseases into its work. He supported the options and timeline for strengthening and facilitating multisectoral action for the prevention and control of such diseases through partnership outlined in document A65/7, particularly the call for strengthened multisectoral action and the proposed partnership functions. He also supported the whole-of-government approach to noncommunicable diseases. Mortality indicators should be set according to age, sex and socioeconomic status indices. Data collected by means of WHO's STEPwise approach to surveillance should be used to finalize a set of common global indicators. He supported the establishment of a global monitoring framework, as proposed in document A65/6 Add.1, but agreed that further consultations were necessary to ensure that it would lead to meaningful action at the regional, national and local levels. He supported the proposal put forward by the delegate of the United States of America regarding the inclusion of cholesterol in paragraph 2 of the draft decision.

Dr WARIDA (Egypt), speaking on behalf of the Member States of the Eastern Mediterranean Region, emphasized the need for further work on noncommunicable diseases. The finalization of a set of voluntary global targets before the end of 2012 was crucial to tackling the problem on a global scale and to fulfilling the mandate entrusted to WHO by the United Nations General Assembly. The progress made needed capturing, but it was also essential to conclude the work referred to in resolution EB130.R7, especially in relation to the development of a set of voluntary global targets and indicators. At the regional level, consultations between Member States and stakeholders should be intensified in order to achieve the goal of finalizing the global monitoring framework during the formal consultations scheduled to take place in October 2012. With a view to meeting the deadline for the completion of the process, he called for the establishment of an informal working group at the current session, with the participation of two Member States from each region, to discuss and reach consensus on the set of global indicators and voluntary targets.

Ms SCHJØNNING (Denmark), speaking on behalf of the European Union and its 27 Member States, said that she favoured including cholesterol in the list of targets that required more work, rather than including it after the words "other targets or indicators that may emerge" in paragraph 2 of the draft decision. She would discuss the wording suggested by the delegate of the United States of America with the Member States of the European Union and would report later on the outcome.

Professor ELY (Mauritania) said that developing countries should remain vigilant in managing the double burden of communicable and noncommunicable diseases. Global efforts to tackle noncommunicable diseases should not detract from the work needed to fight against communicable diseases, especially in developing countries. Innovation, imagination and rigour should be the keywords in the development of national public–private partnerships for funding purposes, in order to obviate excessive reliance on external aid.

Dr DIXON (Jamaica) noted that the global monitoring framework was not expected to be adopted until 2013, two years after the High-level Meeting of the United Nations General Assembly; that interval could result in a loss of momentum in terms of the action initiated by the Political Declaration. She therefore suggested that, at the current session, Member States should adopt the proposed target of a 25% relative reduction, by 2025, in overall mortality from cardiovascular disease, cancer, diabetes and chronic respiratory disease, on which there appeared to be consensus.

Dr MALECELA (United Republic of Tanzania) commended the consultative work that had fed into the reports prepared by the Secretariat. She urged WHO to focus on the promotion of activities that linked communicable and noncommunicable disease programmes in order to make optimal use of limited resources. Those activities should include increased surveillance and capacity building through

field epidemiology training programmes. The list of voluntary global targets should include a target relating to harmful use of alcohol, which was specifically linked to injuries and gender-based violence as well as to noncommunicable diseases. She highlighted the need for the participation of the private sector in the global fight against noncommunicable diseases.

Dr TUITAMA (Samoa) supported the proposal by the delegate of Jamaica to endorse during the current session a target of 25% relative reduction in mortality by 2025.

Dr DANKOKO (Senegal) supported the proposal by the delegate of Egypt to establish an informal working group.

Dr ALLENDE (Paraguay) welcomed the reports, in particular as they related to efforts to achieve universal access to health care, extend the coverage of health systems and promote the right to health care for all, so as to enhance quality of life and increase life expectancy. His Government was working within the framework of MERCOSUR (the Common Market of the South) and the Union of South American Nations to raise the priority of noncommunicable diseases on political agendas. He shared the concerns of other speakers regarding the feasibility of some of the targets and indicators and agreed on the need to continue reviewing and revising the targets before their finalization by the end of 2012. He also supported the suggestion made by the delegate of El Salvador to include chronic kidney disease in the list of targeted noncommunicable diseases and underlined the need to develop prevention strategies.

Dr Shu-Ti CHIOU (Chinese Taipei) said that Chinese Taipei provided universal health coverage and attached high priority to prevention and control of noncommunicable diseases. She welcomed the establishment of a global monitoring framework and set of indicators. Chinese Taipei allocated separate funds to noncommunicable disease prevention and health promotion, which were used to plan and implement various health programmes including tobacco control, cancer screening, obesity prevention and control, and maternal and child health programmes. Raising the price of tobacco had generated additional revenue to fund prevention and control of noncommunicable diseases. With regard to social determinants, Chinese Taipei had implemented a multisectoral strategy to reduce levels of obesity, as a result of which the rising trend in obesity had been halted in 2011.

Dr ALOMARI (International Federation of Red Cross and Red Crescent Societies), speaking at the invitation of the CHAIRMAN, said that the Federation's framework to prevent and control noncommunicable diseases focused on prevention, innovation, research, monitoring, evaluation, partnership and advocacy. Prevention should start at the community level by raising public awareness to enable people to adopt healthier lifestyles; the Federation could work closely with governments to provide programmes and services to that end. Such programmes and services should be guided by a holistic approach. The Federation was committed to supporting the efforts of Member States and the Secretariat towards achievement of the goals outlined in the Political Declaration of the High-level Meeting. Member States should support the global monitoring framework and voluntary targets, with a focus on prevention. Noncommunicable diseases should be central to the development agenda and should be included in the outcomes of the United Nations Conference on Sustainable Development (Rio+20), which would be a key process in determining the post-2015 development framework.

Dr TAUBERT (World Heart Federation), speaking at the invitation of the CHAIRMAN, agreed that noncommunicable diseases should rank highly on the post-2015 development agenda and be included in the outcomes of the Rio+20 Conference. Her organization was committed to supporting Member States and the Secretariat in catalysing global action to prevent and control noncommunicable diseases. She called on all countries to support a global monitoring framework and set of targets. The limited number of proposed targets, however, should be doubled and should include an 80%

availability rate for affordable, quality-assured, essential medicines and technologies for noncommunicable diseases. Member States should report on the progress made towards achieving those targets every two years. Countries should support the establishment of a global coordinating platform on noncommunicable diseases led by Member States and organizations in the United Nations system, with representation from civil society and the private sector in order to facilitate multisectoral action to combat noncommunicable diseases, with safeguards against vested interests.

Ms MWATSAMA (International Association for the Study of Obesity), speaking at the invitation of the CHAIRMAN, and representing the National Heart Forum, World Cancer Research Fund International, World Action on Salt and Health, World Public Health Nutrition Association and Consumers International, welcomed the inclusion of nutrition goals in the draft global monitoring framework and endorsed a target to reduce dietary salt intake to five grams per day. She urged Member States to include targets on obesity, alcohol, *trans*-fats, cholesterol and marketing of foods to children. WHO should, in collaboration with other United Nations organizations, develop global governance structures and comprehensive food policies integrating the prevention of noncommunicable diseases with the reduction of hunger and the promotion of nutrition security for all. She welcomed the set of recommendations on the marketing of foods and non-alcoholic beverages to children endorsed in resolution WHA63.14 and called on Member States to mandate the Secretariat to draft an international code to strengthen controls on cross-border marketing and to protect children in countries without national controls.

Dr FISHER (FDI World Dental Federation), speaking at the invitation of the CHAIRMAN, noted that the Political Declaration of the High-level Meeting of the General Assembly recognized the major disease burden posed by oral diseases, in particular dental caries and oral cancer. Such diseases shared common risk factors and could benefit from common responses to noncommunicable diseases. Countries should implement an integrated response to noncommunicable diseases and ensure that oral diseases were incorporated into all global, regional and national noncommunicable disease strategies, in line with resolution WHA60.17; include oral cancer in the proposed global monitoring framework as one of the major outcomes for cancer incidence by type; support targets for diet and obesity, including sugar consumption; and strengthen health systems through emphasis on primary health care, including primary oral health care. He pledged full support for the WHO Global Oral Health Programme.

Mrs GROVES (International Alliance of Patients' Organizations), speaking at the invitation of the CHAIRMAN, said that in order to maintain the momentum generated by the Political Declaration of the High-level Meeting of the General Assembly, coordinated action must be taken in the areas of prevention, diagnosis, treatment, care and support at the global level, and all chronic diseases should be addressed. A robust global monitoring framework for noncommunicable diseases should be developed, with clear indicators and targets. Although the targets should be achievable, they should also set a benchmark encouraging sustained action, and the 10 original targets should be reinstated. The current targets neglected treatment, and that omission should be rectified by inclusion of a target to ensure the availability of affordable, high-quality treatments, diagnostics and palliative care for noncommunicable diseases. Multisectoral action was vital to success. Although patients' organizations provided a wide range of health care services, their essential work was often undervalued. The Secretariat and Member States should undertake a mapping exercise in order to understand better the work of patients' organizations and its impact. All policies, programmes and strategies must be based on the fundamental right to patient-centred health care.

Mr PLEYER (International Federation of Medical Students' Associations), speaking at the invitation of the CHAIRMAN, said that the current set of five targets envisaged under the global monitoring framework was insufficient. A comprehensive set of targets was needed, including targets

relating to the banning of *trans*-fats and the marketing of unhealthy foods to children. Although indicators were crucial for monitoring progress, they did not fulfil the same role as targets. Since noncommunicable diseases disproportionately affected the poorest people in society, the principle of equity was of paramount importance and that should be reflected in the indicators. Mortality was an appropriate overarching target, but any reduction in the global burden of noncommunicable diseases could not be assessed accurately without also monitoring morbidity. WHO should seize the opportunity afforded by the Rio+20 United Nations Conference on Sustainable Development to put noncommunicable diseases firmly on the sustainable development agenda.

Dr FISHER (FDI World Dental Federation), speaking at the invitation of the CHAIRMAN, presenting the statement on behalf of the World Medical Association and speaking also on behalf of the International Council of Nurses, the International Pharmaceutical Federation, and the World Confederation for Physical Therapy, said that WHO should ensure that the monitoring framework covered a broad range of diseases, including, for example, mental illness, musculoskeletal diseases and oral diseases and reflected a holistic approach, emphasizing the importance of healthy lifestyles, social determinants of health and health system strengthening. Morbidity should be included among the indicators, and the proposed targets on alcohol and obesity should be reinstated. It was essential to form a committed partnership that included Member States, organizations of the United Nations system, civil society and the private sector, while avoiding conflicts of interest.

Dr PERICO (International Society of Nephrology), speaking at the invitation of the CHAIRMAN and on behalf of the People's Health Movement, welcomed the reference in the Political Declaration to kidney disease as a major health threat that could benefit from common responses to noncommunicable diseases. His organization had published a comprehensive review of the epidemiological evidence showing that chronic kidney disease was a major risk factor for cardiovascular disease and demonstrating the value of albuminuria as a predictor of renal disease and excess risk of cardiovascular disease. Measuring albumin concentration in urine should be part of the noncommunicable diseases monitoring framework in primary care settings. Strategies for the prevention, detection and early treatment of diabetes and cardiovascular disease would not eliminate the need to address kidney disease separately. In developing countries, up to 40% of those with chronic kidney disease did not have diabetes or cardiovascular disease. Effective low-cost interventions were available for chronic kidney disease when it was caught early. The disease should be recognized as a major noncommunicable disease and a specific policy for its early detection and treatment should be drawn up.

Ms FABRI (CMC – Churches' Action for Health), speaking at the invitation of the CHAIRMAN, said that the prospects for effective regulation of the global agri-food industry were fading because of the inclusion of investor-protection provisions in trade agreements. The attack by the tobacco industry on Australia's plain-packaging regulations should serve as a warning to policy-makers who saw a role for industry regulation in the prevention and control of noncommunicable diseases. The global strategy for the prevention and control of noncommunicable diseases mentioned trade and industry factors, but commitment to effective action in that area was lacking. As WHO's mandate covered the social and economic determinants of noncommunicable diseases and ensuring health and trade policy coherence, she urged Member States to strengthen their commitment to tackling noncommunicable diseases through action in diverse fields, including trade, agriculture, urban development and taxation. Because the global strategy involved collaboration with the private sector, the provisions on conflict of interest envisaged under the WHO reform process were urgently needed.

Dr COSTEA (International Special Dietary Food Industries), speaking at the invitation of the CHAIRMAN, said that good nutrition, especially in early life, was essential to the prevention and control of noncommunicable diseases. Her organization supported exclusive breastfeeding for the first

six months of life and continued breastfeeding thereafter. The timely introduction of safe and appropriate complementary foods beyond six months was important in promoting children's optimal health and development, and her organization would continue to contribute to the improvement of knowledge in that area. Members of her organization continued to invest in research and development to enhance nutrition for infants and young children, which would have a positive impact on health outcomes later in life. She supported the objectives set out in document A65/8.

Dr REED (Stichting Health Action International), speaking at the invitation of the CHAIRMAN, said that medicines were crucial in the treatment of noncommunicable diseases and provisions relating to availability of medicines should be included in all programmes for the prevention and control of such diseases. Studies had shown that generic medicines were significantly less available for noncommunicable diseases, particularly asthma, epilepsy, depression and hypertension, than for communicable diseases. He therefore proposed the inclusion of two targets in the global monitoring framework: 80% availability of generic essential medicines for noncommunicable disease in the public and private sectors; and 80% availability of essential health products for diagnosis, monitoring and treatment of noncommunicable diseases, consistent with the targets established under the WHO Medium-term strategic plan 2008–2013. A method for assessing the affordability of standard treatments for noncommunicable diseases should be developed in order to ensure that meaningful targets and indicators could be established.

Mgr VITILLO (Holy See), speaking at the invitation of the CHAIRMAN, welcomed the report on the implementation of the action plan for the prevention of avoidable blindness and visual impairment (document A65/9), which was an area that did not always receive equitable attention and action from the public health community. In November 2011, the Holy See had sponsored a global conference on the prevention of blindness, at which expertise, experience and lessons learnt by Catholic and other religious institutions working in that field had been shared.

Dr BOULYJENKOV (Thalassaemia International Federation), speaking at the invitation of the CHAIRMAN, said that the global health burden of inherited haemoglobin disorders, such as thalassaemia and sickle/cell disease, was increasing, and he welcomed the governing body resolutions on the subject adopted in 2006.[1] It was to be hoped that a progress report would be prepared, documenting Member States' activities aimed at developing relevant national programmes. Haemoglobin disorders required specific strategies and interventions based on advanced research. He therefore welcomed WHO's ongoing initiatives in that regard (outlined in document A65/8) and supported the global strategy and action plan for the prevention and control of noncommunicable diseases, especially in so far as they related to research.

Dr KEENAN (International Pediatric Association), speaking at the invitation of the CHAIRMAN, said that the prevalence of major noncommunicable diseases in children and adolescents had reached epidemic proportions. Most preventable forms of behaviour that led to noncommunicable diseases took root in childhood or adolescence. Cost-effective, child-focused interventions existed, including second-hand smoke exposure control and nutrition and vaccine programmes. Nevertheless, limited resources had been allocated to the prevention and treatment of noncommunicable diseases in children and adolescents, which meant avoidable deaths. National approaches should take into account the specific needs of those age groups, at all levels of the health care system, to ensure that development assistance included support for child and adolescent health interventions.

[1] Resolutions WHA59.20 and EB118.R1.

Dr CHESTNOV (Assistant Director-General) acknowledged the comments and the general support expressed for the noncommunicable disease agenda, in particular for the five global targets relating to mortality, raised blood pressure, tobacco use, salt intake and physical inactivity. Other targets had also been discussed, and the Secretariat would continue to review the necessary balance between political will and technical expertise, and take into account the need to show that progress had been made in implementing the recommendations contained in the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases.

The comments on the marketing of food and alcohol products to children, the suggestion to establish a database of best practices, and the proposals on cholesterol-related indicators would all be taken into consideration. The Secretariat would continue to prioritize food and nutrition security for children, as well as healthy ageing. It was important to learn from mistakes made in the past relating to the prevention and control of communicable diseases in order to improve future activities. Despite demonstrated political will, international experience and technical expertise in combating obesity, and consumption of sugar and saturated fats was still limited, but those areas would be included among the global targets. He thanked Member States for their participation in the three regional consultations held thus far, and said that consultations would be undertaken shortly in the African, Eastern Mediterranean and Western Pacific Regions. A third web-based consultation would be launched in June or July 2012, followed by a formal consultation with Member States in October in order to finalize the targets and indicators and to formulate a concrete proposal for the comprehensive global monitoring framework.

The CHAIRMAN drew attention to the draft decision on prevention and control of noncommunicable diseases put forward by the delegate of the United States of America in the first meeting.

Ms SCHJØNNING (Denmark) said that she needed time to consult on the draft decision.

Mr McIFF (United States of America), supported by Dr WARIDA (Egypt) and Dr THAKSAPHON THAMARANGSI (Thailand), proposed establishing a drafting group to revise the draft decision in the light of the rich discussion, with particular attention to the proposals concerning mortality targets.

Dr RODRÍGUEZ (El Salvador) emphasized the need for attention to chronic kidney disease and to work-related and environmental risk factors.

The CHAIRMAN took it that the Committee wished to establish a drafting group to discuss the draft decision.

It was so agreed.

The CHAIRMAN took it that the Committee wished to approve the draft resolution contained in resolution EB130.R6.

The draft resolution was approved.[1]

[1] Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA65.3.

(For continuation of the discussion and approval of the draft decision, see the summary record of the seventh meeting, section 2.)

- **Options and a timeline for strengthening and facilitating multisectoral action for the prevention and control of noncommunicable diseases through partnership**

The CHAIRMAN drew attention to the report by the Secretariat contained in document A65/7.

Dr ST. JOHN (Barbados) welcomed the report, but expressed a preference for the use of established networks, without prejudice to the principle of WHO's leadership and coordinating role. Regarding the section of paragraph 18 on capacity building, she urged recognition of the impact of chronic diseases on all developing countries, rather than only low-income, middle-income and least developed countries.

Dr RODIN (Canada) said that national contexts had to be taken into account in considerations of effective and sustained multisectoral action. Existing mechanisms should be used where possible, ensuring integration and sharing of best practices for the optimal use of limited resources. Partnerships would only continue when their impacts were tangible and relevant. Paragraphs 12 and 13 of the report noted the importance of civil society and the private sector, but not the higher priority assigned to those sectors in paragraph 37 of the Political Declaration of the High-level Meeting. A multisectoral approach would support national efforts for the prevention and control of noncommunicable diseases and strengthen their effectiveness. Those key principles for multisectoral action, as well as the value of sharing effective partnership models among Member States, should be highlighted in WHO's input to the United Nations Secretary-General.

Mr KOLKER (United States of America) said that multisectoral action was critical to the prevention and control of noncommunicable diseases and stressed the need for engagement by non-health sectors to address the growing burden of such diseases. The Secretariat's report contained practical ideas on how stakeholders could work together to address the social and environmental factors contributing to noncommunicable diseases, and he welcomed its conclusion that a single, stand-alone partnership might not cover all needs. Existing global partnerships, alliances and results-oriented arrangements should be strengthened, and new ones established only when required. Task-focused networks could effectively exchange information and improve coordination to achieve specific goals while maintaining operational flexibility with minimal transaction costs. The report contained a useful set of questions to be considered in determining the work streams and structure of a global partnership mechanism. It was unlikely that all those questions could be answered at the current stage, but the Secretariat, in preparing recommendations for the United Nations Secretary-General, should use existing examples of best practice in multisectoral approaches, results-oriented alliances and national programmes embodying effective communication strategies.

Ms SCHJØNNING (Denmark) said that all sectors and stakeholders that had an impact on health should contribute to the prevention and control of noncommunicable diseases. Such diseases required local solutions, and partnerships with nongovernmental organizations and civil society were essential. The six necessary functions of partnerships, listed in paragraph 18 of the report reflected a disease- or treatment-based approach; more emphasis should be placed on determinants, prevention and the development of public policy measures in consultation with stakeholders. More research on public health interventions, policies and capacities was needed, and conflicts of interest would have to be addressed. The report to be submitted to the United Nations Secretary-General should provide a strategic approach, driven by policies to reduce the burden of noncommunicable diseases. She encouraged Member States to participate fully in consultations to finalize that report.

Dr JACOBS (New Zealand), recognizing that multisectoral action was crucial to success in the fight against noncommunicable diseases, said that the challenge was to put theory into practice. The likelihood of success, which depended on the investment of resources, expertise and political will, would be reduced if responses were limited to the health sector. He strongly encouraged the Secretariat to continue to prioritize multisectoral action and to adopt a motto such as "Noncommunicable diseases are everyone's business", which could be put forward in the forthcoming report to the United Nations Secretary-General as an approach applicable across the United Nations system.

Mr THOMSON (Switzerland) said that health issues could no longer be dealt with by the health sector alone. He therefore welcomed the report's emphasis on multisectoral action in the fight against noncommunicable diseases, noting that the implementation of the options set out in the report would be the responsibility of Member States. He expressed concern at the short time available for the preparation of the report to the United Nations Secretary-General. His Government was anxious to make its own national contribution to the report and trusted that the Secretariat would include in it all relevant information relating to multisectoral cooperation. He welcomed the consultations that had been undertaken in that regard. In the light of its international experience and expertise, WHO was well placed to respond to the expectations raised by the new global awareness of the burden of noncommunicable diseases.

Dr TUGSDELGER (Mongolia) said that her country had made considerable progress in the area of multisectoral action for the prevention and control of noncommunicable diseases over the previous two years. Flows of foreign aid to prevention and control programmes had only recently increased, and limited resources had to be used effectively. Development partners should support and not complicate coordination at country level, avoiding activities that undermined national institution-building, optimizing the use of country systems and procedures, and minimizing overheads for development assistance, in accordance with the principles enshrined in the Paris Declaration on Aid Effectiveness. Those principles should guide all multisectoral action for the prevention and control of noncommunicable diseases.

Dr AL-TAAE (Iraq) stressed the relevance of partnerships to the achievement of Millennium Development Goal 8 (Develop a global partnership for development). Active partnerships with clearly defined targets and indicators were important to WHO's work at country and regional levels. National partnerships should be enhanced, with the involvement of civil society as well as international organizations. All partnerships should be active, including those within the United Nations system, to ensure optimal use of the resources available. They should be reviewed regularly to ensure their continued usefulness, and enable them to be strengthened.

Professor UDOM KACHINTORN (Thailand) said that multisectoral collaboration was required to tackle noncommunicable diseases. Experience had shown, however, that in some cases the private sector had opposed proven and effective interventions, and it was therefore essential to safeguard health from any potential conflict of interest involving, for example, the tobacco and alcohol industries. National legislation should be developed to that end. Regarding the functions of partnerships outlined in the report, product access and the availability and affordability of all health products, not just medicines and technologies for the treatment of diseases, should be guaranteed. Commending the report, he endorsed the health-in-all-policies approach.

Ms BENNETT (Australia) said that her Government was committed to a multisectoral approach to health and had put in place programmes and activities that promoted healthy outcomes in various non-health settings, such as schools and workplaces. She agreed that there was no "one-size-fits-all" solution and that a single, stand-alone, formal partnership might not cover all needs. A mix of

partnerships, alliances and collaborations would be more flexible, and should build on existing models wherever possible. She asked for clarification of the possible function of a collaborative network or coordination mechanism and of how it would build on existing mechanisms such as the Global Noncommunicable Disease Network (NCDnet).

Mr MESBAH (Algeria) agreed that a multisectoral approach was essential. The challenge lay in the implementation of partnerships. He wondered whether participation by the various stakeholders in surmounting that challenge would be voluntary and emphasized the public health obligations of all. That issue should be examined in the light of existing experience.

Dr CHESTNOV (Assistant Director-General) welcomed Member States' recognition of the need to engage other sectors in health policies and policy development, and to build and coordinate results-oriented partnerships in the context of national efforts to address noncommunicable diseases. Such partnerships should have the following key functions: advocacy, political leadership, coordination, resource mobilization, capacity building and the expansion of access to health technology. Increased clarity of function would facilitate a more rational, effective and efficient allocation of resources to strengthen national programmes for noncommunicable disease prevention and control. Member States had indicated a strong preference for building on existing structures rather than creating new ones. To that end, a platform for dialogue was needed, which would be guided by WHO norms and values and shaped by ongoing challenges. Member States had welcomed regional and bilateral consultations and had proposed further informal consultations, which would take place in June or July 2012. He underlined the importance of synthesizing the experience of countries and the Secretariat as a basis for further multisectoral collaboration.

The Committee noted the report.

- **Implementation of the action plan for the prevention of avoidable blindness and visual impairment**

The CHAIRMAN drew attention to the report contained in document A65/9.

Dr ESCOBAR (Chile) said that her country had made significant advances in eye health. Access to eye care and treatment for a variety of eye diseases, including cataract, retinopathy of prematurity, retinoblastoma, strabismus, diabetic retinopathy and refractive errors, had been expanded. Specialized ophthalmology services were provided in remote rural areas by travelling medical and surgical teams. An intersectoral programme involving the health and education sectors ensured the availability of ophthalmology services, including the provision of glasses, to all primary schoolchildren. Prevention of blindness and visual impairment should remain a priority for WHO.

Mr DESIRAJU (India), emphasizing the seriousness of visual impairment, said that his country's national programme for control of blindness focused on comprehensive eye care delivery and the quality of services. An integrated public–private partnership for treatment of cataracts had become the best model health programme in the country, and budgetary allocations to eye care had steadily increased. According to a rapid assessment of avoidable blindness conducted during 2006–2007, the prevalence of blindness had fallen to 1.0%. The target was 0.3%. India was also committed to eliminating trachoma by 2020.

Problems to be tackled during the period covered by the action plan included integrating eye care into broader health plans to reflect the rise in chronic noncommunicable eye conditions and scaling up funding. The Secretariat, in collaboration with Member States and international partners,

should begin work on a follow-up plan for the period 2014–2019, the draft of which could be submitted through the Executive Board to the Sixty-sixth World Health Assembly.

Dr AL-TAAE (Iraq) said that Iraq had established a visual health programme as an integral part of its primary health care system. Eye care coverage was to be extended to all schools, and a programme to raise awareness was under way. As children accounted for 10% of visual impairment cases, special provision should be made for them, particularly in view of the economic and social implications of such disabilities.

Ms LAMOURELLE (United States of America) observed that avoidable blindness and visual impairment disproportionately affected countries with the least resources. She welcomed the action taken to increase awareness through advocacy, strengthen national policies and programmes, expand research, improve coordination, enhance data collection and surveillance and monitor progress. Those activities would be crucial in strengthening Member States' capacity to identify and prioritize issues and areas for improvement in relation to accurate assessment of disease burden, better monitoring of the causes of avoidable blindness and visual impairment, and more coordinated and multidisciplinary research. The provision of vision care that reflected the disease burdens and demographics of individual Member States should be encouraged in order to address the varying causes of preventable blindness and visual impairment. It was also imperative to enhance awareness among the public and health care providers of all aspects of visual impairment, including comorbidity, and to ensure that screening and prevention were integrated into routine health services.

In the current global economic situation, the Secretariat should continue to play a role in coordinating health activities, focusing on high-impact, cost-effective interventions. Despite concerns as to the financial and technical capacity of Member States and the Secretariat to carry out the activities envisaged under the current action plan, her Government supported the development of a new action plan for the period 2014–2019, as called for in decision EB130(1).

Dr SA'IDI (Saudi Arabia) said that the Member States of the Eastern Mediterranean Region also supported the development of a new action plan, which would lend continuity to current blindness prevention efforts at national and regional level. Greater political will was required on the part of national governments, which should step up their efforts to provide better training in visual health and ensure that visual health care was provided in remote and rural areas. The Secretariat should play a coordinating role, facilitating cooperation among stakeholders at various levels.

Dr WU Liangyou (China) said that the protection of visual health was a compelling obligation on governments at all levels. He welcomed the progress made in visual health since the establishment of the Global Initiative for the Elimination of Avoidable Blindness (VISION 2020: the Right to Sight). His Government had implemented many programmes for the prevention and treatment of blindness, especially in the context of a major reform of the health system in 2009. A national programme was being developed, covering the period 2011–2015. Under a special project, cataract surgery had been provided to 1.09 million people by the end of November 2011. He called on WHO to continue efforts to raise awareness of visual health, to enhance support for the prevention and treatment of blindness by governmental and nongovernmental organizations and to help to strengthen health education in less developed regions. Greater support was also needed for investment, epidemiological research, strengthening of information systems and professional training.

Ms SKACHKOVA (Russian Federation) said that health centres in her country had begun to provide ophthalmological services for the detection and prevention of serious eye problems, including blindness, cataract and glaucoma. She supported the development of national action plans, for which adequate funding should be provided. Such plans should include the provision of social reintegration

services. She called on the Secretariat and all Member States to prioritize intersectoral approaches to blindness and visual impairment.

Ms PATTERSON (Australia) thanked the Secretariat for its work on the five objectives set out in the current action plan and its work with Member States and international partners on an initial draft of the action plan 2014–2019. She commended its role in promoting investment in eye health and in drawing attention to the barriers to implementing the plan fully. Eye health and vision care remained priorities for Australia, where consultations were under way on the development of the new action plan. She encouraged all Member States to continue to engage in the consultation and drafting process.

Dr ALLENDE (Paraguay) said that his Government was addressing the serious public health problems of blindness and visual impairment in an integrated manner, in accordance with the principles of universality and equality. Gaps in detection, monitoring, treatment, rehabilitation and funding were being tackled systematically under a strategic plan, and the coverage of the national programme had been expanded through service networks encompassing a range of facilities, from family health units to specialized hospitals. Despite progress made since 2008, better intersectoral cooperation was required to meet WHO targets, with particular regard to prevention, epidemiological surveillance and primary health care guidelines.

Dr RAPEEPONG SUPHANCHAIMAT (Thailand), acknowledging the good progress reported, noted that activities related to Objective 1 of the action plan had been mostly technical, without reference to political or financial issues. Assessments of the global magnitude of visual impairment should include policy analysis in order to provide lessons about how best to implement policies. Priority should be given to cataract as recent estimates had shown that it was the second leading cause of visual impairment and the leading cause of blindness. It was not clear whether the actions described for Objective 2 were sufficient to sustain eye care programmes at country level. They did not address fundamental problems of health systems, in particular with regard to resources, delivery mechanisms, early screening, diagnosis and treatment. Screening and enhanced access to treatment were essential to reverse the increasing prevalence of diabetic retinopathy. More auxiliary eye health workers were needed. Cooperation between developing countries could offer benefits.

Work on Objective 3 should focus on strengthening countries' research capacity and the use of cost-effectiveness analyses to guide decisions on investment and resource allocation. The activities undertaken in respect of Objective 4 seemed to consist mostly of holding WHO meetings. The question of what other activities had been undertaken to improve collaboration between partners arises. Member States themselves had a critical role to play. He commended the progress reported under Objective 5 for the elimination of trachoma and onchocerciasis but urged more attention to the increasing burdens of age-related macular degeneration, cataract and diabetic retinopathy. Improvements in eye care services needed to be monitored and sustained.

Mr SIME (Ethiopia), providing data from the 2006 National Survey on Blindness, Low Vision and Trachoma in Ethiopia, said that the prevalence rates of blindness (1.6%) and visual impairment (3.7%) in his country were among the highest in sub-Saharan Africa. National five-year strategic plans based on the recommendations of the VISION 2020 initiative had been implemented since 2001. The current strategic plan, which was based on the national health policy and drew on national and regional data, included advocacy for greater financial, political and technical commitments and gave priority to strengthening and expanding research, monitoring programme implementation, and technical support.

Dr BRENNEN (Bahamas), recognizing the dual burden of disease related to avoidable blindness, asked the Secretariat to ensure that global and regional policies, plans and programmes for eye health were focused on a balanced and comprehensive approach encompassing communicable and

noncommunicable diseases. Noting the national and regional shortage of human resources for comprehensive eye care programmes, he said that his country wished to be included in the strategy and activities for training more eye care professionals, as both a contributor and recipient of support.

The meeting rose at 12:30.

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