## FOURTH MEETING

**Tuesday, 22 January 2008, at 14:10**

**Chairman:** Dr B. SADASIVAN (Singapore)

**TECHNICAL AND HEALTH MATTERS:** Item 4 of the Agenda (continued)

**Climate change and health:** Item 4.1 of the Agenda (Document EB122/4) (continued)

Dr HEYMANN (Assistant Director-General) thanked speakers for their suggestions and guidance. It was clear from the accumulating evidence that climate change would affect the health of everyone, especially the poorest. The effects were projected to increase in all countries and regions. That would require all public health authorities to take into account the potential impact of climate change on human health. The preparation of a workplan with Member States would encourage activities and research that would place health issues at the centre of the climate change agenda. The Secretariat had therefore selected "Protecting health from climate change" as the theme for World Health Day 2008. The Organization would continue to collaborate with the Intergovernmental Panel on Climate Change, promote research, and produce evidence. The Secretariat would align its report more closely with the findings of the Intergovernmental Panel and Member States' comments when preparing a revised document for the Health Assembly, with particular attention paid to paragraph 7. The relevant references from peer-reviewed literature would, where necessary, validate the evidence provided.

The CHAIRMAN announced that the informal group convened had reached consensus on the text of a draft resolution. A final version would be made available to the Board the following morning and he therefore proposed that any further discussion on the subject should be postponed accordingly.

**It was so agreed.**

(For adoption of the resolution, see summary record of the fifth meeting.)

**Prevention and control of noncommunicable diseases: implementation of the global strategy:** Item 4.6 of the Agenda (Document EB122/9)

Dr VOLJČ (Slovenia), speaking on behalf of the Member States of the European Union, the European Free Trade Association countries Iceland and Norway that were also members of the European Economic Area, and Switzerland, said that the candidate countries Turkey, Croatia and The former Yugoslav Republic of Macedonia, the countries of the Stabilisation and Association Process, and potential candidates Albania, Bosnia and Herzegovina, Montenegro and Serbia, and also Armenia, Georgia and Ukraine, aligned themselves with his statement. He acknowledged the priority accorded by the Director-General to the dramatically increasing burden of noncommunicable and chronic diseases. The strengthening of health systems called for concerted global action. The focus should be on the main risk factors, on challenges in the areas of mental and environmental health, and on promoting healthy lifestyles, especially for poor people and disadvantaged populations. Those elements should be dealt with, using a coherent multisectoral approach. WHO's action plan for the prevention and control of noncommunicable diseases constituted a strong and integrated approach to implementing the global strategy. It had been issued late, thereby limiting Member States' ability to

give it due consideration. He therefore proposed the convening of an informal consultation on the action plan, to be held before the Sixty-first World Health Assembly. In addition to Member States, the consultation should involve all relevant stakeholders, including representatives of international partners, in order to concert action. The Secretariat should give support and priority to all efforts aimed at preventing and treating noncommunicable diseases, as set out in the draft action plan.

Dr SUGIURA (alternate to Dr Shinozaki, Japan) welcomed the draft action plan. A training programme on noncommunicable diseases had operated in Japan since 2005 for health professionals involved in the prevention and control of noncommunicable diseases in the Western Pacific Region and a communications network was being established. A health promotion movement using quantitative indicators had also been set up increasing awareness of healthy lifestyles. Japan was willing to share its experience in that area.

Regarding the action plan, he pointed out that objectives 1 and 2 were interrelated in terms of national awareness raising and establishing policies. Member States should improve their surveillance and diagnostic systems, with technical support from the Secretariat. The WHO Framework Convention on Tobacco Control provided a good basis for implementation of objective 3. As to objective 5, the number of diseases targeted might make it difficult to establish suitable partnerships. WHO's expertise in the area would qualify it to assume a leadership role.

Dr BIN SHAKAR (United Arab Emirates), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that noncommunicable diseases accounted for an estimated 52% of the total burden of disease in the Region; that figure was expected to rise to 60% by 2020. The root causes of the global epidemic of noncommunicable diseases were smoking, unhealthy diet and physical inactivity. Although their impact varied between populations, they were responsible for some 75% of chronic disease conditions. Humanitarian crises affecting the Region inhibited governments' ability to address the escalating problem posed by noncommunicable diseases. In health emergencies affecting displaced populations and refugees, preparedness was as important for noncommunicable diseases as it was for communicable ones.

The Secretariat was raising awareness among Member States on the magnitude of that public health problem; and providing technical support for the framing of national policies by bringing together regional and global experts in order to identify effective prevention and control mechanisms. Countries of the Region were formulating national dietary guidelines and introducing a regional cancer control strategy.

He therefore urged WHO and other partners, including the private sector and nongovernmental organizations, to assist in resource mobilization, particularly in developing countries where the twofold burden of communicable and noncommunicable diseases was causing huge loss of life and lifelong disabilities.

Dr JEAN LOUIS (Madagascar), speaking on behalf of the Member States of the African Region, welcomed the fact that the Health Assembly had recognized the extent to which noncommunicable diseases were undermining development, particularly in the African Region. Public health services struggled to cope with the additional burden of increased morbidity and mortality occasioned by those diseases. Most Member States had begun to treat noncommunicable diseases as a priority area. In the African Region, 27 countries were developing surveillance systems based on WHO's STEPwise approach and the Global student health survey in order to evaluate risk factors. Data included the prevalence of noncommunicable diseases among 13 to 15 year-olds in seven African countries.

A framework document on the elaboration of national programmes and on dealing with sickle-cell disease had been adopted at the Fifty-sixth session of the Regional Committee for Africa.[1]

[1] Document AFR/RC56/17.

Cancer registers had been established in 12 countries. At its subsequent session, the Regional Committee had adopted a resolution on prevention and control of diabetes and a strategy to eliminate avoidable blindness. [1]

Madagascar was implementing prevention and control of noncommunicable diseases through elaboration of a national policy; approval of standard procedures for treatment at primary health-care level; pilot projects for the prevention of cervical cancer; fluoridization of iodized salt; and improved dental, oral and ocular health at community level and in schools. As long as countries refused to prioritize such diseases, allocated resources would remain inadequate.

Dr JAKSONS (Latvia) acknowledged the report's improvements. The draft action plan must be translated into concrete actions and working documents, which would require the participation of all Member States.

Objective 2 of the action plan needed a more precise description of activities. For example, there was no mention of providing access to essential medicines, although objective 4 suggested that such access should be further studied. Objective 3 required a more general statement of the public health issues. Where alcohol was concerned, less was better; that premise was in line with the promotion of healthy lifestyles and societies advocated by the European Union. It was not enough merely to encourage people to avoid drinking to intoxication or resorting to substitutes for alcohol. Latvia was willing to participate in the drafting of a resolution.

Mr FISKER (Denmark) said that the increase in the burden of noncommunicable diseases emphasized the urgent priority to implement the global strategy. He welcomed the Board's agenda that included progress reports on health promotion in a globalized world, and infant and young child nutrition; and particularly the fact that the harmful use of alcohol was the subject of a draft resolution. Issues such as mental health were also important.

He favoured a horizontal approach to tackling risk factors of chronic diseases and their long-term consequences. The draft action plan constituted a promising platform for further action. He supported the suggestion made by the member for Slovenia for an informal consultation in order to allow Member States and stakeholders to discuss the draft action plan before its submission to the forthcoming Health Assembly.

Mr KWON Jun-wook (alternate to Professor Sohn Myongsei, Republic of Korea) supported the draft action plan but drew attention to the medical and organizational relationship between mental health and noncommunicable diseases. He proposed clarifying the distinction between mental health and noncommunicable diseases with text that might also address the comment by the previous speaker on that issue. After the first occurrence of the phrase "noncommunicable diseases" in paragraph 1 a footnote should be inserted, to read:

> "From a medical perspective, the concept of noncommunicable disease encompasses a vast range of conditions, including mental conditions. For practical purposes, however, the extensive work by WHO relating specifically to mental health has been compartmentalized from the work concerning other noncommunicable diseases, such as the four categories of disease highlighted herein: cardiovascular disease, cancer, chronic respiratory disease and diabetes."

Dr REN Minghui (alternate to Mr Li Baodong, China) welcomed the report and draft action plan. The activities and measures proposed and the strategies and workplans would provide guidance and impetus. Most developing countries faced with the difficulty of controlling communicable diseases with limited resources had neglected noncommunicable diseases. WHO should mobilize

[1] Resolution AFR/RC57/R4.

resources and increase efforts in national planning and programming, information, capacity building, health promotion and clinical prevention.

China had included cardiovascular disease and malignant cancers in national programmes and was determined to fully utilize existing resources and strengthen multisectoral cooperation.

Dr FORSTER (Namibia) said that Africa was disproportionately affected by the two-fold burden of communicable and noncommunicable diseases and action was needed on both fronts in order to achieve long-term health outcomes. He welcomed the draft action plan particularly the section entitled "Relationship to existing strategies and plans". With regard to objective 1, the Secretariat should make available advocacy material and, at the request of Member States, provide guidance or technical assistance for local production of appropriate material.

Surveillance, research and evaluation should be given more prominence. He commended objective 5 and urged partners to increase technical support and funding for prevention and control with an emphasis on the four most common risk factors. That section should request the Secretariat to establish collaboration with governments and the private sector in order to improve access to medicines and technologies for noncommunicable diseases in developing countries. The plan should include monitoring and outcome indicators, building on progress made in national surveys on risk surveillance through WHO's STEPwise approach. Namibia looked forward to the updated plan at the Sixty-first World Health Assembly.

Mr McKERNAN (New Zealand) welcomed the progress made on implementing resolution WHA60.23. The draft action plan brought together evidence on risk factors and interventions in the key areas of tobacco control, diet and physical activity, and the harmful use of alcohol. New Zealand supported the position of the European Union: the plan should be strengthened through broader consultation involving all Member States and stakeholders before the Sixty-first World Health Assembly. A process should ensure that the plan became a useful tool for reducing the burden of noncommunicable diseases.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) fully supported the objectives in the draft action plan. The prevention of noncommunicable diseases needed a balance between individual and government action in order to change behaviours. Governments could create an environment to help individuals make healthy lifestyle choices. They could encourage sport in schools, physical activity throughout life, and work with the food industry in order to reduce salt content. In the United Kingdom, 75% of the salt consumed was hidden in processed foods, so that without government action it would be difficult for individuals to reduce their salt intake. He would provide specific comments on the plan directly to the Secretariat, and also during the informal consultation process proposed by Slovenia.

He emphasized three particular areas: tackling underlying health inequalities; infant and child nutrition, in particular breastfeeding; and the need to include a set of recommendations, as agreed at the Health Assembly, on the promotion and marketing of foods and beverages to children. Finally, the term "strengthening health systems" was for many people synonymous with "strengthening health-care systems". A broader approach was needed, since there was a limit to what health-care systems could do to prevent noncommunicable diseases, with multisectoral involvement from partners not naturally oriented to health goals. In health-care systems, wider participation should be built in from the start, so that the focus was not just on the treatment and care of patients.

Dr WRIGHT (United States of America) said that the increasing two-fold burden of disease faced by developing countries gave importance to a prevention and control strategy for noncommunicable diseases. For that reason, he requested that discussion of the item should be postponed until the Board's 124th session in January 2009. The document concerned had been distributed only four days before the start of the current session. Every global strategy reflected a commitment and investment by Member States, and they needed more time to make the present strategy as effective, measurable and evidence-based as possible. The Secretariat, in collaboration with

other stakeholders, including the private sector, could help Member States strengthen their capacity to measure the growing disease burden, and especially the prevalence and impact of chronic diseases. His Government would continue to address the problem of noncommunicable diseases, which accounted for seven out of 10 deaths in the country and affected the quality of life of 90 million Americans. His country looked forward to sharing its experience and expertise worldwide.

Dr AHMADZAI (Afghanistan) noted that two Health Assembly resolutions had addressed the elimination of avoidable blindness, which was included as a strategic objective in WHO's Medium-term strategic plan 2008–2013. However, the draft action plan for noncommunicable disease prevention and control did not specifically address visual impairment. The Board should request the Secretariat to develop a plan of action for the prevention of avoidable blindness, to be submitted to the Board at its 124th session.

Professor PEREIRA MIGUEL (Portugal) welcomed the draft action plan, which would help prioritize the prevention and control of noncommunicable diseases at the national and global levels. His country aligned itself with the declaration by the member for Slovenia and supported the proposal for a consultation between Member States before the next Health Assembly. Portugal supported the proposal by the Republic of Korea that mental health should be covered in the action plan, as it was in the European Strategy for the Prevention and Control of Noncommunicable Diseases, approved in 2006. Mental health problems were prevalent globally, causing high levels of morbidity, disability and suffering. There were risk factors shared with noncommunicable diseases, such as harmful use of alcohol and lack of physical activity.

Professor SALANIPONI (Malawi) expressed his country's growing concern over the view that Africa should give priority to communicable rather than noncommunicable diseases. To do so would result in noncommunicable diseases in Africa attracting less attention than they merited. Unless WHO helped to raise countries' awareness of the importance of noncommunicable diseases, Africa might well be overtaken by events, with the determinants and implications of such diseases outweighing the impact of communicable diseases. To accord insufficient attention to noncommunicable diseases would fail to respect one of the Director-General's priorities: Africa.

Dr MENESES GONZÁLEZ (alternate to Dr Hernández Ávila, Mexico) said that Mexico was experiencing an increasing burden of noncommunicable diseases. Type 2 diabetes was spreading and 9% of adults over the age of 40 were currently diabetic. The increasing morbidity burden and mortality levels in many countries were threatening to result in high levels of social expenditure and a collapse of health services. In addition there was also the indirect cost borne by families. Mexico had established a six-year programme to diagnose, prevent and control type 2 diabetes with the aim of: changing behaviour and attitudes; training health staff; integrating health services; improving infrastructure, the supply of drugs and medical equipment; and ensuring universal health insurance.

He welcomed the Secretariat's draft action plan, which reflected the real situation at country level and set out best practices in public health in order to cope with noncommunicable diseases. However, the section on nutrition should mention action such as the health labelling of processed food in order to enable people to select healthier foods when shopping. Much of the guidance on public health actions was already being developed in Mexico. Meeting the challenges set out in the plan would depend on adequate resources and the willingness of countries to abide by their commitments. In the revised version of the document, incorporating all comments made in the Board, the proposed actions should be aligned with actions already set out in existing Health Assembly resolutions. Mexico would share with other countries its experience in the promotion of healthy living and the prevention and control of chronic noncommunicable diseases with other countries.

Dr ABABII (Republic of Moldova) emphasized the implementation of a global strategy on noncommunicable diseases. His country supported the statement made by the member for Slovenia.

He also supported actions by the Regional Office for Europe on the issue. Noncommunicable diseases were leading to increased morbidity and mortality in the European Region, and accounted for more than 80% of all deaths. He noted that elements of the decision taken at the high-level conference on noncommunicable diseases held in Moscow in October 2007 had been incorporated into the draft resolution. His country had taken basic measures to prevent the main noncommunicable diseases, namely: cardiovascular diseases, cancer, chronic respiratory disease and diabetes. It was working on nutrition and lifestyle, and improving early diagnosis, care and treatment, and rehabilitation. It supported the proposal for a consultation before the next Health Assembly.

Dr ABEYKOON (alternate to Mr de Silva, Sri Lanka) said that in 2007 the Regional Committee for South-East Asia had endorsed the regional framework for prevention and control of noncommunicable diseases.[1] The Regional Office had found that existing information systems in most countries were not able to ensure the tracking of noncommunicable diseases in order to reach the goal of reducing related deaths globally by 20% in 10 years. He requested support from the Secretariat for studies on the burden of disease, and upgrading databases and registration systems on mortality due to noncommunicable diseases.

The report did not specify references to behavioural change, nor distinguish between primary and secondary prevention, which involved different strategies, efforts and costs. It might also highlight links between noncommunicable and communicable diseases, such as that between tuberculosis and smoking. A multisectoral approach was needed and the Secretariat should develop actions in order to strengthen health systems and mobilize support from other sectors.

Mr VALLEJOS (Peru), declaring his support in principle for the proposal made by the member for Slovenia, announced that Peru would be hosting the next biennial meeting of the *Conjunto de Acciones para la Reducción Multifactorial de Enfermedades No Transmisibles* (the CARMEN network), a PAHO initiative to promote the integrated prevention and control of noncommunicable diseases. The network helped produce policies, standards and regulations intended to reduce the prevalence of risk factors and determinants associated with such diseases throughout the Region. Its four main lines of action were health policy and advocacy, health promotion, surveillance, and integrated management of diseases and risk factors. It integrated capacity building and training, operational research, resource mobilization, and communication and social marketing. Since the launch of Peru's national programme for the prevention of blindness and cataract in 2007, operations had already been carried out on 5000 of the 80 000 recorded cases of cataract blindness, with 90% of patients fully recovering their eyesight. The country's mental health plan was helping the many households left fatherless in the wave of terrorism that had claimed more than 20 000 lives. Peru had also gathered data on the prevalence of noncommunicable diseases and risk factors; it had implemented a surveillance system covering analysis of data on mortality and hospital admissions due to noncommunicable diseases; and it had conducted specialized screening for cancers. A mass communication campaign was needed in order to promote healthy lifestyles and foster a culture of health.

Professor AYDIN (Turkey), referring to the annex to document EB122/9, stated that Turkey would be hosting the third general meeting of the Global Alliance against Chronic Respiratory Diseases in Istanbul in March 2008.

Mr MACMULLAN (Consumers International), speaking at the invitation of the CHAIRMAN, said that his global federation represented more than 220 consumer organizations from 115 countries. Resolution WHA60.23 had requested the Director-General to develop "a set of recommendations on marketing of foods and non-alcoholic beverages to children". He asked the Executive Board to honour

[1] Resolution SEA/RC60/R4.

that resolution by ensuring that WHO developed those recommendations, together with regulations to protect children and adolescents. The Regional Committee for Europe had already adopted the Second WHO Action Plan for Food and Nutrition Policy (2007–2012) in September 2007, stressing the need to "ensure adequate control of the marketing of foods and beverages to children and establish independent monitoring and enforcement mechanisms"; and the Regional Committee for the Eastern Mediterranean at its fifty-fourth session in Cairo in October 2007 had in resolution EM/RC54/R.9 recognized the need for "regulatory […] responses to counterbalance the adverse public health impact of food marketing to children and adolescents". WHO must take global action in order to prevent disparities around the world, with irresponsible marketing shifting to areas with the fewest controls and the most vulnerable customers. He urged the Secretariat to develop global policies to protect children and adolescents from the marketing of food and non-alcoholic beverages. These policies could be best achieved by an international code on marketing.

Dr GHEBREHIWET (International Council of Nurses), speaking at the invitation of the CHAIRMAN and representing his federation of 129 national nursing associations, said that success in reducing the major risk factors for emerging epidemics of cardiovascular disease, cancer, chronic respiratory disease and diabetes – including obesity, sedentary lifestyles, tobacco use and alcohol abuse – would hinge on the full and effective deployment of the world's 13 million working nurses. Studies had shown that nurses had been crucial in lipid management programmes, which led to lower serum cholesterol, lipoprotein and triglyceride concentrations and promoted a better diet, exercise and adherence to treatment regimens, thereby reducing risk factors, morbidity and mortality.

WHO, governments and others should invest in strengthening the nursing workforce because effective implementation of the global strategy would depend on sufficient numbers of skilled nurses and other health workers operating in efficient health systems.

Dr BENZIAN (FDI World Dental Federation), speaking at the invitation of the CHAIRMAN, said that the Federation, the global representative body of the dental profession in more than 140 countries, had repeatedly highlighted oral health as a key to general health. Evidence linked oral disease to systemic disease, and oral diseases shared risk factors and determinants with other chronic diseases. He drew attention to resolution WHA60.17 on oral health, and to the highly relevant guidelines in its associated action plan. The Federation called for renewed commitment to integrated control and prevention of oral disease, especially in deprived communities. Federation members and oral health professionals worldwide were keen partners in implementing Health Assembly policy recommendations, and offered their expertise in oral health promotion. He announced the conference for oral health in the Americas, organized through PAHO, which was scheduled for November 2008.

He stressed the importance his Federation attached to a well-resourced global oral health unit at WHO headquarters, not least in the light of the oral health implications set out in the report.

Mr RIGBY (International Association for the Study of Obesity), speaking at the invitation of the CHAIRMAN, said that the Association coordinated the Global Alliance for the Prevention of Obesity and Related Chronic Diseases and its partners, the International Union of Nutritional Sciences, the International Diabetes Federation, the World Heart Federation and the International Paediatric Association. Welcoming the draft WHO action plan, he recalled the strong conviction expressed by Member States at the Sixtieth World Health Assembly that sustained, far-reaching actions were needed to cope with noncommunicable diseases. The declaration by the Caribbean Community at its September 2007 summit of Heads of Government, entitled "Uniting to stop the epidemic of chronic NCDs", recognized obesity as a principal cause of noncommunicable diseases. Health ministers needed the support of other ministries, their heads of government, and society as a whole.

Echoing the comments of the representative of Consumers International on action to tackle the marketing of certain foods and beverages to children and adolescents, he said that regulation was a clear responsibility of Member States but national regulation could not control the cross-border nature of global marketing and the influence of marketing techniques using global communication media.

WHO must provide leadership and support to ensure that recommendations for international standards were developed, applied and sustained.

He commended the draft action plan, but it was unclear why the responsibility for preparing a regulatory framework and mechanisms to limit the marketing of food and non-alcoholic beverages to children appeared in objective 3 under the heading "Action for Member States" and not under "Action for the Secretariat". Member States, with the support of the Secretariat, should consider a future intergovernmental drafting group in order to elaborate the recommendations on marketing referred to in paragraph 2(6) of resolution WHA60.23.

Mr AITKEN (Assistant Director-General ad interim) said that the various points raised would all be taken into account in the revision of document EB122/9. WHO was meanwhile working on the subject of food marketing to children, and consultations were expected to take place in 2009. Although staffing of the Department of oral health had unfortunately been affected by extended sick leave, competent short-term professional staff had been recruited as replacements and would remain until the forthcoming Health Assembly.

Finally, in regard to the concerns expressed by the member for the United States of America about the shortness of notice of the document, the point had been well taken; others had noted that point but were interested in making progress on the substance of the matter at hand. Member States could, as in the past when documents had been delivered late and the Health Assembly had needed to see a plan of action, be allowed time to reflect on the document and then be given a formal opportunity to send written comments in, say, a month's time. A one-day consultation could be held thereafter to reflect on the comments made during the present session of the Board and those submitted in writing, and a new document would be submitted to the Sixty-first World Health Assembly. It would then, of course, be for the Health Assembly to decide whether to take it any further.

Dr WRIGHT (United States of America) said that his delegation could, in the interests of compromise, accept those recommendations.

The CHAIRMAN said that he took it that the Board wished to follow the procedure and timetable suggested by the Secretariat for further consideration of the draft global strategy on noncommunicable diseases.

**It was so decided.**[1]

**Strategies to reduce the harmful use of alcohol:** Item 4.7 of the Agenda (Documents EB122/10 and EB122/10 Corr.1)

The CHAIRMAN invited the Board to consider the following draft resolution, proposed by Kenya and Rwanda and cosponsored by Algeria, Austria, Belgium, Bulgaria, China, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Hungary, Ireland, Italy, Latvia, Lesotho, Liberia, Libyan Arab Jamahiriya, Lithuania, Luxembourg, Madagascar, Malawi, Mali, Malta, Namibia, Netherlands, New Zealand, Norway, Poland, Portugal, Romania, Sao Tome and Principe, Slovenia, South Africa, Sweden, Switzerland and United Kingdom of Great Britain and Northern Ireland.

> The Executive Board,
> Having considered the report on strategies to reduce the harmful use of alcohol;[2]

[1] Decision EB122(11).

[2] Documents EB122/10 and EB122/10 Corr.1.

RECOMMENDS to the Sixty-first World Health Assembly the adoption of the following resolution:

The Sixty-first World Health Assembly,

Having considered the report on strategies to reduce the harmful use of alcohol and noting that the report contains further guidance on strategies and policy element options to reduce harmful use of alcohol;

Reaffirming resolutions WHA32.40,[1] WHA36.12,[2] WHA42.20[3] and WHA57.16;[4]

Recalling resolution WHA58.26 on public-health problems caused by harmful use of alcohol and decision WHA60(10);

Noting the report by the Secretariat presented to the Sixtieth World Health Assembly on evidence-based strategies and interventions to reduce alcohol-related harm, including the addendum on a global assessment of public health problems caused by harmful use of alcohol;[5]

Noting the second report of the WHO Expert Committee on Problems Related to Alcohol Consumption[6] and acknowledging that effective strategies and interventions that target both the population at large, vulnerable groups, individuals and specific problems are available and should be optimally combined in order to reduce alcohol-related harm;

Mindful that such strategies and interventions must be implemented in a way that takes into account different national, religious and cultural contexts, including national public health problems, needs and priorities, as well as differences in Member States' resources, capacities and capabilities;

Deeply concerned by the extent of public health problems associated with harmful use of alcohol, including injuries and violence, and possible links to certain communicable diseases which add to the disease burden, notably in the developing world;

Mindful about intensifying international cooperation in reducing public-health problems caused by the harmful use of alcohol, and to mobilize the necessary support at global and regional levels;

1. URGES Member States:

(1) to collaborate with the Secretariat in developing a draft global strategy on harmful use of alcohol based on all evidence and best practices, to support and complement public health policies in Member States, with special emphasis on an integrated approach to protect at-risk populations, youth and people hurt by harmful drinking of others;

(2) to develop, in interaction with relevant stakeholders, national monitoring systems on alcohol consumption, its health and social consequences and the policy responses, and report regularly to WHO's regional and global information systems;

(3) to consider strengthening national responses, as appropriate and where necessary, to public health problems caused by harmful use of alcohol, taking advantage of evidence on effectiveness and cost-effectiveness of strategies and interventions to reduce alcohol-related harm generated in different contexts;

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[1] Development of the WHO programme on alcohol-related problems.

[2] Alcohol consumption and alcohol-related problems: development of national policies and programmes.

[3] Prevention and control of drug and alcohol abuse.

[4] Health promotion and healthy lifestyles.

[5] Documents A60/14 and A60/14 Add.1.

[6] WHO Technical Report Series, No. 944, 2007.

2. REQUESTS the Director-General:

(1) to develop a draft global strategy to reduce harmful use of alcohol that is based on all available evidence and existing best practices and that addresses relevant policy options, taking into account different national, religious and cultural contexts, including national public health problems, needs and priorities, as well as differences in Member State resources, capacities and capabilities;

(2) to comprehensively include ongoing and emerging regional, subregional and national processes as vital contributions to a global strategy;

(3) to collaborate with Member States during the entire process, and actively consult with intergovernmental organizations, health professionals, nongovernmental organizations and economic operators on ways they could contribute to reducing harmful use of alcohol;

(5) to present to the Sixty-third World Health Assembly a draft global strategy to reduce harmful use of alcohol, through the Executive Board.

The financial and administrative implications were as follows:

**1. Resolution** Strategies to reduce the harmful use of alcohol: call for a global strategy

**2. Linkage to programme budget**

| Strategic objective: | Organization-wide expected result: |
|---|---|
| 6. To promote health and development, and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex. | 6.4. Evidence-based and ethical policies, strategies, recommendations, standards and guidelines developed, and technical support provided to Member States with a high or increasing burden of disease or death associated with alcohol, drugs and other psychoactive substance use, enabling them to strengthen institutions in order to combat or prevent the public health problems concerned. |

**(Briefly indicate the linkage with expected results, indicators, targets, baseline)**

The resolution is linked to the above-mentioned expected result and its indicators, including number of policies, strategies and recommendations developed in order to provide support to Member States in preventing or reducing public health problems caused by alcohol and other psychoactive substance use. The resolution requests the development of a draft global strategy to reduce harmful use of alcohol, provides guidance on the process of the draft development and sets out the requirements for reporting to the Health Assembly.

**3. Financial implications**

**(a) Total estimated cost for implementation over the life-cycle of the resolution (estimated to the nearest US$ 10 000, including staff and activities)**

The estimated maximum cost to the Secretariat for developing a draft global strategy based on all available evidence and existing best practices and in collaboration with Member States and in active consultation with relevant stakeholders for the period 2008–2010 is US$ 1 940 000

**(b) Estimated cost for the current biennium (estimated to the nearest US$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant)** US$ 1 720 000

**(c) Of the estimated cost noted in (b), what can be subsumed under existing programmed activities for the current biennium?** US$ 430 000.

**(d) For the amount that cannot be subsumed under existing programmed activities, how will the additional costs be financed? (indicate potential sources of funds)**

Additional funding is expected from core contributions and other sources.

**4. Administrative implications**

**(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken, identifying specific regions where relevant)**

Headquarters, with close collaboration with all regional offices.

**(b) Additional staffing requirements (indicate additional required staff – full-time equivalents – by levels of the Organization, identifying specific regions where relevant and noting necessary skills profile)**

One full-time staff member in the professional category for one year at US$ 230 000 per year is required in addition to those staff members needed to fill positions whose cost has already been budgeted in the workplan and the Programme budget 2008–2009.

**(c) Time frame (indicate broad time frames for implementation)**

Two and a half years (2008–2010), after which a draft global strategy to reduce harmful use of alcohol will be submitted to the Health Assembly.

Ms SEBUDANDI (alternate to Dr Ntawukuriryayo, Rwanda), speaking on behalf of the Member States of the African Region, said that the harmful use of alcohol was a major problem needing to be taken up by all States. It was responsible for deaths and serious injuries in road traffic accidents, the spread of HIV infection and tuberculosis, acts of violence including suicides and family violence, and other adverse health effects such as mental illness. The economic and social cost, including for law enforcement, was considerable. Alcohol use in the workplace and illegally produced alcohol were matters of concern. The campaign to prevent and mitigate the effects of the harmful use of alcohol included the State, nongovernmental organizations, the private sector and academics, but respective responsibilities were unclear. States should, in adopting policies, take into account the nation's religious and cultural context, its needs and priorities.

Member States in the African Region had prepared the present draft resolution, which had won the support of many other States elsewhere. The text took into account the recommendations of the Sixtieth World Health Assembly and an informal consultation among Member States, held at WHO headquarters in December 2007. The draft resolution, containing universal guidelines, sought contributions from all, leading to a draft global strategy to reduce the harmful use of alcohol. She called upon the Board to adopt the draft resolution by consensus.

Dr VOLJČ (Slovenia), speaking on behalf of the Member States of the European Union, said that the candidate countries Turkey, Croatia, The former Yugoslav Republic of Macedonia, and the countries of the Stabilisation and Association Process, and potential candidates Albania, Bosnia and Herzegovina, Montenegro and Serbia, the European Free Trade Area countries Iceland and Norway, members of the European Economic Area and Switzerland, together with Armenia, Georgia, the Republic of Moldova and Ukraine, aligned themselves with his statement.

The report showed the devastating health, social and economic consequences of the harmful use of alcohol and stressed the common features of alcohol use in all societies. It summarized potential strategies and policies to reduce the burden of harmful alcohol use, which was associated with a wide range of social and economic problems. The health burden facing low- and middle-income countries was large in absolute terms, and weakened vulnerable health systems.

Alcohol consumption per capita in Europe was the highest in the world, responsible for an estimated 195 000 deaths every year. The total direct cost of alcohol use in the European Union countries in 2003 had been put at €125 000 million, or 1.3% of gross domestic product. The indirect cost was even higher. In 2005, the Regional Committee for Europe had adopted the Framework for alcohol policy. Other regional committees had since followed suit. In 2006, the European Union had adopted a strategy to reduce alcohol-related harm in Europe. Further strategic initiatives were still required and should take into account existing measures to prevent and control other determinants of

noncommunicable diseases. He focused on the link between the harmful use of alcohol and other health and social problems, including HIV/AIDS, tuberculosis, violence, conflict or post-conflict situations, poverty and malnutrition.

Alcohol-related harm was influenced by many different factors, and policies should involve organizations representing patients and consumers, family and young people's organizations, health professionals, teachers and educators, together with the media, advertisers, the alcoholic beverages industry, retailers and caterers.

WHO's continued leadership and support at all levels were vital for sustained progress. He expressed his support for the draft resolution, particularly the request to the Director-General to work closely with Member States in developing the proposed strategy, and the deadline of the Sixty-third World Health Assembly in 2010 for its submission.

Dr SHINOZAKI (Japan) expressed his support for the draft resolution. Each Member State should respond to problems caused by alcohol with policies adapted to its economic, social and cultural context. Information exchange should include the nature of current problems and their causes, the burden of alcohol-related disease and the responses employed.

Japan had introduced policy measures on underage drinking and drink-driving. In a 1996 survey, 43.9% of male students and 34.9% of female students in the 10th grade, aged around 16 years, had reported use of alcohol in the previous month. Thanks to government measures including increased penalties for selling alcoholic beverages to minors, stricter age checks and preventive campaigns, that figure had decreased to 30.5% for males and 30.1% for females by 2004.

The alcohol limit for drivers had been reduced from 0.25 mg/litre to 0.15 mg/litre. Causing death or injury by reckless driving had been added to the Penal Code in 2001, and other penalties for reckless driving had been increased. Deaths in road traffic accidents had fallen from 1161 in 2000 to 395 in 2007.

Dr AL-HASNAWI (Iraq), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that the original proposal to adopt a framework convention to combat the harmful use of alcohol appeared to have given way to one for a global strategy. Such a strategy would increase the momentum of alcohol-control activities and promote compliance, although it would have to be adapted to the needs of each region.

The global assessment of public health problems caused by harmful use of alcohol, submitted to the Sixtieth World Health Assembly in 2007,[1] indicated much lower per capita alcohol consumption in the Eastern Mediterranean Region than elsewhere, mainly attributable to religious beliefs. However, alcohol consumption was spread unevenly across population groups and strategies to combat the harmful use of alcohol should emphasize young people and other vulnerable groups.

The Regional Committee for the Eastern Mediterranean had adopted a resolution on the public health problems of alcohol consumption in the Region at its fifty-third session in 2006.[2] It had agreed that promotion of healthier lifestyles was feasible. However, pricing measures, curbs on sales of alcohol to minors and measures to combat drink-driving could not be applied throughout the Region. The new global strategy should take regional differences into account and support the implementation of regional resolutions.

The global strategy should focus on alcohol, but measures to combat other mind-altering substances that endangered public health were also important. The health systems of most Eastern Mediterranean countries would require support in developing capacity to manage alcohol dependence and related health problems. In October 2007, the sixth Eastern Mediterranean Regional Advisory Panel on Drug Abuse had endorsed the application of the Alcohol, Smoking and Substance

[1] Document A60/14 Add.1.

[2] Resolution EM/RC53/R.5.

Involvement Screening Test, which would help to screen and manage alcohol problems in young people.

He supported the measures outlined in paragraph 1 of the draft resolution. However, many of the strategies proposed in the Secretariat's report would not be applicable to his Region, particularly strategies 13–17. The document should be revised before submission to the Sixty-first World Health Assembly, with the addition of a footnote before paragraph 13, indicating that the strategies described in paragraphs 13–17 might be adopted in countries where alcoholic beverage production, distribution and consumption were not legally banned.

Mr TINAJERO (alternate to Dr Hernández Ávila, Mexico), speaking on behalf of the Member States of the Region of the Americas, stressed that the harmful use of alcohol could cause serious health problems and lead to premature death. Unregulated alcoholic beverages, which were not subject to any quality control, were of particular concern. The proposed global strategy gave Member States flexibility to take account of differing national, religious and cultural contexts.

He suggested the following amendments: at the end of the seventh preambular paragraph, the words "notably in the developing world" should be replaced by "in both developing and developed countries"; since the harmful use of alcohol was a serious problem for both developed and developing countries. Existing paragraph 2(3) should be amended to read "to collaborate and consult with Member States, as well as with intergovernmental organizations …"; and a new paragraph 2(2) should be introduced, reading: "the draft global strategy will be composed of a set of proposed measures recommended for States to implement at the national level, taking into account the national circumstances of each country", with existing paragraphs 2(3) and 2(4) being renumbered accordingly.

Dr BLOOMFIELD (alternate to Mr McKernan, New Zealand) said that his country had actively supported regional work to reduce the harmful use of alcohol and welcomed similar global action. The diverse views of Member States on the issue had been well canvassed at the Sixtieth World Health Assembly, and a global strategy to reduce the harmful use of alcohol should build on regional work already undertaken. He supported the draft resolution, which provided clear guidance to the Secretariat and a realistic time frame.

Mr HOHMAN (alternate to Dr Wright, United States of America) said that prevention was the key to tackling problems related to the harmful use of any substance, alcohol included. Research was also essential in educating young people on the benefits of delaying their first use of alcohol and in raising awareness among all age groups about the serious impact of alcohol abuse. Public health strategies and policies should be practicable, measurable, sustainable and evidence-based.

Traditional and home-produced alcoholic beverages were widely consumed and a global strategy must include ways to mitigate the health risks they posed. He took the term "economic operators", used in paragraph 2(3) of the draft resolution, to mean the alcoholic beverage industry, retailers, restaurants and other private-sector stakeholders, all of whom must be involved in the development of a global strategy. He supported the draft resolution.

Dr JAKSONS (Latvia) expressed support for the draft resolution and WHO's global approach, which recognized the importance of different national policies. He was pleased with the emphasis on reducing the harmful use of alcohol, rather than simply limiting the consequences of such use. Recalling the unmanageable number of amendments proposed during the discussion of an earlier draft resolution by the Sixtieth World Health Assembly, he encouraged members to leave the draft resolution in its current form as far as possible.

Professor AYDIN (Turkey), supporting the draft resolution, said that all children and adolescents had the right to grow up in an environment free of the unfavourable effects of alcohol consumption. He emphasized education in order to reduce the health, social and economic burden of alcohol consumption among young people and of the combined use of drugs and alcohol.

He highlighted strengthening national surveillance systems and monitoring alcohol consumption and resulting social and health problems. National strategies and support from manufacturers, distributors and marketers would be crucial to reducing the harmful use of alcohol. Unfortunately, there seemed to be no clear will on the part of national authorities to combat harmful alcohol use or reduce consumption. Decisive action was needed.

Dr REN Minghui (alternate to Mr Li Baodong, China) said that the report provided an objective analysis. China supported law enforcement to reduce drink-driving, control the marketing of alcoholic beverages to children and young people, and reduce illegally produced alcohol. However, policies aimed at reducing alcohol consumption must take account of cultural factors.

China had formulated regulations on alcohol control, including standardized alcohol marketing and distribution. WHO should promote research into the disease burden and health impact caused by harmful alcohol use in order to provide more evidence for policy making and strategy development. The Secretariat should provide more support to developing countries in raising public awareness, training health professionals, and monitoring trends, including conducting epidemiological surveys. He supported the draft resolution.

Dr DAHL-REGIS (Bahamas), speaking on behalf of the member countries of the Caribbean Community, supported the draft resolution, which took account of differences in Member States' resources and capabilities. A global strategy on the harmful use of alcohol should recognize the need for country-specific approaches.

Dr ABEYKOON (alternate to Mr de Silva, Sri Lanka), speaking on behalf of the Member States of the South-East Asia Region, highlighted the problems posed by alcohol abuse in South-East Asia, particularly in rural areas where alcohol consumption, previously low, was on the rise, with adverse effects on the lives of individuals and families. Government awareness was increasing and each country had adopted its own control policies.

A gradual shift in national policies was occurring. Alcohol had previously been considered a source of revenue, a view actively promoted by ministries of finance, trade and commerce, but the focus was now moving to prevention and control of the harmful use of alcohol in promotion of public health and socioeconomic development. In Thailand, the proceeds from a tax levied on cigarettes and alcohol were channelled into health promotion, and Sri Lanka had established a national alcohol and tobacco authority.

The Regional Office for South-East Asia played an active advocacy role at the highest level of government. Prevention strategies had been proposed at high-level meetings in the Region and should be taken into account in preparing a future global strategy. The Secretariat should continue to provide technical support to enable the countries of the Region to assess the harm caused by alcohol use and launch evidence-based interventions, targeting women and adolescents in particular. He supported the draft resolution.

Ms DÍAZ RODRÍGUEZ (Cuba)[1] said that reducing the harmful use of alcohol was not always the top priority for developing countries, but was nevertheless important. She expressed support for the draft resolution and had submitted comments during the drafting process. Cuba had welcomed the outcome of the informal meeting held on 3 December 2007, leading towards a draft global strategy, which would not be a binding instrument and which would take account of the priorities, problems and needs of individual countries. In continuing the process in the Health Assembly, the Board's recommendation should enjoy full support and should reflect the understanding reached at the December 2007 meeting. She supported the amendments to the draft resolution proposed by Mexico.

[1] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

Dr SHEVYREVA (Russian Federation)[1] said that, given the scale of the problem of alcohol consumption in the world and its direct link to ensuring the health of future generations, alcohol-related public health problems should be tackled as soon as possible through a coordinated global strategy. That would assist the Russian Federation in formulating its own national strategy and reinforce its international contribution.

Mr DEL PICÓ (Chile)[1] endorsed the views expressed in the report. Harmful use of alcohol could cause permanent health problems, premature mortality and increased morbidity, and serious consequences for individuals, families and society. The proposed format for a global strategy gave Member States sufficient flexibility to adopt measures appropriate to their institutional and cultural characteristics. The strategy should be prudent and well-balanced, so as to avoid undesired counterproductive effects. Policies should take account of the social, economic, political and cultural factors involved.

Ms SEBUDANDI (alternate to Dr Ntawukuriryayo, Rwanda) was grateful to Board members for their support for the draft resolution. In the interests of consensus, she could accept the amendments put forward by Mexico.

Dr VOLJČ (Slovenia), speaking on behalf of the European Union, said that the draft resolution showed flexibility and reflected the different views and requests of members. The European Union welcomed the amendments put forward by Mexico.

Dr BLOOMFIELD (alternate to Mr McKernan, New Zealand), recalling his experience as chairman the drafting group on the topic at the Sixtieth World Health Assembly, endorsed the comments of the member for Latvia. The amendments put forward by the member for Mexico appeared to be acceptable, but it might be prudent to avoid proposing further amendments as that might open up lengthy discussion on the draft resolution, on which broad agreement had already been reached.

Mr AITKEN (Assistant Director-General ad interim) confirmed that the comments by the member for Iraq would duly be taken into account in preparing the report for the Sixty-first World Health Assembly. In response to the comments by the member for the United States of America, he said that consultations with the alcohol industry were next due to be held on 20 and 21 February 2008 and would continue as appropriate. He thanked Rwanda and the other countries involved for their work in preparing the draft resolution.

Dr KEAN (Executive Director, Office of the Director-General) read out the amendments proposed by Mexico. In the seventh preambular paragraph, the words: “notably in the developing world” would be replaced with “in both developing and developed countries”. A new paragraph 2(2) would read: “the draft global strategy will be composed of a set of proposed measures recommended for States to implement at the national level, taking into account the national circumstances of each country”. Current paragraph 2(2) would then become 2(3). Current paragraph 2(3) would become 2(4) and would be amended to read: “to collaborate and consult with Member States as well as with international organizations …”. New paragraph 2(2) also took into account the wording requested by the member for Iraq.

**The resolution, as amended, was adopted.[2]**

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[1] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

[2] Resolution EB122.R2.

**Public health, innovation and intellectual property: draft global strategy and plan of action:** Item 4.9 of the Agenda (Document EB122/12)

Mr HOHMAN (alternate to Dr Wright, United States of America) enquired whether the dates of the next meeting of the subgroup of the Intergovernmental Working Group on Public Health, Innovation and Intellectual Property had been confirmed.

Dr AL-HASNAWI (Iraq), speaking on behalf of the Member States of the Eastern Mediterranean Region, expressed appreciation for the work accomplished by the Intergovernmental Working Group in developing a global strategy and plan of action. Member States of the Region had met in August 2007, and submitted an extensive and substantive report to the Secretariat. At the second session of the Intergovernmental Working Group, 33 delegates from 19 countries had participated. The Working Group aimed to produce a strategy and action plan in time for the Sixty-first World Health Assembly.

Recognizable progress had been made, but consensus had not been reached on the basic principle that the right of everyone to enjoy the highest attainable standard of physical and mental health should be recognized as a fundamental human right in instruments of international human rights. Another concern was that the Working Group should not restrict itself to a list of diseases, but maintain an open approach that allowed for future needs.

Ms TJIPURA (alternate to Dr Forster, Namibia), speaking on behalf of the Member States of the African Region, recalled that the draft strategy and plan of action had been discussed at the fifty-seventh session of the Regional Committee for Africa. The African countries had also participated in the second session of the Intergovernmental Working Group. They were concerned at the slow progress but remained hopeful that the draft strategy and plan of action would be finalized before the next Health Assembly. All parties should focus on the original reason for the Working Group, namely, the millions of poor people around the globe who suffered because they could not afford health care.

Dr REN Minghui (alternate to Mr Li Baodong, China) welcomed in principle the draft action plan produced by the Intergovernmental Working Group. The subject of public health, innovation and intellectual property was wide-ranging, significant and closely connected to public health security, scientific innovation and trade. It raised questions about how to balance public health interests against commercial interests. His Government attached great importance to the issue and supported respect for innovation and the protection of intellectual property rights, while also appreciating public health needs. The Working Group should ensure that developing countries had access to appropriate medicines and technologies. Further work was needed to support innovation and the development of medicines, as well as to establish a mechanism to separate research and development from the pricing of medicines so that developing countries would have equal access to health products and technologies. Referring to the draft plan of action,[1] he suggested that the responsibilities of Member States, the measures to be taken, and the specific performance indicators should be identified under the specific actions and progress indicators. The parties responsible for establishing monitoring and reporting systems should also be identified. Traditional medicines should be included among the priorities for research and development.

Mgr TOMASI (Holy See), speaking at the invitation of the CHAIRMAN, said that the Holy See had been pleased to participate in both sessions of the Intergovernmental Working Group with the aim of finding a more equitable approach to public health, innovation and intellectual property. With regard to competition and pricing of medicines consistent with public health, he emphasized removal

[1] Document A/PHI/IGWG/2/2.

of tariffs and taxes on health-care products and monitoring their supply and distribution chain. Health workers of the Catholic Church and of other civil society organizations often reported difficulties in gaining access to medications, diagnostic tools and other life-saving resources on which high tariffs were charged, or which were not released by customs authorities until long after their expiry dates. Religious organizations, as participants in strengthening health-care delivery, should be included among the stakeholders identified in the draft plan of action.

The Working Group had not discussed the severe lack of both medicines formulated specifically for children and paediatric diagnostic tools. More targeted planning should be undertaken to address the discrepancy in access to treatment for adults and for children living in low- and middle-income countries.

Mr OLDHAM (Chairman, Intergovernmental Working Group on Public Health, Innovation and Intellectual Property), responding to the comment by the member for the United States of America, said that the proposed dates for the subgroup meeting were 17–19 March 2008. He thanked all members for their comments. The secretariat of the Working Group would work hard to ensure that the draft strategy and plan were completed when the second session resumed.

**The Board noted the report.**

**The meeting rose at 17:35.**