

## **EIGHTH MEETING**

**Thursday, 21 January 2009, at 14:40**

**Chairman:** Dr S. ZARAMBA (Uganda)

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

**Food safety:** Item 4.8 of the Agenda (Document EB126/11)

The CHAIRMAN drew attention to a draft resolution on advancing food safety initiatives proposed by Canada, which read:

The Executive Board,  
Having considered the report on food safety,<sup>1</sup>

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

The Sixty-third World Health Assembly,

Recalling resolution WHA53.15 on food safety, which requested the Director-General to put in place a global strategy for the surveillance of foodborne diseases and for the efficient gathering and exchange of information in and between countries;

Recalling resolution WHA55.16 on the global public health response to natural occurrence, accidental release or deliberate use of biological and chemical agents or radionuclear material that affect health, which noted that such agents can be disseminated through food- and water-supply chains;

Noting the endorsement by the Executive Board in 2002 of WHO's global strategy for food safety,<sup>2</sup> which had as its aim the reduction of the health and social burden of foodborne disease;

Noting also, that other food safety-related activities identified in resolutions WHA53.15 and WHA55.16 have been undertaken, including: the revision of the International Health Regulations in 2005; the establishment of the International Food Safety Authorities Network in 2005; the establishment of WHO's Foodborne Disease Burden Epidemiology Reference Group in 2006; and increased participation, particularly by developing countries, in the elaboration of international food safety standards by the Codex Alimentarius Commission;

Recognizing that the Codex Alimentarius Commission presents a unique opportunity for all countries to join the international community in formulating and harmonizing food standards and ensuring their global implementation;

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<sup>1</sup> Document EB126/11.

<sup>2</sup> Document EB109/2002/REC/2, summary record of the fourth meeting.

Further recognizing the important roles of WHO and FAO in support of the Codex Alimentarius Commission as the international reference point for developments associated with food standards;

Confirming that foodborne disease continues to represent a serious threat to the health of millions of people in the world, particularly those in developing countries with poor nutritional status;

Mindful of the inextricable links between food safety, nutrition and food security and acknowledging the instrumental role of food safety in eradicating hunger and malnutrition, in particularly in low-income and food-deficit countries;

Aware of increasing evidence that many communicable diseases, including emerging zoonotic diseases, are transmitted through food, and that exposure to chemicals and pathogens in the food supply is associated with acute and chronic diseases;

Acknowledging that climate change will increase rates of some foodborne diseases, including those of zoonotic origin, owing to the more rapid growth of microorganisms in food and water with higher temperatures, resulting in the emergence of toxins in new geographical areas and in possible higher levels of toxins or pathogens in food;

Recognizing that the global trade in food is increasing every year, contributing to the risk of spread of pathogens and contaminants across national borders, thereby creating new challenges for food authorities and necessitating more efficient global sharing of food safety information;

Acknowledging the continuing need for closer collaboration between the health sector and the agriculture sector, and increased action on food safety at the international and national levels, across the full food production chain, in order to reduce significantly the incidence of foodborne disease;

Noting the continuing need for updated and comprehensive risk assessments and scientific advice to support measures and interventions to improve the safety and nutritional quality of food;

Recognizing the importance of international agreement on global management of food safety, the application of scientific principles in finding solutions, the efficient exchange of monitoring and surveillance data, and practical experience,

1. URGES Member States:<sup>1</sup>

- (1) to continue to establish and maintain the activities and measures elaborated in resolutions WHA53.15 on food safety and WHA55.16 on the global public health response to natural occurrence, accidental release or deliberate use of biological and chemical agents or radionuclear material that affect health;
- (2) to further develop and implement the core capacities as defined in Annex 1 of the International Health Regulations (2005), specifically for food-safety events, including the development of systems for: surveillance for foodborne disease and food contamination; risk assessment, risk management and risk communication; food safety emergency response; and product tracing and recall;
- (3) to participate fully as a member of International Food Safety Authorities Network in its activities, including supporting the timely transmission of data, information and knowledge about food-safety emergencies through the network;

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<sup>1</sup> And, where applicable, regional economic integration organizations.

- (4) to enhance the integration of food-safety considerations into food aid, food security and nutrition interventions in order to reduce the occurrence of foodborne diseases and improve the health outcomes of vulnerable populations;
- (5) to improve the evidence base for food safety through systematic efforts on disease burden estimation and surveillance, and through comprehensive risk and risk-benefit assessment, and to provide support for international activities in these areas, in particular, WHO's initiative to estimate the global burden of foodborne diseases from all major causes (microbiological, parasitic and chemical);
- (6) to contribute to the timely conduct of international risk assessments through the provision of relevant data and expertise in order to tackle more efficiently and consistently foodborne diseases and food-safety issues that threaten global public health security;
- (7) to continue to develop and maintain sustainable preventive measures, including food safety-education programmes, aimed at reducing the burden of foodborne diseases through a systems approach encompassing the complete food-production chain from farm to consumption;
- (8) to promote dialogue and collaboration among human health, veterinary and food-related disciplines, focused on an integrated effort of foodborne risk reduction along the whole food-production chain, including consideration of zoonotic risks;
- (9) to participate actively in the Codex Alimentarius Commission's standard-setting process and to adopt Codex standards whenever appropriate;

2. REQUESTS the Director-General:

- (1) to develop the International Food Safety Authorities Network further through the implementation of a strategic plan in collaboration with partners and Member States; to encourage communication and technical exchange of risk assessments and best practices among members of the Network; and to facilitate Member States' involvement in the Network's operation and development;
- (2) to strengthen the emergency function of the International Food Safety Authorities Network as a critical component of WHO's preventive and emergency operations relative to food safety, and linkages to other relevant international organizations and networks in this area;
- (3) to continue to provide global leadership in providing technical assistance and tools that meet the needs of Member States and the Secretariat for scientific estimations on foodborne risks and foodborne disease burden from all causes;
- (4) to promote the inclusion of food safety into the international debate on food crises and hunger emergencies, and provide technical support to Member States and international agencies for considering food safety, nutrition and food security issues in a comprehensive, integrated manner;
- (5) to monitor regularly and report to Member States on the global burden of foodborne and zoonotic diseases from the country, regional and international perspectives;
- (6) to promote research, including investigation of the association of foodborne hazards with acute and chronic diseases, in order to support evidence-based strategies for the control and prevention of foodborne and zoonotic diseases;
- (7) to provide support to Member States in building relevant capacity to improve cross-sectoral collaboration and action at international and national levels along the whole food-production chain, including the assessment, management and communication of foodborne and zoonotic risks;
- (8) to develop guidance on the public health aspects arising from zoonotic diseases that originate at the human-animal interface, in particular prevention, detection and response;

- (9) to provide adequate and sustainable support for the joint expert bodies of FAO and WHO, the Codex Alimentarius Commission and the International Food Safety Authorities Network in order to advance the international development, provision, utilization, and sharing of scientific risk assessments and advice; to support the development of international food standards that protect the health and nutritional well-being of consumers; and address and communicate more effectively on food safety issues at the national and international levels;
- (10) to report to the Sixty-fifth World Health Assembly, through the Executive Board, on progress in implementing this resolution.

The financial and administrative implications for the Secretariat were:

<b>1. Resolution</b> Advancing food safety initiatives	
<b>2. Linkage to programme budget</b>	
Strategic objective:	Organization-wide expected result:
1. To reduce the health, social and economic burden of communicable diseases.	1.3. Effective coordination and support provided to Member States in order to provide access for all populations to interventions for the prevention, control, elimination and eradication of neglected tropical diseases, including zoonotic diseases.
5. To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact.	5.5. Support provided to Member States for strengthening national preparedness and for establishing alert and response mechanisms for food-safety and environmental health emergencies.
9. To improve nutrition, food safety and food security, throughout the life-course, and in support of public health and sustainable development.	9.1. Partnerships and alliances formed, leadership built and coordination and networking developed with all stakeholders at country, regional and global levels, in order to promote advocacy and communication, stimulate intersectoral actions, increase investment in nutrition, food-safety and food-security interventions, and develop and support a research agenda.
	9.2. Norms, including references, requirements, research priorities, guidelines, training manuals and standards, produced and disseminated to Member States in order to increase their capacity to assess and respond to all forms of malnutrition, and zoonotic and non-zoonotic foodborne diseases, and to promote healthy dietary practices.
	9.5. Systems for surveillance, prevention and control of zoonotic and non-zoonotic foodborne diseases strengthened; food-hazard monitoring and evaluation programmes established and integrated into existing national surveillance systems, and results disseminated to all key players.
	9.6. Capacity built and support provided to Member States, including their participation in international standard-setting in order to increase their ability to assess risk in the areas of zoonotic and non-zoonotic foodborne diseases and food safety, and to develop and implement national food-control systems, with links to international emergency systems.

<p align="center"><b>(Briefly indicate the linkage with expected results, indicators, targets, baseline)</b></p> <p>The resolution will provide an updated framework for WHO's normative work on food safety within the existing expected results, with an additional emphasis on strengthening scientific advice, the estimation of the health burden imposed by foodborne disease, support for the International Food Safety Authorities Network (INFOSAN) and cross-sectoral prevention of zoonotic diseases.</p>
<p><b>3. Budgetary implications</b></p> <p><b>(a) Total estimated cost for implementation over the life-cycle of the Secretariat's activities requested in the resolution (estimated to the nearest US\$ 10 000, including staff and activities):</b></p> <p>US\$ 29.1 million over the coming six-year period (staff: US\$ 16.5 million, activities: US\$ 12.6 million).</p> <p><b>(b) Estimated cost for the biennium 2010–2011 (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):</b></p> <p>US\$ 9.7 million at headquarters.</p> <p><b>(c) Is the estimated cost noted in (b) included within the existing approved Programme budget for the biennium 2010–2011?</b></p> <p>US\$ 8 million are included in the Programme budget.</p>
<p><b>4. Financial implications</b></p> <p><b>How will the estimated cost noted in 3(b) be financed (indicate potential sources of funds)?</b></p> <p>Through the extrabudgetary funds of interested Member States and relevant nongovernmental organizations.</p>
<p><b>5. Administrative implications</b></p> <p><b>(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken, identifying specific regions where relevant)</b></p> <p>Implementation will be organized at headquarters, in coordination with all six regional offices and selected countries of each region.</p> <p><b>(b) Can the resolution be implemented by existing staff? If not, please specify in (c) below</b></p> <p>No.</p> <p><b>(c) 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)</b></p> <p>Two staff members in the professional category at headquarters.</p> <p><b>(d) Time frames (indicate broad time frames for implementation of activities)</b></p> <p>Food safety initiatives are continuing activities. The next progress report will be made to the Sixty-fifth World Health Assembly; thus the major new initiatives should be evaluated by the end of the period 2010–2011.</p>

Dr DODDS (Canada), introducing the draft resolution, said that the following Member States wished to cosponsor it: Israel, Kazakhstan, Oman, Paraguay, Republic of Korea and South Africa. She recalled WHO's global leadership over the past decade in the promotion of food safety as an essential part of public health policy, but recent developments such as the increasingly global reach of foodborne diseases, the rising incidence of chronic diseases, emerging zoonoses and global warming meant that the time had come for WHO to consider a new resolution to advance food safety initiatives. The draft resolution encouraged Member States to engage fully in international activities and forums,

including the International Food Safety Authorities Network, to assess, manage and communicate risks globally. It also highlighted the link between human health, animal health and the environment, given their implications for food safety.

She proposed amendments, resulting from consultations with interested Member States, which strengthened the content and aligned the wording with previously agreed international texts. The phrase “and in particular the participation of developing countries in this regard should be encouraged” should be added at the end of the fifth preambular paragraph. The first line of the tenth preambular paragraph should be amended to read: “Acknowledging that climate change could be a factor in the increasing rates of some foodborne diseases”. The phrase “taking into account that protection of food safety cannot lead to discrimination or a disguised restriction on international trade” should be added at the end of the eleventh preambular paragraph. The first part of the twelfth preambular paragraph should be amended to read: “Acknowledging the continuing need for closer collaboration among the health sector and other sectors”; and the words “internationally agreed standards and agreements for” should be added after “updated and comprehensive” in the thirteenth preambular paragraph. In subparagraph 1(2), the words “as applicable and those required for participation in INFOSAN” should be added after “International Health Regulations (2005)” and “traceability” should be inserted after “risk assessment”. The word “regional” should be inserted after “international” in subparagraph 2(7), and a new subparagraph 2(10) should be added, reading: “to establish with the International Food Safety Authorities Network an international initiative for the collaboration of laboratory partners in support of surveillance for foodborne disease, identification of food contamination and emergency response, including outbreak investigation and linking product to illness to support recall; to also include the establishment of mechanisms for data sharing”. The existing subparagraph 2(10) would be renumbered accordingly.

She suggested that the Secretariat organize a technical briefing on food safety, concerning in particular diseases at the human–animal interface, during the forthcoming Health Assembly in May 2010.

Professor HAQUE (Bangladesh) said that his Government’s Ministry of Health and the Secretariat were implementing a collaborative programme on food safety that sought to strengthen laboratory training for human resources; provide food safety information for community leaders, food handlers and others; and promote quality control in the food industry. In addition, FAO, with the collaboration of WHO, was implementing a three-year project on improving food safety and quality control in Bangladesh, which was aimed at improving consumer health and reducing foodborne diseases.

Speaking on behalf of the Member States of the South-East Asia Region, he welcomed the draft resolution but proposed several amendments. The words “and strengthen laboratory capacity” should be added at the end of subparagraph 1(2), and “in a transparent manner” should be added at the end of subparagraph 1(3). The last part of subparagraph 1(4), should be amended to read: “improve the health outcomes of populations, in particular the vulnerable groups”. At the beginning of subparagraph 1(5), the words “establish or” should be inserted before “improve”. For the purposes of clarity, the words “within and among Member States” should be inserted after “related disciplines” in subparagraph 1(8). In subparagraph 2(1), “implementation of a strategic plan” should be replaced by “implementation of the WHO Global Strategy for Food Safety”, and the words “and to encourage additional membership into the International Food Safety Authorities Network” should be added at the end of the paragraph.

Dr KÖKÉNY (Hungary), speaking on behalf of the European Union, 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, as well as Ukraine, the Republic of Moldova and Armenia, aligned themselves with his statement. The European Union continued to support the global food safety initiatives promoted by WHO. Concerted efforts by all WHO’s Member States were necessary to overcome the global threats from foodborne diseases through targeted actions that covered the entire food chain, including the animal feed sector. The use of safe feed for animals destined for food production was a key element in ensuring the highest levels of food safety. Animal feed production

should therefore be included within the remit of the International Food Safety Authorities Network, which should work in cooperation with the European Union's Rapid Alert System for Food and Feed, so that European Union Member States did not have the burden of reporting to both. The European Union was willing to work with WHO on that matter.

Sustainable funding for the joint FAO/WHO expert bodies and the Codex Alimentarius Commission must be ensured. WHO currently provided 14.5% of the budget for the Codex Alimentarius Commission; the remainder came from FAO. That funding imbalance should be rectified, particularly as many Codex activities had a direct bearing on WHO's priorities. Such action would reflect the importance that WHO attached to food safety and ensure that the setting of food safety standards did not shift from the Codex to non-transparent private bodies.

Dr SEDYANINGSIH (Indonesia) commented that climate change and emerging zoonoses had increased the global burden of foodborne diseases. The spread of pathogens and contaminants across borders, for example through trade in food, could pose risks to public health. In developing countries, food safety issues were highly complex: steps should be taken to prevent food dumping, in particular in disaster areas, and to recognize other sensitive issues associated with food, such as halal food.

An unhealthy environment, poor animal-breeding conditions, and the use of unsafe chemicals on crops could also put safety at risk. A sound policy framework providing for appropriate monitoring and evaluation using existing tools should be implemented.

As an addition to the draft resolution, which she supported, she proposed that the words "the safety and quality of traditional foods, and" be inserted after "to promote research, including" in subparagraph 2(6).

Dr OULD HORMA (Mauritania), speaking on behalf of the Member States of the African Region, said that food safety was a major concern for all the countries of the Region, where up to five episodes of foodborne and waterborne diarrhoeal disease were recorded per child every year. In Africa, numerous epidemics of foodborne disease (including typhoid and botulism) had been recorded, cholera remained endemic in many countries, and recently there had been an unprecedented number of emergency hospital admissions due to the ingestion of contaminants through food, including toxic waste, pesticides and bromide. Climate change was likely to increase the incidence of foodborne disease owing to the faster growth of microorganisms at higher temperatures.

Training in laboratory research had been provided, through the Global Foodborne Infections Network, for more than 50 epidemiologists and microbiologists from 25 countries, organized in Cameroon, Kenya and Madagascar, and applied to food safety, foodborne diseases and epidemics caused by contaminated water and food.

With regard to the chemical contamination of foodstuffs, Cameroon and Ghana had received support to organize training workshops in October 2006. Melamine-contaminated milk had been detected in Burkina Faso, Burundi, Ghana, Seychelles and South Africa. National authorities had been informed of detection methods by the International Food Safety Authorities Network.

Guidelines and manuals for evaluations of quality control systems and monitoring of foodborne diseases in the African Region had been elaborated at the regional level.

Workshops on strengthening food safety in food businesses using the Hazard Analysis and Critical Control Point system had been held in several countries and further workshops on that system had also received funding. A regional training seminar on the Codex Alimentarius, attended by 40 delegates from seven countries, had been organized in Cameroon by WHO, FAO and other partners. A similar workshop had been organized during the 17th session of the Codex Coordinating Committee for Africa. National Codex Committees had been strengthened in several countries; and 21 countries had evaluated their food safety programmes and drawn up policies, legislation and plans of action. Twenty countries had also strengthened their information, education and communication systems on the basis of WHO's Five Keys to Safer Food.

Food safety programmes in African countries remained underfunded and in most countries responsibilities were dispersed among different ministries and institutions.

Dr ABDESSELEM (Tunisia), speaking on behalf of the Member States of the Eastern Mediterranean Region, drew attention to the devastating health and economic consequences of outbreaks of foodborne diseases. A strategy should be developed to reduce the incidence of foodborne diseases, including emerging zoonoses; to contribute to reducing morbidity levels; and to promote policies on food safety. All Member States should be encouraged to participate in the International Food Safety Authorities Network. Support for capacity building should be provided for developing countries to collect and transmit data on the emergence of foodborne diseases. In addition, research should continue on food production and safety, and the developing countries in particular should be encouraged to strengthen their legislation on food safety.

Mrs CHISTYAKOVA (adviser to Dr Starodubov, Russian Federation) said that her country prioritized food safety and had legislation that was consistent, as far as possible, with international guidelines and requirements, including those of FAO and WHO. Research on contaminants and pollutants in food and food products had led recently to new indicators for permissible concentrations of several chemical and biological contaminants. She concurred with the need to improve legislation concerning risk assessment and food standards.

Welcoming WHO's new strategic directions concerning zoonoses, which focused on human health aspects and strengthened epidemiological surveillance, the Russian Federation was ready to participate in international work in that area. Increasing international trade in food products required international exchange of information on the safety of food products. The experience gained in the exchange of information concerning the pandemic (H1N1) 2009 could be applied to the food safety issue.

Dr GIMÉNEZ (Paraguay), noting the regional impact of foodborne diseases, including zoonoses and poisoning due to agricultural chemicals, and their public health priority, welcomed the focus on strengthening zoonosis surveillance; forecasting and alert and response mechanisms; and providing tools for the assessment, management and communication of zoonotic risks. Expressing support for the draft resolution, he emphasized the implementation of sustainable integrated surveillance and alert systems for human and animal health and food quality, and providing support to Member States in building capacity along the whole chain of food production, particularly in the communication of foodborne and zoonotic risks. Member States were urged to participate actively in the Codex process of standard-setting, and the Director-General was requested to provide sustained support in that regard. Those actions could determine the future exposure of populations to biological and chemical pollutants in food. Effective policies for the protection of consumer health could only be established on the basis of scientific risk assessment.

Dr MOHAMED (Oman) said that reference to the Hazard Analysis and Critical Control Point system would have strengthened both the report and the draft resolution. He proposed that such a reference be included in paragraph 13 of the report and in the draft resolution.

Dr LEE Young-chan (alternate to Professor Sohn Myongsei, Republic of Korea) welcomed the Secretariat's continued provision of scientific advice to Member States, in particular concerning food safety assessment and decision-making from farm to table. The decrease in financing for food safety cause him concern; he encouraged the Secretariat to continue working with Member States and organizations such as FAO to reverse the trend, and, importantly, to develop scientific risk assessments and food standards. He urged adoption of the draft resolution, which would provide WHO with a key role in guaranteeing global food safety.

Dr ALBRAIKY (alternate to Dr Al Darmaki, United Arab Emirates) emphasized the link between food safety and the need for adequate scientific assessment of the quality of locally-produced and imported foods in laboratories.



Dr MUÑOZ (Chile) supported the draft resolution. Food safety was most important for public and environmental health, and for the food trade, which generated substantial revenue for developing countries and for agricultural workers. The draft resolution provided for the protection of food safety without raising arbitrary barriers to exports. He welcomed in particular the call for funding of the Codex Alimentarius Commission, an initiative that had led to positive changes to his country's food regulations and thus to increased exports of safe and healthy food products. Chile would continue to support WHO's food safety strategy.

Ms TOELUPE (Samoa) said that her country was working to improve food safety and strengthen the link between food safety and Millennium Development Goal 1 (Eradicate extreme poverty and hunger) and Goal 4 (Reduce child mortality). A food hygiene standard had been drafted, and national food safety legislation was being updated. The Codex Alimentarius Commission was an ideal forum for all States to harmonize food standards and ensure their international implementation; Samoa was preparing its first Codex standard. Small island States would need to balance food safety standards with the survival of food industries, while complying with WTO requirements. She requested the Director-General to strengthen the International Food Safety Authorities Network. Pacific island nations would require significant technical assistance to meet the standards outlined in the report. She supported the draft resolution, as amended.

Dr OSPANOV (Kazakhstan)<sup>1</sup> said that in the past, in his country, poor food quality had been responsible for disease, low birth rates, increased mortality and reduced life expectancy. Specific measures taken had educated the population about healthy eating and had improved access to quality food products and overall food safety. Vitamins and minerals were added to flour to combat iron-deficiency anaemia, and iodized salt was available to all the population. He supported WHO's food safety strategy as a priority. He welcomed the draft resolution and had asked for Kazakhstan to be added to the list of sponsors.

Dr REN Minghui (China)<sup>1</sup> said that the report should have reproduced points contained in the 2007 Beijing Declaration on Food Safety, including those relating to food safety awareness, regulatory regimes, policies, education and international communication. Food safety was a complex issue: food producers should bear the primary responsibility but intergovernmental coordination was also important. His Government had legislated in June 2009 to reinforce the risk monitoring of food safety along the whole food-production chain; that would be extended progressively to cover rural food pollutants and foodborne diseases. He supported the draft resolution and said that China would continue to work with the International Food Safety Authorities Network, sharing information and data with the Secretariat and other Member States. China would require further technical support from the Secretariat on risk evaluation management.

Mr ADAM (Israel)<sup>1</sup> recalled that foodborne and waterborne diarrhoeal diseases were major causes of childhood deaths, along with other preventable diseases such as pneumonia. He supported WHO's food safety strategy, and commended the organization by the Secretariat of a seminar on bridging the research policy gap in food safety in October 2009. Israel's Centre for International Cooperation was among research centres that were sharing knowledge and technology to prevent foodborne diseases, and to improve water management and treatment, in developing countries. Israel was a sponsor of the draft resolution.

Dr AHMAD (Food and Agriculture Organization) expressed satisfaction with the synergies achieved in the collaboration between WHO and his Organization. FAO's new emergency prevention system for food safety complemented the International Food Safety Authorities Network, and together

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<sup>1</sup> Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

they covered all sectors of food safety from primary production to consumption. FAO's food-chain approach was well positioned to counter possible threats at different stages of the supply chain. Collaboration between the health and agriculture sectors should further enhance the effectiveness of food-control systems and improve consumer protection. The WHO Foodborne Disease Burden Epidemiology Reference Group provided essential information to support policy decisions. International coordination on scientific advice was encouraging, notably the Codex Alimentarius Commission. The technical scope of that advice should be expanded so that all decisions on food safety could be taken on the basis of scientific evidence. Recent efforts to establish a trust fund for scientific advice initiatives required greater donor support. The joint FAO/OIE/WHO Global Early Warning and Response System for Major Animal Diseases had proven essential, for example during the recent influenza emergencies. He supported the draft resolution, and emphasized the need to sustain funding for joint FAO/WHO normative work on food safety.

Dr SCHLUNDT (Food Safety and Zoonoses) recognized that food safety was an international problem, as had been emphasized in the 2007 Beijing Declaration. WHO would continue to work closely with FAO to encourage a strategic integrated approach to human and animal health, including animal feed, especially in relation to zoonotic diseases. With regard to scientific advice, he agreed with Member States on the importance of common international food safety standards. Care must be taken to ensure adequate funding for all relevant programmes, including Codex standards and other scientific advice initiatives. The International Food Safety Authorities Network could be used to improve emergency response capabilities in both developing and developed countries. The inclusion of a laboratory component would strengthen food safety capacity as a whole.

The DIRECTOR-GENERAL stressed the importance of efficiencies in dealing with a complex, cross-cutting issue such as food safety. She acknowledged progress in multisectoral collaboration, covering the entire food chain from farm to table, clarity in government policies, and cooperation between United Nations agencies. It was also important to take into account the globalization of food. There was a need to continue promoting and supporting health and prevention initiatives in national health ministries. She welcomed the draft resolution, which encouraged WHO in its continued collaboration with FAO and OIE. She exhorted all States to work together, as WHO could not be the sole provider of funding for every programme, for example, for capacity building to develop Codex standards in developing countries.

The CHAIRMAN encouraged developing countries to provide more input to the Codex system, which would mean budgeting for participation in Codex meetings instead of relying on outside support.

Dr YOUNES (Office of Governing Bodies) read out the proposed amendments to the draft resolution proposed by Canada on advancing food safety initiatives. A phrase should be added at the end of the fifth preambular paragraph, reading: "and in particular the participation of developing countries in this regard should be encouraged". The first part of the tenth preambular paragraph should read: "Acknowledging that climate change could be a factor in the increasing rates of some foodborne diseases,". Preceded by a comma, the phrase "taking into account that protection of food safety cannot lead to discrimination or a disguised restriction on international trade" should be added at the end of the eleventh preambular paragraph; and the first part of the twelfth preambular paragraph should read: "Acknowledging the continuing need for closer collaboration among the health sector and other sectors,".

In paragraph 1, subparagraph (2) should be amended to read: "to further develop and implement the core capacities as defined in Annex 1 of the International Health Regulations (2005), as applicable, and those required for participation in the International Food Safety Authorities Network (INFOSAN), specifically for food-safety events, including the development of systems for surveillance for foodborne disease and food contamination; risk assessment, traceability, risk management, including Hazard Analysis and Critical Control Points (HACCP) and risk communication; food safety

emergency response; and product tracing and recall, and strengthen laboratory capacity;”. Preceded by a comma, the phrase “in a transparent manner” should be added to the end of subparagraph (3). The last part of subparagraph (4) should read: “... and improve the health outcomes of populations, in particular the vulnerable groups;”. The first part of subparagraph (5) should read: “to establish or improve the evidence base ...”; and the first part of subparagraph (8) should read: “to promote dialogue and collaboration among human health, veterinary and food-related disciplines, within and among Member States, focused on ...”.

In paragraph 2, subparagraph (1) should read: “to develop the International Food Safety Authorities Network further through the implementation of the WHO global strategy for food safety; to encourage communication and technical exchange of risk assessments and best practices among members of the Network; to facilitate Member States’ involvement in the Network’s operation and development; and to encourage additional membership into the International Food Safety Authorities Network;”; and subparagraph 6 should read: “to promote research, including the safety and quality of traditional foods and investigation of the association of foodborne hazards with acute and chronic diseases, in order to support evidence-based strategies for the control and prevention of foodborne and zoonotic diseases, such as the hazard analysis and critical control points;”. A new subparagraph (10) should be added, reading: “to establish with the International Food Safety Authorities Network an international initiative for the collaboration of laboratory partners in support of surveillance for foodborne disease, identification of food contamination and emergency response, including outbreak investigation and linking product to illness to support recall, to also include the establishment of mechanisms for data sharing;”. The current subparagraph (10) would then be renumbered as subparagraph (11).

**The resolution, as amended, was adopted.<sup>1</sup>**

**Prevention and control of noncommunicable diseases: implementation of the global strategy:**  
Item 4.9 of the Agenda (Document EB126/12)

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) said that, as extensive debates had produced little significant change, the marketing of food and non-alcoholic beverages to children should be more strongly considered in the set of recommendations annexed to the report. Furthermore, those recommendations should be limited neither to children under 12 years of age, nor to such traditional forms of marketing as television advertising; they should also cover new and less obvious forms of marketing, including the use of non-licensed cartoon characters designed to appeal to children in advertising unhealthy foods. Regarding the coverage of promotions, he pointed out that not all food companies had signed voluntary pledges to avoid marketing to children and some had different policies for different markets. The definitions of less healthy foods needed greater consistency in order to ensure that voluntary restrictions were evenly applied. A reference to energy should be made in several of the recommendations in order to include high-calorie foods within their scope. He said that further emphasis, and regular progress reports, on implementation of the Framework Convention on Tobacco Control would be welcome.

Dr KÖKÉNY (Hungary), speaking on behalf of the Member States of the European Union, 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, as well as Ukraine, the Republic of Moldova and Armenia, aligned themselves with his statement. The prevention and control of noncommunicable diseases merited the priority assigned to it by the Director-General; the dramatic increase in preventable noncommunicable diseases required concerted action at all levels. Political focus on the control of risk

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<sup>1</sup> Resolution EB126.R7.

factors, including the consumption of tobacco, salt, fat and alcohol, was also required, together with improved living and working conditions, effective health systems and preventive measures.

The action plan for the global strategy for the prevention and control of noncommunicable diseases provided a first step towards combating the alarming trends. Prevention of such diseases should be further integrated into global development work. He welcomed the set of recommendations against the irresponsible marketing of foods and non-alcoholic beverages to children. The European Union had produced its own list of unfair marketing practices in that context and supported all such actions, their monitoring and evaluation. Parents and schools were vital to promoting nutrition and health education at an early age.

All major elements of the global strategy to tackle noncommunicable diseases, including health determinants and social factors, must be integrated into a joint approach to implementation; that could not be achieved by the health sector alone. Furthermore, the promotion of health and the prevention of noncommunicable diseases should be integral to all health-care services.

Inclusive leadership, universal coverage, fair financing and primary health care centred on the patient were all principles on which to develop and sustain strong health systems. Large population groups suffering from, or at risk of, noncommunicable diseases needed more effective organization of systems. Capacity building for Member States to meet the challenges posed by noncommunicable diseases would be crucial to the future work of WHO and supported by the European Union, as would intersectoral efforts to implement measures set forth in the action plan. Future resource allocations must therefore be commensurate with the share of noncommunicable diseases in the global disease burden.

Dr SEDYANINGSIH (Indonesia) said that the perceptive report reflected the urgent need for prevention and control of noncommunicable diseases. The prevalence of those diseases in ageing populations was growing as a result of higher life expectancy, and their nature had implications for social and public health spending. Cardiovascular diseases, cancer, chronic respiratory diseases and diabetes were responsible for more than half all deaths globally. In Indonesia, there had been an epidemiological shift in the causes of mortality from communicable to noncommunicable diseases, a pattern that paralleled the demographic transition of patient age from the younger to older populations. Most noncommunicable diseases, however, were preventable through the elimination of shared risk factors such as tobacco use, unhealthy diet and physical inactivity.

The implementation of prevention strategies was crucial in developing countries; the management of noncommunicable diseases and their risks was an additional financial burden. Indonesia wished to participate in the monitoring and evaluation of the Global Strategy on Diet, Physical Activity and Health. It had recently legislated on tobacco control and was taking steps to ratify the WHO Framework Convention on Tobacco Control. She urged continued technical support, particularly for developing countries needing to increase capacity building, epidemiological profiling and risk-factor surveillance.

Dr DJIBO (Niger), speaking on behalf of the Member States of the African Region, said that the fragile health systems in African countries were being further weakened by the rise in noncommunicable diseases, to which insufficient attention had been devoted. Cardiovascular diseases, strokes and diabetes mellitus could be largely avoided through the elimination of such risk factors as tobacco use, unbalanced diet and a sedentary lifestyle.

The WHO STEPwise approach to chronic disease risk factor surveillance had been implemented in 23 African countries and had provided data for awareness-raising activities on noncommunicable diseases. Other activities had included holding capacity-building workshops, elaborating national plans and establishing a cancer register. WHO had also been active in prevention, early screening and primary care. Training and health-promotion activities had included community-based action to encourage healthier diets and active lifestyles among schoolchildren. Implementation of the WHO Framework Convention on Tobacco Control was under way and several countries had enacted anti-tobacco laws and conducted sensitization campaigns on the harmful effects of alcohol. All Member States in the Region had participated in the International Conference on Diabetes and Associated Diseases (Mauritius, 12–14 November 2009), a meeting supported by WHO.

Strengthened systems for monitoring noncommunicable diseases in the Region were needed, by defining base indicators and using standardized data-collection methods, together with innovative financing, especially in poor countries with no social security systems in place. The availability of resources for the implementation of action plans for the prevention and control of noncommunicable diseases seriously challenged a continent already facing a multitude of priority demands.

Ms TOELUPE (Samoa) said that the Western Pacific Regional Action Plan for Noncommunicable Diseases<sup>1</sup> was aligned with the global strategy for the prevention and control of those diseases, which were regarded as a pandemic in Pacific island States such as Samoa, with substantial negative impacts on their health systems and economies. The inclusion of noncommunicable diseases in the resolution on monitoring achievement of the health-related Millennium Development Goals was heartening.

Samoa would require significant assistance to implement the recommendations contained in the report on prevention and control of noncommunicable diseases. It had held the Samoa Food Summit in August 2009 and its health plan advocated a whole-society approach as part of the Healthy Islands concept.

WHO's Global Noncommunicable Disease Network, recognizing the clear linkages between specific noncommunicable diseases and risk factors, aimed to harmonize disjointed efforts in those areas. WHO should follow suit with a more integrated approach to tackling noncommunicable diseases. She requested technical support in linking and balancing the competing demands of public health promotion and of policies driven by economic considerations.

Dr DAHL-REGIS (Bahamas) endorsed the statement made by the member for Hungary. The profile of noncommunicable diseases had been raised and the support of non-health sectors was vital in the fight against them. The risk factors had been widely identified and she shared the concern about the marketing of unhealthy foods to children, among whom there was an epidemic of obesity in the Caribbean region. International collaboration, as well as regional and subregional support, was needed to tackle the problem of such diseases. She expressed the hope that the Board would support the proposal first made at a summit of Caribbean Heads of State in 2007 for the convening of a United Nations summit on noncommunicable diseases.

Mr CHAUDHRY (adviser to Ms Sujatha Rao, India) said that developed countries had a higher prevalence of noncommunicable diseases than developing countries such as India, where they were nevertheless afforded priority attention because of their growing incidence among the poor. As a result, India was launching a programme to prevent tobacco use.

A global strategy must embrace equitable access to treatment, the greatest barrier to which was the high cost of diagnostics and medicines. WHO should develop a strategy on both of those fronts without delay, and thus avoid a repetition of the sad experience of HIV/AIDS. WHO should also develop treatment protocols on the basis of rational use of technology and the principles of cost effectiveness, which would steer care providers away from commercial considerations; that approach would yield dividends in the case of noncommunicable diseases.

Dr MUÑOZ (Chile), commending the report, said that obesity in children was a problem of epidemic proportions that would negatively affect the future prevalence of chronic noncommunicable diseases. Alongside the WHO Framework Convention on Tobacco Control and, if approved, the global strategy to reduce the harmful use of alcohol, the global strategy for the prevention and control of noncommunicable diseases should provide for a set of coherent measures in the areas covered. He welcomed the report's emphasis on the need for regulatory mechanisms, consistent with the realities of individual countries, which would provide for raising consumer awareness about *trans*-fatty acids,

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<sup>1</sup> Endorsed by the Regional Committee for the Western Pacific in resolution WPR/RC59.R5.

free sugars and salt in food. However, some of the wording was too cautious, especially on the aggressive advertising of junk foods. Public policies should seek to curb television advertising during children's viewing hours, as well as offers of free gifts and prizes with unhealthy goods, and other subliminal means of stimulating consumption. He looked forward to the next progress report.

Ms ARTHUR (alternate to Mr Houssin, France) recalled that, according to many participants at the Annual Ministerial Review of the United Nations Economic and Social Council in July 2009, combating the global proliferation in noncommunicable diseases should be considered a development goal. WHO had a crucial role to play, and the global strategy for the prevention and control of noncommunicable diseases must take account of how behavioural risk factors affected quality of life. Many of those behaviours could be changed. Emphasis should be placed on research, primary prevention and action to promote reduced tobacco and alcohol consumption, a balanced diet and regular physical exercise. Action on the social and environmental determinants of health, especially exposure to toxic substances such as pesticides, fertilizers and carcinogenic substances, was essential; WHO's work in that field should be better coordinated with, and even integrated into, the global strategy. The recommendations on the marketing of foods and non-alcoholic beverages to children appeared far-reaching but underestimated conflicts of interest between the food processing industry and the advertising sector. Reduced advertising of foods high in fat, sugar and salt intended for consumption by children should be emphasized. In that connection, recommendation 2 should be more detailed.

Dr REITENBACH (adviser to Dr Seeba, Germany), welcoming in particular the recommendations contained in the report on the marketing of foods and non-alcoholic beverages to children, said that her Government was working with industry, in a multisectoral and multistakeholder framework, on a plan of action focusing on nutrition, children's eating habits and physical activity, and on a voluntary, self-regulatory code of conduct that sought to reduce the impact of such marketing, especially in schools. She proposed that the word "and" in the phrase "stepwise and comprehensive" in recommendation 3 should be replaced by "or"; that "Settings where children gather" at the beginning of recommendation 5 should be replaced by "Schools, child-care and other educational settings"; and that in the penultimate line of recommendation 6 the words "including self-regulatory initiatives" should be inserted between "other stakeholders" and "while protecting the public interest".

Dr MOHAMED (Oman), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that noncommunicable diseases accounted for half the morbidity in the Region; no expense should be spared to implement the global strategy for their prevention and control. Most were caused by modifiable behavioural risk factors and civil society could help to contain their spread. The requisite primary health-care protocols and a programme should be introduced for early detection and treatment, especially among adults aged 40 years or older, with a review of screening techniques for conditions such as kidney disease, hypertension and diabetes. Countries in the Region had implemented, in addition to the global strategy, a regional strategy for cancer prevention and control. They had fostered cooperation between governments and nongovernmental organizations; developed partnerships and networks; established the Eastern Mediterranean Approach to Noncommunicable Diseases Network; and endorsed the Doha Declaration on Noncommunicable Diseases and Injuries. Noncommunicable diseases should be included in the Millennium Development Goals.

Dr ABDESSELEM (Tunisia) supported the action plan presented in the report. WHO must provide the financial and human resources needed to implement it because more forceful efforts to combat noncommunicable diseases and their dramatic social and economic consequences were crucial for sustainable global development and growth. He welcomed the recommendations on the marketing of food and non-alcoholic beverages to children and wanted to see a progress report in two years on their implementation. Meanwhile, a new paragraph should be inserted in resolution EB126.R4 requesting that the impact of noncommunicable diseases and tobacco use on the Millennium

Development Goals be included in the agenda for the United Nations Millennium Development Goals Summit scheduled for September 2010.

Dr GOPEE (Mauritius) described the extent to which his country's population had been affected by the high prevalence of diabetes and associated diseases, mental health problems and cardiovascular diseases owing to alcohol consumption and tobacco use by adults and, increasingly, young people. More was spent on those two commodities than the combined budgets of the ministries of health and education. Concern about the situation had been reflected locally in an international conference on diabetes and associated diseases organized with the support of WHO headquarters and regional offices in November 2009. Nevertheless, his Government was carrying out an aggressive prevention and control campaign; regulations had been put in place to control tobacco use; and the consumption of alcoholic beverages in public places, as well as sales to minors and advertising, promotion and sponsorship, had all been prohibited. Meanwhile, in spite of strong opposition, the Government had recently banned the sale in school canteens of foods high in fat, sugar and salt, recommending other, healthier, foods. It was also campaigning, with media support, to encourage physical activity, including yoga, through both schools and community outreach programmes.

Mrs BUGROVA (adviser to Dr Starodubov, Russian Federation) said that methodological and technical assistance by WHO would be important in the formulation and application of national plans to combat noncommunicable diseases, the training of health personnel, the introduction of modern diagnostic methods and the treatment of patients. Her Government's recent efforts in the prevention and treatment of noncommunicable diseases with a significant social impact had already visibly affected health indicators: since 2006, first time registration of disability cases had declined and mortality had dropped by 5.6%. Since 2009, a programme had been in progress to promote healthy lifestyles; to counter alcohol and tobacco use; and to uncover risk factors for noncommunicable diseases in ostensibly healthy individuals. Future efforts would see introduction of new pedagogical standards, the promotion of popular sports and information campaigns. The Russian Federation would like to see its own institutions and specialists participate in WHO programmes and projects on noncommunicable diseases and renewed its offer to convene, in cooperation with WHO, an international ministerial conference on noncommunicable diseases in 2011.

Ms ROCHE (New Zealand) welcomed the suggestion by members to strengthen the emphasis on tobacco control. Regarding the set of recommendations in the report, she noted that recommendation 6 stated that governments should be the key stakeholders in developing policy and providing leadership. However, they must also be urged to work with relevant food and advertising industries and other agencies to maximize the implementation of policies. In her country, for example, a self-regulatory system administered by the relevant authority was in effect. Recommendation 8 required mention of an appropriate time frame so that all countries and multinational corporations worked towards the same goals at the same time. In general, it should be recognized that approaches to implementation and the extent to which the recommendations were given effect should be worked through with stakeholder groups. At the national level, long-term commitment to an agreed approach, closely linked to obesity prevention policies, was needed.

Ms BILLINGS (alternate to Dr Dodds, Canada) said that her country remained committed to the implementation of the global strategy for the prevention and control of noncommunicable diseases. Despite wide agreement on the serious nature of the problem, global efforts were needed to reduce the number of unnecessary and premature deaths caused by such diseases, primarily through a focus on prevention. Her Government was very concerned about levels of childhood obesity; there was increasing evidence linking marketing to the eating preferences and behaviour of children and young people. There should be further discussions at the Health Assembly on the implementation of the global strategy and on strengthening and clarifying the recommendations on the marketing of food and beverages to children.

Dr ALBRAIKY (alternate to Dr Al Darmaki, United Arab Emirates) said that, when the global strategy had been adopted in 2008, Member States had been urged to develop national strategies to reduce the incidence of noncommunicable diseases, analyse causative factors and improve public services to those affected by such diseases. Her Government had set up administrative units to devise national and local strategies for the prevention of noncommunicable diseases: it already had a strategy to combat cancer and was about to institute others to combat respiratory and cardiovascular diseases, in accordance with WHO's recommendations. It had been applying the global strategies against cancer, diabetes, cardiovascular diseases and chronic respiratory diseases and had taken steps to combat tobacco use. It would work with other governments and the Secretariat in implementing regional plans in those areas.

Mr D'AVINO (Italy)<sup>1</sup> drew attention to the wide consensus on the growing threat to global public health represented by noncommunicable diseases. A priority area under the action plan on such diseases concerned the responsible marketing of food and non-alcoholic beverages to children. In that area, his Government was cooperating closely with the various stakeholders, nutrition experts, industries, nongovernmental organizations and academia. Italy emphasized cooperation with the food industry, on the basis of scientific evidence, in campaigns to change product composition in favour of a healthier diet; enhance the clarity of available information; promote healthier lifestyles through physical activity; and encourage greater responsibility in advertising directed at children. It was also important to examine the kind of cooperation that might be established with the private sector.

Mrs NYAGURA (Zimbabwe)<sup>1</sup> said that, while noncommunicable diseases accounted for more than half of global mortality, there was a glaring disparity in the funding to combat such diseases. Hypertension, for example, was more prevalent than HIV/AIDS in the African Region. Noncommunicable diseases caused a huge drain on individual households and on national economies, further straining health systems. She called for a realignment of resources; an integrated approach to redressing the situation; technical support by the Secretariat for the implementation of policies; the establishment of viable health information systems; and effective strategies for health promotion. Donors should consider supporting the provision of essential medicines to people living with noncommunicable diseases in developing countries.

Ms QUACOE (Côte d'Ivoire)<sup>1</sup> encouraged the Secretariat to support Member States in strengthening their systems for monitoring noncommunicable diseases through the identification of core indicators and the collection of data on risk factors. Consideration should be given to devising innovative means of financing treatment of noncommunicable diseases, especially in developing countries, in view of their weak social welfare systems, the heavy burden of morbidity caused by such diseases and the cost of treatment.

Dr REN Minghui (China)<sup>1</sup> said that his Government agreed with WHO's analysis of the global situation with regard to noncommunicable diseases and the estimates of trends in their development. He welcomed the Organization's prioritization of prevention and control of such diseases and supported the efforts of the Secretariat and Member States to make combating noncommunicable diseases an important part of the Millennium Development Goals. China had a high disease burden from noncommunicable diseases, and a mortality rate of about 75% from cardiovascular diseases, cancer, chronic respiratory diseases and heart disease. In 2005, the economic burden of noncommunicable diseases had been equivalent to about 12% of gross domestic product. In response, his Government planned to formulate and strengthen prevention and control policies and plans, promote multisectoral collaboration, and implement the WHO Framework Convention for Tobacco Control. It was striving to involve the whole population in the prevention and control of

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<sup>1</sup> Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.



noncommunicable diseases; to promote healthy lifestyles; to introduce appropriate technology at grassroots level; and to integrate prevention and control of cardiovascular diseases, diabetes and cancers into community health and primary health care. China was ready to work with the Secretariat to strengthen its internal coordination in order to better manage its budgets and resources.

Mr HOHMAN (United States of America)<sup>1</sup> said that the recommendations on the marketing of food and non-alcoholic beverages to children could significantly help Member States to promote healthier patterns of eating. Reducing the growing epidemic of childhood obesity was a priority for his Government, and especially for the First Lady, who had raised awareness of the importance of healthy eating habits. He was pleased to see that the stakeholder consultations carried out by the Secretariat had resulted in considerable improvements in the recommendations and he welcomed the range of implementation mechanisms mentioned. There was a shared responsibility for tackling the growing obesity epidemic. Governments, industry, nongovernmental actors and individuals all had roles to play, and no stakeholder should be left out.

Mr ADAM (Israel)<sup>1</sup> said that WHO's work on prevention and control of noncommunicable diseases had resulted in important global and national action. Israel was committed to implementing tobacco control measures in line with the WHO Framework Convention on Tobacco Control, and had devised an interministerial action plan on diet, physical activity and the prevention of chronic diseases, in line with the global strategy. More collection of data by the Secretariat on the effectiveness of interventions to reduce obesity could be useful for work at country level. His country was currently developing an approach to the issue of marketing to children and valued the recommendations contained in the annex to the report.

Ms DE MORA (International Federation of Red Cross and Red Crescent Societies), speaking at the invitation of the CHAIRMAN, noted the strong links between poverty and noncommunicable diseases. Growing health inequities must be resolved if global health promotion was to be achieved. Low-income communities must be empowered to conduct their own health promotion activities in order to curtail the spread of noncommunicable diseases. Through coordinated approaches to tackling contemporary health problems, her organization would continue its partnership with WHO at national and international levels. National societies were already assisting governments to build community capacity in order to find sustainable solutions to address the social determinants of poor health.

Mr CHAN Xuanhao (International Pharmaceutical Federation), speaking at the invitation of the CHAIRMAN and also on behalf of the International Council of Nurses, said that front-line health professionals in hospitals and particularly in communities were in a position to facilitate action to counteract chronic disease, identify unhealthy lifestyles and provide corrective health promotion services such as smoking cessation support. However, a sustainable health workforce to deliver such services was needed. WHO estimated the minimum number of health workers needed to deliver basic care at 2.3 per 1000 population; crisis countries had less than 1 health worker for every 1000 population. Only through sustained and urgent funding, directed to health systems and the training of health professionals, could the challenge of prevention and control of noncommunicable diseases be met. Regarding objectives 4 to 6 on promoting sustainable research and partnerships such as the proposed Global Noncommunicable Disease Network and the global tracking of progress, WHO should strengthen the role of health professionals in health promotion, surveillance, prevention and management of chronic noncommunicable diseases at both national and regional levels.

Ms ALDERSON (World Heart Federation), speaking at the invitation of the CHAIRMAN and also on behalf of the International Diabetes Federation and the International Union against Cancer,

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<sup>1</sup> Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

said that the Board should take the following specific actions: support the resolution being put forward at the United Nations General Assembly requesting the holding of a special session on noncommunicable diseases; support the inclusion of indicators on noncommunicable diseases in Millennium Development Goal 6 at the United Nations Millennium Development Goals Summit in September 2010; ensure that noncommunicable diseases were included in discussions on the successor goals of the Millennium Development Goals; and address the availability and affordability of essential medicines for noncommunicable diseases in developing countries. Member States should address the main obstacles to implementing the global strategy cited in the Secretariat's report without further delay.

Mr FAIRCLOTH (Corporate Accountability International), speaking at the invitation of the CHAIRMAN, said that the recommendations contained in the report upheld important principles including a rationale for Member States to take action to reduce the impact of food marketing on children; they also restated the importance of governments in setting policy, most important considering the food industry's promotion of ineffective self-regulatory and voluntary approaches. Nonetheless, the recommendations should be strengthened. Statutory regulation, rather than voluntary corporate agreement, was the best approach for reversing the impact of the food industry's direct marketing of unhealthy food to children. Effective action to address cross-border marketing must be identified. The WHO definition of unhealthy foods lacked specificity: the food industry would continue to bend it and market junk food directly to children. Technical support should be developed by WHO for the nutrient profiling of foods. WHO must monitor the marketing of foods and beverages to children and develop preventive measures to guard against industry conflicts of interest. Article 5.3 of the WHO Framework Convention on Tobacco Control provided precedent and guidance on how industries with potential conflicts of interest should interact with public health policy.

Ms NORTON (Consumers International), speaking at the invitation of the CHAIRMAN, said that the recommendations took an important step towards protecting children but they could be strengthened. The current definition of the foods to be covered excluded those high in vegetable oil. It should be amended to include all energy-dense foods that were poor in nutrients and high in fat, sugar and salts. She urged for more specific recommendations to define broadcast marketing, non-broadcast marketing, the age of children and the nutrient profile of the foods covered. That would clarify guidance to governments as to what effective regulation should include and increase the likelihood of the recommendations achieving the stated aims. Specific definitions developed by a European network on the marketing of food to children could be included in the WHO recommendations. The Secretariat should be mandated to develop technical support for the nutrient profiling of foods and for monitoring the marketing of foods to children; that would ensure public health criteria, free from conflicts of interest. It should be given a mandate also to devise mechanisms to meet concerns raised about the cross-border marketing of foods and to facilitate uniform implementation of the recommendations.

Dr ADEBAYO (Inter-African Committee on Traditional Practices affecting the Health of Women and Children), speaking at the invitation of the CHAIRMAN, drew attention to the Nairobi Call to Action adopted at the 7th Global Conference on Health Promotion (Nairobi, 26–30 October 2009). Member States should mandate the Director-General to develop a global health promotion strategy and action plan, with regional follow-up; assist Member States in developing sustainably funded structures; set up reporting mechanisms; and gather and disseminate evidence on the social, economic, health and other benefits of health promotion. Civil society would provide a vital link in spanning the health equity gap. By working directly in local communities at the grassroots level and in partnership with their governments, their responsibilities would promote the health and well-being of all citizens, build the capacities of communities, and find sustainable solutions for tackling the social determinants of poor health.

Professor MBEWU (Global Forum for Health Research), speaking at the invitation of the CHAIRMAN, welcomed the report's recommendations for more research towards the prevention and

control of noncommunicable diseases, particularly in resource-poor settings. His organization estimated that five major governments had invested US\$ 12 200 million in research on the five noncommunicable diseases with the highest burden in 2008; and that 68.4% of research and development expenditure by pharmaceutical companies was devoted to noncommunicable diseases. However, it remained unknown how much of that research was relevant to low- and middle-income countries. Therefore, research and development expenditure on noncommunicable diseases should be accurately tracked at both national and global levels; that would assist the setting of priorities and the monitoring of progress on prevention and control.

Dr ALWAN (Assistant Director-General) thanked speakers for their important contributions. The set of recommendations in the report had been developed in accordance with a mandate given to the Secretariat by the Health Assembly in resolution WHA60.23, which specifically referred to reducing the impact of foods high in saturated fats, *trans*-fatty acids, free sugars or salt. However, under the recommendations, Member States could determine which foods were to be covered by their national plans to reduce marketing; high-energy foods and foods high in vegetable oil could be included. The recommendations did not include a specific age limit; Member States were free to establish their own. Paragraph 19, on implementation by Member States, stated that important definitions included the age group for which restrictions should apply. Marketing communication channels that appealed to children were addressed in paragraphs 8 and 19. The amendment proposed by the member for Germany to recommendation 3 was acceptable, but the amendment to recommendation 5 would narrow the intent and might create many loopholes. The amendment to recommendation 6 might be seen as creating a bias towards industry-led self-regulation, which went against the spirit of allowing each Member State to choose the course it considered best. He thanked the member for New Zealand for support in implementing the global strategy and the development of the recommendations. Referring to her comment on recommendation 6, he said that the recommendation already referred to a multistakeholder platform, which could include the private sector if individual governments so wished.

The DIRECTOR-GENERAL, responding to the call from the member for Hungary and others for more resources to be allocated to prevention of noncommunicable diseases, said that the help of Member States would be needed. The Programme budget and contributions from Member States provided lamentably few resources for noncommunicable diseases. In 2008 and 2009, despite the very limited flexibility she had been given, she had maximized the budgetary allocation to that area. Although much was said about the importance of noncommunicable disease prevention, progress was insufficient. She endorsed the remark by the representative of the United States that every stakeholder must play a role. The Secretariat would certainly play its part, but its best contribution would be to improving health system capacity to deal with noncommunicable diseases through an integrated approach. Several Board members had spoken of ensuring that essential medicines were affordable and accessible, and she would look into making additional efforts in that area.

**The Board noted the report.**

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