INTERNATIONAL LEADERSHIP TEXAS/ OSGOOD CENTER

LONE STAR / TEXAS MODEL UNITED NATIONS 2024

WORLD HEALTH ASSEMBLY (WHA)

Background Guide

November 2024

What is the role of the World Health Assembly (WHA)?

The World Health Assembly (WHA) is the supreme decision-making body of the World Health Organization (WHO) and adopts decisions and resolutions recommended by the WHO Executive Board and the Director General or introduced by (groups) of WHO Member States during the WHA. **CHECK:** https://apps.who.int/gb/index.html

You can also get a sense of the topics discussed in the WHA: https://www.paho.org/en/wha

WATCH: https://youtu.be/ktdpQRpteh0

To cite an example, the 75th WHA took place in Geneva, Switzerland, from 22 to 28 May 2022. The main topic was **"health for peace and peace for health".** This assembly discussed matters focused on four pillars, three of which contribute to the **"triple billion targets":**

- **Pillar 1**: One billion more people benefiting from **universal health coverage**
- **Pillar 2:** One billion more people better protected from **health emergencies**
- **Pillar 3:** One billion more people enjoying **better health and well-being**
- **Pillar 4: More effective and efficient WHO providing better support to countries**

Delegations from 194 WHO Member States and other organizations (with observer status) participated in the meeting, which consists of a plenary and two committees. Between sessions, technical meetings and social events were organized.

On the topic "Health for peace and peace for health" and in the face of multiple crises around the globe that require well-coordinated and coherent action discussions took place. The WHO considers peace as a structural determinant of health and delivers humanitarian work in fragile environments. WHO's Health for Peace approach aims at promoting dialogue, participation, inclusiveness, and trust

and conflict sensitivity. The focus is currently set on the COVID-19 pandemic, and on war, emergencies and crisis in Ukraine, Northern Ethiopia, Afghanistan, Syria, and other regions. WHO monitors health emergencies globally.

History, Mandate, and Functioning of the WHA

The **World Health Organization (WHO)**, the United Nations (UN) specialized agency for health, was established in 1948 with the **objective** for **all people to attain the highest possible level of health.** In its constitution, **health is defined as a state of complete physical, mental, and social well-being and not merely the absence of illness or infirmity. CHECK:** https://www.who.int/about/governance/constitution **and** https://apps.who.int/gb/bd/

Functioning and Structure of the WHO and the Role of the World Health Assembly

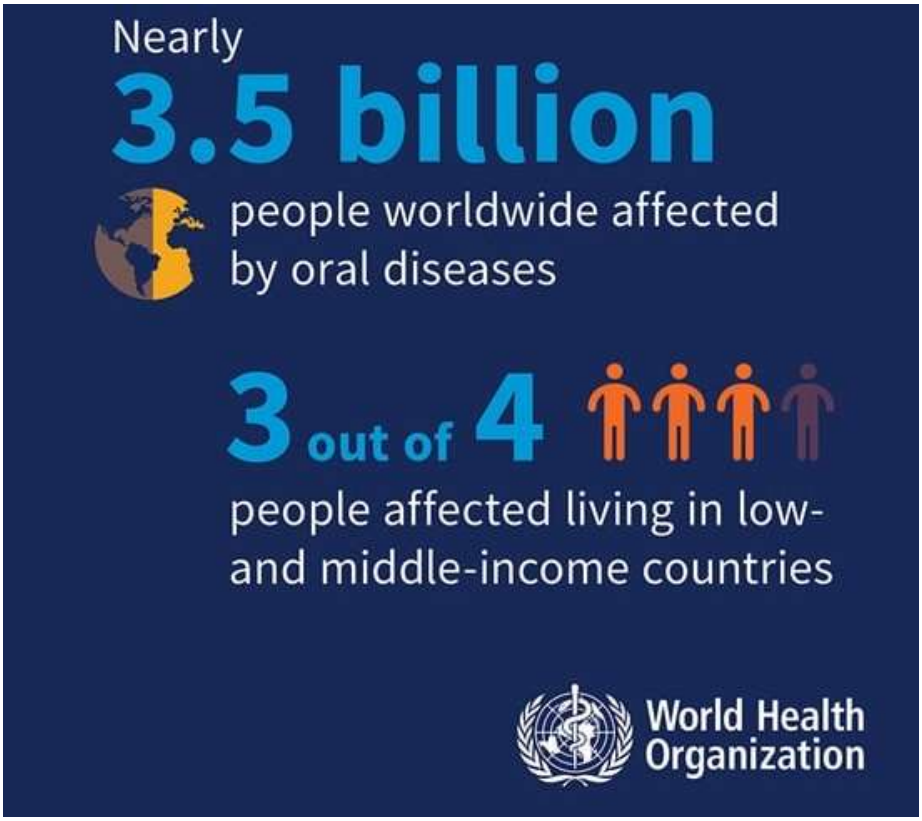
Member States (MS)	194 Member States Accept WHO Constitution MS and associate MS
Regions	6 Regional Offices Coordinate regional efforts and offices
Secretariat Headquarter (HQ)	Headed by Director General (DG) DG elected for 5 years term by WHA Technical and administrative matters
Executive Board (EB)	Executive organ of the WHA 34 Members (representing regions) – 3 years term headed by chair (two years term) Meetings at least twice a year (January & May)
World Health Assembly (WHA)	**Supreme decision-taking body** **Meetings generally once a year (in May) A L** **L Members States and delegations participate** **Elects members of Executive Board** **Approves budget**

Each WHO Member State delegates no more than three representatives to attend the session of the WHA held in Geneva, Switzerland, each year in May. The WHA may convene in special sessions, as necessary; so far, this has happened only twice - in 2006 to accelerate the procedure to elect a **Director General (DG)**, and at the end of 2021 to discuss the development of *the "Pandemics Treaty"*. **The first WHA was held in Geneva in June 1948 with delegations from 53 of its then 55 Member States. Since then, the WHA has met every year for the past 74 years. In 2021, the WHA was held virtually for the first time due to the COVID-19 pandemic.**

The WHA elects an **Executive Board (EB)** which consists of **34 members** that are technically qualified in the field of health. **Meetings take place in January and in May (shortly after the WHA annual meeting).** The EB prepares decisions and resolutions to be considered by the WHA and is mandated to give effect to the WHA decisions and to act as its executive organ. The WHO **Secretariat** at the **headquarters (HQ)** of the WHO in **Geneva** consists of the DG and all technical and administrative staff. In addition to the secretariat, there are six regional offices responsible for the coordination of tasks in the respective region. **CHECK:**
https://apps.who.int/gb/gov/en/composition-of-the-board_en.html
https://www.who.int/about/governance/executive-board/executive-board-151st-session

Participants of the WHA are delegations from WHO Member States, international organizations (such as the European Union, organizations of the United Nations or the World Bank) and other **non-state actors in official relations with the WHO** (nongovernmental organizations, international business associations and philanthropic foundations, academic institutions) invited to attend the WHA as **observers** and to participate in technical briefings and (social) side events, such as the "walk the talk" . **Non-state actors must be granted the privilege of "official relations with the WHO" by the Executive Board, which is reviewed every three years. CHECK:** https://www.who.int/about/collaboration/non-state-actors/non-state-actors-in-official-relations-with-who For instance, for the 75th WHA, Taiwan requested to be granted an observer status. **CHECK:** https://www.state.gov/taiwan-as-an-observer-in-the-world-health-assembly/

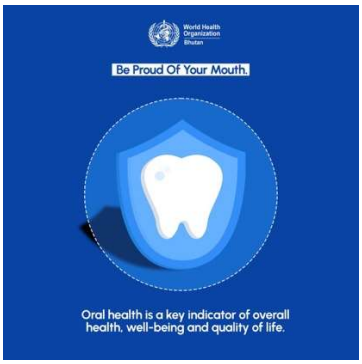
CHECK: https://www.who.int/about/governance/world-health-assembly/seventy-fifth-world-health-assembly/the-who-and-the-wha-an-explainer
https://www.paho.org/en/wha

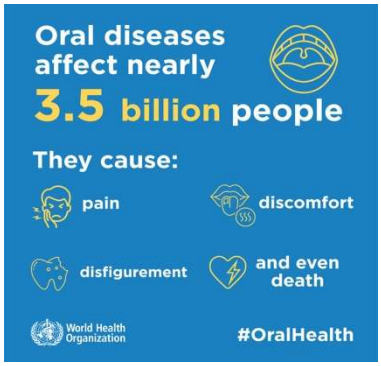


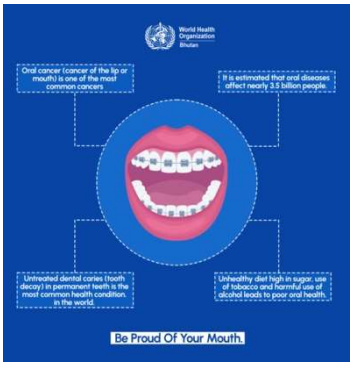
TOPIC 1: PROMOTING ORAL HEALTH AS PART OF UNIVERSAL HEALTH COVERAGE (UHC)

What is oral health?

Oral health is the state of the mouth, teeth and **orofacial** (of or relating to the mouth and face) structures that enables individuals to perform essential functions such as eating, breathing, and speaking, and encompasses psychological and social dimensions such as self-confidence, well-being, and the ability to socialize and work without pain, discomfort, and embarrassment. Oral health varies over the life course from early life to old age, is integral to general health and supports individuals in participating in society and achieving their potential. **CHECK:** https://www.afro.who.int/sites/default/files/2024-03/WorldOralHealthDay-%20What%20is%20oral%20health%20%28EN%29.pdf







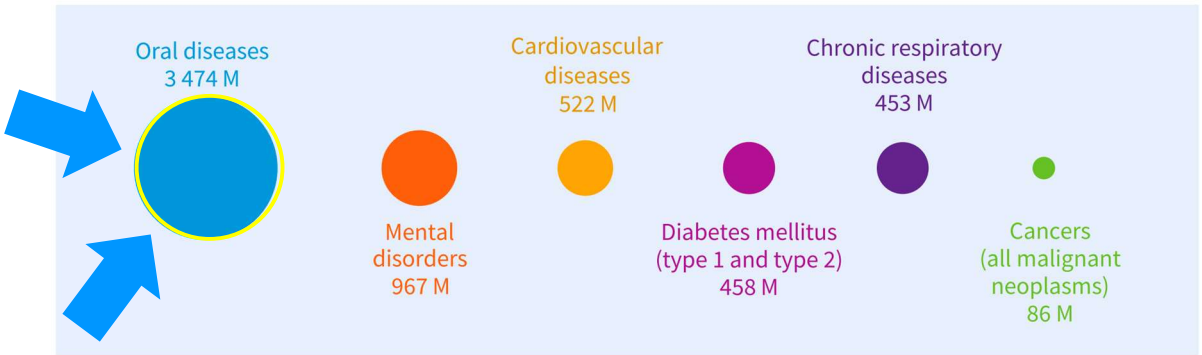
Oral diseases encompass a range of diseases and conditions that include **dental caries, periodontal (gum) disease, tooth loss, oral cancer, oro-dental trauma, noma, and birth defects such as cleft lip and palate.**

Oral diseases are among the most common noncommunicable diseases worldwide, affecting an estimated 3.5 billion people.
The burden is increasing, particularly in low- and middle-income countries.

While the global burden of oral health conditions is growing, particularly in low- and middle-income countries, the overall burden of oral health conditions on services is likely to keep increasing because of population growth and ageing.

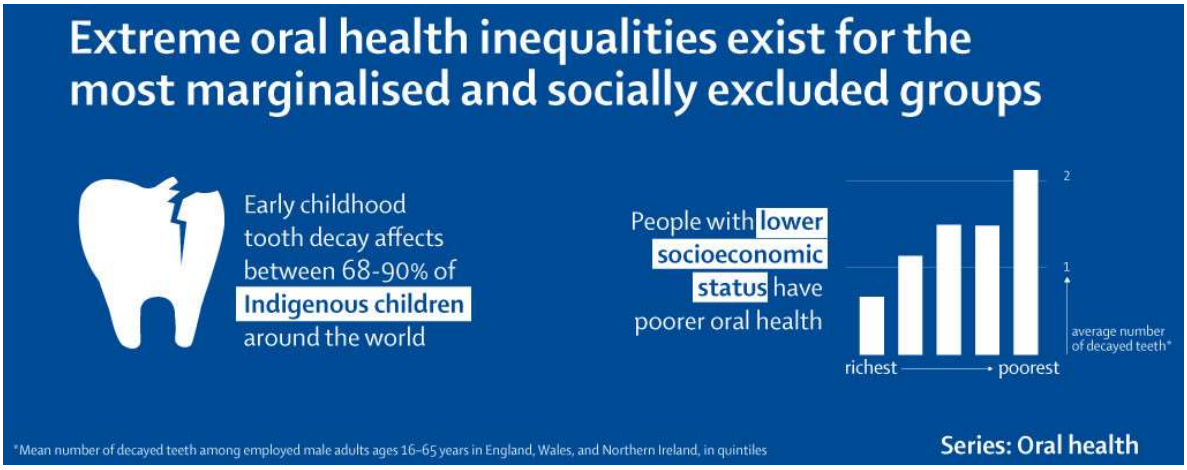
What are noncommunicable diseases (NCDs)?

Comparison of estimated global case numbers for selected NCDs



Note. Data are for all ages and both sexes from GBD 2019; oral diseases do not include lip and oral cavity cancer. A standard method has been applied to incorporate the latest UN population estimates.

Noncommunicable diseases (NCDs), also known as chronic diseases, tend to be of long duration and are the result of a combination of genetic, physiological, environmental, and behavioral factors. The main types of NCD are cardiovascular diseases (such as heart attacks and stroke), cancers, chronic respiratory diseases (such as chronic obstructive pulmonary disease and asthma) and diabetes. **PLAY Kahoot to find our more about it!** **https://kahoot.it/challenge/7a93d122-07cf-4976-8005-f4ecd5836859_1703114060934**



Source: https://www.weforum.org/agenda/2022/11/half-world-oral-disease-health-stories-this-week/

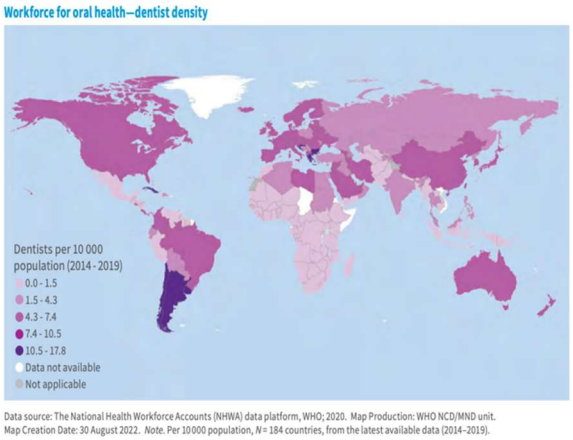
Oral diseases disproportionately affect the most vulnerable and disadvantaged populations. People of low socioeconomic status carry a higher burden of oral diseases and this association remains across the life course, from early childhood to older age, and regardless of the country's overall income level.

What is the problem? Why is oral health important?

WATCH: https://youtu.be/_J2bn46bACg
https://youtu.be/yHXwpwW2k3A
https://www.voaafrica.com/a/health-report-promoting-good-oral-health/7543504.html

Between 1990 and 2019, estimated case numbers of oral diseases in the world increased by more than 1 billion - a 50% increase.

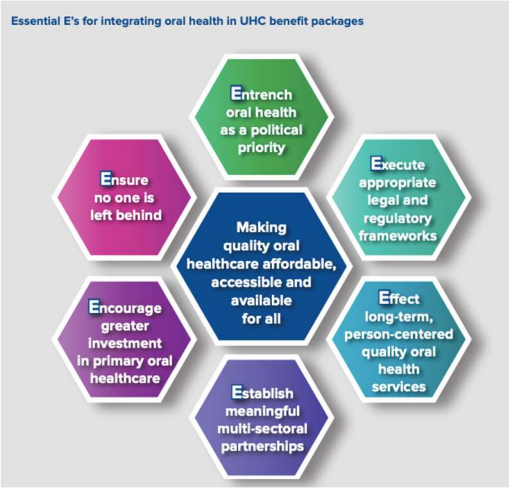
As you read before more than 3.5 billion people suffer from oral diseases. Oral health has long been neglected in the global health agenda. **The biggest challenge now is ensuring that all people, wherever they live and whatever their income, have the knowledge and tools needed to look after their teeth and mouths, and access to prevention and care when they need it. For this to happen, all countries need sufficient staff trained in oral health, and oral health services must be included in national health coverage packages, either free of charge or at a price that people can afford.**



Workforce availability is at the heart of failures to address the oral health threat.

How did COVID-19 change dental health services? WATCH: https://www.who.int/multi-media/details/oral-services-during-covid-19---video1#

What is essential to integrate oral health in Universal Health Coverage (UHC) packages? Check the essential E's:



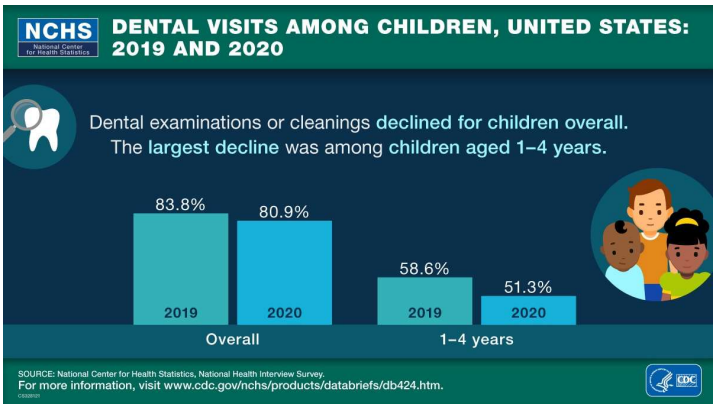
The global health problem is that untreated dental caries (tooth decay) in permanent teeth is the most common. **Severe periodontal (gum) disease affects almost 10% of the global population and more than 530 million children suffer from dental caries of primary teeth.** Oral diseases disproportionally affect the poor and socially disadvantaged populations. Most oral diseases have been linked with other noncommunicable diseases.

Most oral health conditions are largely preventable and can be treated in their early stages, **but treatment is often not affordable as usually is not part of universal health coverage packages.** The use of fluoride, which can substantially reduce the risk of dental caries, remains inaccessible in many parts of the world.

Among the six World Health Organization (WHO) regions, South-East Asia reported the highest number of oral diseases and conditions in 2019 – approximately 900 million cases. This region also had the world's highest oral cancer incidence and mortality, with the estimated age-standardized mortality for males at 8.1 per 100 000 being more than double the global average of 3.7 per 100 000. The incidence rate for males and females at 14.4 and 4.5 per 100 000 respectively are also more than double the global average. Across the South-East Region, the oral disease burden also shows strong inequalities, with higher prevalence and severity among poor and disadvantaged populations who generally have lower access to prevention, care, and rehabilitation.

The World Health Organization says over the past three decades, Africa has experienced the most substantial increase in major oral diseases among the organization's six defined regions. Despite being largely preventable, oral diseases such as tooth cavities, gum disease, and tooth loss pose a significant public health challenge, impacting 44% of the region's inhabitants. Africa faces a chronic shortage of oral health professionals, with a ratio of only 0.33 dentists per 10,000 people.

Did you that…?



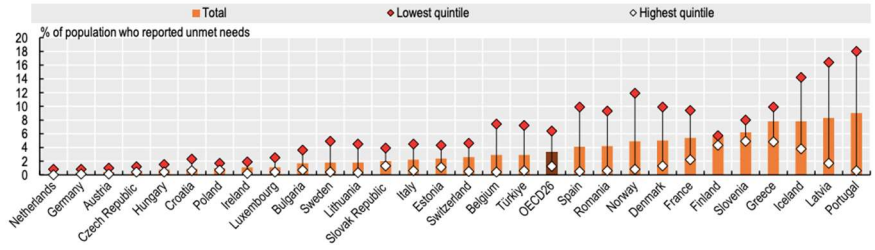
"Public coverage for the cost of dental care is far more limited across OECD countries due to restricted service packages (frequently limited to children) and higher levels of cost sharing. On average, less than one-third of dental care costs were borne by government schemes or compulsory insurance (Figure 5.7).

CHECK: https://hpfhub.info/wp-content/uploads/2024/05/Health-at-a-Glance-2023-OECD-Indicators-OECD-2023.pdf

More than half of dental spending was covered in only three OECD countries (Japan, Germany, and France), while the level of compulsory coverage was very low in Greece, Spain, and Israel. Voluntary health insurance may play an important role in providing financial protection when dental care is not comprehensively covered in the benefit package – this is the case for adults in the Netherlands, for example."

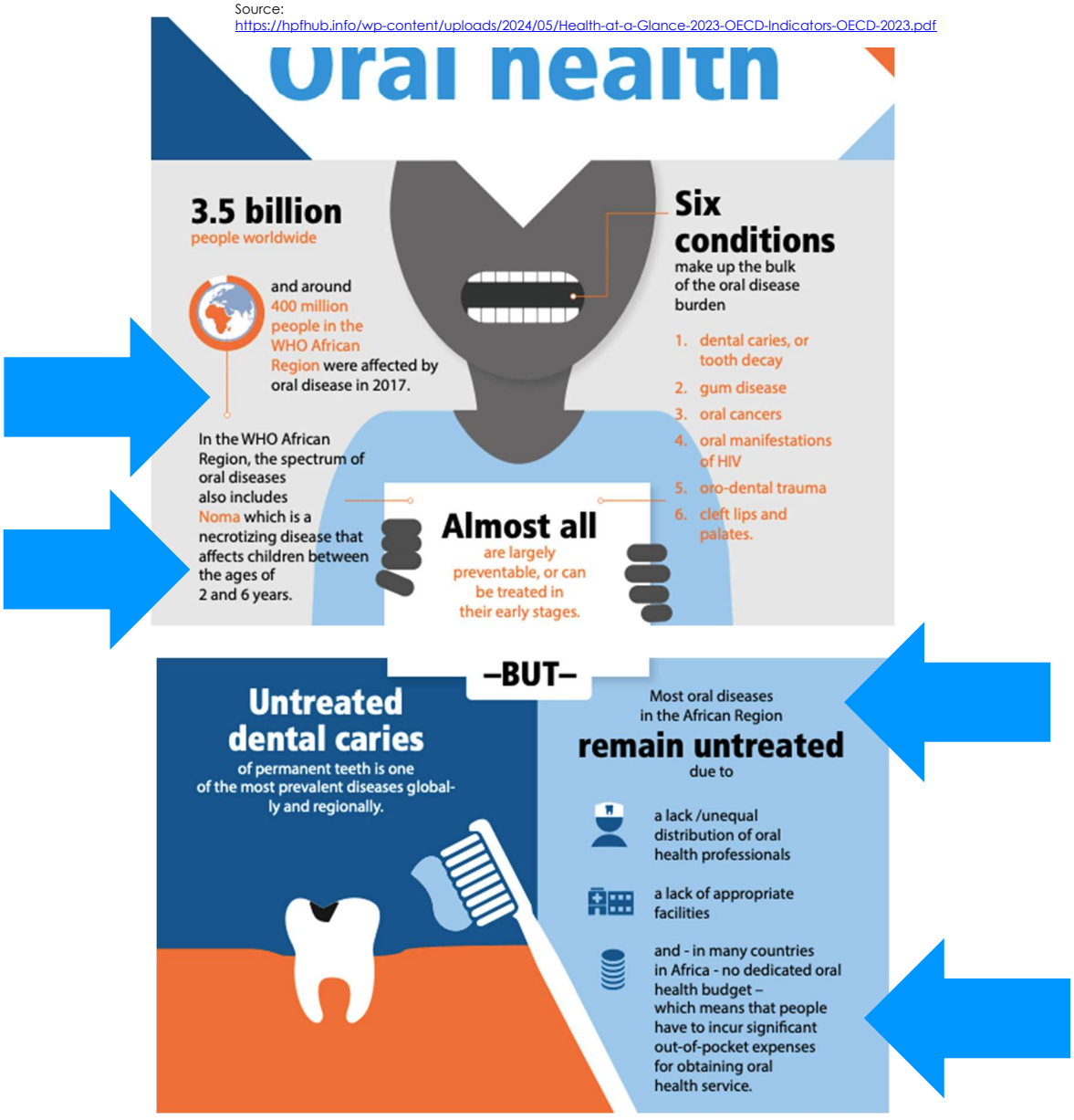
Reported unmet needs are generally larger for dental care than for medical care (Figure 5.5). This reflects the fact that dental care is less well covered by public schemes than medical care in most OECD countries, so people often must pay out of pocket or purchase additional private health insurance (see section on "Extent of healthcare coverage"). **More than 7% of people in Portugal, Latvia, Iceland, and Greece reported unmet dental care needs in 2021, compared to fewer than 0.5% in the Netherlands, Germany, and Austria.** In all analyzed countries, the burden of unmet needs for dental care falls disproportionately on people on lower incomes. This was most evident in Portugal and Latvia, where more than 16% of people in the lowest income quintile reported forgoing needed dental care in 2021, compared to fewer than 2% in the highest quintile. Recently, Portugal has aimed to improve access to dental care by creating dental health offices within public primary healthcare facilities.

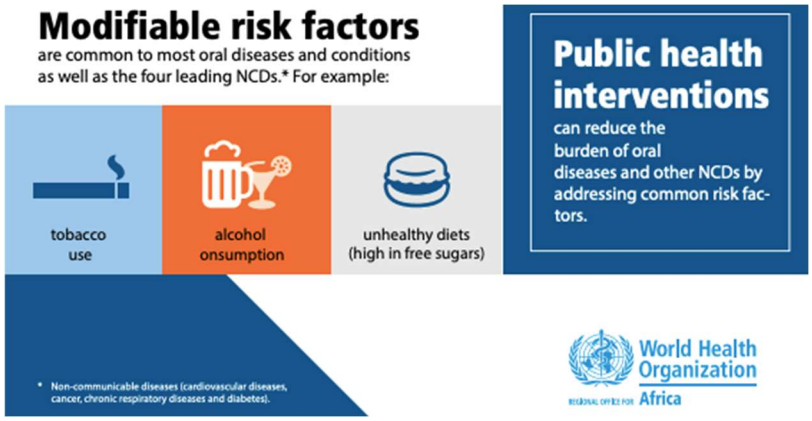
Figure 5.5. Population reporting unmet needs for dental care, by income level, 2021



Note: Data for Iceland refer to 2018 and data for Norway refer to 2020.
Source: Eurostat, based on EU-SILC.

Source:
https://hpfhub.info/wp-content/uploads/2024/05/Health-at-a-Glance-2023-OECD-Indicators-OECD-2023.pdf





What has been the history of oral health in the World Health Organization and the World Health Assembly?

ORAL HEALTH COUNTRY/AREA PROFILE PROGRAMME (CAPP)



In 1996, the World Health Organization established the **Oral Health Country/Area Profile Programme (CAPP)** to monitor oral health status, supported by Malmö University, Sweden for dental status and information concerning oral health system and Niigata University, Japan for periodontal conditions. The most updated Decayed/ Missing/Filled Teeth Index for 12-year-old children is from 2017 reported by Malaysia, Sweden and the UK,14 while the latest periodontal data reported from Thailand was in 2017, Japan in 2016 and Namibia in 2013.15 The Global Health Observatory (GHO), in the section for non-communicable diseases, covers oral health-related common risk factors, for example, diet, use of tobacco and alcohol, and oral health workforce. **CHECK:** https://capp.mau.se/country-areas/

RESOLUTION 60/16
ORAL HEALTH: ACTION PLAN FOR PROMOTION AND INTEGRATED DISEASE PREVENTION

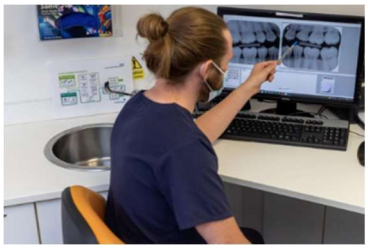


On **March of 2007** the World Health Assembly adopted a **resolution 60/16** urging Member States to adopt measures to ensure that oral health is incorporated into policies for the integrated

prevention and treatment of chronic noncommunicable and communicable diseases and into maternal and child health policies; to study mechanisms for providing basic oral health care to populations; to incorporate oral health into the framework of primary health care; to ensure the prevention of oral disease associated with HIV/AIDS and the promotion of oral health among people living with the virus; to implement national noma programs within integrated management of childhood illness programs; and to increase the budgetary provisions for these policies and strengthen partnerships among relevant stakeholders.

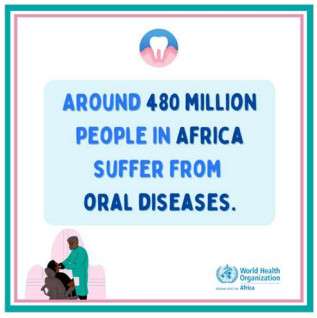
It requested the World Health Organization to provide advice and technical support for Member States that requested it; to promote international cooperation and interaction with partners in the application of oral health action plan, and to strengthen WHO's technical leadership in this area, including increasing human and budgetary resources. **READ:** https://apps.who.int/gb/archive/pdf_files/WHA60/A60_16-en.pdf

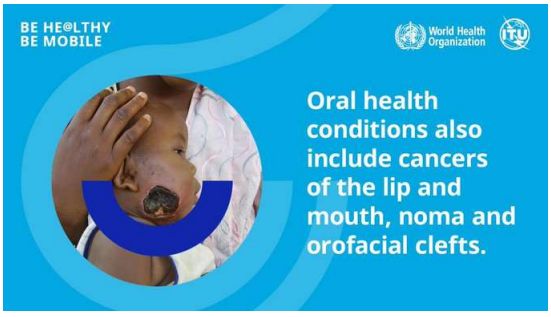
RESOLUTION WHA 74.5 ORAL HEALTH

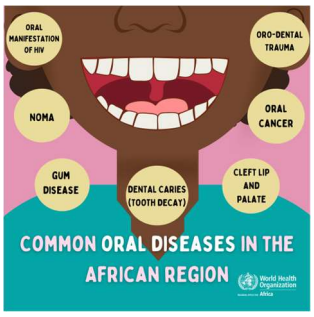




The World Health Assembly approved **a historic resolution on oral health in 2021. This was an important step. READ** the whole text of this resolution: https://apps.who.int/gb/ebwha/pdf_files/WHA74/A74_R5-en.pdf

The resolution urged Member States to address key risk factors of oral diseases shared with other noncommunicable diseases such as high intake of free sugars, tobacco use and harmful use of alcohol, and to enhance the capacities of oral health professionals. It also recommends a shift from the traditional curative approach towards a preventive approach that includes promotion of oral health within the family, schools, and workplaces, and includes timely, comprehensive, and inclusive care within the primary health-care system. **During the discussion, clear agreement emerged that oral health should be firmly embedded within the noncommunicable disease agenda and that oral health-care interventions should be included in universal health coverage programs.**





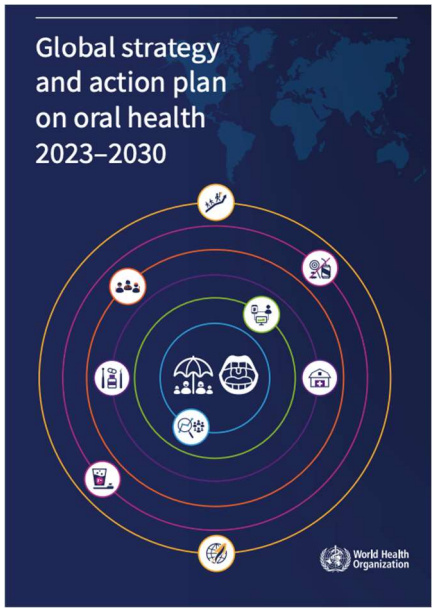


RESOLUTION OF THE WORLD HEALTH REGIONAL COMMITTEE FOR SOUTH-EAST ASIA SEA/RC75/R2

CHECK: https://iris.who.int/bitstream/handle/10665/363096/sea-rc75-r2-eng.pdf?sequence=1&isAllowed=y

GLOBAL STRATEGY AND ACTION PLAN ON ORAL HEALTH 2023-2030

The World Health Assembly delegates asked WHO to develop, by 2022, a draft global strategy on tackling oral diseases for consideration by WHO governing bodies in 2022 and by 2023; to translate the global strategy into an action plan for oral health; to develop "best buy" interventions on oral health; and to explore the inclusion of **noma (a disease which is fatal for 90% of children affected)** within the roadmap for neglected tropical diseases 2021-2030.



"The strategy is the outcome of a long process that that was kickstarted in 2020 and spearheaded by the Member State from Sri Lanka, who in a statement – supported by 17 other Member States – to the WHO 146th Executive Board, stated that:

"…there is an urgent need for more international political commitment to oral health and its integration into primary health care. Oral health care should not be an isolated part within the healthcare domain. It should be clearly embedded into the NCD and UHC agendas."

CHECK: https://www.fdiworlddental.org/global-oral-health-strategy-approved-who-world-health-assembly

The development and adoption of a comprehensive Global Strategy on Oral Health, with a bold vision for universal coverage of oral health services by 2030 was another milestone. The **Global Oral Health Action Plan** discussed in 2023 includes a monitoring framework, with clear targets to be achieved by 2030. These policies will provide a clear path towards ensuring oral health for all. **CHECK:** https://iris.who.int/bitstream/handle/10665/376623/9789240090538-eng.pdf?sequence=1

Good oral health

is essential in our daily lives, from

eating

breathing

speaking

It contributes to our
overall health and well-being
and gives us confidence
in interacting with others

World Health Organization

What should you discuss in your committee to promote oral health as part of Universal Health Coverage (UHC)?




As you read in this background guide, in May 2021, the 74th World Health Assembly adopted a resolution on oral health. 14 years after its last resolution on oral health **(WHA60.17)** in 2007, with slow progress on access to oral health services. The lack of global-level indicators (information) for oral health monitoring is one of the major deficiencies in driving national and global universal health coverage (UHC) agendas on oral health.

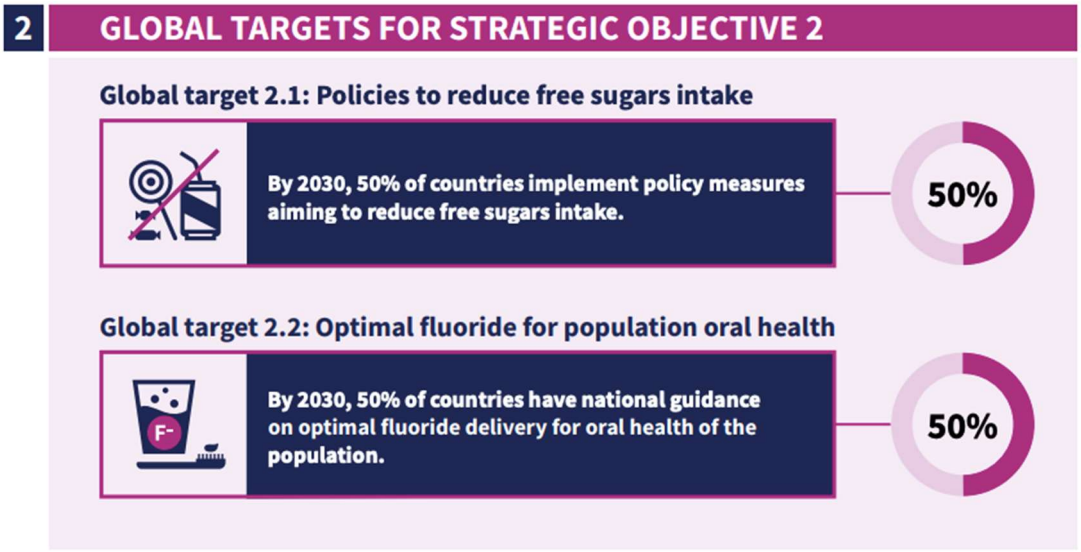
Prevalence of untreated oral diseases has increased over the last two decades, and the global prevalence rate of oral disorders was ranked first among all diseases since 1990. Oral health services are expensive and usually not included in or are only partially covered by UHC benefit packages. This results in either high levels of out-of-pocket payments or high incidence of unmet needs, affecting vulnerable populations. For these reasons, private insurance shifts in to cover oral health costs in high-income countries.

Only 35% of people with oral health problems in low-income countries were able to receive treatment within a year, whereas the rate was as high as 82% in high-income countries. Out-of-pocket expenditure for oral health services is a significant drain of the limited household budgets in the most vulnerable and can increase poverty. Even in high income countries, oral health expenditure accounted for approximately 20% of out-of-pocket health expenditure. Furthermore, availability and access to oral health services at a primary care level are inadequate or lacking in low-income and middle-income countries. Unmet oral health needs are higher than unmet medical needs and there is a large rich–poor gap in unmet oral health needs reported by members of the Organization for Economic Co-operation and Development (OECD).

Ask yourself:

- Does your country include oral health coverage in its national health coverage plans?
- Are oral health services affordable in your country?
- Does your country provide a **Basic Package of Oral Health** that includes **(1)** the promotion of affordable fluoride toothpaste **to prevent dental decay**; **(2)** oral urgent treatment aimed at relief of oral pain and providing emergency treatment; and **(3)** atraumatic restorative treatment to treat existing dental decay and prevent further decay?
- Does your country have **sufficient oral health professional available** to provide services to its population?
- Is your country or region affected by some specific oral health diseases? Does your country and region work to effectively prevent and treat them?
- Has your country worked with other countries to effectively prevent and treat oral diseases?
- Does your country have exemplary programs to promote good oral health? What **good examples** can your country provide in preventing and treating oral diseases?
- Has your country made progress in addressing oral diseases?

- What is your country doing to achieve the goals of the **Global Oral Health Action Plan? CHECK:**



3 GLOBAL TARGETS FOR STRATEGIC OBJECTIVE 3

Global target 3: Innovative workforce model for oral health

By 2030, 50% of countries have an operational national health workforce policy, plan or strategy that includes workforce trained to respond to population oral health needs.

4 GLOBAL TARGETS FOR STRATEGIC OBJECTIVE 4

Global target 4.1: Integration of oral health in primary care

By 2030, 80% of countries have oral health care services generally available in primary health care facilities.

Global target 4.2: Availability of essential dental medicines

By 2030, 50% of countries include dental preparations listed in the WHO Model Lists of Essential Medicines in their national essential medicines list.

5 GLOBAL TARGETS FOR STRATEGIC OBJECTIVE 5

Global target 5: Monitoring implementation of the national oral health policy

By 2030, 80% of countries have a monitoring framework for the national oral health policy, strategy or action plan.

6 GLOBAL TARGETS FOR STRATEGIC OBJECTIVE 6

Global target 6: Research in the public interest

By 2030, 50% of countries have a national oral health research agenda focused on public health and population-based interventions.

CHECK the profiles for countries and regions:

https://data.wpro.who.int/node/645
https://capp.mau.se/country-areas/
https://capp.mau.se/oral-health-promotion/
https://www.who.int/europe/news/item/20-04-2023-who-europe-calls-for-urgent-action-on-oral-disease-as-highest-rates-globally-are-recorded-in-european-region
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7652557/
https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Dental_Services_in_Australia/DentalServices/Final_report/Appendix_5_-_Summary_of_public_dental_arrangements_for_selected_countries
https://www.canada.ca/en/health-canada/news/2024/02/government-of-canada-announces-the-services-covered-under-the-canadian-dental-care-plan.html
https://iris.who.int/bitstream/handle/10665/363753/9789290210061-eng.pdf?sequence=1
https://ncdalliance.org/why-ncds/universal-health-coverage-uhc/tackling-oral-disease-in-thailand-through-universal-health-coverage-uhc
https://www.jda.or.jp/en/
CHECK the CASE STUDIES: https://www.fdiworlddental.org/sites/default/files/2021-02/Vision-2030-Delivering%20Optimal-Oral-Health-for-All_0.pdf
https://www.unicef.org/lac/en/reports/digital-marketing-of-unhealthy-food-and-beverages

TOPIC 2: PROTECTING CHILDREN FROM THE HARMFUL IMPACT OF FOOD MARKETING

What is marketing? What is food marketing?



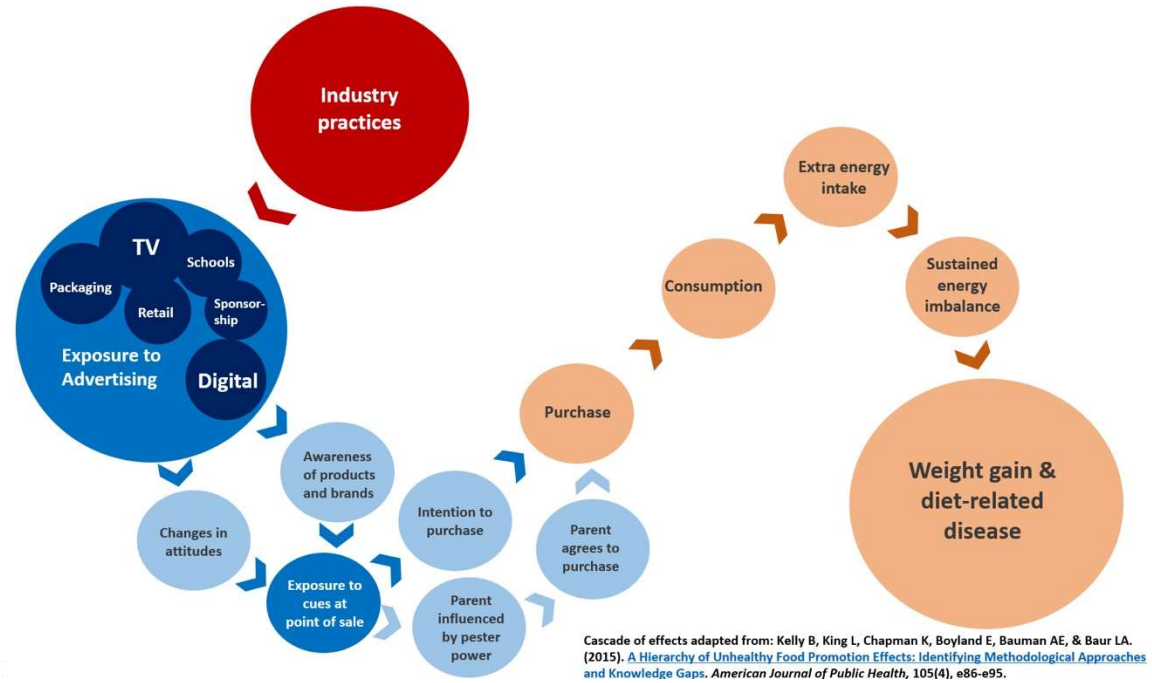
The United Nations has defined marketing as **any form of commercial communication, message or action that acts to advertise or otherwise promote a product or service, or its related brand, and is designed to increase, or has the effect of increasing, the recognition, appeal and/or consumption of products or services.** **CHECK:** https://www.youtube.com/watch?v=NsHhoiixLJE

CHECK: https://www.unicef.org/lac/media/42146/file/Reporte-marketing-digital-ing.pdf


Moreover, according to *A framework for implementing the set of recommendations on the marketing of foods and non-alcoholic beverages to children*, produced by the World Health Organization, **food marketing is one commercial activity that shapes the food environment and marketing of foods and drinks that are high in fat, salt, or sugar foods (HFSS) has long been recognized as having an especially harmful impact on the diets of children.** **CHECK**: https://www.unicef.org/media/139591/file/A%20Child%20Rights-Based%20Approach%20to%20Food%20Marketing.pdf

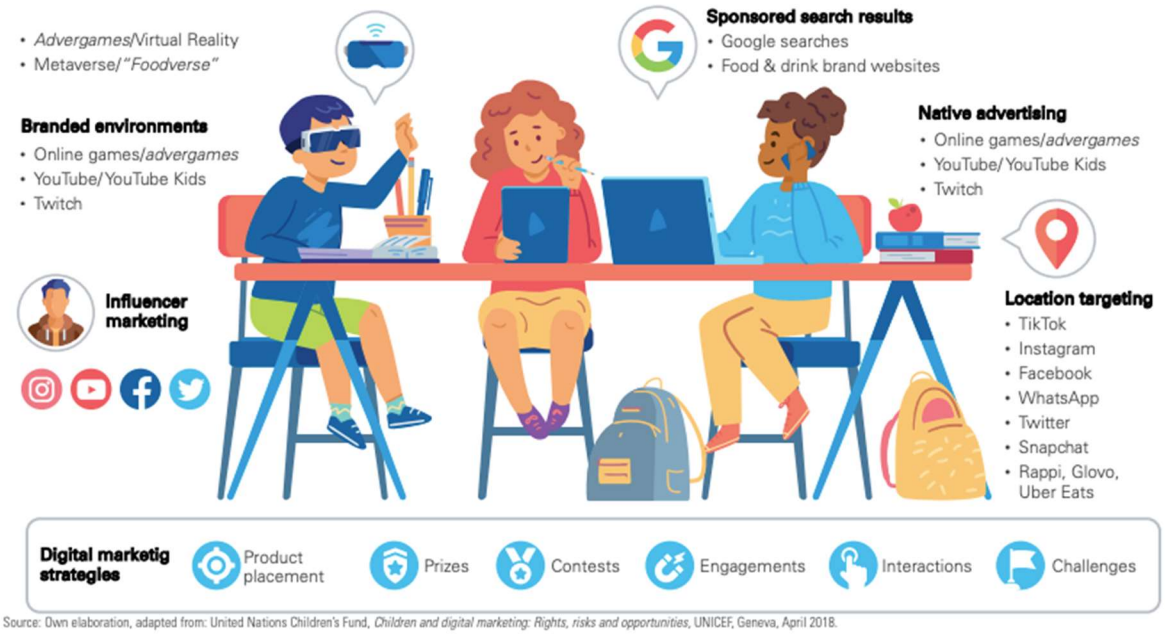
CHECK the glossary provided in **pages 4-6** to learn some important words and abbreviations: https://www.wcrf.org/wp-content/uploads/2021/01/PPA-Building-Momentum-3-WEB-3.pdf


What are the effects of food marketing in children?



Source:
https://www.canada.ca/en/health-canada/services/food-nutrition/healthy-eating-strategy/policy-update-restricting-food-advertising-primarily-directed-children.html

Marketing is a recognized means to promote products that are harmful to health, such as **HFSS foods.** Arguments in defense of marketing fade when the marketed products harm health and when marketing poses a threat to children's rights. In 2009, a review on the extent, nature, and effects of food promotion to children found that food marketing affects children's nutrition knowledge, food preferences and consumption patterns, and that the foods promoted by food marketing represented a "very undesirable dietary profile, with [a] heavy emphasis on energy dense, high fat, high salt and high sugar foods". More recent evidence has echoed these findings, showing that exposure to food marketing affects children's food preference, food choice and food intake in undesirable ways, and that food marketing continues to be predominantly for HFSS foods. **Numerous studies have documented the wide variety of media used for food marketing, including television, packaging, magazines, outdoor media, digital and sponsorship media, and promotions in and around schools.** The advent and growth of digital marketing has raised new concerns, including the use of novel marketing techniques (e.g. food-themed apps, influencer marketing, user-generated content). **Another concern is the collection of copious personal data from internet users and the use of these data to target marketing to users.**



Source: Own elaboration, adapted from: United Nations Children's Fund, *Children and digital marketing: Rights, risks and opportunities*, UNICEF, Geneva, April 2018.

What do young people like you believe about food marketing strategies? Is marketing food to kids ethical? Is it legal? What do you think as a delegate?
WATCH: https://youtu.be/V0JjggCHGtw

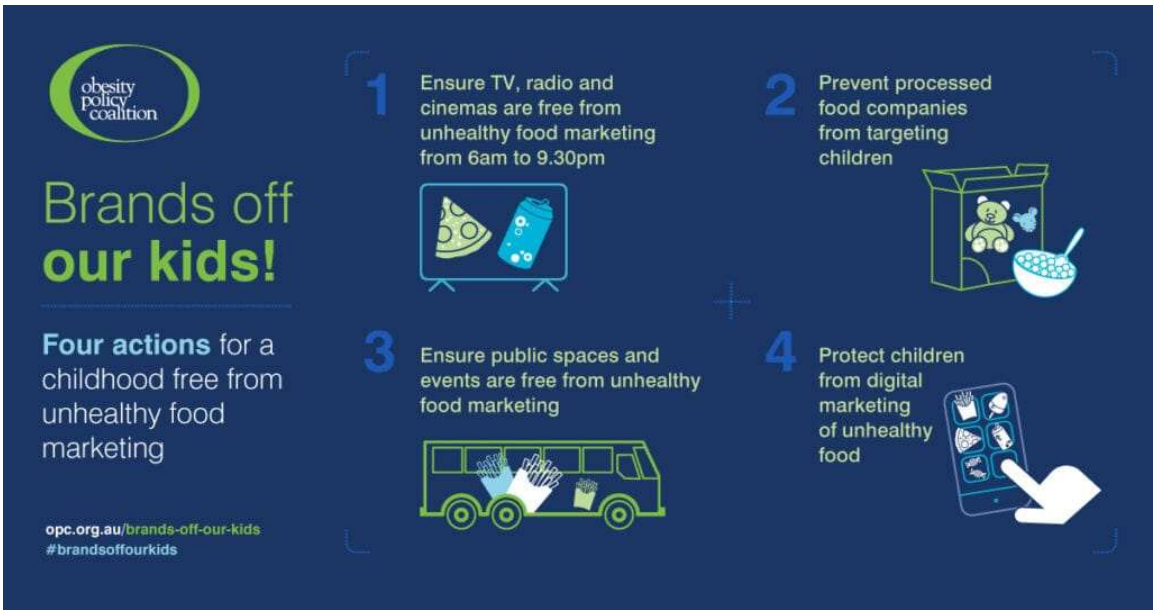
What is the problem? How does food marketing affect children's health?

WATCH:
https://youtu.be/Bjmj_Z7AXg0
https://youtu.be/Gc07YTWVapo
https://www.youtube.com/watch?v=JEqn2DNOt5Y
https://www.youtube.com/watch?v=TsZlTe_4LTU
https://youtu.be/fvxsrhl4vfM
https://youtu.be/ey6MgSQercM
https://youtu.be/c7tfgYccr28
https://youtu.be/nX6jg1VzG8o

How are HFFS products marketed?
CHECK:

Source:
https://www.wcrf.org/wp-content/uploads/2021/01/PPA-Building-Momentum-3-WEB-3.pdf

How are different organizations demanding to protect childhood? Why? CHECK some examples:



Source:
https://www.diabetesaustralia.com.au/blog/7-out-of-10-australians-support-push-to-protect-children-from-unhealthy-food-marketing/

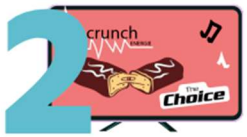
2 BEUC'S RECOMMENDATIONS IN A NUTSHELL

We are calling on the European Commission to end the reliance on self-regulation and finally regulate the marketing and advertising of unhealthy foods to children at EU level including:

1

An online ban for the marketing of unhealthy food products, including food company websites and social media accounts.

2



A TV watershed from 6am-11pm to stop the broadcast of unhealthy food advertising when children watch TV the most.

3

A ban on the use of marketing techniques appealing to children on food packaging (e.g. cartoon characters and brand mascots).

4

Rules should apply to children up to the age of 18 as opposed to the 13 years old limit typically set by self-regulatory initiatives.

5

The widely recognised World Health Organisation Nutrient Profiles should be used to determine which foods should not be advertised to children.[13]

In the meantime, European governments should recognise the pervasive and persuasive influence of the marketing of HFSS foods. In the absence of adequate action from industry, they should therefore not hesitate to already introduce national regulatory measures to properly tackle this issue.

[13] World Health Organisation, *WHO Regional Office for Europe Nutrient Profile Model*, 2015.

SOURCE:
https://www.beuc.eu/sites/default/files/publications/beuc-x-2021-084_food_marketing_to_children_needs_rules_with_teeth.pdf

Millions of children worldwide are consuming too many HFSS foods and non-alcoholic beverages with devastating consequences for their health and development. Today, unhealthy diets are a leading cause of death and disability globally, and overweight and obesity are on the rise. While these problems were once limited to high-income countries, middle-income countries now account for more than three quarters of all children under the age of 5 affected by overweight. Globally, overweight affects 1 in 5 children 5–19 years of age, and the issue is impacting a broad cross-section of the population, including urban, rural, and poor communities. The food environment, including how foods are marketed, plays a critical role in influencing children's diets. Evidence shows that food marketing is linked to childhood overweight and obesity. **Food marketing is a profit-driven activity that represents "one of the most underappreciated risks to [children's] health and well-being", as highlighted by the recent World Health Organization (WHO)–United Nations Children's Fund (UNICEF)–Lancet Commission on the future for the world's children.** Food marketing is pervasive globally. It typically uses persuasive and entertaining messages and experiences to engage children in negative ways.

Unhealthy diets are a leading global public health risk, contributing to all forms of malnutrition (i.e. undernutrition; micronutrient-related malnutrition; and overweight, obesity and diet-related noncommunicable diseases (NCDs)). Food environments, which include food marketing, are recognized as one of the key influences on diets. A 2009 review, for example, found that **food marketing affected children's nutrition knowledge, food preferences and consumption patterns, and that the foods promoted by food marketing represented a "very undesirable dietary profile, with [a] heavy emphasis on energy dense, high fat, high salt and high sugar foods".** More recent evidence has reinforced these findings, and the advent and growth of digital marketing have raised new concerns. **Food marketing is also increasingly recognized as a children's rights concern.** Marketing of foods high in saturated fatty acids, trans-fatty acids, free sugars and/or salt negatively impacts several of the rights enshrined in the Convention on the Rights of the Child, including the rights to health, adequate and nutritious food, privacy, and freedom from exploitation. **The Committee on the Rights of the Child has stated that the marketing of such foods should be regulated.**

Children and young people like you continue to be exposed to powerful food marketing, which predominantly promotes foods high in saturated fatty acids, trans-fatty acids, free sugars and/or sodium and uses a wide variety of marketing strategies that are likely to appeal to you. Food marketing has a harmful impact on children's and youth's food choices and their dietary intake, affects their purchase requests to adults for marketed foods and influences the development of their norms about food consumption. **Food marketing is also increasingly recognized as a children's rights concern, given its negative impact on several of the rights enshrined in the United Nations Convention on the Rights of the Child.**

What has been the history of food marketing in the World Health Assembly?

RESOLUTION WHA 63.14
MARKETING OF FOOD AND NON-ALCOHOLIC BEVERAGES TO CHILDREN

The need to protect children from the harmful impact of food marketing and to enable children to develop healthy food values and preferences has long been recognized. In **2010**, the Sixty-third World Health Assembly unanimously endorsed the WHO Set of recommendations on the marketing of foods and nonalcoholic beverages to children, recognizing that a significant amount of marketing is for foods high in fats, sugars or salt and is widespread across the world. **Resolution WHA63.14** on the marketing of food and non-alcoholic beverages to children urges Member States to:

- To take necessary measures to implement the recommendations on the marketing of foods and non-alcoholic beverages to children, while taking into account existing legislation and policies, as appropriate.
- To identify the most suitable policy approach given national circumstances and develop new and/or strengthen existing policies that aim to reduce the impact on children of marketing of foods high in saturated fats, trans-fatty acids, free sugars, or salt;
- To establish a system for monitoring and evaluating the implementation of the recommendations on the marketing of foods and non-alcoholic beverages to children;
- To take active steps to establish intergovernmental collaboration in order to reduce the impact of cross-border marketing;
- To cooperate with civil society and with public and private stakeholders in implementing the set of recommendations on the marketing of foods and non-alcoholic beverages to children in order to reduce the impact of that marketing, while ensuring avoidance of potential conflicts of interest;

As noted in the set of recommendations, governments are in the best position to set direction and overall strategy to achieve population-wide public health goals, and should therefore set the scope of a country's marketing restriction

CHECK: https://iris.who.int/bitstream/handle/10665/361630/WPR-RC068-Res03-2017-en.pdf?sequence=2&isAllowed=y

A FRAMEWORK FOR IMPLEMENTING THE SET OF RECOMMENDATIONS ON THE MARKETING OF FOODS AND NON-ALCOHOLIC BEVERAGES TO CHILDREN

The framework for implementing the set of recommendations proposes the following three comprehensive policy approaches that are considered to have the highest potential to achieve the desired policy impact:

- Eliminating **all forms of food marketing that is "high in saturated fats, trans-fatty acids, free sugars, or salt"** to which a broad range of children are exposed;
- Eliminating **all forms of food marketing** to which a broad range of children are exposed; and
- Eliminating **all forms of marketing** to which a broad range of children are exposed.

CHECK:https://iris.who.int/bitstream/handle/10665/80148/9789241503242_eng.pdf?sequence=1&isAllowed=y

The framework for implementation acknowledged that some Member States may choose to start with a narrower, stepwise policy approach, and to restrict marketing of only certain foods and of some forms of marketing through some channels. However, experience since endorsement of Resolution WHA63.14 showed that such approaches left children inadequately protected because exposure to food marketing that encouraged unhealthy diets continued. **Narrow policy criteria allow for gaps that companies may use to shift their marketing investment from regulated to unregulated areas. Food marketing originating from sources outside a country's jurisdiction may be beyond the scope of a current national policy.** This issue of cross-border marketing already recognized in Recommendation 8 of the WHO set of recommendations, is gaining importance, especially also with increased digital marketing.

In 2016, the WHO Commission on Ending Childhood Obesity noted with concern in its final report "the failure of Member States to give significant attention to Resolution WHA 63.14 endorsed by the World Health Assembly in 2010 and requests that they address this issue". Furthermore, in 2018, the WHO Independent High-Level Commission on Noncommunicable Diseases called for an increase in effective regulation; in particular, that "governments should give priority to restricting the marketing of unhealthy products (those containing excessive amounts of sugars, sodium, saturated fats and trans fats) to children". To date, no country has implemented a comprehensive policy, despite evolving evidence on the harmful impact that food marketing can have on children of all ages, including those aged over 12 years, and despite the lack of evidence that stepwise approaches can reduce both exposure to and the power of food marketing, and have a positive impact on children's health. **As of May 2022, a total of 60 countries have adopted policies that restrict marketing of food and nonalcoholic beverages to children, especially in the Region of the Americas and the European Region.** Twenty of these countries have mandatory marketing restriction policies and another 18 mandatory policies in the school setting. Several countries have multiple approaches, mandatory and voluntary and there is great variation in scope, such as channels or settings covered. Some policies cover all food and beverage products, others restrict marketing of products based on their nutrient content, and some focus on a specific product such as energy drinks or SSB. Furthermore, many countries have policies that do not cover children up to 18 years of age.

RESOLUTION WPR/RC 68.R3
PROTECTING CHILDREN FROM THE HARMFUL IMPACT OF FOOD MARKETING

The meeting of WHO's Western Pacific Region (WPRO) took place last in Brisbane, Australia in **2017** where **RESOLUTION WPR/RC 68.R3** was adopted. The 37 countries and areas of the Western

Pacific stretch more than a third of the way around the globe — its 1.9 billion people make up the world's most diverse Region in terms of people and places. Dr. Shin Young-soo, WPRO Regional Director, explained to the press: ***"When children are exposed to food marketing, their diets change … And when parents are exposed to formula marketing, this undermines breastfeeding."***

There was evident concern about the marketing in the WPRO region. Several countries, including Brunei, Malaysia and the Philippines made statements about the importance of regulation. Hong Kong mentioned the industry pressure (including threats to their 'voluntary code'). **CHECK:** https://apps.who.int/gb/ebwha/pdf_files/WHA63/A63_R14-en.pdf

RESOLUTION WPR/RC70.R1
PROTECTING CHILDREN FROM THE HARMFUL IMPACT OF FOOD MARKETING

CHECK: https://iris.who.int/bitstream/handle/10665/366011/WPR-RC070-Res01-2019-en.pdf?sequence=2&isAllowed=y

CHECK the list of other UN documents calling on Member States to implement marketing restrictions and other international reports addressing HFSS in pages 13 and 14: https://www.wcrf.org/wp-content/uploads/2021/01/PPA-Building-Momentum-3-WEB-3.pdf

UN documents calling on Member States to implement marketing restrictions

- **2004** – WHO, *Global Strategy on Diet, Physical Activity and Health,* recommended multi-sectoral approaches to the marketing of food and non-alcoholic beverages to children, including sponsorship, promotion and advertising.(54)
- **2008** – WHO, *2008–2013 Action Plan for the Global Strategy for the Prevention and Control of Non-communicable Diseases*, to translate the Global Strategy into concrete actions.(55)
- **2011** – UN General Assembly, *Political Declaration of the UN High-Level Meeting on the Prevention and Control of NCDs*, highlighting recommendations on actions and policies to restrict marketing and advertising to children.(56)
- **2013** – WHO, *Global Action Plan for the Prevention and Control of NCDs 2013–2020*, Appendix 3 of which provides a list of policy options including implementing the WHO Recommendations.(57)
- **2014** – FAO, *Rome Declaration on Nutrition*, states 'governments should protect consumers, especially children, from inappropriate marketing and publicity of food'.(58)
- **2014** – UN General Assembly, *Outcome Document on the High-level Meeting of the General Assembly on the Comprehensive Review and Assessment achieved in the Prevention and Control of NCDs*, reiterating recommendations on actions and policies to restrict marketing and advertising to children, including a call to mobilise political will and financial resources.(59)
- **2016** – WHO, *Report of the Commission on Ending Childhood Obesity* (the ECHO Commission), adopted by the World Health Assembly, which included a call for improving actions to restrict marketing to children.(10)
- **2017** – WHO, *Tackling NCDs: 'Best Buys' and other Recommended Interventions for the Prevention and Control of Non-communicable Diseases,* listed implementing the WHO recommendations as an overarching/enabling action.(60)
- **2018** – UN, *Political Declaration of the Third UN High-Level Meeting on the Prevention and Control of NCDs* highlighted recommendations on actions and policies to restrict marketing and advertising to children.(61)

What should your committee be discussing?

- What actions are globally needed **to protect children from food marketing strategies?** Who (ages) should be protected?

- How can children be protected from **marketing exposure** and **power**? **REVIEW** what these words mean (exposure and power) What are HFSS foods and beverages?

Definitions of marketing, HFSS foods, and marketing exposure and power

Marketing: The WHO defines marketing as 'any form of commercial communication of messages that are designed to, or have the effect of, increasing the recognition, appeal and/or consumption of particular products and services - it comprises anything that acts to advertise or otherwise promote a product or service' (45). This broad definition of marketing is intended to cover the wide breadth of marketing strategies, including, but not limited to, advertising, sponsorship, direct marketing (e.g. mail, text), product placement and branding and product packaging. Although it is not explicitly stated in the WHO Set of Recommendations on the Marketing of Foods and Non-alcoholic Beverages to Children (46), marketing also encompasses the promotion of brands (usually the only marketing element for sponsorship), as brand loyalty awareness is one of the mechanisms through which marketing increases HFSS food consumption.

HFSS foods and non-alcoholic beverages: Foods and non-alcoholic beverages considered to be harmful to health due to the high content of saturated fat, trans-fatty acids, free sugars or salt (often referred to as 'unhealthy' foods and beverages). These are the target foods and beverages for food marketing policies and, throughout this document, are collectively referred to as HFSS foods.

Marketing exposure and power: The impact of marketing is a function of exposure and power (45). ***Exposure*** refers to the reach (how many people are exposed to given marketing message or campaign over a specified period) and frequency (how many times people are exposed). ***Power*** refers to the content, design and execution of the marketing message (e.g. using techniques of cartoon characters or celebrities, use of competitions or games).

- What kind of restrictions should be considered? Why? Why not? **CHECK:** https://www.unicef.org/eap/media/9581/file/Controls%20on%20the%20marketing%20of%20food%20and%20non-alcoholic%20beverages%20to%20children%20in%20Thailand.pdf

Definitions for settings-based, time-based and medium-based restrictions		
Settings-based restrictions: total ban on HFSS marketing in specific venues and locations • Child-centred settings (schools, child services, playgrounds, children's sports, etc) • Public spaces, public transport and public events • Retail environments	**Time-based restrictions:** total ban on HFSS marketing between pre-specified times • All broadcast media including television, cinemas and radio	**Medium-based restrictions:** total ban on HFSS marketing disseminated through specified mediums • Non-digital, non-broadcast media with mixed-use audiences • Digital media including online environments

- What can be learned from the actions taken in **Chile, India, Ireland, Hungary, South Korea, Thailand, and the United Kingdom? What can be learned from the Caribbean countries? CHECK:** https://www.globalfoodresearchprogram.org/wp-content/uploads/2021/02/UNCGFRP_FactSheet_Child_Marketing_2020_August-1.pdf

TAKE CHILE AS A CASE STUDY

IMPACT OF CHILE'S POLICIES

Three studies[1] recently published in peer-reviewed journals found that Chilean households **purchased fewer sugary drinks** (a **24% reduction**) while Chilean **children saw less advertising and marketing of unhealthy food and drinks**, thanks to the suite of policies contained in the Food Advertising and Labeling Law.

KEY FINDINGS

REDUCED PURCHASES OF SUGARY DRINKS

After the implementation of the policy package there was a **decrease of**:
24% ↓ (-22.8 mL per person per day)
in the household volume **of high sweetened beverages purchased**.

The **largest decrease** in household purchases was **among these beverages:**
- high sweetened fruit: **42%** ↓
- dairy: **20%** ↓

The volume of **non-high sweetened beverages** purchased **increased by:** **4.8%** ↑

IMPACT OF RESTRICTION OF ADS TO CHILEAN CHILDREN

After implementation of the television advertisement restriction, **exposure to unhealthy food decreased by:**
- **44%** ↓ for preschoolers
- **58%** ↓ for adolescents

Exposure to advertising of unhealthy foods **featuring child-focused tactics** such as **cartoon characters decreased by:**
- **52%** ↓ for adolescents
- **35%** ↓ for preschoolers

Children who viewed more television saw higher decreases in exposure to advertising for unhealthy foods.

CHILD-DIRECTED MARKETING ON CEREAL PACKAGES

The **percentage** of food and beverage products **that targeted children decreased:**	from **36%**	before implementation of the law	to **21%** ↓	after implementation
The **percentage** of "high-in" packages that used at least one **child-directed marketing strategy decreased:**	from **43%**	before implementation of the law	to **15%** ↓	after implementation
The **percentage** of "high-in" packages that **used characters** (e.g. image of human youth, superhuman characters) **decreased significantly:**	from **36%**	before implementation of the law	to **15%** ↓	after implementation
The **percentage** of "high-in" packages that **used non-character child appeals** (e.g. child-oriented gifts in the package, games on the box, school references) **decreased:**	from **23%**	before implementation of the law	to **0%** ↓	after implementation

Country examples of regulating food packaging

Chile (2016): Tony theTiger, a significant Kellogg's brand identity, was removed by Chilean marketing restrictions that ban techniques and incentives that could attract the attention of children, such as cartoons, animations and toys.

UK (proposed): The UK government has committed to legislative ban on unhealthy food price promotions. Specifically, this includes a restriction on multi-buys (buy-one-get-one-free), sale of unhealthy foods at check-outs and at shop entrances and on the sale of unlimited refills of unhealthy foods and beverages in places where they are sold to the public.

Country examples of regulation of digital marketing

South Korea (2010): Internet advertising, not limited to, but includes, unhealthy food, that includes "gratuitous" incentives to purchase (e.g. free toys) is prohibited.

UK (2020 proposed):To harmonise regulation of both broadcast and non-broadcast media (media neutrality) the UK has proposed to ban online unhealthy food advertising, including banner and video advertising, between 5.30am and 9pm. It is proposed that brands and marketers may be responsible for compliance and complaints for potential breach to be referred to the Advertising Standards Authority.

Finland (2015): Law prohibits use of advertising, indirect advertising or sales promotion for alcohol using online games and apps, online competitions, requests of users to share content from brand-controlled sites and social media accounts and for content intended to be virally shared. Banner and pop-up advertising is permitted if it is not aimed at children, does not contain high alcohol content and does not contain irresponsible messages. User-generated content is permitted but there must be no financial ties with the alcohol industry. Marketers cannot op-opt users to participate in the marketing process. The National Supervisory Authority for Welfare and Health is tasked with enforcement of regulations, with breaches of compliance largely indicated through a third-party complaints system.

Country example of regulations in settings where children gather

India (2020): Foods and beverages high in saturated fat or trans-fat or added sugar or sodium cannot be marketed on a school campus or to school children in an area within 50 meters from the school gate in any direction.

Ireland (2018): Generally, for the voluntary code of practice, locations primarily used by children should be free from all forms of marketing communication for foods high in fat, salt and sugar. Examples of such settings include registered crèches, pre-schools, nurseries, family and child clinics, paediatric services, schools, dedicated school transport, playgrounds and youth centres.

Hungary (2008): All advertising (not just food related) directed at children (<18 years) is prohibited in child welfare and child protection institutions, kindergartens, elementary schools and their dormitories.

- **How can rules "have teeth"? What kind of regulations are needed?**
  CHECK: https://youtu.be/ey6MgSQercM

- What foods are to be restricted from marketing? What foods should be permitted?
- What marketing types, techniques and channels are to be restricted?
- What kind of **labeling** is effective to **CHECK:** https://youtu.be/Vw_hr7bED90
- What kind of regulations should be in place in food packaging?

Chile's front-of-package warning labels alert consumers to high levels of sugar, salt and saturated fat, as well as calories, following the implementation of the Law of Food Labeling and Advertising.

CHECK: https://healthpolicy-watch.news/chiles-comprehensive-food-policy/#:~:text=Chile%20implemented%20bans%20on%20the,in%20much%20of%20the%20world.

Source: https://www.healthycaribbean.org/wp-content/uploads/2020/05/fact-sheet-multi-colour-background-final-may-2020.pdf

What is the Caribbean region doing? CHECK:

FRONT OF PACKAGE LABELS (FOPL)

Source: https://www.healthycaribbean.org/wp-content/uploads/2020/05/fact-sheet-multi-colour-background-final-may-2020.pdf