WORLD HEALTH ORGANIZATION

ORGANISATION MONDIALE DE LA SANTÉ

WHO/HPP/FOS/90.3

ENGLISH ONLY

Distr.: LIMITED

REPORT OF THE

TASK FORCE

ON

INTEGRATED APPROACHES TO HEALTH EDUCATION IN FOOD SAFETY

Geneva, 3 to 7 December 1990

1991

TASK FORCE ON INTEGRATED APPROACHES
TO HEALTH EDUCATION IN FOOD SAFETY

TABLE OF CONTENTS

Page Number

ANNEXES:

1. INTRODUCTION

Dr Käferstein, Chief, Food Safety Unit, World Health Organization, welcomed the participants and expressed the hope that this would be the first of a series of Task Force meetings aimed at the promotion and implementation of health education in food safety (HEFS). He referred to the Joint FAO/WHO Expert Committee on Food Safety (Ref. 1, Annex V) held in 1983 in Geneva which concluded that

(i) illness due to contaminated food was perhaps the most widespread health problem in the contemporary world and an important cause of reduced economic productivity; and
(ii) education of food handlers, i.e. those who prepare food for consumption, in hygienic food preparation was one of the most important interventions towards preventing foodborne diseases.

Contrary to the beliefs of many consumers particularly in industrialized countries who fear poisoning as a result of food additives, pesticide residues, or other chemicals in foods, the overwhelming majority of the foodborne diseases are caused by biological contaminants, notably bacteria, viruses and parasites. Dr Käferstein pointed out that certain mistakes made during the preparation of food for consumption were responsible for a large number of foodborne diseases. These mistakes

(i) allowed contamination of food with foodborne pathogens;
(ii) failed to kill or denature the contaminant during the preparation of the food; and
(iii) failed to prevent the multiplication of pathogens.

Following the 1983 Expert Committee on Food Safety and the 1987 WHO Consultation on Health Education in Food Safety (Ref.2, Annex V), the World Health Organization (WHO), with the support of the German Technical Cooperation Agency (GTZ) and the Industry Council for Development (ICD), initiated pilot projects in the Dominican Republic and Pakistan to implement a programme on health education in food safety, based on the identification of factors responsible for the growth and proliferation of bacteria.

A critical review of these two pilot projects was one of the objectives of the Task Force. Monitoring and evaluation of their progress is essential if: (a) guidance to countries for these and new projects is to be provided; (b) their requirements are to be assessed; and (c) the resources necessary for their implementation determined.

Additionally, the Task Force seeks to provide: (a) advice on the respective roles of the various sectors/partners involved in ensuring the safety of food; and (b) guidance to countries for the implementation of national coordinated strategies in health education in food safety which involve collaboration between governments, industry and consumer and other nongovernmental, private, voluntary, religious or grass-root organizations.

In closing, Dr Käferstein thanked all those who participated at the expense of their own organizations. In particular he thanked the Dutch National Institute for Public Health and Environmental Protection for its financial contribution which allowed the participation of one colleague each from the Dominican Republic and Indonesia.

Professor Abdussalam was elected to act as Chairman and Dr Ashley as Rapporteur.

2. WHY HEALTH EDUCATION IN FOOD SAFETY? THE RATIONALE FOR A COMPLEMENTARY APPROACH

There are a vast number of public health problems which, despite the application of advanced technology and knowledge, arise from the faulty handling of food.

Diseases caused by the ingestion of contaminated food (foodborne diseases) are still the number one cause of human suffering and ill-health in many countries, particularly amongst children. Often ignored is the fact that diarrhoeal diseases in infants is, to a large extent, due to the ingestion of contaminated food.

Foodborne disease also has consequences which affect the economic development of countries and the well-being of all populations. These include losses of food at all stages of the food chain, losses in manpower, income and the heavy cost of medical care. In certain countries it may have a considerable impact on the tourist and food export industries.

The problem of foodborne disease is world-wide. Industrialized countries, even with their well-organized food safety infrastructure - food safety laws, standards and enforcement mechanisms - are still not able to quell the spread of foodborne disease.

The World Health Organization (WHO) proposes that an effective food safety infrastructure should develop concomitantly with an appropriate educational programme on food safety for food handlers and consumers. The latter should be conceived as part of an overall primary health care strategy and be designed to show how the risk of contaminating food during handling, preparation and storage may be minimized.

The implementation of such a strategy needs the cooperation of three sectors, i.e. governments, industry-trade and associations representing the interests of consumers. Together these sectors are responsible for the design and implementation of programmes to educate food handlers and to inform and to educate consumers.

The design of these programmes should be based on two kinds of evidence: 1) sociocultural evidence which covers information regarding the food habits, rituals and beliefs of the population: 2) technical information on the observed risks and hazards for the contamination of food current in the population.

The first implies investigations by anthropologists and sociologists, the second requires application of the Hazard Analysis Critical Control Point (HACCP) system by food scientists.

The educational programme should be implemented using all available resources and means. These include the participation of health educators, food scientists, a rational use of the mass media, schools, teachers, contacts with health workers, etc. The programme's impact must be constantly evaluated.

Before being able to implement this strategy, public health and public education authorities must clearly understand:

1. Foodborne diseases are a major public health problem facing all societies. To a large extent these can be prevented if proper measures are taken.

2. A formal food safety infrastructure alone (e.g. legislation, enforcement, compliance) will not prevent the spread of foodborne disease.

3. The provision of safe food for populations is the result of concerted efforts by governments, industry and groups or associations representing the interests of consumers, and the consumers themselves. These three sectors share the responsibility for food safety.

4. The consumer and all food handlers are important targets in the fight against foodborne disease. Through primary health care programmes they should be taught how to handle, prepare and store food so as to minimize biological and chemical contamination and proliferation of microorganisms.

5. An effective, culturally appropriate educational programme for food handlers and consumers should be designed and implemented in all countries.

3. REPORT OF RECENT WHO ACTIVITIES RELATED TO HEALTH EDUCATION IN FOOD SAFETY

The Task Force was informed about the global and interregional activities in health education in food safety.

In 1983, a Joint FAO/WHO Expert Committee on Food Safety (Ref.1) proposed a strategy for public education and community participation to prevent and control foodborne diseases.

In 1987, a WHO Consultation on Health Education in Food Safety (Ref.2) established that health education in food safety (HEFS) was the shared responsibility of governments, industry and consumers. Appropriate mechanisms had to be developed to establish partnerships with organizations so as to harness all possible resources for the implementation of national programmes.

The Consultation also recommended the creation of an International Task Force representing the interests of those who share the responsibility for food safety.

In 1989, the Eighty-third Session of WHO's Executive Board established official relations with the Industry Council for Development (ICD), a non-profit, private development organization supported by corporations world wide. WHO and ICD, with the invaluable support of the German Agency for Technical Cooperation (GTZ), have commenced, inter alia, pilot projects in the Dominican Republic and in Pakistan. Recently, ICD, in cooperation with the International Council of Women (ICW) conducted a project feasibility mission to Indonesia.

In 1989, a Consultation was held on Health Surveillance and Management Procedures for Food-handling Personnel (Ref.3, Annex V), which recommended inter alia, that those governments, industries and institutions that rely at present on medical examinations of food-handling personnel for the prevention of foodborne disease should discontinue this practice, because it has no value for that purpose, another recommendation was that request by food importers of certification of food-handling personnel in an exporting country, should be discontinued. This consultation stressed the importance of education and training in good hygienic practices for food-handling personnel. Implementation and maintenance of HACCP in all food establishment was another recommendation. The managers have also to be trained in good hygiene practices. As one of the results of this Consultation, in association with ICD, and with the cooperation of WHO, as of 1991, the Pro Gastronomia Foundation will sponsor training courses for training trainers in food safety and food hygiene for food service operations.

WHO participated in important conferences and seminars, presenting papers related to health education. The most important were: The Asia Regional Conference of the International Union for Health Education, 17-20 July 1990, Singapore; The First Asian Conference on Food Safety, 3-7 September 1990, Kuala Lumpur; and the EMRO Interregional Seminar on Health Education in Food Safety, 23-27 September 1990, Islamabad.

A list of the principal WHO publications on Health Education in Food Safety is included in Annex V.

The work of the Joint FAO/WHO Codex Alimentarius Commission in developing standards for foods can also be highlighted. Numerous commodity standards were adopted by the Commission and contain elements related to the safety of food. In addition, codes of hygienic and/or technological practice for foods have been developed by the Commission. These codes serve as guidelines to improve the processing and hygienic quality of food as well as to train food inspectors, processors and handlers throughout the world.

4. SOCIO-CULTURAL AND ECONOMIC FACTORS INFLUENCING HEALTH EDUCATION IN FOOD SAFETY

The topic of socio-cultural and economic factors which influence health education in food safety has received, because of its importance, due attention in various meetings and articles. The Task Force discussed these factors, arriving at the general agreement that priority has to be given to this subject.

Any improvement in the safety of foods through health education activities at different stages throughout the food chain will depend on the interaction between the physical environment, and socio-cultural and economic variables. Given the conditions present in developing countries, ways to motivate behavioural change will have to be found. Methods to influence existing unsafe food practices will have to be realistic and people taught to cope within the context of their economic and socio-cultural circumstances. Identification of culture-specific, positive, safe food practices and behaviours should also be identified and promoted. Otherwise, non-compliance to health education in food safety may be high in poor communities of the developing world.

5. METHODOLOGIES TO IDENTIFY FACTORS RESPONSIBLE FOR FOOD CONTAMINATION BY BIOLOGICAL AGENTS AND OF THE GROWTH AND SURVIVAL OF FOODBORNE DISEASE PATHOGENS IN DEVELOPING COUNTRIES

Identifying factors responsible for foodborne disease through epidemiological investigations and food contamination monitoring is time consuming and usually beyond the financial means of many countries. The Hazard Analysis Critical Control Point approach (HACCP) is much less costly, and is a relatively fast way to obtain the necessary information. It is a systematic and logical approach which can be applied in the food-processing industry, food service establishments, street vendor operations, and food distribution systems, as well as in the home. Components of the HACCP system are summarized in Figure 1.

The HACCP approach identifies contamination, survival and growth of microorganisms in foods that are prepared in homes and small food shops and at street vending operations etc., and determines critical control points of the operations. Basically, the hazard analyses consists of (a) observing food preparation and storage practices to identify sources and modes of contamination; (b) measuring temperatures of the inner parts of foods during each sequential step of operation; and (c) collecting samples of food before and after sequential stages of preparation and of leftovers and testing them microbiologically. Flow diagrams with demotions of hazards and critical control points of the processes or preparation steps are drawn for each operation (see Figure 2). (A critical control point is an operation (practice, procedure, process, location at which control or preventive measures can be implemented to eliminate, prevent or minimize hazards.)

Based upon these data, effective and practical preventive measures are chosen or devised. Information about high-risk hazards and preventive measures at critical control points is converted to health education messages.

Figure 1

THE HACCP SYSTEM

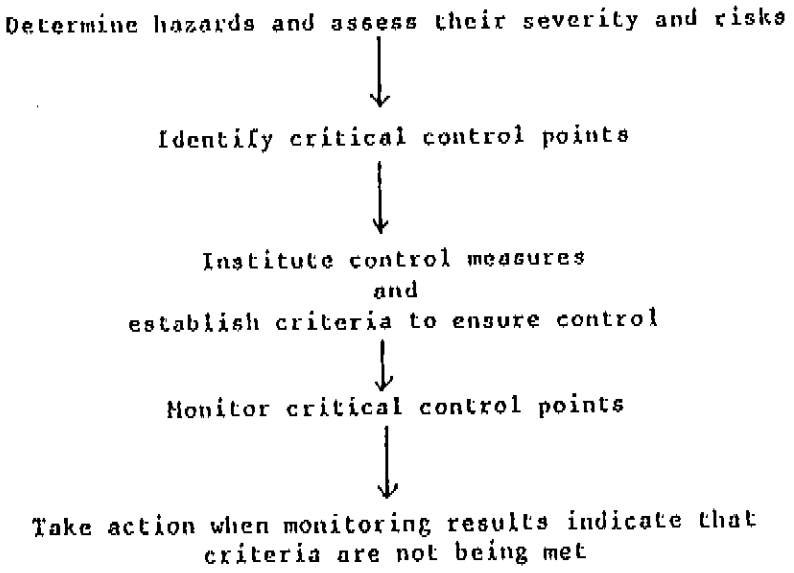
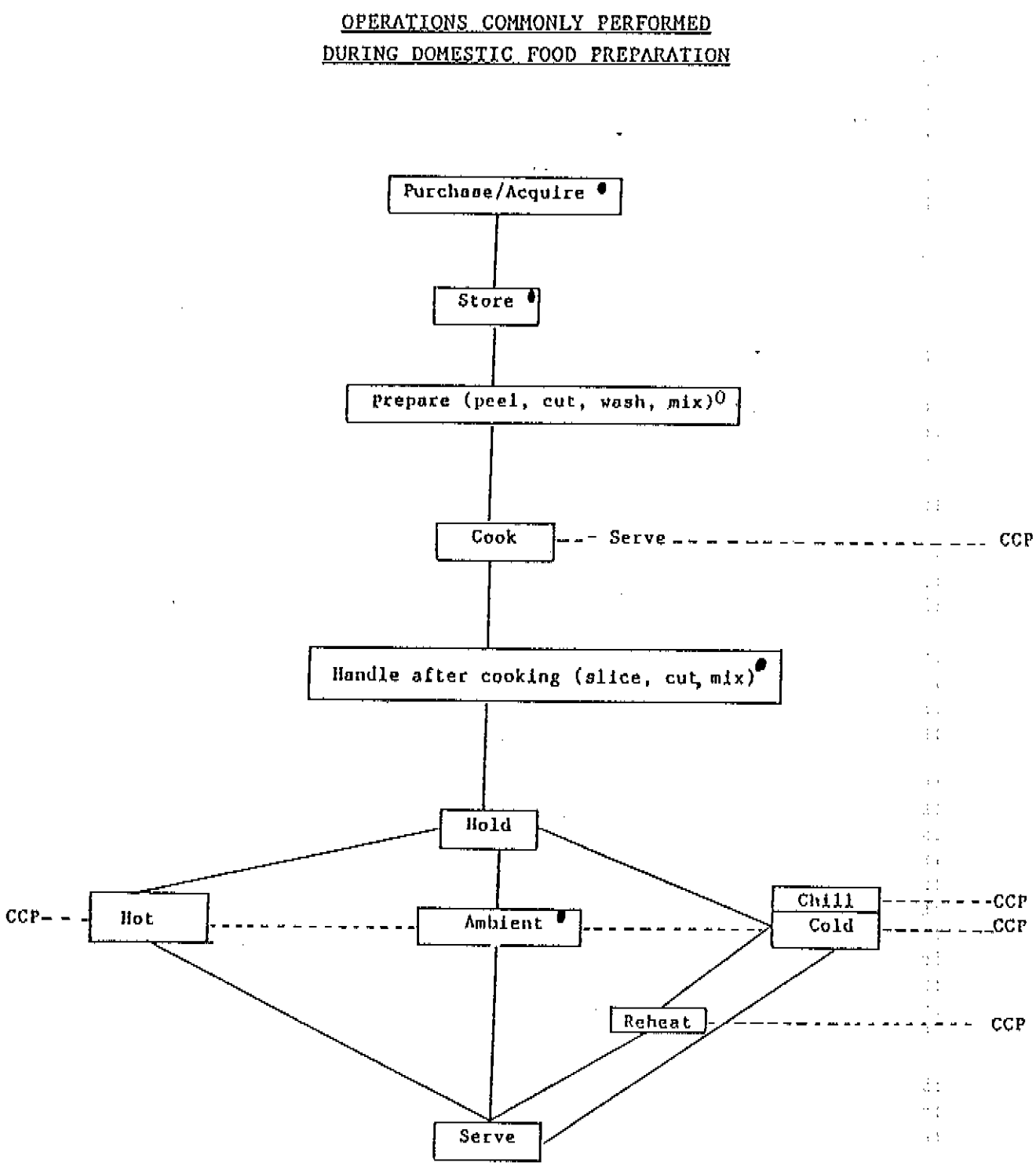


Figure 2



● = major hazard (significant microbial contamination, survival or growth)
O = possible hazard
CCP = Critical control point

6. CHEMICAL CONTAMINATION OF FOODS

Environmental conditions in many countries are such that the food supply may be severely contaminated with undesirable chemical substances. While the magnitude of the problem and its health consequences have not been extensively assessed, chemical contamination of food from the environment is not believed to be a major factor contributing to the high incidence of foodborne disease commonly affecting populations of the world. It may however, to varying degrees, have consequences to neurological dysfunction, learning disabilities and micro-nutrient deficiencies in populations. When infants and young children are affected, the long-term consequences could be severe. Because of this perspective, it is important to examine how food contamination with chemicals may occur and its relative place in health education in food safety. Agricultural workers may be given education on safe use of pesticides and preventative measures for other chemical and microbiological contamination of foods. The contribution that home-based and cottage food preservation, processing industries and fraudulent practices makes to food's chemical and biological contamination needs to be studied.

7. COMMUNITY INVOLVEMENT IN THE PROMOTION OF FOOD SAFETY

Health education activities to prevent food borne diseases should be designed to help people: 1) learn the most important causes and determinants of food borne diseases; and 2) act individually and collectively to prevent them. In developing such a programme, community participation must be considered an essential element.

Community involvement is important for reasons including the following: 1) participation itself is an effective learning experience, i.e. the more people participate in a learning experience, the more likely they are to be influenced by it; 2) participation increases the likelihood that learning experiences are relevant, i.e. focused on influencing important beliefs, customs, habits, perceptions, policies, and quality controls; and 3) participation leads to the mobilization of untapped community resources and contributes to sustained efforts.

The participation of a broad range of community and social institutions is important because improved food safety requires actions by the government and food industry, as well as individual actions by food handlers and consumers. Programme planners should seek the participation of women's organizations, commercial organizations, consumer's organizations, trade unions, farmer's and agricultural associations, social clubs, youth groups, religious institutions, and other interested organizations. Consumers' organizations have a special capacity for leadership in the motivation, education and organization of people and groups. Such broad participation can help maintain pressure for support of social policies, including food safety policies, and help transform policies and guidance into practice.

Programme planners should involve community organizations early in the development of the programme, as well as throughout the programme's implementation. This should include involvement in advocating for supportive

policies, strengthening social support systems and educating their constituents and others in support of food safety. Mechanisms, such as networks and alliances, should be planned to maintain frequent contact and dialogue with organizational leaders and to encourage their active participation.

In order to facilitate community involvement in preventing foodborne disease and promoting food safety, programme planners will need to provide the following:

- Information about specific actions that food handlers, and consumers can take to protect themselves, their families and their communities from food borne disease. This information should identify actions that will be effective in preventing or reducing disease risk even where governmental and food industry controls are inadequate. This information should be given the highest priority for programmatic action because it enables people to begin protecting themselves without delay. Legislation, policies and quality controls often take time to formulate and implement. Education that can result in effective prevention can immediately begin.

- Information about specific actions that national and local governments, and food industries can take to help prevent foodborne disease. This information should include examples of strong national and local commitments to food safety, such as laws, regulations, enforcement measures; and quality controls. It is important to identify specific examples so that people will know what is possible and effective, and can then determine the extent to which such measures are needed in their nation or community.

With this knowledge, and the capacity of organized participation, people can be helped to protect themselves and to participate in the educational and policy making processes that will lead to improved governmental and industrial actions for food safety.

8. COUNTRY PROGRAMMES

1. Review of Procedures for their Implementation

The present strategy for the implementation of country pilot programmes which has been applied is shown in Annex 1.

These strategies have led to some successful interventions.

However, they need to be reviewed to take into account strategies for implementation and coordination of HEFS by the different sectors.

A special group was appointed by the Task Force to establish guidelines for the implementation of HEFS programmes in developing countries for presentation at the second Task Force meeting in December 1991.

DOMINICAN REPUBLIC

A technical mission from WHO visited the country in 1984. It was thereafter decided to initiate a pilot HEFS project in the Dominican Republic and to discuss with the authorities the form of such pilot projects which could include the Dominican Republic in the development of a pilot project, and to assess the conditions prevailing in the country relative to food safety.

In 1985, PAHO/WHO, in cooperation with officials from the Dominican Institute of Technology of the Central Bank (INDOTEC) and the Ministry of Health, performed various studies on the application of HACCP during the preparation of foods in homes and in street vending operations. Hazard and critical control points were identified for several food preparation procedures. The results have been already published (Refs. 11,12,13, annex V).

In February 1987, as a result of an intensified WHO/ICD initiative to promote food safety through health education, a regional course on HACCP was conducted in the Dominican Republic for microbiologists and public health officials from Argentina, Dominican Republic, Guatemala, Peru and Venezuela.

The course was jointly funded by WHO, PAHO and ICD. Participation of international teachers was contributed by WHO, PAHO and the international food industry. Likewise, some international food industries donated equipment and reagents for use during the course. Local industries supported the local organization and the course's social activities. After attending the course, various programmes and applied studies, supported by PAHO/WHO, have been organized by the participants in their own countries.

As a consequence of this course, HACCP courses were conducted in the Dominican Republic by INDOTEC for food industry personnel, hotel and restaurant personnel and universities. No HACCP studies were performed as a consequence of the course. However, in Argentina, Peru and Venezuela, research using the HACCP approach has been published, mainly under the auspices of PAHO/WHO.

In 1988, an ICD/PAHO/WHO mission visited the country and received promise of continuing support from authorities in the Ministries of Health, Tourism, and Public Education, the Central Bank and from the Secretary of the Presidency of the Republic. Local industry offered to give full support to the project. As a result of a GTZ/ICD mission in 1989, a project for integration of food safety into primary school curricula, financed by GTZ and implemented by the Catholic Mater y Magistra University of Santiago de los Caballeros (UCAMAIMA) was approved.

Integration of Study on Food Safety into Primary School Curricula

The project has as its major components:

(a) Training of primary school teachers and students
(b) Use of HACCP methodology for the evaluation of failures during the preparation of food in homes, and evaluation of the food safety knowledge of the persons responsible for cooking
(c) Survey and observations on safe food handling practices

Teacher training was undertaken using the following:

(a) A didactic guide for teachers
(b) Manual on food safety for the students (one of the most important references used for its elaboration was the guide for primary school teachers published recently by WHO)
(c) Guide for the students notebook and exercises

At present, students' training is in progress. The project directors are supporting their training with provision of

(a) Education material
(b) Regular passive inspection and supervision
(c) Designing pictures, activities and other support interventions

The problems encountered in the development of this programme have been:

(a) Lack of permanent participation of the social institutions of the target community
(b) Lack of availability of mass media support
(c) Lack of logistic support from local industry and other sectors

At the end of the project, however, it is hoped the following will be achieved:

(a) A final manual for training in food safety for use in primary schools
(b) Improved knowledge (after evaluation) of students and mothers in food safety
(c) A confirmed proposal regarding the specific way to integrate food safety into the curricula of 5th grade primary school pupils

Future Directions

1. Reassessment Mission

The project for the integration of food safety into the primary health curricula will finish officially in May 1991. This would therefore be the ideal time to conduct a reassessment mission to a) evaluate the present project within the context of the present administrative situation and b) plan future projects.

2. Future Projects

Given that the Government places tremendous importance on food safety within the tourist sector, HEFS in food service establishments and other areas related to tourism ought to be considered for inclusion as part of the future national food safety programme.

ARGENTINA

Several HACCP courses and seminars have been held and research published. A public health education campaign was initiated by the National Food Protection Programme (PRONAPAL), Ministry of Health, with the advice of the Course Participants.

GUATEMALA

The participants of the Dominican Republic course undertook an evaluation of their national food safety activities, after which they proposed and actively participated in the organization of a National Coordinating Committee under the auspices of the Ministries of Health and Agriculture, the Municipality of Guatemala City and PAHO/WHO. In 1988, they adapted and distributed the 1987 Peruvian calendar that includes messages on food safety. They were reproduced in Guatemalan newspapers. In 1990, they organized activities for the public and in schools during the First National Food Protection Week. They have prepared an original and very useful calendar to be published in 1991.

PERU

In January 1985, WHO/PAHO consultants, in cooperation with the Ministry of Health, performed HACCP evaluation in different areas of the country to assess the feasibility of doing hazard analyses in homes and to determine their critical control points. The results have been reported and published (Refs. 14,15,16, Annex V).

The results of the studies stimulated the interest of the authorities of the Ministries of Health and of Public Education, and with the technical and financial support of PAHO/WHO, and the active participation of an NGO (Centro do Orientación y Promoción Humana), a series of activities in health education was performed from 1986 to date. Many courses were presented to primary school teachers and mothers, and four colourful calendars with health messages on food safety have been produced and distributed in the schools. Brochures and manuals and audiocassettes have been produced. A National Food Protection Week was organized in 1988.

VENEZUELA

Two HACCP courses have been held. Both had participation of local professionals and from Aruba and Curacao. Research findings using the methodology have been published, and the one related to the preparation of weaning foods received awards at the II Latin American Congress of Food Microbiology held in Caracas in November, 1989 (Ref. 17,18, Annex V). A national meeting to create public awareness was held in May 1990 under the theme "All united we will win the fight against the foodborne disease".

PAKISTAN

A WHO/GTZ/ICD mission visited Pakistan in late 1988, and agreed with the Government on the development of a programme focusing on control of foodborne diseases through health education and other related activities.

The Government assigned the National Institute of Health (NIH) responsible for the project and later appointed a National Coordinating Committee representing Government, industry, consumers and other NGOs, following the concept of shared responsibility developed with WHO.

In 1989, initial studies using HACCP methods were carried out by a WHO/GTZ mission to identify hazards and critical control points of foods prepared in rural and city homes, cottage industries, and in street vending operations. The results will be published shortly. (Refs 19, 20, Annex V)

A HACCP methodology training course took place at the National Institute of Health in Islamabad in May 1990. Participants included professionals from all provinces of Pakistan and four representatives from industry. (Ref. 21) It is planned that trainees will use this methodology in the field to compile a national profile of hazards in food preparation. At least three teams are being organized: one at the National Institute of Health (NIH), one in Lahore at the Pakistan Council for Scientific and Industrial Research (PCSIR) laboratories, and the third possibly in Peshawar. These teams, with the financial and/or technical support of the Pakistani Government, GTZ, WHO and local industry, will perform HACCP studies. The results will be applied to the elaboration of health messages which could be used by educational programmes in food safety in each province, and will be reviewed in a technical workshop, the report of which will be a major input to a National Food Safety Conference.

The National Coordinating Committee had its first meeting in May 1990, following the HACCP training course. The committee reviewed the various components of the food safety programme and their financial implications, and discussed procedures for project identification and implementation.

In September 1990, the WHO Interregional Seminar on Health Education in Food Safety was held in Islamabad. This activity has given a boost to the Pakistan programme.

ICD representatives in Pakistan have been actively mobilizing the local food industry to collaborate in activities to prevent foodborne diseases. They have submitted to the Chairman of the National Coordinating Committee propositions for projects which will be supported by specific member companies, provided that this collaboration is acceptable to the Committee. The projects include a research project on weaning behaviour which would lead to the development of an appropriate educational strategy for the promotion of proper weaning practice and food hygiene as well as appropriate educational materials. This project already has the support of the Pakistan Paediatric Association. The research should, however, be associated to work being done in the the HACCP survey and coordinated by the National Coordinating Committee. The local food industry has also offered to organize a training course for HACCP application in factories and food processing hygiene and quality control. The International Advertising Association (Pakistan) Chapter, through ICD, has proposed their collaboration in the design and elaboration of a national food safety media campaign, targeting consumers.

Future Actions

1. Confirmation of Interest

The Task Force proposes that WHO, through EMRO, seek confirmation from the Government of their interest in continuing the Health Education in Food Safety programme initiated in Pakistan.

2. Reassessment Mission

As soon as this has been received, a reassessment mission to Pakistan should take place. The mission should seek to develop, with the Pakistan National Coordinating Committee, a detailed plan of work clearly indicating the responsibilities of the various partners (Government, WHO, GTZ, ICD, NGOs, etc.), together with time schedules. Measures should also be taken to resolve existing administrative problems.

3. Planning Committee

The mission should give consideration to the setting up of a smaller technical advisory or planning committee to assist the National Coordinator.

4. Consultant

Consideration ought to be given to the secondment of a consultant to Pakistan to help strengthen the NIH and other institutions in food safety and to help in the building of the national programme.

INDONESIA

Several activities relating to HEFS have been undertaken in Indonesia in recent years. They are only part of a larger Government food safety programme which is described in Annex II. HACCP methodology is not yet applied in any of the programmes.

Principal activities in the Government food safety programme concern the training of food inspectors in the District Health Services and the training of managers in food establishments in cooperation with the Ministry of Tourism and the food establishment associations. Seminars on food safety for health professional organization members, consumer organizations and journalists are held regularly to create awareness in the community. Guidance in all these sectors is provided through training manuals and other written materials.

Future plans include application of HACCP in programmes for strengthening of institutions and laboratories at the national, provincial and district levels, intensification of programmes to train food inspectors and health personnel and food handlers, development of educational materials, etc., programmes for street food vendors and home-based industries at the domestic level, and a training programme in Good Manufacturing Practice (GMP) for the food industry.

Future Action

1. Assessment Mission

The Indonesian representatives who attended the Task Force indicated their intention to request WHO assistance in setting in motion the appropriate procedures for a programme of Health Education in Food Safety, and for the implementation of HACCP approach.

9. THE ROLE OF THE DIFFERENT SECTORS

The Task Force recognizes that the promotion of food safety in the community cannot be achieved without full collaboration between the different sectors sharing the responsibility for safe food. An essential ingredient for building any national health education in food safety programme will therefore be the development of an efficient mechanism for mobilization of local resources and the coordination of activities within and between different sectors.

The Task Force also recognizes that governments play a pivotal role in promoting food safety in the community. They are principally responsible for organizing the programmes. They also have the responsibility for coordinating the international aspects of the national food safety programmes, especially those linked to political, social, scientific and commercial interests.

Governments are asked to recognize, however, the importance of the industrial sector and of nongovernmental and community organizations in health promotion in general, and in particular in the fight against foodborne diseases. The development of action plans which enlist the support and collaboration of these sectors is not only an efficient use of resources but it is also in keeping with the spirit of the 1978 WHO Alma Ata Declaration (Annex III).

In conformity with the latter, governments are encouraged to seek ways to aid the respective sectors in accepting their individual roles and promote planned, coordinated inputs from industry, nongovernmental and grass-root organizations.

9.1 The Specific Role of the Government

a) Plan, organize and implement an Integrated National Food Safety Programme
b) Provide a legislative basis and administrative support for compliance and other regulatory activities
c) Arrange evaluation for various components of the whole programme
d) Epidemiological surveillance and monitoring, along with gathering of other relevant data for dissemination to the community
e) Training on food safety matters at the primary, secondary and tierciary level

f) Formulating, guiding and supporting the development of health education messages and materials, and their use as required
g) Promote research, especially Health Systems research, and studies on the different aspects of food safety, as required to improve and strengthen the programme
h) Reinforce the local authorities in charge of food safety activities, providing them with the information, knowledge, means and mandate they need for these tasks.
i) Stimulate the participation of private sector, NGO's, and consumer organizations in food safety activities, specially in the health education process. Promote the coordination of all sectors.

9.2 The Specific Role of Industry and Trade

The food industry - small, medium and large - is socially responsible for the production, processing, storage and distribution of safe food. The food trade - small, medium and large - is responsible for vending, preparing and serving safe food. In this context, and in their special field of competence, they should make every effort to implement HACCP systems in their operations. This would include training of their personnel in the application of hazard analysis and critical control point (HACCP) methodology in all food production, processing, storage, distribution, preparation and serving operations.

Recognizing that severe constraints may exist for small and some medium-sized industries to do so, the larger food industries are encouraged to find channels through which assistance for the application of these techniques may be made available to them.

With its expertise and resources, the food industry should make additional contributions to the implementation of the activities in Health Education of the national Food Safety Programmes, viz:

a) Contribute with appropriate resources to the implementation of HEFS programmes

b) Contribute expertise in the field of communication

c) Contribute to finding practical solutions to specific technical food safety problems

d) Where possible, share appropriate data for the design of HEFS programme components

e) Use their resources for the dissemination of food safety information

All industries and trade should introduce food safety as part of their personnel education and training programmes.

9.3 The Specific Role of Consumers Organizations

Consumer organizations and health-related NGOs have particular responsibility for promoting health education for food safety.

This can be done through programmes of information and instruction in specific activities directed toward food safety (developed by WHO and technical services) and geared to consumers and individual food handlers/individual food preparers.

At the local level, the widest possible involvement of local organizations could effect the mobilization of local resources among consumer organizations, farmers' associations, trade unions, church/religious groups, youth clubs and "grass roots" organizations, each having a concern for the health and well-being of its members and an interest in their informed participation. It should be noted that womens' and mothers' organizations in particular can play a leading role and are essential for affecting changes, as their individual members are responsible for the preparation of food.

At the national level, the coordinated efforts of consumers organizations and other NGOs could launch nation-wide campaigns to disseminate the message of food safety. Together with professional organizations and aided by appropriate expertise, they could be involved in the production of locally-adapted and culturally-specific health education materials. In view of their effectiveness in reaching large audiences, the collaboration of the mass media, radio and TV should be secured.

The contribution of teachers and institutes for the training of health personnel should be sought so that their prestige and expertise can be of support to these efforts.

National and regional workshops/conferences held by NGOs related to health should be encouraged to put food safety problems and methods of prevention of foodborne diseases on their agenda.

The exchange of information among NGOs on food safety problems and methods of overcoming them should be facilitated, and should be publicized in magazines, newsletters, etc.

As advocates of the health interests of the individual and the community, as well as the protection of the consumer, attention should be given by NGOs to the commitment of government to food safety, as implemented in national policies, laws and regulations. Support should be given, inter alia, to:

- The formation of a national strategy for food quality control
- The setting up or, as necessary, the strengthening of food inspectorate services
- The motivation of consumer participation in food quality control activities

- The establishment/strengthening of food contamination monitoring and control programmes which would permit remedial measures
- The regulation of business practices affecting the processing and marketing of food
- The promotion of consumer education and information on consumer rights in relation to food safety and in emergency situations, such as food poisoning.

NGOs and consumers, individually and in organized groups, are in a position to protect themselves from foodborne diseases as well as being able to participate in the necessary action for food safety with international organizations, government and industry.

9.4 The Specific Role of Other Health-Related Nongovernmental Organizations

Health-related Nongovernmental Organizations (NGO'S) have an important and specific responsibility for health education in food safety.

As advocates for food safety, they have to be an important part of the international and national networks for implementation of the HEFS strategy. The strategy for advocacy calls for cooperation and collaboration. Thus the creation of networks of professional organizations and social institutions to integrate HEFS into existing programmes is necessary. These should develop intersectorally.

At the community level, nongovernmental organizations should help to build up national fervour to stimulate the development of an appropriate social climate for the promotion of safe food practices in the community, in homes, and in institutions and mass catering establishments, to help local leaders take appropriate political action that will lead to a commitment of resources for wider application of HEFS and safer food practices.

Nongovernmental organizations can give effective support in the field of food safety at the international, national and local levels, through the following high priority actions:

a) Establish and strengthen national and local focal points for health education responsibility to implement HEFS programmes that include the three major components of any health promoting strategy:

   - to advocate health interests in all sectors of society and at all political levels
   - to enable individuals and communities to achieve their fullest health potential
   - to mediate between different interests in society for the pursuit of health for all

b) Build strong alliances and networks among many individuals, social groups, institutions, and other nongovernmental organizations in support of HEFS, and for the development of training activities and applied projects

c) Pursue active collaboration with mass media, educators, teachers and other special ways of reaching wide audiences

The Task Force asked the health-related NGO's represented at the meeting to present a short statement on their specific roles. The International Union for Health Education (IUHE), the Industry Council for Development (ICD), and the International Life Sciences Institute (ILSI), prepared the following:

9.4.1 The Specific Role of the International Union for Health Education (IUHE)

As a worldwide association of professionals and an NGO with members from more than 80 nations (these include national organizations whose main purpose is to promote, coordinate, and strengthen in their particular area of work, health education activities in their country), IUHE has the potential of supporting HEFS.

The principal aims of IUHE are:

- to clarify the role of education in the promotion of health
- to support the members
- to advise other agencies

The IUHE attempts to achieve its objectives by means of five core functions:

(a) advocacy/information services/networking
(b) conferences/seminars
(c) liaison/consultancy/technical services
(d) training
(e) research
(f) applied field projects

Possible specific activities of IUHE in the field of HEFS:

(a) Produce and disseminate a policy paper on food/nutrition, including food safety, as guidelines for the work of national members of the IUHE
(b) Publish a special issue of the HYGIE (Journal of the IUHE) on HEFS
(c) Workshop on "Food Safety" at the next World Conference on Health Education, Helsinki, June 1991

9.4.2 The Specific Role of Industry Council for Development

As a worldwide association of industries in the food, agriculture and health sectors, ICD supports the objectives of the WHO HEFS Programme. ICD thus accepts its role as advocate amongst the industrial sector for the implementation of industry's role to promote hygiene and safer food handling practices at all parts of the food chain.

ICD also seeks to bring together industry's managerial, technical, marketing and communications skills to collaborative programmes, particularly involving small and medium-size industries and consumers. ICD will also channel these resources where needed to governments and nongovernmental, voluntary or grass-root organizations working towards the same objectives.

ICD entered into official relations with WHO to provide an international non-commercial channel for industry's views and expertise in food safety. As such, ICD formulates industry's recommendations to WHO and represents them at international level such as to WHA, WHO Consultations and the International Task Force in Health Education in Food Safety.

As partner to WHO, ICD participates in country assessment missions, in particular to examine the situation with regard to food safety and hygiene in the food industry and for the organization of the industrial sector.

In follow-up to country assessments, ICD cooperates with international organizations and governments, providing advice and assistance in structuring national HEFS programmes to include the participation of the private sector organizations in National Coordinating Committees that also encompass government and consumers.

ICD achieves its functions through core activities such as:

1. Advocacy and promotion of the concept of shared responsibility for food safety at the international and national levels

2. Advocacy and promotion of the concept of social responsibility and the role of industry in HEFS amongst industry

3. Participation and organization of fora for issues related to private and public sector partnership in the production, distribution and marketing of safe food in developing countries

4. Organization of training seminars

5. Strengthening institutions serving industry in food safety and quality control

6. Consultancy/technical or expert services

7. Research projects

8. Innovative field projects - taking an active and innovative approach to proposing, designing and implementing new initiatives, based on proposals from cooperating companies and organizations. This may include providing project management and helping to secure financial and other resources

9. Publications and information diffusion

9.4.3 The Specific Role of the International Life Sciences Institute (ILSI)

International Life Sciences Institute (ILSI) is a worldwide foundation that advances the understanding and resolution of scientific problems in nutrition, food safety, toxicology, and environmental safety through the cooperation of scientists in academia, government and industry. With branches in Argentina, Australia, Brazil, Europe, Japan and North America, and an industrial membership made up of more than 200 companies world-wide, ILSI has already set in place an international network of individuals and organizations dedicated to the improvement of environment and of human health.

Underlying ILSI's activities is the premise that sound science is essential to resolve health and safety issues. Accordingly, the organization stimulates and supports scientific research and educational programmes in nutrition, toxicology, and food and environmental safety. Through its extensive publications programme, ILSI makes the results of such programmes widely available for the well-being of the general public.

The World Health Organization recognizes ILSI as a Nongovernmental Organization of international significance. Furthermore, ILSI has also been granted specialized consultative status with the Food and Agriculture Organizations of the United Nations (FAO).

ILSI achieves its objectives by supporting programmes dedicated to the resolution of long-term, basic scientific issues as well as programmes that address issues of regional, more immediate concern. In this respect, ILSI has established a committee structure that on the one hand facilitates the ongoing monitoring and evaluation of issues of interest to its members, and, on the other, enables its members to respond quickly to challenge that requires immediate attention. In relation to the issue of health education in food safety of particular significance is the Committee on Food Microbiology which monitors and coordinates efforts to understand and control foodborne disease. The Committee also provides a mechanism for exchange of information with other professional and trade associations, scientists, and regulatory agencies working to improve the microbiological safety of the food supply.

The ILSI mission is not restricted to the industrialized world and the research community. ILSI also participates and supports pogrammes that benefit primarily the populations of developing countries. Among these programmes is the initiative to assist countries to eradicate vitamin A and iron deficiencies and to help food processors in developing countries to upgrade their systems, expand food supply and improve food safety and nutrition.

ILSI's activities are also educational. By communicating the results of the studies it sponsors to the international research communities, industry, regulatory agencies, and indirectly to the general public, ILSI promotes rational and effective decision making.

10. CONCLUSIONS AND RECOMMENDATIONS

Conclusions

The Task Force agreed by consensus on the following:

1. Diseases caused by biologically contaminated food are still the number one cause of human suffering and ill-health in many countries, and a considerable economic burden, particularly to developing countries.

2. A conventional food safety infrastructure alone is not able to quell the spread of foodborne disease.

3. An appropriate education programme in food safety for food handlers and consumers at all points along the food chain is an important complementary strategy for the prevention of foodborne disease.

4. Implementation of that strategy needs the coordinated collaboration of three sectors: governments, industry and all associations and organizations representing the interests of the community.

5. Educational strategies to influence unsafe food practices have to develop from within the existing social and economic context.

6. A relatively fast, cheap and easy way of identification of factors responsible for unsafe food is through the application of the Hazard Analysis Critical Control Point system (HACCP).

7. Application of HACCP is recommended to devise practical preventive and educational measures in the food-processing industry, food service industry, food service establishments, street-vendor operations, food distribution systems and to the domestic preparation and handling of food.

8. Special consideration have to be given to the factors responsible for the chemical contamination of food.

9. The contribution of home-based and cottage food preservation and processing industries and fraudulent practices to biological and chemical food contamination needs to be studied.

10. Programme planning in HEFS should involve community organizations in the early stages of the development of the programme.

11. Participation by the community is facilitated if programme planners provide organizations with information on (a) specific measures that food handlers and consumers can adopt to protect themselves, their families and communities from foodborne diseases and (b) specific information on actions that national and local governments and food industries can take to prevent them.

12. Despite insufficiencies in the planning mechanisms for the HEFS pilot projects in the Dominican Republic and Pakistan, considerable progress has been made.

Recommendations

Recommendations to the Governments:

- Governments are encouraged to develop an Integrated National Food Safety Programme. This has to include a Plan of Action which enlists the support and collaboration of industry, nongovernmental and grass-root organizations, and to develop a mechanism for the implementation, coordination, surveillance and evaluation of that plan. Health education has to be given priority attention.

Recommendations to Industry:

- The food industry, large, medium and small, is encouraged to train all food handlers to apply appropriate methodologies to the production, preservation, processing and distribution of safe food.

- Recognizing that severe constraints exist for small and medium-size operations, larger corporations are requested to find channels through which assistance may be provided to smaller operations.

- Industry is encouraged to contribute whatever technical or other resources (e.g. communication, research, information processing or other) may be available to them to ensure the implementation of successful national and coordinated HEFS programmes.

Recommendations to related NGO's:

- Nongovernmental organizations have to give continued support to national programmes, both as advocates for HEFS and as networks through which the HEFS plan of action at the community level may be implemented.

Recommendations to WHO:

- The present WHO strategy for the development of HEFS needs to be reviewed.

- Guidelines for the preparation of national Food Safety programmes have to be prepared and presented to the next meeting of the Task Force.

- The Food Safety Unit should contact the Programme for the Control of Diarrhoeal Diseases in order to stimulate the realization of studies and research to obtain experimental data proving that infant diarrhoea is to a large extent foodborne and that improvements in hygienic quality of foods reduce diarrhoeal morbidity rates.

- It is recommended that other international organizations be invited by WHO to report on their HEFS activities in future meetings of the Task Force.

- It is recommended that, in the light of experience, present activities in Dominican Republic and Pakistan be reviewed in relation to the development of nationally-integrated programmes.

- When officially requested, a WHO task force or group delegation should visit Indonesia to evaluate the present situation and to cooperate with the Government in the development of a national, coordinated programme in HEFS.

- Taking into consideration the important activities developed in Peru concerning health education activities, cooperation with this country for the continuation of the activities is recommended.

- WHO should identify additional countries where pilot projects or other specific activities could be developed. Bolivia, Jamaica, Kenya, Thailand and an Arabic country, including a French-speaking one, could be appropriate choices.

- The Task Force strongly recommended that WHO organize and implement a special project for Integration of Food Safety into Primary Health Care activities.

Annex I

METHODOLOGIES USED IN THE FOOD SAFETY HEALTH EDUCATION PILOT PROJECTS 1985-1990

Phases of the projects were as follows:

Phase I. Generating interest in the project. It is necessary that officials in the national government have attitudes that are favorable to start the programme. If so, a project officer must be chosen to provide leadership and administrative guidance of the programme.

Phase II. Acquisition of equipment and supplies. After money sources have been obtained, field equipment, course material and laboratory supplies and media to support the activities will have to be purchased.

Phase III. Review of epidemiological information on factors that contributed to outbreaks of foodborne diseases. Presently available epidemiological data, if available, are reviewed to get an impression of national and regional foodborne (and/or diarrhoeal) disease problems. Factors that have lead to outbreaks should be sought. If this sort of data is unavailable or scanty, such data from other places may be used as a guide to anticipated problems.

Phase IV. HACCP studies to detect actual problems and critical control points upon which to base subsequent activities. Initial hazard analysis critical control point evaluations will be done by persons who are skilled in the approach, perhaps by consultants (food microbiologists/technologists) in cooperation with local health authorities and WHO regional and country personnel. This will be done to focus attention on high-risk hazards and their prevention associated with commonly eaten foods and weaning foods.

Phase V. Anthropological or sociocultural studies. If trained anthropologists are available, studies might be conducted to ascertain reasons why certain practices are unsafe or why resistance to changes that are proposed will occur and ways to modify behaviour to accept safe practices.

Phase VI. Training. National and local health personnel are trained in food microbiology and the HACCP approach. This training features field experience and opportunity to conduct HACCP evaluations in homes and food operations and to analyze and present the data and to recommend appropriate health education messages.

Phase VII. Continuation of HACCP studies by trained nationals. Additional data about preparation/processing foods that the initial workers have not collected and to repeat the work in various parts of the country and to look at various ethnic foods.

Phase VIII. Development of education activities. Based upon the HACCP evaluations, educational activities are planned and appropriate messages and audiovisuals prepared.

Phase IX. Initiation of educational activities. The health education project is implemented. This may include education of people who prepare foods in homes and of school children and training of food handlers and public health personnel.

Phase X. The effectiveness of health education activities will be evaluated.

Annex II

Food Safety Programme in Indonesia

(A Summary Report)

I. Introduction

Although there is by and large enough food available in Indonesia in terms of quantity, its safety very often is inadequate. Outbreaks of food poisoning are common and there are many recorded cases of other foodborne illnesses. In recent years, surveillance of communicable disease has even showed an increase in outbreaks of these diseases. The extent of the problem on a national level is not really known. A number of case studies and surveys have been carried out, and it has been established that contamination of food products and ready-to-eat food with E. coli is very common.

Efforts have been made by the Government to improve the standard of food establishments, but until now the achievements are very low and they do not meet the needs of the consumers. Unless other complementary actions are applied, it is obvious that the contamination by microbiological agents and chemicals will continue.

II. Present Activities

A. Strengthening of Infrastructure:

1. Formulation of a (draft) food law
2. Formulation of several Codes of Practice, microbiological and chemical contaminants' standards
3. Training of food inspectors and health controllers for food inspection and sampling techniques
4. Preparation of several modules for training courses for food handlers

B. Elements of the Food Control Programme

1. Education
   - (a) Training of food handlers
   - (b) Information for public
   - (c) Promotion and implementation of Codex Codes of Practice
2. Regulatory Programmes
   - (a) Inspection
   - (b) Sampling and laboratory analysis

3. Licensing and Registration

4. Survey on Food Additives Production and Distribution (two Provinces)

C. National Workshop on Food Control System for the improvement of coordination and harmonization with other sectors.

Specific activities in food safety to control foodborne diseases in connexion with the control of communicable diseases are as follows:

1. Food establishment legislation.
2. Training of food inspectors.
3. Inspection of food establishments.
4. Another means used to improve the sanitary conditions in restaurants is "grading".
5. To some extent, the surveillance of foodborne diseases is also carried out as a part of the surveillance of certain communicable diseases.

   As only major outbreaks of foodborne diseases are reported, at national level only a very small number of cases of foodborne diseases are recorded.

6. Laboratory examination of samples in Province capitals is also carried out.
7. Teaching seminars in food safety for managers of food establishments, i.e. restaurants, hotels and food caterers.
8. Seminars on food safety for health professional organization members, consumer organizations, reporters, etc.
9. Surveys of the sanitary conditions of food establishments and food contamination are carried out regularly.
10. Provide guidance for health personnel in charge of food safety through publication of manuals and/or other written materials.

Annex II.I

Food Control Programme, Indonesia

Infrastructure of Food Safety connected to Director General, Food and Drug Control

A. Legislation:

Several ministerial regulations

i.e. - production and distribution
- labelling
- additives
- other regulations related to specific foods

B. Organization:

1. National level:

(a) Directorate General of Drug and Food Control

(b) Directorate of Food Control

(c) National Quality Control Laboratory

2. Provincial level:

(a) Division of drug and food at Health Provincial Office

(b) Drug and food inspection and analytical services

3. District level:

Section food and sanitation

Annex II.II

Infrastructure of Food Safety connected to Control of Communicable Diseases

A. Legislation

Several ministerial regulations

i.e.
- Health requirements of hotels
- Health requirements of restaurants
- Health requirements of food catering establishments

B. Organization

1. National level:

(a) Directorate General for Communicable Disease Control and Environmental Health
(b) Directorate of Environmental Health
(c) Sub-Directorate of Food Sanitation

2. Provincial level:

(a) Division of Health Promotion and Disease Prevention of Provincial Health Office (Central Government)
(b) Service for the Promotion of Environmental Health of the Provincial Health Service (Provincial Government)
(c) Public Health Laboratory

3. District Level:

- Environmental Health Section

4. Health Centre Level:

- Assistant Sanitary Inspector

Annex III

WHA42.44 FORTY-SECOND WORLD HEALTH ASSEMBLY

HEALTH PROMOTION, PUBLIC INFORMATION AND EDUCATION FOR HEALTH

The Forty-second World Health Assembly,

Recalling previous resolutions on public information and education for health, in particular resolutions WHA27.27, WHA27.28 and WHA31.42;

Stressing the importance of the proclamation in the Alma-Ata Declaration that "education concerning prevailing health problems and the methods of preventing and controlling them" is the first of the eight basic elements of primary health care;

Recognizing that the spirit of Alma-Ata was carried forward in the Ottawa Charter for Health Promotion developed at the First International Conference on Health Promotion (1986) in Ottawa, Canada, and in the strategies for Healthy Public Policy developed at the Second International Conference on Health Promotion (1988) in Adelaide, Australia;

Mindful that information and education on health matters are vital for social policies supportive of health promotion and public health development, for fostering intersectoral cooperation, and for ensuring people's participation in achieving health for all;

Having due regard to the increasing importance of health promotion, information and education for achieving health goals, especially with the emergence of new and serious health problems such as AIDS, as reflected in the London Declaration on the prevention of AIDS;

Bearing in mind the great potential of modern mass media, and the rapid development in communication technology, and taking into account the evident achievements resulting from their use;

Mindful of the relatively low priority so far given to health promotion and public information and education for health by the health sector in general and the potential for strengthening social marketing, educational technology, behavioural research and strategies and resources for health promotion, public information and education for health;

1. URGENTLY CALLS UPON Member States:

   (1) to develop, in the spirit of the Alma-Ata, Ottawa and Adelaide conferences, strategies for health promotion and health education as an essential element of primary health care, and to strengthen the required infrastructure and resources at all levels;

   (2) to take necessary action for the training of health and related manpower in health promotion and health education principles and practice, including the use of the mass media for social marketing, health advocacy and education for health;

   (3) to make wider use of mass media and actively involve the media sector in health promotion and education of the public in support of national health-for-all strategies;

   (4) to strengthen cooperation and encourage the exchange of experience in the development and application of health promotion strategies and communication and education technology, including technical cooperation among developing and developed countries;

2. CALLS UPON the Director-General:

   (1) to provide support to Member States in strengthening national capabilities in all aspects of health promotion, public information and education for health, particularly the training of manpower;

   (2) to pay particular attention to research and the development of new and more effective methodologies and strategies in the fields of health promotion, public information and education for health, and to the evaluation of their impact on individual life-styles, the health of families and communities, and the health status of the population;

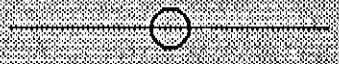
   (3) to promote the documentation of significant experiences of Member States regarding health promotion and health education, and its dissemination through WHO publications;

   (4) to submit a progress report to the Forty-fifth World Health Assembly.

May 1989 WHA42/1989/REC/1,46

Forty-fourth World Health Assembly

"General health protection and health promotion enables individuals, families and communities to develop to their full health potential... It is an evolving concept that encompasses fostering life-styles and other social, economic, environmental and personal factors conducive to health. Progress in health promotion does not depend solely on individual behaviour; the family and community also have a major role to play in influencing individual choice and action. So also do social and economic policies, many of which relate to sectors other than health... It can be seen that to protect and promote people's health, advocacy for health needs to be pursued vigorously..."



"Public information and education for health focuses essentially on: advocacy aimed at convincing policy-makers, administrators and professional groups that investment in health is sound economics, a political asset with popular appeal, and a social imperative; developing and strengthening organized community groups for their active involvement in health development; and informing the public and enlisting people's participation in specific health programmes while at the same time promoting healthy living. To do this requires intersectoral collaboration, particularly in strengthening health education of the school-age child, and in mobilizing all available community resources."

From the WHO Eighth General Programme of Work covering the period 1990-95

DECLARATION OF ALMA-ATA

The International Conference on Primary Health Care, meeting in Alma-Ata this twelfth day of September in the year Nineteen hundred and seventy-eight, expressing the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world, hereby makes the following Declaration:

I

The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

II

The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.

III

Economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The promotion and pro-

tection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace.

IV

The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.

V

Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.

VI

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of indi-

viduals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

VII

Primary health care:

1. reflects and evolves from the economic conditions and socio-cultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience;

2. addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;

3. includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;

4. involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors;

5. requires and promotes maximum community and individual self-reliance and participaton in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate;

6. should be sustained by integrated, functional and mutually-supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need;

7. relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

VIII

All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors. To this end, it will be necessary to exercise political will, to mobilize the country's resources and to use available external resources rationally.

IX

All countries should cooperate in a spirit of partnership and service to ensure primary health care for all people since the attainment of health by people in any one country directly concerns and benefits every other country. In this context the joint WHO/UNICEF report on primary health care constitutes a solid basis for the further development and operation of primary health care throughout the world.

X

An acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of independence, peace, détente and disarmament could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part, should be allotted its proper share.

* * *

Annex IV

List of Participants

BONI, Mr Anthony
U.S. Agency for International Development
320 21st Street, N.W.
Washington, D.C. 20523
USA

BUZINA, Dr Ratko
International Life Sciences Institute (ILSI)
1126 Sixteenth Street, N.W.
Washington, D.C. 20036
USA

DAVATELIS, Dr. George
AAAS Fellow
U.S. Agency for International Development
320 21st Street, N.W.
Washington, D.C. 20523
USA

EVERS, Mr Th.
Deputy Head
Bureau of International Cooperation
National Institute of Public Health
and Environmental Protection
P.O. Box 1
3720 BA Bilthoven
The Netherlands

HAVELAAR, Dr Arie H.
Head
Laboratory of Water and Food Microbiology
National Institue of Public Health
and Environmental Hygiene
Antonie van Leeuwenhoeklaan 9
P.O. Box 1
3720 BA Bilthoven
The Netherlands

MORSINK, Ms Mary E.
International Organization of Consumers Unions
Central Office
Emmastraat 9,
2595 EG The Hague
The Netherlands

MUKTI, Dr Sofyan
Chief
Directorate of Environmental Health
Directorate General of CDC & Environmental Health
Ministry of Health
Jl. Percetakan Negara 29
Jakarta 10560
Indonesia

PEGUERO, Dr Reynaldo
Chief
Project on Health Education in Food Safety
Pontificia Universidad Catolica Madre y Maestra
P.O. Box 822
Santiago de los Caballeros
Dominican Republic

SCHOENEBERGER, Dr Hans
Project Planner
Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ)
Dag-Hammarskjöld-Weg, 1-2
Postfach 5180
6236 Eschborn 1 bei Frankfurt
Germany

SCHMIDT, Prof. Dr Werner
Vice-President
International Union for Health Education
c/o Institut Santé et Développement
15-21 rue de l'Ecole de Médecine
75270 Paris Cedex 06
France

SIMONS, Mr Walter
Executive Director
Industry Council for Development
300 East 44th Street
New York, NY 10017
United States of America

SITABA, Mrs Syamsimar
Head
Sub-Directorate of Food Legislation
Directorate of Food Control
Directorate General of Drug and Food Control
Ministry of Health
Jl. Percetakan Negara 23
Jakarta 10560
Indonesia

SOEGIYANTO, Mrs Indrawati
Head
Sub-Directorate of Food Standardization
Directorate of Food Control
Directorate General of Drug and Food Control
Ministry of Health
Jl. Percetaken Negara 23
Jakarta 10560
Indonesia

TEUFEL, Dr Paul
Head of Microbiology/Hygiene Unit
FAO/WHO Collaborating Centre for Research and Training in Food Hygiene
Institute for Veterinary Medicine
Federal Health Office
Postfach 33 00 13
D-1000 Berlin 33
Germany

WINDISCH, Mrs Petra — Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ)
Dag-Hammarskjöld-Weg, 1-2
Postfach 5180
6236 Eschborn 1 bei Frankfurt
Germany

Specialized Agencies of the United Nations

BASTA, Dr S.S. — Director
UNICEF Office for Europe
Palais des Nations
1211 Genève 10
Switzerland

CANET, Dr C. — Nutrition Officer
Food Contamination Monitoring
Food Quality and Standards Service,
Food Policy & Nutrition Divison
Food and Agriculture Organization
Via delle Terme di Caracalla
00100 Rome
Italy

INVITED, BUT UNABLE TO ATTEND:

Aga Khan Foundation
P.O. Box 435
1211 Genève 6
Switzerland

Dr A. Ghafoor
Executive Director
National Institute of Health
Islamabad
Pakistan

International Council of Women
13 rue Caumartin
75009 Paris
France

Agencia Española de Cooperación Internacional (AECI)
Avenida de los Reyes Católicos 4
Madrid 2804
Spain

Program for Appropriate Technology in Health (PATH)
Suite 700
1990 M Street, N.W.
Washington, D.C. 20036
U.S.A.

Mrs Patricia Desmarchelier
Tropical Health Program
University of Queensland Medical School
Herston Road,
Herston
Brisbane
Australia

UNICEF - United Nations Childrens Fund

UNESCO - United Nations Educational, Scientific and Cultural Organization

SECRETARIAT:

ABDUSSALAM, Prof. Dr M.	-	Temporary Adviser CHAIRMAN of the Task Force
BRYAN, Dr Frank	-	Temporary Adviser
KAFERSTEIN, Dr F.	-	Chief, Food Safety Unit
QUEVEDO, Dr F.	-	Food Safety Unit SECRETARY of the Task Force
ATALLAH, Mr S.		World Health Organization Regional Office for the Eastern Mediterranean P.O. Box 1517 Alexandria - 21511 Egypt
ASHLEY, Dr David	-	ICD Senior Associate Coordinator of WHO/ICD Cooperation
JONES, Mr J.	-	Health Education and Health Promotion, Division of Health Education
MOAREFI, Dr Akbar	-	Technical Expert (former Associate Director (Health Education) Division of Information and Education for Health WHO Headquarters, Geneva)

The Task Force acknowledges with thanks the written contribution on Food Safety and Community Participation prepared by Mrs. Cristina PUENTES, PAHO/WHO, HSI/HSP, Washington, D.C.

Annex V

References

1. The Role of Food Safety in Health and Development. Report of Joint FAO/WHO Expert Committee on Food Safety. TRS 705, WHO, Geneva, 1984

2. Health Education in Food Safety. Provisional document. WHO/EHE/FOS/88.7, WHO, Geneva, 1988

3. Report of a WHO Consultation on Health Surveillance and Management Procedures for Food-Handling Personnel, 47 pp, TRS 785, WHO, Geneva, 1989

4. Food Safety - Examples of Health Educational Material, WHO/EHE/FOS/89 2, WHO, Geneva, 1989

5. Safe Food Handling - A Training Guide for Managers of Food Service Establishments, by M. Jacob, 142 pp. WHO, Geneva, 1989

6. Evaluation of Programmes to Ensure Food Safety - Guiding principles, 47 pp. WHO, Geneva, 1989

7. Food Environment and Health: A Guide for Primary School Teachers, by T. Williams, 129 pp. WHO,. Geneva, 1990

8. The WHO Golden Rules for Safe Food Preparation, Food Safety Unit, WHO, Geneva

9. In Point of Fact: Food Safety - a Worldwide Public Health Issue. No. 67, WHO, Geneva

10. Michanie, Silvia and Bryan, F.L., Spin-Off from Space Travel, World Health, pp. 26-27, Geneva, August/September 1987

11. Bryan, F.L., Michanie, S., Alvarez, P., Paniagua, A. Critical Control Points of Street-Vended Foods in the Dominican Republic, J.Food Protection, 51:5, 373-383, 1988

12. Michanie, Silvia, Bryan, F.L., Alvarez, P., Barros Olivo, A., Paniagua, A. Critical Control Points for foods prepared in households whose members had either alleged typhoid fever or diarrhea. Int. J. Food Microb., 7, 123-134, 1988

13. Michanie, Silvia, Bryan, F.L., Alvarez, P., Barros Olivo, A. Critical control points for foods prepared in households in which babies had salmonellosis, Int. J. Food Microb. 5, 337-354, 1987

14. Bryan, F.L., Michanie, S., Moscoso Vizcarra, M., Navarro, O., Taboada, P., Mendoza Fernandez, N., Guerra Requejo, EA., Perez Munoz, B., Hazard analyses of foods prepared by inhabitants near Lake Titicaca in the Peruvian Sierra. J. Food Protection 51: 412-418, 1988

15. Michanie, S., Bryan, F.L., Mendoza Fernandez, N., Moscoso Vizcarra, M., Taboada, P., Navarro, O., Bravo Alonso, A., Guerra Requejo, E., Hazard analyses of foods prepared by migrants living in a new settlement at the outskirts in Lima, Peru. J. Food Protection 51:314-323, 1988

16. Michanie, S., Bryan, F.L., Mendoza Fernandez, N., Moscoso Vizcarra, M., Taboada, P., Navarro, O., Bravo Alonso, A., Santillan, M.L., Hazard analyses of foods prepared by inhabitants along the Amazon River, J. Food Protection 51:293-302, 1988

17 Perdomo, M, Castro, R., Mendoza, S., Analisis de Riesgos y Puntos Criticos de Control en la preparacion de teteros para niños menores de un año en 2 barrios del distrito sanitario Juan Griego del Estado de Nueva Esparta (HACCP during the preparation of infant formula destined to children under 1 year in 2 localities of district Juan Griego- Estado Nueva Esparta, Venezuela), presented at the II Latin American Congress of Food Microbiology, Caracas, Venezuela, November, 1989

18. Aplicacion de Analisis de Riesgos y Control de puntos criticos en cafeterias universitarias, (Application of HACCP in University Cafeterias), Thesis directed by S. Mendoza, University of Simon Bolivar, Caracas, Venezuela, 1989

19. Bryan, F. L., Teufel, P., Roohi, S., Qadar, F., Riaz, S., Malik, Z., Hazard Analyses of Foods prepared in homes of a village and town in Pakistan (To be published)

20. Bryan, F.L., Teufel, P., Qadar, F., Riaz, S., Roohi, S., Malik, Z., Hazard Analyses of Foods prepared in two cottage industries in Pakistan (to be published)

21. GOP/WHO/GTZ/ICD, HACCP Training Course for Health Education in Food Safety, Islamabad, Pakistan, May 1990, Final Report, 58 pp, WHO Geneva, 1990

= = =