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**PROGRESS REPORTS ON TECHNICAL PROGRAMMES**

As a follow-up to discussions at previous sessions of the WHO Regional Committee for the Western Pacific, progress reports on the following technical programmes and issues are presented herein:

- 15.1 Malaria
- 15.2 TB: Preparation for regional operationalization of the Global TB Strategy after 2015
- 15.3 Dengue
- 15.4 Noncommunicable diseases
- 15.5 Environmental health: Regional Forum on Environment and Health
- 15.6 Violence and injury prevention
- 15.7 Nutrition: Double burden of malnutrition
- 15.8 Universal Health Coverage
- 15.9 Millennium Development Goals
- 15.10 International Health Regulations (2005)
- 15.11 Food Safety: Implementing the Western Pacific Regional Food Safety Strategy (2011–2015)

The Regional Committee is requested to note the progress made and the main activities undertaken.

## **15.1 MALARIA**

### **1. BACKGROUND AND ISSUES**

Malaria is endemic in 10 of the 37 countries and areas in the Western Pacific Region. The *Regional Action Plan for Malaria Control and Elimination in the Western Pacific (2010–2015)*, endorsed by the Regional Committee for the Western Pacific in 2009 (WPR/RC60.R5), defines the road map for national plans and targets. Malaria-endemic countries have made good progress, achieving an overall reduction in confirmed malaria cases to 299 000 in 2012 from 396 000 in 2000. Malaria deaths have dropped to 460 from 2400 in the Region. Eight of the malaria-endemic countries — Cambodia, China, Malaysia, the Philippines, the Republic of Korea, Solomon Islands, Vanuatu and Viet Nam — have already reached the World Health Assembly target of a 75% reduction in malaria burden by 2015 (compared to 2000). The two others are making progress: the Lao People's Democratic Republic is expected to achieve the target by 2015, even though the country experienced a twofold increase in malaria cases in 2012; and Papua New Guinea may also achieve the 2015 targets if progress continues.

Despite these achievements, more than 700 million people — or about 40% of the Region — are still at risk. Progress on malaria is fragile. International resources to fight malaria are expected to shrink with significant reductions from the Global Fund to Fight AIDS, Tuberculosis and Malaria in coming years. There is an urgent need to increase domestic spending and identify new funding sources to maintain momentum against malaria. If efforts are scaled back, resurgences may occur, and countries may not reach milestones.

Among the biggest challenges in fighting malaria is the emergence of artemisinin-resistant *Plasmodium falciparum* in the Greater Mekong Subregion (GMS). Resistance has been detected in five Member States in the Western Pacific and South-East Asia regions. WHO continues to work with Member States to contain and eliminate these parasites. The recent discovery of a molecular marker for artemisinin resistance will help programmes map the spread of the problem and improve the response.

## 2. ACTIONS TAKEN

The *Emergency Response to Artemisinin Resistance in the Greater Mekong Subregion (ERAR) — Regional Framework for Action 2013–2015* was launched in April 2013. The WHO ERAR regional hub in Phnom Penh, Cambodia, provides technical support to scale up malaria interventions. The hub coordinates regional efforts with Member States and partners, such as the Regional Artemisinin Resistance Initiative funded by the Global Fund. The hub has developed action plans in key areas, including: migrants and mobile populations; pharmaceutical issues, such as the ban on oral artemisinin monotherapy; surveillance and monitoring and evaluation; communications; and operational research. To identify knowledge gaps, the hub and the Bill & Melinda Gates Foundation held a consultation with affected countries and partners. Together, they identified operational research priorities that are now being taken forward. Surveillance of antimalarial drug resistance was intensified throughout the Region via meetings of the two subregional networks for malaria drug efficacy monitoring (in the Greater Mekong Subregion and in the Pacific) and through country follow up.

With WHO support, most malaria-endemic countries in the Region have updated national malaria strategic plans with costing. These plans and gap analyses form the basis for mobilizing future funding, including proposals for the Global Fund's new funding model and other donors. WHO organized mock reviews for countries planning to submit proposals to the Global Fund. Close collaboration has been established with new initiatives, including the Asia Pacific Leaders Malaria Alliance (APLMA), which is hosted by the Asian Development Bank to work on advocacy, regional financing and pharmaceutical issues, to ensure continued political commitment and adequate and sustainable resources for malaria.

With most Member States moving towards malaria elimination, the WHO regional offices for the Western Pacific and South-East Asia organized a course on malaria elimination for national malaria programme representatives in February 2014.

In consultation with Member States, WHO is developing a global technical strategy for malaria for 2016–2025. The strategy will be presented to the World Health Assembly for endorsement in 2015. The strategy will be the technical basis for the second generation Global Malaria Action Plan, to be developed by the Roll Back Malaria Partnership. Both plans will shape malaria control and elimination for the coming decade. Regional consultations with Member States and partners in June 2014 provided important feedback and input for the strategy.

### **3. ACTIONS PROPOSED**

The Regional Committee is requested to note the progress and the remaining challenges in the fight against malaria and artemisinin resistance.

## 15.2 TUBERCULOSIS: PREPARATION FOR REGIONAL OPERATIONALIZATION OF THE GLOBAL TB STRATEGY AFTER 2015

### 1. BACKGROUND AND ISSUES

Since the endorsement of the *Regional Strategy to Stop Tuberculosis in the Western Pacific (2011–2015)* (WPR/RC61.R4), the Region has made substantial progress and reached Millennium Development Goal (MDG) targets in advance of the 2015 deadline. TB prevalence and mortality are less than half of 1990 levels. Case detection and treatment success remain high. However, the challenges of TB continue to be monumental. There are an estimated 1.6 million new cases and 110 000 deaths in the Region every year from this curable disease. In 2012, about 85% of cases were notified, likely leaving the rest with substandard or no treatment.

TB concentrates on vulnerable populations, such as migrants, children, elderly and poor people. These groups often have the lowest capacity to cope with the burden. Detecting cases in vulnerable populations is often more difficult than in the general population. In addition, every year an estimated 75 000 people develop multidrug-resistant TB (MDR-TB), only 6.8% of whom are treated under quality-assured programmes. As the challenges mount, however, donors are increasingly moving away from funding communicable diseases, creating considerable financial gaps. For these reasons, TB services should be integrated and harmonized with national health systems to ensure sustainable control efforts.

The Sixty-seventh World Health Assembly endorsed the *Global strategy and targets for tuberculosis prevention, care and control after 2015* (resolution WHA67.1). The strategy spells out ambitious targets for TB control over 20 years. The strategy emphasizes the need for bold national policies, including universal health coverage and social protection, to ensure the sustainability of TB control efforts.

### 2. ACTIONS TAKEN

WHO assists countries with a high TB burden to review their national strategies and plans for TB control in order to operationalize the new global strategy. Extensive consultations are underway to identify priority actions that are tailored to the programmatic and epidemiological situation of each country of the Region. WHO has been providing platforms for identifying challenges and facilitating country-specific action.

The Regional Green Light Committee (Western Pacific), assembled to guide the strengthening TB programmes, supported countries with the scale up of programmatic management of drug-resistant TB. All high-burden countries received intensified technical assistance. WHO also delivered technical assistance on surveillance, laboratory and diagnostic strengthening, new tools and strategies on TB/HIV co-infection. WHO organized training activities in several fields to build national capacity.

The global TB strategy encompasses a cross-cutting health systems approach to consolidate TB control efforts. The quality and rational use of TB medicines is paramount for effective treatment and prevention of drug resistance. WHO organized a consultation workshop with national TB programmes, national medicine regulatory authorities and technical partners to establish priorities and strategies for strengthening and harmonizing the regulation of TB medicines. Much was accomplished during a WHO meeting for the development of a regional childhood TB action plan: country experiences, lessons learnt and best practices were discussed; priorities were established; country-specific activities were designed for strengthening childhood TB initiatives; and a task force was formed to oversee activities and progress. WHO will continue to play a pivotal role in facilitating cross-cutting collaborative work to improve TB control and strengthen national health systems, especially in universal health coverage and social protection.

### **3. ACTIONS PROPOSED**

The Regional Committee is requested to note progress in TB control and the need to operationalize the new global TB strategy.

## 15.3 DENGUE

### 1. BACKGROUND AND ISSUES

The Regional Committee for the Western Pacific endorsed the *Dengue Strategic Plan for the Asia Pacific Region (2008–2015)* in 2008 (WPR/RC59.R6). This plan serves as the road map to prevent and control dengue in the Region. In 2010 the Asia Pacific Strategy for Emerging Diseases or APSED (2010) was endorsed by the Regional Committee (WPR/RC61.R5). APSED covers all aspects of surveillance, outbreak control and capacity-building for emerging diseases including dengue.

The number and intensity of dengue outbreaks continues to increase despite Member States' efforts. In 2013, Member States reported a total of 392 182 dengue cases with 810 deaths in the Region. The Lao People's Democratic Republic, Malaysia, the Philippines and Pacific island countries all reported high burdens. Member States continue to experience significant constraints in availability of funding and qualified human resources. These constraints negatively impact disease and vector surveillance, and routine preventive interventions, such as early and effective outbreak response.

### 2. ACTIONS TAKEN

In 2011, WHO and the Association of Southeast Asian Nations (ASEAN) stressed the need to combat dengue by strengthening capacity in an efficient and sustainable way, using existing strategies and initiatives for emerging infectious diseases (such as APSED and Integrated Vector Management (IVM)). Capacities built over time under APSED — such as event-based surveillance, laboratory, and risk communication — have proven invaluable for early detection of outbreaks. Strengthening capacities to implement IVM helps countries to use scarce resources for more effective vector control to reduce transmission potential.

Enhanced surveillance capacities in countries allow WHO to collect and collate dengue data provided by Member States in order to monitor regional and in country epidemiological trends. Member States provide dengue situation summary reports, which are posted on the Internet every two weeks and published periodically by WHO. Member States continue to strengthen laboratory capacities for detecting emerging infectious diseases, including dengue, under APSED. WHO provided technical support to the governments of

Fiji, the Lao People's Democratic Republic, Solomon Islands and Vanuatu to successfully control dengue outbreaks over the past year. WHO also supported Pacific island countries facing outbreak situations by providing vector control equipment and insecticides.

Cambodia, Fiji and Solomon Islands developed and updated national action plans for dengue vector control with technical support from WHO. Countries supported by WHO and WHO collaborating centres continue to strengthen laboratory, case management and vector control capacities through trainings and improved insecticide resistance monitoring.

On ASEAN Dengue Day 2013, a WHO-developed curriculum was launched to improve early diagnosis and case management. In selected at-risk countries, WHO also strengthened outbreak response capacities for dengue and other vector-borne diseases, utilizing funds earmarked for building resilience to climate change. Continued mobilization of national and partner resources for strengthening emerging disease surveillance capacities through APSED and scaling up routine vector surveillance and control capacities is also taking place.

### **3. ACTIONS PROPOSED**

The Regional Committee is requested to note the progress and remaining challenges in dengue prevention and control in the Region.

## 15.4 NONCOMMUNICABLE DISEASES

### 1. BACKGROUND AND ISSUES

Noncommunicable diseases (NCDs) impose a major burden on health in the Western Pacific Region. The four major NCDs — cardiovascular disease, cancer, diabetes and chronic respiratory disease — account for more than 80% of deaths. NCDs account for 50% of all premature mortality (deaths before 70 years of age) in low- and middle-income countries. In many Pacific island countries and areas, diabetes prevalence is more than double the world average. Efforts to combat NCDs have been insufficient to curb the epidemic.

As political commitment to NCDs increases at the national level, the post-2015 development agenda provides an opportunity to advocate action. Member States should find practical entry points for NCD prevention and control in the context of equity and sustainable development, with careful consideration of existing capacities in communities through primary health care and all levels of health systems. Policy dialogues on universal health coverage can address NCDs with respect to access to drugs and technologies. Special attention must be devoted to NCDs during disasters and emergencies.

In 2013, the Regional Committee for the Western Pacific endorsed the *Western Pacific Regional Action Plan for the Prevention and Control of Noncommunicable Diseases (2014–2020)* (resolution WPR/RC64.R6). The plan is fully aligned with the *Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020*, and adopts the nine voluntary global targets. A comprehensive assessment of the progress achieved in NCD prevention and control was undertaken by the United Nations General Assembly from 10 to 11 July 2014. NCD interventions are to be integrated into the United Nations Development Assistance Framework. The Joint Forum Economic and Health Ministers Meeting, held in Solomon Islands in July 2014, endorsed the template for country road maps to respond to the NCD crisis.

## **2. ACTIONS TAKEN**

To increase the importance given to NCD prevention and control: six Member States were supported to develop national NCD policies and multisectoral action plans, with targets aligned with the nine voluntary global targets; and cities, schools and workplaces implemented NCD programmes to advance national programmes. To strengthen national capacity and accelerate country response: an approach called “action for healthier families” has been developed to link and strengthen community and primary health-care activities for NCDs and was piloted in the Lao People's Democratic Republic and the Philippines; the city-to-city learning study tours as part of the Healthy City Leadership Programme were instrumental in improving the skills and competencies of national and city level programme managers in healthy settings; the Western Area Health Initiative in China and a subnational initiative in Davao in the Philippines have been platforms for multiple NCD interventions; and LeAd-NCD, a programme for strengthening leadership and advocacy for the prevention and control of NCDs, first held at the National Institute of Public Health in Japan, will be continued as a regional training programme and a series of national workshops, already applied in three other countries and in the Pacific NCD integrated course.

To reduce the modifiable risk factors for NCDs: approximately half of Member States in the Region have reached the target of reducing the prevalence of tobacco use by 10% in the past five years; the health ministers of Pacific island countries have announced a goal to reduce adult tobacco use prevalence to less than 5% by 2025; a consultation on overweight, obesity, diabetes and law, held in the Philippines in April 2014, highlighted the need to develop stronger legal frameworks and build capacities for implementing public health law; in follow-up, Fiji held a national multisectoral stakeholder meeting in Suva in July 2014 to strengthen the linkages between law and NCD prevention and control and to identify ways of better integrating health into national legal frameworks; 10 Member States implemented "best buy" interventions under "Actions that make a difference" that helped to operationalize the "very cost-effective interventions"; in addition to salt reduction programmes in various Member States, including reductions in the salt content of bread by 10% in Mongolia and by 15% in popular noodles in Fiji, a regional salt reduction network is being initiated to share good practices and disseminate the salt advocacy pack; regional salt reduction targets have been developed in the Pacific and were presented to the directors of health at their meeting in Nadi, Fiji, in April 2014; and specifically to develop guidance for engagement with the labour sector on health promotion, a technical

consultation on worker health in the Region, held in the Philippines in March 2014, outlined strategies to strengthen the intersect between occupational health and health promotion and ways of improving collaboration between health and labour sectors in promoting the health of workers. To strengthen and orient health systems: a knowledge network on NCD management was initiated in June 2014; and while uptake of the WHO Package of Essential NCD Interventions (PEN) was supported in 20 countries and areas in the Region. All Pacific island countries have initiated implementation of PEN. Several countries have moved into the roll-out phase. Fiji and Cook Islands have completed the PEN costing study; and Kiribati, Solomon Islands and Tonga will conduct the costing study in 2014.

To promote and support national capacity for high-quality research: academic institutes in selected Member States were invited to participate in the LeAd-NCD, a programme for strengthening leadership and advocacy for the prevention and control of NCDs.

To monitor the trends and evaluate progress: an intercountry workshop for NCD surveillance and reporting of global voluntary targets was held in September 2014 in the Republic of Korea; reports of WHO STEPwise approach to Surveillance (STEPS) surveys and global school-based student health surveys were completed in 10 countries; support for strengthening cancer registration was provided to eight countries; and in the Pacific, WHO has been actively engaged in discussions about establishing a Monitoring Alliance for NCD Action (MANA), which would help countries strengthen NCD surveillance.

Technical and financial support was provided by: the Ministry of Health and Welfare of the Republic of Korea; the Ministry of Health, Labour and Welfare of Japan; the Government of Macao SAR (China); the Australian Department of Foreign Affairs and Trade; and the New Zealand Aid Programme.

### **3. ACTIONS PROPOSED**

The Regional Committee is requested to note progress in fighting NCDs in the Region.

## **15.5 ENVIRONMENTAL HEALTH: REGIONAL FORUM ON ENVIRONMENT AND HEALTH**

### **1. BACKGROUND AND ISSUES**

About one quarter of the total deaths in the Western Pacific Region are attributable to environmental risks. Some of these risks are long-standing, such as unsafe drinking water, poor sanitation and lack of appropriate waste management systems. Emerging threats are increasing, such as air pollution, exposure to toxic and hazardous chemicals, climate change and poor occupational conditions. In March 2014, WHO reported that air pollution is now the world's largest single environmental health risk. Air pollution is estimated to cause 16% of lung cancer deaths, 11% of deaths due to chronic obstructive pulmonary disease (COPD) and more than 20% of ischaemic heart disease and stroke. Other environmental chemicals, such as persistent organic pollutants, are linked to the increase in type 2 diabetes. An estimated 41% of deaths in the world due to indoor and outdoor air pollution occur in the Western Pacific Region.

Many environmental health risks are linked to economic development, rapid and unplanned urbanization and industrialization. Most governments are unprepared to address these threats to health that require close collaboration between health and environment ministries and policy measures involving other sectors (such as transport, energy, housing, agriculture and trade).

The WHO Regional Committee for the Western Pacific adopted a resolution on environmental health in 2005 (WPR/RC56.R7), encouraging Member States to participate actively in a platform for dialogue and action by health and environment ministries through the Regional Forum on Health and Environment in Southeast and East Asian countries. The Regional Forum provides a venue for sharing knowledge and experiences, improving policy and regulatory frameworks and promoting policy dialogue between health and other sectors to implement integrated environmental health strategies.

Since 2005, the Regional Forum has convened high-level officials and ministers of health and environment of Brunei Darussalam, Cambodia, China, Indonesia, Japan, the Lao People's Democratic Republic, Malaysia, Mongolia, Myanmar, the Philippines, the Republic of Korea, Singapore, Thailand and Viet Nam to address long-standing and emerging environmental health issues. WHO regional offices for South-East Asia and the Western Pacific, together with the United Nations Environment Programme Regional Office for Asia Pacific, serve as Secretariat of the Regional

Forum. The high-level officials have met eight times since 2004, and the ministers of health and environment have met every three years since 2007. The Fourth Ministerial Regional Forum to discuss health and environmental concerns in the Region will be hosted by the Philippines in 2016.

## 2. ACTIONS TAKEN

WHO has provided technical support and worked closely with the Member States of the Regional Forum on the following:

- 2.1 The development of national environmental health action plans (NEHAPs) to strengthen links between environmental health programmes and health systems. Through the Regional Forum, NEHAPs have been formalized in Cambodia, the Lao People's Democratic Republic, Malaysia, Mongolia, and the Philippines. Similar plans were in place for Japan and the Republic of Korea. The Regional Forum served as catalyst for approval of NEHAP at the highest level of the government. In Malaysia for example, conduct of the Regional Forum drew attention to environmental health and subsequently, the NEHAP was approved by the Cabinet as the umbrella programme for environmental health in Malaysia.
- 2.2 Advocacy for policies are stronger when both health and environment ministries join forces. Inter-agency mechanisms play an important role in the process. In the area of chemical safety for example, inter-agency committees have been established in Cambodia, Malaysia, Mongolia and the Republic of Korea to enable stronger measures to protect people and mitigate exposure to hazardous chemicals.
- 2.3 The Regional Forum established various thematic working groups (TWGs) composed of representatives from Member Countries to work on specific environmental health issues such as air quality; water, sanitation and hygiene; climate change; and health impact assessment. The Regional Forum TWGs have linked up with other initiatives such as the Strategic Approach to International Chemicals Management (SAICM), the Tokyo 3R (Reduce,

Reuse and Recycle) Statement and the East Asia Ministerial Conference on Sanitation and Hygiene (EASAN).

- 2.4 Environmental health is a rapidly evolving scientific discipline. The Regional Forum has provided updates to Member Countries on emerging and priority environmental health issues through scientific conferences. Four scientific conferences were convened on emerging and priority environmental health issues, climate change and health, and environmental impacts on vulnerable groups such as pregnant women, newborn children and the elderly.

Based on the recommendations from the Second Ministerial Meeting held in the Republic of Korea in 2010, a task force was formed. Its function is: to assess the impact of the Regional Forum at the country level; to study issues affecting the activities of the Regional Forum; to clarify the roles of the different bodies created by the forum; to explore options for sustainable funding; and to assess the need to revise the forum's charter to better reflect emerging issues and the current situation in the Region. A report was prepared to strengthen the Regional Forum based on a new charter, known as the Framework for Cooperation of the Regional Forum on Environment and Health in Southeast and East Asian Countries. The framework provides an improved vision statement, goals, objectives, strategies and a new structure to optimize collaboration across and within countries. This framework was endorsed at the Third Ministerial Regional Forum in 2013. The Third Ministerial Forum proposed expanding the Regional Forum to include Pacific island countries and other Member States.

### **3. ACTIONS PROPOSED**

The Regional Committee is requested to note the progress on environmental health in the Region.

## 15.6 VIOLENCE AND INJURY PREVENTION

### 1. BACKGROUND AND ISSUES

In 2011, violence and injuries killed nearly a million people in the Western Pacific Region. That figure represents one death every 32 seconds. Among people 5- to 49-years-old in the Region, violence and injury are the leading cause of death; these include road traffic crashes, falls, drowning, burns and interpersonal violence.

Despite compelling evidence, efforts to protect people from violence and injury fall short. It is critical that Member States ensure that safety underpins national development plans, infrastructure projects and the design and development of health systems.

At the sixty-third session of the Regional Committee for the Western Pacific, Member States endorsed a resolution prioritizing the scale up of violence and injury prevention in countries, with the support of the WHO Secretariat.

### 2. ACTIONS TAKEN

A situational assessment of violence and injury prevention was completed in priority countries, and a Technical Consultation on Prevention, Control and Response to Injuries and Violence in the Western Pacific Region was held in Manila, Philippines, in October 2013 and in Nadi, Fiji, in November 2013. Mechanisms for strengthening prevention of violence against women and children in Member States were also discussed.

A series of short documentaries has been produced advocating supportive environments for violence and injury prevention.

Twenty Western Pacific Member States contributed to the *Global Status Report on Violence Prevention*. The report, to be launched in December 2014, highlights standardized information on fatal assaults and national responses to intimate partner, sexual, child maltreatment and youth violence. This report will inform efforts to scale up evidence-based interventions.

As part of the Bloomberg Philanthropies Global Road Safety Program, WHO and partner organizations continued to work with multisectoral stakeholders in China, Cambodia and Viet Nam to accelerate the implementation of good practices and enhanced enforcement interventions to improve road safety. WHO also completed the second *Global Status Report on Road Safety 2013*, with the participation of 25 Western Pacific Member States. Only Australia reported legislation addressing five major risk factors, consistent with WHO recommendations.

The third Global Status Report on Road Safety is slated to be published in 2015, ahead of the Second Global Ministerial Conference on Road Safety to review progress towards the objectives of the *Global Plan for the Decade of Action for Road Safety 2011–2020*.

Specifically for children, support has been directed towards the prevention of burns in Mongolia and drowning in Malaysia and Viet Nam.

WHO's TEACH-VIP curriculum has been adapted for use in the Pacific Open Learning Health Network and other settings to build capacity for the prevention of injuries and violence. An interactive training for road safety was provided to senior counterparts from low- and middle-income countries by the WHO Collaborating Centre at Monash Injury Research Institute at Monash University in Melbourne, Australia.

Following preliminary discussions with Member States, a draft regional action plan for violence and injury prevention (2016–2020) has been developed for consultation with Member States in 2015.

### **3. ACTIONS PROPOSED**

The Regional Committee is requested to note progress made in violence and injury prevention in the Region.

## **15.7 NUTRITION: DOUBLE BURDEN OF MALNUTRITION**

### **1. BACKGROUND AND ISSUES**

In 2012, the Regional Committee for the Western Pacific endorsed a resolution on Scaling up Nutrition in Western Pacific Region (WPR/RC63.R2). The resolution calls on countries to maximize cost-effective nutrition interventions to make progress towards the six global nutrition targets of the comprehensive implementation plan on maternal, infant and young child nutrition. Countries are urged to report regularly on progress, with support from WHO and partners. Endorsed by the World Health Assembly in 2012, the comprehensive implementation plan aims to address the double burden of malnutrition in children starting from the earliest stages of development.

In 2013, the Regional Committee endorsed the *Western Pacific Regional Action Plan for the Prevention and Control of Noncommunicable Diseases 2014–2020* (resolution WPR/RC64.R6), which includes nutrition-related targets.

All Western Pacific Member States face the double burden of malnutrition. Malnutrition undermines economic growth and perpetuates poverty, and its human costs are enormous. Undernutrition alone contributes to 187 000 preventable deaths per year of children under 5 years old; 12 million children are chronically malnourished in the Region. Micronutrient deficiencies continue to be a public health problem throughout the Region, with 21 million pregnant women and 97 million women of reproductive age suffering from anaemia. At the same time, diets have become an important risk factor in the noncommunicable disease epidemic. Diets are shifting from traditional foods towards more processed foods and foods high in salt, fat and sugar and low in micronutrients and fibre. These changing dietary patterns are contributing mightily to increased rates of overweight, obesity, diabetes, hypertension, cancer and cardiovascular disease. One in four adults is overweight in the Region, and one in three adults has high blood pressure. In some countries nearly half of the adult male population have high blood pressure and up to 75% of the adult female population are overweight. Pacific island nations have diabetes prevalence rates that are among the highest in the world while their rates of micronutrient deficiencies remain high. Changing patterns in nutrition

indicators are also seen in certain population groups: the prevalence of underweight among women of reproductive age has remained stable; whereas, the prevalence of overweight (BMI >25) among women of reproductive age has doubled in some low- and middle-income countries.

## 2. ACTIONS TAKEN

With support from WHO, Member States have been developing national nutrition policies, plans and legal documents and strengthening multisectoral collaboration mechanisms. Tools have been developed to support planning and costing of national programmes to protect, promote and support breastfeeding, including a tool for verification of the implementation of the International Code on Marketing of Breast-Milk Substitutes. Country advocacy efforts and high-level policy dialogue on the double burden of malnutrition have been supported.

WHO has held consultations and provided technical support to countries on laws and regulations to improve nutrition, including labelling and marketing to children. An Informal Consultation on Reducing the Harmful Impact on Children of Marketing Foods, Beverages, Tobacco and Alcohol, held in September 2013, recommended strategies to fight industry interference, including health sector engagement with public health lawyers and economists. Also discussed were methodologies for strengthening legal frameworks and enforcement of regulations. A Consultation on Overweight, Obesity, Diabetes and Law, held in April 2014, identified legal issues relating to the prevention, detection and treatment of overweight, obesity and diabetes, and discussed the implications for trade, finance, intellectual property and universal health coverage.

In response to Regional Committee mandates, an *Action Plan to Reduce the Double Burden of Malnutrition in the Western Pacific (2015–2020)* has been developed, in consultation with Member States (Annex 1). The action plan addresses the increasing double burden of malnutrition reflected in the unfinished agenda of reducing undernutrition and the increasing burden of diet-related noncommunicable diseases. The plan also incorporates global and regional guidance to address diet-related diseases and to reduce risk factors for malnutrition. Emphasis is placed on a life-course approach to address the double burden of malnutrition, recognizing the critical importance of the first 1000 days of life.

### **3. ACTIONS PROPOSED**

The Regional Committee is requested to note the progress on nutrition and the remaining challenges to address the double burden of malnutrition.

## 15.8 UNIVERSAL HEALTH COVERAGE

### 1. BACKGROUND AND ISSUES

Universal health coverage (UHC) is a shared vision in the Western Pacific Region: all people being able to use needed health services — prevention, promotion, treatment, rehabilitation, and palliation — of sufficient quality to be effective, without financial hardship. UHC builds on WHO's mandate, the Alma Ata Declaration and the principle of Health for All.

The 2010 World Health Report *Health systems financing: the path to universal coverage* built on these mandates and aspirations as well as Member States' achievements. UHC is also emphasized as part of the post-2015 development agenda. Findings from the health system strategies review presented at the Sixty-fourth session of the Regional Committee for the Western Pacific further highlighted Member States' commitment towards UHC using whole-of-system and multisectoral approaches.

### 2. ACTIONS TAKEN

#### 2.1 Strengthened health system stewardship for UHC

Governments are ultimately responsible for health system performance. WHO supports Member States to achieve their vision of UHC with equity-focused policies, strategies and plans; to have services efficiently reach all in need; and to monitor and evaluate their progress.

Well-designed and enforced legislation and regulation are powerful governance tools for advancing UHC. Member States are reviewing and strengthening legislation and regulation for health technologies, medicines, human resources, integrated services, financing and social health protection. Trends towards political and fiscal decentralization pose new legislative challenges to ensure equity, efficiency and accountability across the health system.

In the Lao People's Democratic Republic, Mongolia, the Philippines and Viet Nam, health ministries and WHO have engaged in high-level, multisectoral policy dialogue with government officials and civil societies.

With WHO support, Viet Nam recently revised its Health Insurance Law to introduce compulsory membership, mandatory family-based enrolment for the informal sector and expanded benefits for vulnerable populations, especially poor people and ethnic minorities. The Regional Director personally advocated this revision to high-level officials.

Reliable and timely information is critical for policy-making and monitoring. Member States are improving information systems, including civil registration and vital statistics, resource tracking and indicators of priority programmes. Cambodia, the Lao People's Democratic Republic and the Philippines are developing tools to help demonstrate UHC progress in a user-friendly way.

Member States are building capacity to gather and use evidence through WHO-supported workshops on health systems research, health technology assessment, routine service quality control, health workforce governance, national health insurance, health accounts and household survey analyses of financial risk protection, access to health services and health equity. The Asia Pacific Observatory on Health Systems and Policies also builds country capacity in knowledge generation.

## 2.2 Improved financial risk protection

From 2007 to 2012 in the Region, 14 countries increased their government expenditure on health as a share of total government expenditure. The Philippines expenditure, for example, went from 8.2% in 2007 to 10.3% in 2012. For the same period, out-of-pocket payments on health as a share of total health expenditure declined in 15 countries. In China, the share went from 44% in 2007 to 34% in 2012. Member States are actively improving financial protection mechanisms through a combination of general taxation and payroll tax to extend essential services to more people. The portion of the population covered by at least partial financial protection reached 67% in Viet Nam, above 90% in Mongolia and nearly 100% in China. In the Philippines, some tobacco tax revenue is used to pay health insurance premiums for poor people. In Cambodia, health equity funds allow most poor people to access services at no or low cost. In the Lao People's Democratic Republic, the Government earmarks part of the revenue from hydropower to support a free maternal and child health programme.

### 2.3 Improved equity in access to quality health services

Member States are working to meet the demand for health services by improving access and quality of services, especially for vulnerable groups, including the elderly population.

Mekong countries are upgrading primary facilities and improving the availability and skill mix of the health workforce in remote areas. Mongolia and Viet Nam are introducing internship programmes for recent medical school graduates, and Cambodia recently introduced a national exit exam to ensure standardized competency of newly qualified health professionals. Kiribati, Malaysia, Papua New Guinea and the Philippines are developing policies and strategies to address health workforce challenges to UHC. Across the Region, improving regulation of health professional education and practice is contributing to quality and safe practices.

In Mongolia, decentralization and strengthening provincial and district health services are important approaches to reaching the substantial numbers of people who live outside urban areas. In the Philippines, massive efforts are being made to recover from several natural disasters while strengthening the health system towards UHC. In Pacific islands, the package of essential noncommunicable disease interventions is being introduced at primary level facilities, and efforts are being made to improve coordination across all levels of care.

China, Malaysia, the Philippines and Viet Nam have been improving policies for affordability of medicines. Meanwhile, Cambodia, the Lao People's Democratic Republic, the Philippines and Viet Nam have strengthened regulations to improve the quality of medicines.

### 2.4 Using resources efficiently

Member States are progressively taking action to correct health system inefficiencies, such as resource allocation to tertiary care, inappropriate hospital admissions and length of stay, wrong incentives to service providers, overpriced medicines, medical errors and poor quality of care and system fragmentation.

Cambodia, the Lao People's Democratic Republic, Malaysia and Mongolia are attempting to correct imbalances in spending on prevention and primary services compared to secondary and tertiary services. Pacific island countries are also examining improved allocative efficiency in the context of the high prevalence of NCDs.

Hospitals can make significant efficiency gains. In China, public hospital reform is on the agenda for the next stage of the health system reform. Mongolia, the Lao People's Democratic Republic and Viet Nam are piloting different provider payment methods designed to control hospital costs and improve efficiency. WHO and the Asia Pacific Observatory reviewed hospital issues with Member States to develop efficient approaches for secondary and tertiary services.

Reducing fragmentation in service delivery also improves efficiency. With reduced funding from global health initiatives for countries in the Region, integration of disease programmes is essential for long-term sustainability. For example, Papua New Guinea integrated immunizations with the maternal and child health programme. Cambodia, the Lao People's Democratic Republic, Papua New Guinea, Solomon Islands and Viet Nam are streamlining immunization, tuberculosis, malaria and HIV/AIDS programmes with the delivery of other services. Viet Nam is merging health insurance registration groups to reduce administrative costs and expand coverage. The Lao People's Democratic Republic, the Philippines and Pacific island countries are integrating health information systems to obtain more comprehensive, reliable and timely data.

Pharmaceutical and medical supplies are an important component of health-care costs and often a major source of inefficiency. Several countries in the Region recently introduced health technology assessments to select medicines and technologies to be paid with public funds. Japan, Malaysia, the Philippines and the Republic of Korea are exploring ways to institutionalize and build capacity for health technology assessment.

China, the Lao People's Democratic Republic, Pacific island countries, Papua New Guinea and the Philippines have taken action to improve uptake of generic medicines, and strengthen procurement and supply chain management to reduce inefficiencies. Malaysia and the Philippines have taken steps to improve governance in the pharmaceutical sector.

2.5 The way forward: implementing national health plans for progress on UHC

Over the next two years, many Member States will renew their multi-year national strategic health plans. The process will be guided by the principles of equity, quality, efficiency and sustainability — requirements for UHC. Cambodia, the Lao People's Democratic Republic, Palau and Solomon Islands have started this process.

WHO can assist Member States to develop policies, strategies and plans based on their specific context and facilitate implementation on the path towards UHC. In this way, WHO country cooperation strategies will align with Member States' emerging priorities.

WHO will also introduce new ways to strengthen coordination across different technical teams and regional and country offices to support Member States to implement national health plans towards UHC.

### **3. ACTIONS PROPOSED**

The Regional Committee is requested to note the progress in universal health coverage in the Region.

## 15.9 MILLENIUM DEVELOPMENT GOALS

### 1. BACKGROUND AND ISSUES

The Millennium Development Goals (MDGs) have been a successful global action to alleviate poverty. Governments, civil society, partners and stakeholders have all worked towards the MDG targets, which were set in 2000 for achievement by 2015. With that deadline fast approaching, Western Pacific Member States are likely to achieve several of the health and health-related MDGs. Some countries may not reach all the goals by 2015; however, they have made substantial progress in improving coverage, mortality and morbidity rates. Several issues still hinder the achievement of MDGs, including uneven progress among and within countries, the emergence of drug resistance, and a lack of reliable information to monitor progress in essential medicines. Efforts must be intensified to increase availability and access to health services to reduce health disparities overall.

#### **MDG 1: Eradicate extreme poverty and hunger**

Most countries in the Region have a decreasing prevalence of underweight among children under 5 years old. China and Mongolia have achieved the target while Malaysia and Viet Nam are most likely to reach the target by 2015. Issues remain, including relatively high stunting rates in many countries, particularly Cambodia, the Lao People's Democratic Republic and Papua New Guinea. Low rates of early initiation of breastfeeding and exclusive breastfeeding as well as poor complementary feeding practices still need to be addressed. National nutrition planning across sectors (including trade and agriculture) needs to be aligned and adequately funded.

#### **MDG 4: Reduce child mortality**

China and Mongolia have already achieved the target, while Cambodia, the Lao People's Democratic Republic and Viet Nam are likely to reach the target in 2015. Fiji, Papua New Guinea and Solomon Islands are not likely to achieve this target in 2015. Disparities in mortality rates across and within countries are increasing, particularly between urban and rural populations.

Four countries and areas in the Region — Australia, Macao SAR (China), Mongolia and the Republic of Korea — have achieved measles elimination. Across the Region, measles incidence had decreased to historically low levels in 2012. However, measles outbreaks in a few countries in 2013 and early 2014 highlight the need to intensify immunization efforts.

**MDG 5: Improve maternal health**

Maternal mortality rates show a decreasing trend in most countries in the Region. Maternal mortality rates are still high in Cambodia, the Lao People's Democratic Republic, Papua New Guinea, the Philippines and Solomon Islands. Challenges remain in availability and access to quality maternal and reproductive health-care services, and in the shortage of reliable data. Many causes of maternal death in the Region are not recorded.

**MDG 6: Combat HIV/AIDS, malaria and other diseases**

HIV prevalence in the Region remains low at 0.1–0.8%, indicating a stabilized epidemic. More than 90% of the regional burden is concentrated in Cambodia, China, Malaysia, Papua New Guinea and Viet Nam (based on 2013 estimates). While there has been progress, challenges remain in relation to health promotion, preventing new cases and ensuring access to HIV services.

In the 10 malaria-endemic countries in the Region, malaria mortality and morbidity have declined. The regional target of a 75% decrease in malaria mortality since 2000 has been achieved by Cambodia, the Lao People's Democratic Republic, the Philippines and Viet Nam. A similar reduction in morbidity was attained in China, the Republic of Korea and Viet Nam. The threat of antimicrobial resistance and artemisinin resistance exists, particularly in Cambodia, Viet Nam and other Mekong countries.

Member States are on track, except for Papua New Guinea, to achieve the tuberculosis-related MDGs and related international targets by 2015. Despite this dramatic success, the TB burden remains unacceptably high with 1.6 million new cases and 110 000 deaths every year. TB disproportionately affects vulnerable populations with limited access to health care. The catastrophic economic burden of the disease pushes many patients deeper into poverty. Multidrug-resistant TB (MDR-TB) and the TB/HIV co-infection epidemic threaten to undermine progress.

**MDG 7: Ensure environmental sustainability**

The majority of Member States have reached the MDG targets for access to improved sources of drinking water and improved sanitation, but with disparities between urban and rural areas. Papua New Guinea and Solomon Islands may not reach the targets for water and sanitation by 2015. Cambodia, Mongolia and the Philippines may not reach the goals for improved sanitation by 2015.

**MDG 8: Develop a global partnership for development**

Limited access to essential medicines is still common in many countries and areas in the Region. Limited access is often disproportionately higher in public than in private sectors. Reporting progress on access to affordable essential medicines is a challenge in many countries due to lack of reliable data.

**2. ACTIONS TAKEN**

To accelerate efforts towards MDG 1, Member States endorsed the *Comprehensive Implementation Plan on Maternal, Infant and Young Child Nutrition* at the Sixty-fifth World Health Assembly in 2012. They reaffirmed that commitment at the sixty-third session of the Regional Committee for the Western Pacific. WHO helps countries strengthen legislative, regulatory and other effective measures to control the marketing of breast-milk substitutes (in line with the International Code of Marketing of Breast-milk Substitutes and Health Assembly resolutions) and to institutionalize the Baby-friendly Hospital Initiative. WHO supports strengthening national nutrition plans to prioritize and improve delivery of nutrition services. WHO supported the revision of micronutrient guidelines to reflect updated WHO guidelines on daily iron and folic acid supplementation in pregnant women.

To accelerate progress towards MDGs 4 and 5, the *Action Plan for Healthy Newborn Infants in the Western Pacific Region (2014–2020)* and the *Regional Framework for Reproductive Health in the Western Pacific* were developed. Both documents provide guidance to improve women and children's health. There is continuous monitoring of the seven priority countries in the Region with accountability frameworks and road maps to implement the 10 recommendations of the Commission on Information and Accountability for Women's and Children's Health. With expanded immunization activities, the Region is on the verge of eliminating measles and maternal and neonatal tetanus.

Relevant to MDG 7, efforts to combat HIV focus on more efficient case-finding, links to care, timely initiation of antiretroviral therapy and adherence to lifelong treatment. With strong political commitment, countries are addressing antimalarial drug resistance and artemisinin resistance issues. Actions to implement the *Regional Strategy to Stop Tuberculosis in the Western Pacific (2011/2015)* are ongoing. Other actions include greater collaboration between governments and the private sector, technical assistance in cases of MDR-TB and TB/HIV co-infection, the strengthening of health systems, resource mobilization and drug management.

On MDG 7, WHO continues to work with countries to monitor progress on water and sanitation, especially through national committees. National standards and guidelines on drinking water quality were developed for Cambodia, the Lao People's Democratic Republic, the Philippines and Viet Nam. In addition, provision of safe drinking water has been further strengthened through water safety plans, systems and the provision of household water treatment and storage mechanisms.

In relation to MDG 8, WHO helps countries to improve quality, safety and access to affordable medicines by developing national policies on medicines and implementing guidelines, as described in the *Regional Framework for Action on Access to Essential Medicines in the Western Pacific (2011–2016)*. Access to affordable essential medicines is difficult to measure. Currently, availability of an assortment of several medicines and their median prices are used as proxy indicators to monitor access to affordable essential drugs.

### **3. ACTIONS PROPOSED**

The Regional Committee is requested to note the progress on health and health-related MDGs, and urge Member States to make a concerted effort to achieve the remaining targets before the 2015 deadline.

## **15.10 INTERNATIONAL HEALTH REGULATIONS (2005)**

### **1. BACKGROUND AND ISSUES**

The Western Pacific Region remains a hotspot for emerging diseases as demonstrated by several disease outbreaks over the past year. Human infections with avian influenza A(H5N1) virus in Cambodia and A(H7N9) virus in China have been reported regularly throughout the year. Dengue infections reached unprecedented levels in the Lao People's Democratic Republic in 2013, and multiple dengue subtypes were widely reported in several Pacific island countries and areas. In 2014, the first case of human infection with the Middle East respiratory syndrome coronavirus (MERS-CoV) was reported in the Western Pacific Region.

The International Health Regulations (2005), or IHR (2005), provide a legal framework for all Member States to strengthen capacities to prevent, detect, assess and respond to public health threats. In June 2012, 14 Member States were granted a two-year extension to develop the IHR (2005) minimum core capacities. The extension expired in June 2014. Despite continuous improvements in surveillance and response capacities, nine Member States required a second two-year extension of the target date for establishing national core capacities under the IHR (2005).

The Asia Pacific Strategy for Emerging Diseases, or APSED (2010), was endorsed at the sixty-first session of the WHO Regional Committee for the Western Pacific in October 2010. APSED (2010) has proven to be an effective framework to accelerate capacity development for IHR (2005) in Member States. Through the partnership approach promoted by APSED (2010), Member States, WHO and partners have successfully worked together towards common regional priorities. Going forward, WHO will maintain the momentum to continue improving regional systems and capacities in the years to come.

### **2. ACTIONS TAKEN**

Responses to public health emergencies have tested regional capacities, yet the systems built and strengthened through the implementation of APSED (2010) have allowed Member States to address these threats in an increasingly effective manner.

National surveillance systems have proven their capacity to detect new pathogens with event-based surveillance playing a key role. Public health laboratories in Member States have increased capacities to detect novel pathogens, including MERS-CoV. Functional linkages to global networks such as the Global Influenza Surveillance and Response System (GISRS) have allowed for rapid detection and virus characterization in cases such as avian influenza A(H5N1) and A(H7N9) virus.

Health emergency communications plans were tested during public health emergencies, and ministries of health have activated — some for the first time — emergency operations centres to coordinate response efforts. WHO's Regional Office for the Western Pacific has continued to perform an important regional role in surveillance and response.

Risk assessments for human infections with avian influenza and dengue fever were undertaken and continuously updated to guide national control measures. The IHR event communications channel between national IHR focal points and WHO was used extensively during disease outbreaks and other acute public health events. More than 1000 IHR email messages were received by the WHO Regional Office for the Western Pacific from Member States between July 2013 and May 2014. The annual IHR communications exercise — with 23 Member States participating — successfully tested the connectivity and capacities of this communications channel.

The Monitoring and Evaluation Guide for APSED (2010) was updated based on country experiences, and a new tool to illustrate APSED capacities was included. This tool, a programmatic outbreak review, aims to demonstrate the capacities used to detect, assess and respond to outbreaks. At the Regional Meeting of the Asia Pacific Technical Advisory Group on the Asia Pacific Strategy for Emerging Diseases (2010) in 2014, it was recommended that an evaluation of APSED be conducted to provide a comprehensive picture of achievements and lay out future priorities beyond APSED (2010).

### **3. ACTIONS PROPOSED**

The Regional Committee is requested to note the progress in the implementation of the IHR (2005) to increase health security in the Western Pacific Region.

## 15.11 FOOD SAFETY: IMPLEMENTING THE WESTERN PACIFIC REGIONAL FOOD SAFETY STRATEGY (2011–2015)

### 1. BACKGROUND AND ISSUES

Access to sufficient and safe food is a basic human necessity. Food safety is vital to achieve poverty reduction and ensure sustainable development. Unsafe food causes many acute and lifelong diseases. Increasing global trade in food commodities, the growth of international travel and the spread of foodborne diseases internationally have made food safety an essential component of health security.

The Regional Committee for the Western Pacific in 2011 endorsed the *Western Pacific Regional Food Safety Strategy 2011–2015* to address Member States' concerns. The strategy focuses on strengthening national food control systems and promoting coordination and collaboration within and among countries, as well as among partners and national governments. The strategy also calls for enhanced cooperation among key agencies and programmes at the regional level.

The *Western Pacific Regional Food Safety Strategy 2011–2015* covers seven themes, each containing background information and strategic direction, actions and indicators.

Resolution WPR/RC62/R5 calls on Member States to use the strategy as a framework for strengthening national food control systems. The Regional Director for the Western Pacific was requested to support countries in implementing the strategy and enhancing collaboration.

The current report provides an update at the midterm of the implementation of the strategy, recognizing that actions will be required even after 2015 to develop food control systems.

### 2. ACTIONS TAKEN

Progress has been made in nearly all Western Pacific Member States in developing national food laws, regulations or policies to facilitate food safety control, establish infrastructure for food safety control and institute mechanisms for cross-sectoral collaboration. National or international food safety standards are applied in most countries in the Region. Food laws and regulations are up to date and being implemented.

In addition, risk-based food inspection services are in place in most Member States. Laboratory capacity to confirm suspected food safety events is accessible in three quarters of the countries in the Region, as are communication mechanisms and materials to inform, educate and advise stakeholders across the farm-to-fork continuum.

Despite progress, more work is needed in evaluating and implementing comprehensive plans for managing food safety events, especially national multisectoral coordination mechanisms. Response plans for food safety events have not been fully developed and evaluated in half of the countries of the Region.

In addition to supporting countries, the Regional Office has played a major coordinating role: strengthening the work of the International Food Safety Authorities Network (INFOSAN) in Asia; developing guidance to strengthen surveillance of foodborne diseases; and linking surveillance mechanisms to the mechanisms used by INFOSAN and others. Further coherence and cooperation among regional agencies and programmes with food safety responsibilities were achieved through the establishment of the Food Safety Cooperation Working Group in 2012. The group includes the Asia-Pacific Economic Cooperation (APEC) Food Safety Cooperation Forum, the Association of Southeast Asian Nations (ASEAN) Expert Group on Food Safety, the World Organisation for Animal Health (OIE) and the Food and Agriculture Organization of the United Nations (FAO).

### **3. ACTIONS PROPOSED**

The Regional Committee is requested to note progress towards ensuring food safety in the Region.



**Action Plan to Reduce the Double Burden of  
Malnutrition in the Western Pacific Region  
(2015–2020)**

**World Health Organization  
Western Pacific Region**

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**Abbreviations**

BF	breastfeeding
BFHI	Baby Friendly Hospital Initiative
BMI	body mass index
CIP	Comprehensive Implementation Plan for Maternal, Infant and Young Child Feeding
CF	complementary feeding
CRC	Convention on the Rights of the Child
EBF	exclusive breastfeeding
FAO	Food and Agriculture Organization of the United Nations
ILO	International Labour Organization
MDG	Millennium Development Goals
NCD	noncommunicable disease
SD	standard deviation
SPC	Secretariat of the Pacific Community
SUN	Scaling Up Nutrition
TB	tuberculosis
UHC	universal health coverage
UNDAF	United Nations Development Assistance Framework
UNICEF	United Nations Children's Fund
WHO	World Health Organization
WRA	women of reproductive age

## 1. The double burden of malnutrition in the Western Pacific Region

Member States in the Western Pacific Region face a double burden of malnutrition: undernutrition – including wasting, stunting, micronutrient deficiencies and low birth weight – coexisting with overweight and obesity, as well as an increase in nutrition-related noncommunicable diseases (NCDs).

At the Sixty-fifth World Health Assembly in May 2012, Member States endorsed the *Comprehensive Implementation Plan on Maternal, Infant and Young Child Nutrition*, or CIP, which includes six global nutrition targets intended to “address the double-burden of malnutrition in children starting from the earliest stages of development”.

The *Global Action Plan for the Prevention and Control Noncommunicable Diseases 2013–2020* was endorsed at the World Health Assembly in 2013. The action plan includes nine voluntary targets, including one target on the reduction of salt consumption and another on halting the rise in obesity among adolescents and adults.

Member States of the Western Pacific Region at the sixty-third session of the Regional Committee for the Western Pacific endorsed resolution WPR/RC63.R2 on Scaling up nutrition in the Western Pacific Region, which requests WHO to provide support to Member States in implementing the CIP. At the sixty-fourth session of the Regional Committee for the Western Pacific in October 2013, Member States endorsed the *Western Pacific Regional Action Plan for the Prevention and Control Noncommunicable Diseases (2014-2020)*.

The *Action Plan to Reduce the Double Burden of Malnutrition in the Western Pacific Region (2015–2020)* was developed in response to resolution WPR/RC63.R2 on scaling up nutrition. It brings together nutrition-related actions from global and regional guidance documents to address diet-related diseases and reduce nutritional risk factors.

The action plan creates a platform for sectors to accelerate action to address the double burden of malnutrition in partnership with civil society and relevant stakeholders.

### 1.1 The magnitude and impact of the double burden of malnutrition

The nutrition landscape has changed dramatically in the past decades. Rapid economic and income growth, urbanization, and globalization have contributed to changes in human diets, activity patterns and nutritional status. Food systems have been transformed by macroeconomic and structural adjustment policies, liberalization of international food trade and foreign direct investments. This has changed the local availability, nutritional quality, affordability and acceptability of foods. Diets are shifting away from their traditional composition and are moving towards diets dominated by processed foods that are high in salt, fat and sugar and low in micronutrients and fibre. With these changes, diets have become an important risk factor for the growing NCD epidemic.

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Malnutrition in all its forms heightens the risks for morbidity and mortality throughout the life course. While undernutrition impedes children's achievement of their full economic, social, educational and occupational potential, unhealthy diets contribute to the rise in diet-related NCDs, which results in premature mortality (below 70 years of age) and the early onset of disease with high levels of disability. The double burden of malnutrition within the same individual is of increasing concern. Children who are overweight can be micronutrient deficient, and stunted children may have increased risk of obesity. An emphasis must be placed on healthy nutrition throughout the life course.

Within the Western Pacific Region, undernutrition alone contributes to 187 000 preventable deaths of children under 5 years of age annually. Undernutrition, especially in the first 1000 days – from start of pregnancy, through infancy and young childhood and until 24 months of age – leads to increased childhood and adult morbidity and mortality. Among adults, undernutrition increases the risk of tuberculosis (TB). People with active TB are often malnourished and suffer from micronutrient deficiencies as well as weight loss and decreased appetite.

Overweight and obesity in children and adolescents increases the risk of diabetes and other NCDs in later life. In addition to increased future risks, obese children experience immediate health problems, including breathing difficulties, a tendency to be less physically active, increased risk of fractures and psychological effects. The risk of hypertension, coronary heart disease, stroke and type 2 diabetes grows progressively with increasing body mass index (BMI), which is used as the measure of obesity, as do the risks of cancers of the breast, colon, prostate, endometrium, kidney, gall bladder and other organs. Comorbidities of mental health problems and malnutrition have also been noted, including eating disorders. Among older people psychological risk factors, including anxiety, dementia or depression can increase the risk of malnutrition; micronutrient deficiencies, overweight and obesity become more common in the same individuals.

Reducing the double burden of malnutrition has been critical in progress towards achieving the Millennium Development Goals (MDGs), especially MDG 1 (eradicate extreme poverty and hunger) and MDG 4 (reduce child mortality). Reducing the double burden of malnutrition remains critical in the post-2015 development agenda, particularly as it relates to the reduction of poverty. Stunted children earn an estimated 22% less than non-stunted children later in life and anaemia contributes to decreased adult productivity. Developed countries spend an estimated 2–7% of their health budget to treat obesity and associated chronic diseases. These may translate to proportionately higher spending for developing countries. Reducing the double burden of malnutrition will contribute to a reduction in lost wages and increased productivity that helps sustain economic and social development. If NCDs are left unmanaged, countries risk reversing achievements in development.

The past 20 years has seen a major reduction in undernutrition, an important achievement in a Region with more than 120 million children under the age of 5. The prevalence of stunting decreased from 38.2% in 1990 to 9.7% in 2012 and underweight from 17.5% to 3.9% over the same time frame.

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Despite these remarkable achievements, the Region still has 12 million children stunted, and 4.8 million underweight. Only one third of infants in the Region are exclusively breastfed for the first six months. Anaemia remains an unresolved issue affecting more than 21 million pregnant women and 97 million women of reproductive age (WRA). Simultaneously, overweight is rapidly becoming a problem throughout the life course. More than 6.5 million children under 5 are overweight in the Region. In several countries, overweight affects 5–15% of under-5 children. Overweight among adolescents is increasing to alarming rates, reaching almost 60% in some Pacific island countries and areas and over 20% in some Asian countries. One in four adults in the Region is overweight. Obesity is becoming increasingly prevalent, with adult obesity rates surging beyond 50% in several countries in the Pacific. One in three adults has high blood pressure in the Region. Over consumption of salt is a key risk factor for high blood pressure, and most countries exceed the recommended maximum limit for daily salt consumption, some by up to or more than four times.

### 1.2 Necessary conditions for improved nutrition

Undernutrition results from inadequate dietary intake of nutrients, as well as the presence of disease. Obesity and overweight result from more calories being consumed than expended. Excess consumption of saturated fats, trans fats, sugars and salt; low consumption of fresh vegetables and fruits; and sedentary lifestyles are risk factors for NCDs. Improving the nutrition of populations, families and individuals and ensuring that nutritious food is available, affordable and acceptable are complex endeavours.

Sustainable and health-promoting food systems, the provision of quality health services, and optimal care-giving practices in homes and communities are necessary conditions associated with improved nutrition. If any of these conditions is not met, malnutrition will likely appear. These three conditions are shaped by economic, social and cultural factors (Fig. 1).

Food systems encompass production, processing, distribution, marketing, preparation and consumption of food. A health-promoting, sustainable and equitable food system should ensure that nutritious food is accessible, affordable, acceptable, and meets dietary and safety requirements. Marketing and labelling of food products should not be misleading, rather they should provide consumers with easy-to-understand and accurate information to enable informed decisions when making food choices. Agriculture, transport, trade and land use policies that enable local food production and self-sufficiency, as well as efficient distribution systems and infrastructure, promote sustainable food systems and impact nutritional outcomes.

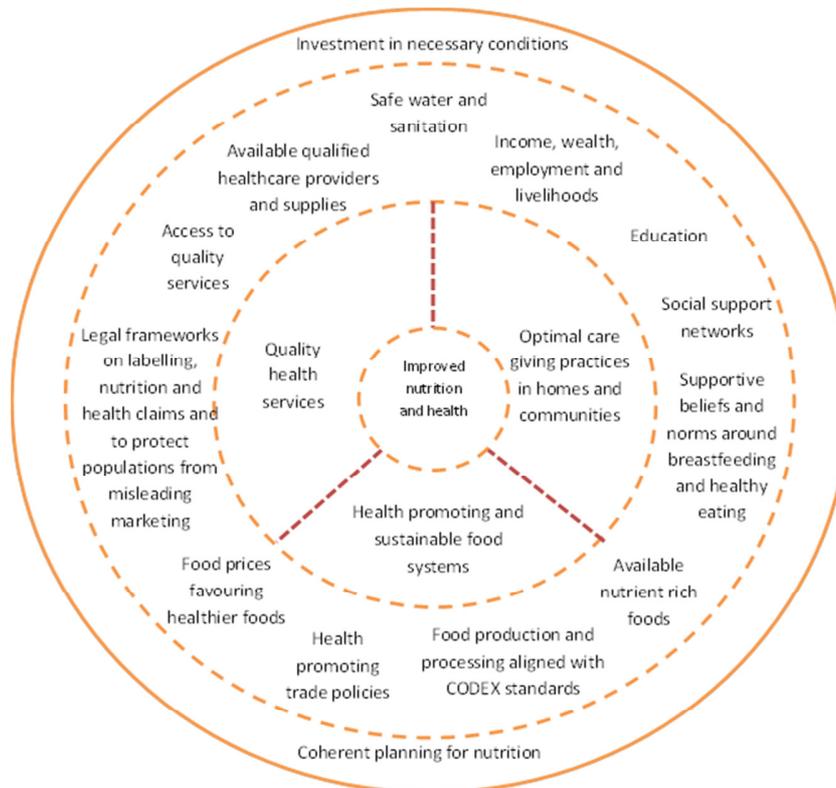
Quality health services that all people can access without financial hardship are critical in reducing the double burden of malnutrition. Universal health coverage (UHC) support nutrition goals by requiring essential nutrition services and counselling for all diseases, including for the four major NCDs: cancer, cardiovascular disease, diabetes and chronic respiratory conditions, at all levels. Growth monitoring; diagnosis and treatment of acute malnutrition and diet-related NCDs; treatment of diarrhoea; protection, promotion and support of breastfeeding; nutrition counselling; and provision of micronutrient

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supplementation are important nutrition services delivered through health facilities. Concurring health issues often exacerbate malnutrition. On the other hand, malnutrition may contribute to prolonged, serious disease manifestation.

While the Region progresses towards measles-free status, recent outbreaks point to faltering immunization coverage and vitamin A deficiency. Severe measles and its complications are more likely to occur in poorly nourished young children. Infants born prematurely, people with acquired HIV/AIDS, tuberculosis or diabetes, smokers, and people regularly exposed to second-hand smoke all have reduced immune responses to diseases. When malnutrition is present, the likelihood of successfully preventing, managing and treating these conditions decreases. Soil-transmitted helminthiasis, other parasitic infections and neglected tropical diseases contribute to malnutrition even though simple school-based interventions, such as deworming and treatment of infections, can prevent it. Low birth weight results from weakened maternal health conditions, inadequate birth spacing, tobacco use and inappropriate alcohol consumption, as well as from suboptimal health-care practices.

**Fig. 1. Necessary conditions for nutrition improvement**



A life-course approach to improving nutrition and health requires a whole-of-society approach, and it should start before pregnancy and continue throughout pregnancy and with good caregiving practices after birth. A women’s nutritional and health status before and during pregnancy, including micronutrient deficiencies as well as gestational diabetes, obesity and hypertension, has implications on the health of the baby. Good caregiving practices include ensuring optimal feeding practices and nutrition decisions for infants and young children, especially breastfeeding, optimal complementary feeding and food nutrient density, feeding frequency, and feeding style. Breastfeeding protects infants immediately from infection and later in life by reducing the risk of obesity, hypertension and type 2 diabetes. It protects women by reducing the risk of breast and ovarian cancer and post-partum depression. Good caregiving practices include choosing fruits and vegetables and diets low in salt, trans fats, saturated fats and free sugars, as well as encouraging healthy lifestyles. Good caregiving practices go beyond feeding practices and include ensuring safe drinking water, providing adequate sanitation and personal hygiene, early recognition of disease, stimulating language and other cognitive capabilities, and emotional support.

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### 1.3 Actions needed to fight the double burden of malnutrition

The *Action Plan to Reduce the Double Burden of Malnutrition in the Western Pacific Region (2015–2020)* brings together actions from global and regional guidance on health and nutrition and encourages coordinated and comprehensive implementation of strategies to address diet-related diseases and to reduce risk factors for malnutrition. It provides a platform for dialogue for sectors to accelerate action to address the double burden of malnutrition in partnership with civil society and stakeholders. While engaging with stakeholders, safeguarding public health from any form of real, perceived or potential conflicts of interest is of critical importance. The involvement of multiple sectors, including for example, agriculture, trade and industry, environment, communication, education and labour, is critical to fight malnutrition.

The action plan recommends actions for countries and WHO to achieve the following five objectives:

1. elevate nutrition in the national development agenda;
2. protect, promote and support optimal breastfeeding and complementary feeding practices;
3. strengthen and enforce legal frameworks that protect, promote and support healthy diets;
4. improve accessibility, quality and implementation of nutrition services across public health programmes and settings; and
5. use financing mechanisms to reinforce healthy diets.

Member States throughout the Western Pacific Region have all taken action to fight malnutrition. The remarkable progress made by the Region in reducing undernutrition has been due to the increasingly supportive policy environments in many countries, driven by the *World Declaration and Plan of Action for Nutrition (1992)*. The WHO *Global Nutrition Policy Review (2013)* included 17 responding countries from the Region. Most countries have developed policies aimed at addressing undernutrition (14); maternal, infant and young child nutrition (16); food security (15); food fortification (11); and obesity and diet-related NCDs (17).

In the Region policies and actions are in place for obesity prevention, and more generally for NCD prevention and control. However, where these are present they are often based on clinical and individual risk-based interventions. There are few population-based approaches and they could be more broadly linked to food security and malnutrition. Fragmented and vertical efforts may have been more convenient than whole-of-government approaches with policy dialogue and partnerships between government departments or ministries and other key stakeholders.

Globalization of food systems has created a complex context for nutrition policies and actions, hence a comprehensive approach is needed, but countries will have to prioritize strategic interventions that can contribute to the reversal of current trends. Trade policy frameworks, economic cooperation agreements and financial policies have contributed to the liberalization of international food trade and increased foreign direct investments in the Region. The impacts of trade and trade agreements and food

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security, as well as land-tenure systems and land-use policies on nutrition and health, need to be better understood and acted upon. There is increasing concern about the sustainability of current food systems and its impact on the environment and health. As globalization continues, climatic and environmental issues, such as flooding, droughts and extremes of temperature, affect food security and impact on nutrition. Human-induced and natural disasters that result in the displacement of communities can push vulnerable groups into malnutrition in a matter of days. **Objective 1** of this action plan addresses the need to elevate nutrition in the national development agenda and ensure adequate investment. Coherence of policies and plans that impact nutrition, for example from health, agriculture, trade, environment, education, disaster risk management and social protection, is necessary to improve nutrition. Trade or agriculture policies should enhance the availability and affordability of healthy diets.

Monitoring policy development, implementation and the impact of nutrition action in a surveillance system helps guide policy decisions and actions. However, nutrition data vary from country to country, and in some countries data may not be available at the national and subnational levels or is not collected routinely. Policy and programme reviews are continuously needed to address the underlying and dynamic determinants of malnutrition. **Objective 1** also recommends establishing and/or strengthening national and regional surveillance systems aligned to global monitoring frameworks for nutrition and NCDs.

Improving the health and well-being of children and families includes enforcing legal instruments that protect breastfeeding practices and women's capacity to continue providing optimal feeding to their children even when returning to work. Only three countries have fully implemented the *International Code of Marketing of Breast-milk Substitutes*, and two provide the minimum recommended paid period of maternity leave recommended in the International Labour Organization (ILO) Maternity Protection Convention, 2000 (No. 183). **Objective 2** addresses the protection, promotion and support for optimal breastfeeding and complementary feeding practices.

The overwhelming growth of food manufacturers, retail chains and transnational food- service operators has affected the availability, affordability, accessibility and diversity of food products, as well as the way they are marketed. Processed foods, often high in salt/sodium, sugar, fats (especially saturated fatty acids and trans-fatty acids), already dominate diets and nutrient patterns in many countries. To achieve the global targets for nutrition and NCD prevention and control, countries are encouraged to develop and enforce policy measures that engage food producers, processors and other commercial operators to reformulate and improve the nutrient composition of processed foods. Some countries have initiated efforts to reduce salt/sodium content of processed foods, including identification of population salt consumption and major sources of sodium in the diet and reformulation of a set number of products available in the market. Accurate food information that overrides false claims is critical to protect populations from misleading marketing, which affects decisions on feeding often to the detriment of breastfeeding, healthy complementary feeding and healthier family food choices. This can be supported through enforced legal instruments and monitoring frameworks, empowered consumers, mobilized partners and good information systems. Industry interference with policy development and implementation needs to be prevented and counteracted through robust legal measures. **Objective 3** recommends establishing and/or strengthening legal frameworks to protect, promote and support healthy

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diets. This includes protection of children from marketing of unhealthy foods and non-alcoholic beverages, nutrition labelling, nutrition and health claims, and reformulating processed foods, specifically to reduce salt content and eliminate trans-fatty acids.

Many standards and recommendations have stimulated actions to reduce the double burden of malnutrition. These include for example the WHO/UNICEF *Global Strategy on Infant and Young Child Feeding*; the WHO *Global Strategy on Diet, Physical Activity and Health*; subsequent guidance to support the implementation in schools and workplaces; and WHO's *Essential Nutrition Actions*, which provide guidance on nutrition interventions targeting the first 1000 days of life. Some countries may need revitalization, retraining and supportive supervision of the workforce that delivers nutrition services through public health programmes and settings. Behavioural and social change interventions and health promotion initiatives identify and address the social and environmental factors that affect food preferences and nutrition practices.

As cultural practices and belief systems impact eating habits and food preferences, formative research may be needed to gain insight on social and historical changes in diets of populations. Interventions should be based on such research and translated into sustained community-level programmes, also encouraging the scaling up of pilot projects. Capacity to deliver behavioural and social change interventions to improve nutrition often is limited.

**Objective 4** addresses accessibility, quality and implementation of nutrition services across the life course through public health programmes and settings, including schools and workplaces. It calls for renewed efforts to gain insight of the underlying factors related to social, cultural and historical contexts for changing diets that can be applied to updated guidelines, clinical protocols and curricula for health and non-health professionals, to strengthen the workforce that delivers nutrition services, and to engage local government and the community in the design of plans to expand nutrition services.

The changing nutrition landscape has, on the one hand, helped reduce undernutrition for hundreds of millions of people. On the other hand however, it has created food environments that contribute to diet-related NCDs. Highly processed, energy-dense and nutrient-poor foods are often cheaper than healthier alternatives and are widely available. Healthier choices should be easy choices. Food pricing policies that favor healthier decisions contribute to nutrition improvements. Taxation of unhealthy foods including those high in salt, sugar and/or fat, could contribute to reduced consumption and increased revenue to support coherent planning for nutrition action. Cash transfer programmes providing financial aid to the poor and most vulnerable are highly complementary to other nutrition actions and are of increasing importance for improving nutrition. **Objective 5** suggests financing mechanisms to reinforce healthy diets.

Since the first International Conference on Nutrition, jointly organized by the Food and Agriculture Organization of the United Nations and WHO in 1992, the nutrition landscape has changed. It has become necessary to reposition nutrition to address the double burden of malnutrition and its complex web of determinants. Renewed high-level commitment presents opportunities to galvanize support needed to refocus policies, strategies, programmes, plans and resources to fight malnutrition. These include the

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political declaration adopted at the United Nations High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, the United Nations Secretary-General's Zero Hunger Challenge, the *Global Strategy for Women's and Children's Health*, the *Comprehensive Framework for Action of the High-Level Task Force on the Global Food Security Crisis*, and the Scaling Up Nutrition (SUN) movement.

It is clear that the pathways that have created the double burden of malnutrition are complex and inextricably linked. While there is no single guiding document that provides comprehensive guidance to address the double burden of malnutrition, Member States may prioritize actions relevant to their context.

## Annex 1

### 2. Guiding principles and approaches

These principles and approaches guide the implementation of the *Action Plan to Reduce the Double Burden of Malnutrition in the Western Pacific Region (2015–2020)*.

#### 1. Human rights-based approach

Strategies to address the double burden of malnutrition should be formulated and implemented in accordance with the principle of international human rights. Human rights law sets out components critical to this action plan, including available, accessible, affordable and acceptable food for all, sensitive to gender and life-course requirements.

#### 2. Life-course approach

A life-course approach starts with maternal health. Integral components of a life-course approach include the promotion of breastfeeding; appropriate infant and child feeding practices; a healthy lifestyle for children, adolescents and youth; a healthy working life; healthy ageing; and care of people in later life are.

#### 3. Evidence-informed policies and practices

Evidence-informed guidance for nutrition interventions should be considered, where available. More country-specific research is needed to identify the common causal pathways of the double burden of malnutrition, the risks of economic (price surges) and environmental (climate variability) shocks that jeopardize the availability and affordability of and access to healthy diets and feeding practices and options for diet diversification.

#### 4. Health in All Policies (HiAP)

HiAP is an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies and avoids harmful health impacts to improve population health and health equity. Policy coherence, one of the outcomes of the HiAP approach, is critical for improved nutrition.

#### 5. Participatory approach

Effective interventions to address the double burden of malnutrition require commitment and actions by various sectors (health and non-health) to ensure supportive policy coherence. It requires meaningful community participation and engagement, as well as active partnerships among national authorities, civil society organizations, academia and private sector –free from conflicts of interest.

#### 6. Ecological approach

Strategies for reorienting food systems so that they become health promoting and environmentally sustainable mean simultaneous attention to food-producing natural environments, farmer livelihoods within a context of market forces, household incomes, food security, and food preparation capacity and preferences.

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**3. Action Plan to Reduce the Double Burden of Malnutrition in the Western Pacific Region (2015–2020)**

This action plan brings together actions from global and regional guidance on health and nutrition and encourages coordinated and comprehensive implementation of strategies to address diet-related diseases and to reduce risk factors for malnutrition. It provides a platform for dialogue for various sectors to accelerate action to address the double burden of malnutrition in partnerships with civil society and relevant stakeholders. While engaging with stakeholders, safeguarding public health from any form of real, perceived or potential conflicts of interest is of critical importance.

It supports and strengthens the implementation of existing regional and global resolutions, strategies and plans.<sup>1</sup> Emphasis is placed on a life-course approach to addressing the double burden of malnutrition, recognizing the critical importance of the first 1000 days of life.<sup>2</sup>

Countries take leadership and ownership in developing responses to reduce the double burden of malnutrition and in harmonizing and aligning partner support. As appropriate to their national context, countries are encouraged to prioritize actions recommended in this action plan. Countries may combine the actions in a stand-alone national nutrition plan, or they may incorporate them into other plans, such as national NCD plans, infant and young child feeding plans, and trade and agricultural plans.

**Goal:** To improve nutrition throughout the life course in the Western Pacific Region.

**3.1 Global nutrition-related targets to be achieved by 2025**

1. 40% reduction in children under 5 that are stunted<sup>3</sup>
2. 50% reduction in anaemia in women of reproductive age<sup>3</sup>
3. 30% reduction of low birth weight<sup>3</sup>
4. 0% increase in childhood overweight<sup>3</sup>
5. 0% increase in adult and adolescent overweight and obesity<sup>4</sup>
6. increase in the rate of exclusive breastfeeding in the first six months to at least 50%<sup>3</sup>
7. reduce and maintain childhood wasting to less than 5%<sup>3</sup>
8. 30% relative reduction in mean population intake of salt/sodium.<sup>4</sup>

**3.2 Objectives, recommended actions and indicators**

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<sup>1</sup> Annex 3 lists key global and regional guidance documents on improving nutrition.

<sup>2</sup> Annex 4 summarizes outcomes of this action plan by stage of life.

<sup>3</sup> Global nutrition targets as stated in the *Comprehensive Implementation Plan on Maternal, Infant and Young Child Feeding*, against a 2012 baseline.

<sup>4</sup> Global voluntary targets for the prevention and control of NCDs as stated in the *Western Pacific Regional Action Plan for the Prevention and Control of Noncommunicable Diseases (2014–2020)*, against a 2010 baseline.

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**Objective 1. Elevate nutrition in the national development agenda**

Nutrition should not only be included but should be high on the national development agenda and linked to poverty reduction, as well as other whole-of-society approaches to social and environmental development and health, which are being influenced by rapid and unplanned urbanization, globalization of food systems, disasters, and climate change, as well as other factors. Nutrition is also an important goal of UHC. National nutrition planning, which includes planning with health and non-health sectors that impacts nutrition, for example planning in trade and/or agriculture, needs to be coherent and adequately funded.

Recommended actions for countries:

1. Strengthen and/or establish a functional national multisectoral coordinating structure as a mechanism to facilitate high-level policy dialogue on health and nutrition and to ensure coherent nutrition planning.
2. Conduct comprehensive reviews of plans and policies from health and non-health sectors impacting nutrition and update these for policy coherence through legal instruments, if necessary.
3. Advocate for sustainable funding for nutrition and ensure adequate national and subnational government investment for updated plans and policies that impact nutrition, as well as for monitoring, evaluation and surveillance.
4. Identify national targets and indicators for nutrition and NCDs that address priorities in countries.

Indicators for countries:

1. National coordinating structure for nutrition strengthened and/or established and used for high-level multisectoral policy dialogue and coherent nutrition planning.
2. Funding secured for updated and costed plans, monitoring, evaluation and surveillance.
3. Nutrition reports generated to monitor achievement of implementation of national and global nutrition and NCD targets and indicators in line with global monitoring schedules.

Recommended actions for WHO:

1. Facilitate high-level policy dialogue within the United Nations System and within countries to include action to address the double burden of malnutrition in national development plans.
2. Provide technical support to ensure policy coherence in national nutrition planning and investment across sectors, including advocacy and guidance for necessary investments of national and local governments.
3. Establish a regional monitoring system for nutrition, including indicators for legal instruments, policies, processes and outcomes, published on the WHO website by 2015 and updated regularly.

Indicators for WHO:

1. Percentage of countries with updated and budgeted plans that impact on the double burden of malnutrition.
2. Established regional monitoring system for nutrition.

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**Objective 2. Protect, promote and support optimal breastfeeding and complementary feeding practices**

Interventions to prevent the double burden of malnutrition start early in life. They include creating supportive and conducive environments for mothers, caregivers and children, especially in the first 1000 days, to protect, promote and support breastfeeding and optimal complementary feeding. Early initiation, exclusive breastfeeding and continued breastfeeding until 2 years of age and beyond, as well as optimal complementary feeding, set the stage for healthy growth and development and reduce the risk of childhood obesity and diabetes.

Recommended actions for countries:

1. Fully adopt, enforce and monitor the *International Code of Marketing of Breast-milk Substitutes* (the Code) and subsequent relevant World Health Assembly resolutions into effective national measures.
  - a. Implement measures to eliminate conflicts of interest, including in health professional and civil society groups.
  - b. Conduct regular monitoring exercises on marketing practices.
2. Institutionalize Baby Friendly Hospital Initiative (BFHI), including assessment and reaccreditation into national accreditation, licensing, financial standards or other acceptable health-care system structures.
3. Develop and align maternity protection as a minimum with International Labour Organization Maternity Protection Convention, 2000 (No. 183).
4. Support optimal and appropriate complementary feeding practices of locally available and acceptable foods.
5. Implement measures to prohibit inappropriate promotion of complementary feeding.
6. Use social marketing approaches to promote breastfeeding as an intervention to prevent childhood undernutrition, reduce the risk of childhood obesity and prevent diabetes.
7. Incorporate the progress of infant and young child feeding in the national report to the Committee on the Rights of the Child.
8. Allocate funds to protect, promote and support breastfeeding based on internationally available benchmarks (e.g. World Bank).<sup>5</sup>

Indicators for countries:

1. The Code fully adopted into effective national measures.
2. Code monitoring mechanisms in place and functioning
3. Percentage of hospitals assessed within the past two years and meeting BFHI standards.
4. Maternity protection measures enacted and aligned with ILO Convention 183.
5. Regular reports to the Committee on the Rights of the Child include breastfeeding and complementary feeding.

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<sup>5</sup> Scaling up nutrition, what it will cost? World Bank, Washington, D.C, 2010

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Recommended actions for WHO:

1. Support biannual regional monitoring of the Code.
2. Develop and disseminate guidance materials and support countries to eliminate conflicts of interest, including in health professional societies.
3. Support the development of breastfeeding promotion campaigns and public education.
4. Engage international standards organizations to incorporate BFHI as requirements for quality assurance of health facilities.
5. Develop a guidance note for how to report on infant and young child feeding to the Committee on the Rights of the Child.
6. Develop mechanisms for sharing best practices on complementary feeding among countries.

Indicators for WHO:

1. Percentage of countries that fully adopted and monitored the *International Code of Marketing of Breast-milk Substitutes* and subsequent relevant World Health Assembly resolutions into effective national measures.
2. Percentage of hospitals per country assessed within the past two years and meeting BFHI standards.
3. Percentage of countries with reports to the Committee on the Rights of the Child that include information on progress on infant and young child feeding.
4. Percentage of countries with enacted maternity protection measures aligned with ILO Convention 183.

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**Objective 3. Strengthen and enforce legal frameworks that protect, promote and support healthy diets**

A legal and policy environment is necessary to ensure the population receives accurate and unbiased information and to ensure availability of nutritious food options. Food regulations and standards should align with Codex Alimentarius guidance, be risk based, and facilitate trade in safe and healthier food. Legal frameworks to protect, promote and support healthy diets are also within non-health sectors, including for example education (the WHO *Set of Recommendations on the Marketing of Foods and Non-alcoholic Beverages to Children* and measures to ban of sales of sugar-sweetened beverages to address childhood obesity) or agriculture (Codex Alimentarius). Whole-of-government approaches to salt reduction will contribute to the reduction of preventable deaths from hypertension. Evidence-based restrictions on marketing to children may be considered based on country-specific regulatory regimes to include food labelling and warnings; bans on advertising, sponsorship, brand mascots or characters popular with children; point-of-purchase displays; and communication through “viral marketing” of foods high in salt, sugar and fats.

Recommended actions for countries:

1. Implement measures to protect dietary guidance and food policy from undue commercial and other vested interests.
2. Ensure the following are fully incorporated into effective national measures:
  - a. The WHO *Set of Recommendations on the Marketing of Foods and Non-alcoholic Beverages to Children*.
  - b. Standards for foods and drinks sold in schools.
  - c. Health and nutrition claims based on Codex Alimentarius guidelines.
  - d. Nutrition labelling (including front of pack labelling)
  - e. Fortification of staple foods (such as rice and wheat) with vitamins and minerals relevant to country needs.
  - f. Whole-of-government approaches to salt reduction.
3. Develop guidelines, recommendations or policy measures that engage food producers, processors and other commercial operators to reformulate processed foods to reduce salt/sodium, sugar, saturated fatty acids and eliminate trans-fatty acids.

Indicators for countries:

1. Measures implemented to protect dietary guidance and food policy from undue commercial and other vested interests.
2. Full incorporation of the following into effective national measures:
  - a. The WHO *Set of Recommendations on the Marketing of Foods and Non-alcoholic beverages to Children*.
  - b. Standards for foods and drinks sold in schools.
  - c. Health and nutrition claims based on Codex Alimentarius guidelines.
  - d. Nutrition labelling (including front of pack labelling).

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- e. Appropriate evidence-informed food fortification standards.
  - f. Whole-of-government approaches to salt reduction.
3. Proportion of processed food reformulated to have improved nutrient composition.

Recommended actions for WHO:

1. Develop and disseminate guidance materials and support countries to implement measures to protect dietary guidance and food policy from undue commercial and other vested interests.
2. Provide technical assistance to develop and implement effective national measures, including developing model legal instruments, for:
  - a. The WHO *Set of Recommendations on the Marketing of Foods and Non-alcoholic beverages to Children*.
  - b. Standards for foods and drinks sold in schools.
  - c. Health and nutrition claims based on Codex Alimentarius guidelines.
  - d. Nutrition labelling (including front of pack labelling).
  - e. Appropriate evidence-informed food fortification standards.
  - f. Whole-of-government approaches to salt reduction.
3. Provide technical assistance to countries in developing guidelines, recommendations or policy measures that engage food producers, processors and other commercial operators to reformulate processed foods.

Indicators for WHO:

1. Percentage of countries with measures implemented to protect dietary guidance and food policy from undue commercial and other vested interests.
2. Percentage of countries incorporating the following into effective national measures:
  - a. The WHO *Set of Recommendations on the Marketing of Foods and Non-alcoholic beverages to Children*.
  - b. Standards for foods and drinks sold in schools.
  - c. Health and nutrition claims based on Codex Alimentarius guidelines.
  - d. Nutrition labelling (including front of pack labelling).
  - e. Food fortification standards.
  - f. Whole-of-government approaches to salt reduction.
3. Percentage of countries in which processed food is reformulated.
4. Percentage of countries declared free of trans-fatty acids.

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**Objective 4. Improve accessibility, quality and implementation of nutrition services across public health programmes and settings**

The health system has a major role in addressing the double burden of malnutrition, in particular, ministries of health might play a more active role in convening and building consensus with other sectors on policies that will result in improved nutrition outcomes. Accessibility and quality of nutrition services through the health system need to be ensured and sustained. UHC presents an important opportunity to ensure nutrition services also reach the most vulnerable and marginalized groups.<sup>6</sup> Integration of nutrition into programmes that impact nutrition from other sectors (e.g. agriculture, water and sanitation, education and trade) and into settings-based programmes (e.g. including ensuring healthier food choices in canteens through health-promoting schools and workplaces) will contribute to reducing the double burden of malnutrition. During emergencies, mobilizing support to reach affected and displaced populations.

Recommended actions for countries:

1. Strengthen delivery of nutrition services through public health programmes and settings<sup>7</sup> by:
  - a. updating policies, guidelines, clinical protocols and curricula of health and non-health sectors on nutrition;
  - b. increasing the trained workforce (skilled and lay) that delivers nutrition services in health and non-health sectors;
  - c. providing supportive supervision of staff through continuing professional development;
  - d. ensuring availability and accessibility of basic nutrition supplies, commodities and equipment;<sup>8</sup> and
  - e. engaging local governments and communities in the design of plans to expand nutrition services and to ensure their integration into existing community programmes (including health-promoting schools, marketplaces or workplaces).
2. Enhance knowledge management to support delivery of evidence-informed nutrition services:
  - a. Establish/strengthen routine nutrition surveillance, including prioritization of vulnerable groups in disaster-prone areas to support emergency response.
  - b. Conduct research into feeding practices and options for diet diversification for families across the life course.
  - c. Implement a comprehensive communication plan focused on feeding and dietary behavioural practices, including complementary feeding.
3. Ensure national disaster preparedness and response plans, including cost-effective and evidence-informed nutrition interventions.

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<sup>6</sup> See Annex 4 for a detailed list of essential nutrition actions through out the life course.

<sup>7</sup> This includes integration of nutrition within settings, such as schools and workplaces.

<sup>8</sup> Including for example: measuring tapes and weighing scales, growth charts, stethoscope, blood pressure measurement devices, vitamin supplements, micronutrient powders, oral rehydration solution, essential tools for assessing risks through the *Package of Essential Noncommunicable Disease Interventions for Primary Health Care in Low-resource Settings* (PEN).

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- a. Support capacity-building activities on nutrition in emergencies, including rapid nutritional assessments during and after emergencies.<sup>9</sup>

Indicators for countries:

1. Increased national and subnational coverage of nutrition services.
2. Updated policies, guidelines, clinical protocols and curricula in health and non-health sectors. Established/strengthened routine nutrition surveillance, including prioritization of vulnerable groups in disaster-prone areas to support emergency response.
3. Identified and implemented optimal diverse diets for pregnant women and children (6–23 months).
4. Implemented communication plan focused on feeding and dietary behavioural practices.
5. Nutrition interventions included in national disaster planning and response plans.

Recommended actions for WHO:

1. Provide technical support to all countries to strengthen delivery of nutrition services.
2. Develop and disseminate tools to support countries establishing and updating evidence-informed policies, guidelines, clinical protocol and curricula on nutrition and to support countries integrating nutrition components into curricula of health and non-health professional.
3. Provide technical support to establish/strengthen routine nutrition surveillance, including prioritization of vulnerable groups in disaster-prone areas.
4. Support research on feeding practices and diet diversity and to develop a comprehensive communication plan.
5. Technical support to countries to integrate nutrition into national disaster preparedness and response plans.

Indicators for WHO:

1. Percentage of countries with updated policies, guidelines, clinical protocol and curricula.
2. Percentage of countries with inclusion of nutrition components in health and non-health sector programmes.
3. Percentage of countries with optimal diverse diets identified for pregnant women and children (6–23 months) identified.
4. Percentage of countries conducting routine nutrition surveillance, including of vulnerable groups
5. Percentage of countries with inclusion of nutrition components in public health programmes, including for disaster preparedness.

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<sup>9</sup> Building on available guidance, including for example *The Management of Nutrition in Major Emergencies* (WHO, 2000) and *Guiding Principles for Feeding Infants and Young Children during Emergencies* (WHO, 2004)

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**Objective 5. Use financing mechanisms to reinforce healthy diets and ensure delivery and use of nutrition services**

Mobilizing resources and generating sustainable financing sources, for example through taxation, are pivotal to secure funds for policy implementation. Creating incentives through taxes and subsidies that improve the affordability and encourage consumption of healthier food products and discourage the consumption of less healthy options can be considered by countries as relevant to national contexts.<sup>10</sup>

Recommended actions for countries:

1. Ensure nutrition services and supplies are affordable to all through government funding channeled through subsidies to service providers, people in need or insurance benefit packages.
2. Consider food pricing schemes/policies that favour healthier decisions, where applicable:
  - a. Implement social protection schemes (e.g. conditional and unconditional cash transfer programmes, food vouchers and food discounts).
  - b. Provide economic incentives (e.g. provision of raw agricultural inputs, tax discounts for producers) for local production, processing and distribution or importation, and marketing of healthier food options.
  - c. Impose tax increases on unhealthy foods (foods high in saturated and trans fats, salt, and free sugars) and consider allocating a percentage of this to promoting healthier food products.

Indicators for countries:

1. Nutrition services and supplies are affordable to all through government funding channeled through subsidies to the service providers, people in need or insurance benefit packages.
2. Financing mechanisms to increase the consumption of healthier foods.
3. Financing mechanisms to support local production and/or importation of healthier food options.

Recommended actions for WHO:

1. Facilitate the development of tools and models for calculating taxes and subsidies on food products.
2. Support countries to develop financial mechanisms to increase access to healthier foods and evidence-informed nutrition interventions.

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<sup>10</sup> *Global Action Plan for the Prevention and Control of Noncommunicable Diseases (2013–2020)*. WHO, 2013.

Indicators for WHO:

1. Percentage of countries with nutrition services and supplies covered through government funding.
2. Percentage of countries that developed financing mechanisms to increase the consumption of healthier foods.

#### **4. Partnerships and networks: the role of the United Nations agencies and development partners**

Various United Nations agencies and international organizations have been working to fight malnutrition for the past 30 years or more and, more recently, to fight NCDs. Several global calls have been made to reposition nutrition high on national government agendas, and numerous movements, networks and alliances have been constituted to achieve that goal. A High-level Panel Discussion on Joint Action to Achieve Food and Nutrition Security in the Western Pacific Region was held at the sixty-third session of the WHO Regional Committee for the Western Pacific in Hanoi, Viet Nam, in September 2012. The panel discussion was attended by the Regional Director of the United Nations Children's Fund (UNICEF) for East Asia and the Pacific, the Regional Director of the World Food Programme for Asia, the FAO Assistant Director-General and Regional Representative for Asia and the Pacific, and the WHO Regional Director for the Western Pacific. All emphasized the need for collaboration to address the nutrition problems where they still stubbornly exist and the problem of overweight/obesity and NCDs where they are increasing.

The United Nations Development Assistance Framework (UNDAF), which is a strategic programme framework that describes the collective, coherent response of the United Nations system to national development priorities, also provides an important platform to engage in nutrition improvement. Seven countries in the Region currently have UNDAF plans, including Cambodia, China, the Lao People's Democratic Republic, Mongolia, Papua New Guinea, the Philippines and Viet Nam, and there is a plan for Pacific island countries and areas. More UNDAF plans are being planned during the time frame of this action plan and provide an important opportunity to further emphasize nutrition for health and development.

To assist and guide countries in the process from formulation to implementation of comprehensive plans, United Nations agencies and development partners should consider:

1. creating convergence to support the creation of sustainable food systems, and the provision and maintenance of quality health-care services;
2. where possible, pooling expertise and resources to gain greater traction among government and other partners; and
3. ensuring policy coherence in addressing nutrition issues.

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**Appendix 1. Glossary of terms**

**Cash transfer programmes**

Cash transfer programmes provide assistance in the form of money to increase household income. They can be unconditional or conditional. Conditions may include periodic health visits, growth monitoring, vaccination when applicable, antenatal care and education sessions. Cash transfer programmes are complementary to other nutrition actions and involve establishing eligibility, usually based on low income. Their effect on nutrition is both through increasing resources (income) and, for conditional programmes, enhancing use of services.

**Codex Alimentarius**

In 1963, the Sixteenth World Health Assembly approved the establishment of the Joint FAO/WHO Food Standards Programme with the Codex Alimentarius Commission as its principal organ. The protection of consumer health and fair practices in the food trade come under the Commission's scrutiny. The Codex Alimentarius (the Food Code), has become the global reference point for consumers, food producers and processors, national food-control agencies and the international food trade.

**Complementary feeding**

Complementary foods include those that are manufactured or locally prepared, suitable as a complement to breast milk or to a breast-milk substitute when either becomes insufficient to satisfy the nutrition requirements of the infant. A working definition refers to complementary feeding as the process starting when breast milk or infant formula alone is not longer sufficient to meet the nutrition requirements of infants, and therefore other foods and liquids are needed along with breast milk or a breast-milk substitute. The target range for complementary feeding is generally taken to be 6–23 months.

**Double burden of malnutrition**

The double burden of malnutrition refers to the burden of undernutrition (wasting, stunting, low birth weight and micronutrient deficiencies, including among those of normal weight or the overweight) along with the burden of overweight and obesity linked to a rise in NCDs.

**Exclusive breastfeeding**

The infant only receives breast milk without any additional food or drink, not even water. As a global public health recommendation, infants should be exclusively breastfed for the first six months of life to achieve optimal growth, development and health.

### **Fortification**

Food fortification is the addition of micronutrients to food, with the objective to add the level of specific nutrients or to restore nutrients lost during processing (e.g. milling) and preparation (e.g. washing, cooking).

### **Food security**

Food security exists “when all people at all times have access to sufficient, safe, nutritious food to maintain a healthy and active life” (The World Food Summit, 1996).

### **Food Systems**

“Food systems encompass (i) activities related to the production, processing, distribution, preparation and consumption of food; and (ii) the outcomes of these activities contributing to food security (food availability, with elements related to production, distribution and exchange; food access, with elements related to affordability, allocation and preference; and food use, with elements related to nutritional value, social value and food safety). The outcomes also contribute to environmental and other securities (e.g. income).” (Global Environmental Change and Food Systems).

The United Nations Secretary-General’s High-Level Task Force on the Global Food Crisis (2012) has summarized the features of a healthy and sustainable food system as follows: “Sustainable, nutrition-sensitive agriculture and food security policies help improve the availability and accessibility of nutritious food, and promote healthy and sustainable diets and prosperity in rural areas.”

### **ILO Convention 183**

Maternity Protection Convention (2000) No. 183 is an international labour standard on maternity protection, including maternity benefits, cash benefits, job security during pregnancy or maternity leave, and working conditions. Safeguarding the health of expectant and nursing mothers and protecting them from job discrimination are preconditions for achieving genuine equality of opportunity and treatment for men and women at work and enabling workers to raise families in conditions of security.

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### **Industry interference**

The use of a multitude of tactics by industry to shape and influence public policy. It includes, but it is not limited to, the use of the industry's economic and political power through lobbying, marketing, public relations and philanthropic contributions, among others, to maintain its ability to function with minimal to no regulatory constraints.

### **International Code of Marketing of Breast-milk Substitutes**

The *International Code of Marketing of Breastmilk Substitutes* was adopted by World Health Assembly Resolution (WHA34.22) in 1981. The Code bans all promotion of bottle feeding and sets out requirements for labelling and information on infant feeding. Any activity, which undermines breastfeeding, violates the Code. The Code and subsequent related resolutions by the World Health Assembly are intended as a minimum requirement in all countries.

### **Life course approach to improve nutrition**

People have unique nutritional requirements at different stages of the life course, from conception to infancy, through childhood and adolescence, during adulthood, and into old age. Pregnancy and the postpartum are unique stages of life bringing about particular nutritional needs.

### **Low birth weight**

Low birth weight is defined as newborn infants weighing as less than 2500 grams (up to and including 2499 grams).

### **Malnutrition**

Malnutrition refers to the body not getting the right balance of nutrients and calories needed to sustain good health and development. It arises mainly as a result of inadequate or unbalanced diets, but is also caused by poor nutrient absorption or a loss of nutrients due to illness. The causes of malnutrition are directly related to inadequate dietary intake as well as disease, but are directly related to many factors, including household food security, maternal and child care, health services, the environment and other factors. Malnutrition thus includes undernutrition, micronutrient deficiencies and overweight/obesity.

### **Noncommunicable diseases**

Noncommunicable diseases (NCDs) are not passed from person to person. They are of long duration and generally slow progression. The four main types of NCDs are cardiovascular diseases (e.g. heart disease), cancers, chronic respiratory diseases (e.g. asthma and chronic obstructed pulmonary disease) and diabetes. Tobacco use, physical inactivity, unhealthy diets and the harmful use of alcohol are the chief risk factors for most NCDs.

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**Nutrient profiling**

Nutrient profiling is the science of classifying or ranking foods according to their nutritional composition for reasons related to preventing disease and promoting health. Nutrient profiling can be used for various applications, including marketing of foods to children, health and nutrition claims, product labelling logos or symbols, information and education, provision of food to public institutions, and the use of economic tools to orient food consumption.

**Overweight/obesity**

Overweight among children under 5 years of age is defined as weight-for-height greater than 2 standard deviations (SD) of the WHO Child Growth Standards median.

A population measure of obesity is the body mass index (BMI), a person's weight (in kilograms) divided by the square of his or her height (in metres).

For children aged 5–9 years, the BMI for age is used as an indicator. A BMI for age greater than or equal to 1 SD (equivalent to BMI 25 kg/m<sup>2</sup> at 19 years) is considered overweight, and a BMI for age greater than or equal to 2 SD (equivalent to BMI 30 kg/m<sup>2</sup> at 19 years) as obese.

An adult with a BMI of 30 or more is generally considered obese. A person with a BMI equal to or more than 25 is considered overweight.

**Policy coherence**

Policy coherence promotes mutually reinforcing policy actions across government departments and agencies. Policies from health, education, trade, agriculture, water and sanitation, and other relevant government sectors should positively reinforce national development goals and contribute to reducing the double burden of malnutrition.

**Food pricing schemes**

Price is one of the most important factors influencing food choice. Food pricing schemes include the introduction of taxes on unhealthy foods, including foods containing high levels of saturated or trans fat, salt and free sugar, and subsidies on healthy foods, including foods high in fibre and micronutrients. Taxation, subsidies or direct pricing to influence prices may encourage healthier choices.

**Stunting**

Stunting is defined as height-for-age below -2 SD of the WHO Growth Standard median. Stunted growth reflects a process of failure to reach linear growth potential as a result of suboptimal health and/or nutritional conditions.

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**Undernutrition**

The WHO Global Database on Child Growth and Malnutrition uses a Z-score cut-off point of  $<-2$  SD to classify low weight-for-age, low height-for-age and low weight-for-height as moderate and severe undernutrition, and  $<-3$  SD to define severe undernutrition.

**Underweight**

Underweight among children below 5 years of age is defined as weight-for-age below -2 SDs of the WHO Growth Standard median.

**Unhealthy foods**

Foods high in saturated fats, trans-fatty acids, free sugars and salt. Member States can choose to distinguish food types in several ways, for example by using national dietary guidelines, definitions set by scientific bodies or nutrient profiling models.

**Wasting**

Wasting is defined as weight-for-height below -2 SDs of the WHO Growth Standard median. Wasting or thinness indicates in most cases a recent and severe process of weight loss, which is often associated with acute starvation and/or severe disease. However, wasting may also be the result of a chronic unfavourable condition.

**Water safety plans**

Using health-based targets as a point of departure, water safety plans provide a systematic approach towards assessing, managing and monitoring risks from catchment to consumer. It provides a way of structuring and applying tools, methods and procedures to replace end-of-pipe measurements of water quality by a hazard analysis critical control points approach, referring to a series of actions to be taken to ensure safety of the drinking-water supply chain at critical control points. Water safety plans follow the logical sequence of this chain and enable system-tailored hazard identification and risk assessment/management. Wastewater or sanitation safety plans work in a similar manner.

**Appendix 2. Nutrition situation in the Western Pacific Region**

**Table A2.1 Overweight and obesity and consumption of carbonated soft drinks in selected countries among students aged 13–15 years**

		Percentage of students who were overweight (>+1SD from median for BMI by age and sex)	Percentage of students who were obese (>+2SD from median for BMI by age and sex)	Percentage of students who usually drank carbonated soft drinks one or more times per day during the past 30 days
Cambodia	2013	3.7	0.4	45.6
Malaysia	2012	23.7	9.6	31.3
Philippines	2011	10.2	2.8	42.2
Mongolia	2013	11.5	1.6	33.8
Fiji	2010	19.2	5.2	.
Vanuatu	2011	11.4	0.1	37.9
Cook Islands	2011	58.5	24.3	61.5
Kiribati	2011	39.8	8.2	22.3
Nauru	2011	44.5	16.7	.
Niue	2010	56.7	29.7	77.3
Solomon Islands	2011	20	2.2	45.1
Samoa	2011	51.7	19.2	53.5
Tonga	2010	59.6	21.9	57

Source: Global School-based Health Survey

**Table A2.2 Nutrition assessment of selected countries and the Western Pacific Region**

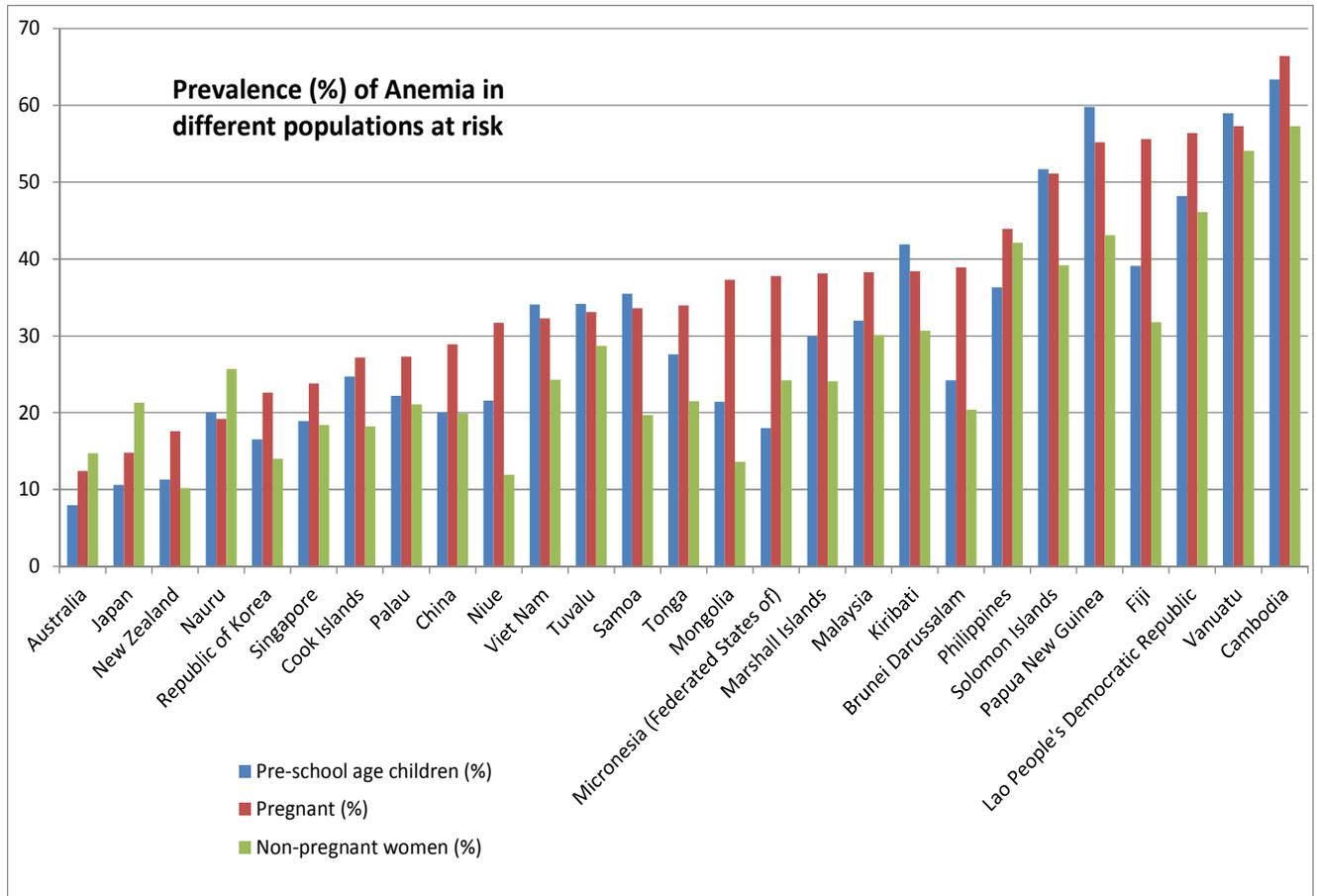
Country	Low birth weight (%)	Stunting (%), <-2*	Wasting (%), <-2*	Underweight (%), <-2*	Overweight (%)>+2*	Exclusive Breastfeeding (%) < 6 months	Anemia in women of reproductive age (%)	
							Pregnant	Non-pregnant
Cambodia	9	41	11	29	2	74	66	57
China	3	9	3	3	7		29	20
Lao People's Democratic Republic	11	48	7	32	1	26	56	46
Papua New Guinea	10	48	16	27	.	.	55	43
Philippines	21	34	7	20	4	34	44	42
Solomon Islands	13	33	4	12	3	74	51	39
Viet Nam	5	29	4	12	5	17	32	24
Western Pacific Region (average)	5	10	3	4	5	29	31	22

\* Children < 5 years of age

Source: Joint WHO World Bank and UNICEF 2013 data, WHO Global Observatory, World Health Statistics 2012, WHO Global database on Anemia, 2005 (figures have been approximated for presentation purposes)

Annex 1

**Fig. A2.1 Anemia prevalence in high-risks populations in the Western Pacific Region (1993–2005)**



Source: WHO, Worldwide prevalence of anaemia 1993–2005

**Appendix 3. Global and regional guidance documents: year and weblinks**

Global and regional guidance documents	Year	Weblink
FAO/WHO World Declaration and Plan of Action for Nutrition (1992)	1992	<a href="http://whqlibdoc.who.int/hq/1992/a34303.pdf">http://whqlibdoc.who.int/hq/1992/a34303.pdf</a>
WHO/UNICEF Global Strategy for Infant and Young Child Feeding	2002	<a href="http://apps.who.int/gb/archive/pdf_files/WHA55/ea5515.pdf">http://apps.who.int/gb/archive/pdf_files/WHA55/ea5515.pdf</a>
WHO Global Strategy on Diet, Physical Activity and Health  (and related documents)	2004	<a href="http://apps.who.int/gb/ebwha/pdf_files/WHA57/A57_R17-en.pdf">http://apps.who.int/gb/ebwha/pdf_files/WHA57/A57_R17-en.pdf</a>  ( <a href="http://www.who.int/dietphysicalactivity/implementation/toolbox/en">http://www.who.int/dietphysicalactivity/implementation/toolbox/en</a> )
WHO Set of Recommendations on the Marketing of Food and Non-Alcoholic Beverages to Children	2010	<a href="http://whqlibdoc.who.int/publications/2010/9789241500210_eng.pdf">http://whqlibdoc.who.int/publications/2010/9789241500210_eng.pdf</a>
WHO Comprehensive Implementation Plan for Maternal, Infant and Young Child Nutrition	2012	<a href="http://www.who.int/nutrition/topics/WHA65.6_annex2_en.pdf">http://www.who.int/nutrition/topics/WHA65.6_annex2_en.pdf</a>
Essential Nutrition Actions: Improving maternal, newborn infant and young child health and nutrition	2013	<a href="http://apps.who.int/iris/bitstream/10665/84409/1/9789241505550_eng.pdf">http://apps.who.int/iris/bitstream/10665/84409/1/9789241505550_eng.pdf</a>
WHO Western Pacific Regional Food Safety Strategy (2011–2015)	2011	<a href="http://www.wpro.who.int/foodsafety/documents/docs/Food_Safety_Strategy_2011-2015_final.pdf">http://www.wpro.who.int/foodsafety/documents/docs/Food_Safety_Strategy_2011-2015_final.pdf</a>
Towards a food secure Pacific, Framework for Action on Food Security in the Pacific (FAO, UNICEF, WHO, SPC, GHI, PFIS)	2011	<a href="http://www.spc.int/lrd/pafnet-publications/doc_download/1055-towards-a-food-secure-pacific-2011-2015-">http://www.spc.int/lrd/pafnet-publications/doc_download/1055-towards-a-food-secure-pacific-2011-2015-</a>
WHO/UNICEF Regional Action Plan towards Healthy Newborns in the Western Pacific Region (2014–2020)	2013	<a href="http://www.wpro.who.int/publications/regional_action_plan_newborn_infants.pdf">http://www.wpro.who.int/publications/regional_action_plan_newborn_infants.pdf</a>
WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases (2013–2020)	2013	<a href="http://apps.who.int/iris/bitstream/10665/94384/1/9789241506236_eng.pdf">http://apps.who.int/iris/bitstream/10665/94384/1/9789241506236_eng.pdf</a>
WHO Regional Action Plan for the Prevention and Control of Noncommunicable Diseases (2014–2020)	2013	<a href="http://www.wpro.who.int/noncommunicable_diseases/about/ncd_regional_action_plan_2014-2020/en/">http://www.wpro.who.int/noncommunicable_diseases/about/ncd_regional_action_plan_2014-2020/en/</a>
NCD Road Map Report ( <i>Pacific</i> ) (World Bank, SPC, WHO)	2014	(Finalization in progress)

## Annex 1

## Appendix 4. Outcomes of the Action Plan to Reduce the Double Burden of Malnutrition in the Western Pacific Region by stage of life

Outcomes of the action plan	Birth	Infants and young children		Pre-school 3–6 yrs	School age		Women		Working age population	Older people
		6 mo	2y+		Primary	Secondary	WRA	Pregnant		
<b>1. Breastfeeding (BF)</b>										
1a. initiation of BF within 1 hour (and appropriate and timed cord clamping) <sup>2</sup>										
1b. exclusive BF for 6 months and continued BF for $\geq 2$ years <sup>2</sup>										
<b>2. Complementary feeding (CF)</b>										
2a. introduction of CF at 6 months while continuing to BF <sup>2,4</sup>										
2b. increased consumption of locally available, diverse foods <sup>2,4,5</sup>										
2c. fortified complementary foods or multi-micronutrient supplements for home use (when necessary) <sup>2,4</sup>										
<b>3. Fortification</b>										
3a. fortified staple foods and condiments: flour, oil, salt, fish and soy sauce (country specific) <sup>3</sup>										
<b>4. Healthy diets</b>										
4a. reduced level of salt/sodium in prepared or processed foods <sup>3,5</sup>										
4b. trans fats replaced with unsaturated fats <sup>3,5</sup>										
4c. reduced saturated fatty acids in foods and replaced with unsaturated fats <sup>3,5</sup>										
4d reduced free added sugars in food and non-alcoholic <sup>3,5</sup>										
4e. reduced portion size and energy density of foods and limit to calories <sup>3,5</sup>										
4f. increased consumption of fruits and vegetables <sup>3,4,5</sup>										
4g. reduced consumption of processed foods high in salt, sugar and trans fats <sup>3,4,5</sup>										
<b>5. Micronutrient supplementation and treatments</b>										
5a. Iron/folic acid supplementation <sup>4</sup> :										
-Women of reproductive age: weekly if anemia >20%										
-Pregnancy: weekly if not anaemic, daily if anaemic or unknown										
5b. deworming, if a public health problem <sup>4</sup>										
5c. vitamin A if a public health problem <sup>4</sup>										
5d. calcium supplementation in pregnancy where calcium intake is low <sup>4</sup>										
5e. iodine to pregnant and lactating women (countries where <20% of households have access to iodized salt). <sup>4</sup>										
<b>6. Height, weight and age monitoring<sup>4</sup></b>										
6a. growth monitoring (weight, height, age) and counseling <sup>4</sup>										
6b. growth surveillance using BMI <sup>4</sup>										
6c. BMI screening <sup>4</sup>										
<b>7. Water and sanitation<sup>4</sup></b>										
7a. Access to safe water and proper sanitation <sup>4</sup>										

\* Objective 1: repositioning nutrition planning contributes to all outcomes

2, 3, 4, 5: Numbers refers to objectives of the action plan that contribute to the outcome