WORLD HEALTH ORGANIZATION

ORGANISATION MONDIALE DE LA SANTÉ

REGIONAL OFFICE FOR THE WESTERN PACIFIC
BUREAU RÉGIONAL DU PACIFIQUE OCCIDENTAL

REGIONAL COMMITTEE

Forty-fourth session
Manila
13-17 September 1993

Provisional agenda item 13

WPR/RC44/9

2 July 1993

ORIGINAL: ENGLISH

NUTRITION IN THE WESTERN PACIFIC REGION, INCLUDING FOLLOW-UP OF THE INTERNATIONAL CONFERENCE ON NUTRITION

This report summarizes the nutrition situation in the Western Pacific Region. It incorporates the two-yearly report to the Regional Committee on infant and young child nutrition and describes action taken on the implementation of the International Code of Marketing of Breast-milk Substitutes in compliance with Regional Committee resolution WPR/RC36.R15 and the World Health Assembly resolutions on the subject.

This report also covers activities following on from the FAO/WHO International Conference on Nutrition, held in Rome in December 1992, which endorsed a World Declaration and Plan of Action for Nutrition. Member States are asked to endorse these and formulate national plans for eliminating or substantially reducing nutrition-related disorders and promoting sound nutrition policies.

1. NUTRITION IN THE WESTERN PACIFIC REGION

The diversity of geographical, socioeconomic and cultural conditions in the Western Pacific Region is reflected in the nutrition situation. The most serious problem is still undernutrition, involving both protein-energy malnutrition and micronutrient deficiencies. Vitamin A and iodine deficiency disorders and iron deficiency anaemia remain major public-health problems in many countries.

Increases in life expectancy, the decline in infant mortality and generally higher levels of prosperity have dramatically increased the relative importance of noncommunicable diseases among the causes of death. In 16 of the 33 countries and areas of the Region that keep cause-of-death statistics, at least three of the five leading causes are noncommunicable diseases.

Changes in eating habits resulting from increased spendable income and rapid urbanization, and particularly increased consumption of high-energy, high-fat fast foods, have led to the emergence of such problems as childhood obesity and a greater incidence of diabetes.

Aspects of nutrition such as food quality and safety, although important, will not be discussed here in any detail. Food supply is only briefly touched upon, since, although it is obviously of fundamental importance to nutritional well-being, it is generally dealt with by the United Nations Food and Agricultural Organization (FAO).

1.1 Undernutrition

Protein-energy malnutrition

There has been encouraging progress; the proportion of children under five years of age who are malnourished has declined. However, the continuing growth in populations has meant that in some countries the actual numbers are continuing to increase. In others, such as China, they have decreased. Where there has been an improvement, it appears to have been largely due to improving socioeconomic conditions, although public health and other factors have also undoubtedly played a significant role. On the basis of nutrition surveys undertaken in the 1980s it can be concluded that the prevalence of undernutrition is relatively high in Cambodia, the Lao People's Democratic Republic and Viet Nam. Although less prevalent in Papua New Guinea, the Philippines, Solomon Islands and Vanuatu, it continues to be a problem. In China, Fiji, Kiribati, Malaysia and the Republic of Korea some pockets of undernutrition still exist.

However, even in countries with high levels of malnutrition, it occurs, in general, in its more mild to moderate forms. Isolated pockets of severe protein-energy malnutrition remain, especially during periods of social turmoil, in certain very poor rural areas and among the children of very disadvantaged shanty town dwellers. The interaction between malnutrition and communicable disease is complex but very important and it appears likely that control of both must be achieved to ensure optimal growth in early childhood.

Malnutrition of the young or multiparous mother continues to be a widespread problem and is reflected in the percentages of low-birth-weight infants in the Region. The percentages of low-birth-weight infants range from 39% of all births in the Lao People's Democratic Republic, to 25% in Papua New Guinea, 9% in China and the Republic of Korea, and between 5% and 7% in Australia, Japan, New Zealand and Singapore. The problem is not so great in many of the Pacific island countries, where on average birth weights are slightly above the standard levels.

1.2 Micronutrient deficiencies

Vitamin A deficiency

Vitamin A deficiency is still a major public health problem in countries such as the Lao People's Democratic Republic, the Philippines, Viet Nam and probably Cambodia. Certain dietary intake survey reports suggest there may be some localized, predominantly subclinical, problems in parts of China. There appears to be an emerging problem in the Micronesian island countries, particularly those that are becoming overcrowded and urbanized, such as Chuuk in the Federated States of Micronesia and Kiribati, and in the Marshall Islands where cases have been anecdotally reported from Majuro Hospital. Atoll islands whose soil capacity is limited and which already import much of their food appear to be at special risk. Table 1 below indicates reported prevalences in those countries in the Region in which measurements of vitamin A deficiency against WHO standards indicate a public health problem.

Xerophthalmia, sometimes leading to blindness and early death, is one of the most serious sequelae of vitamin A deficiency and there is also increasingly strong evidence that mortality due to respiratory and gastrointestinal infections is greater in vitamin A-deficient children.

Table 1. Reported prevalence (%) of vitamin A deficiency in countries and areas of the Western Pacific Region

Country	Signs			
	Night blindness (XN) (1.0%)*	Bitot's spots (X1B) (0.5%)*	Corneal xerosis &/or ulceration/ keratomalacia (X2/X3A/X3B) (0.01%)*	Corneal scar (XS) (0.05%)*
Lao People's Democratic Republic	3.8	...	0.011	...
Kiribati	3.5	10.9	0.34	...
Chuuk (Federated States of Micronesia)				
Hospital	12.0	5.0	...	...
National	9.5	2.0	...	...
Philippines				
Localized	2.5	6.9	...	...
National	0.8	0.3	...	0.2
Viet Nam	0.45	0.14	0.07	0.12

... Data not reported.

* Prevalence above which a public health problem is said to exist.

Iodine deficiency disorders

The insidious subclinical effects of iodine deficiency disorders have been increasingly recognized in recent years and have stimulated a fresh interest in controlling this deficiency. Many countries in the Region are affected, in particular China, the Philippines and Viet Nam. Table 2 below summarizes the prevalence in the countries affected. As with Table 1, the localized prevalence rates illustrate how serious the problem is in the areas at risk.

Iodine deficiency was previously a significant problem in Australia and New Zealand, but was effectively dealt with by salt iodization programmes launched during the first half of this century, and by other sources of dietary iodine. Viet Nam has had a prevention and control

Table 2. Prevalence of iodine deficiency disorders in countries of the Western Pacific Region

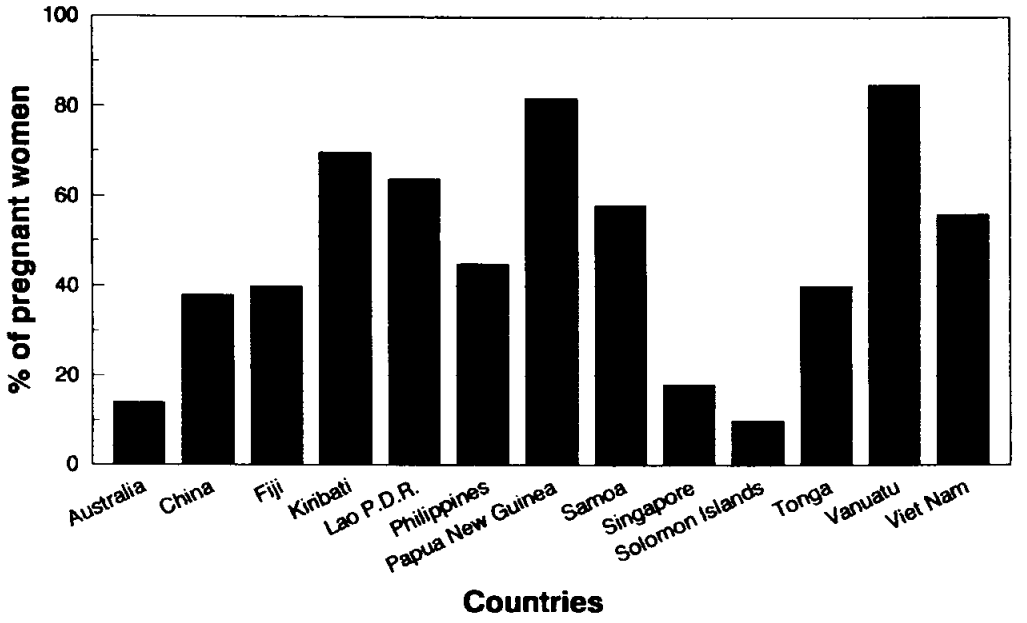
Country	Percentage (%) of population at risk	Range of goitre prevalence (%) in endemic areas	Prevalence (%) of cretinism & other manifestations
Cambodia	22		
China	29-35	5.2-85	Reported
Fiji	12-25	24-70	Not reported
Lao People's Democratic Republic	27	9.5-46.7	Not reported
Malaysia	7		
West		10-58	Not reported
Sabah		38-76	Not reported
Sarawak		0.7-99.5	Neurological cretinism has been estimated at 3.6% in the severely goitrous Ai River region
Papua New Guinea	41-51	0.5-70	0.9-6.5
Philippines	50	10.3-93.2	Reported
Viet Nam	17-25	20-80	2-8

programme since 1970, managed by the Central Hospital for Endocrinology. The programme is currently estimated to cover 11 northern provinces, accounting for 3 million of the estimated 12 million population at risk. China has had a national programme since 1958. By 1991, over 85% of the estimated 370 million population at risk were reported to be covered.

Iron deficiency anaemia

This most widespread and intractable of the micronutrient deficiencies in the Region affects both pregnancy outcome and working capacity. Women of child-bearing age, especially when pregnant, followed by infants, preschool children and adolescents, are at greatest risk of developing iron-deficiency anaemia. Figure 1 below shows the prevalences of nutritional anaemia in pregnant women in countries of the Region. Papua New Guinea and Vanuatu have the highest percentage of iron-deficient pregnant women. There are also high prevalences of the disorder in children (sometimes up to 90% in limited areas) and even in adult males in the Region.

Figure 1. Prevalence of iron deficiency anaemia among pregnant women in the Western Pacific Region*
(Expressed as a percentage)



* Iron deficiency anaemia is defined as haemoglobin concentration below 110 g/l.

Anaemia is mainly caused by a deficiency of iron or, less often, of other nutrients such as folic acid, although malaria, parasitic diseases, schistosomiasis and other infections, as well as congenital haemolytic diseases such as sickle cell anaemia and thalassaemia may all play an important role. In some countries in the Region, e.g., the Lao People's Democratic Republic, Malaysia, Viet Nam and parts of the Pacific, high prevalences of megaloblastic anaemia (up to 36% for women of Indian origin in Malaysia) and possibly of thalassaemia should be taken into account when considering the data in Figure 1.

Other deficiencies

Other significant reported disorders include thiamin deficiency, which reemerged several years ago as a problem in some rural parts of the Philippines. It is also frequently reported in certain groups in Australia such as alcoholics and homeless men and, to a lesser extent, the Aboriginal populations. Riboflavin deficiency has been reported in the Lao People's Democratic Republic and the Philippines. It is also reported in other countries but remains of less importance. In a rural community in China, rickets (caused by vitamin D deficiency) was found in 34.4% of weaning children. Rickets is also reported in Viet Nam.

1.3 Diseases of inappropriate nutrition

Obesity

Obesity in children is a growing problem. A factor here is almost certainly changing food habits, often representing a change to high-energy, high-fat, fast foods. Changing exercise patterns are also a factor. In Singapore, for example, obesity, after being virtually unknown in children, now ranks as the second most common health problem among schoolchildren, affecting about 12% of the school population in the 6-16 age group.

In Australia, 43% of adult men and 35% of women have been found to be overweight. In the Federated States of Micronesia over 50% of women 40-49 years of age are obese, and 80% are overweight. Even among 15-19 year old women, 40% are overweight and 25% obese. This kind of pattern, although extreme, is becoming less uncommon.

Noncommunicable diseases

Nutrition plays a very important role in the multifactorial causation of noncommunicable diseases. However, other factors such as tobacco use and exercise and, to an unknown extent, stress also contribute to these diseases. Nevertheless current estimates, for example in Australia, attribute 52% of all deaths in females and 62% of all deaths in males to nutritionally related diseases.

The increase in life expectancy in the Region has meant that larger proportions of the population are moving into the age range in which chronic degenerative diseases become the major determinants of health status. At the same time, an epidemiological transition in diseases has also come about through the increased use of foods high in saturated fat and energy in the diet and through a higher prevalence of risk factors for noncommunicable diseases. The effect of changing diet and lifestyles, for example, on diabetes prevalence in the Pacific has been well documented.

Some countries have shown declines in mortality; the age-standardized death rates from all cardiovascular diseases decreased over a 15-year period by one half in Australia and Japan and by one third in New Zealand and these trends have continued to a lesser extent in countries such as Singapore. There have been even more significant changes in the decline in mortality from cerebrovascular diseases. However, even in countries where there have been marked declines, rates can be very different. For example, mortality due to ischaemic heart disease is still five times higher in Australia than in Japan. At the same time adult mortality due to other causes such as cancer is increasing, and in many countries there is an increase in mortality due to noncommunicable diseases. In Viet Nam, for instance, the number of deaths from cardiovascular causes tripled during the 1970s and continues to increase.

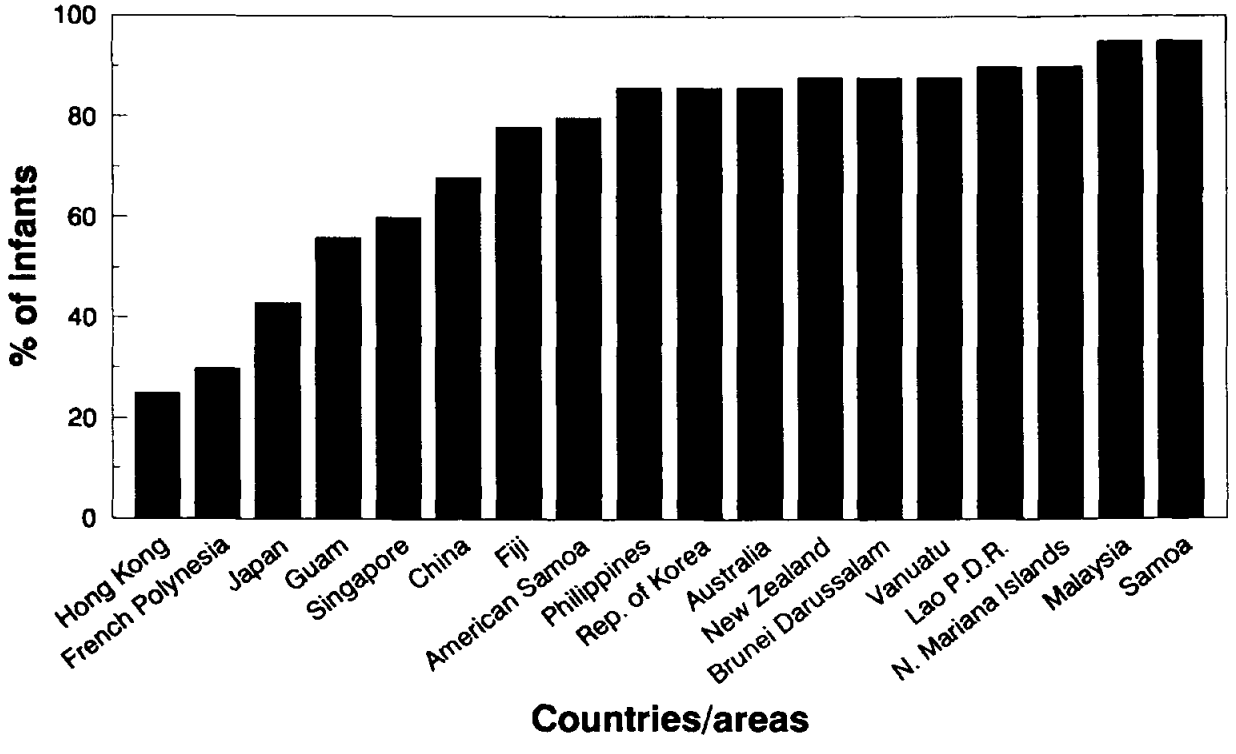
2. INFANT AND YOUNG CHILD NUTRITION

This section represents the two-yearly report to the Regional Committee in compliance with resolution WPR/RC36.R15. Twenty-four countries had reported to WHO as of 9 June 1993.

Current situation

In Cambodia, Cook Islands, Kiribati, Marshall Islands, the Federated States of Micronesia, Niue, Palau, Papua New Guinea, Solomon Islands, Tokelau, Tonga and Viet Nam, breast-feeding is the norm (95%-100% of the newborn). In China, French Polynesia, Guam, Hong Kong, Japan, the Republic of Korea and Singapore, less than 75% of infants are being breast-fed (see Figure 2 below). Trends over the years show that breast-feeding has been declining overall in the Region. Encouraging reverse trends occurred in Australia and New Zealand where the percentage of breast-fed babies increased to over 75%. Even in these countries, however, there has been a recent small decline. Conversely, among the countries and areas with low rate of breast-feeding, Hong Kong reflects an encouraging trend towards increased breast-feeding.

Figure 2. Prevalence of breast-feeding in the Western Pacific Region*
(% of infants ever breast-fed)



* Only countries and areas where the prevalence of breast-feeding is less than 95% are included.

Exclusive breast-feeding of the infant until four to six months of age is now acknowledged to protect it against infectious diseases and to maintain sufficient production of breast milk.

After four to six months, complementary foods should be introduced. Insufficient or inappropriate weaning foods and contaminated foods given to the child are still common causes of child health problems. There are indications that prelacteal feeding (for instance, glucose water) and giving babies additional liquids are still common practices in most of the Region. Weaning in general is reported to be occurring before four months in China, French Polynesia, Kiribati, the Lao People's Democratic Republic, Northern Mariana Islands, the Marshall Islands, the Federated States of Micronesia and Viet Nam. Macao, New Zealand, the Philippines and the Republic of Korea reported that the starting age for complementary feeding of children is on average six months.

Improving infant feeding

Breast-feeding in the Region is promoted through government programmes, the International Code of Marketing of Breast-milk Substitutes, the baby-friendly hospital initiative, social support and health education. Activities to improve complementary feeding practices are less specific, such as weaning recommendations and health education. Appropriate training of health workers is a general approach to improve infant feeding practices in most countries.

In 1981, the World Health Assembly adopted the International Code of Marketing of Breast-milk Substitutes as a recommendation for further action. The aim of the International Code is to contribute to the provision of safe and adequate nutrition for infants by the protection and promotion of breast-feeding, and by ensuring the proper use of breast-milk substitutes, when these are necessary, on the basis of adequate information and through appropriate marketing and distribution. The status of implementation of the Code can be seen in Annex 1. Twelve countries have adopted the Code (some partly or voluntarily) and in three countries draft legislation has been prepared. Article 5, on government control of marketing direct to the general public, has been particularly broadly implemented. Twelve governments report that some form of control now exists. However, Article 11, on the participation of different sectors in implementation and monitoring of the Code, is reported to be implemented to a limited extent in only nine countries.

The baby-friendly hospital initiative, a joint strategy of WHO and UNICEF, aims at making hospitals "baby-friendly", i.e. establishments in which maternity services have adopted practices known to promote breast-feeding, such as the early initiation of breast-feeding and rooming-in. This has received enthusiastic support in the Region with related activities in at least ten countries

(Annex 2). The initiative only started in 1991, but already 133 hospitals in six countries have been awarded baby-friendly hospital status.

Although social and community support for breast-feeding appears to be strong in most of the Region, some components are not well established. Maternity leave for women working in the civil service is reported to be 12 weeks or more (the minimum duration recommended by the International Labour Organisation) in only thirteen countries. The majority of women do not participate in the paid work force. They are working at home, in subsistence farming or in the informal sector, and there is therefore considerable pressure to return to work as soon as possible. However, in countries where breast-feeding has always been the norm, members of the extended family are able to support breast-feeding, as reported from Tuvalu. Community support for breast-feeding may also be provided by women's organizations or childcare groups, as indicated by 18 governments.

In most countries health education on breast-feeding and complementary feeding practices is common. Various media (radio, newspapers, printed materials, etc.), are used to inform the general public about breast-feeding. In 27 countries education on breast-feeding is an integral part of prenatal care. The most common methods reported to promote breast-feeding among pregnant women are the distribution of printed materials (booklets, posters, for example) and the organization of classes. Weaning recommendations are issued by the ministry or department of health in Australia, Fiji, Hong Kong, Malaysia, New Zealand, the Philippines and Viet Nam. Education on complementary feeding is part of postnatal care in 25 countries. In most countries training on infant feeding is a part of the basic and continuing education of the majority of health workers. In the training of traditional birth attendants, however, infant feeding is not usually included.

In conclusion, the reports show that social support to promote breast-feeding, while encouraging, needs to be further developed. Measures to grant working women at least 12 weeks' maternity leave need to be encouraged. Infrastructural support is required to facilitate breast-feeding at work and to promote the continuation of breast-feeding. Correct health education for pregnant women, young mothers and the general public is most important in increasing awareness, with more emphasis placed on not starting complementary feeding too early. To reverse the decline in the Region, breast-feeding needs continuous support. The International Code of Marketing of Breast-milk Substitutes and the baby-friendly hospital initiative are successful strategies in this respect, and it is recommended that they should be implemented in more countries of the Western Pacific Region. In both strategies, it is important to maintain international standards and guidelines so as to ensure a qualitatively sound breast-feeding promotion programme.

3. INTERNATIONAL CONFERENCE ON NUTRITION

3.1 Background

The FAO/WHO International Conference on Nutrition (ICN), held in Rome in December 1992, was the most important milestone in global food and nutrition terms since the World Food Conference, which addressed the growing food shortages in the world in 1974. The aim of the Conference was to provide the world community with an opportunity to look critically at the continuing problems of hunger and malnutrition and the increasing problems of diet-related diseases, and examine ways in which they could most effectively be addressed. Two years of national, regional and global preparations led up to the Conference.

In the national phase, countries arranged intersectoral meetings to analyse the food and nutrition situation and develop country papers. China was commissioned to prepare a case study, "Policies and trends in food and nutrition in China during the last four decades".

In the next phase, the Region, with the WHO South-East Asia Regional Office and the Asia and Pacific Office of FAO, held a regional meeting in Bangkok in January 1992, attended by 98 participants from 30 countries, as well as nongovernmental organizations and other international agencies. The deliberations of this meeting were for use in the development of a world declaration and plan of action.

During a technical preparatory meeting, primarily organized by WHO in Geneva in August 1992, participants from 150 countries contributed to the final draft of the world declaration and plan of action. The actual Conference was then held from 5 to 11 December 1992. It lasted six days and was attended by 1387 participants from 159 governments and over 150 international and nongovernmental organizations. Twenty countries from the Western Pacific Region of WHO were represented with seven ministers or directors of health, two vice-ministers and one undersecretary.

The Conference adopted the World Declaration on Nutrition, expressing a determination to eliminate hunger and reduce all forms of malnutrition. *Inter alia*, the Declaration states: "We all view with the deepest concern the unacceptable fact that about 780 million people in developing countries - twenty per cent of their population - still do not have access to enough food to meet their basic daily needs for nutritional well-being".

The Plan of Action for Nutrition adopted at the Conference contains a wide range of relatively detailed strategies. It should serve as a basis for national plans of action which countries

are being asked to prepare or revise before the end of 1994. The Plan of Action endorsed the nutritional goals of the Fourth United Nations Development Decade and of the World Summit for Children. Contrary to expectations, no resources were committed by donors. Further guidance on follow-up to the Conference is given in the resolution adopted by the World Health Assembly (WHA46.7) attached as Annex 3.

3.2 Follow-up strategies

Member States of WHO, organizations of the United Nations system and other intergovernmental and nongovernmental organizations pledged at the Conference to follow up the Declaration: to strive to eliminate, by the year 2000, famine and nutritional deficiency diseases, in particular iodine and vitamin A deficiencies; to reduce substantially during the remainder of the decade the prevalence of undernutrition, iron deficiency anaemia, diet-related chronic diseases, social and other impediments to optimal breast-feeding, and inadequate sanitation and poor hygiene; and to develop and implement plans of action.

At the global level, WHO has stated its intention of supporting Member States in developing and implementing their national plans of action for nutritional improvement. A report on the progress by Member States in implementing the World Declaration and Plan of Action will be given to the World Health Assembly in 1995. In the meantime, priority will be given to least developed, low-income, and drought-affected countries. In this context, funds have already been committed through the Intensive Programme of Cooperation for the thirteen most vulnerable of the least developed countries, including Cambodia in the Western Pacific Region.

In the Region, the development of national plans of action will be targeted, on the basis of country papers and existing activities. Three categories of countries are proposed for funding purposes: (i) most vulnerable countries (as above); (ii) least-developed, low-income countries and/or countries with a high likelihood of action (Kiribati, the Lao People's Democratic Republic, Papua New Guinea, the Philippines, Samoa, Solomon Islands, Vanuatu and Viet Nam); and (iii) other countries, such as Australia, which is actively revising a national nutrition policy; Fiji, which is preparing for a national survey to revise its existing national food and nutrition policy; and Malaysia and Singapore, which are developing nutrition policy through a health promotion approach.

Three phases are proposed:

(i) Development of the country paper, which will be used as the basis for developing a plan of action adapted to national conditions. In some cases, this will mean acquiring more baseline data.

Current status: 20 country papers have been prepared: Australia, Cambodia, China, Cook Islands, Fiji, Kiribati, the Lao People's Democratic Republic, Malaysia, Marshall Islands, Federated States of Micronesia, New Zealand, Northern Mariana Islands, Papua New Guinea, Philippines, Samoa, Solomon Islands, Tonga, Tuvalu, Vanuatu and Viet Nam.

(ii) Development of national plans of action which reflect the problems found. One method might be to hold a multisectoral post-Conference meeting in each country to prepare these plans. Some countries, for example, Australia and Malaysia, did this in the course of preparing their country paper and little further elaboration of their plan of action is required. All countries have been approached by WHO and follow-up activities have been suggested.

Current status: Cambodia, Malaysia and the Philippines had held post-ICN intersectoral meetings at the time of preparation of this report. The Philippines has since developed a plan of action, launched by the President at the start of National Nutrition Week in July 1993.

(iii) Implementation of the plans of action, incorporating nutrition objectives into national development policies and programmes and taking an intersectoral approach at all levels, including nongovernmental organizations and the private sector. Plans of action should be characterized by long-term sustainability and environmental soundness. Plans of action will therefore be part of, or incorporate existing, new or revised national food and nutrition policies.

As indicated, during the Conference there was no commitment of resources by donors, although both donor countries and agencies indicated that funds would be available for acceptable projects. Countries will, therefore, be encouraged to prepare proposals, with WHO and FAO technical support, for submission through these agencies to potential donors.

Current status: All countries are being encouraged to submit proposals to the WHO Regional Office. To date, no proposals have been received, although China has indicated its intention to make one. This will be the next area of follow-up.

3.3 Conclusion

The International Conference on Nutrition was not an end in itself. Member States should now concentrate on developing plans of action. WHO resources would be available to them for the purpose. Follow-up of these efforts will determine how far the commitment made at the Conference to contain any increase in malnutrition levels and if possible to reduce them is being honoured.

ANNEX 1

IMPLEMENTATION OF THE INTERNATIONAL CODE OF MARKETING OF BREAST-MILK SUBSTITUTES IN THE WESTERN PACIFIC REGION

Implementation of the International Code by Article

		Article						
Country/Area	**Status**	**2**	**4**	**5**	**6**	**7**	**9**	**11**
Australia	in law	+++	++	++	++	++	++	++
China	awaiting legislation		++	++	+	+		
Cook Islands	national measures	+	++	++	++	++	++	+
Fiji	awaiting legislation	+	++	++	++	+	+	+
French Polynesia	in law	+++	++	++	++	++	++	+
Hong Kong	partly in law	+	++	++	++	++	++	++
Kiribati	voluntary		++	++	++	++		
Malaysia	in law	++	++	+	++	++	++	+
New Zealand	voluntary	+++	++	++	++	++	++	++
Papua New Guinea	in law	+++			++		++	
Philippines	in law	++	++	++	++	+++	++	++
Republic of Korea	partly in law			++				+
Singapore	in law							
Viet Nam	awaiting legislation			++				

Article 2 - Degree of implementation of the Code
Article 4 - Government controls on health education on infant feeding
Article 5 - Ban on marketing of products covered by the Code to the general public
Article 6 - Health care system supportive of the Code
Article 7 - Health workers supportive of breast-feeding
Article 9 - Government control on labelling
Article 11 - Participation of different sectors in implementation and monitoring of the Code

+++ - Full implementation
++ - Partial implementation
+ - Minor implementation

NOTE: Data collected from official government reports and other publications.
No Code implementation (or no data available) in countries not included in this table.

ANNEX 2

IMPLEMENTATION OF THE BABY-FRIENDLY HOSPITAL INITIATIVE (BFHI) IN THE WESTERN PACIFIC REGION

Country/area	Number of government hospitals				Remarks
	Total	With full rooming-in	Written breast-feeding policy	Awarded BFH status	
Australia	705	...	...	...	Several hospitals are engaged in self-assessment Initiative started in 1992 Workshops held in several states
China	...	22	22	21	
Cook Islands	9	9	0	0	
Fiji	25	16	25	0	Initiative started
French Polynesia	8	8	8	0	
Guam	2	2	2	0	
Hong Kong	14	13	...	0	
Japan	...	...	...	1	
Kiribati	1	1	0	0	
Lao P.D.R.	138	138	138	...	
Macao	1	1	...	...	
Malaysia	95	...	0	0	Initiative started
Mariana Islands, N.	1	1	0	0	
Marshall Islands	2	2	0	0	
Micronesia, F.S.	4	4	4	0	
New Zealand	90	90	...	0	Participants in Australian BFHI-workshops
Niue	1	1	0	0	
Palau	1	...	1	...	
Philippines	557	103	103	103	
Republic of Korea	...	...	...	1	Six hospitals to be assessed in coming 6 months
Singapore	...	...	...	...	Special nurses and volunteers for breast-feeding in hospitals
Solomon Islands	6	6	0	0	All hospitals considered baby-friendly as all criteria are met
Tokelau	3	3	0	3	Breast-feeding compulsory in hospitals
Tonga	4	4	2	4	
Vanuatu	5	5	0	0	
Viet Nam	12 086	...	...	0	Teams trained

... Data not known.

NOTE: Data collected from official government reports and other publications.
No data available for countries not included in the table.

ANNEX 3

世界卫生大会决议 قرارات جمعية الصحة العالمية

RESOLUTION OF THE WORLD HEALTH ASSEMBLY

RÉSOLUTION DE L'ASSEMBLÉE MONDIALE DE LA SANTÉ

РЕЗОЛЮЦИЯ ВСЕМИРНОЙ АССАМБЛЕИ ЗДРАВООХРАНЕНИЯ

RESOLUCION DE LA ASAMBLEA MUNDIAL DE LA SALUD

FORTY-SIXTH WORLD HEALTH ASSEMBLY **WHA46.7**

Agenda item 18.2 10 May 1993

INTERNATIONAL CONFERENCE ON NUTRITION: FOLLOW-UP ACTION

The Forty-sixth World Health Assembly,

Having considered the report of the Director-General on the International Conference on Nutrition and the consequent proposed WHO strategy for supporting nutrition action at all levels;

Commending Member States, organizations of the United Nations system and other intergovernmental and nongovernmental organizations concerned for their participation in the preparatory process and in the International Conference itself, and for their pledge to follow it up;

Commending the Director-General for his effective collaboration with other organizations of the United Nations system, especially FAO, in organizing the International Conference and for according high priority to nutrition by allocating additional resources, in particular for those countries most in need,

1. ENDORSES in their entirety the World Declaration and Plan of Action for Nutrition adopted by the Conference;[1]

2. URGES Member States:

(1) by the year 2000, to strive to eliminate famine and famine-related deaths, starvation and nutritional deficiency diseases in communities affected by natural and man-made disasters, and in particular iodine and vitamin A deficiencies;

(2) by the year 2000, to reduce substantially the prevalence of starvation and widespread chronic hunger; undernutrition, especially among children, women and old people; iron deficiency anaemia; foodborne diseases; and social and other impediments to optimal breast-feeding; and to remedy inadequate sanitation and poor hygiene;

(3) to contain and reduce the rising prevalence of diet-related diseases and conditions related to them;

---

[1] International Conference on Nutrition. World Declaration and Plan of Action for Nutrition. Rome, December 1992, Food and Agriculture Organization of the United Nations and World Health Organization.

Annex 3

(4) to develop, or strengthen as appropriate, plans of action setting out national nutritional goals and how they are to be achieved in keeping with the objectives, major policy guidelines and nine action-oriented strategies that were elaborated in the Plan of Action adopted by the International Conference on Nutrition, which also endorsed the nutritional goals of the Fourth United Nations Development Decade and of the World Summit for Children;

(5) to ensure the implementation of plans of action which:

(a) incorporate nutrition objectives into national development policies and programmes;

(b) strengthen measures in various sectors to improve nutrition through governmental mechanisms at all levels, especially district development plans, and in collaboration with nongovernmental organizations and the private sector;

(c) include community-based measures, particularly through primary health care activities, for nutritional improvement that are crucial if full and sustainable benefits are to be obtained for all people;

(d) are sustainable in the long term and contribute to protection of the environment;

(e) enlist the cooperation of all groups concerned;

3. CALLS UPON organizations of the United Nations system, other intergovernmental and nongovernmental organizations and the international community as a whole:

(1) to renew their commitment to the achievement of the objectives and strategies set out in the World Declaration and Plan of Action for Nutrition including, to the extent that their mandates and resources allow, technical cooperation and financial support to recipient countries;

(2) to reinforce and foster concerted action at all levels for the establishment and implementation of national plans of action in nutrition with a view to attaining health and nutritional well-being for all;

4. REQUESTS the Director-General:

(1) to support Member States in establishing and implementing national plans of action for nutritional improvement that emphasize self-reliance and community-based action, especially as regards their health-related aspects;

(2) to reinforce WHO's capacity for food and nutrition action in all relevant programmes, so that increased emphasis can be given as a priority to maternal, infant and young child nutrition, including breast-feeding; micronutrient malnutrition; nutrition emergencies (particularly training in preparedness and management); monitoring of nutritional status; control of diet-related chronic diseases; food safety control and the prevention of foodborne diseases; and research and training in subjects related to food and nutrition, including health implications of the misuse of chemicals and hormones in agriculture;

(3) to give priority to least developed, low income, and drought-affected countries, and to provide support to Member States in establishing national programmes, especially those concerned with nutritional well-being of vulnerable populations, including women and children, refugees and displaced persons;

(4) to stimulate regional exchange of ideas and plans;

(5) to report on progress in implementation by Member States of the World Declaration and Plan of Action for Nutrition to the Health Assembly in 1995 as stated in the Plan of Action.

Eleventh plenary meeting, 10 May 1993
A46/VR/11

= = =