Meeting Report

Consultation on the Action Plan to Reduce the Double Burden of Malnutrition in the Western Pacific Region, 2015-2020

19–21 November 2013
Manila, Philippines

World Health Organization
Western Pacific Region
REPORT

CONSULTATION ON THE ACTION PLAN TO REDUCE THE DOUBLE BURDEN OF MALNUTRITION IN THE WESTERN PACIFIC REGION, 2015–2020

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NOTE

The views expressed in this report are those of the participants in the Consultation on the Action Plan to Reduce the Double Burden of Malnutrition in the Western Pacific Region, 2015-2020.

This report has been prepared for the World Health Organization Regional Office for the Western Pacific for the use of governments from Member States in the Region and for those who participated in the Consultation on the Action Plan to Reduce the Double Burden of Malnutrition in the Western Pacific Region, 2015–2020, which was held at Manila, Philippines from 19 to 21 November 2013. Financial support was provided by Micronutrient Initiative.
## CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUMMARY</td>
<td>i</td>
</tr>
<tr>
<td>1. INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>1.1 Background</td>
<td>1</td>
</tr>
<tr>
<td>1.2 Objectives</td>
<td>1</td>
</tr>
<tr>
<td>1.3 Participants</td>
<td>2</td>
</tr>
<tr>
<td>1.4 Organization</td>
<td>2</td>
</tr>
<tr>
<td>1.5 Opening session</td>
<td>2</td>
</tr>
<tr>
<td>2. PROCEEDINGS</td>
<td>3</td>
</tr>
<tr>
<td>2.1 Session 1 – Global and regional perspectives on nutrition</td>
<td>3</td>
</tr>
<tr>
<td>2.2 Session 2 – Country presentations</td>
<td>4</td>
</tr>
<tr>
<td>2.3 Session 3 – Group work: issues, challenges and barriers to addressing the double burden</td>
<td>4</td>
</tr>
<tr>
<td>2.4 Session 4 – Overview of the draft Action Plan</td>
<td>5</td>
</tr>
<tr>
<td>2.5 Session 5 – Food systems</td>
<td>5</td>
</tr>
<tr>
<td>2.6 Sessions 6-7 – Review of the draft Action Plan:</td>
<td>7</td>
</tr>
<tr>
<td>chapters 1-3 and overarching strategies</td>
<td></td>
</tr>
<tr>
<td>2.7 Sessions 8-10 – Review of the draft Action Plan: Objectives 1-6</td>
<td>8</td>
</tr>
<tr>
<td>2.8 Session 11 – Next steps for country implementation</td>
<td>9</td>
</tr>
<tr>
<td>2.9 Session 12 – Closing session</td>
<td>10</td>
</tr>
<tr>
<td>3. CONCLUSIONS</td>
<td>10</td>
</tr>
<tr>
<td>3.1 Conclusions</td>
<td>10</td>
</tr>
<tr>
<td>3.2 Recommendations</td>
<td>11</td>
</tr>
<tr>
<td>ANNEXES</td>
<td></td>
</tr>
<tr>
<td>ANNEX 1 - List of participants, temporary advisers, resource persons, observers and secretariat</td>
<td></td>
</tr>
<tr>
<td>ANNEX 2 - Programme of activities</td>
<td></td>
</tr>
<tr>
<td>ANNEX 3 - Country Presentations: situation analysis</td>
<td></td>
</tr>
<tr>
<td>ANNEX 4 - Panel presentations</td>
<td></td>
</tr>
<tr>
<td>ANNEX 5 - Country presentations: way forward</td>
<td></td>
</tr>
</tbody>
</table>

**Keywords**

Nutrition, double burden, underweight, obesity, food systems
SUMMARY

Countries within the Western Pacific Region are facing the double burden of malnutrition: undernutrition (e.g. wasting, stunting, micronutrient deficiencies, low birth weight) coexisting with overweight and obesity. Malnutrition in all its forms heightens the risks for morbidity and mortality throughout the life course. Within the Region, undernutrition alone contributes to 187,000 preventable deaths of children under 5 years old per year. Simultaneously, overweight is rapidly becoming a problem throughout the life course, with 6.5 million children under 5 years of age and one in four adults being overweight. Nutrition underpins both the prevention of childhood morbidity and mortality, as well as the prevention of premature deaths due to diet-related noncommunicable diseases.

With solid evidence pointing to proper nutrition as essential for survival, health and development, global commitments have recently been made to fight the double burden of malnutrition through global and regional resolutions on nutrition (WHA65.6, WPR/RC63.2R) and noncommunicable diseases (WHA64.11, WHA66.10 and WPR/RC64.R6). In resolution WPR/RC63.RC on “Scaling up Nutrition in the Western Pacific”, Member States requested support in implementing the WHO Comprehensive Implementation Plan on Maternal, Infant and Young Child Nutrition. In response to this request, and based on lessons learnt in the Region, a draft Action Plan on Reducing the Double Burden of Malnutrition in the Western Pacific (2015-2020) was developed by the WHO Regional Office for the Western Pacific in collaboration with WHO technical units, country counterparts and other United Nations regional offices and development partners. This draft action plan complements the Western Pacific Regional Action Plan for the Prevention and Control of Noncommunicable Diseases (2014-2018), endorsed at the Regional Committee for the Western Pacific in 2013.

A Consultation on the draft Action Plan to Reduce the Double Burden of Malnutrition in the Western Pacific Region, 2015-2020 was conducted from 19 to 21 November 2013 to present and discuss the action plan.

The objectives were as follows:

(1) to update country information/data on the double burden of malnutrition and implications for health and development in the Western Pacific Region;

(2) to introduce the recent WHO guidelines on nutrition in the context of the double burden of malnutrition, and prioritize implementation of the guidelines based on particular country contexts and;

(3) to refine and adapt the draft action plan to ensure buy-in from Member States at the Sixty-fifth session of the Regional Committee for the Western Pacific in 2014.

The three-day consultation comprised plenary presentations and panel discussions on the global and regional nutrition situation and on the issues, challenges and barriers to addressing the double burden of malnutrition; a review of the draft action plan; and identification of priority areas for action of participant countries. The consultation resulted in recommendations to revise the draft Action Plan to Reduce the Double Burden of Malnutrition (2015–2020) and also identified the support needed for implementing the actions. Overall, participants from Member States and partners supported the action plan. Countries shared ways that they could
utilize the action plan in the next 12 months. These included mid-term reviews and/or updates of national plans of action, aligning current national frameworks on food security and nutrition with the action plan, and using the action plan to reach out to other sectors and to advocate at high political level for policy coherence.

Delegates recognized the value of the action plan to support national nutrition planning and approaches. Delegates requested the Secretariat to finalize the action plan soon but emphasized that the following aspects should be included and/or modified:

- increase emphasis on overweight and obesity both in the background and in the essential nutrition interventions;

- reorganize specific sections to condense and improve the flow (e.g. Chapter 3: Coherence, sustainability and effectiveness and “overarching strategies” in Chapter 4);

- enhance multi-sectoral engagement so that sectors other than the health sector are taking action and measuring indicators related to nutrition.

Additionally, delegates noted the following:

- A strength of the meeting was its focus across areas that affect nutrition based on a simple causation model: food, health and care. Solutions to improve nutrition need to address all three. The delegates shared experiences and identified commonalities of problems and solutions that can be used to inform similar processes in countries across the Region.

- Stronger guidance is requested from WHO on dealing with industry and industry interference and improved complementary feeding.

- The comprehensiveness of the plan is a strength as it covers critical elements, e.g. sustainable food systems, health and nutrition services, policy and plans, legislation and regulations, as well as multisectoral and intersectoral collaboration.

- A focused approach to key and pragmatic issues, like protection, promotion and support of breastfeeding, ensuring appropriate budgets allocate and dynamic, monitored and resourced nutrition plans need to be in place.

- Interconnection among the different sectors is necessary to ensure appropriate foods are accessible to all.

The consultation participants put forth the following recommendations:

1. Actions to reduce the double burden of malnutrition need to be part of comprehensive and whole-of-government approaches, and need to be integrated into the national development agenda.

2. Member States should strengthen and promote essential nutrition interventions at key stages of the life-course by incorporating proposed actions for countries and areas into national and subnational plans, policies and budgets. Ensuring policy coherence, sustainable food systems, and continuous improvement of the quality of health care should
be considered when making the framework for identifying national actions. Development partners should align with and provide support to implement the national plans.

(3) Member States should identify and allocate appropriate resources (human and financial) to support the implementation, supervision and monitoring of the country-based plans.

(4) All key stakeholders should be engaged to ensure the action plan is implemented with due consideration of the different roles and contributions of those stakeholders while protecting the public interest and avoiding conflict of interest. Professional organizations and civil society should be engaged as key stakeholders.

(5) WHO collaborating centres, other partner institutions and professional organizations should facilitate the exchange of information and work collectively towards capacity-building.

(6) WHO should prioritize testing and finalization of the various tools to support countries to implement essential nutrition interventions.

(7) WHO will continue to provide technical support in monitoring and surveillance, priority setting and strengthening of linkages between nutrition and other relevant programmes.

(8) In line with the global and regional commitments to improve nutrition, consideration should be taken toward noting this action plan at the sixty-fifth session of the WHO Regional Committee in 2014.
1. INTRODUCTION

1.1 Background

Countries within the Western Pacific Region are facing the double burden of malnutrition: undernutrition (e.g. wasting, stunting, micronutrient deficiencies, low birth weight) coexisting with overweight and obesity. Malnutrition in all its forms heightens the risks for morbidity and mortality throughout the life course. The immediate underlying causes of malnutrition are varied and include lack of access to clean water and sanitation, prevalence of infectious diseases and poor support of breastfeeding. Social inequity, poverty, globalization of food systems and aggressive marketing of unhealthy foods and beverages for children significantly contribute to the double burden of malnutrition. Severe food insecurity, high prevalence of low birth weight, stunting and anaemia are still major problems in many countries. At the same time, obesity and diet-related noncommunicable diseases (NCDs) are rising rapidly.

Simple, evidence-based interventions across the life course are available. They include exclusive breastfeeding in the first six months of life, continued breastfeeding until at least two years of age, appropriate complementary feeding, micronutrient supplementation and food fortification. Policies and regulations that improve access to food, inform and empower consumers and promote sustainable food systems may also be needed.

With solid evidence pointing to proper nutrition as essential for survival, health and development, global commitments have been made to fight the double burden of malnutrition. In 2012, the World Health Assembly (resolution WHA65.6) and Regional Committee for the Western Pacific (resolution WPR/RC63.R2) endorsed six global nutrition targets to be achieved by 2025 through the Comprehensive Implementation Plan on Maternal, Infant and Young Child Nutrition (CIP). The Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013-2020 also calls on countries to develop and/or strengthen national food and nutrition policies and action plans and implement related global strategies, including CIP.

A draft Action Plan to Reduce the Double Burden of Malnutrition in the Western Pacific Region (2015-2020) was developed by the WHO Regional Office for the Western Pacific in collaboration with WHO technical units, country counterparts and other United Nations regional offices and development partners. The draft action plan brings together actions to address undernutrition, overweight and obesity, placing emphasis on a life-course approach, to achieve the six global nutrition targets aligned with the global CIP and two targets aligned with the global NCD action plan (all targets to be achieved by 2025).

A Member State consultation on the draft Action Plan to Reduce the Double Burden of Malnutrition in the Western Pacific Region (2015-2020) was conducted from 19 to 21 November 2013 in Manila, Philippines.

1.2 Objectives

(1) To update country information/data on the double burden of malnutrition and implications for health and development in the Western Pacific Region.
(2) To introduce the recent WHO guidelines on nutrition in the context of the double burden of malnutrition, and prioritize implementation of the guidelines based on particular country contexts.

(3) To refine and adapt the draft action plan to ensure buy-in from Member States at the sixty-fifth session of the Regional Committee for the Western Pacific in 2014.

The three-day consultation comprised plenary presentations and panel discussions on the global and regional nutrition situation and on the issues, challenges and barriers to addressing the double burden of malnutrition; a review of the draft regional action plan; and identification of priority areas for action of participant countries. The consultation resulted in recommendations to revise the draft Action Plan to Reduce the Double Burden of Malnutrition in the Western Pacific Region (2015-2020) and also identification of support needed for implementing the actions.

1.3 Participants

The workshop was attended by 20 senior officers from government agencies responsible for nutrition in Brunei Darussalam, Cambodia, China, Fiji, the Republic of Korea, the Lao People’s Democratic Republic, the Federated States of Micronesia, Mongolia, Papua New Guinea, the Philippines, Samoa, Solomon Islands, Vanuatu and Viet Nam; 11 observers representing partner organizations; and two temporary advisers. Staff members from the Division of Building Healthy Communities and Populations and from the Division of Health Sector Development of the WHO Regional Office for the Western Pacific provided secretariat support for the consultation. A list of participants, observers, temporary advisers, resource persons and Secretariat members is given in Annex 1.

1.4 Organization

The workshop comprised nine plenary sessions and country presentations in smaller groups, in addition to the opening and closing sessions. The first session, which set the scene of the consultation, focused on global and regional mandates for nutrition and presented an overview of the nutrition situation. Countries presented on their current nutrition situation, looking at the double burden of malnutrition and responses. The remaining sessions included a review of the draft action plan and panel discussions on the country-specific experiences and next steps for country implementation. A full outline of the programme is provided in Annex 2.

1.5 Opening session

Dr Susan Mercado, Director, Division of Building Healthy Communities and Populations, WHO Regional Office for the Western Pacific, delivered the opening address on behalf of Dr Shin Young-soo, WHO Regional Director for the Western Pacific.

Following participant introductions, the officers of the meeting were nominated, with Ms Christine Quested (Samoa), Mr Sok Silo (Cambodia) and Mr Ganzorig Dorjdagva (Mongolia) as Chairperson, Vice-Chairperson and Rapporteur, respectively, for the consultation.
2. PROCEEDINGS

2.1 Session 1 – Global and regional perspectives on nutrition

Dr Francesco Branca, Director of Nutrition, Health and Development at WHO Headquarters, shared the epidemiology of nutrition globally. He emphasized that nutrition remains an unfinished agenda. However, since the first International Conference on Nutrition, which was convened by WHO and the Food and Agriculture Organization of the United Nations (FAO) in 1992, the narrative for nutrition has changed. At that time, the top risk factor for the global burden of disease was childhood underweight. More recently, a 2010 analysis of the burden of disease indicated that the leading risk factor for poor health is high blood pressure, and of the top 20 leading risk factors in the world, half deal with nutrition. Dr Branca introduced the available online platforms that collate evidence-informed nutrition guidelines and interventions, including e-LENA, Gina and EvipNet. Building on the evidence, WHO was given the mandate to scale up efforts in nutrition, not only through World Health Assembly resolution WHA65.11, which endorsed the CIP and the six global nutrition targets related to reductions in stunting, wasting, anaemia in women of reproductive age, low birth weight, an increase in exclusive breastfeeding and no increase in childhood overweight, but also through the WHO Global Action Plan on the Prevention and Control of Noncommunicable Diseases (2013-2020) and the plan’s actions linked to the promotion of a healthy diet. Dr Branca also pointed to the importance of nutrition in the post-2015 development agenda in ensuring sustainable diets in the context of food security and nutrition. He highlighted global initiatives and instruments aimed at getting nutrition higher on the international agenda, including the United Nations System High Level Task Force on the Global Food Security Crisis (HLTF) through the Comprehensive Framework for Action (CFA) on Food Security, the Scaling-up Nutrition (SUN) Movement and the 1000 days campaign, the Renewed Efforts Against Child Hunger (REACH), the reform of the United Nations Standing Committee on Nutrition, the reform of the Committee on World Food Security (CFS) and the establishment of the High Level Panel of Experts on Food Security and Nutrition (HLPE-FSN). Dr Branca mentioned that the second International Conference on Nutrition in November 2014, which will focus on food systems and nutrition, will offer an opportunity to explore how food systems can be redirected to achieve dietary goals and improve nutrition.

Dr Urban Jonsson, consultant on human rights and nutrition, followed with a presentation on the nutrition situation in the Western Pacific Region. Overall, the Region has made spectacular improvements in young child nutrition during the last 20 years, including a decrease in the prevalence of stunting, underweight and wasting. Despite these remarkable achievements, the problem of undernutrition persists, overweight and obesity among both children and adults are increasing, and diet-related NCDs are on the rise. Dr Jonsson called for caution when looking at averages and pointed to great variations, e.g. variations within a country, between urban and rural populations as well as between high- and low-income populations. While poverty is a basic cause of malnutrition, other causes are due to processes in many different sectors and at different levels of society, which require simultaneous and well-coordinated actions by different ministries and other institutions in a country to be resolved. Although the level of malnutrition varies among countries in the Western Pacific Region, the causes of malnutrition are similar, making regional planning and cooperation critical for solving the problem of malnutrition in countries. Household food security, adequate access to health services and adequate caring practices are all necessary conditions associated with improvement nutrition. Thus, action plan to reduce the double burden of malnutrition must place emphasis on all three.
Three key issues were raised in the discussion session. First, participants discussed household food security, not only in terms of food quantity but also quality and as the result of a healthy household food environment. The second issue, nutrition in the context of climate change, was discussed in terms of understanding the impact of climate change on food systems, ensuring sustainable production, the use of local products, protection of biodiversity and how it translates into policy. Lastly, the quality of available foods (including complementary foods) was discussed in relation to consumers’ “choice”. The debate of “choice” has been perpetuated by commercial interests. Choice is an illusion in environments with heavy marketing - unless consumers are empowered to make “informed choices”. Governments must use their regulatory power to ensure that consumers have easy access to unbiased information and affordable healthy food options. Participants were encouraged to use the meeting to explore policy options and ways to engage civil society.

2.2 Session 2 – Country presentations

Countries were divided into three heterogeneous groups to present their nutrition situation, highlight challenges and share their responses to nutrition problems. The three groups were organized as follows:

(1) China, Lao People’s Democratic Republic, Samoa, Solomon Islands, Viet Nam;

(2) Brunei Darussalam, Philippines, Papua New Guinea, Vanuatu;

(3) Cambodia, Fiji, Republic of Korea, Federated States of Micronesia and Mongolia.

Acknowledging the diversity of participating countries (in terms of income level, agricultural productivity, population and land size), the presentations all showed country progress in reducing the prevalence of stunting, wasting and underweight among children under 5 years of age. In addition, countries raised concerns about the increasing availability and marketing of highly processed energy-dense and nutrient-poor foods. In most countries, response to the remaining nutrition problems is hampered by limited financial resources and technical capacity. All countries have national nutrition policies and/or plans in place, but implementation and/or enforcement is often weak.

Country presentations are shown in Annex 3.

2.3 Session 3 – Group work: issues, challenges and barriers to addressing the double burden of malnutrition

Participants were organized into three groups: (1) Pacific: Fiji, Federated States of Micronesia, Papua New Guinea, Samoa, Solomon Islands, Vanuatu; (2) Asia (A): Cambodia, Lao People’s Democratic Republic, Philippines, Viet Nam; and (3) Asia (B): Brunei Darussalam, China, Republic of Korea, Mongolia. Each group was given the task to brainstorm about key issues and existing challenges to taking action to address the double burden of malnutrition, and to discuss responses to these challenges.

In terms of challenges to taking action within the countries, participants mentioned: lack of awareness of the double burden, lack of long-term political will (but also lack of political choices), lack of data (and the need for stronger evidence), economic arguments win over health arguments, uncosted nutrition plans and policies that hinder their implementation. The availability (and understanding) of data was also mentioned as one of the challenges.
Proposed responses to the challenges included learning how to frame "nutrition" and showing economic arguments to support nutrition actions (e.g. showing financial impact of malnutrition, including undernutrition and nutrition-related NCDs). Economic reasoning could facilitate high-level policy dialogue and gain high-level policy support for nutrition actions. Other responses included costing nutrition-related plans and policies, engaging civil society and creating a common platform - exchange best practices and share the responsibilities of dealing with malnutrition (including the trade and agriculture sectors).

Overall, it was considered necessary to increase awareness about the double burden of malnutrition and the coexistence of underweight and overweight and obesity (within the same person, the same family and the same community).

For all groups, responding to the double burden requires strengthening regulatory measures, such as the regulation of breast-milk substitutes, food fortification and reformulation (e.g. reduction of salt, fats and/or sugar), food and nutrition labelling and import (trade) regulations. For this to happen, it is critical to build legal capacity among public health professionals and to build better relations between the nutrition (health) and legal experts. The importance of the government’s role (expanding beyond the health sector) in protecting the population’s health was thus underscored.

2.4 Session 4 – Overview of the draft regional action plan

Dr Katrin Engelhardt, Technical Officer, Maternal, Child Health and Nutrition (MCN), Division of Building Healthy Communities and Populations, WHO Regional Office for the Western Pacific, presented the scope and details of the draft Action Plan to Reduce the Double Burden of Malnutrition in the Western Pacific Region (2015–2020), including the mandate provided to the WHO Regional Office through resolution WPR/RC63.R2 to scale up nutrition in the Western Pacific by supporting countries in implementing the CIP. The resolution also urges Member States to develop or, where necessary, strengthen nutrition policies so that they comprehensively address the double burden of malnutrition.

This draft action plan places emphasis on a life-course approach to addressing the double burden of malnutrition and aims to foster coordinated and comprehensive implementation of strategies across diet-related diseases and other nutritional risk factors, thereby supporting countries to implement the CIP.

2.5 Session 5 – Food systems

Dr Jane Dixon, Australian National University, presented on the role of food systems in reducing the double burden of malnutrition. She started by giving a brief history of the understanding of food systems, which has evolved over the decades. Initially, FAO focussed on food supply and quantity in particular places, and as a result, discussions were mainly about "reducing hunger". The thinking has grown and now encompasses food production, distribution, retailing, marketing, food waste, food preferences and consumption, and chronic diseases related to diet. Food systems have become extremely complex, as well as global, involving food markets, food prices linked to food yield, food trade, biosecurity and how climate change affects food supply. These developments brought rise to food sovereignty movements, which assert the right of people to define their own food systems, with alternative, niche markets appearing.

Dr Dixon highlighted that sustainable development being central to the post-Millennium Development Goals agenda encourages a focus on health-producing, culturally appropriate food systems for the present and future, rather than a more narrow focus on the current food supply
(i.e. what commodities are being produced and traded, where, and accessed by whom).
Improving food systems links closely with how land and marine resources are being used, energy
is produced and consumed, commodities are grown (including water utilization, handling of
waste, use of pesticides, technological innovation) and transported, and how livelihoods through
food sector activities are generated, valued and invested in (education/training/seed funding).
Food systems also work synergistically with social protection, livelihoods and cultural systems.
The right to social protection is deeply linked to the right to adequate food. Improving food
systems - all components - will contribute to improving nutrition throughout the life course. As
highlighted in the draft action plan, sustainable food systems, quality health-care services and
good care-giving practices are all necessary conditions associated with improved nutrition.
Dr Dixon commented that the action plan sketches the terrain for decision-making in relation to
developing healthy and sustainable food systems in the Western Pacific Region.

Dr Temo Waqanivalu, Coordinator, Noncommunicable Diseases and Health Promotion,
Division of Pacific Technical Support, WHO Regional Office for the Western Pacific, presented
on the developments towards food security in the Pacific, which are driven by “health” and have
their foundations in the “Healthy Islands” concept. He gave a brief history of events, starting
with a meeting in 2008 of Pacific Island Forum leaders who made food security a priority in the
Pacific. This meeting was followed by the Pacific Food Summit in Vanuatu in 2010, at which a
Framework for Action on Food Security was endorsed. Food security in the Pacific is a serious
concern - the case for action being the NCD crisis fuelled by unhealthy foods, and the threats to
food security from climate change. In addition to alarming rates of NCDs, childhood obesity,
micronutrient deficiencies, stunting and wasting continue to be problems in some Pacific island
countries and areas. The Pacific Food Summit in 2010 was a landmark meeting that brought
together more than 170 participants from multiple sectors, including trade, agriculture, health,
regional and national food security agencies, food industry representatives, academics,
community and faith-based organizations and consumer groups as well as media. Key
achievements since the Pacific Food Summit have been subregional food submits, establishment
of salt targets for Pacific food, marketing legislation in Fiji, movements in Food Control Acts in
Fiji, Kiribati, Federated States of Micronesia, Samoa and Tonga, and a joint health and economic
ministers meeting to discuss NCDs and trade (raising the question: “Healthy trade or trading
health?”). Another joint health and economic ministers meeting has been planned to chart a
financial roadmap to address NCDs. Dr Waqanivalu shared some lessons learnt since the Pacific
Food Summit and emphasized that any action towards food security in the Pacific needs country
ownership, local champions, a multisectoral approach, as well as recognition and leadership at
the highest political level.

The discussion focussed on trade versus health policies, the importance of policy
coherence and the growing importance of the health sector in trade negotiations. The situation in
the Pacific verified the need for sustainable, health-promoting food systems. To stimulate actions
towards food security in the Pacific, it was suggested to utilize the Convention of the Rights of
the Child to win high-level buy-in.

Plenary presentations are shown in Annex 4.
2.6 Sessions 6 and 7 - Review of the draft action plan: Chapters 1-3 and overarching strategies

Participants were again organized into three small groups: (1) Pacific: Fiji, Federated States of Micronesia, Papua New Guinea, Samoa, Solomon Islands, Vanuatu; (2) Asia (A): Cambodia, Lao People’s Democratic Republic, Philippines, Viet Nam; and (3) Asia (B): Brunei Darussalam, China, Republic of Korea, Mongolia. Each group reviewed Chapters 1-3 and the overarching strategies.

Main criticisms of the draft were that it did not adequately reflect the double burden of malnutrition and that the double burden was not clearly defined. Furthermore, the background section was considered to be too focused on the early stages of life. To fully reflect a life-course approach, it would need to include adult populations. One suggestion was to incorporate columns for “working age” and “older populations” into Table 1 (Key interventions at stages of the life course to reduce the double burden of malnutrition).

Actions that relate to the promotion of a healthy diet should be spelt out in Chapter 2 (Policies, strategies and interventions to fight the double burden of malnutrition) and should also be included in Table 1.

In reference to the Annex (Conceptual Framework – Childhood stunting: context, causes and consequences), other necessary interventions should be highlighted in Table 1, e.g. Water, Sanitation and Hygiene (WASH) and/or community and homestead food production.

There was consensus among participants that Table 1 provided a very useful summary of key interventions to reduce the double burden of malnutrition, but it should be expanded as suggested.

A recommendation was made to replace the current Chapter 3 (Coherence, sustainability and effectiveness) with one that summarizes “guiding principles and approaches” to guide implementation of the regional action plan. Furthermore, the added value of the "overarching strategies" was questioned, as they did not link to the objectives and actions.

Overall, participants agreed that more research was needed to assess the common causal pathways of undernutrition, overweight and obesity. Two pathways that lead to the double burden of malnutrition were discussed, the first one being the possible direct causality from underweight or severe malnutrition during the first years of life and overweight in later life, leading to increased risk of NCDs, and the second (and possibly more important) one being simultaneous causality, i.e. structural processes in society that simultaneously produce or are factors for creating undernutrition in infants and among schoolchildren. Causal pathways obviously include poverty - but also marketing forces and industry interference. A better understanding of the common causal pathways would help identify relevant and country-specific actions to address the double burden of malnutrition.

Participants from Member States reiterated their support of the action plan and shared ways that they would make use of it. These included mid-term reviews and/or updates of national plans of action, aligning current frameworks on food security and nutrition with the action plan, and using the action plan to reach out to other sectors and to advocate at high political level for policy coherence.
2.7 **Sessions 8-10 - Review of the draft action plan: Objectives 1-6**

Participants remained in the three small groups to review Objectives 1-6, looking specifically at the “country actions” and “WHO actions”. The summary below does not include suggestions on minor revisions or rewording; rather, it presents the main suggestions and comments in relation to content.

**Objective 1: To reposition national nutrition planning to address the double burden of malnutrition**

Suggestions included:

- highlight the environment sector as one of the key sectors with which to strengthen partnerships;

- add a new action for countries: “establish and/or strengthen a national coordinating structure for nutrition”; and

- add a new action for WHO: “facilitate high-level policy dialogue to include nutrition in national development plans”. This action was considered crucial. High-level policy dialogue is needed as national nutrition policies and plans are often only driven by the ministry of health without involvement of other sectors.

Overall, this objective was considered important, as national nutrition action plans are now in the second or third generation (after the World Declaration and Plan of Action for Nutrition, 1992). Countries have had plans for many years, but without effective implementation, they sometimes becoming obsolete. The nutrition landscape has changed dramatically since the 1990s, making it essential to reposition nutrition planning and link nutrition and the food we need to climate change, disasters, globalization and rapid and unplanned urbanization. The impact of other sectors, including trade, agriculture, environment and education on nutrition needs to be considered and policy coherence ensured.

**Objective 2: Protect, promote and support optimal breastfeeding practices**

Suggestions included:

- include complementary feeding in this objective (as it would otherwise be neglected);

- change the title to: “Protect, promote and support optimal breastfeeding and complementary feeding practices”; and

- add a new action for WHO: “develop mechanisms for sharing best practices on complementary feeding programmes.”

**Objective 3: Improve the quality of nutrition services**

Suggestions included:

- change the title to: “Improve the quality and accessibility of nutrition services”;
• focus the second action for countries on “enhancing knowledge management to support evidence-informed good practice” (supported through formative research and the development of comprehensive communication plans); and

• clarify WHO’s support to countries to strengthen “service delivery” and add two new actions for WHO, namely: “develop tools to support countries to establish guidelines and evidence-informed policies” and “disseminate existing and develop new tools to support countries to integrate nutrition components into health professional curricula”.

Participants debated at length the idea of combining Objective 3 and Objective 5, as both focus on skills and capacity of professionals.

Objective 4: Regulation and legislation

The overall content of this objective was agreed to. However, the suggestion was made to add more explicitly that food regulations and standards should align with Codex Alimentarius guidance, be risk-based and facilitate trade in safe and healthy food.

Objective 5: Integration of nutrition, including education and counselling across public health initiatives

The overall content of this objective was also agreed to, even though the discussion on whether to merge Objectives 3 and 5 continued. Main comments included rewording of actions for countries and WHO, which did not change the objective’s content.

Objective 6: Sustainable financing mechanisms, including taxation and subsidies

Suggestions included:

• add an action for countries: “advocate for sustainable funding for nutrition including public-private partnerships”; and

• add that food pricing schemes/policies should be aligned to national dietary guidelines (where available).

All comments made on Chapters 1-3, on the overarching strategies and on Objectives 1 and 2 were integrated after Day 2 and presented to the participants on Day 3 during the morning session. Comments received on Objectives 3-6 were integrated after the consultation due to limited time to make further amendments.

2.8 Session 11 - Next steps for country implementation

In this session, the participants set out to identify the next steps for country implementation of the draft action plan and how to best align their national nutrition-related plans and policies with the action plan.

All countries highlighted the necessity for cooperation, partnerships and even networks to join forces for nutrition improvements in their countries and to ensure policy coherence, specifically in the areas of health, trade and agriculture. Participants felt in a stronger position to advocate for placing nutrition higher on the agenda of policy-makers within their countries.
Common next steps included reviewing existing or developing new nutrition policy instruments and building capacity within their countries to better address the double burden of malnutrition.

They called upon WHO and partners to support them technically and financially, to help facilitate a high-level policy dialogue and to share best practices to improve nutrition within the Region.

Outcomes of this session by country are presented in Annex 5.

Timeline for finalization

At the completion of the final group work, in which next steps for country implementation were identified, Dr Howard Sobel discussed the timeline for the finalization of the action plan. He indicated that all contributions would be considered and incorporated into the next draft, which would be reviewed internally and sent out to all Member States of the Western Pacific Region by the end of January 2014 for further comments. Countries would then be given one month to reply. After consideration of additional comments made by countries, the draft would be finalized in May 2014 and presented as a progress report to the Regional Committee for the Western Pacific in October 2014.

2.9 Closing session

Dr Howard Sobel, Team Leader, Maternal Child Health and Nutrition, Division of Building Healthy Communities and Populations, WHO Regional Office for the Western Pacific, delivered the closing remarks on behalf of Dr Susan Mercado. Dr Sobel thanked participants and temporary advisers and acknowledged their significant contributions. There was consensus among participants about the need for and urgency of action plan that brings together actions to address undernutrition, overweight and obesity and that can be used as a guidance document to support countries implement the CIP. He looked forward to continuous collaboration with all countries in the Region.

3. CONCLUSIONS

3.1 Conclusions

3.1.1 The objectives of the Consultation on the Action Plan to Reduce the Double Burden of Malnutrition in the Western Pacific Region (2015-2020) were met, and the meeting successfully engendered an exchange of experience and expertise among participants.

3.1.2 Delegates recognized the value of the action plan to support national nutrition planning and approaches. Delegates requested the Secretariat to finalize the action plan soon but emphasized that the following aspects should be included and/or modified:

- increase emphasis on overweight and obesity both in the background and in the essential nutrition interventions;
• reorganize specific sections to condense and improve the flow (e.g. Chapter 3: Coherence, sustainability and effectiveness and the “overarching strategies” in Chapter 4); and

• enhance multisectoral engagement so that sectors other than health sector are taking action and measuring indicators related to nutrition.

3.1.3 Additionally, delegates noted the following conclusions.

• A recognized strength of the meeting was that it focused across areas that affect nutrition based on a simple causation model: "food", "health" and "care". Solutions to improve nutrition need to address all three. The delegates shared experiences and identified commonalities of problems and solutions that can be used to inform similar processes in countries across the Region.

• Stronger guidance is requested from WHO on dealing with industry and industry interference and improved complementary feeding.

• The comprehensiveness of the plan is a strength as it covers critical elements, e.g. sustainable food systems, health and nutrition services, policy and plans, legislation and regulations, as well as multisectoral and intersectoral collaboration.

• A focused approach to key and pragmatic issues, like protection, promotion and support of breastfeeding, ensuring appropriate budgets allocate and dynamic, monitored and resourced nutrition plans need to be in place.

• Interconnection among the different sectors is necessary to ensure appropriate foods are accessible to all.

3.2 Recommendations

The consultation participants put forth the following recommendations:

3.2.1 Actions to reduce the double burden of malnutrition need to be part of comprehensive and whole-of-government approaches, and need to be integrated into the national development agenda.

3.2.2 Member States should strengthen and promote essential nutrition interventions at key stages of the life-course by incorporating proposed actions for countries and areas into national and subnational plans, policies and budgets. Ensuring policy coherence, sustainable food systems, and continuous improvement of the quality of health care provided should be considered when making the framework for identifying national actions. Development partners should align with and provide support to implement the national plans.

3.2.3 Member States should identify and allocate appropriate resources (human and financial) to support the implementation, supervision and monitoring of the country-based plans.

3.2.4 All key stakeholders should be engaged to ensure the action plan is implemented with due consideration of the different roles and contributions of those stakeholders while protecting
the public interest and avoiding conflict of interest. Professional organizations and civil society should be engaged as key stakeholders.

3.2.5 WHO collaborating centres, other partner institutions and professional organizations should facilitate the exchange of information and work collectively towards capacity-building.

3.2.6 WHO should prioritize testing and finalization of the various tools to support countries to implement essential nutrition interventions.

3.2.7 WHO will continue to provide technical support in monitoring and surveillance, priority setting and strengthening of linkages between nutrition and other relevant programmes.

3.2.8 In line with the global and regional commitments to improve nutrition, consideration should be taken toward noting this action plan at the sixty-fifth session of the WHO Regional Committee in 2014.
CONSULTATION ON THE ACTION PLAN TO REDUCE THE DOUBLE BURDEN OF MALNUTRITION IN THE WESTERN PACIFIC REGION, 2015–2020

Manila, Philippines 19-21 November 2013

INFORMATION BULLETIN NO. 2

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AGENDA

(1) Opening ceremony

(2) Global perspectives on nutrition and evidence informed guidelines and tools

(3) The nutrition situation in the Western Pacific Region

(4) Country presentations

(5) Group work 1: Issues/challenges barriers to addressing the double burden and stakeholder analysis

(6) Overview of the draft Regional Action Plan (RAP) to reduce the double burden of malnutrition (2014-2020)

(7) The role of food systems in reducing the double burden of malnutrition

(8) Towards a food secure Pacific

(9) Group work 2: Review of chapters 1-3

(10) Group work 3: Review of overarching strategies

(11) Group work 4: Review of objectives 1 and 2: actions for countries and WHO

(12) Group work 5: Review of objectives 3 and 4: actions for countries and WHO

(13) Group work 6: Review of objectives 5 and 6: actions for countries and WHO

(14) Group work 7: Identify next steps for country implementation

(15) Timeframe for RAP finalization

(16) Rapporteur’s report

(17) Conclusions and recommendations

(18) Closing
BRUNEI DARUSSALAM

Double Burden of Malnutrition,
19-21 November, 2013
WPRO - Manila

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BRUNEI DARUSSALAM'S SITUATION
<table>
<thead>
<tr>
<th>IYCF practices</th>
<th>WHO’s IYCF: A tool for assessing national practices, policies &amp; programme</th>
<th>IBFAN Asia’s Guidelines for scoring &amp; rating World Breastfeeding Trend initiatives (WBTI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initiation of Breastfeeding within 1 hour of birth</td>
<td>92% (90-100%)</td>
<td>Key to rating  Score /Colour code/Grading</td>
</tr>
<tr>
<td>Exclusive Breastfeeding for first 6 mths</td>
<td>26% (12-49%)</td>
<td>Score 6 Grade C</td>
</tr>
<tr>
<td>Median Duration of Breastfeeding</td>
<td>8mths (0-17mths)</td>
<td>Score 3 Grade D</td>
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<tr>
<td>Bottle-feeding (0-12mths)</td>
<td>73% (30-100%)</td>
<td>Score 3 Grade D</td>
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<tr>
<td>Complementary feeding (6-9mths)</td>
<td>93.2%</td>
<td>Score 10 Grade A</td>
</tr>
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</table>

**HB ESTIMATION AT FIRST ANTENATAL VISIT – MCH CLINICS (2012)**

<table>
<thead>
<tr>
<th>Hb Levels</th>
<th>1st Trimester Presentation</th>
<th>2nd Trimester Presentation</th>
<th>3rd Trimester Presentation</th>
<th>Total</th>
<th>%</th>
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<tbody>
<tr>
<td>Normal</td>
<td>2355</td>
<td>1845</td>
<td>273</td>
<td>4473</td>
<td>78.4%</td>
</tr>
<tr>
<td>Mild anemia (10 - 10.9 g/dl)</td>
<td>277</td>
<td>401*</td>
<td>115</td>
<td>793</td>
<td>13.9%</td>
</tr>
<tr>
<td>Moderate anemia (7 - 9.9 g/dl)</td>
<td>102</td>
<td>209</td>
<td>116</td>
<td>427</td>
<td>7.5%</td>
</tr>
<tr>
<td>Severe anemia (&lt; 7 g/dl)</td>
<td>2</td>
<td>4</td>
<td>7</td>
<td>13</td>
<td>0.2%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>5706</strong></td>
<td></td>
<td></td>
<td></td>
<td>100%</td>
</tr>
</tbody>
</table>

**Comments:**
The total number of pregnant women who are found to be anaemic at the first antenatal clinic presentation is **21.6%**.

[A total of 6536 pregnant women were registered at MCH clinics in 2012; 830 data are missing]
## Double Burden of Malnutrition (2009)

<table>
<thead>
<tr>
<th>Index</th>
<th>Nutritional Status</th>
<th>Male %</th>
<th>Female %</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight for Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(n=1126)</td>
<td>&lt;-2 SD</td>
<td>10.8</td>
<td>8.5</td>
<td>9.6</td>
</tr>
<tr>
<td></td>
<td>&lt;-3 SD</td>
<td>2.0</td>
<td>0.7</td>
<td>1.3</td>
</tr>
<tr>
<td>1995</td>
<td>&lt;-2 SD</td>
<td>12.2</td>
<td>14.8</td>
<td>13.3</td>
</tr>
<tr>
<td></td>
<td>Moderate underweight</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Severe underweight</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Weight and Height (2009/1995)

<table>
<thead>
<tr>
<th>Index</th>
<th>Nutritional Status</th>
<th>Male %</th>
<th>Female %</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Height for Age (n=1114)</td>
<td>Moderate stunting</td>
<td>22.8</td>
<td>16.7</td>
<td>19.7</td>
</tr>
<tr>
<td></td>
<td>Severe stunting</td>
<td>6.9</td>
<td>2.8</td>
<td>4.8</td>
</tr>
<tr>
<td>1995 &lt;2SD</td>
<td>Moderate stunting</td>
<td>13.2</td>
<td>12.7</td>
<td>12.9</td>
</tr>
<tr>
<td>Weight for Height (n=1104)</td>
<td>Moderate wasting</td>
<td>2.7</td>
<td>3.0</td>
<td>2.9</td>
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<tr>
<td></td>
<td>Severe wasting</td>
<td>0.4</td>
<td>0.5</td>
<td>0.4</td>
</tr>
<tr>
<td></td>
<td>Overweight</td>
<td>8.8</td>
<td>7.8</td>
<td>8.3</td>
</tr>
<tr>
<td>1995 &lt;2SD</td>
<td>Moderate wasting</td>
<td>3.7</td>
<td>3.6</td>
<td>3.6</td>
</tr>
<tr>
<td></td>
<td>Overweight</td>
<td>8.4</td>
<td>9.5</td>
<td>9.1</td>
</tr>
</tbody>
</table>

### BMI, MUAC, HC (2009/1995)

<table>
<thead>
<tr>
<th>Index</th>
<th>Nutritional Status</th>
<th>Male %</th>
<th>Female %</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>BMI for Age (n=1104)</td>
<td>Moderate wasting</td>
<td>1.6</td>
<td>2.8</td>
<td>2.2</td>
</tr>
<tr>
<td></td>
<td>Severe wasting</td>
<td>0.7</td>
<td>0.7</td>
<td>0.7</td>
</tr>
<tr>
<td></td>
<td>Overweight</td>
<td>9.0</td>
<td>8.7</td>
<td>8.8</td>
</tr>
<tr>
<td></td>
<td>Obese</td>
<td>4.4</td>
<td>2.3</td>
<td>3.3</td>
</tr>
<tr>
<td>Mid Upper Arm Circumference (n=900)</td>
<td>Moderate wasting</td>
<td>0.5</td>
<td>0.0</td>
<td>0.2</td>
</tr>
<tr>
<td></td>
<td>Severe wasting</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Head Circumference (n=395)</td>
<td>Moderate wasting</td>
<td>9.1</td>
<td>8.5</td>
<td>8.8</td>
</tr>
<tr>
<td></td>
<td>Severe wasting</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
</tr>
</tbody>
</table>
**FOOD SYSTEM ISSUES:**

- Wicked, complex issues → multifactorial
- Human attitudes -→ resistance to change at the individual level; lack of effort
- People not seeing NCDs as a problem, 'I am big, I am obese but I feel happy and okay'
- "Everything is free in Brunei, so if I get ill the Government will help me..."...lack of appreciation (by looking after own health) towards what Government have provided so far;
- Certain healthier options more expensive e.g. PUFA cooking oils/spreads; low-fat milk
- Nobody dares to be bold...and cruel....(lacking in champions)

**ACTIONS TAKEN TO ADDRESS:**

*Draft National Strategy on Maternal, infant & Young Child Nutrition for Brunei Darussalam 2013-2017*
CHALLENGES/ISSUES ENCOUNTERED

Individuals:
- Attitudes - resistance to change;
  - Lack of effort
- Lack of knowledge
- Lack of confidence
- Lack of support
- Lack of champions

Environment:
- Healthcare facilities & skilled professionals
- Legislation
- Marketing by industries
- Pricing policy
- Workplace
- Community attitude

**committed, people willing to do extra tasks very small in no.

NEXT STEPS/COUNTRY PLAN....

✓ Implementation of BruMAP-NCD 2013-2018 (refer to BruMAP-NCD)

✓ Implementation of National Strategy on MIYCN 2013-2017 (refer draft)
### Consultative Workshop on the Regional Action Plan to Reduce Double Burden of Malnutrition in the Western Pacific Region 2014-2020

Manila, Philippines, Date: 19th to 21st November 2013

"Double Burden of Malnutrition"

Kingdom of Cambodia

#### Situation and Problems of Malnutrition

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>UNDERWEIGHT</td>
<td>38.4</td>
<td>28.2</td>
<td>28.8</td>
<td>28.3</td>
<td>49.7</td>
<td>43.2</td>
<td>39.5</td>
<td>39.9</td>
<td>16.8</td>
<td>8.4</td>
<td>8.9</td>
<td>10.9</td>
</tr>
<tr>
<td>STUNTED (short)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WASTED (thin)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

2010 CMDG: 24.5
2015 CMDG: 19.2
2010 CMDG: 31.2
2015 CMDG: 11.2
2010 CMDG: 31.2
2015 CMDG: 24.5
Achievements in the Health Sector

Early initiation of breastfeeding and exclusive breastfeeding show great progress (CDHS 2010)

Anaemia rates decreased among WRP, and pregnant women between 2005 and 2010 (CDHS)

Coverage of IFA supplementation for pregnant women is over 85%

Coverage of vitamin A supplementation for children increased to above 71% (CDHS 2010)

Coverage of household using iodized salt increased from 72.5% in 2005 to 82.7% in 2010

Coverage of de-worming for postpartum women and children increased to above 50% (CDHS 2010)

Early initiation and exclusive breastfeeding in Cambodia from 2000-2010

<table>
<thead>
<tr>
<th>CDHS 2000</th>
<th>CDHS 2005</th>
<th>CDHS 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>35.1</td>
<td>65.2</td>
</tr>
<tr>
<td>11.4</td>
<td>60</td>
<td>73.5</td>
</tr>
</tbody>
</table>

Breastfeeding within 1 hour | Exclusive breastfeeding

Food System Issues

- **Macro level food security** in Cambodia has been achieved for many years as the country produces large surpluses of the national staple food, rice, and is becoming an important rice exporter in the region.

- **Household food security** depends strongly on the entitlements of a household to food either from its own food production, through food purchase from own income or food and cash transfers. Some rural and urban areas remains a key challenge to ensure adequate access to food over time.

- **Individual food security** depends on appropriate intra-household distribution of food, as well as the nutritional dimensions which depend on the correct utilization of food, the individual health status and the physiological interaction between nutrient absorption and diseases. Child and maternal malnutrition is still high, there is an urgent need to address this issue.
Achievements in Agricultural & Multisectoral Achievements

- Increases in productivity and cultivated area has led to a surplus paddy of over 4 million tones
- Household dietary diversity is improving with a higher percentage of calories from animal sources, especially in urban areas (CSES 2009)
- The poorest households are consuming 13% more calories (CSES 2009) and spending a lower percent of overall expenditure on food

Actions to address Malnutrition

Improving Use and Utilization of Food

- Scale up nutrition services and nutrition education
- Improve safe domestic water supply, sanitation and hygiene practices
- Expand food fortification with micronutrients
- Increase the availability and appropriate use of nutritious foods at household level
- Use social protection instruments to enhance nutrition
- Develop and implement a nutrition based nutrition program

Increased Food Availability and Access

- Enhance Diversification and Market Integration of Small Holder Farming
- Enhance Land Distribution and Titling for Poor Households
- Improve Access and sustainable Use of Fishery and Forest Resources
- Enhance Employment and Income Opportunities for the Food-Insecure
Challenges/Issues encountered

- FSN issues are insufficiently integrated into the national and sub-national planning process due to the limited knowledge and understanding of policy makers and planners.
- Sub-national coordination structures for nutrition are not currently active.
- Some current programs have not been adequately evaluated; need to improve national monitoring systems.
- Increased agricultural productivity and economic growth is not sufficient for changing the diet of young children; improved feeding practices are needed.
- Unclear future financial support to scale up interventions.
- Comprehensive policy and legislation is lacking for food fortification.
- Postgraduate degrees in agriculture are available in-country, but still lacking for nutrition.
- Active participation of key players is still limited.
- Fluctuating food prices require different strategies, including nutrition-sensitive social safety nets, targeted to most vulnerable.

Next steps/Country Plan

- Coordination and the policy oversight for FSN.
- Capacity building at national and decentralized level.
- Monitoring and evaluation of the NSFSN and its programs.
- FSN related knowledge and information management.
- Selection of beneficiaries/targeting of FSN interventions.
- Develop and disseminate road map to reduce malnutrition for 2014-2020.
- Continue to work on pre-service training in nutrition, to include IYCF and nutrition topics in medical, nursing, and midwifery curriculum.
- Scale up interventions with high impact on maternal and child nutritional status; e.g. breastfeeding, complementary feeding, micronutrient supplementation, and management of acute malnutrition.
Many thanks for your kind attention.
# Double Burden of Malnutrition

**CHINA**

## Malnutrition in children under 5 years old

<table>
<thead>
<tr>
<th>Year</th>
<th>National Underweight</th>
<th>Urban Underweight</th>
<th>Rural Underweight</th>
<th>National Stunting</th>
<th>Urban Stunting</th>
<th>Rural Stunting</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>13.7</td>
<td>5.3</td>
<td>16.5</td>
<td>33.1</td>
<td>11.4</td>
<td>40.3</td>
</tr>
<tr>
<td>1995</td>
<td>11.4</td>
<td>3.4</td>
<td>14.1</td>
<td>33.2</td>
<td>10.4</td>
<td>40.8</td>
</tr>
<tr>
<td>1998</td>
<td>7.8</td>
<td>1.8</td>
<td>9.8</td>
<td>22.3</td>
<td>5.3</td>
<td>27.9</td>
</tr>
<tr>
<td>2000</td>
<td>8.2</td>
<td>2.0</td>
<td>10.3</td>
<td>20.0</td>
<td>4.1</td>
<td>25.3</td>
</tr>
<tr>
<td>2005</td>
<td>4.9</td>
<td>1.4</td>
<td>6.1</td>
<td>13.0</td>
<td>3.1</td>
<td>16.3</td>
</tr>
<tr>
<td>2008</td>
<td>-</td>
<td>-</td>
<td>5.1</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>2009</td>
<td>-</td>
<td>-</td>
<td>4.6</td>
<td>-</td>
<td>-</td>
<td>12.6</td>
</tr>
<tr>
<td>2010</td>
<td>3.6</td>
<td>1.3</td>
<td>4.3</td>
<td>9.9</td>
<td>3.4</td>
<td>12.1</td>
</tr>
</tbody>
</table>

*Source: Chinese food and nutrition surveillance system*
Anemia in children under the age of 5

<table>
<thead>
<tr>
<th>Year</th>
<th>National</th>
<th>Urban</th>
<th>Rural</th>
</tr>
</thead>
<tbody>
<tr>
<td>1992*</td>
<td>16.5</td>
<td>13.1</td>
<td>17.6</td>
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<td>1998</td>
<td>17.6</td>
<td>11.3</td>
<td>19.8</td>
</tr>
<tr>
<td>2000</td>
<td>22.6</td>
<td>12.9</td>
<td>25.8</td>
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<tr>
<td>2002*</td>
<td>18.8</td>
<td>12.7</td>
<td>20.8</td>
</tr>
<tr>
<td>2005</td>
<td>19.3</td>
<td>11.3</td>
<td>21.9</td>
</tr>
<tr>
<td>2010</td>
<td>12.6</td>
<td>10.3</td>
<td>13.3</td>
</tr>
</tbody>
</table>

Source: Chinese food and nutrition surveillance system
*China nutrition and health survey 1992 and 2002

Breastfeeding and complementary feeding

- **Exclusive breastfeeding rates for 0-6 months**
  - National: 28%
  - Urban: 30%
  - Rural: 16%

- **Complementary feeding rates for 6-9 months**
  - National: 43%
  - Urban: 36%
  - Rural: 16%

- **Continued breastfeeding rates for 12-15 months**
  - National: 45%
  - Urban: 37%
  - Rural: 16%

Source: National Health Services Survey 2008
The pilot project to improve the nutrition of infants in poor areas

- The former Ministry of Health and All-China Women's Federation (ACWF) cooperation implemented this project in 2012.
- The Ministry of Finance earmarked special funds for this project.
- Public health service project for children.
- The first health alleviation project designed for poor areas.
- Provide Ying Yang Bao (YYB), Multi-nutrient powders (MNPs), for infants aged 6-24 months
- So far, about 200,000 infants in 100 impoverished counties in 10 provinces benefited.
China’s National Nutrition Improvement Program for Rural Students in Compulsory Education

- Started in 2011
- Allocates three yuan per person each day to provide free lunch for impoverished school children. (200 day/year)
- Covered 699 county-level units in 22 provinces
- 33 millions students were benefited from the program.
- 7 millions students benefited from the local government financial investment.

China plans to build enough school canteens to provide safe and nutritional meals for all primary and junior high school students in impoverished rural regions by 2015.
- So far, the central government has invested 30 billions for the construction of new canteens.
- Preliminary results showed, the nutritional status of students has improved.
- The program succeeds in improving students’ physique and easing the stunting problem among rural poor students.
Outline for the development of food and nutrition in China (2013–2020)

- Outline of China's reform and development of food structure during the 1990s
- Outline for the development of food and nutrition in China (2001–2010)
- Guide China's nutrition work in the next 7 years.

- Development goals
  - Food production
    - Food intake: Dietary diversity
    - Nutrient intake
    - Nutritional diseases control
  - Key population
    - Maternal and infant
    - Children and adolescents
    - Elderly
  - Key areas
    - Poor areas
    - Rural areas
    - New urbanization areas
Thank you!
Double Burden of Malnutrition

FSM

Prevalence (%) of Anemia in High Risk Populations in Kosrae by Year

- One year olds
- Pregnant women

2008 2009 2010 2011 2012
Prevalence of Overweight/Obesity (%) in 2-5 year olds in Kosrae

Food System Issues
- shift from local foods to imported foods
  - high reliance on nutritionally poor imports
- Limited food choices
- Production/Marketing – inadequate supply
Actions taken:

✓ Awareness Campaigns through communities, schools and on-site counseling
✓ Physical Activities Promotions
✓ Salt Reduction Awareness Campaign

Local Food Promotions
✓ Local Recipe Book Development Project

Challenges/Issues Encountered:

• Insufficient policies
• Lack of Enforcement
• Resistance from key stakeholders – e.g. community leaders/functions, church activities
• Mindset - bottlefed babies are richer; Exercise is from Western Culture
• Unskilled workers

• Lack of Environmental Support e.g. no school canteens selling healthy food; no day care centers for breastfeeding promotion
Next steps/Country Plan

- Strengthen national nutrition planning to address the double burden of malnutrition
- Create multi-sectoral approach to the double burden of malnutrition
- Create policies/regulations to ensure quality nutrition and promote healthy lifestyle
- Interventions for behavioral change e.g. COMBI for Salt Reduction
- Expand on nutrition and physical activities promotion in schools, communities and workplaces
DOUBLE BURDEN OF MALNUTRITION

FIJI

THE PROBLEM/ SITUATION:

- FIJI HAS 861,000 PEOPLE.

- 19,000 BIRTHS A YEAR.

- 90,000 Children are under-five years of age

- Neonatal Mortality Rate – 8/1000

- Infant under-five mortality rate – 15/1000
THE PROBLEM/SITUATION:

- Malnutrition is a burden & account for 54% of total under-five deaths.
- 7.1% of under five are underweight
- 3.8% are stunted
- 4.5% are wasted
- 10.2 of births are LBW [Fiji National Nutrition Survey 2004].

FOOD SYSTEM ISSUES:

- What Issues exist in the food system that impede consumption of healthy foods?
- Availability of cheap and unhealthy options of food.
- Healthier options are expensive.
- Prices of food are generally expensive.
- Natural disasters e.g. floods, hurricanes...
- Accessibility & accessibility of healthier foods & beverages in public places.
- Poverty.
- Poor nutritional Knowledge & behaviour.
CHALLENGES ENCOUNTERED:

- The need to improve the collaboration of Public Health & Clinical settings.
- Improvement of multi-sectoral approach in addressing the double burden of Malnutrition.
- The lack of active participation of other government departments and the food production companies in efforts to combat this problem.
- Unsupportive environment eg lack or no provision of playgrounds in urban areas.

ACTIONS TO ADDRESS:

- [Establishment of NFNC in 1982 – the need for inter-sectoral action to improve the F & N situation of the country.]
- National Nutrition Survey every 10 years; next one due 2014.
- 2008 – Fiji revised its National Food and Nutritional Policy Statements:
  - 2009 Fiji Food Summit to address Fiji Food Security.
Cont’d (MOH-FIJI):

- Baby Friendly Hospital Initiatives & Infant Young Child Feeding Programme.
- Code of Marketing of breastfeeding supplements.
- Milk Supplementation Programme. (MSP)
- Fiji National Iron & Multivitamins Supplementation.
- Iron fortification of flour.
- Health Promoting Schools.
- Backyard Gardening.
- PH prog eg Hand washing/Safe water...etc.

CHALLENGERS/ISSUES ENCOUNTERED:

- (...IN ADDRESSING THE DOUBLE-BURDEN?
- Food Price Increase.
- Natural Disasters.
- Accessibility & Availability of healthier food and beverage choices in communities/public service places.
- Poverty
- Poor Nutrition Knowledge & behaviour.
NEXT STEPS/COUNTRY PLAN.

- POLICY 1: Advocacy to mainstream nutrition
  - Link to sustainable development
  - Multisectoral Action

- POLICY 2: Promote & sustain HH Fd Security:
  - Div Wkshp to advocate food security.
  - Annual “Young Farmers Show in schools”
  - Support Village communities to produce food for their own consumption.
  - Supt & maintain food production for local consumption – local fish & poultry avail at affordable prices.

NEXT STEPS/COUNTRY PLAN.

- POLICY 3: IMPROVE NATIONAL NUTRITIONAL STATUS:
  - Monitor level of fortificant in the flour at point of sale periodically.
  - Monitor regulation of import of iodised salt.

- POLICY 4: PROTECT CONSUMERS THRU IMPROVED QUAL. AND SAFETY OF FOOD & WATER:
  - Expand accessed piped safe water supply
  - train community Grps, institutions & orgs on safe food handling and practices.
  - enforce and monitor Food Safety Act and Regulation.
  - Monitor nutrient content labelling.
  - Empower village elders & parents upgrade existing sanitary facilities.
  - Empower village elders and parents to enforce hygiene by-laws.
NEXT STEPS/COUNTRY PLAN.

- POLICY 5: Improve nutrition for vulnerable groups
  - Maintain BFH status.
  - Implement & monitor the code of Marketing of Breastmilk Substitutes.
  - Celebrate World Breastfeeding Week.
  - Conduct routine growth monitoring clinics at the Health Centers & outpost clinics for all children under 5 years.
  - Demonstrate and counsel mothers and caregivers during non-thrivers clinics on appropriate diets.
  - Counselling couples during AND on appropriate diets.

NEXT STEPS/COUNTRY PLAN.

- POLICY 6: School Nutrition
  - Health Promoting Schools

- POLICY 7: Healthy Diets and lifestyles
  - Train & assist community HW and key community leaders on healthy diets and lifestyle.
  - Promote consumption of fruits and vegetables in communities.
  - Disseminate nutrition info thru the NFNC newsletter and website www.nnutrition.gov.fj
  - Support for Strategic Health Communication (SHC) training
NEXT STEPS/COUNTRY PLAN.

• POLICY 8:
  - Disseminate info from F&N Surveillance thru newsletter, website etc
  - CONDUCT NNS 2014.

• POLICY 9:
  - Strengthening collaboration with public & private sectors, regional and international organisations in the implementation of FPAN

****************THANK YOU/VINAKA***************
Double Burden of Malnutrition

Republic of Korea

Yeseung Sol

Problem and/or situation (2012)

<table>
<thead>
<tr>
<th></th>
<th>1-3 yrs.</th>
<th>2-5 yrs.</th>
<th>WRA</th>
<th>PW</th>
<th>Adolescents</th>
<th>Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underweight (BMI&lt;18.5)</td>
<td>-</td>
<td>-</td>
<td>10.4</td>
<td>-</td>
<td>-</td>
<td>5.0</td>
</tr>
<tr>
<td>Overweight (BMI&gt;85th%)</td>
<td>-</td>
<td>9.4</td>
<td>-</td>
<td>-</td>
<td>4.9</td>
<td>-</td>
</tr>
<tr>
<td>Obese (BMI≥25 or 95th%)</td>
<td>-</td>
<td>2.8</td>
<td>22.2</td>
<td>-</td>
<td>13.1</td>
<td>31.9</td>
</tr>
<tr>
<td>Anemic</td>
<td>-</td>
<td>-</td>
<td>15.5</td>
<td>-</td>
<td>4.0</td>
<td>8.1</td>
</tr>
<tr>
<td>Exclusive BF (6 mo.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>49.1</td>
</tr>
<tr>
<td>Continued BF (12 mo.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>46.6</td>
</tr>
<tr>
<td>Complementary feeding</td>
<td></td>
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<tr>
<td>N Hypertension</td>
<td></td>
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<td></td>
<td></td>
<td>7.1</td>
</tr>
<tr>
<td>C Diabetes</td>
<td></td>
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<tr>
<td>C Hyper-triglyceridemia</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>5.1</td>
</tr>
<tr>
<td>C Hyper-cholesterolemia</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>7.3</td>
</tr>
</tbody>
</table>

Unit: %

< No data available
Problem and/or situation (2012)

- under & over nutrition at food & nutrient level

**Beverages & Alcoholic Drinks Intake**

People w/ sub-adequate nutrient intake

People w/ excess nutrients intake

---

Food System issues

- Issues that impede consumption of healthy foods
  - **Production**: more imported foods, more processed foods (w/ higher sodium/sugars/fat)
  - **Marketing**: targeting children is under some control for EDNP foods but using celebrities is widespread
  - **Affordability**: fruits are relatively expensive
  - **Food preferences**: children prefer western fast-foods
  - **Social environment**: more meals away from home & more one-person households
  - **Distribution**: not much of problem
  - **Access**: not much of problem
  - **social determinants**: not much of problem
Actions taken to address

- Key strategies/actions taken to address the problem
  - **Key strategies of national plans(2012):** customised services for life cycle, monitoring & surveillance, change dietary environment (information, education), develop nutrition service industry
  - **Key interventions/measures:** NutriPlus w/education & specific supplementary foods for vulnerable WIC, restriction on TV ads.
  - **Legislations:** National Nutrition management Act, Special Act on Safety Control of Children's Dietary Life, Dietary Education Supporting Act, School Lunch Act
  - **Capacity building programs:** mandating nutrition education at local government level, mandate courses for nutrition teachers at schools/dietitians at public health centers, licensure for clinical dietitians, etc.

Government-funded nutrition programs

- ✓ Korea National Health and Nutrition Examination Survey (KNHANES)
- ✓ **NutriPlus** program for vulnerable women, infants and children under 6 years: breastfeeding
- ✓ School lunch program w/ nutrition education
- ✓ Children's Food Service Management Support Center (CFSMSS)(nursery schools and kindergartens)
- ✓ Sodium reduction: Campaign for Less Sodium [CLS] launched on March 2012
- ✓ **Free fruits & vegetables for children of low SES...**
- ✓ **Fruits in school tuck shops...**
- ✓ **Free meals for the elderly of low SES on welfare side**
BACKGROUND of NutriPlus

- Poor nutritional status of children from low-income families (especially, children under 6 yrs in 1998-2001 KNHANES)

Low Birth-weight Prevalence among NutriPlus participants (2010)

Low Birth-weight Prevalence among general population: 4.9%

<table>
<thead>
<tr>
<th>Participants</th>
<th>Number</th>
<th>Prevalence (BW &lt; 2.5Kg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infants</td>
<td>15,913</td>
<td>6.30%</td>
</tr>
<tr>
<td>Infants born from Women who</td>
<td>3,401</td>
<td>3.18%</td>
</tr>
<tr>
<td>participated during Pregnancy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Challenges/Issues encountered

- What were/are the challenges issues encountered in addressing the double-burden
  - insufficient policies: more on treating diseases
  - resources, skills: relatively OK, good No. of nutritionists
  - industry interference: resistance from food industry
  - Marketing: resistance from Advertisement industry
  - other environmental factors: biased social norm on body shape???
  - other competing program: promotion of food industry from MOFAFF side
Next steps/Country Plan

- List key/concrete steps planned for 2014
  - Basic plan for national nutrition management:
    - Getting other ministries in central government involved (by amending Presidential decree)
    - Government-led establishment of Dietary Reference Intakes (DRIS)
    - Model development on nutrition service industry
    - Development of tools for ‘healthy eating index’
  - Comprehensive plan for safety control on children’s dietary life:
    - Nationwide expansion of CFSMSS: > 100
    - Development of measures to control sugar intake from beverages
Double Burden of Malnutrition and Government response to those Malnutrition in Lao P.D.R

Prepared by
Ministry of Health, Ministry of Agriculture
WHO & UNICEF, Lao P.D.R

Presentation Outline

- Nutrition overview in Lao PDR

- Lao PDR response to address malnutrition
  - Policy and strategy framework
  - Implementation status

- Challenges

- Next steps for Lao PDR
Nutrition Profile of Children Under-5 and Target to be achieved according to NNP

<table>
<thead>
<tr>
<th>Indicators</th>
<th>2006 (%)</th>
<th>2012 (%)</th>
<th>2015 (%)</th>
<th>2020 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stunting of CUS*</td>
<td>48</td>
<td>44</td>
<td>34</td>
<td>28</td>
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<tr>
<td>Wasting of CUS*</td>
<td>7</td>
<td>6</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Underweight of CU 5*</td>
<td>31</td>
<td>27</td>
<td>22 (MDG 20)</td>
<td>15</td>
</tr>
<tr>
<td>Overweight and obesity of CUS (&gt;2SD)*</td>
<td>NA</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exclusive Breastfeeding</td>
<td>26</td>
<td>40</td>
<td>50</td>
<td>70</td>
</tr>
<tr>
<td>Anemia in CUS</td>
<td>41</td>
<td>?</td>
<td>30</td>
<td>20</td>
</tr>
<tr>
<td>Anemia in WRA</td>
<td>37</td>
<td>?</td>
<td>25</td>
<td>15</td>
</tr>
<tr>
<td>IDD in school age children</td>
<td>27*</td>
<td>?</td>
<td>17</td>
<td>10</td>
</tr>
<tr>
<td>IDD in WRA</td>
<td>13</td>
<td>?</td>
<td>9</td>
<td>5</td>
</tr>
<tr>
<td>Vitamin A deficiency in CU 5</td>
<td>45*</td>
<td>?</td>
<td>30</td>
<td>20</td>
</tr>
</tbody>
</table>

*WHO standards, 2005
2006, MICS-3; 2012, LUS

Child mortality trends in Lao PDR

Lao PDR has registered an important decline in infant and under-five mortality and is on track for reaching MDG4

Source: 2011/12 Lao Social Indicator Survey
Undernutrition trends among children under-5 in Lao PDR, 2006-2011
( WHO growth standards)

Trends in anemia among young children,
Lao PDR 2000-2011
Status of breastfeeding in Lao PDR
Breastfeeding trends in Lao PDR, 2000-2011

- Breastfeeding practices are improving
- Nearly 3% point increase per year for exclusive breastfeeding and 2% point increase per year for early initiation
- Giving water and early introduction of food remain the main barriers to exclusive breastfeeding

There seem to be an association between lower rates of early initiation and exclusive breast-feeding and stunting...

Prevalence of stunting, early initiation and exclusive breastfeeding in Lao PDR by residence

- Urban
  - Stunting: 27%
  - Early Initiation: 47%
  - Exclusive Breastfeeding: 38%
- Rural with road
  - Stunting: 38%
  - Early Initiation: 48%
  - Exclusive Breastfeeding: 42%
- Rural without road
  - Stunting: 54%
  - Early Initiation: 31%
  - Exclusive Breastfeeding: 30%

Source: 2011/12 LSIS
Infant formula use is increasing

Percentage of children fed with formula by age in months and year, MICS 2006 & LSIS 2011

Infant and Young Child Feeding

Source: 2011/2012 LSIS
Target population 2013

Children < 5 years of age: 834,211
women of reproductive age: 1,525,597
Pregnant women: 176,869
59% of the population less than 25 years of age

Food System issues

Production:
- Rice production is adequate

Marketing:
- Legislation on marketing of food products present; limited monitoring

Affordability and Access:
- Low income generation; limited agriculture technology; small land holding and rural population may have less access.
- Deforestation reduces access to populations dependent on forest products for food consumption

Food Preference:
- mainly sticky rice which is the staple food; lack of food diversity (eg. low intake of oil, animal protein sources, vegetables)

Social Determinant:
- Poor infrastructure for agriculture especially in mountainous regions
Natural disasters (flood and drought)
- Food taboos (post-partum women; sick children)
- Poverty and low literacy levels among agricultural households especially among women
Lao PDR response to address malnutrition: Key Strategies and actions

Existing Framework Related to Nutrition

Law:
- Food Law
- Hygiene Law
- Agriculture Law

Policy:
- School Healthy Food Policy
- National Nutrition Policy
- Food Safety Policy
- Food Security Strategy
- Maternal Protection

Decree:
- Food fortification: Dose as on Iodized Salt

Agreement:
- Agreement on Code of Marketing of Breast milk Substitutes

Guideline:
- Community Management of Acute Malnutrition
- National Infant and Young Child Feeding Guidelines (draft – being finalized)
**Evidence-based specific/direct nutrition interventions – Lao PDR**

**Promoting good nutritional practices**
- Exclusive breastfeeding
- Complementary feeding for infants after the age of six months
- Improved hygiene practices including handwashing

**Provision of micronutrients for young children and their mothers:**
- Periodic Vitamin A supplements for children 6-59m
- Therapeutic zinc supplements for diarrhea management
- Multiple micronutrient powders for children 6-59m
- De-worming drugs for children (to reduce losses of nutrients)
- Weekly iron-folic acid from women of reproductive age group

**Provision of micronutrients through food fortification for all:**
- Salt iodization

**Therapeutic feeding for malnourished children with special foods:**
- Prevention or treatment for moderate acute malnutrition
- Treatment of severe acute malnutrition with ready-to-use therapeutic foods (RUTF)


---

**Existing nutrition sensitive interventions**

- Water and sanitation; hygiene promotion
- Organic food production in target areas; insect production in select provinces
- Good agriculture practices in select areas
- Livestock raising; fisheries
- Upland food security programme
- School Meal programme
Challenges/Constraints

Coordination:

- various sectors need to be strengthened; integration and synergy with others projects/programmes to be improved

Capacity Building:

- Limited resources for expanding nutrition-specific interventions
- Limitation of capacity of nutritional institution and human resources

Management:

- Limitation of funding support for filling all nutrition interventions gaps
- Weak capacity for planning, delivering and monitoring quality nutrition and food security interventions, especially at the district and community level
- Community-based interventions are very limited in scope/coverage

---

Next Steps to address the double burden of malnutrition

Law:

- Development of the new Nutrition Law with focus on breastfeeding promotion and protection which has an impact on both under- and over nutrition.

Policy and Interventions:

- Promoting early and EBF, appropriate complementary feeding, adequate water and sanitation, micronutrient supplementation for women and children, salt iodization and partnering with other sectors such as education and agriculture to ensure food security

Capacity Building:

- Building capacities around interventions such as management of acute malnutrition
- Develop preventive measures for overnutrition

Coordination:

- new Multi-sectoral Food and Nutrition Security Action plan: convergence of interventions to implement nutrition specific and nutrition sensitive interventions to accelerate progress towards MDG targets and new global nutrition targets by 2025

Strategy:

- Continue focus on undernutrition; look for synergies and opportunities to develop preventive measures for overnutrition
THANK YOU: KOP CHAI
Double Burden of Malnutrition
(Mongolia)

<table>
<thead>
<tr>
<th>STUDY FINDINGS</th>
<th>2000</th>
<th>2005</th>
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<tbody>
<tr>
<td>Children under 5 yrs</td>
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<td></td>
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<tr>
<td>Stunting (HAZ &lt; -2SD)</td>
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<td>27.5</td>
<td>15.3</td>
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<tr>
<td>Underweight (WAZ &lt; -2SD)</td>
<td>11.6</td>
<td>5.3</td>
<td>3.3</td>
</tr>
<tr>
<td>Wasting (WHZ &lt; -2SD)</td>
<td>7.1</td>
<td>2.7</td>
<td>1.6</td>
</tr>
<tr>
<td>Overweight (BAZ &gt; 2SD)</td>
<td>14.7</td>
<td>17.1</td>
<td>12.3</td>
</tr>
<tr>
<td>Obese (BAZ &gt; 3SD)</td>
<td>4.6</td>
<td>4.9</td>
<td>2.5</td>
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<tr>
<td>Exclusive BF up to 6 months</td>
<td>57</td>
<td>65.7</td>
<td></td>
</tr>
<tr>
<td>LBW (&lt; 2500g)</td>
<td>5.3</td>
<td>5.5</td>
<td>4.7</td>
</tr>
<tr>
<td>Anemia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vitamin D deficiency</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vitamin A deficiency</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Targets</td>
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<tr>
<td>2013</td>
<td>13</td>
<td></td>
<td>10.7</td>
</tr>
<tr>
<td>2015</td>
<td>9.6</td>
<td></td>
<td>25</td>
</tr>
<tr>
<td>2016</td>
<td>2</td>
<td>3.8</td>
<td>6</td>
</tr>
<tr>
<td>Adolescents 7-11yrs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stunting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overweight (BMI ≥ 25.0kg/m²)</td>
<td></td>
<td>4.1</td>
<td></td>
</tr>
<tr>
<td>Goiter</td>
<td>21.4</td>
<td>13.8</td>
<td>7.4</td>
</tr>
<tr>
<td>Women (15-49yrs)</td>
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<td></td>
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</tr>
<tr>
<td>Overweight (BMI ≥ 25.0kg/m²)</td>
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<td></td>
<td>32.9</td>
</tr>
<tr>
<td>Anemia</td>
<td></td>
<td></td>
<td>14.4</td>
</tr>
<tr>
<td>Iron deficiency</td>
<td></td>
<td></td>
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<td>Vitamin D deficiency</td>
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<td></td>
<td>30</td>
</tr>
<tr>
<td>Adults (15-64yrs)</td>
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<td></td>
<td></td>
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<tr>
<td>Overweight (BMI ≥ 25.0kg/m²)</td>
<td>31.6</td>
<td>39.8</td>
<td>54.4</td>
</tr>
<tr>
<td>Households</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Iodized salt consumption</td>
<td>46</td>
<td>74.4</td>
<td>89.1</td>
</tr>
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</table>
**Food System issues**

**Daily Intake of Energy, Protein, Fat and Carbohydrate**

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<th></th>
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</thead>
<tbody>
<tr>
<td>Energy (kcal)</td>
<td>1980.8</td>
<td>2278.2</td>
<td>2629.9</td>
<td>2374.2</td>
<td>2848.8</td>
<td>2500</td>
</tr>
<tr>
<td>Protein (g)</td>
<td>94.6</td>
<td>96.1</td>
<td>107.5</td>
<td>100.0</td>
<td>107.2</td>
<td>105.5</td>
</tr>
<tr>
<td>Fat (g)</td>
<td>77.1</td>
<td>86.1</td>
<td>88.2</td>
<td>92.1</td>
<td>84.2</td>
<td>69.5</td>
</tr>
<tr>
<td>Carbohydrate (g)</td>
<td>213.4</td>
<td>264.5</td>
<td>327.9</td>
<td>385.8</td>
<td>373.3</td>
<td>361.5</td>
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</tbody>
</table>

**Annual consumption of food products**

<table>
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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Meat</td>
<td>88.2</td>
<td>112.8</td>
<td>99.9</td>
<td>103.8</td>
<td>89.4</td>
<td>63.9</td>
</tr>
<tr>
<td>Milk, dairy</td>
<td>116.7</td>
<td>146.4</td>
<td>100.9</td>
<td>163.2</td>
<td>160.8</td>
<td>154.2</td>
</tr>
<tr>
<td>Butter</td>
<td>2.9</td>
<td>2.4</td>
<td>2.4</td>
<td>3.6</td>
<td>3.6</td>
<td>-</td>
</tr>
<tr>
<td>Cereals, crossant</td>
<td>106.9</td>
<td>99.6</td>
<td>110.4</td>
<td>127.2</td>
<td>126.0</td>
<td>110.8</td>
</tr>
<tr>
<td>Hoie</td>
<td>-</td>
<td>9.6</td>
<td>15.6</td>
<td>20.4</td>
<td>21.0</td>
<td>29.5</td>
</tr>
<tr>
<td>Sugar</td>
<td>23.7</td>
<td>8.4</td>
<td>12.0</td>
<td>22.8</td>
<td>16.8</td>
<td>8.4</td>
</tr>
<tr>
<td>N'áx, aëkpyá</td>
<td>26.9</td>
<td>3.6</td>
<td>14.4</td>
<td>27.6</td>
<td>38.4</td>
<td>116</td>
</tr>
<tr>
<td>Potato</td>
<td>59.2</td>
<td>15.8</td>
<td>26.4</td>
<td>36.4</td>
<td>38.4</td>
<td>51.1</td>
</tr>
<tr>
<td>Vegetables</td>
<td>22.6</td>
<td>12.0</td>
<td>16.8</td>
<td>21.6</td>
<td>24.0</td>
<td>73.0</td>
</tr>
<tr>
<td>Fruits</td>
<td>11.2</td>
<td>2.4</td>
<td>3.5</td>
<td>6.0</td>
<td>6.0</td>
<td>6.0</td>
</tr>
<tr>
<td>Vegetable or animal oil</td>
<td>1.3</td>
<td>1.2</td>
<td>6.0</td>
<td>6.0</td>
<td>6.0</td>
<td>9.1</td>
</tr>
</tbody>
</table>

1. Food import dependency (about 70% from abroad)
2. Lack of Nutrition and Food safety knowledge
3. Labelling
4. Behaviour (high fat food)

**Actions taken to address**

  - WHO growth standard adoption, MCH handbook
- Law on Salt Iodiumation and Prevention of Iodine deficiency 2003,
- Law on Breastmilk Subsitle 2005,
  - Vitamin A, D and MNP suplementation
- NPA NCD prevention and control 2006-2013,
- National strategy Healthy food and promote exersice and movement 2007
Challenges/Issues encountered

- What were/are the challenges issues encountered in addressing the double-burden?
  - Lack of resources – national professionals?
  - Coherence in multisectoral action (MoFA, MoE, MoH)
  - Weak laws – by lobby of importers,
  - Nutrition linked with many of NPAs – as by part but some part remained

Next steps/Country Plan for 2014~

- Legal acts: Develop NP on Nutrition, IYCF strategy, Revise National BMS code
- Renew NCD prevention NPA – focus young child and adolescents nutrition,
- Revise standards (Labelling, national RDA)
- Reduce vitamin and micronutrients deficiency (cont. vitamin A, D, MNP distr)
- Window of opportunity (-9 to +24)
DOUBLE BURDEN OF MALNUTRITION

IN

PAPUA NEW GUINEA

19TH NOVEMBER 2013

THE PROBLEM OR SITUATION

Data & Targets

- Children 6-59 months old:
  - Stunting: 43.9%
  - Under nutrition: 18.1%
  - Wasting: 4.5%
  - Anaemia: 4.6.9%
  - Vit.A Deficiency: 15.7%
  - Iodine deficiency: No data
  - Exclusive breastfeeding: 35%
  - Continued breastfeeding to 2 years: 66.7%
  - Complementary feeding: 13.3%
  - Obese: No data

(source: PNG National Nutrition Survey 2005)
THE PROBLEM OR SITUATION

- Pregnant Women
  - No data

- Women Reproductive Age (non pregnant) 15-49 yrs
  - Underweight 5%
  - Overweight 17%
  - Obese 5.1%
  - Anaemia 35.1%
  - Iodine Deficiency 28.9%
  - Non-communicable diseases

- Adults (Men) > 18 yrs
  - Underweight 2.9%
  - Overweight 16.1%
  - Obese 4.0%
  - Anaemia 26.3%
  - Iodine Deficiency No data
  - Non-communicable diseases

*** NCD...raw data collected from health facilities in provinces but not analysed to be made available.

FOOD SYSTEM ISSUES

- What issues?
  - Production – Traditional farming practice lacks plant proteins
    - 4 Fish processing plants (Tuna /Mackerel) & 2 Bully beef
    - however it is expensive to afford
  - Infrastructure – lack of market and post harvest infrastructure
  - Distribution
    - High costs of transport (both land, sea and air)
    - Improper post harvest facilities to maintain quality and store over longer time to minimize wastage
    - Affordability
  - Generally PNG as a low income country, there’s Low per capita income, Cant afford to buy protein foods to compliment their diet.
  - Lack of knowledge
  - Poor nutrition practices and lack of nutritional/dietary awareness
  - Food Preferences -
    - Culture/ traditions influence diet composition (Taboos)
  - Social determinants
    - Cheaper readily prepared food at Fast food/ restaurants
    - Lack of appropriate government policies and Legislations
**ACTION TAKEN TO ADDRESS**

Key Strategies/ actions to address the problem

- National Health Plan KRA 4: strategy on Exclusive breastfeeding, complementary feeding and increase access to micronutrients supplementation and KRA7 to promote healthy lifestyles.
- Developed Infant & Young Child Feeding (IYCF) Policy to be endorsed by the NEC Training of Health workers on IYCF
- Awareness of Exclusive breastfeeding through Information, Education and Communication (IEC)
- Currently reviewing National Nutrition Policy
- National Agricultural Development Plan eg Promoting, multiplication and distribution of small livestock to rural farming community.
- Encourage more participation of women in food processing
- IYCF Training since 2007
- Introduction of the Combined Course on IYCF and Child Growth Assessment trainings since early 2013
- Accountability Committee for the Child Health including Nutrition with WHO
- Implementation of COMBI in Bogia District in Madang Province

---

**ACTION TAKEN TO ADDRESS**

- Exclusive Breastfeeding campaign during Health Week. Development and distribution of IEC materials on EB6 and complementary feeding
- Revitalization of Baby Friendly Hospital Initiative
- Training is focused in the districts
- Develop Baby Friendly Hospital Initiative (BFHI) Policy
- Established Wellness and AT 40 clinics in two provinces.
- Reviewed and Aligned National Agriculture Development Plan to the country’s Vision 2050 to have a Healthy, Wealthy and Smart and Happy people.
- Under Food Security Program, we support and promote more involvement of women in food processing and by-product utilization
- Promote small livestock farming with household/family through an integrated farming approach under food security policy.
- Promote inland fish farming (aquaculture) in inland areas as protein source under the food security program.
**CHALLENGES/ISSUES ENCOUNTERED**

- Lack of financial resources
- Lack of qualified nutritionists and dieticians in the country.
- Lack of staff/trainers to run quality trainings
- Law and order activities
- High costs of printing
- High costs of training (huge logistics challenges, high costs of accommodations. Eg. To train one person in the district USD 500 (K1,400)
- Lack of understanding among decision makers about nutrition program and its activities.

**NEXT STEPS**

- Roll out the implementation of the IYCF Policy
- Further capacity to roll out IYCF and Child Growth Assessment trainings.
- Accreditation of Baby Friendly Hospital Initiatives
- Completion and roll out of the implementation of National Nutrition Policy
- Evaluation of Communication for Behavioural Impact (COMBI) in pilot district and implementation of COMBI to other districts in Madang province.
- Conduct baseline surveys in provinces of worst region/provinces
- Roll out Wellness and At 40 clinics to towns and provinces with high prevalence of overweight and obesity.
- Advocate 1000 Days Windows of opportunity
- Review of National Food Security Policy 2000-2010
- Preparation for national nutrition survey
- National Livestock survey (Household)
- Establish In-country capacity development in Nutrition
Double Burden of Malnutrition

Philippines

Presented by:
Jovita B. Raval, MPS, RND
Chief, Nutrition Information and Education Division
National Nutrition Council
Department of Health
Republic of the Philippines
jovie.raval@nnc.gov.ph or jovie_raval@yahoo.com

The problem /situation (max 2 slides)

- Data on under/over nutrition and related (most recent national data)
  - stunting, wasting, underweight, overweight, obese, anaemic, iodine deficiency, exclusive and continued breastfeeding rates, complementary feeding, non communicable diseases
- Target < 5 years of age, women of reproductive age, pregnant women, adolescents, adults
The problem /situation

<table>
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<tr>
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<th>0-5 yrs.</th>
<th>Pregnant women</th>
<th>Adolescents</th>
<th>Adults</th>
</tr>
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<tbody>
<tr>
<td>Stunting</td>
<td>33.6</td>
<td></td>
<td>35.7</td>
<td></td>
</tr>
<tr>
<td>Wasting</td>
<td>7.3</td>
<td>25.0 - all</td>
<td>12.7</td>
<td>10.0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>35.7 - adol.</td>
<td></td>
<td>(CED)</td>
</tr>
<tr>
<td>Underweight</td>
<td>20.2</td>
<td></td>
<td>17.0</td>
<td>11.6</td>
</tr>
<tr>
<td>Overweight</td>
<td>4.3</td>
<td></td>
<td>6.7</td>
<td>22.3</td>
</tr>
<tr>
<td>Obese</td>
<td></td>
<td></td>
<td>6.1</td>
<td></td>
</tr>
<tr>
<td>Anemia</td>
<td>55.7 (6-11 mos)</td>
<td>42.5</td>
<td>18.2</td>
<td>14.9</td>
</tr>
<tr>
<td></td>
<td>20.8 (1-5 y/o)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Iodine Deficiency</td>
<td>No data</td>
<td>94.1</td>
<td>11.8</td>
<td>29.4</td>
</tr>
<tr>
<td>(Median UIE)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vit. A Deficiency</td>
<td>15.2</td>
<td>9.5</td>
<td>4.6</td>
<td>3.4</td>
</tr>
</tbody>
</table>

The problem /situation

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Prevalence</th>
<th>Remarks</th>
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<tr>
<td>Exclusive BF</td>
<td>46.7</td>
<td>0-5 months</td>
</tr>
<tr>
<td>BF with comple fdg</td>
<td>58.0</td>
<td>6-8 months</td>
</tr>
<tr>
<td>Appropriate comple fdg.</td>
<td>33.5%</td>
<td>6-8 months</td>
</tr>
<tr>
<td>Hypertension</td>
<td>25.3</td>
<td>Adults</td>
</tr>
<tr>
<td>Diseases of the heart</td>
<td>36.4/100,000</td>
<td>(2008 Morbidity data)</td>
</tr>
<tr>
<td>Diabetes</td>
<td>5.0</td>
<td>Adults</td>
</tr>
<tr>
<td>Cancer</td>
<td>82,468 predicted new cases (2010)</td>
<td></td>
</tr>
</tbody>
</table>
Food System Issues

- Inadequate food supply (importation of rice)
- Urbanization at 45.3% (land use)
- Trade liberalization (high cost of Fruits/Vegs.)

- Underemployment, volatile food prices
- Economic access (10% of HHs are food poor)
- Physical access (archipelago)

- Diet high in carbs, minimal in protein and low in fat but animal-source food increasing but decreasing in fruits & vegetables
- 69.3% of HHs food insecure
- Meals eaten out
- Influence of marketing through mass media

- Infectious diseases

Food System Issues

- What issues exist in the food system that impede consumption of healthy foods?
  - E.g., production, marketing, distribution, affordability and access, food preferences, social determinants,
Actions taken

**Policy/legislation**
- Mandatory food fortification of staples and salt
- Milk Code, Breastfeeding Promotion, Rooming-In
- National NCD prevention and control policy
- Higher taxes for tobacco and alcohol

**Plans/Program**
- Food staples self-sufficiency program
- Philippine Plan of Action for Nutrition
- Universal Health Care (with health financing)
- School health and nutrition program

**Strategies**
- Conditional cash transfer program
- IYCF including peer counselling, IYCF-E, trainings
- Healthy lifestyle and nutrition promotion
- Food fortification and micronutrient supplementation
- Growth monitoring and promotion
- Food insecurity mapping and nutrition surveillance
- Supplementary feeding

**Management**
- NNC and local nutrition committees and volunteers
- NCD Coalition

---

Actions taken to address (1 slide)

- Key strategies/actions taken to address the problem
  - key strategies of national plans, key interventions, measures, legislations, capacity building programs in place
Challenges/Issues encountered

- Difficulty in scaling-up IYCF interventions, height assessment, iron supplementation
- Philippine policy for management of acute malnutrition
- Development of strategy for complementary feeding and maternal nutrition
- Marketing strategies of milk companies
- Conditional cash transfer program has had limited impact on nutrition outcomes
- Changes in political leadership with nutrition less of a priority and turn-over of human resource complement and key organizational changes
- Capacities for evidence-based policy formulation and planning
- Preparedness for disasters

Challenges/Issues encountered
(1 slide)

- What were/are the challenges issues encountered in addressing the double-burden?
  - E.g., resistance from key stakeholders, insufficient policies, resources, skills, industry interference, marketing, other environmental factors, other competing programs
Next steps/Country Plan

- IYCF (support groups, advocacy, Milk Code)
- Develop models for improving complementary feeding practices
- Continue promotion of nutritional guidelines, healthy lifestyle
- Strengthen Nutrition in Emergencies response and preparedness
- Signing up for the Scaling Up Nutrition movement
- Mid-term review and updating of the PPAN

For more details:
National Nutrition Council
2332 Chino Roces Ave Extn., Taguig City

http://www.nnc.gov.ph
https://www.facebook.com/nncofficial
https://www.facebook.com/wastongnutrisyon
http://www.youtube.com/user/NNC1974
info@nnc.gov.ph
Tel. (02)843-0142  Fax. 818-7398
Double Burden of Malnutrition
(Samoa)

The problem /situation

- < 5 years of age
  - 1999: Underweight, 1.9%; Stunting, 4.2%; Wasting, 0.9%; Overweight, 3.8%;
  - 1999: Anaemic 35.5%
- Women of reproductive age
  - 1999: Anaemic 21.7% (20–49yrs)
  - 2013: Possible evidence of iodine deficiency (18–64yrs)
- Pregnant women
  - 1999: Anaemic, 41.9%
  - 2009: Night blindness, 1.4%
- Children / Adolescents
  - 2003 (6–8yrs): Obese, males 3.3%; females 14.3%
  - 2011 (13–15 yrs): Underweight, 0.7%; overweight, 51.7%; obese, 19.2%
  - 1999 (13–19 yrs): Anaemic, 20.7%
- Adults 2002 STEPS (25–64yrs)
  - Underweight 0.2%; overweight 35.9%; obese 54.7%
  - Diabetes 22.1%; high blood pressure 21.1%; raised total cholesterol 13.7%
The problem /situation

- Infant feeding (2009):
  - 88% initiation of BF in 1st hour
  - 51% exclusive breastfeeding (children < 6 months)
  - 74% continued breastfeeding to 20–23 months
  - 40% fed in accordance with IYCF guidelines 6–23 months
  - 25% 0–5 months use of bottles, teats, pacifiers
  - 92% consumed vitamin A rich foods (6–35 months)
  - 81% consumed iron rich foods (6–35 months)
- Women of reproductive age (15–49yrs) (2009):
  - 98% consumed Vitamin A rich foods daily
  - 86% consumed iron rich foods 6–35 months daily
- Adolescents (13–15 yrs) (2011):
  - 53.5% drink one/more carbonated soft drinks per day
- Adults
  - Fish consumption decreased significantly between 1991 and 2003
  - Fruit & vegetables 2002: 37.7% < 5 servings a day (includes starchy vegetables/fruit)

Food System issues

- Significant dietary changes
  - Modern diets replaced traditional – now high in fat, salt and sugar
    fiber and micronutrients decreased
- Total energy increased substantially, 47%, between 1961 & 2007
  - Increased oils, meats and packaged foods (largely imported)
  - Locally grown foods little to no increase over this time.
- Disasters (cyclones, taro blight) reduced root crops/more cereals
- Socio-demographic changes e.g. urbanization, cash economy,
  changing work – changes in food preferences and lifestyle
- Food marketing
  - Mainly ‘junk’ food advertising within the food and drink advertising
  - Particularly a problem during hours when children are likely to be watching
Actions taken to address

- Legislation / policy
  - New Food Bill currently before parliament
  - Draft Food Regulations including food labelling, importation of fortified food, marketing of infant feeding products
  - National Food and Nutrition Policy reviewed and updated
- Health Promotion Foundation planned – improve nutrition promotion
- Key interventions
  - Promoting appropriate infant and young child feeding
  - School Nutrition Standards developed and currently being implemented in schools
  - Starting salt reduction programme

Challenges/Issues encountered

- Food supply issues
  - Significant quantities of fatty & packaged foods in the market
  - Changing food preferences – people prefer fatty & processed foods
  - Food marketing
  - Limited income – difficulty accessing healthy food
  - Disasters (cyclones)
- Lack of understanding about issues surrounding healthy eating / foods
- Lack of support for breastfeeding mothers
- Limited human and other resources
- Lack of technical capacity to address the problems
Next steps/Country Plan

- Enact and enforce food legislation & regulations
- Seek assistance to identify policy options to address food supply issues
- IYCF programme
  - Strengthen current activities e.g. BFHI
  - Capacity building on complementary feeding and growth monitoring
- Seek assistance with possible micronutrient supplementation
- Strengthen School nutrition programme
- Strengthen promotion of healthy eating
- Salt reduction programme
- Conduct DHS 2014

Thank you for your attention
Double Burden of Malnutrition

SOLOMON ISLANDS

Current Nutrition Situation - Solomon Islands

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Stunting : 32.8% under 5 yrs, severely 8.5%</td>
<td>Overweight : 67.8% of adults</td>
</tr>
<tr>
<td>Wasting: 4.3%, severely 2%</td>
<td>Obese: 32.8%</td>
</tr>
<tr>
<td>Underweight: 11.8% under 5 yrs, severely 2.4%</td>
<td>High Risk of NCD: 46%</td>
</tr>
</tbody>
</table>
| Anaemic :  • under 5yrs: 48.5%, severely 0.5%  
  (highest in children of 12-17 months of age)  
  • Pregnant women: 60.1%, 44.3% of women  
  15-49 year old are anaemic | Diabetes:13.5% |
| Iodine deficiency: no data | Hypertension: 10.7% |

FEEDING PRACTICES

- Exclusive Breastfeeding Rate: 92.6%
- Continued Breastfeeding Rate: 85.1%
- Complementary feeding (6-23 months): 36.9% met all 3 IYCF practices
Current Nutrition Situation –SI

TARGETS: Through the implementation of the SI National Nutrition & Healthy Lifestyle Plan 2007-2017

1. Reduce prevalence of NCD risk factors by 5%
2. Reduce prevalence of Diabetes and hypertension by 5%
3. Reduce prevalence of Malnutrition in children by 25%
4. Reduce prevalence of iron deficiency anaemia amongst women & children to below 15%
5. Reduce hospital admission rates attributable to diabetes & hypertension by 10%
6. Reduce rate of Diabetes amputation by 20%
7. Reduce cancer mortality by 10%
8. Increase food production to maintain high level of food sufficiency & increase diversification of food produced by 10%
9. Increase coverage of health awareness by 80%

Food System Issues

- What issues exist in the food system that impede consumption of healthy foods?
  - Production: 84% rural population- subsistence agriculture & fisheries.
  - Limited access to planting material & lack of production support systems for traditional staple crops & animals.
  - No subsidies for primary production inputs & limited access to credit facilities at the rural level.
  - No lending to the primary productive sector for either investment or working capital.
  - Marketing: media focus on imported foods only, none on local foods
  - Distribution: imported food items down to community level.
  - Affordability and access: increase prices on local food products and limited livestock; unavailability of animal protein foods.
  - Food preferences: 41% of household income is spent on cereal & cereal products, 10% on bread, compare to 10% on fruits and vegetables. Rural areas spent twice the amount spent by urban areas.
  - Social determinants: low educational background and income
  - Urbanisation: people moving away from gardens (sup sup gardens)
**Actions taken to address**

- Undertaking a review of progress against existing nutrition plans- highlight gaps in action
- Key strategies/ actions taken to address the problem
  - **Pure Food Act (1996) Food Control Act (2010):** mandates iodised salt, fortified flour and bans marketing of BM substitutes
  - **BFHI /MBFHI:** 3 Hospitals achieved BFHI, 1 MBFHI, 2 more ready for assessment, 1 done first training, 4 left to progress. Work to be done in health centres
  - **IYCF:** All Provinces participated (>50 per province) and zone level workshops underway
  - **Helti Kaikai Kit (HKK):** Training other community level workers using participatory nutrition materials (HKK)
  - **Supplementation:** Vitamin A and deworming now integrated into EPI.

**Challenges/Issues encountered**

- **What were/ are the challenges issues encountered in addressing the double burden?**
  - Plans heavily emphasising action around NCD’s - no maternal and child health nutrition plan or taskforce to drive agenda in MC Nutrition
  - Too many plans, too many taskforces (except nutrition) plans not convening anymore
  - Motivation: hard to get traction- need incentive to attend meetings
  - No high level leadership to champion the cause
  - Strong policy but no action.
  - No dissemination of policies beyond the MOH.
  - One DHS survey (2007) and STEPS (2007) no other nutrition data exists
  - Many other competing priorities
  - Only 3 qualified nutrition/dietetics staff in country- no training course
  - No specific implementation plan or roles or responsibilities in National Food Security Policy.
Next steps/Country Plan

- MHMS and WHO review of progress against existing nutrition plans.
- Pick the low-hanging fruit and focus on achieving progress in those. Possibly:
  - More IYCF (roll out Child Health Books)
  - More BFHI
  - Support EHD implement salt iodisation and flour fortification
  - School health- canteen policy, Vitamin A & Deworming, nutrition education
  - Prioritise IEC funding and dissemination to meet demand from communities, churches and schools
DOUBLE BURDEN OF MALNUTRITION
19-21 NOV 2013

VANUATU

BY DR ROSEMARY TAUN-KALTACK

2007 NATIONAL NUTRITION SURVEY
2007 VANUATU MULTIPLE INDICATOR CLUSTER SURVEY

2009 census
Total pop of 232,023
14.2% < 5 years
41% < 15 years
24.8% women of reproductive age
53% 18yrs or above
22.1% adolescents
FOOD SYSTEM ISSUES

Severe food insecurity
Primary sector development currently focused on exploring niche-market production for export rather than on increasing production for domestic consumption
Aggressive marketing of unhealthy food and beverages
unreliable transport infrastructure
energy sources
Food preference
Social inequity
Lack of clean water and sanitation
Lack of accessibility to land in urban areas
Lack of awareness/education
**Vanuatu National Policy and Strategic Plan for Nutrition 2013-2016**

- Improve nutrition issues into the wider government decision making process through partnerships and multisectoral collaborations
- Improve national nutritional status through promoting healthy diets and lifestyles
- Improve delivery of quality services
- Promote and sustain national and household food security

**Vanuatu Plan of Action on Food and Nutrition Security 2013-2025**

- Improve and strengthen leadership and coordination of food security activities
- Strengthen food security information systems, particularly monitoring an evaluation and research capacity
- Empower consumers and mobilise industry partners to make informed decisions
- Enhance the sustainable production, processing, trading, marketing and use of safe and nutritious foods
- Strengthen regulatory frameworks, enforcement and compliance activities and public-private sector collaborations
- Empower consumers and mobilise industry partners to make informed decisions to protect infants and vulnerable populations

---

**Challenges Encountered**

- Leadership and coordination
- Insufficient policy
- Resources
  - Wearing many different hats therefore affecting priority
  - Instability
  - Skills
  - Funding
NEXT STEPS

Vanuatu MoH going through reform

Endorsement
- Vanuatu National Plan of Action on Food and Nutrition Security
- Vanuatu National Policy & Strategic Plan for Nutrition

Vanuatu needs
- Strong leadership
- Partnerships
- Collaborations
- Holistic multisectoral approach
- Political awareness/education
  - Resources
  - Staffing
  - Priorities
Double Burden of Malnutrition

(Vietnam)

Feeding practices (NIN, 2010)

- Early breastfeeding: 62%
- Exclusive breastfeeding in the first 6 months: 19.6%
- Appropriate complementary feeding (6-8 months): 51.7%
Low birth weight

Prevalence of malnutrition among children under 5 year old
General nutrition survey 2009-2010

• 14.2% of under 5 year old children in Vietnam had low serum vitamin A. This prevalence is varied for different ecological areas: from lowest in South-East area (7.9%) to highest in Central Highland (20.9%).

• The Vitamin A capsule coverage rate was 79.5% and 51.4% in children and lactating women after delivery, respectively.

General nutrition survey 2009-2010

• Iron Deficiency Anemia affected 29.2% among children under 5. Prevalence of Iron Anemia in non-pregnant women and pregnant women were 28.8% and about 36.5%, respectively.
Cross-sectional survey in 6 province in North, Central and South in 2011: Prevalence of vitamin D deficiency among primary school children in 6 provinces is 46.6%-58.3%
General nutrition survey 2009-2010

- The percentage of reproductive aged women with low Body Mass Index (BMI < 18.5) was 18%. Meanwhile, the proportion of reproductive aged women with BMI ≥ 25 was 8.2% (overweight and obesity).

Survey in 2005

- The survey in 17,213 adult from 25 to 64 years old in 64 provinces in 2005 showed that the prevalence of overweight and obesity (BMI > 23 kg/m²) is 16.3%, the urban is 32.5% and the rural is 13.8%
High prevalence of high blood pressure status among adult aged 25-64 y old (2005)

Metabolic syndrome in men and female aged 25-64 y old (2005): 13% of Vietnamese adult suffered from Metabolic syndrome
General nutrition survey 2009-2010

- Daily household food consumption has had remarkable changes in comparison with previous time. There has been no significant changes of the average energy intake since 1985 (1925 kcal in 1981 and 1925.4 kcal in 2010) but the proportion of total energy from protein, lipids, carbohydrate has changed. In the energy composition was made up by the ratio of Protein: Lipids: Carbohydrate as following 11.2: 6.2: 82.6 (1983) and 15.9: 17.8: 66.3 (2010). Among children 2-5 years old, food consumption provided an average energy intake of 97% compared to the recommended standard of National Institute of Nutrition (NIN). The total protein intake was 49 gram per day and it provided 17% energy intake of food consumption which met the recommended standard of NIN. Dietary iron intake in children between 24-35 months of age currently meets only 56% of dietary reference intake (DRI).

National Nutrition strategy (2011-2020)

- The prevalence of chronic energy deficiency in reproductive-aged women will be reduced to 15% by 2010 and less than 12% by 2020.
- The rate of low birth weight (infants born less than 2,500g) will be reduced to under 10% prevalence by 2015 and less than 8% by 2020.
- The rate of stunting in children under 5 years old will be reduced to 26% by 2015, and to 23% by 2020.
National Nutrition strategy (2011-2020)

- The prevalence of underweight among children under 5 years old will be reduced to 15% by 2015 and to 12.5% by 2020.
- By 2020, the average height of children under 5 will increase by 1.5 – 2cm in both boys and girls; and height in adolescents by sex will increase by 1-1.5 cm compared with the averages from 2010.
- The prevalence of overweight in children under 5 will be less than 5% in rural areas and less than 10% among urban populations by 2015, and will be maintained at the same rate by 2020.

National Nutrition strategy (2011-2020)

- The prevalence of children under five with low serum vitamin A (<0.7 μmol/L) will be reduced to 10% by 2010 and below 8% by 2020.
- The prevalence of anaemia in pregnant women will be reduced to 28% by 2015 and to 23% by 2020.
- The prevalence of anaemia among children will be reduced to 20% by 2015 and 15% by 2020.
- By 2015, standardised iodized salt (≥20 ppm) will be regularly available throughout the country, with coverage of more than 90% of households. Mean urinary iodine levels in mothers with children under 5 will be between 10-20 mcg/dl, and these concentrations will be maintained by 2020.
National Nutrition strategy (2011-2020)

- The prevalence of overweight and obesity in adults will be controlled to a rate of less than 8% by 2010 and will increase to no more than 12% by 2020.
- The proportion of adults with elevated serum cholesterol (over 5.2 mmol/L) will be less than 28% in 2015 and will remain relatively controlled with less than 30% prevalence in 2020.

National Nutrition strategy (2011-2020)

- The rate of exclusive breast feeding (EBF) for the first 6 months will reach 27% by 2015 and 35% by 2020.
- The proportion of mothers with proper nutrition knowledge and practices when caring for a sick child will reach 75% by 2015 and 85% by 2020.
- The proportion of adolescent females receiving maternal and nutrition education will reach 60% by 2015 and 75% by 2020.
Approaches

- Approaches for policy
- Approaches for developing resources
- Approaches for nutrition advocacy, education and communication
- Technical approaches
- Approaches for science and technology and international cooperation

Challenges/Issues encountered

- Iron supplement and nutrition consulting is covered by health insurance
- Lack of co-operation between the health and agriculture sectors in nutrition and food safety
- Limited capacity of health care worker in nutrition counselling
- There exists disparate inequities between rural and urban health system
- Lack access to quality health and nutrition services of ethnic and other vulnerable groups
Objectives

1) to update country information/data on the double burden of malnutrition and implications for health and development in the Western Pacific Region;

2) to introduce the recent WHO guidelines on nutrition in the context of the double burden of malnutrition, and prioritize implementation of the guidelines based on particular country contexts and;

3) to refine and adapt the draft regional action plan to ensure buy-in from Member States at the Sixty-fifth session of the Regional Committee for the Western Pacific in 2014.
Global perspectives on nutrition

F. Branca
Director, Department of Nutrition for Health and Development
WHO/HQ

Malnutrition: is MDG1 (target 1c) enough?

Source: UN MDG report 2013
162 million children with stunted growth in 2012


51 million wasted children in 2012

496 million non pregnant women and 32 million pregnant women with anemia

Source: Stevens et al. 

---

44 million children are overweight

500 million obese individuals aged 20+ years (2008)

Source: Global status report on noncommunicable diseases 2010. World Health Organization 2011

Leading risk factors for global burden of disease in 1990 and 2010

Goal 1
End extreme poverty and hunger

TARGET
Half, between 1990 and 2015, the proportion of people who suffer from hunger.
Burden of disease attributable to 20 leading risk factors in 2010, as a % of global DALYs

- High blood pressure
- Tobacco smoking, including second-hand smoke
- Alcohol use
- Household air pollution from solid fuels
- Diet low in fruits
- High body mass index
- High blood glucose
- Childhood undernourishment
- Ambient particulate matter pollution
- Physical inactivity and low physical activity
- Diet low in vegetables
- Diet low in nuts and seeds
- Iron deficiency
- Suboptimal breastfeeding
- High total cholesterol
- Diet low in fruits and vegetables
- Diet low in seafood omega-3 fatty acids
- Drug use
- Occupational risks for injury

High BMI accounted for 3.4 M deaths and 3-8% of global DALYs in 2010 Poor diet and physical inactivity 10% of global DALYs

Nutrition in the post 2015 development agenda

- UN High Level Panel (May 2013) : separate goal focused on “ensuring food security and good nutrition” including targets on stunting, wasting and anaemia as well as food security, productivity and waste
- FAO/WFP led Global Thematic Consultations, on Hunger, Food Security and Nutrition : “all forms of malnutrition – including nutrient deficiencies and obesity – should be addressed.”
- 30-member Open Working Group (OWG) and Intergovernmental Committee of Experts on Sustainable Development Financing (ICE) : proposal on Sustainable Development Goals (SDGs) for consideration by the UN General Assembly in September
• **Strategic Objective 1:** Create an enabling political environment, with strong in-country leadership, and a shared space where stakeholders align their activities and take joint responsibility for scaling up nutrition.

• **Strategic Objective 2:** Establish best practices for scaling up proven interventions, including the adoption of effective laws and policies.

• **Strategic Objective 3:** Align actions around high quality and well-costed country plans, with an agreed results framework and mutual accountability.

• **Strategic Objective 4:** Increase resources directed towards coherent aligned approaches.

Forty-one countries and the Indian state of Maharashtra are now in the Movement to Scale Up Nutrition (SUN) network.

---

**United Nations System Network for Scaling Up Nutrition**

- Joint planning and programming
- Joint advocacy and resource mobilization
- Better Together Mechanism
- Capacity development
- Documenting lessons learned and sharing knowledge
- UN support to SUN processes
- Engaged and sustained leadership
- Accountability
NUTRITION FOR GROWTH

Nutrition for growth

Global Nutrition for Growth Compact

- On 8th June, world leaders including SUN countries came together to sign a global compact that will prevent at least 20 million children from being stunted and save at least 1.7 million lives by 2020. The Global Nutrition for Growth Compact was endorsed by 90 stakeholders, including development partners, businesses, scientific and civil society groups. An ambitious set of individual commitments to beat hunger and improve nutrition were made including a $4.15 billion financial commitment.
- The Global Nutrition for Growth Compact outlines bold targets to achieve by 2020, including:
  - Improving the nutrition of 500 million pregnant women and young children;
  - Reducing the number of children under 5 who are stunted by an additional 20 million; and
  - Saving the lives of at least 1.7 million children by preventing stunting, increasing breastfeeding, and improving treatment of severe and acute malnutrition.
In May 2012 the WHA endorsed the Comprehensive Implementation Plan on maternal, infant and young child nutrition
Global nutrition targets endorsed by the WHA in May 2012

1. Reduce and maintain childhood wasting to less than 5%
2. 50% reduction of anaemia in women of reproductive age
3. Increase the rate of exclusive breastfeeding in the first 6 months up to at least 50%
4. No increase on childhood overweight
5. 40% reduction in the number of children under 5 who are stunted

CIP-MIYCN
5 high-priority actions for Member States

ACTION 1: To create a supportive environment for the implementation of comprehensive food and nutrition policies

ACTION 2: To include all required effective health interventions with an impact on nutrition in plans for scaling up

ACTION 3: To stimulate the implementation of non health interventions with an impact on nutrition

ACTION 4: To provide adequate human and financial resources for the implementation of health interventions with an impact on nutrition

ACTION 5: To monitor and evaluate the implementation of policies and programmes
44. With a view to strengthening its contribution to non-communicable disease prevention and control, call upon the private sector, where appropriate, to:

(a) Take measures to implement the WHO set of recommendations to reduce the impact of the marketing of unhealthy foods and non-alcoholic beverages to children, while taking into account existing national legislation and policies;

(b) Consider producing and promoting more food products consistent with a healthy diet, including by reformulating products to provide healthier options that are affordable and accessible and that follow relevant nutrition facts and labelling standards, including information on sugars, salt and fats and, where appropriate, trans-fat content;

(c) Promote and create an enabling environment for healthy behaviours among workers, including by establishing tobacco-free workplaces and safe and healthy working environments through occupational safety and health measures, including, where appropriate, through good corporate practices, workplace wellness programmes and health insurance plans;

(d) Work towards reducing the use of salt in the food industry in order to lower sodium consumption;

(e) Contribute to efforts to improve access and affordability for medicines and technologies in the prevention and control of non-communicable diseases.

---

**Global Monitoring Framework**

9 targets for 2025

- Harmful use of alcohol: 10% reduction
- Physical inactivity: 10% reduction
- Salt/sodium intake: 30% reduction
- Tobacco use: 30% reduction
- Raised blood pressure: 25% reduction
- Non-communicable disease mortality: 25% reduction
- Essential NCD medicines and technologies: 80% coverage
- Drug therapy and counselling: 50% coverage
- Obesity: 0% increase

---

**World Health Organization**
WHO NCD Action Plan 2013-2020
Proposed action for Member States: promoting a healthy diet

- Promote and support exclusive breastfeeding, for the first six months of life, continued breastfeeding, until two years old and beyond and adequate and iron-rich complementary feeding.
- Implement WHO’s set of recommendations on the marketing of foods and non-alcoholic beverages to children, including recommendations for monitoring.
- Develop guidelines, recommendations or policy measures that engage different actors in the food system, such as food producers and processors, and other relevant commercial operators, as well as consumers, to:
  - Reduce the level of salt added to food prepared or processed.
  - Increase availability, affordability and consumption of fruits and vegetables.
  - Reduce saturated fatty acids in food and reduce awareness among fatty acids.
  - Reduce trans fats in food.
  - Reduce the content of free and added sugars in food and non-alcoholic beverages.
  - Link taxes and subsidies to reduce portion size and fat content of foods.
- Develop policy measures that reduce food waste and control the portion sizes of meals and household portions.
- Promote the nutrition and availability of healthy foods in all public institutions, including schools, other educational institutions and workplaces.
- As appropriate to national context, consider economic tools that are justified by evidence, and may include taxes and subsidies, that create incentives for healthy diets and discourage consumption of unhealthy food products and discourage the consumption of less healthy products.
- Develop policy measures to cooperate with the agricultural sector to reinforce the measures directed at food processors, retailers, consumers and public institutions, and provide greater opportunities for U.S. Elevation of healthy agricultural products and teams.

WHO evidence-informed guideline development process

1. SETTING UP OF WHO STEERING GROUP AND TEAM FOR THE GUIDELINE
2. SETTING UP OF GUIDELINE DEVELOPMENT GROUP AND A TECHNICAL REVIEW GROUP
3. MANAGEMENT OR COMPLETION OF GUIDELINE
4. FORMULATION OF THE QUESTIONS SPECIFIC AND CHOOSE OF THE RELEVANT GUIDELINES
5. EXECUTIVE DECISION OF DEVELOPMENT AND SYNTHESIS OF GUIDELINES
6. FORMULATION OF THE RECOMMENDATIONS GUIDE, INCLUDING PROPOSAL AND IDENTIFICATION OF BENEFITS AND HARMs VALUE-AND-BASED DECISIONS
7. EXECUTION OF IMPLEMENTATION GUIDELINE
8. EXECUTION
9. PLAN FOR UPDATES

WHO Handbook - Guideline Development

Evidence & Programme Guidance
Department of Nutrition for Health and Development
WHO Nutrition Guideline Development Process

WHO Guideline Steering Committee
- WHO Departments Directors or alternate appointee

Guideline Development Group
- geographic representation
- multi-disciplinary
- gender-balanced
- un-conflicted as possible
- 20-25 members overall

External Experts and Stakeholders Panel
- open documented process
- WHO Microsites/Mailing List
- SCN Mailing List
- WHO Nutrition Website

Formulation of the questions (PICO) and choice of the relevant outcomes

- PICO-drafted by WHO Secretariat
  - Population
  - Intervention
  - Control
  - Outcome

- Call for comments
  - 2-3 weeks for comments
  - Publish WHO's response/action to each comment
  - Discuss comments with the guideline development group

Subscription form for the call for public comments on WHO evidence-informed guidelines on micronutrient interventions

Evidence & Programme Guidance
Department of Nutrition for Health and Development
Evidence retrieval, assessment and synthesis
[systematic review(s)]

WHO has followed four approaches to retrieve, assess and synthesise the evidence:

1. Use of existing systematic reviews, and contact authors if not current
2. Build on the systematic reviews developed by other groups
3. Commission "tailored" systematic reviews
4. Lead review teams to undertake the systematic reviews

Systematic reviews on micronutrient interventions

Intermittent iron supplementation for improving nutrition and development in children under 12 years of age (Review)
Intermittent iron supplementation for reducing anemia and its associated impairments in menstruating women (Review)

THE COCHRANE COLLABORATION®

Evidence & Programme Guidance
Department of Nutrition for Health and Development

World Health Organization
## Current clinical trials in the WHO International Clinical Trials Registry Platform

<table>
<thead>
<tr>
<th>Trial</th>
<th>Date Registered</th>
<th>Date Recruiting</th>
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<tbody>
<tr>
<td>Failing dromedary tests with directed rivaroxaban or extended-release aspirin in patients with recurrent or recurrent-to-relapsed meningococcal disease (Meningo-Meningococcal Disease)</td>
<td>Not recruiting</td>
<td>05/03/2010</td>
</tr>
<tr>
<td>Educational intervention with peer-led and non-peer-led counseling on hygiene and antibiotic prescribing (Hygiene and Antibiotic Prescribing)</td>
<td>Not recruiting</td>
<td>15/09/2010</td>
</tr>
<tr>
<td>Early Childhood Development: Linking successful interventions and the transitions to adulthood</td>
<td>Not recruiting</td>
<td>26/02/2010</td>
</tr>
<tr>
<td>Microcephaly Syndromes in a Chorionic Plateau</td>
<td>Recruiting</td>
<td>15/12/2009</td>
</tr>
<tr>
<td>Community management and rural institutionalisation in carepathy for children in rural Côte d'Ivoire through an institutional carepathy and a community education program in the community</td>
<td>Not recruiting</td>
<td>27/06/2008</td>
</tr>
<tr>
<td>Safety and Administration of Zakirah, a drug for children with Pneumonia</td>
<td>Not recruiting</td>
<td>02/02/2008</td>
</tr>
<tr>
<td>Use and use evaluation in neonatal services</td>
<td>Not recruiting</td>
<td>24/10/2006</td>
</tr>
</tbody>
</table>

The grading of recommendations assessment, development and evaluation approach

- Clear separation of the two issues:
  - Quality of the evidence (high, moderate, low, very low)
    - Methodological quality of evidence
    - Likelihood of bias
    - By outcome
  - Ideally, people who grade evidence should have available to them systematic reviews of the evidence regarding the benefits and risks of the alternative management strategies they are considering.
  - Better research gives better confidence in the evidence (and the following decisions)
The Grading of Recommendations Assessment, Development and Evaluation approach

2) Two grades of recommendation: strong or conditional (for or against)
   - Quality of evidence only one factor
   - Evidence alone is never sufficient to make a clinical or public health decision

---

The quality of the evidence
The extent to which one can be confident that an estimate of effect or association is correct.

<table>
<thead>
<tr>
<th>Grade</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>Further research is very unlikely to change our confidence in the estimate of effect</td>
</tr>
<tr>
<td>Moderate</td>
<td>Further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate.</td>
</tr>
<tr>
<td>Low</td>
<td>Further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate</td>
</tr>
<tr>
<td>Very low</td>
<td>Any estimate of effect is very uncertain</td>
</tr>
</tbody>
</table>
Guideline: Intermittent iron supplementation in preschool and school-age children

<table>
<thead>
<tr>
<th>Supplementation in preschool and school-age children</th>
<th>Preschool-age children (2-5 years)</th>
<th>School-age children (6-12 years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target group</td>
<td>15 mg of elemental iron</td>
<td>45 mg of elemental iron</td>
</tr>
<tr>
<td>Supplement form</td>
<td>Drops/capsules</td>
<td>Tablets/capsules</td>
</tr>
<tr>
<td>Frequency</td>
<td>One supplement per week</td>
<td></td>
</tr>
<tr>
<td>Duration and time of administration</td>
<td>2 months of supplementation followed by 3 months of no supplementation after which the provision of supplements should restart</td>
<td></td>
</tr>
<tr>
<td>Settings</td>
<td>Where the prevalence of anaemia in preschool or school-age children is 20% or higher</td>
<td></td>
</tr>
</tbody>
</table>

* (strong recommendation)
WHO guidelines on nutrition

1. Acceptable medical reasons for use of breast-milk substitutes, 2009
2. Baby-Friendly Hospital Initiative, (Revised, updated and expanded for Integrated care, 2009
3. Guideline: Daily iron and folic acid supplementation to menstruating women 2013
4. Guideline: Intermittent iron and folic acid supplementation to menstruating women 2011
5. Guideline: Intermittent iron and folic acid supplementation to non-menstruating pregnant women 2012
9. Guideline: Use of multiple micronutrient powders for home fortification of foods consumed by pregnant women 2011
10. Guideline: Vitamin A supplementation during pregnancy for reducing the risk of maternal-to-child transmission of HIV 2011
11. Guideline: Vitamin A supplementation for infants 1-5 months of age 2011
15. Guidelines for an integrated approach to multiple-case of HIV-infected children (6 months-5 years) (Preliminary version for country introduction) 2009
16. Guidelines on HIV and infant feeding 2010 (Principles and recommendations for infant feeding in the context of HIV and a summary of evidence) 2010
17. Infant and young child feeding: Module 1: for textbooks for medical students and allied health professionals 2009
18. Potassium Intake for adults and children, 2012
20. Sodium intake for adults and children, 2012
21. Weekly Iron, Folic Acid, and Zinc Supplementation (BIWAS) in women of reproductive age: its role in promoting optimal maternal and child health 2009

e-Library of Evidence for Nutrition Actions (eLENA)

New nutrition actions

As part of eLENA’s expanding catalogue of nutrition actions, the latest guidance is now included on four new topics. If you would like to suggest a new topic to be included in eLENA, please contact us at elena@who.int.

- Micronutrient supplementation in children with severe acute malnutrition
- Insecticide-treated nets to prevent malaria and anaemia in pregnant women
- Nutrition care for adults with acute tuberculosis
- Optimal timing of cord clamping for the prevention of iron deficiency anaemia in infants

New in eLENA
New nutrition actions
New guidelines on intermittent iron supplementation in preschool and school-age children
New Cochrane review on vitamin D supplementation during pregnancy
Global database on the Implementation of Nutrition Actions

- collect key data on nutrition policy and action in a standard format
- visualize what's happening where, when with whom and how
- compare policy commitments with implemented action
- maps actions and policies against nutrition indicators

The Global database on the Implementation of Nutrition Action (GINA) is an interactive platform for sharing standardized information on nutrition policies and actions, i.e. what are the commitments made and who is doing what, where, when, why and how (including lessons learnt). More about GINA

Select policies and/or action

1000 policy documents
2000 action reports

Choose your theme of interest

Time slider to see evolution
Adaptation and implementation

- Evidence-informed guidance and prescription of nutritional provisions at the global level are a fundamental step to address the nutritional burden of disease, but are not enough.

- Each country presents unique cultural, economic, and social characteristics that will affect the capacity to deliver and manage services to the population.

Evidence-informed policy network

- Promote systematic use of evidence in policy-making in low and middle-income countries.

- Promotes partnerships at country level between policy-makers, researchers and civil society to facilitate policy development and implementation through use of the best scientific evidence available.
Additional information

- [www.who.int/nutrition](http://www.who.int/nutrition)
- [www.who.int/vmnis](http://www.who.int/vmnis)
- [www.who.int/elena](http://www.who.int/elena)
The Nutrition Situation in the Western Pacific Region

Manila, November 19, 2013
Dr Urban Jonsson
Stunting in the Western Pacific region

Stunting Prevalence (%) of children under five in the Western Pacific Region, 2012

The boundaries and names shown and the designations used on this map do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. This map does not purport to show claims to jurisdiction over any area.
COUNTRIES AND AREAS OF THE WHO WESTERN PACIFIC REGION

Vietnam stunting prevalence by province

- >30%
- 20 to <30%
- <20%
Underweight disparities in the Western Pacific Region:
Urban vs. Rural

Underweight disparities: Poorest vs. Richest quintile in the Western Pacific Region
Overweight in the Western Pacific Region

- Infant and Young Child Malnutrition
- Child overweight
- Adult overweight
- Adult NCDs
### SUB-REGIONAL OVERWEIGHT SITUATION

<table>
<thead>
<tr>
<th>Countries</th>
<th>Prevalence Child Overweight (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>China</td>
<td>6.6</td>
</tr>
<tr>
<td>East Asia*</td>
<td>1.5-5</td>
</tr>
<tr>
<td>Pacific**</td>
<td>2.5-6.5</td>
</tr>
<tr>
<td>Singapore</td>
<td>2.6</td>
</tr>
<tr>
<td>WPR</td>
<td>5</td>
</tr>
</tbody>
</table>

* 4 countries, ** 5 countries

Joint child malnutrition estimates (UNICEF-WHO-WF) 1990-2012

---

### Micronutrient Malnutrition
Prevalence (%) of anaemia in preschool age children in the Western Pacific Region

WPR: 23.%

Prevalence of anaemia in non-pregnant women of reproductive age in the Western Pacific Region

WPR: 21.5%
Vitamin a deficiency in pre-school age children in the Western Pacific Region

WPR: 13%

Vitamin a deficiency in pregnant women in the Western Pacific Region

WPR: 22%
Causes of Malnutrition

Causality Framework

Child Malnutrition

INADEQUATE DIETARY INTAKE

DISEASE

FOOD
CARE
HEALTH
Average Dietary Energy Supply Adequacy (%) in the Western Pacific Region
Prevalence (%) of Food inadequacy in the Western Pacific Region

HEALTH
Under 5 children (%) with diarrhea received ORT treatment in the Western Pacific Region

Measles Immunization Coverage (%) in the Western Pacific Region (2011)
CARE
ADEQUATE CHILD CARING PRACTICES

- Feeding practices
- Health seeking behaviour
- Hygiene practices
- Psycho-social stimulation

Feeding Practices

1. **Breastfeeding practices**
   - Early initiation of breastfeeding within the first hour of life
   - Exclusive breastfeeding (0-6 months)
   - Continued breastfeeding (until 2 years or beyond)

2. **Complementary feeding practices**
   - Feeding frequency
   - Energy density of the complementary diet
Continued breastfeeding rates (% up to two years in the Western Pacific Region)

International Code of Marketing of Breast-milk Substitutes

World Health Organization
Geneva
SOME CONCLUSIONS

Conclusion

1. The Western Pacific Region has made spectacular improvement in young child nutrition during the last 25 years
Conclusion

2. Malnutrition is caused by processes in many different sectors and at different levels of society, which requires simultaneous and well coordinated actions by different ministries and other institutions in a country

Conclusion

3. Poverty is a basic cause of young child malnutrition. Sustainable and sustained good nutritional status of young children therefore often requires a significant reduction of the poverty level
Conclusion

4. The new awareness of the impact of young child malnutrition on overweight and obesity contributing to a rise in noncommunicable diseases in adults is an additional great challenge (double burden of malnutrition)

Conclusion

5. Although the level of malnutrition varies among the countries, the causes of the problems are often the same. This makes regional planning and cooperation very useful in exchanging experiences for solving the problem of malnutrition in all countries
THANK YOU!
Advancing Health Promoting Food Systems

WPRO Consultation

November 19-21, 2013

Jane Dixon
National Centre for Epidemiology & Population Health

The food system & food security

3 pathways to ‘good nutrition’

1. The food supply – availability and accessibility
2. Affordability – food prices and household incomes
3. Food preferences/Acceptability – cultural system

Food system works synergistically with the social protection/livelihoods and cultural systems
The underlying issues

- A complex and uneven nutrition transition promotes good health and disease, making it difficult to determine global policy prescriptions
- Governments have ceded responsibility for regulating the nutrition transition
- A focus on increasing food yields rather than eliminating food waste to increase food stocks has side-lined environmental considerations, undermining the sustainability of food systems
- A focus on cheap food: encourages processed food consumption and creates farmer livelihood problems
- Food insecurity is linked to human insecurity, social protection & national development
- The climate change challenge

Human insecurity, social protection & food security

Malnutrition is closely linked to the standard of living, the environmental conditions, and whether a population is able to meet its basic needs such as food, housing and health care. Malnutrition is thus a health outcome as well as a risk factor (Kickbush 2010, p. 19)

The right to social protection is deeply linked to the right to adequate food (De Schutter and Sepulveda 2012, p. 6).

Social policies are important: poverty elimination
- Countries that have high food insecurity commonly have poor infrastructure, low levels of education and skills, limited investment in agriculture

- In turn, food insecurity contributes to famine, civil unrest, warfare, degradation of land, and protectionist trade policies

Heat waves, fewer cold waves, floods, fires

Pests, irrigation shortfalls, water pollution, soil erosion, mangrove destruction, food price spikes

Famine, conflict, population displacement, refugees

Butler, C. 2013
Mean BMI Increases compared with average

- Increasing relative cost of fruit and vegetable

Adapted from Sturm & Dibner 2005.

Affluent country diets are not sustainable

- Meat, dairy and pre-prepared foods sectors are high energy and water users
- The 3 sectors contribute disproportionately to GHG emissions; and meat and dairy contribute to degraded biophysical environments
- Globally, ag sector = 22% of total GHGs
  - Livestock production (due to methane and nitrous oxide) and fossil-fuel- powered transport = 80% of above
  - Low-intensity livestock production = 60% of above
Because of the complex inputs into food and nutrition systems, food systems provide an opportunity to mitigate or amplify the risks posed by finite water, non-renewable energy, fertiliser, health, education, and fiscal resources. These resource limitations are at the root of most human conflict. Therefore, greater emphasis on an ecological approach to food security should go some way to improve human security at-large while being attentive to planetary health (Waihquist et al., 2012).

in many cases, the best choices for health are also the best choices for the planet; and the most ethical and environmental choices are also good for health (Kickbush 2010, p.7)
Food & nutrition security: multiple drivers & multiple building blocks

Nutrition, bio-sensitive food systems

Government monitoring of good practices, compliance checks, resource allocation
Population health policies

Food and nutrition security as an output and input

Equitable social development

Human development and security

Civil society activism to advance food security

Promote and advocate the following principles

- The promotion of a more sustainable, healthier and more equitable food system is a primary health goal (Kickbush 2010, p.14)
- The right to [nutritious] food advances the right to health, and is a fundamental input to national and human development
- Access to nutritious food is a key dimension of human security, while human security underpins nutrition security
- International and national food policies must immediately begin to address the environmentally unsustainable production as well as the environmentally unsustainable consumption of food
- National food sovereignty – in the form of government scrutiny of free trade agreements, land and sea leasing, private equity schemes and foreign investment in food companies, control of food advertising - should take precedence over free trade as administered under current WTO rules
- An approach to feeding the world equitably will require major changes at all levels of governance and a reorientation of many international organizations and programmes (Kickbush 2010, p. 25)
Leadership by the WHO

The WHO position on development, as part of the Post 2015 Development process (2012):

- Health is central to development: it is a precondition for, as well as an indicator and outcome of, progress in sustainable development

The Vienna Declaration on Nutrition and Noncommunicable Diseases in the Context of Health 2020, WHO Regional Office of Europe 2013

- Recommends that investing in diet-related ND prevention and control will support a country's human capital and its economy

WPRO: this meeting

- The RAP
<table>
<thead>
<tr>
<th>Proposed next step(s)</th>
<th>Who is responsible? (Lead)</th>
<th>Who else can contribute? (partners, other actors?)</th>
<th>What is expected?</th>
<th>Timeframe to see some results</th>
<th>What resources are available?</th>
</tr>
</thead>
</table>
| 1. Maternal, Infant and Young Child Nutrition (MIYCN)  
• To review draft National Strategy for MIYCN for Brunei Darussalam (2013-2017) and align, integrate with the objectives and “Actions” identified in draft RAP – on Reducing Double Burden of Malnutrition in the WPRO (2014-2020) | Maternal, Infant & Young Child Nutrition Task Force (MoH) | e.g. Legislation of Code of Marketing of BMS Partners: Prime Minister → Atty General Chambers; → media cabinet General media For both will involve interactions with other non-health sectors when necessary | • MIYCN is strong in Brunei Darussalam  
• Improvement in rates of Exclusive BF + Continuous BF  
• Appropriate CF practices specifically nutrient quality  
• Obesity pandemic controlled  
• Improvements in rates of under-nutrition (e.g. stunting, anaemia among pregnant mothers) | e.g. Legislation of Code on BMS → six years  
To review draft National Strategy on MIYCN → six months  
To implement priority action areas of Nutrition in BruMAP-NCD → 5 years – in stages | • Budget → to request from MoH → MoF  
• Institute Health Science, UBD – assist in research/surveys  
• Currently: 31 dietitians and or nutritionists in Brunei (MoH+1 private hospital)  
• Manpower increase → requires additional budget |
| 2. NCD Prevention & Control  
• To implement priority action areas in nutrition identified in BruMAP-NCD | National NCD Prevention & Control Committee (MoH) | | | | |

Objective 2 (of
<table>
<thead>
<tr>
<th>BruMAP-NCD: To Promote Balanced and Healthy Diet</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommended Actions for Ministry of Health</td>
</tr>
<tr>
<td>1) To ensure compliance to the National Dietary Guidelines.</td>
</tr>
<tr>
<td>2) To develop and implement policies that limit salt, sugar and saturated fat and eliminate partially hydrogenated vegetable oil (PHVO) in processed foods.</td>
</tr>
<tr>
<td>3) To develop and implement policies to reduce the impact of marketing of food and non-alcoholic beverages high in sugar, salt and fat to children.</td>
</tr>
<tr>
<td>4) To develop and implement mandatory food labelling for all domestic and imported food products including a consumer-friendly</td>
</tr>
</tbody>
</table>
labelling to identify healthier food products.
5) To ensure healthier dietary options in schools, workplaces and where children gather.
6) To conduct sustained mass media campaigns to increase consumption of fruits and vegetables.
7) To develop and implement guidance to interact with food industry for implementing policies

WHO support requested:

1. High-level advocacy e.g. Legislation Code on BMS

2. To assist in a more detailed, comprehensive infant & young child feeding survey
<table>
<thead>
<tr>
<th>Proposed next step(s)</th>
<th>Who is responsible? (Lead)</th>
<th>Who else can contribute? (partners, other actors?)</th>
<th>What is expected?</th>
<th>Timeframe to see some results</th>
<th>What resources are available?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Coordination and the policy oversight for FSR</td>
<td>CARD</td>
<td>MOH, MAFF, MOLRAM, MoEYs, MOP, FAO, WHO, UNICEF, USAID, WFP, HKI, RACHA</td>
<td>Better coordination, mobilize resources</td>
<td>2016-2018</td>
<td>Human resources lack of financial support</td>
</tr>
<tr>
<td>2. Capacity building at national and sub-national</td>
<td>CARD, MOH</td>
<td>FAO, HSSP2, WHO, UNICEF, UN, NGOs and local authority</td>
<td>Better knowledge and skills is improve for stakeholders</td>
<td>2016-2018</td>
<td>Human resources lack of financial support</td>
</tr>
<tr>
<td>3. Knowledge and information management on FSN</td>
<td>CARD</td>
<td>Relevant ministries and partners</td>
<td>Information and knowledge on FSN updating and sharing</td>
<td>Quarterly report</td>
<td></td>
</tr>
<tr>
<td>4. Develop national nutrition action plan with costing</td>
<td>MOH, CARD</td>
<td>Relevant stakeholders</td>
<td></td>
<td>2014-2020</td>
<td>NO</td>
</tr>
<tr>
<td>5. Develop and provide pre-service training in nutrition to include IYCF and nutrition topic in medical, nursing and midwifery curriculum.</td>
<td>MOH</td>
<td>University, UNICEF, WHO</td>
<td>Skilled nutrition professional available in Cambodia</td>
<td>Start of 2016</td>
<td></td>
</tr>
<tr>
<td>6. To design a community-based nutrition programme</td>
<td>MOH, CARD</td>
<td>Local authorities, DPs, NOGs, line ministries</td>
<td>Community-based nutrition programme are available in Cambodia with sufficient fund</td>
<td></td>
<td>NO</td>
</tr>
<tr>
<td>7. Develop the National</td>
<td>MOH</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Guidelines on Maternal nutrition</td>
<td></td>
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<tr>
<td>--------------------------------</td>
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</tr>
</tbody>
</table>

WHO Support requested:

- Support TA and financial support on development of Nutrition Action Plan and Capacity Building on Nutrition
**COUNTRY:** CHINA

<table>
<thead>
<tr>
<th>Proposed next step(s)</th>
<th>Who is responsible? (Lead)</th>
<th>Who else can contribute? (partners, other actors?)</th>
<th>What is expected?</th>
<th>Timeframe to see some results</th>
<th>What resources are available?</th>
</tr>
</thead>
</table>

**WHO Support requested:**

- Technical support and funding on evidence-based regulation policy, guidelines, intervention development and programme

- Sharing best practices

- Playing a coordination role on food system and nutrition improvement at international levels
### Proposed next step(s)

<table>
<thead>
<tr>
<th>Proposed next step(s)</th>
<th>Who is responsible? (Lead)</th>
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<th>What is expected?</th>
<th>Timeframe to see some results</th>
<th>What resources are available?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Enforcement on Food Control Act</td>
<td>DHSA Food Safety Unit</td>
<td>Dept. of Justice Chamber of Commerce</td>
<td>Marketing of healthier food supply</td>
<td>2014</td>
<td>Existing Legislation Staff</td>
</tr>
<tr>
<td>2. Review and update current BF and IYCF protocols/guidelines</td>
<td>Family Health Healthy Lifestyle Unit DHS</td>
<td>Nutrition Extension Programme (College) NGO's (Women's group ) Agriculture Education</td>
<td>BF Coverage childhood obesity</td>
<td>2014</td>
<td>Existing guidelines HR Staff</td>
</tr>
</tbody>
</table>

**WHO Support requested:**

- Technical support
- Funding

*Finalize NCD plan and review nutrition component of it.*
<table>
<thead>
<tr>
<th>Proposed next step(s)</th>
<th>Who is responsible? (Lead)</th>
<th>Who else can contribute? (partners, other actors?)</th>
<th>What is expected?</th>
<th>Timeframe to see some results</th>
<th>What resources are available?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Breastfeeding</td>
<td>National Advisor Family Health</td>
<td>UNICEF</td>
<td>Strengthen BFHI</td>
<td>2014</td>
<td>BFHI Budgetary allocations</td>
</tr>
<tr>
<td>2. Legislation Enforcement</td>
<td>Food Unit</td>
<td>WHO</td>
<td>Passing legislation on banning of high salt, sugar, fatty foods</td>
<td>2014</td>
<td>Food Unit budget</td>
</tr>
<tr>
<td>3. Legislation on Marketing of Foods high in salt, sugar and fats</td>
<td>N.A.- NCD</td>
<td>WHO</td>
<td>Total ban on marketing of foods high in salt, sugar and fats</td>
<td>2014</td>
<td>NCD budget</td>
</tr>
</tbody>
</table>

WHO Support requested:

Funding and technical assistance.
<table>
<thead>
<tr>
<th>Proposed next step(s)</th>
<th>Who is responsible? (Lead)</th>
<th>Who else can contribute? (partners, other actors?)</th>
<th>What is expected?</th>
<th>Timeframe to see some results</th>
<th>What resources are available?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Update of National Plan toward policy coherence</td>
<td>MOHW</td>
<td>Other ministries &amp; stakeholders</td>
<td>Policy coherence</td>
<td>Amend legislation</td>
<td>Laws: NHPA, NNMA</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Operate TF</td>
<td>Health promotion committees</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Health Promotion Fund</td>
</tr>
<tr>
<td>Integration of nutrition in public health initiatives</td>
<td>MOHW</td>
<td>Health professional societies Local governments</td>
<td>Cost effective</td>
<td>Building working group</td>
<td>Sufficient health professionals</td>
</tr>
<tr>
<td></td>
<td>MOSPA</td>
<td></td>
<td>Strengthen the public health care delivery</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

WHO support requested:

- Facilitate policy dialogue with other ministries
<table>
<thead>
<tr>
<th>Proposed next step(s)</th>
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<th>What is expected?</th>
<th>Timeframe to see some results</th>
<th>What resources are available?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. LAW - Develop new NUT law With focus on BF Promotion, Protection and Support Update 100 degree</td>
<td>DHHP, MOH NUT Center</td>
<td>Ministry of Justice Prime Minister Office Curative Department, MOA, MOE, UNICEF, WHO, WFP, FAO, Relevant NGOs (NNC)</td>
<td>To improve NUT management as well as quality control, To improve NUT status for population</td>
<td>End of 2015 with NUT Law End of 2015 with BF Code 2015 get IDD</td>
<td>- support consultant - Government budget - UN's budget</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What resources are available?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>Resource person and fund investment</td>
</tr>
<tr>
<td>3 CAPACITY BUILDING</td>
<td></td>
</tr>
<tr>
<td>---------------------</td>
<td></td>
</tr>
<tr>
<td>- Building capacities around interventions (Refer Act N-2)</td>
<td></td>
</tr>
<tr>
<td>- Establish masters on NUT training</td>
<td></td>
</tr>
<tr>
<td>MOH + Schools + University + Health Facility</td>
<td></td>
</tr>
<tr>
<td>MOE, MOA, Mass Media, UN &amp; NGOs who implement NUT</td>
<td></td>
</tr>
<tr>
<td>↑ Number of resource person</td>
<td></td>
</tr>
<tr>
<td>↑ service quality</td>
<td></td>
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<tr>
<td>↓ MMR, IMR</td>
<td></td>
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<tr>
<td>2015</td>
<td></td>
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<tr>
<td>Need more resource persons</td>
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<table>
<thead>
<tr>
<th>4. COORDINATION</th>
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</thead>
<tbody>
<tr>
<td>Establish multisectoral coordination mechanism</td>
</tr>
<tr>
<td>NNC</td>
</tr>
<tr>
<td>UN + NGOs Related Ministry</td>
</tr>
<tr>
<td>↑ coordination</td>
</tr>
<tr>
<td>Comprehensive integrated implementation plan</td>
</tr>
<tr>
<td>2014</td>
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<td>2014</td>
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<tr>
<td>HR and Budget</td>
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WHO Support requested:
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<tr>
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<tbody>
<tr>
<td>Revised and adopted national BMS code</td>
<td>Ministry of Health</td>
<td>Other ministries (Ministry of Industry and Agriculture, Ministry of Education, Ministry of Social Welfare, NGOs)</td>
<td>Most of Nutrition services and supplies covered by public funding or HP funding</td>
<td></td>
<td>Government, WHO, UNICEF, World Vision, Other stakeholders, Private companies</td>
</tr>
<tr>
<td>Developed 2nd NPA on NCD prevention and control (include child nutrition indicators)</td>
<td></td>
<td></td>
<td>US Stunting reduce by 9-7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revise standards (labelling, food fortification, high level of fat, sugar in processed food e.g.)</td>
<td></td>
<td></td>
<td>US OW and Ob rate below 8%</td>
<td></td>
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<tr>
<td>Developed national plan on nutrition in emergencies</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Taxation in unhealthy food?</td>
<td>Nutrition policy and activities coherence with other sectors</td>
<td>No increase adult OW and Ob</td>
<td></td>
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</tr>
<tr>
<td>1. Finalize and submit National Nutrition Policy for endorsement and finalize Nutrition Strategic Action Plan (2014-2023) and the Baby Supplies Control Act</td>
<td>National Department of Health</td>
<td>Department of Agriculture and Livestock; Department of Education; Depart of Comm Development, NGOs, UPNG Development Partners Dept. of Attorney General</td>
<td>Present draft to stakeholders and NNP is endorsed and passed by NEC</td>
<td>3 months</td>
<td>Funds/Tech Assistance</td>
</tr>
<tr>
<td>2. Training of IYCF and Child Growth Assessment (combined course)</td>
<td>National Department of Health</td>
<td>Peadiatric Society NGOs</td>
<td>All health workers in disadvantage regions are trained</td>
<td>1 year</td>
<td>Funds</td>
</tr>
<tr>
<td>3. To advocate for in-country nutrition and dietetic training and secure funding</td>
<td>NDOH</td>
<td>UPNG/Divine Word University</td>
<td>To secure funding to commence the training in 2015</td>
<td>6 months</td>
<td>Training institutions</td>
</tr>
<tr>
<td>4. Baby Friendly Hospital Initiative - Accreditation of provincial hospitals</td>
<td>NDOH</td>
<td>Paediatric Society OBs and Gynecologists Societies NGOs</td>
<td>Training completed and to see 10 hospitals accreditation</td>
<td>1 year</td>
<td></td>
</tr>
</tbody>
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WHO Support requested: Funding and technical assistance
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<tr>
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</table>
| 1. Conduct a study to determine common causal pathway of the double burden of malnutrition (research) | NNC-DOH                   | -Professional medical societies  
- Food and nutrition research institute  
- Nutrition experts  
- NCD coalition | Common causative factor to DB identified as basis for policy and programme formulation | 2014                         | Coordinating structure Research institutions |
| 2. Mid-term review of the Philippine Plan of Action for Nutrition, 2011-2016          | NNC                       | Different sectors - agriculture, trade, health, NCD Coalition | Updated PPAN with consideration of interventions to address the double burden of malnutrition | 2014                         | Existing funds |
| 3. Improve nutrition – Cluster response to emergencies including capacity building, addressing severe acute malnutrition | NNC, DOH                  | Members of the nutrition cluster, local governments | Nutrition response in Emergency Plan | 2014                         |                              |
| 4. Signing up for the Scaling up Nutrition Movement                                 | NNC as the overall focal person/group | Various sectors | Generate commitments and resources for scaling-up nutrition interventions and the nutrition - sensitive interventions |                              |                              |

WHO Support requested:

- Provide technical support and facilitate policy dialogue on DB as input to 1 and 2 actions.
COUNTRY: Samoa

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<tr>
<td>1. Advocate for collecting data on children's nutrition status, anaemia, and Vit. A deficiency as part of 2014 DTFS</td>
<td>Nutrition Section</td>
<td>MOH Planning, Policy, and Research Division Bureau of Statistics</td>
<td>Recent data on stunting, anaemia and Vitamin A</td>
<td>2014</td>
<td>DHS taking place. Possible UNICEF assistance. Need technical advice and funding to include nutrition data collection.</td>
</tr>
<tr>
<td>2. Finalize and enact Regulations on Marketing Infant feeding products, fortified foods, labelling</td>
<td>Nutrition section Food Safety section</td>
<td>MOH Lawyers AG's office</td>
<td>Regulations in place</td>
<td>2013</td>
<td>Draft regulations</td>
</tr>
<tr>
<td>3. Identify strategies to address iodine deficiency</td>
<td>Nutrition section</td>
<td>OBY-GYN doctors</td>
<td>Identified actions for implementation</td>
<td>2016</td>
<td>Data showing iodine deficiency</td>
</tr>
<tr>
<td>4. Identify options to control high fat, salt, and sugar in the diet</td>
<td>Nutrition section</td>
<td>Ministry of Foreign Affairs and Trade</td>
<td>Policy options for consideration</td>
<td>2015</td>
<td>WTO Commitment to be implemented</td>
</tr>
</tbody>
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WHO Support requested:

- Technical advice and funding

- Technical advice on regulations and funding for consultations with stakeholders
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<tr>
<td>2. Roll out new baby books</td>
<td>Nutrition and Food Security Unit</td>
<td>Procurement Unit, WHO, AusAID, UNICEF</td>
<td>New baby books are printed and distributed to all provinces</td>
<td>6 months (2014)</td>
<td>SIG Pool of trainers</td>
</tr>
<tr>
<td>3. Ensure all hospitals are accredited BFHI/MBFHI</td>
<td>RCHD</td>
<td>Nutrition and Food Security Unit, Community Support Groups UNICEF</td>
<td>Remaining 6 hospitals are accredited</td>
<td>2 years (2014-2015)</td>
<td>SIG Pool of trainers External accessors</td>
</tr>
<tr>
<td>4. Ensure Nutritionists and Dieticians in country program</td>
<td>Available at SINU</td>
<td>SINU</td>
<td>Nutrition Unit/ SINU MOE</td>
<td>Programme in place by mid 2014</td>
<td></td>
</tr>
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</table>

WHO Support requested:

- Technical Advisor
- Funding
- Training

Provide a technical background papers.
## Proposed next step(s)

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<tr>
<td>1. Update/review/ finalize and endorse nutrition plan/nutrition security</td>
<td>MOH</td>
<td>WHO/UNICEF Multisectoral</td>
<td>Endorse</td>
<td>6/12</td>
<td>Existing Legislation Staff</td>
</tr>
<tr>
<td>2. Enforce legislation -Employment act</td>
<td>Ministry of Labor</td>
<td>MOH</td>
<td>All pregnant women – maternity leave 3/12</td>
<td>2014</td>
<td>Existing guidelines HR Staff</td>
</tr>
<tr>
<td>3. Get all hospital certified as BFHI</td>
<td>MOH</td>
<td>UNICEF/Government</td>
<td>100% Hospital BFHI certified (6/6) Start on health centres</td>
<td>2014 (end)</td>
<td>Government</td>
</tr>
<tr>
<td>4. New MCH booklets</td>
<td>MOH/VCH Panel</td>
<td>WHO/Government</td>
<td>All hospital pools HC staff trained MCH booklet – more distributed</td>
<td>2014 (end)</td>
<td>MOH, Ministry of Labour Employment act</td>
</tr>
<tr>
<td>5. Taxation on unhealthy food (imported)</td>
<td>MOH</td>
<td>WHO</td>
<td>30-50% tax unhealthy food</td>
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**WHO Support requested:**

- Technical support
- Funding
- Training
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<tr>
<td>1. Meeting on raising the awareness on the double burden of malnutrition to find out way to implement Regional Action Plan - assign a leading/coordinating agency</td>
<td>Ministry of Health (MCH Department call this meeting)</td>
<td>MOH + Legal Department + Food Administration + Health Administration + Health Preventive + Training Scientific Dept. + NIN</td>
<td>Awareness of leaders Coordinate mechanism Assign the focal point</td>
<td>December 2013</td>
<td>No need</td>
</tr>
<tr>
<td>2. Advocacy workshop on the double burden of malnutrition</td>
<td>MOH</td>
<td>MOH, Ministry of Education and Training, Rural, Agriculture Development, Ministry of Finance Int'l organizations NGOs</td>
<td>Awareness Coordination mechanism</td>
<td>June 2014 August</td>
<td>Government UN</td>
</tr>
<tr>
<td>3. Meeting to discuss integrated action plan to reduce the double burden of malnutrition into PEM (National programme on protein energy malnutrition (on tool programme) and NCD programme.</td>
<td>MCH Department (MOH)</td>
<td></td>
<td>Commitment that they will put into their plan</td>
<td>4/2014</td>
<td></td>
</tr>
<tr>
<td>序号</td>
<td>项目描述</td>
<td>推行者</td>
<td>目标</td>
<td>年份</td>
<td>支持来源</td>
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<tr>
<td>5.</td>
<td>开发全国性学校午餐指导方针</td>
<td>NIN</td>
<td>提高儿童营养</td>
<td>2014-2015</td>
<td>政府</td>
</tr>
<tr>
<td>6.</td>
<td>实施学校膳食计划</td>
<td>NIN</td>
<td>帮助学校制定合理膳食菜单并介绍学校午餐</td>
<td>2014-2015</td>
<td>其他来源</td>
</tr>
<tr>
<td>7.</td>
<td>软件开发</td>
<td>NIN</td>
<td>提供开发学校菜单工具</td>
<td>2014</td>
<td>其他来源</td>
</tr>
</tbody>
</table>

支持请求:
- 提供技术建议：报告，基于证据的
- 信函劝说组织会议
- 准备技术背景论文