
Maternal, infant and young child nutrition

Report by the Secretariat

1. The Executive Board at its 138th session considered an earlier version of this report.¹ The Board agreed to further discussions on the draft resolution between the 138th Executive Board and the Sixty-ninth World Health Assembly. Paragraphs 2, 10, 26–30 and 36 of the report have been amended in the light of comments raised and actions following the session.

2. This report describes progress in carrying out the comprehensive implementation plan on maternal, infant and young child nutrition, endorsed by the Health Assembly in resolution WHA65.6 (2012); provides information on the status of national measures to give effect to the International Code of Marketing of Breast-milk Substitutes, adopted in resolution WHA34.22 (1981) and updated through subsequent related Health Assembly resolutions; summarizes progress made in developing, as requested in resolution WHA65.6, risk assessment, disclosure and management tools to safeguard against possible conflicts of interest in policy development and implementation of nutrition programmes. In response to the request of the Board, the Secretariat has revised the draft guidance on ending the inappropriate promotion of foods for infants and young children mentioned in resolution WHA63.23 (2010) on infant and young child nutrition, as requested by the Health Assembly in decision WHA67(9) (2014), taking into account comments made during the discussion at the Board's 138th session and in writing during the following four weeks as well as the outcome of an informal consultation (Geneva, 8 April 2016).²

PROGRESS MADE IN CARRYING OUT THE COMPREHENSIVE IMPLEMENTATION PLAN ON MATERNAL, INFANT AND YOUNG CHILD NUTRITION

3. The following paragraphs describe progress towards the global nutrition targets set out in the comprehensive implementation plan and the steps being taken to put the plan's constituent actions into effect.³ Data in this area are regularly collected by WHO and its partners. For example, country progress is monitored by the target tracking tool that was developed jointly by WHO, UNICEF and the European Commission.⁴ Overall, however, 49% of countries do not have enough nutrition data to determine whether they are on course for meeting the global targets.

¹ See document EB138/8 and the summary record of the Executive Board at its 138th session, twelfth meeting, section 4, (document EB138/2016/REC/2).

² See document A69/7 Add.1.

³ Document WHA65/2012/REC/1, Annex 2.

⁴ See <http://www.who.int/nutrition/trackingtool/> (accessed 6 April 2016).

Progress towards the global targets

4. **Global target 1 (Stunting).** In 1990, the total number of stunted children under 5 years of age worldwide was 255 million. In 2014, that figure was 159 million, of which 57% were living in Asia and 37% in Africa. The downward trend continues. Of the 114 countries for which data are available in 2015, 39 are on course to meet the global target, as compared with 24 in 2014.¹

5. **Global target 2 (Anaemia).** The most recent estimates suggest that the global prevalence of anaemia in 2011 among women of reproductive age was 29%. By applying this percentage to the latest population estimates released by the United Nations, it is estimated that 533 million women of reproductive age were suffering from anaemia in 2011. The highest rates are found in central and west Africa and south Asia.

6. **Global target 3 (Low birth weight).** Global estimates on the prevalence of low birth rate are in preparation and expected to be released in 2016, pending the outcome of methodological work currently being undertaken by a group comprising representatives of UNICEF, the London School of Hygiene and Tropical Medicine, Johns Hopkins University and WHO. For the time being, the global estimate for the period 2005–2010 – that 15% of neonates weighed less than 2.500 kg – remains unchanged.

7. **Global target 4 (Overweight).** Globally, an estimated 41 million children under 5 years of age were overweight in 2014. Although this figure is slightly lower than that of 2013, the overall trend is increasing. There is a high prevalence of overweight among children under 5 years of age in southern Africa (14%), central Asia (11%) and northern Africa (11%).

8. **Global target 5 (Breastfeeding).** Globally, in the period 2007–2014, an estimated 36% of infants under 6 months of age were exclusively breastfed. Based on survey estimates for that period, 33 countries have breastfeeding rates of above 50% and 98 have rates that are below this threshold.

9. **Global target 6 (Wasting).** Globally, an estimated 50 million children under 5 years of age were wasted in 2014 – of which 16 million were severely wasted. Of these wasted children, 68% lived in Asia and 28% in Africa. The region of southern Asia is home to over half of the world's wasted children.

Steps being taken to put the plan's constituent actions into effect

10. **Action 1: To create a supportive environment for the implementation of comprehensive food and nutrition policies.** A major development has been the adoption by the United Nations General Assembly of the 2030 Agenda for Sustainable Development.² The Agenda includes a goal to end hunger, achieve food security and improved nutrition and promote sustainable agriculture. This Goal 2 includes the specific target 2.2: “by 2030 end all forms of malnutrition, including achieving by 2025 the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons”.

¹ International Food Policy Research Institute. Global nutrition report 2015: actions and accountability to advance nutrition and sustainable development. Washington, DC: International Food Policy Research Institute; 2015 (<http://ebrary.ifpri.org/utils/getfile/collection/p15738coll2/id/129443/filename/129654.pdf>, accessed 6 April 2016).

² United Nations General Assembly resolution 70/1. Transforming our world: the 2030 Agenda for Sustainable Development (http://www.un.org/ga/search/view_doc.asp?symbol=A/RES/70/1&Lang=E, accessed 6 April 2016).

On 1 April 2016, the United Nations General Assembly adopted a third resolution on the Second International Conference on Nutrition (Rome, 19–21 November 2014) and its follow-up,¹ in which it proclaimed 2016–2025 to be the United Nations Decade of Action on Nutrition and called on the FAO and WHO to develop a work programme. Further details are provided in document A69/7 Add.2.

11. Several WHO regions have developed regional nutrition strategies that are aligned with the comprehensive implementation plan, for example: the PAHO Plan of action for the prevention of obesity in children and adolescents (2014–2019);² the European food and nutrition action plan (2015–2020);³ and the Action plan to reduce the double burden of malnutrition in the Western Pacific Region (2015–2020).⁴ The African regional nutrition strategy (2015–2025)⁵ includes the six global targets set out in the WHO’s comprehensive implementation plan. A regional nutrition action plan for the South-East Asia Region is currently being developed, which will reflect the comprehensive implementation plan. The Eastern Mediterranean Region has endorsed the global targets and identified a package of nutrition interventions for immediate scale-up.

12. Since the Second International Conference on Nutrition, WHO, FAO and UNICEF have provided technical support to seven countries in the central Africa subregion (Cameroon, Chad, Congo, Democratic Republic of the Congo, Equatorial Guinea, Gabon and Sao Tome and Principe) with a view to developing road maps (2015–2017) for national follow-up action. Furthermore, a regional road map has been developed in the Eastern Mediterranean Region, which has been adapted for use at the country level in Morocco, Somalia and Sudan.

13. The creation of a supportive environment for nutrition policies has been a goal of the Scaling Up Nutrition movement, which now includes 56 countries. In 2015, 28 of the countries participating in the movement reported that they had established national common results frameworks and 21 that they had developed action plans. Many of the countries in the movement are experiencing significant reductions in malnutrition.⁶ Likewise, United Nations organizations have agreed on a United Nations global nutrition agenda to facilitate joint country support.⁷ Based on the data currently available in the WHO global database on the implementation of nutrition action, 76 countries have recent plans and strategies on maternal, infant and young child nutrition that comprehensively respond to nutrition challenges, span different sectors and include monitoring and evaluation. In 60 countries in the African, South-East Asia and Western Pacific regions, the targets most often covered in national policies are exclusive breastfeeding, stunting and anaemia, whereas overweight is less often addressed. About half of those countries have quantified targets and are aiming to accelerate progress beyond the current trends; in many cases, the level of ambition exceeds that of the global targets. To assist

¹ United Nations General Assembly resolution 70/259. United Nations Decade of Action on Nutrition (2016–2025).

² Approved by the 53rd Directing Council of PAHO/66th Session of the Regional Committee for the Americas, in October 2014.

³ Adopted by the Regional Committee for Europe at its 64th Session, in September 2014.

⁴ Developed in response to resolution WPR/RC63.R2 on scaling up nutrition in the Western Pacific Region, adopted by the Regional Committee for the Western Pacific at its 63rd Session, in September 2012.

⁵ Endorsed by African Union Heads of State and Government in June 2015.

⁶ Scaling Up Nutrition. SUN Movement Annual Progress Report; September 2015.

⁷ See http://www.unscn.org/files/Activities/SUN/UN_Global_Nutrition_Agenda_final.pdf (accessed 6 April 2016).

countries in setting national targets – and to chart their progress towards them – WHO and partners have developed a web-based tracking tool.¹

14. Nearly 60 countries have been reviewing their national food and nutrition action plans² in 2014–2015 with WHO's support, with reference to the comprehensive implementation plan and the outcomes of the Second International Conference on Nutrition (11 in the African Region; three in the Region of the Americas; seven in the South-East Asia Region; 22 in the European Region; nine in the Eastern Mediterranean Region; and six in the Western Pacific Region).

15. **Action 2: To include all required effective health interventions with an impact on nutrition in national nutrition plans.** WHO has developed, published and updated where necessary evidence-informed guidelines to support public health strategies in several areas related to nutrition interventions and healthy diets.³ These include guidelines on: fortification of food-grade salt with iodine for the prevention and control of iodine deficiency disorders; optimal serum and red blood cell folate concentrations in women of reproductive age for prevention of neural tube defects; delayed umbilical cord clamping for improved maternal and infant health and nutrition outcomes; and intake of sugars by adults and children. Together with UNICEF and WFP, WHO has published an interim guideline on nutritional care of children and adults with Ebola virus disease in treatment centres. WHO's evidence-informed guidelines are available online and through the WHO e-library of evidence for nutrition actions portal. Currently, the online library contains details of 100 nutrition interventions and the website has been viewed by more than 1 million users since its launch in 2011.

16. WHO has developed policy briefs,⁴ linked to each of the global targets, to guide national and local policy-makers on what actions should be taken and at what scale, in order to reach the global targets by 2025 to improve maternal, infant and young child nutrition. The policy briefs consolidate the evidence around which interventions and areas of investment need to be scaled up, and guide decision-makers on what actions need to be taken in order to achieve them. The actions recommended by WHO to scale up effective priority interventions for achieving the six global targets should include both nutrition-specific and nutrition-sensitive investments at the policy, health system and community levels, using an intersectoral approach.

17. In 55 countries, there is evidence that stunting, wasting and anaemia are being tackled through WHO's recommended approach. In a number of countries, effective nutrition programmes are starting to be factored into the achievement of universal health coverage, with the active support of WHO. These include programmes on: the early initiation of breastfeeding and reduction in anaemia linked to the implementation of early essential newborn care through delayed cord clamping and skin-to-skin contact;⁵ the national implementation and enforcement of the International Code of Marketing of

¹ See <http://www.who.int/nutrition/trackingtool/en/> (accessed 6 April 2016).

² Including national nutrition and food security strategies and action plans, national strategies on infant and young child feeding, national strategies for nutrition in emergencies and road maps or action plans to prevent childhood obesity.

³ WHO guidelines on nutrition. Available at <http://www.who.int/publications/guidelines/nutrition/en/> (accessed 6 April 2016).

⁴ WHO. Global nutrition targets 2025: policy brief series (WHO/NMH/NHD/14.2). Geneva: World Health Organization; 2014.

⁵ Afghanistan, Cambodia, China, Colombia, Honduras, Lao People's Democratic Republic, Mongolia, Papua New Guinea, Philippines, Solomon Islands, Sudan, United Arab Emirates and Viet Nam.

Breast-milk Substitutes;¹ baby-friendly hospital initiatives;² micronutrient supplementation;³ growth monitoring and promotion;⁴ and the management of acute malnutrition in stable and emergency situations.⁵

18. **Action 3: To stimulate development policies and programmes outside the health sector that recognize and include nutrition.** The Committee on World Food Security has established a nutrition workstream to follow up on the outcome of the Second International Conference on Nutrition and to implement the 2030 Agenda for Sustainable Development, with the aim of developing healthier food systems.

19. Most Member States have taken action using a food systems approach to improve nutrition. WHO indicated the usefulness of food fortification as part of integrated actions in public health nutrition based on need or on the risk of deficiencies or insufficiencies. WHO provided technical support for the first Global Summit on Food Fortification (Arusha, United Republic of Tanzania, 9–11 September 2015). Currently, 159 countries have national plans on food fortification. WHO has provided technical support on fortification to countries in the African and Eastern Mediterranean regions, to India and to the Solomon Islands.

20. WHO has supported the development of food-based dietary guidelines in the South-East Asia, Eastern Mediterranean and Western Pacific regions. The Regional Office for Europe has developed a nutrient profile model for the purpose of restricting food marketing to children. Similar initiatives have been taken in the Region of the Americas and in the Eastern Mediterranean and Western Pacific regions to guide school feeding programmes, fiscal policies and regulations for the marketing of high-calorie low-nutrient food products and non-alcoholic beverages. Price policies to promote healthy diets have been discussed in 12 countries in the European Region and taxes on sugar-sweetened beverages have been discussed in the Philippines. In the Region of the Americas, an excise tax on sugar-sweetened beverages with the goal of preventing obesity has been enacted in Barbados, Dominican Republic and Mexico. In line with WHO's global action plan for the prevention and control of noncommunicable diseases 2013–2020, several countries (four in the Region of the Americas, seven in the European Region and 10 in the Eastern Mediterranean Region) have established policies for the reduction of *trans*-fats. The Eastern Mediterranean Region is also taking steps to promote the reduction of free sugars, as is Mongolia. Several countries in the Region of the Americas have developed or are developing consumer-friendly nutrition labels (Plurinational State of Bolivia, Chile, Ecuador and Peru). In the Western Pacific Region, WHO has supported countries in

¹ Brazil, Cambodia, Chile, Honduras, Iraq, Jordan, Lao People's Democratic Republic, Mongolia, Namibia, Nepal, United Arab Emirates and Viet Nam.

² Plurinational State of Bolivia, Brazil, Cambodia, China, Colombia, Guatemala, Honduras, Jamaica, Seychelles and United Arab Emirates.

³ Bangladesh, Bhutan, Plurinational State of Bolivia, Brazil, Colombia, Dominican Republic, Ecuador, El Salvador, Guatemala, India, Iraq, Democratic People's Republic of Korea, Indonesia, Lao People's Democratic Republic, Maldives, Myanmar, Nepal, Nicaragua, Peru, Sri Lanka, Syrian Arab Republic, Thailand, Timor-Leste and Yemen.

⁴ Bangladesh, Bahrain, Bhutan, Burkina Faso, Colombia, Ethiopia, Honduras, Indonesia, Jordan, Kuwait, Maldives, Morocco, Myanmar, Nepal, Niger, Oman, Qatar, Sierra Leone, Solomon Islands, Sri Lanka, Thailand, Timor-Leste, Togo, Uganda, United Republic of Tanzania and Vanuatu.

⁵ Afghanistan, Bangladesh, Plurinational State of Bolivia, Cambodia, El Salvador, Ethiopia, Guatemala, Iraq, Lesotho, Mauritania, Nepal, Pakistan, Philippines, Somalia, South Sudan, Sudan, Syrian Arab Republic, Swaziland, Timor-Leste, Uganda, Viet Nam and Yemen.

implementing front-of-pack labelling (Fiji) and in developing or revising labelling regulations (Cook Islands, Fiji, Kiribati, Samoa and Tuvalu).

21. WHO supported revisions of the Social Health Insurance Law and is currently supporting work on the inclusion of nutrition services in benefit packages in Viet Nam. Data from Brazil, Colombia and Mexico show that nutrition actions included in conditional cash transfer programmes have a positive impact on nutrition outcomes.

22. **Action 4: To provide sufficient human and financial resources for the implementation of nutrition interventions.** Funding for nutrition is starting to increase, although it still does not meet global needs. Nutrition-specific and nutrition-sensitive investments among reporting donors increased from US\$ 1300 million in 2010 to US\$ 1500 million in 2012, a 15% increase.¹ In April 2015, the Power of Nutrition fund was launched, potentially leading to up to US\$ 1000 million of new private and public funds. In June 2015, the Bill & Melinda Gates Foundation announced that US\$ 776 million of new funding had been made available for nutrition. According to a recent assessment conducted with WHO technical support, US\$ 42 000 million – or US\$ 8.50 per child – of additional financing is needed in order for the 37 “highest burden” countries to reach the global target on stunting over the next 10 years.² A more coherent use of the funding has been leveraged by the inclusion of the global targets in the strategy documents of major donors in the nutrition arena (Bill & Melinda Gates Foundation and United States Agency for International Development).

23. In the context of the Accelerating Nutrition Improvements project, funded by the Department of Foreign Affairs, Trade and Development of Canada, WHO has strengthened health workers’ capacities in the area of nutrition in 11 countries (Burkina Faso, Ethiopia, Mali, Mozambique, Rwanda, Senegal, Sierra Leone, Uganda, United Republic of Tanzania, Zambia and Zimbabwe). More than 1800 health workers at the community, facility and district levels have received training on nutrition surveillance and a similar number has received training on the management of severe acute malnutrition, the promotion of adolescent, maternal, infant and young child nutrition, and planning and budgeting for nutrition. The training of health professionals in the area of nutrition is being supported by WHO in five countries in the South-East Asia Region (Bangladesh, Democratic People’s Republic of Korea, Indonesia, Maldives and Sri Lanka), six countries in the Western Pacific Region (China, Lao People’s Democratic Republic, Mongolia, Philippines, Tonga and Viet Nam) and in 10 countries with emergencies in the Eastern Mediterranean Region, with priority being given to growth monitoring and promotion and to the implementation of the International Code of Marketing of Breast-milk Substitutes.

24. **Action 5: To monitor and evaluate the implementation of policies and programmes.** WHO and UNICEF have jointly established a Technical Expert Advisory Group on Nutrition Monitoring to support the implementation of the global nutrition monitoring framework as approved by the Sixty-seventh and Sixty-eighth World Health Assemblies.³ Since 2014, the Global nutrition report has brought together various stakeholders to describe progress in combating malnutrition and to identify gaps and propose ways of filling them. The 2015 report called for a nutrition data revolution and recommended that all countries, including high-income countries, should reach out to United Nations

¹ Scaling Up Nutrition. SUN Movement Annual Progress Report; September 2014.

² World Bank Group, Results for Development, Children’s Investment Fund Foundation, 1000 Days partnership, Bill & Melinda Gates Foundation. Meeting the global goals for malnutrition: how much will it cost, and who will pay? Presentation for the Third International Conference on Financing for Development, Addis Ababa, 13–16 July 2015.

³ See decisions WHA67(9) (2014) and WHA68(14) (2015).

agencies to facilitate the conversion of their own data into international databases convened by the United Nations agencies.¹

25. Through the Accelerating Nutrition Improvements project, WHO has provided support to eight African countries for reviewing nutrition indicators and integrating them into health management and information systems (Burkina Faso, Ethiopia, Mali, Mozambique, Senegal, Uganda, United Republic of Tanzania and Zimbabwe). The Regional Office for Europe has established a WHO European childhood obesity surveillance initiative, which collects nationally representative, nationally measured and internationally comparable data on overweight and obesity among primary school children in 31 Member States. WHO has also supported nutrition surveillance activities in eight countries and territories in the Eastern Mediterranean Region (Afghanistan, Bahrain, Kuwait, Oman, Pakistan, Saudi Arabia, Syrian Arab Republic and the West Bank and Gaza Strip), six countries in the Western Pacific Region (China, Fiji, Kiribati, Lao People's Democratic Republic, Solomon Islands and Tuvalu) and some countries in the Region of the Americas.

PROGRESS IN IMPLEMENTING THE INTERNATIONAL CODE OF MARKETING OF BREAST-MILK SUBSTITUTES

26. Under Article 11.1 of the Code, Member States are requested to “take action to give effect to the principles and aim of this Code, as appropriate to their social and legislative framework, including the adoption of national legislation, regulation or other suitable measures”. In resolution WHA34.22 (1981), in which the Code was adopted, the Health Assembly stressed that adoption of and adherence to the Code is a minimum requirement for all countries and urges all Member States to implement it “in its entirety”. Implementation and enforcement by Member States of the standards and recommendations contained in the Code and in subsequent related Health Assembly resolutions are critical to ensuring that proper infant and young child feeding practices are in place, and that parents and other carers are protected from inappropriate and misleading information.

27. In 2014, Member States were invited to provide updated information on the status of implementation of the International Code of Marketing of Breast-milk Substitutes, as part of their periodic reporting requirements under the Code. Information was received from Member States on legislative and other measures taken, including available legislative documentation. WHO incorporated the results into the WHO Global Database on the Implementation of Nutrition Action. Additional information on the legal status of the Code in Member States was obtained from the UNICEF database on national implementation of the Code and the International Code Documentation Centre database.

28. The 2011 status report on country implementation of the Code indicated that a total of 103 out of 194 Member States had some form of legislative measure in place.² Since 2011, there has been a substantial increase in the adoption of national legal measures to give effect to the Code and subsequent relevant resolutions of the Health Assembly. As at March 2016, that number stood at 136. The substantial increase owes in part to Member States having adopted new legislation or other legal

¹ International Food Policy Research Institute. Global nutrition report 2015: actions and accountability to advance nutrition and sustainable development. Washington, DC: International Food Policy Research Institute; 2015 (<http://ebrary.ifpri.org/utils/getfile/collection/p15738coll2/id/129443/filename/129654.pdf>, accessed 6 April 2016).

² WHO. Country implementation of the International Code of Marketing of Breast-milk Substitutes: status report 2011. Geneva: World Health Organization; 2013 (revised).

measures, but also to improved information on existing legal measures. At the same date, 39 Member States had comprehensive legislation or other legal measures reflecting all or most provisions of the Code. This number is similar to the number reported in 2011 (37 Member States). Legal measures incorporating many provisions exist in 32 Member States, and further 65 Member States have legal measures that contain a few provisions. Forty-six Member States have non-legal or no measures in place, and no information was available for 11 Member States. Since the 2011 status report, 21 Member States have developed or updated relevant legislation (Algeria, Armenia, Bosnia-Herzegovina, Brazil, Burundi, China, Comoros, El Salvador, Indonesia, Kenya, Kuwait, Madagascar, Mexico, Myanmar, Panama, Republic of Moldova, Solomon Islands, South Africa, United Republic of Tanzania, Venezuela and Viet Nam). In 2015, China revised its advertisement and food safety laws, regulating the production of breast-milk substitutes and introducing a ban on advertisements for such products in the mass media and on public premises. In addition, the European Union passed a new regulation in 2013 that applies to all Member States in the Union and the European Economic Area.

29. Successful implementation of the Code requires an independent and transparent monitoring and enforcement mechanism that is free from commercial influence, capable of identifying violations of national legislation and sufficiently empowered to apply sanctions. However, few Member States to date have an operational monitoring and enforcement mechanism that meets all or most of these criteria. As at March 2016 information received from 54 Member States indicated that a total of 27 Member States have a mechanism in place. These mechanisms were reported as being transparent (23 Member States); independent (23 Member States); free from commercial influence (23 Member States); budgeted or funded (9 Member States); empowered to take administrative and legal action (22 Member States); and sustainable (10 Member States).

30. Availability of data and expertise on Code-related matters and coordination between responsible stakeholders are weak in many countries. In addition, political commitment to, and sustained funding of, national Code monitoring and enforcement remain insufficient. In response to these continuing challenges, WHO and UNICEF have established a global network of civil society organizations and experts from several countries to provide technical support to those countries in improving their efforts to monitor and enforce Code implementation (NetCode).

RISK ASSESSMENT AND RISK MANAGEMENT TOOLS ON CONFLICT OF INTEREST IN NUTRITION PROGRAMMES

31. A technical consultation was convened in Geneva on 8 and 9 October 2015 to develop definitions, criteria and indicators in order to help to identify and prioritize conflicts of interest in the development and implementation of policies advocated by the comprehensive implementation plan on maternal, infant and child nutrition at the country level; to identify situations in which the development and implementation of policies advocated by the comprehensive implementation plan involve interactions between governments and non-State actors (with a focus on the private sector) which may lead to conflicts of interest; and to identify a list of tools, methodologies and approaches that may help identify and manage conflicts of interest. Participants included experts in the area of risk

assessment, disclosure and management of conflicts of interest, as well as experts in other areas, and representatives of Member States participated as observers.¹

32. The consultation concluded that Member States have a duty to ensure that undue influence – either actual or perceived – is not exerted on individuals or institutions responsible for public decision-making for interests other than the public good, as such influence would affect integrity and public trust. It also concluded that conflicts of interest can be financial or non-financial and direct or indirect; that Member States also have a duty to take into account diverging interests between different actors in society, and between different government actors; and that conflicts of interest may arise at different stages in the policy process: when making a decision on the need to establish a policy or a programme; when the policy or programme is set up; when it is implemented; and when it is monitored. The second and third stages are those at which the possibility of engagement with the private sector is more common, and a set of tools is needed to identify and address conflicts of interest.

33. The consultation further concluded that, when Member States initiate a policy discussion, an initial risk assessment is required. This may involve mapping the different interests, understanding corporate tactics and also understanding the level of risk associated with different types of engagement of public and private actors. In order to prevent conflicts of interest, Member States could establish guidelines on who should participate in groups responsible for policy-setting and normative work; rules on disclosure and the transparency of interests; and policies to manage conflicts of interest (including divestment, screening, recusal, sanctions for violations, post-employment policy rules and codes of ethics). When Member States decide to establish partnerships, the definition of clear rules of engagement may mitigate conflicts of interest. These might set out clear governance structures and terms of reference; establish that a clear priority must be given to public health goals; set rules for partnership and define the roles of the different actors; and require disclosure and transparency of interests. Reference to global policies, such as the International Code of Marketing of Breast-milk Substitutes or the Global Strategy for Infant and Young Child Feeding, can help to protect partnerships from undue influence. Other useful practices include transparent and independent monitoring, rules for sponsorship, lobbying registers and policies to protect whistle-blowers. Complementary actions include the capacity building of public officials on conflict of interest management and the strengthening of civil society through public awareness.

DRAFT GUIDANCE ON ENDING THE INAPPROPRIATE PROMOTION OF FOODS FOR INFANTS AND YOUNG CHILDREN

34. In May 2010, in resolution WHA63.23, the Sixty-third World Health Assembly recognized that the promotion of breast-milk substitutes and some commercial foods for infants and young children undermines progress in optimal infant and young child feeding. In May 2012, in resolution WHA65.6, the Sixty-fifth World Health Assembly requested the Director-General “to provide clarification and guidance on the inappropriate promotion of foods for infants and young children cited in resolution WHA63.23, taking into consideration the ongoing work of the Codex Alimentarius Commission”. Accordingly, the Secretariat established a Scientific and Technical Advisory Group on Inappropriate Promotion of Foods for Infants and Young Children, which produced a first report in 2013 providing a

¹ The report of the consultation is available at http://www.who.int/nutrition/publications/technicalconsultation_conflictofinterest_nutprogram_report.pdf (accessed 6 April 2016).

definition of the term “inappropriate promotion”¹ and a second report in 2015, containing draft guidance to help achieve the goal of ending the inappropriate promotion of foods for infants and young children.²

35. According to the reports of the Scientific and Technical Advisory Group, evidence from numerous countries has shown that foods (understood in this context to refer to both foods and beverages, including complementary foods and breast-milk substitutes) are being promoted as being suitable for infants under 6 months of age, that breast-milk substitutes are being indirectly promoted through association with commercial complementary foods, and that inaccurate claims are being made that products will improve a child’s health or intellectual performance. Furthermore, complementary foods have been shown to displace the intake of breast-milk if the amounts provided represent a substantial proportion of energy requirements. Commercial complementary foods vary widely in quality, with some improving nutrient intake by providing those nutrients which are either lacking or are present in insufficient quantities in the diets of young children, while others are of concern because of high levels of added sugars or salt. The inappropriate promotion of commercial foods for infants and young children can mislead parents and other caregivers about the nutrition and health-related qualities as well as the safe and age-appropriate use of these foods. In particular, the differences between milk products promoted for children of different ages are not well understood. Furthermore, the promotion of foods for infants under 6 months of age has been associated with earlier cessation of exclusive breastfeeding.

36. With support from the Scientific and Technical Advisory Group on Inappropriate Promotion of Foods for Infants and Young Children, the Secretariat drafted a discussion paper³ containing a set of recommendations on ending the inappropriate promotion of foods for infants and young children. The document was made available for public comments from 20 July to 10 August 2015. In addition, in order to develop the text further, the Secretariat convened informal dialogues with nongovernmental organizations in official relations with WHO and private sector entities on 17 August 2015 and an informal consultation with Member States and other United Nations organizations on 18 August 2015. The Executive Board at its 138th session in January 2016 considered document EB138/8 with draft guidance on ending the inappropriate promotion of foods for infants and young children. Following the comments given by representatives of Member States during the Board’s session and submitted in writing to the Secretariat in the subsequent four weeks (as requested by the Board), the Secretariat prepared a new version of the draft guidance. This was circulated to Member States in advance of the Sixty-ninth World Health Assembly so as to facilitate intersessional consultations on finalizing the guidance and the draft resolution.

ACTION BY THE HEALTH ASSEMBLY

37. The Health Assembly is invited to note the report.

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¹ See http://www.who.int/nutrition/publications/2013_STAG_meeting_24to25Jun_report.pdf?ua=1 (accessed 11 December 2015).

² See <http://www.who.int/nutrition/events/stag-report-inappropriate-promotion-infant-foods-en.pdf> (accessed 6 April 2016).

³ See <http://www.who.int/nutrition/events/draft-inappropriate-promotion-infant-foods-en.pdf?ua=1> (accessed 6 April 2016).