



Implementation of resolutions and decisions

Infant and young child nutrition

This complements document A51/6, part IX, providing a more comprehensive evaluation of the most serious forms of child malnutrition, the progress made in reducing them, and action taken by Member States and WHO in response, *inter alia*, to resolutions WHA33.32 (1980) and WHA49.15 (1996), and EB97.R13 (1996), which called for "collecting and evaluating meaningful quantitative information on global progress in breastfeeding, complementary feeding, implementation of the International Code of Marketing of Breast-milk Substitutes and other aspects of infant and young child nutrition".

The situation is slowly improving, but although malnutrition is decreasing in some countries and regions it is increasing or stationary in others; the vast numbers of children killed, stunted, crippled, blinded, retarded or otherwise affected remain unacceptable.

Since its inception, WHO has regarded nutrition as one of the fundamental cornerstones of health and development, especially the promotion of good nutrition, and the prevention, control and elimination of malnutrition among infants and young children. Improving nutrition is singled out in Article 2 of WHO's Constitution and is one of the eight essential elements of primary health care. Nutrition also provides key indicators for health for all, and the Health Assembly has identified it as one of the Organization's continuing priorities. Reporting to the Health Assembly thus reflects the concern of Member States and their commitment to tackling major problems, in particular protein-energy malnutrition, micronutrient malnutrition, the need for breast-feeding and proper complementary feeding, and the growing problems of child obesity and nutritional emergencies.

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BACKGROUND

1. Protein-energy malnutrition, iodine deficiency, vitamin A deficiency, anaemia, and other specific deficiency diseases still affect almost one-third of infants and young children, resulting in growth failure, physical stunting, brain damage, blindness, disability, and death. Having declared hunger and malnutrition unacceptable at the International Conference on Nutrition (Rome, 1992), governments reached a new global consensus on their nature and multiple causes, and on the urgent action required to prevent, reduce and ultimately eliminate malnutrition. Nine goals for the year 2000 have been agreed (see below), together with nine areas for strategic action; the responsibilities of Member States and the international community are detailed in the World Declaration and Plan of Action for Nutrition.¹ No fewer than 160 Member States have since developed, or reinforced, their nutrition programmes using the Declaration and Plan as a common blueprint; the resulting increase in commitment and resources for improving child nutrition are apparent on a national, regional and global scale.

THE NINE GOALS OF THE WORLD DECLARATION ON NUTRITION (Rome 1992)

As a basis for the Plan of Action for Nutrition and guidance for formulation of national plans of action, including the development of measurable goals and objectives within time frames, we (the Ministers and Plenipotentiaries) pledge to make all efforts to eliminate before the end of this decade:

- Famine and famine-related deaths.
- Starvation and nutritional deficiency diseases in communities affected by natural and man-made disasters.
- Iodine and vitamin A deficiencies.

We also pledge to reduce substantially within this decade:

- Starvation and widespread chronic hunger.
- Undernutrition, especially among children, women and the aged.
- Other important micronutrient deficiencies, including iron.
- Diet-related communicable and noncommunicable diseases.
- Social and other impediments to optimal breast-feeding.
- Inadequate sanitation and poor hygiene, including unsafe drinking-water.

PROTEIN-ENERGY MALNUTRITION

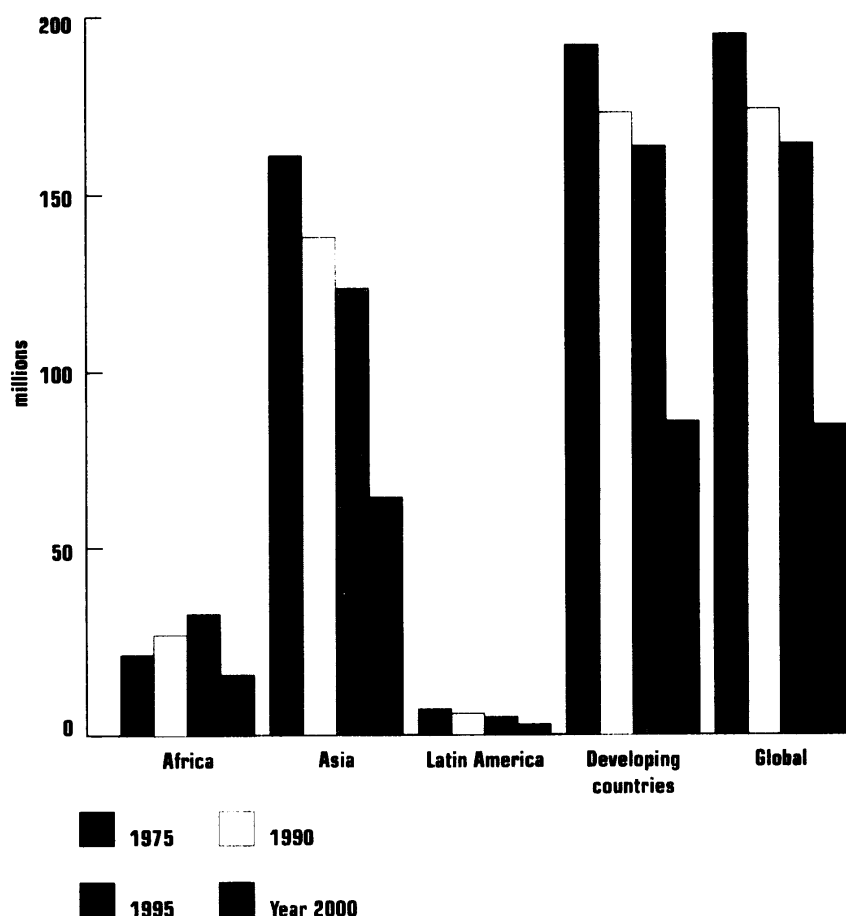
2. Global progress is slow and completely inadequate in view of the goal of a 50% reduction in 1990 prevalence levels by the year 2000. Currently, an estimated 168 million children under five years of age, i.e., over a quarter (27%) of children in this age group, are still malnourished in terms of weight for age. Nevertheless, this clearly represents significant progress when compared with the nearly 200 million children - a prevalence of well over a third (36%) - who were malnourished in 1975.

3. In some regions - Africa, for example - the actual number of malnourished children has in fact risen with the population. Natural disasters, wars, civil disturbances, and population displacement have only exacerbated

¹ Endorsed in its entirety by the Health Assembly in 1993 (resolution WHA46.7).

the situation; nevertheless, although 21% are found in Africa and only 3% in Latin America, more than three-quarters still live in Asia (especially southern Asia) (Figure 1).

FIGURE 1. REGIONAL AND GLOBAL TRENDS IN ESTIMATED NUMBERS OF UNDERWEIGHT CHILDREN BELOW FIVE YEARS OF AGE



4. The associated morbidity and mortality are tragic, accounting for nearly half (49%) of the 11 million deaths occurring annually among under-fives in developing countries, reduced physical activity, lowered resistance to infection (especially diarrhoea, respiratory disease, and measles), and impaired intellectual development and cognitive abilities.

Intrauterine growth retardation

5. Fetal malnutrition, measured in terms of intrauterine growth retardation (IUGR), is a major clinical and public health problem in developing countries, where an estimated 30 million newborns per year (24%) are

affected according to the first in-depth study¹ of the global magnitude and geographical distribution of IUGR based on data from 106 developing countries. When estimated regional incidences are compared, using the more traditional indicator of IUGR in full-term babies (<2500 g at ≥37 weeks' gestation), 11% of newborns in developing countries are affected compared with about 2% in developed countries. The majority (almost 75%) are in Asia.

6. Maternal malnutrition is the major determinant of IUGR in developing countries, with low gestational weight gain, low pre-pregnancy body mass index, and short maternal stature. Maternal anaemia, gastrointestinal and respiratory infections, malaria and cigarette-smoking are also important etiological factors. High rates of IUGR should be interpreted as an urgent public health warning of risk of malnutrition and morbidity in women of childbearing age and not merely an indicator of a high risk for the newborn.

Action and progress

7. High global prevalence of protein-energy malnutrition conceals the remarkable successes being achieved thanks to the considerable resources that a substantial number of Member States are allocating to combat malnutrition and its underlying causes; 25 of a recent sample of 60 developing countries show a measurable improvement in child nutritional status, with declining rates of protein-energy malnutrition, including 6 out of 25 countries in Africa, 9 out of 19 in Latin America, 4 out of 5 in the Eastern Mediterranean, 3 out of 6 in South-East Asia, and 3 out of 5 in the Western Pacific.

8. By December 1997, 160 Member States (84%) had established, revised or reinforced national programmes, adapting the World Declaration and Plan of Action to meet their specific needs, including nutritional objectives in development policies; improving infant feeding food quality and safety; caring for vulnerable groups such as refugees; eliminating micronutrient malnutrition; preventing obesity; and institutionalizing monitoring.

9. Collaboration with other United Nations organizations, e.g., FAO, UNICEF, UNHCR, WFP and the United Nations University, is also strong at country, regional and headquarters levels; the ACC Sub-Committee on Nutrition harmonizes interagency activities; 29 WHO collaborating centres and regional research networks continue to play an important role.

10. WHO supports Member States, *first*, technically and financially, by developing and implementing national policies and programmes, especially in least developed countries with high rates of malnutrition; and *secondly*, through the establishment and dissemination of scientific standards, methodology and requirements, assessment criteria, and guidelines. Both these approaches focus on six areas, all of which are crucial for the nutritional well-being of infants and young children: protein-energy malnutrition; micronutrient malnutrition; infant and young child feeding; obesity and diet-related noncommunicable diseases; national policies and plans of action for nutrition; and nutrition in emergencies.

11. By mid-1997 WHO had provided technical and financial support to 162 Member States specifically for strengthening national nutrition plans and had organized 23 regional meetings, most in collaboration with FAO and UNICEF, to cooperate with countries in determining factors for nutritional improvement, accelerating the reduction of malnutrition, and strengthening national nutrition programmes. A joint FAO/WHO report² on

¹ de Onis M, Blössner M, Villar J. Levels and patterns of intrauterine growth retardation in developing countries. *European Journal of Clinical Nutrition*, 1998, **52**: S5-S15. In this context, IUGR is defined as weight below the 10th percentile of the birth-weight-for-gestational-age reference curve.

² *Joint FAO/WHO Progress Report on the Implementation of the ICN World Declaration and Plan of Action for Nutrition*. Geneva, World Health Organization, and Rome, Food and Agriculture Organization, 1996.

global progress and action, presented to the ACC Sub-Committee on Nutrition in March 1997, has been forwarded to the United Nations Economic and Social Council and the General Assembly.

12. In fulfilment of its fundamental normative function, WHO has produced more than 40 technical publications and documents in the last five years that provide authoritative standards and recommendations, and guidance for their application, on human nutrient requirements; assessment of nutritional status and management of severe protein-energy malnutrition; recommended intake levels of, and assessment methodologies for, iodine, vitamin A and iron; obesity prevention; establishment of food-based dietary guidelines; breast-feeding complementary feeding, and implementation of the International Code of Marketing of Breast-milk Substitutes; and meeting the nutritional needs of infants and young children during emergencies.

Development of a new international growth reference

13. In view of serious technical problems with the United States growth reference that WHO had been recommending for international use since the late 1970s, it has initiated a four-year study in collaboration with the United Nations University and other international and national institutions, covering North and South America, Europe, sub-Saharan Africa, and eastern, southern and western Asia. The resulting new growth curves, based on breast-fed infants and healthy young children, are expected to serve for many years to come.

MICRONUTRIENT MALNUTRITION

14. **Iodine deficiency disorders (IDD)** are the greatest cause of preventable brain damage in the fetus and infant, and of retarded psychomotor development in young children. The spectrum of pathological conditions resulting from iodine deficiency includes cretinism, deaf-mutism, squint, spastic diplegia, mental retardation, dwarfism, stillbirth, congenital anomalies, and increased perinatal mortality. It is estimated that over 900 million people (infants, children and adults) suffer from goitre (Table 1), more than half of whom (52%) are in Asia, and that 16-17 million are cretins, with another 50 million suffering from less severe, though still measurable, forms of brain damage due to iodine deficiency.

TABLE 1. IODINE DEFICIENCY DISORDERS: PREVALENCE AND NUMBERS OF PEOPLE AFFECTED BY GOITRE AND CRETINISM

WHO region	Goitre (total goitre rate)		Cretins	
	Prevalence (%)	Population affected (millions)	Prevalence (%)	Population affected (millions)
Africa	23.7	147	1.48	4.21
The Americas	6.5	52	0.33	0.34
South-East Asia	14.9	220	0.81	3.56
Europe	10.7	93	0.26	0.48
Eastern Mediterranean	30.3	145	2.59	7.18
Western Pacific	15.5	254	0.14	0.74
World	15.6	911	0.92	16.51

15. But there has been dramatic progress in reducing IDD, largely thanks to salt iodization: in 1990, whereas only 46 out of 118 countries where IDD was known to be a significant public health problem had salt-iodization programmes, 83 countries had them by 1995, most of the remaining 35 taking steps to determine the magnitude and public health significance of IDD. Since 1990, 72 countries have conducted initial or follow-up surveys, and many have established national monitoring systems. Algeria, Argentina, Bolivia, Brazil, Cameroon, Chile, Costa Rica, Iran (Islamic Republic of), Thailand, and Zimbabwe have in the last five years achieved, or are fast approaching, the elimination goal.

16. WHO, with UNICEF and the International Council for Control of Iodine Deficiency Disorders in particular, has provided technical and financial support to Member States in establishing and monitoring national IDD control programmes. Normative activities included technical consultations to prepare statements and guidelines on safe use of iodized oil during pregnancy¹ and recommended normative values for thyroid volume in children.² An expert consultation (Geneva, 1996) reviewed the results of a WHO-coordinated seven-country study on salt iodization and iodine-induced hyperthyroidism in Africa, and produced new guidelines on recommended iodine levels in salt.³

17. **Vitamin A deficiency** among children in developing countries remains the leading cause of preventable severe visual impairment and blindness, and is a significant contributor to severe infections and death, particularly from diarrhoea and measles. Nearly three million children under five years of age currently exhibit signs of clinical xerophthalmia, while an additional 250 million children are deficient in vitamin A, with an increased risk of infection and death. Current information suggests that 76 countries have clinical or subclinical vitamin A deficiency problems; Africa has the highest prevalence, while the highest numbers of clinically affected subjects and people at risk are in South-East Asia. Nevertheless, there are encouraging signs that severe vitamin A deficiency is decreasing, particularly in some parts of Asia. WHO's technical support to Member States in assessing, reducing and preventing it continued in collaboration with UNICEF, USAID, the Micronutrient Initiative (Ottawa, Canada), and the International Vitamin A Consultative Group. A WHO-coordinated trial to assess the impact of vitamin A supplementation on morbidity is just being completed; an expert consultation on safe vitamin A dosage during pregnancy and lactation was convened in June 1996 and its recommendations distributed widely;⁴ and revised dosage schedules and guidelines for vitamin A supplements were published.⁵

18. The effects of **iron deficiency** and **anaemia** include increased maternal and newborn mortality, impaired, developmental and immune function and reduced learning and working capacity. They affect an estimated 2000 million people in developed and developing countries, and are major impediments to both individual and national development. A recent WHO global analysis showed that 31% of children under five years of age in developing countries are also anaemic, mostly owing to iron deficiency. The main causes are low dietary intake of iron and poor bioavailability of dietary iron, followed by infections and intestinal parasitic infestations. Other factors such as poverty, poor infant feeding practices, illiteracy and ineffective food policies are important. A document presenting assessment indicators and prevention strategies is being prepared.⁶

¹ See: Safe use of iodized oil to prevent iodine deficiency in pregnant women. A statement by the World Health Organization. *Bulletin of the World Health Organization*, 1996, 74(1): 1-3.

² Recommended normative values for thyroid volume in children aged 6-15 years. *Bulletin of the World Health Organization*, 1997, 75(2): 95-97.

³ See: "Recommended iodine levels in salt and guidelines for monitoring their adequacy and effectiveness" (document WHO/NUT/96.13).

⁴ "Safe vitamin A dosage during pregnancy and lactation" (unpublished document NUT/96.14).

⁵ *Vitamin A supplements: a guide to their use in the treatment and prevention of vitamin A deficiency and of vitamin A deficiency xerophthalmia*. 2nd edition. WHO, Geneva, 1997.

⁶ "Iron deficiency: indicators for assessment and strategies for prevention".

INFANT AND YOUNG CHILD FEEDING

19. WHO is supporting Member States' efforts to protect and promote breast-feeding through technical programmes at country, regional and global levels, and with UNICEF, other United Nations organizations, WHO collaborating centres and nongovernmental organizations.

Breast-feeding

20. According to WHO's global data bank on breast-feeding, with data from 94 countries, exclusive breast-feeding rates remain low; an estimated 35% of infants are fed only breast milk at some point between birth and four months of age.¹ As awareness of the advantages grows in both developing and developed countries, more Member States are taking steps to protect and promote breast-feeding, and rates are increasing; e.g., in Australia, Canada, China, Iran (Islamic Republic of), Mali, Norway, Poland, Sweden, Thailand, Zambia, and Zimbabwe, but all too often in countries where malnutrition and mortality are high, breast-feeding rates remain low. In spite of the advantages over artificial feeding in improved cognitive function, protection against allergies, bacterial and viral infections and the risk of contaminants, as well as nutrient excesses or deficiencies from poorly prepared artificial feeds, many, especially European, countries continue to have low, if slowly improving, breast-feeding rates (e.g., France, Italy, Ireland, Netherlands, Spain, Switzerland, and United Kingdom of Great Britain and Northern Ireland).

21. The **Innocenti Declaration** (1990) and its four operational targets² have contributed significantly to increasing breast-feeding rates in many countries, and to establishing and integrating national breast-feeding strategies into overall health and development policies. Results of a recent WHO survey show that more than 130 Member States have established breast-feeding committees (though not all are said to be authoritative and multisectoral); 118 have at least 12 weeks' maternity leave for at least some mothers; and the **Baby-friendly Hospital Initiative**, launched in 1992, is now operating in 171 countries and the number of such hospitals rose from about 4300 in 1995, to more than 11 000 by mid-1997.³

22. WHO's contribution to the Initiative includes advocacy, information dissemination, and production of training materials and monitoring and evaluation tools. Emphasis is on training and assessment, ensuring the Initiative's sustained credibility and integrity, and making it mother-*and*-baby-friendly. Training for health workers and hospital personnel is central to the "integrated management of childhood illness" approach. Training curricula have been developed and tested and courses organized.⁴

23. In response to recent research findings on HIV transmission through breast-feeding, WHO, UNICEF and UNAIDS convened a technical consultation in April 1998 to review the latest scientific evidence and issue

¹ "WHO global data bank on breast-feeding" (document WHO/NUT/96.1).

² These targets are: an authoritative national breast-feeding coordinator and multisectoral committee; all maternity facilities "baby-friendly"; action to give effect to the principles and aim of the International Code; and legislation to protect the breast-feeding rights of working women.

³ The Innocenti Declaration: Progress and achievements, Parts I and II. *Weekly Epidemiological Record*, 1998, 73(5): 25-32 and 73(13): 91-94.

⁴ "Breastfeeding counselling: a training course" (documents WHO/CDR/93.3-93.6) is available in Arabic, English, French, Portuguese, Russian and Spanish; and "Promoting breast-feeding in health facilities: a short course for administrators and policy-makers" (document WHO/NUT/96.3) is available in English, French and Russian (Arabic and Spanish in preparation).

guidelines for policy-makers and health care managers on ways to deal with this public health emergency. The aim is to protect, promote and support breast-feeding for the majority of infants while ensuring that the nutritional needs of infants who are at risk of HIV infection through breast-feeding are appropriately met.

24. **Medical education.** Textbooks in English, French and Spanish used by major medical schools have been evaluated.¹ In close collaboration with Wellstart International a lactation management curriculum is being integrated into basic pre-service education for physicians, nurses and other health professionals.

Complementary feeding

25. Infant and young child malnutrition, growth failure, and morbidity and mortality are closely associated in many countries with frequently faulty complementary feeding practices; nutritionally inadequate - and frequently contaminated - foods are often introduced too early (in developing and developed countries) or too late (in developing countries). WHO is intensifying its technical support to Member States to help improve these practices, for example, through the "integrated management of childhood illness" approach. WHO organized workshops on complementary feeding practices in the African (1994) and Eastern Mediterranean (1995) regions, and Member States of the South-East Asia Region have given the subject priority in research. WHO, with the support of UNICEF and USAID, commissioned a comprehensive review² and later convened a consultation of WHO collaborating centres in nutrition (Geneva, December 1996) to plan operational research. Guidelines for health workers are being drawn up in collaboration with the London School of Hygiene and Tropical Medicine, and a study on complementary feeding, micronutrients and child growth is also under way.

26. In 1995 the report of a WHO Expert Committee³ reaffirmed the suitability of the current recommended timing of exclusive breast-feeding and the introduction of complementary foods, i.e., **4 to 6 months of age**. When applying WHO's current infant-feeding recommendation as a guide for feeding practices - whether for entire populations or on behalf of an individual mother, in consultation with her health worker, based on the specific needs of her child - public health authorities need to take carefully into account prevailing environmental and cultural factors. These include the **quality and safety** of available complementary foods, the possibility of **environmental contamination**, and the **child-spacing benefits** of exclusive breast-feeding. In some circumstances, it may thus be preferable to delay the introduction of complementary foods until they become strictly necessary on nutritional grounds.

Progress in implementing the International Code of Marketing of Breast-milk Substitutes

27. Since the adoption of the Code in 1981, 158 Member States - 83% in all - have reported to WHO on action taken to give effect, in whole or in part, to the principles and aim of the Code (Table 2).

¹ See: *An evaluation of the breastfeeding content of selected medical textbooks*. Washington, D.C., Institute for Reproductive Health, Georgetown University, 1997.

² WHO, UNICEF, ORSTOM, University of California at Davis. "Complementary feeding of young children in developing countries: a review of current scientific knowledge" (document WHO/NUT/98.1) (in preparation).

³ *Physical status: the use and interpretation of anthropometry*. Report of a WHO Expert Committee. Geneva, World Health Organization, 1995 (WHO Technical Report Series, No. 854).

TABLE 2. MEMBER STATES REPORTING ON ACTION TAKEN GIVING EFFECT TO THE INTERNATIONAL CODE OF MARKETING OF BREAST-MILK SUBSTITUTES, 1981-1998

WHO region	Member States	Member States reporting	% of Member States	Territories reporting
Africa	46	38	83	
The Americas	35	34	97	6
South-East Asia	10	8	80	
Europe	51	31	61	
Eastern Mediterranean	22	21	95	
Western Pacific	27	26	96	6
Total	191	158	83	12

28. Although the European Region has the lowest proportion (61%) of Member States reporting, it should be noted that most of the 23 new Member States that have joined WHO between 1991 and 1997 - many of which are facing severe social and economic difficulties - are in that Region.

29. Since the last report by the Director-General,¹ new, predominantly legislative action has been taken by 32 Member States² - eight of which are mentioned for the first time - or a total of 59 Member States since 1994:

- **reinforcing existing measures** to give effect to the Code in the light of evolving circumstances, e.g., Argentina, Australia, Malaysia, Mozambique, New Zealand, Poland, Singapore, Sweden, Switzerland, and Thailand;
- **broadening the scope of action** to include *all* commercial food products for infants, e.g., Argentina, Australia, Bahrain, Botswana, Costa Rica, Madagascar, Malaysia, Senegal, Sweden, and Viet Nam, and sometimes for older children (1-3 years), e.g., Mozambique and United Republic of Tanzania. Frequently, this explicitly includes follow-up formula not generally available when the Code was adopted in 1981, but which has been mentioned in a later resolution (resolution WHA39.28);
- **strengthening monitoring**, drawing public attention to infractions by manufacturers and distributors and imposing sanctions, e.g., Argentina, Australia, Bahrain, Bangladesh, Malaysia, New Zealand, Oman, Senegal, Switzerland, Thailand, and United Arab Emirates;
- **providing infant formula for social purposes**: the precise circumstances under which genuine supplies to meet the long-term nutritional needs of infants who have to be fed on breast-milk substitutes, e.g., in orphanages, are being explicitly defined, e.g., in Bahrain, Botswana, Madagascar, and United Republic of Tanzania;

¹ Document A49/4, part VIII.

² **Africa**: Botswana, Madagascar, Mauritania, Mozambique, Namibia, Seychelles, Togo, and Zimbabwe; **the Americas**: Argentina, Belize, Honduras, Nicaragua, and Trinidad and Tobago; **South-East Asia**: Bangladesh and India; **Europe**: Austria, Malta, Poland, and Sweden; **Eastern Mediterranean**: Cyprus, Djibouti, Iran (Islamic Republic of), and Saudi Arabia; **Western Pacific**: Australia, Cambodia, China, Marshall Islands, New Zealand, Niue, Palau, Singapore, and Tonga.

- **prohibiting distribution of samples** to the general public and mothers as a promotional tool, e.g., Côte d'Ivoire, Dominican Republic, Honduras, Madagascar, Mozambique, Poland, Senegal, Trinidad and Tobago, and the 15 members¹ of the European Union, in conformity with European Directive 91/321/EEC.

30. WHO has produced a review and evaluation framework² to help determine what action has been taken by governments or is under way to give effect to the Code and what factors have facilitated or hindered action, assess their impact, and make appropriate recommendations. International and national nongovernmental organizations remain active in this connection. For example, the International Code Documentation Centre of the International Baby Food Action Network (IBFAN) published a teaching manual³ for its training courses on Code implementation, including a model law and the legislative and other texts of 12 countries that have implemented the Code.

31. Consistent with Article 11.4 of the International Code, a number of nongovernmental organizations continue their own monitoring activities. For example, a coalition of charitable, church, and academic groups in the United Kingdom published a report drawing the attention of manufacturers and distributors in Bangladesh, Poland, South Africa and Thailand to activities which are incompatible with the principles and aim of the Code.⁴ In response, the governments of the countries in question have taken a variety of steps to strengthen their implementation of the International Code.

32. WHO continues to use its good offices to collaborate with interested parties in a process of identifying, examining and overcoming the main obstacles to implementation, by all countries, of the International Code and related subsequent resolutions. In this connection, the Executive Board, at its 101st session, was informed that the Director-General intended to convene a global technical consultation in the second half of 1999 to review the latest scientific evidence relating to infant and young child feeding practices. Likewise, continuing efforts were being made to unite all partners for the purpose of improving the health and nutritional status of infants and young children.

OVERWEIGHT AND OBESE CHILDREN

33. Childhood obesity and its consequences are emerging as a global problem.⁵ Data from 79 developing countries and a number of industrialized countries suggest that, by WHO standards (>+2 SD above reference median weight for height), about 22 million children under five years are overweight (Table 3).

¹ Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Portugal, Spain, Sweden, United Kingdom of Great Britain and Northern Ireland.

² "The International Code of Marketing of Breast-milk Substitutes: a common review and evaluation framework" (document WHO/NUT/96.2, available in English (Arabic, French and Russian in preparation)).

³ Sokol E. *The Code handbook. A guide to implementing the International Code of Marketing of Breast-milk Substitutes*. Penang, International Baby Food Action Network, 1997. IBFAN is a worldwide coalition of citizen groups working for better infant health through the promotion of breast-feeding and elimination of inappropriate marketing and distribution of breast-milk substitutes, bottles and teats through universal implementation of the International Code and relevant Health Assembly resolutions. Founded in 1979, IBFAN now counts more than 150 member organizations and contacts in more than 90 countries.

⁴ *Cracking the Code*. London, The Interagency Group on Breastfeeding Monitoring, 1997.

⁵ Lack of a common measurement standard (e.g., >85th percentile, >120% weight for height, >+2 SD (standard deviations) above reference median weight for height) for defining overweight in children and adolescents has made it difficult to assess its magnitude.

TABLE 3. REGIONAL AND GLOBAL PREVALENCE AND NUMBERS OF OVERWEIGHT CHILDREN AND ADULTS, BY WHO REGION, 1995

WHO region	Children <5 years of age (>+2 SD above median weight/height)		Adults (body mass index >30 kg/m ²)	
	Prevalence (%)	Millions	Prevalence (%)	Millions
Africa	2.8	2.9	2.0	5.1
The Americas	4.8	3.6	17.4	82.7
South-East Asia	1.7	2.8	0.8	6.3
Europe	NA	NA	12.4	76.1
Eastern Mediterranean	4.2	2.9	3.5	6.3
Western Pacific	3.8	5.3	2.5	26.4
Global	3.4	21.9	6.0	203.4

34. Obesity is also a significant risk factor for a range of serious noncommunicable diseases and conditions, e.g., cardiovascular disease, hypertension and stroke, diabetes mellitus, various forms of cancer, and other gastrointestinal and liver diseases, varicose veins, gall-bladder disease, other serious health problems, and accidents. Recently, WHO organized a major consultation to review associated morbidity and mortality with a view to drawing up guidelines for Member States on obesity prevention and management.¹

NUTRITION IN EMERGENCIES

35. Caring for the tens of millions of people in emergencies is a global humanitarian problem receiving high priority, as they frequently show high rates of malnutrition and increased vulnerability, especially the infants and young children. WHO continues to collaborate with UNHCR, WFP and nongovernmental organizations in collective efforts to assess, reduce and prevent malnutrition among these groups. Demand remains high for WHO's technical guidance on standards, evaluation criteria, assessment methodology, and nutrient requirements on behalf of this group. In response to resolution WHA47.5 WHO has prepared guiding principles. Prior to their publication in 1998, a review version has been widely circulated for comment within the international nutrition and emergency relief community.² Comprehensive manuals on managing nutrition in major emergencies³ and on treatment and management of severe malnutrition⁴ are about to be published. Reviews of the diagnosis and management of scurvy, beriberi and pellagra are in preparation. Following an intercountry workshop on managing nutrition during emergencies (Eritrea, 1996), a joint WHO/UNHCR consultation on caring for the nutritionally vulnerable during emergencies (Rome, February 1998) recommended development of guiding principles for caring for those affected. Three practical WHO manuals, covering nutritional assessment in

¹ "Obesity: preventing and managing the global epidemic." Report of the WHO Consultation on Obesity, Geneva, 3-5 June 1997 (unpublished document WHO/NUT/NCD/98.1).

² "Guiding principles for feeding infants and young children during emergencies" (unpublished document NUT/97.3).

³ *Management of nutrition in major emergencies*. Geneva, World Health Organization (in press).

⁴ *Treatment and management of severe malnutrition*. Geneva, World Health Organization (in press).

emergencies,¹ nutrition requirements in emergencies,² and food and nutritional care in emergencies³ are being widely used by UNHCR and other organizations of the United Nations system. Applied research measures for nutrition in emergencies and strategies for their implementation were discussed at a consultation organized by WHO (Geneva, October 1997).

CONCLUSION

36. Substantially reducing - and ultimately eliminating - hunger and malnutrition in infants and young children seems more feasible today than just 10 years ago. Progress achieved in preventing and controlling iodine deficiency disorders is one of the most encouraging examples that malnutrition can be successfully combated on a wide scale. Indeed, within the next decade this age-old scourge should cease to be a public health problem thanks to massive national and international efforts to iodize salt.

37. Nevertheless, more than a quarter of all children under five years of age are *still* undernourished, brain damaged, blinded or functionally impaired, all as a result of malnutrition. This outcome is all the more unacceptable for being so easily prevented - provided the political will can be mustered to tackle the problem at its base by applying existing knowledge and mobilizing existing resources to end hunger and malnutrition for this most vulnerable of vulnerable groups. Measures against other causes of child malnutrition, particularly inappropriate infant and child feeding practices, still require the full attention of Member States and other interested parties, including professional bodies, nongovernmental groups, and commercial enterprises. WHO relies on the contribution of all concerned in fulfilling its own mandate in this crucial area of human health.

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¹ Nutritional assessment in emergencies. A summary of WHO-proposed indicators, reference values and key references. From: *Management of nutrition in major emergencies*. Geneva, World Health Organization (in press).

² Nutritional requirements in emergencies. From: *Management of nutrition in major emergencies*. Geneva, World Health Organization (in press).

³ Food and nutritional care in emergencies. A summary of WHO-proposed guidelines. From: *Management of nutrition in major emergencies*. Geneva, World Health Organization (in press).