



FEB 27 2004

The Honorable J.W. Lee, M.D.
Director-General
World Health Organization
Avenue Appia 20
1211 Geneva 27
Switzerland

Dear Mr. Director-General:

The United States is fully committed to efforts to help people live longer, better and healthier lives by reducing the burden of chronic conditions, such as overweight and obesity and related risk factors, including physical inactivity, poor nutrition and malnutrition, and tobacco use. We stand ready to work with other countries and the World Health Organization (WHO) to present to the 57th World Health Assembly a strong global strategy on diet, physical activity and health to serve as the basis for the actions of Member States. In this spirit, the United States is pleased to submit the enclosed comments and proposed revisions to the draft WHO strategy on diet, physical activity and health (EB113/44/Add.1) for your consideration. Our comments reflect a dynamic interagency process, which engaged a range of experts in such areas as diet, nutrition and nutrition research, physical activity, obesity health promotion and disease prevention, chronic diseases, oral health, child health and development, agriculture policy, food standard-setting, food safety and security, international development, and behavioral risk-factor surveillance.

The U.S. Government, primarily through the Department of Health and Human Services (HHS) and the Department of Agriculture (USDA), has successfully raised the issue of overweight and obesity to the top of the U.S. domestic policy agenda by calling on all those with a stake in the issue to do their part to fight these conditions in America. Chronic, obesity-related diseases like heart disease, cancer, and diabetes are the leading causes of death and disability in the United States. Chronic diseases account for three out of every five health care dollars spent in our country, result in seven of every 10 deaths, and harm the quality of life of an estimated 90 million Americans.

The United States is focusing efforts to promote better health and prevent disease on several fronts:

- In June 2002, President George W. Bush launched the *HealthierUS* Initiative designed to help Americans of all ages take steps to improve their personal health and fitness, by encouraging Americans to be physically active every day, eat a nutritious diet, get preventive health screenings and make healthy choices.

- In support of the President's Initiative, Secretary of Health and Human Services Tommy G. Thompson launched a bold initiative, *Steps to a HealthierUS: Putting Prevention First*, to focus attention on the importance of prevention and promising new approaches for promoting healthy environments.
- HHS and USDA are jointly revising the *Dietary Guidelines for Americans*. The *Guidelines* give advice on food choices for nutrition and health, are based on recommendations from a panel of health and nutrition experts, and serve as the basis for the U.S. Government's nutrition policy. The USDA's Food Guide Pyramid helps put the *Dietary Guidelines* into action by serving as an education tool for the public. The revised *Dietary Guidelines* should be released in early 2005 and the new food guidance will be released shortly thereafter.
- USDA, HHS, and the National 5 to 9 a Day Partnership are working together to promote consumption of five to nine servings of fruits and vegetables a day to the general public and target populations.
- USDA continues to improve the quality of school meals through nutrition standards originally set in the Schools Meals Initiative of 1995. These standards require schools to plan and offer menus that not only meet nutrient and calorie requirements but also limit calories from fat and saturated fats. U.S. studies indicate schools have made significant progress. Our most recent data show that 82 percent of elementary schools and 91 percent of secondary schools offer students the opportunity to select a lunch with no more than 30 percent of calories from fat.
- In 2003, the HHS Steps to a Healthier US Community Program awarded \$13.7 million to 23 communities to implement action plans tailored to achieve success in improving people's health in each individual community. Examples of these initiatives include walking programs, smoking cessation programs and increasing healthy food choices in schools. Each community that receives a grant is encouraged to partner with other government agencies, health care providers, school districts, faith-based agencies, the private sector and academic institutions. In 2004, this program will award \$44 million and substantially increase the number of communities that will take part in creating and implementing local plans. The President and the Secretary are requesting that Congress increase the funding for this program to \$125 million in 2005.
- In 2003, Secretary Thompson initiated a challenge to employees at HHS to be physically active for 30 minutes a day, five times a week. He plans to broaden this contest among employees to other federal departments. Many Governors are initiating similar challenges to the citizens of their state. These challenges raise health awareness, increase motivation to be physically active and teach individuals to take responsibility for their own health.

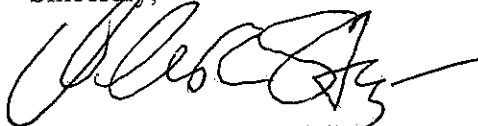
- In March 2004, HHS is partnering with the Advertising Council and will release a television and radio ad campaign to promote physical fitness and healthy eating. The campaign will apply innovative and humorous messages to underscore the importance of healthy living and personal responsibility.
- HHS is partnering with private-sector groups, such as the Girl Scouts and the American Association of Retired Persons, to make best use of resources for targeted prevention-related initiatives with their respective constituencies.
- HHS is working with private stakeholder groups, such as the American Diabetes Association, to create a national action plan on diabetes. This plan will increase national awareness of the disease, its impact, and what individuals can do to prevent or manage the disease. The plan will strive to identify and better coordinate existing efforts within HHS to maximize research, detection, prevention and treatment of the disease, and leverage HHS resources to promote similar opportunities within the private sector. Finally, the plan will develop action-oriented strategies to reduce the prevalence of diabetes and promote improved detection, monitoring and treatment of the disease.
- The USDA spearheads a number of school-based nutrition education campaigns. The *Eat Smart. Play Hard.*[™] Campaign is a cross-program initiative that uses a spokescharacter, Power Panther[™], as the primary communication tool to deliver nutrition and physical activity messages to children and their caregivers. *Changing the Scene*, an educational kit distributed to over 30,000 users helps schools promote a healthy school environment, including through changes in competitive foods policies. *Team Nutrition* is an integrated, behavior-based, comprehensive plan for promoting the nutritional health of the nation's schoolchildren through the Child Nutrition Programs. A new team nutrition initiative, *Fruits and Vegetables—Getting Kids to Eat More*, will help schools motivate students to eat more fruits and vegetables.
- USDA's Research, Education and Economics mission area operates a wide range of obesity research and education activities. For example, six state-of-the-art Human Nutrition Research Centers of USDA's Agricultural Research Service conduct research to identify and understand how nutrients and other bioactive food components affect health. The Economic Research Service investigates how people acquire diet-health knowledge, what they believe about diet, how they use dietary information, and how they react to food prices and other factors that affect dietary choices. The Cooperative State Research, Education, and Extension Service funds many obesity research-related grants and education programs.

- In April 2003, the Director of the National Institutes of Health (NIH) within HHS established the NIH Obesity Research Task Force to develop a strategic plan for obesity research. The strategic plan, to be released this spring, will represent a cohesive, multi-dimensional research agenda for addressing obesity challenges.
- In August 2003, the Commissioner of Food and Drugs called for the formation of the HHS Food and Drug Administration's (FDA) Obesity Working Group (OWG). He charged the OWG to prepare an action plan to address critical dimensions of the overweight and obesity problem from the FDA's perspective. This FDA report will be released in the spring.
- The Centers for Disease Control and Prevention in HHS remains at the forefront of collecting data, statistics and prevalence trends on overweight and obesity in the United States and in developing tools to help improve nutrition and physical activity and prevent chronic disease, including for older adults and children.

The WHO global strategy on diet, physical activity and health holds much promise in the fight against the global epidemic of overweight and obesity and the increasing global chronic disease burden. This means that individuals need to be more active and make better and healthier choices for their family; it means that industry needs to provide and promote healthier choices for customers and include better information about their products; and it means that governments need to make sure the public has accurate, science-based information needed to help us better understand the causes and contributing factors to overweight and obesity, and provide more information about what we can do to decrease the prevalence of overweight and obesity.

The United States looks forward to working with the WHO and its Member States to develop and implement a global strategy on diet, physical activity and health that can truly make a difference in the lives of individuals, families, and communities through improved diet and nutrition, increased physical activity, and healthier lifestyles.

Sincerely,



William R. Steiger, Ph.D.
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for International Affairs

Enclosure

WORLD HEALTH ORGANIZATION

EXECUTIVE BOARD
113th Session
Provisional agenda item 3.7

EB113/44/Add.1
27 November 2003

Integrated prevention of noncommunicable diseases

Draft global strategy on diet, physical activity and health

The Director-General submits herewith for the consideration of the Executive Board the draft global strategy on diet, physical activity and health.

CAPS/BOLD = Additions

~~Strikeouts~~ = Deletions

NOTES: Special commentary and rationale

Where helpful and appropriate, references have been added.

THE DEVELOPMENT PROCESS FOR THE DRAFT GLOBAL STRATEGY CONTAINED A RANGE OF INPUTS, INCLUDING BUT NOT LIMITED TO THE *WORLD HEALTH REPORT 2002: REDUCING RISKS, PROMOTING HEALTHY LIFE*; THE REPORT OF A JOINT WORLD HEALTH ORGANIZATION (WHO)/FOOD AND AGRICULTURE ORGANIZATION (FAO) EXPERT CONSULTATION ENTITLED *DIET, NUTRITION AND THE PREVENTION OF CHRONIC DISEASES* (WHO TECHNICAL REPORT SERIES 916); THE WHO DIRECTOR-GENERAL'S TECHNICAL ADVISORY GROUP; WHO REGIONAL CONSULTATIONS WITH EXPERT REPRESENTATIVES FROM MEMBER STATES; AND A NUMBER OF INFORMAL CONSULTATIONS WITH PUBLIC AND PRIVATE STAKEHOLDERS.

[NOTE: Since it is not clear how the various inputs have been utilized and applied in the development of the strategy, we suggest that all inputs to the strategy be acknowledged in a note at the beginning of the strategy and that no one input be linked directly within this strategy document.]

DRAFT GLOBAL STRATEGY ON DIET, PHYSICAL ACTIVITY AND HEALTH

INTRODUCTION

1. Recognizing the heavy and growing burden of noncommunicable diseases, Member States requested the Director-General to develop a global strategy on diet, physical activity and health through a broad consultation process.¹ To establish the content of the draft global strategy, WHO held six regional consultations with Member States, and consulted with United Nations agencies and other intergovernmental organizations, civil society, and the private sector; a reference group of independent international experts on diet and physical activity from all six WHO regions also advised WHO. Following the adoption of the strategy, an action plan^S for implementing the strategy **SHOULD** ~~will~~ be developed at regional and national levels, **AS APPROPRIATE**. [NOTE: Member States and the WHO Secretariat have used such terms as “a menu approach” or “toolbox” to implement this strategy, as appropriate for the national context and realities of any Member State.]

THE CHALLENGE

2. A profound shift in the balance of the major causes of death and disease **HAS ALREADY OCCURRED IN DEVELOPED COUNTRIES AND** is under way in most **MANY DEVELOPING** countries. Globally, the burden of noncommunicable diseases has rapidly increased. In 2001, noncommunicable diseases accounted for almost 60% of the 56.5 million deaths annually and 47% of the global burden of disease. In view of these figures and the predicted future growth in this disease burden, the prevention of noncommunicable diseases presents a major global public health challenge.

3. *The world health report 2002*² describes in detail how, in most countries, a few major risk factors account for much of the morbidity and mortality, and for noncommunicable diseases, the most important risks included high blood pressure, high concentrations of cholesterol in the blood, **INADEQUATE** low-intake of fruit and vegetables, **AN OTHERWISE UNHEALTHY DIET**, [NOTE: There are data that show diets high in fruits and vegetables are beneficial, but we do not know of data where just a change of fruit and vegetable intake changes risk in absence of change in the remainder of the diet.] being overweight, physical inactivity and tobacco use. Five of these global risk factors are closely related to diet and physical activity. **A MAJOR CHALLENGE IS THE COMPLEX INTERACTIONS OF PERSONAL CHOICE, SOCIAL NORMS, AND ECONOMIC AND ENVIRONMENTAL FACTORS IN INFLUENCING DIETARY PATTERNS AND PHYSICAL ACTIVITY IN A SUSTAINABLE MANNER OVER THE LIFESPAN.**

¹ Resolution WHA55.23.

² *The world health report 2002: Reducing risks, promoting healthy life*. Geneva, World Health Organization, 2002.

4. Unhealthy diets and physical inactivity are ~~thus~~ **AMONG** the leading **CONTRIBUTORS TO OVERWEIGHT AND OBESITY AND** ~~causes of the major~~ noncommunicable diseases, including cardiovascular disease, type 2 diabetes and certain types of cancer, and contribute substantially to the global burden of disease, death and disability. Other diseases related to diet and physical inactivity, such as dental caries and osteoporosis, are widespread causes of morbidity.

##. DIET AND NUTRITION AFFECT ORAL HEALTH IN MANY WAYS. THE ROLE OF SUGAR IN THE DENTAL CARIES PROCESS IS WELL-DOCUMENTED. ACIDIC FOODS AND BEVERAGES CAN CAUSE DEMINERALIZATION OR EROSION OF THE DENTAL ENAMEL. NUTRITIONAL DEFICIENCY CAN LEAD TO DEVELOPMENTAL DEFECTS IN ENAMEL, AND CAN CAUSE SALIVARY GLAND ATROPHY, WHICH SUBSEQUENTLY REDUCES THE MOUTH'S DEFENSE AGAINST ORAL INFECTION. LIKE OTHER CANCERS, ORAL CANCER IS RELATED TO AN UNBALANCED DIET.¹

5. The burden of mortality, morbidity and disability attributable to noncommunicable diseases **IS GROWING** ~~now weighs heaviest~~ in the developing countries, where those affected are on average younger than in the developed world. Rapid changes in diets and in patterns of physical activity are further leading to escalating rates. Smoking also increases the risk for these diseases, although largely through independent mechanisms.

6. In the poorest countries of the world, even though infectious diseases and undernutrition dominate their current disease burden, the major risk factors for chronic diseases are spreading. Malnutrition, both of deficiency and excess, is increasingly being found in developing countries, and even in the low-income segments of richer countries. An integrated approach to the causes of unbalanced nutrition and decreasing levels of physical activity would contribute to reducing the future burden of chronic noncommunicable diseases.

7. In some developed countries where noncommunicable diseases have dominated the national burden of disease, age-specific death and disease rates have been slowly declining. Progress is being made in reducing premature death rates from coronary artery disease, cerebrovascular disease and some tobacco related cancers. However, the overall burden and number of patients remain high and many developed countries are experiencing increasing numbers of overweight and obese adults and children, and closely linked increases in type 2 diabetes.

8. **OBESITY AND, BY EXTENSION, THE DISEASES RELATED TO OBESITY, WERE IN THE PAST PRIMARILY LIMITED TO HIGHER-INCOME GROUPS IN** ~~The experience of developed countries and of low-income and middle-income countries in the early stages of economic development.~~ **RECENT EXPERIENCE** shows that patterns of unhealthy behaviours and the associated diseases, **WHICH** are often **FIRST ESTABLISHED** set by the more affluent sectors of society,

ARE NOW OBSERVED TO BE MORE WIDESPREAD ACROSS THE POPULATIONS IN DEVELOPING COUNTRIES. THIS SUGGESTS THAT However, in time, all the major risk factors for chronic noncommunicable diseases tend to cluster among the poorest communities and **MAY** contribute substantially to **SOCIAL AND ECONOMIC DISPARITIES** inequities associated with social class.ⁱⁱ

9. For all countries, current evidence suggests that the underlying determinants of noncommunicable diseases are largely the same. [NOTE: Data are insufficient to support such a generalization.] These include increased consumption of **FACTORS THAT MAY INCREASE THE RISKS OF NONCOMMUNICABLE DISEASE INCLUDE ELEVATED CONSUMPTION OF** energy-dense, nutrient-poor foods that are high in fat, sugar and salt; reduced levels of physical activity at home, at work and for recreation and transport; and tobacco use. **POPULATION-LEVEL** The variationS in risk levels and related health outcomes at the population level **ARE** is attributEDable, **IN PART**, mainly to the variability in timing and intensity of **ECONOMIC, DEMOGRAPHIC, AND SOCIAL** changes at the national and global levels.ⁱⁱⁱ Of particular concern are the increasingly unhealthy diets and reduced physical activity of children and adolescents.

10. Maternal health and nutrition before and during pregnancy, and early infant nutrition are important in the prevention of noncommunicable diseases throughout the life course. **MALNUTRITION IN AN INFANT CAN LEAD TO AN INCREASE IN EARLY CHILDHOOD CARIES. TASTE, FOOD PREFERENCES AND PHYSICAL ACTIVITY HABITS ARE SET EARLY IN LIFE. THE USE OF** Exclusive breastfeeding for six months^{iv} [NOTE: We suggest a citation be provided similar to the one contained in the endnotes.] and appropriate complementary feeding after that, **CAN** contribute to optimal physical growth, mental development and the prevention of noncommunicable diseases. Infants who suffer growth restriction in utero, are of low birth weight, and/or are not breastfed, or are stunted as a result of micronutrient deficiencies, **MAY BE** are at increased risk for noncommunicable diseases in later life. Taste, food preferences and physical activity habits are set early in life. [NOTE: We suggest this last sentence is better placed following the first sentence.]

11. Most of the world's elderly people live in developing countries, and the ageing of populations has a strong impact on morbidity and mortality patterns. Many developing countries will therefore be faced with an increased burden of noncommunicable diseases at the same time as the persisting burden of infectious diseases. In addition to the human dimension, maintaining the health and functional capacity of the increasing elderly population will be a crucial factor to reducing the demand for and cost of health services.

12. Diet and physical activity influence health both together and separately. Unbalanced **UNHEALTHY** diets [NOTE: The definition of "unbalanced diets" in this context is unclear, and we would suggest that the term "unhealthy" might be more appropriate, similar to its use in Paragraph 4 above.] and physical inactivity **MAY** lead to noncommunicable diseases through multiple mechanisms besides those resulting from overweight and obesity. Thus, while the effects of diet and physical activity on health

often interact, particularly in relation to obesity, there are additional health benefits from physical activity that are independent of nutrition and diet. Further, there are significant nutritional risks that are unrelated to obesity. Physical activity is a fundamental **WELL-DEMONSTRATED, AND PROVEN** means of improving the physical and mental health of individuals.^v **THE DATA ON THE INTERACTION OF THESE MANY COMPLEX VARIABLES ARE EVOLVING, AND INTERVENTIONS NEED TO BE CAREFULLY CRAFTED AND ITERATIVELY DESIGNED SO THAT NEW INFORMATION CAN BE EFFECTIVELY INCORPORATED.**

13. Noncommunicable diseases impose a ~~heavy~~ economic burden on already strained health systems, and inflict great costs on society. [NOTE: Although this seems a reasonable conclusion, citation(s) from economic research should be included.] Health is a key determinant of development and a precursor of economic growth. The WHO Commission on Macroeconomics and Health has demonstrated the disruptive effect that disease has on development, and how investments in health are an important prerequisite for economic development. Programmes aimed at promoting healthy diets and physical activity for the prevention of diseases are key instruments in policies to achieve development goals. Such programmes must be effectively integrated **AND EVALUATED** into broader development and poverty-alleviation programmes.

THE OPPORTUNITY

14. A unique opportunity exists to formulate and implement an effective strategy for substantially reducing deaths and disease worldwide by improving diet and promoting physical activity. Evidence for the links between these health behaviours and later disease and ill-health is strong. ~~There are e~~Effective interventions to enable people to live longer and healthier lives, reduce inequalities, and enhance development **CAN BE DEVELOPED AND IMPLEMENTED.** By mobilizing the full potential of global players, this vision could become a reality for all populations in all countries of the world.

GOAL AND OBJECTIVES

15. The overall goal of the global strategy on diet, physical activity and health is to promote and protect health by guiding the development of sustainable actions at the **INDIVIDUAL**, community, national and global levels that, when taken together, will lead to reduced disease and death rates related to unhealthy diet and physical inactivity in populations. These actions support the United Nations Millennium Development Goals and have immense potential for major public health gains worldwide. The global strategy has four main objectives:

- (1) to reduce the risk factors for chronic noncommunicable diseases that stem from action and health-promoting and disease-preventive measures;
- (2) to increase the overall awareness, **KNOWLEDGE**, and understanding of the role of diet and physical activity in determining **INDIVIDUAL AND** public health, and of the positive potential of preventive interventions;

- (3) to encourage the development, strengthening and implementation of from unhealthy diets and physical inactivity by means of essential public health global, regional, national and community policies and action plans to improve diets and increase physical activity that are sustainable, comprehensive, and actively engage all sectors, including civil society, the private sector and the media; **AND**
- (4) to monitor scientific data and key influences on diet and physical activity; to support research in a broad spectrum of relevant areas, **INCLUDING EVALUATION OF INTERVENTIONS**; and to strengthen the human resources needed to enhance and sustain health in this domain.

EVIDENCE FOR ACTION

16. **SOME** Evidence shows that people can remain healthy into their seventh, eighth and ninth decades, **THROUGH A RANGE OF HEALTH PROMOTING BEHAVIORS, INCLUDING** by following an optimal **HEALTHY** diet, maintaining regular physical activity, and not using tobacco. [NOTE: While these are some of the health-promoting behaviors that can lead to a compression of morbidity and an extended life for many persons, there are other factors to take into account, such as family history, genetics and other considerations.] Extensive **RECENT** research in the past years has provided a good and growing understanding of optimal **HEALTHY** diets and the health benefits of physical activity, as well as the most successful individual and population-based public health interventions. While more research is needed, current knowledge warrants urgent public health action. **A WIDE RANGE OF STRATEGIES AND INTERVENTIONS HAS BEEN USED TO PROMOTE PHYSICAL ACTIVITY IN SCHOOLS, WORKSITES, HEALTH CARE SETTINGS, AND COMMUNITIES. OVER THE LAST DECADE A GROWING BODY OF RESEARCH HAS ACCUMULATED AND CAN BE USED TO GUIDE PUBLIC HEALTH ACTION.**^{vi}

17. Noncommunicable disease risk factors frequently coexist and interact. As the general level of risk factors in the population increases, large proportions of populations are put at risk. Preventive strategies should therefore attempt to reduce risk throughout the population. **PREVENTION EFFORTS**, Such risk reduction, even if modest, **COULD** will cumulatively yield the greatest and most sustainable benefits for populations and ~~which will far~~ **HAVE POTENTIAL TO** exceed the limited impact of interventions restricted to individuals at a high level of risk. Healthy diets and physical activity **HAVE THE POTENTIAL TO** will provide widespread benefits for the population and, together with **MEASURES TO PREVENT AND CONTROL** tobacco **USE control, HIGH BLOOD PRESSURE, HIGH CONCENTRATIONS OF CHOLESTEROL IN THE BLOOD, AND OVERWEIGHT AND OBESITY,**^{vii} will constitute **AN EFFECTIVE** the best strategy to **MODULATE** contain the mounting global threat of noncommunicable diseases. [NOTE: While strategies are likely to influence the development of risks for chronic disease, they are unlikely to fully contain these risks.]

18. The recent report of the Joint WHO/FAO Expert Consultation on Diet, Nutrition and the Prevention of Chronic Disease⁺ [NOTE: The Expert Consultation Report #916 was one of a range of inputs that contributed recommendations to the development of this strategy, including a Technical Advisory Group to the WHO Director-General and a series of regional consultative meetings; and following the Report's release, it has received mixed reviews from Member States within both the WHO and FAO governing body venues. Since it is not clear how these and other inputs have been used in the development of the strategy, we suggest that all inputs to the strategy be acknowledged in a note at the beginning of the document and that no one input be linked directly to the strategy.] **A RANGE OF RECENT PEER- AND NON-PEER REVIEWED INFORMATION** provides updated evidence and recommendations on population nutrient intake and physical activity goals for the prevention of major noncommunicable diseases. The findings confirm that healthy diets and physical activity are necessary for a long and healthy life. The Expert Consultation's **SUCH DATA ALSO** recommendations need to be **CONSIDERED IN THE DEVELOPMENT OF EVIDENCE-BASED** translated into national recommendations **AND DIETARY GUIDELINES, AND** in the light of the local health situation, and into dietary guidelines.

19. For diet, the report recommends that populations should: **INDIVIDUAL AND POPULATION RECOMMENDATIONS COULD CONSIDER THE FOLLOWING:**

- **ACHIEVE ENERGY BALANCE FOR WEIGHT CONTROL THROUGH A DIET ADEQUATE IN NUTRIENTS AND PHYSICAL ACTIVITY APPROPRIATE TO INDIVIDUAL NEEDS AND LIMITATIONS;**
- limit energy intake from **TOTAL** fat and shift consumption away from saturated fats, **CHOLESTEROL**, and *trans*fatty acids towards unsaturated fats;
- increase consumption **AND PROMOTE ADEQUATE INTAKE** of fruits and vegetables as well as legumes, whole grains and nuts;
- limit the intake of “free” sugars; **AND**
- limit salt (sodium) consumption from all sources and ensure that **IODIZED** salt is **AVAILABLE**. ~~iodized:~~
- ~~Achieve energy balance for weight control.~~ [NOTE: Moved to the first bullet.]

20. For physical activity, the report **IT IS** recommends**ED** that individuals should engage in adequate levels throughout the life course. Physical activity is a key determinant of energy expenditure, and thus fundamental to energy balance and weight control. The beneficial effects of physical activity on the metabolic syndrome are mediated by mechanisms beyond controlling excess body weight. Different forms of physical activity are required for different health outcomes: at least 30 minutes of

regular, moderate-intensity physical activity on most days of the week are required to ~~prevent~~ **REDUCE THE RISK OF** cardiovascular disease and diabetes, and muscle strengthening and balance training are needed to reduce falls and increase functional status among older adults.

##. PHYSICAL ACTIVITY ALSO HAS SUBSTANTIAL BENEFITS FOR MANY OF THE DISEASES ASSOCIATED WITH OBESITY THAT ARE INDEPENDENT OF THE EFFECT OF PHYSICAL ACTIVITY ON WEIGHT. FOR EXAMPLE, PHYSICAL ACTIVITY REDUCES BLOOD PRESSURE, IMPROVES HIGH-DENSITY LIPID (HDL)-CHOLESTROL, AND IMPROVES CONTROL OF BLOOD GLUCOSE IN OVERWEIGHT PERSONS WITHOUT A MAJOR IMPACT ON THEIR BODY WEIGHT.^{viii}

21. ~~The translation of these recommendations,~~ Together with **OTHER effective MEASURES TO PREVENT AND CONTROL** tobacco ~~USE control,~~ **HIGH BLOOD PRESSURE, HIGH CONCENTRATIONS OF CHOLESTEROL IN THE BLOOD, AND OVERWEIGHT AND OBESITY,**^{ix} into a global framework **STRATEGY ON DIET, PHYSICAL ACTIVITY AND HEALTH** that leads to regional and national action plans will require sustained political commitment and the collaboration of many stakeholders. This framework will provide the basis for the effective prevention of chronic diseases.

PRINCIPLES FOR ACTION

22. Drawing upon a broad consultation process, and experience with successful policies and strategies in countries and communities, the following principles have guided the development of the draft WHO global strategy on diet, physical activity and health:

- Strategies need to be comprehensive, incorporating both policies and action and addressing all major causes of chronic diseases together; multisectoral, taking a long-term perspective and involving all aspects of society; multidisciplinary and participatory;; consistent with the principles contained in the Ottawa Charter for Health Promotion (1986); [NOTE: We suggest deletion, since there have been a number of informal, subsequent health promotion “charters” following the Ottawa Charter in 1986, including the Jakarta and the Mexico City Declarations, which delineate other additional principles/concepts that could have applicability to this strategy. Further, these charters are health promotional tools, rather than principles formally endorsed by Member States.] based on the best available scientific research and evidence; ~~and~~ transparent; **AND UNDERSTANDABLE BY THE POPULATIONS THAT ARE THE INTENDED AUDIENCE FOR THE STRATEGIES.**
- **THERE NEEDS TO BE RECOGNITION OF THE COMPLEX INTERACTIONS OF PERSONAL CHOICE, SOCIAL NORMS, AND ECONOMIC AND ENVIRONMENTAL FACTORS IN INFLUENCING**

DIETARY AND PHYSICAL ACTIVITY HABITS IN A SUSTAINABLE MANNER OVER THE LIFESPAN.

- **EFFECTIVE COMMUNICATION WITH THE POPULATIONS THAT ARE THE INTENDED PARTICIPANTS IN AND BENEFICIARIES OF THE STRATEGY IS ESSENTIAL FOR SUCCESS. INDIVIDUALS, FAMILIES AND COMMUNITIES NEED ACCESS TO APPROPRIATE INFORMATION TO UNDERSTAND THE ACTIONS THEY CAN TAKE TO IMPROVE THEIR HEALTH. POPULATION-LEVEL ASSESSMENTS OF FUNCTIONAL HEALTH LITERACY SKILLS AND ONGOING RESEARCH AND EVALUATION OF HEALTH LITERACY AND HEALTH COMMUNICATION PROGRAMS PROVIDE THE FOUNDATION AND FRAMEWORK FOR THE DEVELOPMENT OF EFFECTIVE COMMUNICATION WITH DIVERSE POPULATIONS.^x**
- As emphasized in *The world health report 2002*, there is great potential for improving public health by implementing preventive and health promotion measures that reduce the **PREVALENCE** ~~distribution~~ of chronic disease risk factors (most notably in diet and physical activity, taken together) in the population.
- A life-course perspective on noncommunicable disease prevention and control is critical. This starts with maternal health, pregnancy outcomes, infant feeding and child and adolescent health; reaches children at schools, adults at worksites and other settings, as well as the elderly, and encourages a balanced diet and regular physical activity throughout the life span.
- Public health strategies to reduce noncommunicable diseases should be considered as part of a larger, comprehensive and coordinated effort on diet, physical activity and public health. All partners, especially governments, need to address simultaneously a number of issues. Diet extends to all aspects of unbalanced nutrition (e.g., overnutrition as well as undernutrition, micronutrient deficiency and excess consumption of certain nutrients); food security (accessibility, availability and affordability of healthy food choices); food safety; and support for and promotion of six months of exclusive breastfeeding.^{xi}
[NOTE: We suggest a citation be provided similar to the one contained in the endnotes.] Physical activity issues include ~~requirements for~~ physical education and activity in school, working and home life (including both increased sedentariness and heavy **DECREASED** physical labour, particularly in developing countries); increasing urbanization, and various aspects of city planning, transportation, safety and access to physical activity during leisure.
- Priority should be given to activities that have a positive impact in the poorest populations and communities in countries. Many programmes exist that benefit mainly the more affluent populations. Strategies that benefit the lives of the

poorest in a country will generally require community-based action with strong government intervention and oversight.

- All partners need to be accountable in reducing these preventable risks to health and in putting in place [NOTE: It is not clear how stakeholders would be held accountable or who would identify for what each stakeholder is being held accountable. We suggest the following changes make the paragraph more accurate and feasible for implementation.] **EFFORTS SHOULD BE FOCUSED ON** policies and programmes that will **HAVE THE HIGHEST PROBABILITY OF** making a difference **IN REDUCING THESE PREVENTABLE RISKS**. In this regard, evaluation, monitoring and surveillance are essential components of national strategies and actions.
- Decisions about food, nutrition and physical activity are often made by women and are based on culture and traditional diets. Patterns of physical activity vary according to gender, culture and age. In many countries, the prevalence of chronic conditions related to diet and physical activity can vary greatly between men and women. Therefore, the strategy and action plans should be sensitive to gender differences.
- Dietary habits, as well as patterns of physical activity, are often rooted in local and regional traditions. National strategies should therefore be culturally **AND LINGUISTICALLY** appropriate, **REFLECTIVE OF FUNCTIONAL HEALTH LITERACY CAPACITIES** and capable of **WORKING WITHIN THE CONTEXT OF** challenging cultural influences and **VALUES AND** of responding to changes over time.^{xii}

RESPONSIBILITIES FOR ACTION

23. Bringing about changes in diet and increased physical activity will require the combined efforts of many stakeholders, public and private, over several decades. A combination of sound and effective strategies is needed, with close monitoring and evaluation of their impact. The following paragraphs describe responsibilities and provide recommendations, deriving from the consultation process, for **MEMBER STATES, WHO AND FAO, Member States**, international partners, civil society and nongovernmental organizations and the private sector.

[NOTE: Since this is a strategy for Member States, the section for Member States (Paragraphs 30 through 43) within “Responsibilities for Action” should be placed first, followed by the role of United Nations Agencies, etc.]

WHO AND FAO

24. **WHO AND FAO**, in cooperation with other United Nations agencies, has **VE** the role, responsibility and the mandate to lead the development and implementation of the global strategy on diet, physical activity and health. As outlined below, to facilitate

implementation of the strategy, action at the local, national, regional and global levels is warranted.

25. **WHO AND FAO**, in cooperation with other United Nations agencies, will provide the leadership, evidence-based recommendations and advocacy for international action to improve dietary practices and increase physical activity, in keeping with the guiding principles and specific recommendations contained in this strategy.

26. **WHO AND FAO** will hold discussions with the transnational food industry and other parts of the private sector in support of the aims of this global strategy, and of implementing the recommendations in countries.

27. **WHO AND FAO** will support the implementation of programmes as requested by Member States, at any other appropriate level, and will focus on the broad, interrelated areas described below:

- facilitating the development, strengthening and updating of regional and national policies on diet and physical activity for integrated noncommunicable disease prevention;
- facilitating the development, updating and implementation of national food-based dietary and physical activity guidelines, in collaboration with national agencies and drawing upon global knowledge and experience;
- providing guidance to Member States on the formulation of guidelines, norms, standards and other policy-related measures that are consistent with the objectives of the global strategy;
- identifying and disseminating information on evidence-based interventions, policies and structures that are effective in optimizing the level of physical activity and promoting healthy diets in countries and communities;
- providing appropriate technical support to build national capacity in planning and implementing the national strategy and in tailoring the strategy to local circumstances;
- providing models and methods so that interventions on diet and physical activity are a systematic component of health care;
- promoting healthy diet, nutrition and physical activity as an essential part of training for health professionals, by promoting and supporting training for health professionals in healthy diets and an active life, either as part of existing programmes or in special workshops, as key components of the strategy;
- advising, coordinating and supporting Member States, using standardized surveillance methods and rapid assessment tools (such as WHO's STEPwise

approach to surveillance of noncommunicable disease risk factors), to measure changes in population distribution of risk – including patterns in diet, nutrition and physical activity – in order to assess the current situation, trends, and the impact of interventions. **WHO AND FAO** will support Member States in establishing national nutrition surveillance systems, linked with data on the content of food items;

- advising Member States on ways of engaging constructively with industry.

28. **WHO AND FAO**, in close collaboration with **OTHER** United Nations agencies and other intergovernmental organizations (FAO, United Nations University and others), research institutes and other partners, will promote and support research in priority areas to facilitate programme implementation and evaluation. **THIS COULD INCLUDE** ~~WHO will commission~~ **ING** scientific papers, **conductING** analyses, and **holding** technical meetings on priority, practical research topics that are essential for effective country action. The use of evidence, including health impact assessment, cost-benefit analysis, national burden-of-disease studies, evidence-based intervention models, scientific advice and dissemination of good practice, should be improved to inform the decision-making process.

29. **WHO AND FAO** will work with WHO collaborating centres to establish networks for research and training, mobilize resources, and facilitate coordinated, collaborative research as it pertains to the needs of developing countries in the implementation of this strategy. The networks will support WHO's mandate for capacity building and will also serve to mobilize the contributions from nongovernmental organizations and civil society to the implementation of the strategy.

Member States

30. In order to improve diet and physical activity, this global strategy will foster the formulation of, and promote and support national policies and plans. Because of the great variations in and between different countries, regions should collaborate in implementing the strategy; regional strategies can provide considerable assistance to countries in implementing their national policies.

31. The role of government is crucial to achieving lasting change in public health. Governments have a primary steering and stewardship role in initiating and developing the strategy, ensuring that it is implemented and monitoring its impact in the long term.

32. Health **AND AGRICULTURE** ministries have an essential responsibility **TO WORK TOGETHER IN** ~~for~~ coordinating and facilitating the contributions of many other ministries and government agencies **TOWARDS IMPROVING DIET AND NUTRITION AND INCREASING PHYSICAL ACTIVITY**. These include especially: ministries and governmental institutions with responsibility for policies on food, ~~agriculture~~, youth, recreation, sports, education, commerce and industry, finance, transportation, media and communication, social affairs and environmental/sustainability planning, as well as local authorities and those responsible for urban development.

33. Governments are encouraged to build on existing structures and processes that already address aspects of diet, nutrition and physical activity. In many countries, existing national strategies and action plans on food, diet, nutrition and physical activity can be ~~USED developed~~ in accordance with this strategy, while in others they can be developed as the basis for advancing noncommunicable disease control.

GOVERNMENTS ARE ENCOURAGED TO DEVELOP, AS APPROPRIATE, ~~There should be~~ a national coordinating mechanism, WITH LOCAL INVOLVEMENT, that addresses diet and physical activity within the context of a comprehensive noncommunicable disease prevention and health promotion plan. Local government authorities should be closely involved. **GOVERNMENTS ARE ENCOURAGED TO DEVELOP ~~e~~Expert advisory boards THAT ARE ~~should be~~ multisectoral and multidisciplinary, WHICH; ~~they should~~ include technical experts and representatives of government agencies, with an independent chair to ensure that scientific evidence is interpreted without any conflicts of interest. [NOTE: The suggested changes are to help encompass developed and developing countries in the areas of diet, physical activity and the fight against noncommunicable diseases and obesity.]**

34. **AS APPROPRIATE, GOVERNMENTS ARE ENCOURAGED TO DEVELOP ~~n~~National strategies, policies and action plans that are developed to promote healthy diets and physical activity for the prevention of noncommunicable diseases ~~should be~~ supported by effective legislation, an appropriate administrative infrastructure, and adequate funding, ONGOING MONITORING AND EVALUATION, AND FURTHER RESEARCH.** The various aspects of national strategies, policies and plans **COULD** include:

(1) national strategies on diet and physical activity: National strategies describe the **EVIDENCE-BASED** measures to promote healthy diets and physical activity that are crucial to disease prevention and the promotion of health of the population, including integrated strategies for comprehensively addressing all aspects of unbalanced diets, including undernutrition and overnutrition. National strategies and action plans should include specific goals, objectives, and actions, similar to those outlined in this strategy. Of particular importance is the need to focus on elements that are necessary to implement the **SPECIFICS OF THE** plan of action **THAT IS DEVELOPED**. These elements include identification of necessary resources and national focal points (key national institutes); intersectoral collaboration between the health sector and other key sectors such as agriculture, **EDUCATION, COMMUNICATION**, urban planning, and transportation; and monitoring and follow-up.

(2) national dietary guidelines: ~~The report of the Joint WHO/FAO Expert Consultation on Diet, Nutrition and the Prevention of Chronic Diseases and recommendations of national expert bodies may form the basis for~~ **GOVERNMENTS ARE ENCOURAGED TO DEVELOP AND PERIODICALLY UPDATE SCIENCE-BASED** national guidelines **TO ~~Such~~**

guidelines guide national nutrition policy, nutrition education **AND COMMUNICATION** efforts, other public interventions and intersectoral collaboration. ~~These guidelines may be updated p~~ **Periodically in the light of UPDATES SHOULD TAKE INTO ACCOUNT** changes in dietary and disease patterns.

(3) national physical activity guidelines: National guidelines for health-enhancing physical activity should be prepared in accordance with the aims of this strategy and available expert recommendations.

35. **GOVERNMENTS SHOULD PROVIDE** ~~Provision of~~ accurate and balanced information ~~should be ensured~~. Governments need to consider actions that will result in balanced information for consumers to allow healthy choices to be easy decisions, and to ensure the existence of appropriate health promotion and education programmes. In particular, information for consumers should be sensitive to literacy levels and the local culture, and understood by all segments of the population. In some countries, health-promoting programmes have been designed to address communication barriers and needs such as literacy levels. These programmes should be utilized for disseminating information about diet and physical activity. Some governments already have a legal obligation to ensure that factual information enables consumers to make fully informed choices on matters that affect their health. On the other hand, actions may be specific to the policies adopted by the governments of particular countries. Governments should select the optimal mix of policies and programmes. Areas for **EVALUATION AND** action could include:

(1) education, communication and public awareness: Appropriate public knowledge **AND UNDERSTANDING OF** ~~on~~ the relationship between **DIET AND** physical activity **PATTERNS** ~~diet and health,~~ on energy intake and output, ~~on diets and patterns of physical activity that lower the~~ **REDUCED** risk of noncommunicable diseases, and ~~on~~ healthy choices of food items provides a basis of good policy **AND EDUCATIONAL PROGRAMS**. ~~There should be a platform for developing~~ **Consistent, coherent, simple and clear messages, to be conveyed THAT HAVE BEEN TESTED WITH INTENDED AUDIENCES FOR APPROPRIATENESS OF PRESENTATION, CONTENT, SOURCES AND CHALLENGES ARE ENCOURAGED.** ^{xiii} ~~by government experts, nongovernmental and grass roots organizations, and industry.~~ Such messages should be communicated to people through several channels and in forms appropriate to local culture, age, and gender. Schools, workplaces, educational and religious institutions, nongovernmental organizations, community leaders, as well as mass media, are in key positions to influence behaviour **AND HEALTH MESSAGES**. Member States should form alliances to convey appropriate and effective messages about healthy lifestyles, including diet and physical activity. Health, nutrition and physical activity education and media literacy skills, starting in primary school, are important to **PROMOTE HEALTHIER DIETS, AND** counter food fads and misleading dietary advice. It is also important to provide support for action in **ALL** ~~developing~~ countries that improves the level of health

literacy, while taking into account local cultural and socioeconomic circumstances.

(2) marketing, advertising, sponsorship and promotion: Food advertising affects food choices and influences dietary habits. Food and beverage advertisements should not **HAVE THE POTENTIAL TO** exploit children's inexperience or credulity. Messages **SHOULD** that encourage unhealthy dietary practices **AND** or physical inactivity should be discouraged, and positive, healthy messages encouraged. Governments should **ENCOURAGE** work with **PARENTS AND FAMILIES**, consumer groups and with the industry (including the advertising sector) to develop appropriate approaches to deal with the marketing of food to children.

(3) labelling: **GOVERNMENTS ARE ENCOURAGED TO PROMOTE** consumers **ACCESS TO** have the right to accurate, standardized and comprehensible information on the content of food items so that it is conducive to making healthy choices. Governments may require information on key nutritional aspects, as proposed in the Codex Guidelines on Nutrition Labelling.

(4) health claims: As consumers' interest in health grows, and increasing attention is paid to the health aspects of food products, producers increasingly use health-related messages. Such messages must not mislead the public about nutritional benefits or risks. **TESTING OF MESSAGES FOR CONSUMER UNDERSTANDABILITY WITH INTENDED POPULATION SEGMENTS SHOULD BE ENCOURAGED.**

36. National food and agricultural policy should ensure consistency with the protection and promotion of public health. ~~Governments should examine all food and agricultural policies for intended and unintended effects on the healthiness of the food supply.~~

[NOTE: There is little economic analysis or scientific basis for this recommendation.]

Food and nutrition policy should cover nutrition, food safety and sustainable food supply

SECURITY. Where needed, governments should consider policies that **PROMOTE NUTRITIONALLY BALANCED AND VARIED DIETS THAT CONTRIBUTE TO OVERALL ENERGY BALANCE.** ~~provide incentives and support for the production and marketing of healthier food.~~

[NOTE: Little if any data exist to support an association between incentives for the production and marketing of "healthier" food and either reduction in the prevalence of NCDs or decreased levels of obesity. We are also unclear as to the definition of "healthier" foods as used in this context.]

Efforts could involve support for: production and marketing (including storage, transport, preservation, and promotion) of **FOODS NECESSARY FOR A BALANCED AND VARIED DIET NOT SUFFICIENTLY AVAILABLE IN A GIVEN COUNTRY AND AROUND THE WORLD;** fruit, vegetables and legumes and other healthy produce; innovations to **INCREASE THE NUTRITIONAL DENSITY OF PROCESSED** ~~produce~~ healthier foods; **AND** distribution chains and policies for the export of healthy **NUTRITIOUS** products. ~~Member States are also encouraged to use~~

tax policy and other fiscal measures in a manner that promotes health and is fiscally sustainable. Areas for action could include:

(1) promotion of healthier **DIETS** food items: As a result of consumers' increasing interest in health and the growing interest of governments in healthy nutrition, some governments have undertaken various measures, **TO PROMOTE HEALTHY DIETS, ENCOURAGE GREATER MODERATION, VARIETY, AND BALANCE AMONG FOOD GROUPS AND BETWEEN ENERGY INTAKE AND EXPENDITURE.** ~~including market incentives, to promote the development, production and marketing of healthier food items.~~ **SOME** Many companies have responded by developing new products and are committed to reducing incrementally the levels of saturated fats, sugar and salt in their products as well as portion sizes. Governments could **ENCOURAGE PRIVATE SECTOR STAKEHOLDERS TO** consider additional measures to ~~encourage the reduction of the salt content of processed foods, measures to restrict~~ **THE USE OF** hydrogenated ~~oil~~ of oils, and ~~methods of reducing the excess sugar content of beverages and snacks.~~

(2) **FISCAL** price policies: ~~Price~~ Public policies can ~~reflects production costs and influences consumption choices.~~ ~~Public policies can influence prices through taxation, subsidies or direct pricing~~ in a way that encourages healthy eating and lifelong physical activity. Several countries use fiscal measures to promote availability of and access to various foods. ; ~~others use taxes to increase or decrease consumption of food; and some use public funds and subsidies to promote access among poor communities to recreational and sporting facilities.~~ **GIVEN THE OBVIOUS EFFECTS THAT PRICE FLUCTUATION COULD HAVE ON FOOD INSECURITY AND ACCESS, MEASURES SHOULD BE PARTICULARLY WELL-TESTED FOR EFFECTIVENESS IN PROMOTING OVERALL ENERGY BALANCE, WHETHER THEY IMPACT DIET AND HEALTH FAVORABLY, AND ARE COST-EFFECTIVE AND FEASIBLE. MEASURES SHOULD ALSO BE EVALUATED FOR RISK OF UNINTENDED EFFECTS ON MALNUTRITION IN VULNERABLE POPULATIONS OR FOOD AVAILABILITY AND ACCESS PRIOR TO BROAD IMPLEMENTATION.**

(3) food programmes: In many countries, there are programmes to provide food to population groups with special needs or cash transfers to enable families to improve their food purchases. Such programmes often concern children, families with children, poor people, and people with HIV/AIDS and other diseases. Special attention should be given to the quality of the food items and to nutrition education as a main component of these programmes, so that food distributed to or purchased by the families not only provides energy, but also contributes to a balanced and healthy diet. Food and cash distribution programmes should emphasize empowerment and development, local production and sustainability.

(4) agricultural policies: Agricultural production **POLICIES CAN** often has a great effect on national diets. ~~Governments can influence agricultural production through many policy measures.~~ As emphasis on health increases and consumption patterns change, Member States need to take healthy nutrition into account in their agricultural policies. **ANY MEASURES SHOULD BE WELL-TESTED FOR ECONOMIC EFFICIENCY, POSITIVE PUBLIC HEALTH OUTCOMES AND UNINTENDED CONSEQUENCES, AND SHOULD BE IN ACCORDANCE WITH EXISTING INTERNATIONAL AGREEMENTS.**

37. Multisectoral policies to promote physical activity are needed. National physical activity policies should target change in a number of sectors. **AS APPROPRIATE,** Governments should review national physical activity policies to ensure that they are consistent with best practice in population-wide approaches to increasing physical activity. Areas for action include:

(1) ministries of health should take the lead in forming partnerships with key agencies **AND PUBLIC/PRIVATE STAKEHOLDERS**, in order to develop with them a common agenda and work plan aimed at promoting physical activity;

(2) promoting environments that facilitate physical activity, and developing the supportive infrastructure to increase access to and usage of these environments and facilities;

(3) developing and implementing strategies to change social norms and to increase community understanding and acceptance of the need for integrating physical activity into everyday life (active living);

(4) reviewing relevant public policies and legislation that have an impact on opportunities for physical activity – examples include policies on transport, urban planning, education, labour, social inclusion, and on health care funding related to physical activity; ~~(5)~~ promoting community policies related to physical activity – national and local governments can develop policies and provide incentives to ensure that (i) walking, cycling and other forms of physical activity are **ACCESSIBLE** easy and safe; (ii) transport policies include non-motorized modes of transportation; (iii) labour and workplace policies encourage physical activity; and (iv) sport and recreation facilities embody sport-for-all concepts and principles. [NOTE: We suggest combining elements (4) and (5) strengthens the flow of the physial activity concepts presented.]

(5) **CLEAR DELINEATION OF SIMPLE, DIRECT MESSAGE(S) ON THE QUANTITY AND QUALITY OF PHYSICAL ACTIVITY SUFFICIENT TO PROVIDE SUBSTANTIAL HEALTH BENEFITS.**^{xiv}

38. School policies should support the adoption of healthy diets and physical activity. Schools influence the lives of most children in all countries. They **HAVE THE**

OPPORTUNITY TO ~~should~~ protect the good health of children by providing health information, **PROMOTING AND INCREASING** ~~teaching~~ health literacy, and promoting healthy diets and physical activity, as well as other healthy behaviours. Schools **ARE ENCOURAGED TO PROVIDE STUDENTS WITH** ~~should require~~ daily physical education and should be equipped with appropriate facilities **AND EQUIPMENT. GOVERNMENTS ARE ENCOURAGED TO ADOPT** ~~policies~~ **THAT** ~~should~~ support healthy diets at school and limit the availability of products high in salt, sugar and fats. Schools should consider, together with **PARENTS, FAMILIES AND** other responsible authorities, developing contracts with local food growers for school lunches to ensure a local market for healthy foods.

##. GOVERNMENTS ARE ENCOURAGED TO DEVELOP ADULT EDUCATION PROGRAMS THAT SUPPORT THE INCLUSION OF HEALTH LITERACY IN THEIR CURRICULA. ADULT EDUCATION LEARNING CENTERS AND PROGRAMS CAN PROVIDE THE HEALTH FIELD WITH A VENUE FOR REACHING POOR AND MEDICALLY UNDERSERVED POPULATIONS. ADULT EDUCATION SYSTEMS WITH THE GOAL OF BUILDING SKILLS FOR FULL PARTICIPATION IN SOCIETY COULD AUGMENT ADULT STUDENTS' ABILITIES TO ACCESS AND UNDERSTAND HEALTH INFORMATION AND SERVICES TO SUPPORT HEALTHY DIETS AND PHYSICAL ACTIVITY.^{xv}

39. **GOVERNMENTS ARE ENCOURAGED TO ARRANGE** ~~pPolicy~~ consultations **WITH STAKEHOLDERS.** ~~should be arranged. For~~ **BROAD PUBLIC DISCUSSION AND INVOLVEMENT IN THE POLICY DEVELOPMENT PROCESS CAN FACILITATE ACCEPTANCE AND EFFECTIVENESS OF** ~~public~~ policies. ~~To be accepted and effective, there needs to be broad public discussion and involvement.~~ achieve this, Member States should establish mechanisms to **PROMOTE** ~~ensure~~ participation of nongovernmental organizations, civil society, communities, the private sector and the media in activities related to diet, physical activity and health. **GOVERNMENTS ARE ENCOURAGED TO ASSIGN** Ministries of health **AND AGRICULTURE** ~~should be given~~ responsibility for establishing these mechanisms, ~~which should~~ aimed at strengthening intersectoral cooperation at the national, provincial and local levels and ~~at~~ encouraging **PARENTAL, FAMILY AND** community participation., ~~and should be part of the community planning process.~~

40. Prevention **IS A CRITICAL ELEMENT OF** ~~should be built into~~ health services. Routine contacts with health service staff should include practical advice to patients and families on the benefits of ~~optimal~~ **HEALTHY** diets and **MODERATE** ~~increased~~ levels of physical activity. Governments ~~sh~~Could consider incentives to encourage preventive services and identify opportunities for prevention within existing clinical services. Governments **ARE ENCOURAGED TO** ~~should also~~ consider an improved financing structure to encourage and enable health professionals to dedicate more time to preventing and managing chronic diseases. Areas for action could include:

(1) health and other services: Health **CARE PROVIDERS**, services, especially for primary health care **AND DENTAL AND ORAL HEALTH**, but also other services (such as social services) can counsel individuals on healthy diets and necessary physical activity. This **COUNSELING** should take a life-course approach that stresses the importance of prenatal nutrition, **ENCOURAGES** exclusive breastfeeding for six months,^{xvi} [*NOTE: We suggest a citation be provided similar to the one contained in the endnotes.*] and healthy diet and continuing regular physical activity from youth into old age. Special attention should be given to the new WHO growth standards for infants and preschool children (in preparation). These standards help to expand the definition of health beyond the absence of overt disease, to include the adoption of healthy practices and behaviours recommended by WHO and other national and international agencies (e.g., breastfeeding, nutritionally adequate and safe complementary feeding, non-smoking and other lifestyle circumstances that promote physiological growth). Routine inquiries as to key dietary habits and physical activity, combined with simple counselling, can reach a great part of the population and be a cost-effective intervention. The measurement of key biological risk factors, such as blood pressure, serum cholesterol and body weight, combined with education of the population and counselling of patients, helps to promote the necessary changes. The identification of specific high-risk groups and measures to respond to their needs, including possible pharmacological interventions, are important components. Training of health personnel, availability of appropriate guidelines and possible incentives, **AND IMPROVING THE SKILLS OF HEALTH PROFESSIONALS TO COMMUNICATE WITH PERSONS OF ALL LEVELS OF HEALTH LITERACY, AND ESPECIALLY THOSE WITH LIMITED LITERACY SKILLS**,^{xvii} are key underlying factors in implementing these measures;

(2) involvement with health professional bodies, health and consumer groups: Public awareness of government policies will be increased, and their effectiveness amplified, by enlisting strong professional, consumer and community support in a cost-effective way.

41. **GOVERNMENTS ARE ENCOURAGED TO MAKE** investments ~~should be made~~ in surveillance, research and evaluation. **LONG-TERM AND CONTINUOUS** monitoring ~~OF~~ major risk factors **IS CRITICAL. OVER TIME, SUCH DATA ALSO PROVIDE THE BASE FOR NECESSARY ANALYSES OF CHANGES IN THESE RISK FACTORS THAT COULD BE ATTRIBUTABLE** and their responsiveness to changes in policies and strategies. ~~is critical.~~ Many governments can build on systems already in place, at either the national or the regional level. Emphasis should initially be given to standard **INDICATORS RECOGNIZED BY THE GENERAL SCIENTIFIC COMMUNITY AS VALID. EXAMPLES OF SUCH INDICATORS ARE THOSE DEVELOPED FOR** measures of physical activity, selected dietary components, and to body weight, **VITAMIN A, IODINE, AND ANEMIA, AND BODY WEIGHT STATUS, AS WELL AS PHYSICAL MEASURES ON** as well as to levels of blood pressure, serum cholesterol and blood

glucose and to tobacco use. National data, comparable among countries, are essential. **THE LONGER-TERM GOAL IS TO DEVELOP COMPARATIVE DATA AT THE GLOBAL LEVEL. IN THE SHORTER TERM, DATA THAT PROVIDE INSIGHT INTO WITHIN-COUNTRY PATTERNS AND VARIATIONS ARE USEFUL IN GUIDING COMMUNITY ACTION. WHERE POSSIBLE, OTHER SOURCES OF DATA SHOULD BE ANALYZED AND WHEN APPROPRIATE, INTEGRATED INTO COMPOSITE DATA SETS THAT COULD PROVIDE ADDITIONAL HEALTH-RELATED INFORMATION; DATA FROM USED; FOR EXAMPLE, THE TRANSPORT AND AGRICULTURE SECTORS AND OTHER SECTORS, COULD BE EXAMINED AND INTEGRATED.** Areas for action could include:

(1) monitoring and surveillance: Monitoring and surveillance are essential tools for national diet and physical activity policies. Ongoing and standardized monitoring of diet, physical activity, nutrition-related biological risk factors and contents of food products, **INTENDED POPULATIONS' UNDERSTANDING OF THE INFORMATION** and communication to the public of the information obtained **ARE IS AN IMPORTANT PARTS** of national diet and physical activity policy. Of particular importance is the development of methods and procedures utilizing standardized data collection and a common minimum set of indicators, in collaboration with WHO. **INDICATORS SHOULD BE VALID, MEASURABLE, AND USABLE.** [NOTE: The efforts to develop standardized indicators have been fraught with many technical problems; over the years many researchers have opted for "harmonization" over "standardization" because of the problem, particularly in measuring risk factors, of the strong contextual nature of some of the variables such as physical activity, tobacco use, alcohol use, and eating patterns. In addition, the language used in questionnaire development is an issue. Over time, "standardization" is the goal, but as efforts have changed to providing data that is of use to those collecting and needing the data, data that are useful has taken precedence over data that are perfect.]

(2) research and evaluation: Applied research, especially in community-based demonstration projects, and in evaluating different interventions and policies, should be promoted. Such research (e.g., into the reasons for physical inactivity and poor diet, and on key determinants of effective intervention programmes), combined with the increased involvement of behavioural scientists, will lead to better informed policies and policy-makers and ensure that a cadre of expertise is created at national and local levels. Equally important is the need to put in place effective mechanisms for evaluating the efficacy and cost-effectiveness of national disease prevention programmes and policies, as well as the health impact of other policies. More information is needed, especially on the situation in developing countries. **THIS IS CRITICAL FOR DEVELOPING COUNTRIES THAT NEED TO DEVELOP OR STRENGTHEN APPROPRIATE EVALUATION CAPACITY AND INCREASE UNDERSTANDING OF WHAT CONSTITUTES EVIDENCE THAT A GIVEN INTERVENTION IS WORKING. MANY COUNTRIES ALSO NEED SUPPORT TO DEVELOP OR STRENGTHEN THE**

APPROPRIATE PUBLIC HEALTH INFRASTRUCTURE TO CARRY OUT THESE TYPES OF EVALUATION.

42. Institutional capacity. Under the ~~health ministry~~ **MINISTRIES OF HEALTH AND AGRICULTURE**, national institutions for public health, nutrition and physical activity have an important role as focal points for experience, coordination and monitoring in relation to the implementation of national diet and physical activity programmes. They can provide the necessary expertise, monitor the developments, help to coordinate activities, participate in international collaboration and advise political decision-makers.

43. Financing national programmes. Various sources of funding, in addition to the national budget, to assist in the implementation of effective national diet and physical activity programmes, should be identified. The United Nations Millennium Declaration (September 2000) recognizes that economic growth is limited unless people are healthy. The most cost-effective interventions to contain the noncommunicable disease epidemic are prevention and a focus on the risk factors associated with these diseases: unhealthy diets, physical inactivity and tobacco use. Programmes aimed at promoting healthy diets and physical activity should therefore be viewed as a developmental need and should draw policy and financial support from national plans for development. ~~At the same time, care must be exercised to avoid the distortions that often accompany accelerated development and adversely affect diet and patterns of physical activity.~~ [NOTE: Data are insufficient to support such a generalization.]

International partners

44. The role of international partners is of paramount importance in achieving the goals and objectives of the global strategy, particularly with regard to issues of a transnational nature, or where the actions of a single country are insufficient. Coordinated work is needed within the United Nations system and with major international agencies, nongovernmental organizations, professional associations, research institutions and the private sector.

45. WHO AND FAO will enhance **THEIR** ~~its~~ long-standing collaboration ~~with FAO~~ in implementing the strategy. The **FAO** ~~latter organization~~ has a special role in developing agricultural policies, ~~through its work with farmers and others involved in food production,~~ and can play a crucial part in implementing the strategy. ~~The composition of foods in production, and the supply and processing systems along the food chain, will need increasingly to respond to consumer demand and become more environmentally sound, economically viable and nutritionally balanced. Thus, m~~ More research into food supply, availability, processing and consumption will be necessary **TO DEVELOP AND EVALUATE EFFECTIVE AND APPROPRIATE AGRICULTURAL POLICY THAT ALSO HAS THE POTENTIAL TO IMPROVE HEALTH, DIET, AND PHYSICAL ACTIVITY.**

46. Collaboration with United Nations organizations. As a result of the strategy development process, closer interaction has also developed with other organizations of

the United Nations system, such as UNESCO and UNICEF, and other partners, including the World Bank. Cooperation is also planned with organizations such as ILO, the United Nations Economic and Social Council, the regional development banks, WTO and the United Nations University. WHO AND FAO will work with appropriate international agencies in developing and strengthening partnerships, including global and regional networks, consistent with the goal and objectives of this strategy, and in order to disseminate information, exchange experiences, and support regional and national initiatives. International collaboration will be promoted through the establishment and the coordination of networks. WHO AND FAO will convene an ad hoc committee of the concerned United Nations partners to ensure continuing policy coherence and in order to draw upon each organization's unique strengths. Partners can play an important role in a global network that targets such areas as advocacy, resource mobilization, capacity building and collaborative research.

47. ~~Specific areas in which~~ International partners **WITH TECHNICAL EXPERTISE COULD PROVIDE STRONG UNDERPINNINGS FOR ONGOING HEALTH PROMOTION EFFORTS. SUCH PARTNERS** could play a role in implementing the global strategy and **EVIDENCE-BASED** policies for noncommunicable disease prevention and control including:

- developing comprehensive intersectoral global strategies on diet, physical activity and prevention of noncommunicable diseases, including for instance the promotion of healthy diets in poverty-alleviation programmes;
- drawing up guidelines for preventing nutritional deficiencies and infectious diseases in order to integrate and harmonize future dietary and policy recommendations designed to prevent and control noncommunicable diseases;
- facilitating the development of national guidelines on diet and physical activity, in collaboration with national agencies;
- cooperating in the development, testing and dissemination of models of community empowerment, involving local production, nutrition and physical activity education and enhanced consumer consciousness;
- promoting the inclusion of noncommunicable disease prevention and health promotion policies relating to diet and physical activity as components of development policies and programmes;
- promoting incentive-based approaches ~~for global markets~~ to encourage chronic disease prevention and control.

48. International standards. Public health efforts may be strengthened by the **AVAILABILITY AND** use of international norms and standards, **SUCH AS LABELING AND FOOD STANDARDS** particularly those developed by the Codex Alimentarius Commission (see resolution WHA56.23). Areas for **CONSIDERATION**

further development **COULD** include: labelling to **PROVIDE** allow consumers **WITH INFORMATION** ~~to be better informed~~ about the benefits and content of foods **WHILE MINIMIZING THE POTENTIAL FOR MISINFORMATION THAT COULD ENCOURAGE** ~~minimizing the impact of marketing on~~ unhealthy dietary patterns; ~~among children;~~ *[NOTE: This affects adults as well as children.]* ~~increasing~~ information about healthy consumption patterns, including taking steps to increase the availability/consumption of fruit and vegetables; and production and processing standards **REGARDING THE NUTRITIONAL QUALITY AND SAFETY OF PRODUCTS.** ~~New~~ **Multi-stakeholder INVOLVEMENT OF GOVERNMENTS AND NON-GOVERNMENTAL ORGANIZATIONS AS PROVIDED FOR IN THE CODEX SHOULD BE ENCOURAGED.** ~~approaches involving governments, private companies and consumer groups may be required to address issues such as sponsorship, promotion and advertising.~~

Civil society and nongovernmental organizations

49. Diet and physical activity are a fundamental part of the daily behaviours of individuals living within communities. Civil society and nongovernmental organizations have an important role to play in influencing both individual behaviour and the organizations and institutions that affect diet and physical activity. An important aim is to ensure that consumers ask that governments support healthy lifestyles, and that industry provides healthy products. Nongovernmental organizations can support the strategy effectively if they collaborate with national and international partners. Civil society and nongovernmental organizations can particularly:

- lead grass-roots mobilization and advocate for healthy diets and physical activity to be placed on the public agenda;
- support the wide dissemination of **UNDERSTANDABLE** information **APPROPRIATE TO THE INTENDED POPULATION SEGMENTS** on how to prevent noncommunicable diseases through balanced, healthy diets and physical activity;
- form networks and action groups to promote the availability of healthy foods and possibilities for physical activity, and advocate for and support health-promoting programmes and health education campaigns;
- organize campaigns and events that will stimulate action;
- emphasize the role of governments in protecting and promoting public health, healthy diets and physical activity; monitor progress in achieving objectives; and ~~monitor the work~~ **WITH** of other stakeholders such as the private sector;
- play an active and leadership role in fostering the implementation of the global strategy;

- put knowledge and evidence into practice.

Private sector

50. The private sector can be a significant player in promoting healthy diets and physical activity. Food companies, retailers, sporting goods companies, the catering industry, advertising and recreation companies, insurance and banking groups, pharmaceutical companies and the media all have crucial parts to play as responsible employers and as advocates for healthy lifestyles. All could become partners with governments and nongovernmental organizations in implementing measures aimed at sending positive and consistent messages to facilitate and enable integrated efforts to encourage healthy eating and physical activity. Because many companies operate globally, international collaboration is crucial. Cooperative rather than adversarial relationships with industry have already led to many favourable outcomes related to diet and physical activity. **FOOD INDUSTRY-SPONSORED initiatives undertaken by the food industry to THAT INCREASE INTRODUCTION OF INNOVATIVE, HEALTHY, AND NUTRITIOUS CHOICES;** modify the fat, sugar and salt content of processed foods and **to AND review many current marketing practices could PLAY A USEFUL ROLE IN** accelerating health gains worldwide. Specific recommendations include the following:

- promote healthy diets and physical activity in accordance with national guidelines and international standards and the overall aims of this global strategy;
- **ENCOURAGE INDUSTRY-SPONSORED OPPORTUNITIES TO REDUCE CALORIC DENSITY, AND** limit the levels of saturated fats and trans-fatty acids, sugars and salt in existing products;
- continue to develop and provide affordable, healthy and nutritious choices to consumers;
- review the case for introducing new products with better **NUTRIENT/FOOD COMPONENT** health profiles;
- provide consumers with adequate, **UNDERSTANDABLE** product and nutrition information;
- follow responsible marketing practices that support the strategy, particularly with regard to the promotion and marketing of foods high in saturated fats, **TRANSFAT**, sugar or salt, especially to young children;
- implement simple, clear, and consistent food labelling practices and evidence-based health claims that will help consumers to exercise informed and healthy choices with respect to the nutritional content (salt, quality and quantity of fat and sugar) of foods;

- provide information on food composition to national authorities;
- manufacturers of sporting goods and related products can assist in developing and implementing physical activity programmes.

51. Workplaces are important settings for health promotion and disease prevention. In order to reduce exposure to risk through changes in patterns of diet and physical activity, people need to be given the opportunity to make healthy choices in the workplace. Further, the cost to employers of morbidity attributed to noncommunicable diseases is increasing rapidly. Workplaces should provide **ACCESS TO** healthy food choices in cafeterias and support and encourage physical activity.

FOLLOW-UP AND FUTURE DEVELOPMENTS

52. Member States, ~~and WHO AND FAO SHOULD~~ will monitor and report on the progress made in implementing the global strategy and in developing national strategies, **INCLUDING**. ~~Their reports will cover~~ the following aspects:

- patterns and trends of diet and physical activity and major noncommunicable disease risk factors related to diet and physical activity;
- evaluation of the effectiveness of diet and physical activity programmes and policies;
- information on the constraints or barriers encountered in the implementation of the strategy and the measures taken to overcome them;
- information on legislative, executive, administrative, financial or other measures undertaken within the context of this strategy.

53. WHO will work through its regional offices and with Member States on plans for implementing and developing a monitoring system and relevant indicators on diet and physical activity.

54. Drawing on the experience gained, WHO will prepare a report on the progress of the implementation of the strategy, with possible proposals for amendments, for submission to the Fifty-ninth World Health Assembly in 2006.

CONCLUSIONS

55. Actions, based on scientific**ALLY-SOUND** evidence and the cultural context, need to be **DEVELOPED AND TESTED**, implemented and monitored with assistance and leadership from WHO. But WHO and its Member States cannot succeed alone. A truly multisectoral approach that mobilizes the combined energy, resources and expertise of all global stakeholders is essential for sustained progress.

56. Progress in changing patterns of diet and physical activity will be gradual, and national strategies will need a clear plan for long-term and sustained disease-preventive measures. However, changes in risk factors and noncommunicable disease rates can occur quite quickly when effective interventions are made. National plans should therefore also have achievable short-term and intermediate goals.

57. The implementation of this strategy could lead to **SIGNIFICANT** ~~one of the largest~~ and sustained improvements in population health ~~ever seen~~. Success **MAY** will result in improvements in global health that **MAY NOT BE REACHED** ~~can rarely be matched~~ by other possible measures.

ⁱ Petersen PE. The World Oral Health Report 2003: continuous improvement of oral health in the 21st century - the approach of the WHO Global Oral Health Programme. *Community Dental Oral Epidemiology* 2003;31(Supplement 1):3-24.
Moynihan P, Petersen PE. Diet, nutrition and the prevention of dental diseases. *Public Health Nutrition* 2004;7(01A):201-226.

ⁱⁱ Martorell R and Stein AD. The emergence of diet-related chronic diseases in developing countries in "Present Knowledge in Nutrition. Bowman BA and Russel RM (eds.) 8 ed. ILSI Press, Washington, 2001. Ch. 58; pp 665-85.

Monteiro CA, Benicio MHD'A, Conde WL, Popkin BM. Shifting obesity trends in Brazil. *European Journal of Clinical Nutrition*. 2000; 54:342-346.

Martorell R, Khan LK, Hughes ML, Grummer-Strawn LM. Obesity in women from developing countries. *European Journal of Clinical Nutrition*. 2000; 54:247-252.

Navarro V. Health and equity in the world in the era of globalization. *International Journal of Health Services*. 1999; 29:215-225.

Popkin BM. The shift in stages of the nutrition transition in the developing world differs from past experiences. *Public Health Nutrition*. 2002; 5 (1A): 205-214.

ⁱⁱⁱ *The world health report 2002: Reducing risks, promoting healthy life*. Geneva, World Health Organization, 2002.

^{iv} "Infant and Young Child Nutrition" as formulated in the conclusions and recommendations of the Expert Consultation (Geneva, 28 to 30 March 2001) that completed the Systematic Review of the Optimal Duration of Exclusive Breastfeeding (WHO Document A54/INFO.DOC/4) and cited in Resolution WHA 54.2.

^v U.S. Department of Health and Human Services. The Surgeon General's call to action to prevent and decrease overweight and obesity. [Rockville, MD]: U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General; [2001]. Available from: the U.S. Government Printing Office, Washington, D.C.

^{vi} Lenfant C. Can we prevent cardiovascular diseases in low- and middle-income countries? *Bulletin of the World Health Organization*. 2001; 79(10): 980-982.

Unwin N, Setel P, Rashid S, Mugusi F, Mbanya JC, Kitange H, Hayes L, Edwards E, Aspray T, Alberti KGMM. Noncommunicable diseases in sub-Saharan Africa: where do they feature in the health research agenda? *Bulletin of the World Health Organization*. 2001; 79(10):947-53.

U.S. Department of Health and Human Services. The Surgeon General's call to action to prevent and decrease overweight and obesity. [Rockville, MD]: U.S. Department of

Health and Human Services, Public Health Service, Office of the Surgeon General; [2001]. Available from: U.S. Government Printing Office, Washington, D.C.

^{vii} As cited in paragraph 3 of the draft Global Strategy on diet, physical activity and health.

The world health report 2002: Reducing risks, promoting healthy life. Geneva, World Health Organization, 2002.

^{viii} Pate RR, Pratt, M, Blair SN, Haskell WL, Macera CA, Bouchard C, Buchner D, Ettinger W, Heath GW, King AC, et.al. Physical activity and public health. A recommendation from the Centers for Disease Control and Prevention and the American College of Sports Medicine. *Journal of the American Medical Association (JAMA)*. 1995 Feb 1;273(5):402-7. Review.

U.S. Department of Health and Human Services. The Surgeon General's call to action to prevent and decrease overweight and obesity. [Rockville, MD]: U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General; [2001]. Available from: U.S. Government Printing Office, Washington, D.C.

^{ix}*The world health report 2002: Reducing risks, promoting healthy life.* Geneva, World Health Organization, 2002.

^x U.S. Department of Health and Human Services. *Communicating Health: Priorities and Strategies for Progress.* Washington, D.C., July 2003. Available online at <http://odphp.osophs.dhhs.gov/projects/healthcomm>.

Institute of Medicine, Committee on Communication for Behavior Change in the 21st Century: Improving the Health of Diverse Populations. *Speaking of Health: Assessing Health Communication Strategies for Diverse Populations.* Washington, D.C.: The National Academies Press. 2002. Available online at <http://books.nap.edu/catalog/10018.html>.

Healthy People 2010 Health Communication Focus Area. In *Healthy People 2010*, Vol. 1. U.S. Department of Health and Human Services. 2nd edition. With Understanding and Improving Health and Objectives for Improving Health. 2 volumes. Washington, D.C.: U.S. Government Printing Office, November 2000. Available online at www.healthypeople.gov.

^{xi} "Infant and Young Child Nutrition" as formulated in the conclusions and recommendations of the Expert Consultation (Geneva, 28 to 30 March 2001) that completed the Systematic Review of the Optimal Duration of Exclusive Breastfeeding (WHO Document A54/INFO.DOC/4) and cited in Resolution WHA 54.2.

^{xii} U.S. Department of Health and Human Services. *Communicating Health: Priorities and Strategies for Progress.* Washington, D.C., July 2003. Available online at <http://odphp.osophs.dhhs.gov/projects/healthcomm>.

^{xiii} U.S. Department of Health and Human Services. *Communicating Health: Priorities and Strategies for Progress.* Washington, D.C., July 2003. Available online at <http://odphp.osophs.dhhs.gov/projects/healthcomm>.

Institute of Medicine, Committee on Communication for Behavior Change in the 21st Century. Improving the Health of Diverse Populations. *Speaking of Health: Assessing Health Communication Strategies for Diverse Populations.* Washington, D.C.: The National Academies Press. 2002. Available online at <http://books.nap.edu/catalog/10018.html>.

^{xiv} U.S. Department of Health and Human Services. The Surgeon General's call to action to prevent and decrease overweight and obesity. [Rockville, MD]: U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General; [2001]. Available from: U.S. Government Printing Office, Washington.

^{xv} *Healthy People 2010* health literacy action plan. U.S. Department of Health and Human Services. 2nd ed. With Understanding and Improving Health and Objectives for Improving Health. 2 vols. Washington, D.C.: U.S. Government Printing Office, November 2000. Available online at www.healthypeople.gov.

Action plan for the improvement of health literacy. In *Communicating Health: Priorities and Strategies for Progress*. U.S. Department of Health and Human Services. Washington, D.C., July 2003. Available online at <http://odphp.osophs.dhs.gov/projects/healthcomm>.

^{xvi} "Infant and Young Child Nutrition" As formulated in the conclusions and recommendations of the Expert Consultation (Geneva, 28 to 30 March 2001) that completed the Systematic Review of the Optimal Duration of Exclusive Breastfeeding (See Document A54/INFO.DOC/4) and cited in Resolution WHA 54.2.

^{xvii} U.S. Department of Health and Human Services. *Communicating Health: Priorities and Strategies for Progress*. Washington, D.C., July 2003. Available online at <http://odphp.osophs.dhhs.gov/projects/healthcomm>.