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Center for Communications, Health and the Environment

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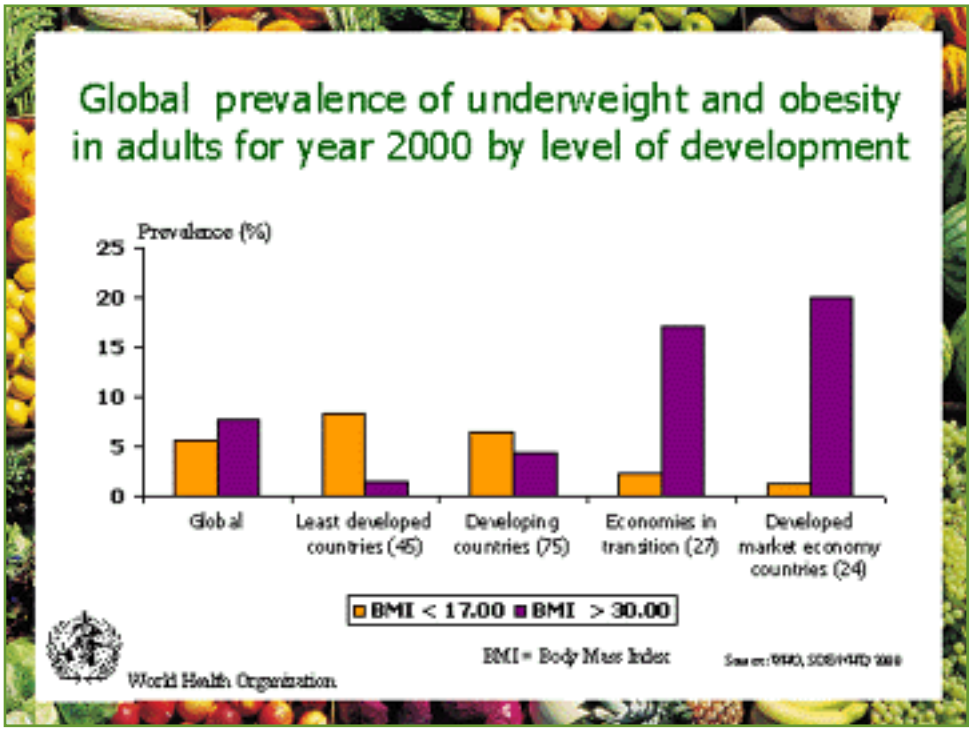
Spring/Summer 2004 **Vol. 12, Issue 1**

Curbing the Obesity & Undernutrition Epidemic Could Forestall Major Assault on Global Health

Sounding the Alarm: Obesity Scourge Spreads Unchecked

by Anna Ferro-Luzzi and Pekka Puska, World Health Organization, Geneva



More people are obese than ever before. In fact, while representative country data remain somewhat limited, the picture emerging is that of a global obesity epidemic, rapidly spreading from the developed to the developing regions of the world.

The Epidemic

The magnitude of the problem is staggering. Recent analysis reveals 1 billion overweight people worldwide. And one in three of them – 300 million men and women – are clinically obese. (World Health Report 2002; www.who.int/whr)

The prevalence of obesity varies across countries. In Europe and the United States, 10 to 25 percent of the population is obese, while in Brazil, 6 percent of men and 13 percent of women tip the scales. In Western Samoa, obesity affects 77 percent of urban women, and it is a fact of life for 44 percent of black women in the Cape Peninsula of the Republic of South Africa. In

Home

Return to MONITOR Front Page

CECHE's Homepage
For more information on the organization and its programs...

CECheck-Up

CECHE Chairman Sushma Palmer Comments on This Issue's Topics.

Insider's View

Individuals alone can't halt the obesity epidemic.

Features

- Dean Ornish presents optimal solution to dieters' dilemma.

CECHE News

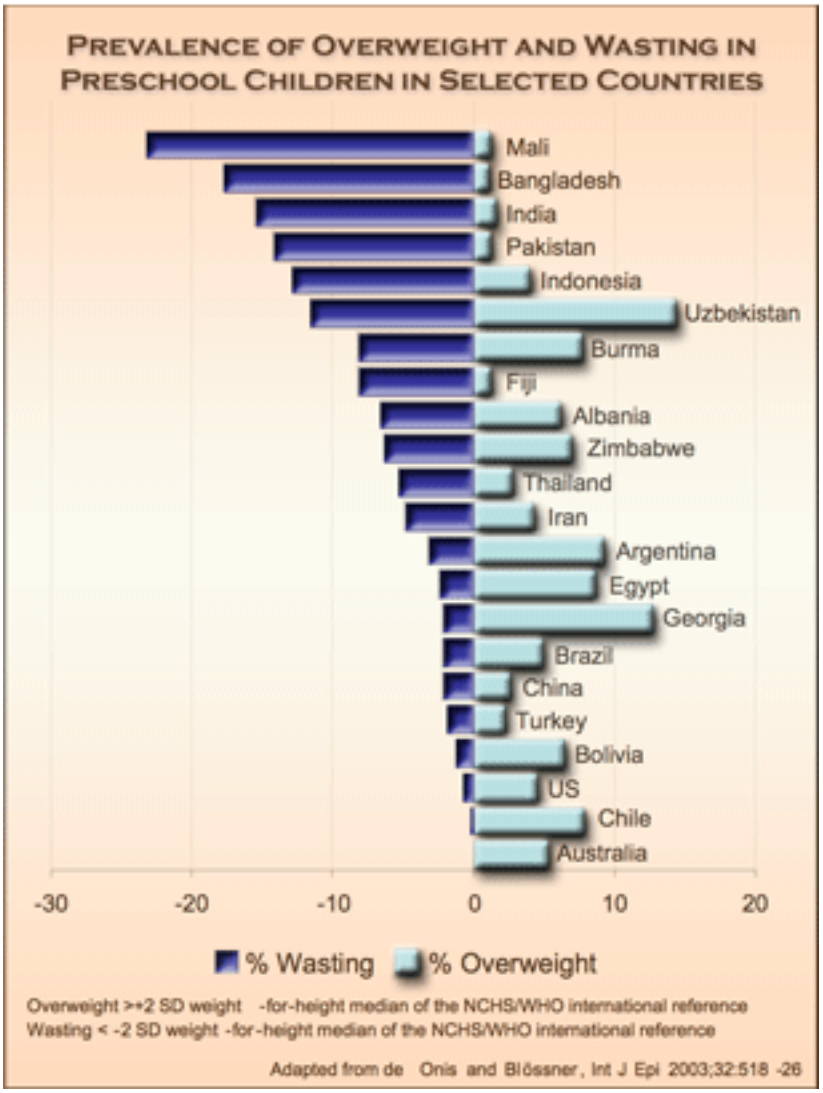
- Universal democracy requires breaking the axis of dictatorships.
- Domestic and international actions ensure education for all children.

general, obesity is highest among lower-income populations in developed countries, and among more affluent people in developing ones. [see full article...]

Undernutrition and Childhood Obesity Together Deliver Potent Punch Worldwide

by Prof. Boyd Swinburn, Centre for Physical Activity and Nutrition Research, Deakin University, Melbourne, Australia

Seemingly unrelated, undernutrition and childhood obesity are actually intricately, and complexly, linked. Over the past 10 years, all but the poorest countries have experienced substantial increases in obesity prevalence, and in many low- to middle-income countries, obesity is overtaking undernutrition as the main national nutrition problem.



Undernutrition On the Wane

Childhood undernutrition, or malnutrition, is a chronic problem in lower-income countries. A high prevalence (>40%) of stunting in children is present in sub-Saharan Africa and many countries in South-Central and Southeast Asia, while low (<20%) and moderate (20-30%) rates are seen in the majority of Latin American and Caribbean nations. Thankfully, in all developing countries combined, the prevalence of stunting has dropped considerably, from nearly 50 percent in 1980 to 30 percent in 2000, and it is projected to fall to about 16 percent by 2020. Unfortunately, African nations continue to suffer severely, with only about a 5 percent decline from 1980 to 2000. [see full article...]

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Home

Return to MONITOR Front Page

CECHE's Homepage
For more information on the organization and its programs...

CECheck-Up

CECHE Chairman Sushma Palmer Comments on This Issue's Topics.

Insider's View

Individuals alone can't halt the obesity epidemic.

Features

- Dean Ornish presents optimal solution to dieters' dilemma.

CECHE News

- Universal democracy requires breaking the axis of dictatorships.
- Domestic and international actions ensure education for all children.

Policy Beat

- WHO's obesity control strategy deserves more applause than critique.

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"For the first time in human history, the number of overweight people rivals the number of underweight people," states the World Watch Institute (WWI).

While the world's underfed population has declined slightly since 1980 to 1.1 billion, the number of overweight people has topped the billion mark, with at least 300 million of them obese. Even more alarming, overweight and obesity are advancing rapidly in the developing world. The World Health Organization (WHO) has coined the phrase "globesity" to describe the escalating global epidemic of overweight and obesity, which paradoxically coexists with undernutrition in many parts of the world.

The Spring/Summer 2004 issue of the Global Health and Environment Monitor heeds WWI and WHO's urgent call for action to prevent obesity and overweight around the globe, while continuing to combat undernutrition. In the lead article, Anna Ferro-Luzzi and Pekka Pushka outline obesity's increasing prevalence, its causes and consequences, and strategies for prevention. In a companion article, Boyd Swinburn focuses on children, underlining the adverse, synergistic effects of obesity and malnutrition on this vulnerable group.

Michael Jacobson traces the origins of obesity in the United States, while highlighting the pitfalls of national policies for obesity prevention and offering proactive actions to halt the epidemic in the Insider's View. In a complimentary feature, Dean Ornish compares his recommended low-fat and the Atkins low-carbohydrate diets, and offers an evidence-based, practical formula to weight reduction and maintenance.

CECHE News features CECHE Vice Chairman Mark Palmer discussing universal democracy and observing that the world's most pressing health and environmental problems are disproportionately concentrated in dictatorships – topics covered in his recent book, "Breaking the Real Axis of Evil." Also included in this section is Phyllis Magrab's update on Communities Can International (CCI), a joint project of the Georgetown University Center for Child and Human Development and CECHE; in her article, she relates CCI and UNESCO's efforts to ensure education for all children by 2015.

An apt conclusion to this issue is Philip James' policy piece, a pithy analysis of national and universal approaches, especially WHO's newly proposed global strategy, for combating the obesity epidemic. WHO's recommendations, implementation of which would necessitate certain long-overdue changes in food, sugar and soft-drink industry practices, are opposed by fast-food industry lobbyists and the U.S. secretary for Health and Human Services, giving James' "toxic environment" label both poignancy and power.

Sushma Palmer

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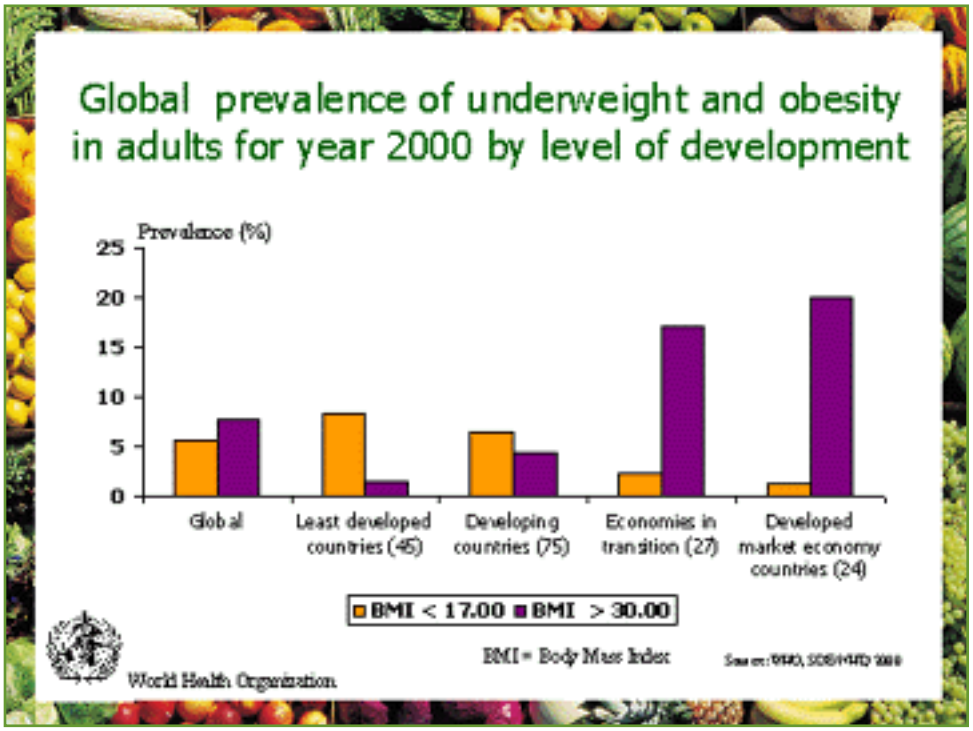

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Home

Return to MONITOR Front Page

CECHE's Homepage
For more information on the organization and its programs...

CECheck-Up

CECHE Chairman Sushma Palmer Comments on This Issue's Topics.

Insider's View

Individuals alone can't halt the obesity epidemic.

Features

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CECHE News

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among more affluent people in developing ones.

One of the most alarming features of the obesity epidemic is how quietly it is spreading. (WHO Expert Consultation 2000; http://www.who.int/hpr/gs.who.fao.report.shtml) The prevalence of obesity has doubled over the last 20 years in the United Kingdom and Japan, and it has increased 10 to 50 percent in most European countries. Sadly, surveys repeated over time show that between 0.5 and 1 percent of all children in the United States, Brazil, Canada, Australia and some European countries become overweight each year, according to *Obesity in Young People: The Coming Crisis in Public Health*, a 2003 report to the World Health Organization (WHO) by T. Lobstein, L. Baur and R. Uauy. Meanwhile, the rate of increase in obesity in Mexico and Morocco is six times higher than it is in the United States.

Today, the total number of overweight people in the world exceeds the number of underweight ones. Nationally, representative data convincingly show that this is true for the urban as well as the rural populations of practically all developing countries, with the notable exception of the Indian subcontinent and sub-Saharan Africa.

The Causes

This rising tide of obesity is the outcome of cumulative exposure to two main factors: energy-dense, "fast food" diets and increasingly sedentary lifestyles. The energy density of foods is directly related to fat content, with added sugar often contributing substantially. The average energy density of a wide range of well-known, typical fast foods is almost 2.5 times higher than that of the African diet and 1.7 times greater than that of the typical British diet. Because humans have only a weak innate capability to down-regulate the bulk of food consumed in order to maintain energy equilibrium, people tend to eat in excess of their needs when exposed to a high-fat, sugar-rich, energy-dense diet. This phenomenon is called "passive over-consumption." (Prentice A.M., Jebb S.A., *Fast foods, energy density and obesity: a possible mechanistic link, Obesity Reviews (2003)* 4, 187-194)

The other major risk factor for obesity, especially powerful if associated with the consumption of an energy-dense diet, is a sedentary lifestyle. Unfortunately, today sedentarism is a fact of life in many communities thanks to the changes over the second half of the last century reducing overall physical activity and energy expenditure. In short, the energy costs of both leisure and labour have plummeted, aided by technological changes and the ubiquity of motorised transportation. In addition, opportunities for physical activity have been curtailed by environmental structural changes in school environments, street safety, transport policies and urban design.

The Consequences

In and of itself, obesity can be a debilitating condition, but its importance as a global public health problem stems primarily from the fact that it represents a substantial risk factor for several health conditions. Type 2 diabetes is one of the most significant health consequences, with about 90 percent of diabetics being obese or overweight. And with 300 million cases of adult diabetes projected in 2025 (228 million of these in developing countries), the situation is only expected to worsen.

Diabetes is not the only co-morbidity of obesity. Hypertension, cardiovascular and gallbladder disease, certain types of cancer, insulin resistance, dyslipidaemia, osteo-arthritis, sleep apnoea and breathlessness, and asthma, hyperuricemia and gout are also associated with the condition.

So is a substantial financial burden. Roughly estimated, the cost of the management and treatment of obesity imposed upon health services is 2 to 8 percent of the overall health budget for the developed countries. (A similar estimate for developing countries is not possible at

present.) It is important to note, however, that the rapidity with which the epidemiological transition is taking place in developing countries has generated a double burden of disease, with the emerging obesity epidemic and its attendant chronic diseases happening at a time when communicable diseases and undernutrition are still paramount problems. The public health implications of this double burden are extremely worrying, as they may impose an intolerable strain on the limited financial resources of impoverished countries.

The situation is severe. In response, at the request of the World Health Assembly (WHA) 2002 (www.who.int/whr), WHO has proposed a "Global Strategy on Diet, Physical Activity and Health" (http://www.who.int/hpr/global.strategy.shtml). If adopted by WHA in May 2004, this action plan will provide a roadmap for countries and other stakeholders to adopt healthier diets and physical activity – and to start to curb the global epidemic of obesity with all of its serious health consequences. [back to front page....]

[Front Page**] - [**CECheck-Up**] - [**Insider's View**] - [**Features**] - [**CECHE News**] - [**Policy Beat**]**

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Home

Return to MONITOR Front Page

CECHE's Homepage
For more information on the organization and its programs...

CECheck-Up

CECHE Chairman Sushma Palmer Comments on This Issue's Topics.

Insider's View

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Features

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CECHE News

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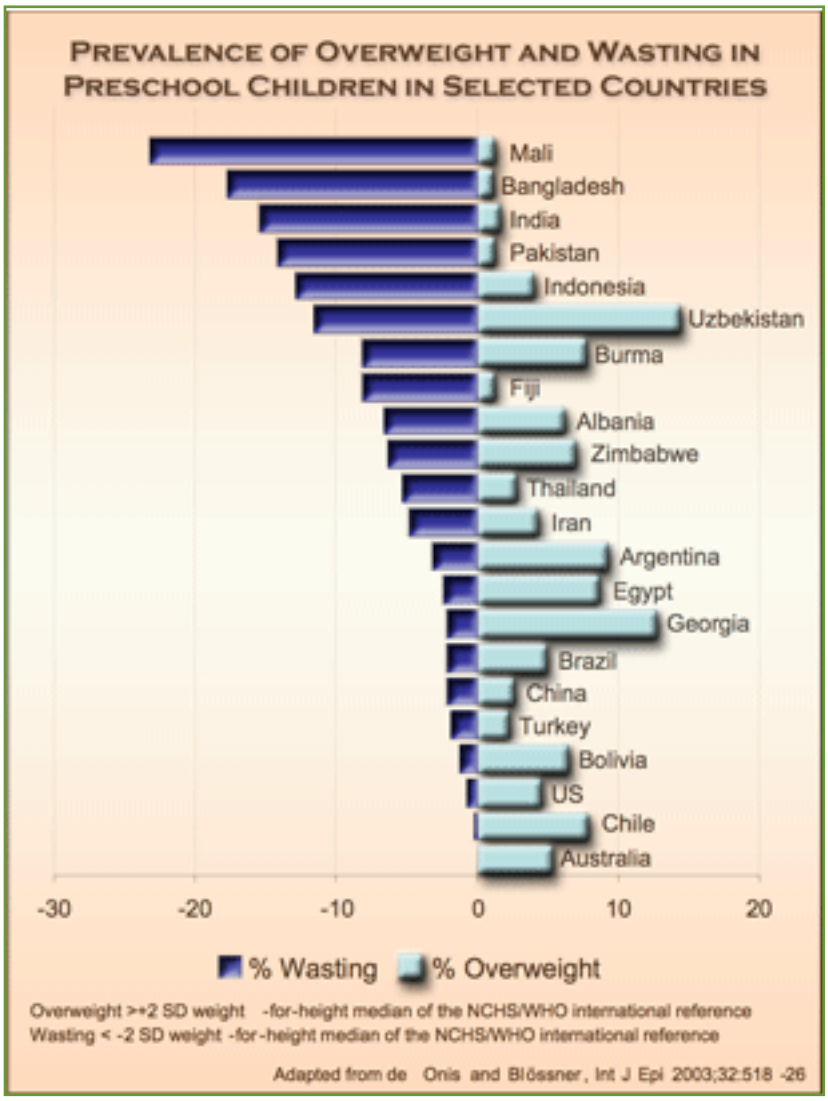

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Undernutrition On the Wane

Childhood undernutrition, or malnutrition, is a chronic problem in lower-income countries. A high prevalence (>40%) of stunting in children is present in sub-Saharan Africa and many countries in South-Central and Southeast Asia, while low (<20%) and moderate (20-30%) rates are seen in the majority of Latin American and Caribbean nations. Thankfully, in all developing countries combined, the prevalence of stunting has dropped considerably, from nearly 50 percent in 1980 to 30 percent in 2000, and it is projected to fall to about 16 percent by 2020. Unfortunately, African nations continue to suffer severely, with only about a 5 percent decline from 1980 to 2000.

Emerging Patterns of Obesity in Childhood

At the same time, levels of obesity are increasing, particularly in higher-income countries and within the wealthier (often urban) populations of low- to middle-income nations. Increases in childhood obesity usually occur some time after upsurges in adult obesity, although there are exceptions. In China, for example, the household pattern of lean parents and grandparents but overweight children is not uncommon. The developing countries with the highest prevalence rates for obesity are the Middle East, North Africa and Latin America.

In some countries, such as many Pacific nations, the prevalence rates of both childhood obesity and undernutrition are low; however, adult obesity is extremely prevalent, and therefore children can expect to gain 1 to 2kg per year during the decade after they leave school.

Coexistence of Malnutrition and Obesity

Malnutrition and obesity coexist in many developing nations. This high double burden (>5% prevalence rates of each among pre-school children) is seen in such diverse countries as Yemen, Uzbekistan, Kiribati, Burma, Albania, Zimbabwe and Malawi. While the majority of overweight children come from urban environments and higher-income families, malnutrition and obesity may, and often do, occur within the same family.

Even in wealthy countries, such as Australia and the United States, where childhood obesity is very common (one-quarter to one-third of all children), there are significant pockets of malnutrition. This is the result of food insecurity – a condition defined by periods of not having enough money to buy food, and one that is increasingly experienced among disenfranchised people, especially migrant populations. A recent childhood nutrition survey in New Zealand, for example, found that more than one-fifth of households reported "running out of food due to lack of money" either "sometimes" (18.5%) or "often" (3.6%).

Except for cases of extreme poverty or poor access to food, undernutrition of total energy is generally not a problem in these wealthier nations; nevertheless, children and adolescents from low-income families in these countries often exhibit higher prevalence rates of obesity, micronutrient deficiency (or inadequate intake) and episodes of food insecurity. So, two apparent paradoxes exist in these "lands of plenty": significant levels of food insecurity and higher prevalence rates of obesity (and micronutrient deficiency) among people who experience food insecurity.

Responding to the New Childhood Nutrition Challenges

Even within wealthier countries, where the childhood obesity epidemic has been brewing for at least a decade, awareness of the need for action is only now gaining ground with the politicians, media and public. Under-recognition of the problem by parents and health professionals, and the sensitivities of discussing childhood obesity are significant barriers to action. Meanwhile, evidence of the effectiveness of potential interventions and programs is sorely lacking.

Within low-income countries plagued by chronic undernutrition, some of the systems used to manage this scourge (e.g., monitoring the height and weight of children, maternal nutrition and education programs) could, in theory, also be used to help address the obesity problem. However, the momentum of these initiatives and their orientation towards feeding programs to increase energy intake may be counterproductive if these efforts cannot be re-configured to address both undernutrition and the emerging obesity problem.

A further challenge is the positive perception that many cultures have of being overweight or obese. In Africa, for example, a large belly is often viewed as a sign of wealth and health because its owner clearly has enough money to buy plenty of food and doesn't harbor diseases such as HIV, AIDS or tuberculosis.

Much needs to be done to manage childhood malnutrition and obesity, and most countries – rich and poor alike – would do well to heed the call. To do so in a meaningful way will require these nations to allocate program resources, institute proactive primary-prevention policies and substantially increase monitoring mechanisms.[back to front page....]

[Front Page**] - [**CECheck-Up**] - [**Insider's View**] - [**Features**] - [**CECHE News**] - [**Policy Beat**]**

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Home

Return to MONITOR Front Page

CECHE's Homepage
For more information on the organization and its programs...

CECheck-Up

CECHE Chairman Sushma Palmer Comments on This Issue's Topics.

Insider's View

Individuals alone can't halt the obesity epidemic.

Features

- Dean Ornish presents optimal solution to dieters' dilemma.

CECHE News

- Universal democracy requires breaking the axis of dictatorships.
- Domestic and international actions ensure education for all children.

Policy Beat

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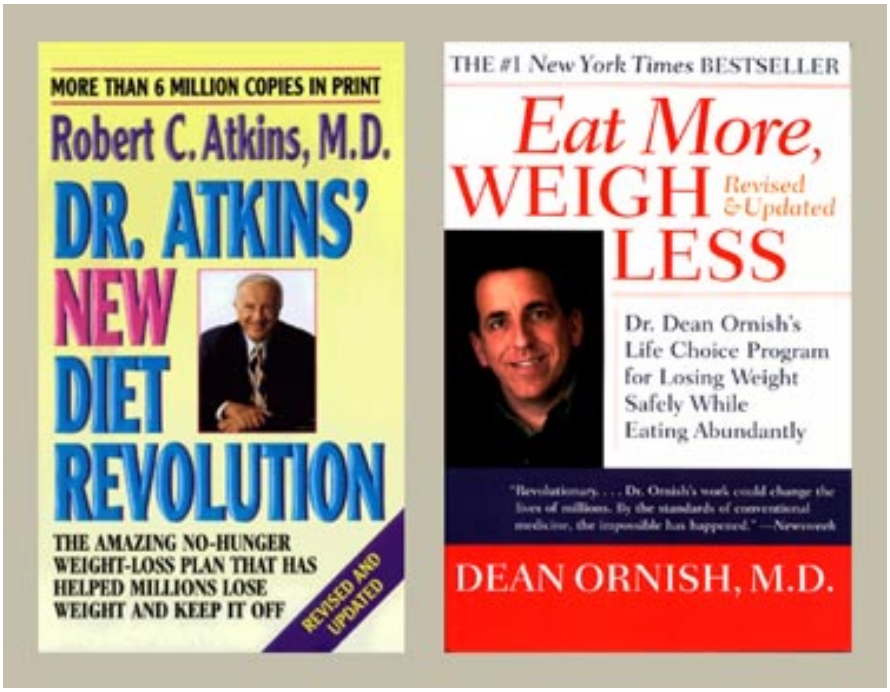
Fed Up With Diets?

by Dean Ornish, M.D., Founder and President, The Preventive Medicine Research Institute, Sausalito, California; Clinical Professor of Medicine, University of California, San Francisco

Dieting is hard enough; but add in the debate over the two major approaches to weight reduction in the Western world – the low-fat diet and the low-carbohydrate diet – and the prospect of losing weight often seems hopeless. The key is to distinguish what sounds good from what is real, what may be hurtful from what is definitely healthful.



Drs. Atkins and Ornish square off on weight loss.

If Truth Be Told

In recent years, there has been a resurgence of interest in low-carbohydrate, high-fat diets such as the Atkins diet. The media have added to the confusion, reporting that, "The percentage of calories from fat in the American diet is lower than ever, yet Americans are more overweight than ever, and so, dietary fat is not responsible for obesity." In fact, per capita consumption of fat has risen by 10 pounds/year since 1975, whereas per capita consumption of simple carbohydrates has increased even more – by 20 pounds/year. So, while the percentage of calories from fat has decreased, the amount of fat consumed has actually increased.

Less Is More

Despite the plethora of diets, losing weight is no mystery: Burn more calories and/or eat fewer calories. It's that simple.

You can burn more calories by exercising. You can eat fewer calories by consuming less food.

While you can lose weight on any diet that restricts portion sizes, it's often hard to keep it off because you may feel hungry and deprived. An easier way to lower caloric intake is to eat less fat, because fat (whether saturated, monosaturated or unsaturated) has nine calories/gram, whereas protein and carbohydrates have only four. A 2001 Pennsylvania State University study, for example, found that healthy women instinctively ate about three pounds of food a day, whether high or low in calories. The primary drive was volume, not calories. Thus, by eating less fat, individuals can cut calories by reducing energy density without sacrificing volume, meaning they can lose weight without feeling hungry or deprived.

Simple Isn't Always Better

The other reason people get too many calories is that they consume too many simple carbohydrates. In my numerous debates with Dr. Atkins, we agreed that many Americans eat excessive amounts of processed foods

high in simple carbohydrates, including sugar, high fructose corn syrup, white flour, white rice and alcohol. Because these foods are low in fiber, large quantities of calories can be consumed without feeling full. Also, these low-fiber foods are absorbed quickly, causing blood sugar to spike, which in turn causes insulin to surge. Excess insulin accelerates the conversion of calories into fat. Insulin surges also promote atherosclerosis, contribute to hypoglycemia and hypertriglyceridemia, and over time, in some people, may lead to insulin resistance and even diabetes.

Although we agreed on the diagnosis — that many Americans eat too many simple carbohydrates — we disagreed about the prescription. Dr. Atkins advocated substituting simple carbohydrates with high-fat, high animal-protein foods such as bacon, sausage, butter, steak, pork rinds and brie. I would love to be able to tell you that these are healthy foods, but they are not. Telling people what they want to believe is part of the reason that the Atkins diet has become so popular.

A more healthful choice is to substitute simple carbohydrates, which have a high glycemic (or sugar) load, with complex (unrefined) carbohydrates, including whole foods such as fruits, vegetables, legumes (including soy products) and whole grains (such as brown rice and whole-wheat flour), which have a lower glycemic load. Complex carbohydrates are high in fiber, which enhances satiety without adding significant calories. Also, fiber slows the absorption of food, thereby preventing blood glucose from rising too rapidly and reducing insulin surges.

Complex carbohydrates and whole foods are also rich in phytochemicals, bioflavinoids, carotenoids, retinols and other substances that may reduce the risk of many chronic diseases. In addition, they are low in cholesterol, saturated fat, oxidants and other disease-promoting substances. In contrast, an Atkins diet is high in disease-promoting substances and low in protective ones. Moreover, body weight is inversely associated with dietary fiber and carbohydrate, and positively associated with protein intake. Meat has virtually no dietary fiber.

When people go on a high-protein diet, they may lose weight and lower triglycerides if, like most Americans, they had been eating a diet high in simple carbohydrates. Even better would be to reduce the intake of simple carbohydrates and most fats, which results in losing even more weight while enhancing health rather than potentially harming it.

Why Some Studies Claim an Atkins Diet Is Better Than a “Low-fat” Diet

While short-term studies show that an Atkins diet does not raise LDL, or bad, cholesterol very much, a five-year follow-up of the Lifestyle Heart Trial conducted in 1998 revealed a diet containing 10 percent of calories from fat with little saturated fat and dietary cholesterol (the diet I recommend) actually decreased LDL-cholesterol (LDL-C) by an average of 40 percent after one year in ambulatory patients not taking lipid-lowering drugs.

Another study, published in 2002 by R.M. Fleming in the peer-reviewed journal Preventive Cardiology, compared 100 people randomly assigned to follow an Atkins diet; a 30 percent-fat diet; a 15 percent-fat calorie-controlled diet; or a 10 percent-fat whole-foods diet with an emphasis on complex carbohydrates. Weight loss was highest (one pound/week) on the 10 percent-fat diet, followed by 0.6 pound/week on the Atkins diet. After one year, there was a 52 percent decrease in LDL-C on the 10 percent-fat diet, whereas there was a 6 percent increase in LDL-C on the Atkins diet. Only patients following the Atkins diet showed a worsening of each cardiovascular disease risk factor, despite achieving statistically significant weight loss.

Short on Proof, Long on Problems

Dr. Atkins often claimed that his diet can reverse coronary heart disease (CHD), but he and other advocates of similar diets have yet to prove this – and disprove the large amount of data linking the intake of a diet high in animal fat and protein with the incidence of CHD. In fact, studies have shown that CHD patients who followed the diet I recommend – a 10 percent-fat whole-foods diet – demonstrated significant reversal of coronary atherosclerosis after one year (as measured by quantitative coronary arteriography), and even more reversal after five years. Meanwhile, the only peer-reviewed study of the effects of a high-protein, high-fat diet on heart disease found that heart disease became more severe (http://my.webmd.com/content/pages/1/3075_903). Also, high-protein diets may cause loss of calcium and decreased levels of urinary citrate, leading to osteoporosis and kidney stones.

In a 2002 study funded by the Atkins Center for Complementary Medicine, 70 percent of patients on an Atkins diet for six months were constipated, 65 percent had halitosis, 54 percent reported headaches, and 10 percent had hair loss. Since our bodies excrete toxic substances through our bowels, breath and perspiration, these results are not surprising. So Atkins dieters beware: You may lose weight and start to attract people to you, but when they get too close it may be counterproductive!

An Optimal Approach…Not a Prescription

An optimal diet is high in good carbohydrates (complex carbohydrates), good fats (omega-3 fatty acids) and good protein (plant-based), and low in ones that are less healthful. This diet is based predominantly on fruits, vegetables, grains and legumes in their natural, unrefined forms.

In practice, someone trying to lose weight may begin by moderately reducing his/her intake of simple carbohydrates and fat, and moderately increasing his/her level of exercise. This is the premise of organizations such as America on the Move. If moderate changes are not sufficient to achieve the desired goals, then the individual can be encouraged to make more intensive ones. The advantage of small changes is that the barriers to change are low; however, the benefits are also modest. Paradoxically, it may be easier for people to make more comprehensive changes in diet and lifestyle because they experience the benefits so quickly and to a much greater degree.

The concept of a dietary spectrum is to empower with information and freedom of choice rather than to focus on feelings of constraint and restriction. Thus, individuals develop a way of eating, rather than simply following a diet with rigid “eat this” and “don’t eat that” guidelines. For example, someone may indulge one day and eat more healthfully the next. To the degree people reduce their overall intake of simple carbohydrates and excessive fat, and increase their intake of whole foods such as complex carbohydrates, they are likely to lose weight – and gain health.

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Return to MONITOR Front Page

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For more information on the organization and its programs...

CECheck-Up

CECHE Chairman Sushma Palmer Comments on This Issue's Topics.

Insider's View

Individuals alone can't halt the obesity epidemic.

Features

- Dean Ornish presents optimal solution to dieters' dilemma.

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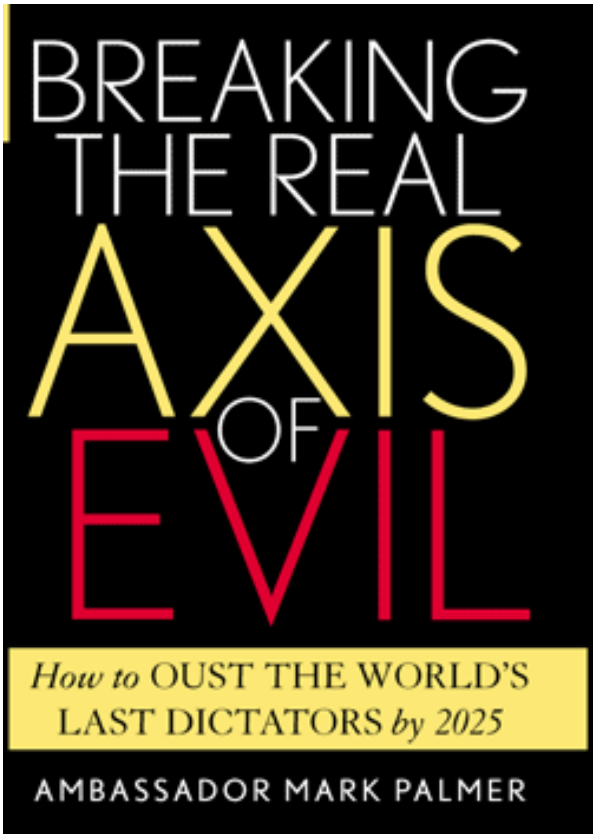
The Demise of Dictators: Achieving Universal Democracy Demands Action

Over the past quarter-century, a tide of democracy has washed across the globe, making democratic forms of government pervasive and shifting the balance of power in the world. In fact, the number of fully free countries has more than doubled during this time: Portugal and Spain. Poland and Hungary. Chile and South Africa. The Philippines and South Korea. All told, a quiet, largely nonviolent, and unpredicted revolution has swept the planet. And it is still gathering steam.



During 2002, 29 countries demonstrated forward progress in freedom, while 11 registered setbacks. Today the majority of the world's Muslims live in electoral democracies; even Iran's people, faced with determined and violent opposition, have repeatedly demonstrated at the ballot box and in the streets the universal desire for popular governance. Taiwan has proven that democracy can take root and thrive in a Chinese culture. Eastern Europe has thrown off half a century's communist conditioning. The Community of Democracies now produces more than 90 percent of the world's gross national product, has the most advanced military forces by far and represents the basic human tenets of self-determination and freedom.

Just 43 dictators remain, oppressing one-third of the planet's population and threatening international peace and prosperity. An arc of tyranny runs unbroken west from North Korea and China, through Central Asia, the Middle East and Angola – with just three outlying dictators in Europe and the Western Hemisphere. The world's most pressing health problems are disproportionately concentrated in these dictatorships; and the highest oppression of women occurs in them. Environmental degradation also has a clear past, present and future link to these tyrants.

The progress over the last quarter-century supports a goal of ousting the remaining dictators and creating a fully democratic world by 2025. There is no reason the peoples of the dictatorships still standing should not join the majority who now exercise their right to elect their own leaders, read independent newspapers, join independent trade unions, and practice their faiths in peace and tolerance.

What needs to be done?

First, a new mind-set must be developed among people both inside and outside dictatorships to accrete a critical mass of real belief that democracy can and will be achieved. The first strategic objective must be to strengthen this conviction, to take as a simple truth that ordinary people have the power to get rid of their oppressors.

Second, the Community of Democracies must reach out to the democrats inside dictatorships and establish a dialogue, process and deadline with the dictators themselves to achieve full democracy.

Third, democrats must develop the political and economic tools and techniques for the nonviolent removal of their oppressors. The past quarter-century abounds with examples: the Indonesian students who filled the streets against Suharto; the predominantly young people of Poland's Solidarity trade union movement who pushed out Wojciech Jaruzelski; the Hungarian students who got the barbed wire cut along the Austrian border; the young East Germans who ripped down the Berlin Wall. Lessons can be learned.

Removal of dictators is first and foremost a domestic political matter, undertaken by the people living under tyranny. Over the past 25 years, a change in domestic consciousness, strategic organization and coordinated, mostly nonviolent action has contributed overwhelmingly to repeated successes. What is not always so clear is the critical part played by the international community. Indeed, it is remarkable that the relatively small efforts of outside democrats had such a significant impact. Imagine what outsiders could do with a creative strategy backed by money and determination.

The accompanying action agenda is being recommended for consideration as just such a strategy.

The Community of Democracies must adopt this common goal: All dictators out by 2025. It must then use its majority within the United Nations to have this goal and program adopted as a matter of binding international policy and law.

Ousting dictators must be brought from the fringes to the center of national-security and foreign policy. Progress over the last generation is encouraging. Now it is time to finish the job – to go beyond outrage, say enough is enough, and join together the world's democracies and democrats to oust the last dictators and build universal democracy.

Action Agenda

PROMOTE THE 21ST CENTURY AS ONE WITHOUT DICTATORS

- **Increase understanding that dictators could make the 21st century bloodier than they made the 20th century.**
- **Dramatize the benefits for peace, prosperity and freedom of a world without dictators.**

Achieve a conceptual breakthrough with a conviction that all dictators can be ousted within one more generation.

- **Educate the world about the huge number of dictators ousted over the last generation and the methods used.**
- **Re-define national security/power as the spread of democracy and alliances among democracies.**
- **Set goal of ousting all dictators by 2025.**

build a new architecture of international power to achieve this goal.

- **Transform the Community of Democracies and NATO into a global democratic alliance, with on-call forces, regional programs and caucuses within existing international organizations.**
- **Declare dictatorship a crime against humanity and prosecute remaining dictators before international tribunals.**
- **Organize non-governmental democrats inside dictatorships and recognize them as the legitimate voices of their peoples.**

open up, instead of walling off, closed societies.

- **Give new policy and budget priority to opening and dictator-ousting programs.**
- **Re-focus the classic opening programs and create new programs, for example an Independent Television and Radio Fund.**

- **Encourage private foundations and businesses to adopt a bolder focus on democracy promotion.**

institute democracy development plans and programs for each of the remaining dictatorships. these plans should include:

- **Completion of the three stages of democratic growth by an agreed-upon date**
- **Creation of an autonomous International Dictatorship-to-Democracy Center under the Community of Democracies and United Nations sponsorship.**
- **Recognition of indigenous democrats as central players through roundtables and other devices.**

transform embassies into freedom houses and ambassadors into freedom fighters by:

- **Visibly supporting the democrats in meetings with them, symbolic events, marches, campaign buttons, electronic billboards.**
- **Holding regular fireside chats with each subjected people via radio, television, Internet by ambassadors, presidents/prime ministers/parliamentarians.**
- **Dialoguing with the dictators and regimes about transition and exit.**

enhance understanding of the nature and power of nonviolent conflict in ousting dictators.

- **Teach the strategy and tactics for a two-stage nonviolent campaign to oust a dictator.**
- **Emphasize the critical role that outsiders play.**

focus attention on each of the last 43 dictators as individuals to prevent their hiding behind a regime, culture or country.

- **Do an annual report on each of the 'Least Wanted' and publicize widely, in key languages.**
- **Develop, and keep updated, a criminal indictment for each dictator.**

develop a comprehensive action plan for every one of the regions and countries with dictators, combining all of the recommended elements.

- **Recognize that highest priority should be given to the largest remaining hotspots: the Greater Middle East and China.**
- **Work with varying coalitions of interested democratic nations and democrats.**
- **Focus sanctions on the dictators, not the populations.**

by Ambassador Mark Palmer, Vice Chairman, CECHE

[Next News Article]

Communities Can International and UNESCO Ensure Education for All Children

Home

Return to MONITOR Front Page

CECHE's Homepage
For more information on the organization and its programs...

CECheck-Up

CECHE Chairman Sushma Palmer Comments on This Issue's Topics.

Insider's View

Individuals alone can't halt the obesity epidemic.

Features

- Dean Ornish presents optimal solution to dieters' dilemma.

CECHE News

- Universal democracy requires breaking the axis of dictatorships.
- Domestic and international actions ensure education for all children.

Policy Beat

- WHO's obesity control strategy deserves more applause than critique.

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E-mail Address

subscribe

Currently, children, youth and adults with disabilities are among the groups most excluded from receiving a basic education. In fact, an estimated 90 percent of children with disabilities in developing countries do not attend school.

To help ensure access to and promote completion of quality education for every child, youth and adult with a disability, **Communities Can International** participated in founding ***A Flagship on Education for All and the Right to Education for Persons with Disabilities: Towards Inclusion***. The flagship is an alliance of global disability organizations, international development and intergovernmental agencies, and experts in the fields of special and inclusive education from developed and developing nations.

Established in 1993 by the Georgetown University Center for Child and Human Development in collaboration with CECHE, **Communities Can International** is actively engaged in the flagship's secretariat at UNESCO. UNESCO actively advocates the right to education for all children, youth and adults, including those with disabilities, in its current Education for All (EFA) initiative, a major global program expected to result in all children receiving a basic education by 2015. The initiative is endorsed by all countries and supported by a wide range of multilateral/bilateral donors and international organizations.

Currently, the flagship is assisting nations in implementing their national plans for EFA, as well as the inclusion of children with disabilities, through a variety of activities and actions, including:

- Promoting full participation of persons with disabilities and families in development of policies and practices on education at local, national, regional and global levels
- Seeking to ensure that all governmental entities, donors and nongovernmental organizations endorse the universal right of education for all children, youth and adults with a disability
- Acting as a catalyst to incorporate fully the flagship goal into national plans of action and regional policies
- Mobilizing resources in support of the flagship goal through obtaining the commitment of new resources from national and international entities, and leveraging existing EFA resources
- Ensuring that EFA monitoring includes quantitative and qualitative data related to persons with disabilities and documentation of resources allocated to the implementation of EFA for these individuals
- Identifying and disseminating effective practices, and stimulating research and studies related to the flagship goal through training and technical activities.

Education and life-long learning opportunities can erase the major gaps in economic and social development that effectively marginalize individuals with disabilities. Through EFA and the flagship, nations can receive support to assure a basic education for all.

by Dr. Phyllis Magrab, Member, CECHE Council

[Previous News Article]

"Toxic Environment" Threatens WHO Strategy to Combat Global Obesity Epidemic

by Philip James, M.D., Chairman, International Obesity Task Force, London

For the first time, the World Health Organization (WHO) has produced an analysis showing the extraordinary importance of both obesity and malnutrition in determining global ill-health (http://www.who.int/whr/2002/en/). And it has proposed a strategy for combating the resulting obesity epidemic worldwide.

Understanding the Nutrition Problem

Perhaps surprisingly, both protein-energy malnutrition (PEM) and obesity coexist in many populations, villages and even families, particularly in Asia, Africa, Latin America and the Middle East. In fact, the two conditions are intimately linked, based on new evidence, which suggests that nutritional deprivation in pregnancy and early childhood makes children much more susceptible to the selective deposition of abdominal fat, with all its enhanced morbid effects, when weight gain subsequently occurs.

Traditionally, childhood malnutrition is prevalent among those with low socio-economic status, and the early phase of economic "development," with its nutrition transition, is linked to the emergence of obesity in women, and then men. Now, however, many parts of the developing, as well as the developed, world reveal poverty-associated obesity.

The deprived and stressful circumstances of urban migration limit physical activity and provide ready access to the cheapest forms of food energy – weight-inducing, energy-dense fats and sugars. Poor access to cheap vegetables, fruits and traditional staples in these urban environments, as well as a universal focus in disadvantaged societies on providing substantial meals and hospitality, amplify weight gain and, consequently, the risk of diabetes, hypertension and coronary heart disease. Therefore, policies geared toward tackling obesity need to incorporate the broader dimensions of the nutrition problem.

Promoting the Obesity Epidemic

The current agricultural, food, trade, marketing and transport priorities, though originally promoted by governments for societal benefit, promote the epidemic of obesity and curtail the chances of eliminating PEM. Governments are therefore primarily, and often inadvertently, responsible for today's global health burdens. Targeting individuals through educational initiatives, by advocating "balanced diets" or more physical activity, is either naïve, or in keeping with the Western food industrial drive to dissemble while continuing to amplify sales, using tactics that remarkably parallel those employed by the tobacco industry.

In fact, unprotected, vulnerable pre-school and school-aged children are targeted to ensure early food brand recognition, which in practice leads to poor eating patterns. Schools and parents are now the focus of marketing schemes, including those touting increased portion sizes, to enhance inappropriate purchases and consumption. Meanwhile, intense lobbying, and heavy political and financial support by industry ensure the maintenance of minimum restrictions on "free trade" and marketing. In effect, food labelling is practically meaningless, except to food technologists, and E.U. and U.S. agricultural subsidies with huge vested interests engage in food dumping of sugar, fat, meat, milk and butter on the developing world.

Preparing to Protect the Vulnerable

The newly proposed WHO strategy (http://www.who.int/gb/EB_WHA/PDF/EB113/eeb11344a1.pdf) is the first to take on board the implications of the innovative WHO 916 technical report, "Diet, Nutrition and the Prevention of Chronic Diseases" (http://www.who.int/hpr/NPH/docs/who_fao_expert_report.pdf), which proposes a life-course (fetus-to-old-age) approach to combating obesity and its resulting health effects, and has engendered intense concern and governmental pleas by soft-drink manufacturers and other food industries. Some scientists are even being encouraged to dispute the WHO findings (http://www.who.int/hpr/nutrition/ExpertConsultationGE.htm).

Evidence suggests that counteracting these barriers to good health requires that governmental policies involve a series of protective measures, with changes in government regulations relating to television advertising, marketing to children, food labelling and school meal provision, not to mention trade, financial, social, agricultural, traffic and urban-planning policies. Legislation in Finland and Norway illustrates the benefits of such protective measures, prompting rapid improvement in national cardiovascular mortality rates in both

Home

Return to MONITOR Front Page

CECHE's Homepage
For more information on the organization and its programs...

CECheck-Up

CECHE Chairman Sushma Palmer Comments on This Issue's Topics.

Insider's View

Individuals alone can't halt the obesity epidemic.

Features

Dean Ornish presents optimal solution to dieters' dilemma.

CECHE News

Universal democracy requires breaking the axis of dictatorships.

Domestic and international actions ensure education for all children.

Policy Beat

WHO's obesity control strategy deserves more applause than critique.

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E-mail Address

subscribe

countries.

Taking National and Global Action

In short, national goals and objectives with realistic timetables, and measurable process and outcome indicators are needed. Some ministries are already on board with nutrition actions, such as opening appropriately accessible health centres; building school playgrounds and suitable cycling and road systems; re-evaluating taxation and subsidy policies; and promoting physical activity and breastfeeding in the workplace.

Potential actions for health ministries, outlined in the table below and focusing on national and local initiatives, include, among other things: creating groups of specialized health professionals targeting the five life-course categories – fetuses, infants, adolescents, adults and older people; monitoring children's and patient's weights and BMIs; and implementing policies on feeding infants and young children, and on promoting physical activity (especially weight-bearing) via nursing homes, caregivers and community centres.

A LifeCourse Approach to Promoting Health and Preventing Obesity & Malnutrition Policies & Actions for Health Professionals and Health Ministries	
For Pregnant Women and Infants: Audit policies on anaemia, weight gain, the optimum pregnancy diet and breastfeeding Support baby-friendly hospital initiatives Develop policy on feeding infants and young children	Apply optimum techniques for limiting low birth weight, anaemia, gestational diabetes and neural tube defects, and implement breastfeeding strategies Initiate breastfeeding within one hour of birth Inform parents on complementary feeding
For children: Promote physical activity in preschools and schools, nursing homes and community centres Coordinate policies with the education ministry on monitoring children's weight and BMI Train school nurses and canteen staff on healthy diets	Monitor iodine levels; promote consumption of iodized salt with education on intake limits Implement policies to reduce vending machines in schools and to limit availability of soft drinks and sweets in general

For Adolescents: Develop policies on weight control, healthy eating and physical activity in schools and community centres, involving adolescents as decision-makers Educate teachers and health professionals on the dietary and psychosocial needs of adolescents	Initiate projects on diet, physical activity and health Implement policies on anaemia in adolescence and in teenage pregnancy
For Adults and the Elderly: Develop nutrient reference values and food-based dietary guidelines Educate health professionals on dietary needs Develop policies to promote physical activity for older people via nursing homes, caregivers and community centres	Ensure dissemination of consistent information on a healthy diet Monitor BMI, bone density, and micronutrient and macronutrient deficiencies
For the General Public: Develop policies for and monitor public health initiatives in hospitals and the community Develop policy on nutrition labelling and health claims	Promote demonstration projects, e.g., on diet, physical activity and health, including those advocating dietary change in the community
For Displaced Persons: Train volunteers and health staff on monitoring the special dietary and nutritional needs of refugees, internally displaced persons and migrant populations	Support policies to provide oral rehydration therapy and nutrient-rich supplements and foods to refugees in camps Monitor refugees for anaemia, and migrant populations for BMI and micronutrient deficiencies

For Hospitals:	
Develop consistent policies on food and nutrition during illness Create a network of health-promoting hospital	Provide consistent information and advice on diet and physical activity

Adapted from Robertson et al. 2004

The WHO strategy supported by many ministers of health favours development of integrated national programmes to alter both diet and physical activity. WHO also calls for international collaboration within the United Nations system and with bilateral agencies to promote a multisectoral approach, given that many physical, economic, political and socio-cultural factors are involved. Guiding principles consist of: strengthening the evidence for policy, advocating the need for policy change and involving stakeholders so that public interest groups, local government and industry can participate in an integrated action plan. Meanwhile, identified areas for international action include education, food marketing and promotion, food labelling (including health claims) and the development of food and agricultural policies consistent with the new public health agenda. Also important is the promotion of healthier foods, with pricing policies and food programmes for needy families. In addition, emphasis is being placed on investment in surveillance, research and evaluation along with the nurturing of an institutional capacity to promote change and adequate financial support in keeping with the international declaration on the U.N. Millennium Goals.

Bracing for the Future

WHO's strategy has been severely criticised by the U.S. government, which highlights the responsibility of individuals for their own wellbeing and limits any reference to the recent WHO 916 report. While some food groups support the WHO strategy, other, more powerful sectors, including the sugar, soft-drink and fast-food industries, have intensely lobbied against this strategy. Alas, the "toxic environment" generated by governmental policies that permit unregulated marketing, and industrial practices and financial arrangements that promote excess food consumption and limited physical activity threaten the WHO strategy, and may trigger compromise, even before it is presented to the World Health Assembly in May 2004.

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Home

Return to MONITOR Front Page

CECHE's Homepage
For more information on the organization and its programs...

CECheck-Up

CECHE Chairman Sushma Palmer Comments on This Issue's Topics.

Insider's View

Individuals alone can't halt the obesity epidemic.

Features

Dean Ornish presents optimal solution to dieters' dilemma.

CECHE News

Universal democracy requires breaking the axis of dictatorships.

Domestic and international actions ensure education for all children.

Policy Beat

WHO's obesity control strategy deserves more applause than critique.

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Obesity Prevention Can't Wait!: Proactive Policies Could Halt the Epidemic

by Michael F. Jacobson, Ph.D., Executive Director, Center for Science in the Public Interest, Washington, D.C.

The impact of obesity on health has been recognized for more than half a century, and weight reduction has been an American preoccupation for decades. Yet, the prevalence of obesity has increased sharply – and continues to soar – among U.S. adults, adolescents and children, with no immediate sign of reversal.

Why has obesity control failed? And what can an ever-expanding nation do to curb such dangerous and debilitating "growth"?

Obesity prevention left to self-control...a lost cause.

Industry Practices, Technological Advances Have Promoted Obesity

Americans spend about half of their food budget and consume about one-third of their daily meals outside the home. Food eaten outside the home, on average, is higher in fat and lower in micronutrients than food prepared at home. There also tends to be more of it, with the standard serving sizes of certain foods increasing greatly in recent decades. For example, in the 1950s, Coca-Cola was packaged only in 6.5-oz. bottles; today single-serving containers are 20-oz. bottles.

Food promotions, pricing, packaging and availability all encourage Americans to eat more food, not less. In 2000, the cost of advertising soft drinks reached $700 million, and for the McDonald's restaurant chain the advertising budget topped $1 billion, dwarfing the National Cancer Institute's $4 million annual investment in the educational component of its 5-A-Day campaign to increase consumption of fruit and vegetables.

Meanwhile, labor-saving devices, from automobiles to e-mail, are ubiquitous and have reduced energy needs, as has the shift of a large proportion of the workforce from manual labor to white-collar jobs that require nothing more active than pressing keys on a computer. In addition, many suburban neighborhoods are geared to automobiles, with few, if any, sidewalks to encourage walking, running and other forms of transportation and exercise. Taken together, such changes in the food and lifestyle environment help explain why it requires more than just willpower for Americans to balance their intake and output of energy.

National Policies Have Pitfalls

By 1952, the American Heart Association had already identified obesity as a cardiac risk factor modifiable through diet and exercise. Subsequently, a number of federal agencies and private organizations issued guidelines advising Americans to reduce energy intake, raise energy expenditure, or do both to maintain healthy weight. Typically, these guidelines focused on individual behavior change, tended to state the obvious – and were grossly ineffective.

Furthermore, while obesity prevention has been an explicit public health goal since 1980, its implementation has been distributed among multiple government agencies, with no one agency taking lead responsibility. Even the U. S. Public Health Service's (PHS) successive 10-year plans, which have made prevention and control of obesity and overweight a priority public health objective, offer little guidance beyond calling for "a concerted public effort" to achieve this goal.

Modifying Individual Behavior Is Not Enough

There is no quick solution to the problem of obesity. Considering the many aspects of American culture that promote obesity, changing individual behavior is not enough to reverse current trends. Meaningful efforts, exemplified in the accompanying list of bulleted action items, must include the development of multifaceted government policies with adequate funding, and national leadership and programs that address both the "energy in" and "energy out" components of weight maintenance.

Education

- Provide federal funding for mass media health-promotion campaigns such as the Center for Science in the Public Interest's "1% Or Less" program.
- Require instruction in nutrition and weight management as part of school curriculums.
- Declare an annual National "No TV" Week, and discourage TV watching in general.
- Require and fund daily physical education and sports programs in primary and secondary schools.

Food Labeling and Advertising

- Restrict advertising of high-calorie, low-nutrient foods on children's television shows or require broadcasters to provide equal time for messages promoting healthy eating and physical activity.
- Require chain restaurants to provide information about calorie content on menus or menu boards, and nutrition labeling on wrappers.
- Require print advertisements to disclose the caloric content of foods.

Food Assistance Programs

- Eliminate the sale of soft drinks, candy bars and high-calorie, low-nutrient snack foods in school

Transportation and Urban Development

- Provide funding and other incentives for health-promoting facilities such as bicycle paths, recreation centers, swimming pools, parks and sidewalks.
- Develop and provide guidelines to modify zoning requirements and residential neighborhoods to promote physical activity.

Food Development

- Reduce the fat limit in ground beef and hot dogs from 30 percent to 22.5 percent.
- Reward farmers who raise cows in ways that lower milk fat and beef cattle in ways that lower body fat.

Policy Development

- Include nutrition and obesity prevention in the scope of the President's Council on Physical Fitness and Sports.
- Develop a coordinated federal implementation plan for the Healthy People 2010 nutrition and physical activity objectives.

Taxes and Subsidies

- Subsidize low-calorie nutritious foods, perhaps by raising the costs of selected high-calorie, low-nutrient foods.

buildings.

• Develop incentives to encourage Food Stamp recipients to purchase healthful foods.

Health Care and Training

• Require that medical, nursing and other health curricula include information on healthful diets and exercise patterns.

• Require health care providers to learn about obesity risks, obesity counseling and health-promoting behavior change.

• Develop and fund research on behavioral and metabolic determinants of weight gain and maintenance, and on cost-effective methods for intervention.

• Revise Medicaid and Medicare regulations to provide incentives to health-care providers for nutrition and obesity counseling, and other cost-effective interventions.

• Remove sales taxes on, or provide other incentives for, the purchase of exercise equipment.

• Provide tax incentives to encourage employers to provide weight management programs.

• Levy city, state or federal taxes on soft drinks and other foods high in calories, fat or sugar to fund campaigns to promote good nutrition and physical activity.

• Provide incentives to restaurants to charge more for less nutritious foods.

The Road Ahead Is Challenging

The outlined measures cannot alone eliminate obesity from the American landscape; but even modest reductions in obesity rates would confer substantial health and economic benefits. Levying small taxes on energy-dense foods or activities could generate big revenues that could be used to promote health. A 2/3-cent tax per 12 ounces on soft drinks, a 5 percent tax on new televisions and video equipment, a $65 tax on each new motor vehicle (about 0.3 percent on a $20,000 car) or an extra penny tax per gallon of gasoline alone would generate an estimated $1 billion per year.

Without such a national commitment and effective new approaches to making the environment more favorable to maintaining healthy weight, the obesity epidemic will be almost impossible to halt.

This article is based on: Marion Nestle and Michael Jacobson's Halting the Obesity Epidemic: A Public Health Policy Approach. Public Health Reports, Vol. 115, Jan/Feb 2000.