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The international declaration on the human right to nutritional care: A global commitment to recognize nutritional care as a human right

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S U M M A R Y

Access to nutritional care is frequently limited or denied to patients with disease-related malnutrition (DRM), to those with the inability to adequately feed themselves or to maintain their optimal healthy nutritional status which goes against the fundamental human right to food and health care. That is why the International Working Group for Patient's Right to nutritional care is committed to promote a human rights based approach (HRBA) in the field of clinical nutrition. Our group proposed to unite efforts by launching a global call to action against disease-related malnutrition through The International Declaration on the Human Right to Nutritional Care signed in the city of Vienna during the 44th ESPEN congress on September 5th 2022. The Vienna Declaration is a non-legally binding document that sets a shared vision and five principles for implementation of actions that would promote the access to nutritional care. Implementation programs of the Vienna Declaration should be promoted, based on international normative frameworks as The United Nations (UN) 2030 Agenda for Sustainable Development, the Rome Declaration of the Second International Conference on Nutrition and the Working Plan of the Decade of Action on Nutrition 2016–2025. In this paper, we present the general background of the Vienna Declaration, we set out an international normative framework for implementation programs, and shed a light on the progress made by some clinical nutrition societies.
Through the Vienna Declaration, the global clinical nutrition network is highly motivated to appeal to public authorities, international governmental and non-governmental organizations and other scientific healthcare societies on the importance of optimal nutritional care for all patients.

1. Introduction

In a landmark step to fight disease-related malnutrition (DRM), international clinical nutrition societies, including American Society for Parenteral and Enteral Nutrition (ASPEN), European Society for Clinical Nutrition and Metabolism (ESPEN), Federación Latinoamericana de Terapia Nutricional, Nutrición Clínica y Metabolismo (FELANPE), Parenteral and Enteral Nutrition Society of Asia (PENSA) in conjunction with the European Federation of Association of Dieticians (EFAD), the European Patients Forum (EPF), and over 75 national societies/associations from across the globe signed a declaration recognizing nutritional care as a human right (https://www.espen.org/espen/vienna-declaration-nutritional-care-is-a-human-right). The Declaration was signed on September 5th during the 44th ESPEN congress on Clinical Nutrition and Metabolism in the city of Vienna at the Messe Wien Exhibition and Congress Center. The event included messages and addresses by ESPEN chairman, Rocco Barazzoni (Italy), FELANPE President, Any Ferreira (Paraguay), ASPEN, President Ryan Hurt (USA) and Director of PENSA Center, Soranit Siltharm (Thailand). The importance of nutritional care was further underscored by patient representative Marek Lichota. Further indicating the importance of the initiative, salutations were given by European Commission - DG Sante and WHO Europe representatives, Stefan Schreck and Kremlin Wickramasinghe.

The Declaration should be conceived as a framework document based on the human rights-based approach, to develop programs and actions that aim to promote access to nutritional care for all patients who are at risk or are already malnourished. In this paper, we present the general background of the Vienna Declaration, we set out an international normative framework for implementation programs, and shed a light on the progress made by some clinical nutrition societies.

2. The background of the Vienna Declaration

Since 2003, the human rights-based approach has been introduced in the field of clinical nutrition through three key international non-legally binding documents [1]. First, the Resolution

Abbreviations: DRM, Disease-related malnutrition; HRBA, Human rights based approach; UN, United Nations; ASPEN, American Society for Parenteral and Enteral Nutrition; ESPEN, European Society for Clinical Nutrition and Metabolism; FELANPE, Federación Latinoamericana de Terapia Nutricional, Nutrición Clínica y Metabolismo; PENSA, Parenteral and Enteral Nutrition Society of Asia; EFAD, European Federation of Association of Dieticians; ONCA, Optimal Nutritional Care for All; EPF, European Patients Forum.

ResAP (2003) on food and nutritional care in hospitals, adopted by the Committee of Ministers of the Council of Europe on 12 November 2003 which recognizes that access to a safe and healthy variety of food is a fundamental human right [2]. Second, the FELANPE's International Declaration on the Right to Nutrition in hospitals, endorsed and signed by Latin American societies, and having as witness ESPEN and ASPEN in Cancún, México, in 2008 [3]. The FELANPE Cancun Declaration advocated for "the human right of patients to receive opportune and optimal nutritional therapy by qualified personnel". Finally, FELANPE's International Declaration on the Right to Nutritional Care and the fight against Malnutrition, signed in Cartagena, Colombia in 2019, endorsed by FELANPE's societies, and having as witnesses ESPEN, ASPEN, Sociedad Latinoamericana de Nutrición (SLAN) and other societies [4]. The latter declaration, based on 13 principles, advocates for the first time the recognition of the right to nutritional care as an emergent human right, inseparable from the right to health and the right to food [4]. Within the framework of principle #13 of the Cartagena Declaration, which calls for international action, several professionals decided to create an international working group to join efforts and provide a global dimension to the proposed actions. The group was formed with representatives from ASPEN, ESPEN, FELANPE, PENSA, West African Society for Parenteral and Enteral Nutrition (WASPEN) and South African Society for Parenteral and Enteral Nutrition (SASPEN) and experts in other fields, such as history and law. Thus, a new document based on five fundamental principles was proposed to address malnutrition associated with disease (disease-related malnutrition – DRM) and the lack of access to nutritional care for patients. Further to position these principles in the context of the international nutrition and healthcare agenda (Fig. 1) (read about the emergence of the concept of nutritional care as a human right [5]).

3. The Vienna Declaration

The International Declaration on the Human Right to Nutritional Care, named the Vienna Declaration, is a global call to policy-makers, medical associations, and civil society organizations for urgent action against DRM. The Declaration is a non-binding document which recognizes that access to nutritional care should be considered as a human right, intrinsically linked to the right to food and the right to health [5,7] (Table 1). It is a global consensus committed to raise awareness on the importance of DRM, and the unacceptably low access to nutritional care for people suffering from chronic and acute diseases, and for anyone with inability to adequately feed themselves or maintain their optimal healthy nutritional state.

This global effort underscores the need to design effective strategies to grant access to nutritional care in the context of DRM, a condition that affects 30–50% of hospitalized patients [8]. While this type of malnutrition is currently insufficiently diagnosed and recognized worldwide [9], the global health and economic burden of DRM is substantial in the hospital care setting [9,10]. Given the potential for malnutrition risk screening/diagnosis and assessment, and for medical nutrition treatments, to prevent and treat malnutrition [11–13], political actions are needed to address and alleviate this burden. The Vienna Declaration is grounded on the international instruments of human rights and bioethics (among others: the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, the Declaration of Bioethics), which provide a solid basis for its principles. This is why, through the Vienna Declaration, clinical nutrition societies commit to promote the five principles that are further described in this paper (Table 2).

The Vienna Declaration principles aim at setting a vision of what involved organizations should promote (i.e.; education and research, ethics, institutional culture on nutritional care, patient empowerment and strategic approaches to modify policy in order to allow practical implementation of nutritional care). However, the Vienna Declaration does not give specific indications on how these principles can become concrete actions leading to improved access to nutritional care for those with DRM or at risk, nor how to achieve outcomes and quality. That is why an implementation program is needed.

4. International normative framework of the Vienna Declaration implementation programs

Given existing national differences in healthcare systems framework, policy and legislation, implementation strategies should be promoted at national level, ideally by national clinical nutrition societies. An implementation program of the Vienna Declaration

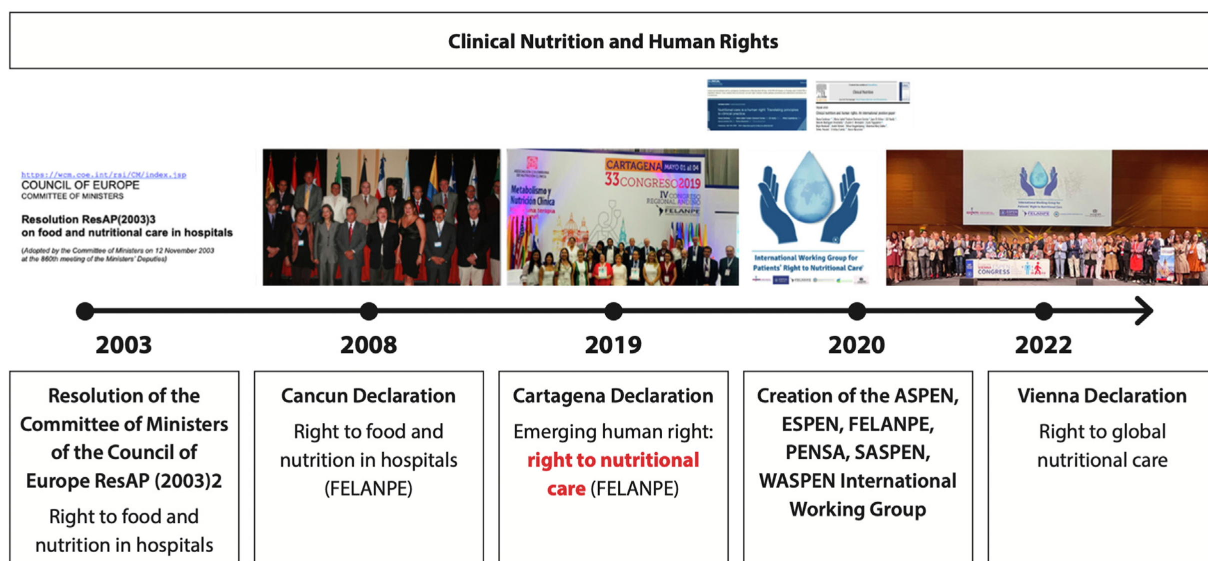

Fig. 1. Emergence of the concept of nutritional care as a human right. Published with permission [6].

Table 1
Scope, aims and main characteristics of the International Declaration on the Human Right to Nutritional Care, The Vienna Declaration.

Scope	The Declaration recognizes that access to nutritional care is a human right intrinsically linked to the right to food and the right to health. It sets out a shared vision and principles for implementation of the human right to nutritional care in all patients with DRM, in all settings and conditions. This Declaration is addressed to each clinical nutrition, scientific and professional organization, and to any healthcare or non-healthcare professional organization or institution that defends the right to food, the right to health and promotes nutritional care for the fight against DRM.
Characteristics	The Declaration is a non -legally binding document Should be considered to be a framework document whose principles constitute the basis for promoting an action plan for the development and practice of nutritional care in the clinical field, and raising awareness among public authorities.
Aims	Promote the recognition of the human right to nutritional care for all people with or at risk for DRM, and the respect for human dignity ensuring respect for human life and fundamental freedoms, in accordance with international law on human rights and bioethics; Provide a frame of reference whose principles serve as the basis to the future development of actions plans from clinical and scientific societies and any stakeholders in clinical nutrition; Define core values, goals, and principles to enhance the quality of care in clinical nutrition Raise awareness of DRM and the lack of nutritional care access.

seeks to translate the five principles of the Vienna Declaration into concrete actions (i.e., programs and policy). The success of national implementation programs should encompass integrated and collaborative action of different stakeholders, including involved organizations and nutrition societies, institutions and ultimately government level. In this regard, the Declaration may serve as a bridge for communication between the nutrition community, governments and policy makers. In this context, implementation

Table 2
Principles of The International Declaration on the Human Right to Nutritional Care, The Vienna Declaration. When societies and organizations to whom this Declaration is addressed develop programs, activities, or action plans in clinical nutrition the following principles are to be respected.

Principle 1: Public health policy must make the fulfillment of the right to nutritional care a fundamental axis in the fight against DRM	1.1 Clinical nutrition must be integrated into public health policy based on human rights, equity, and economic values. 1.2 Clinicians, researchers, and policymakers should work together to translate evidence-based nutrition therapy into policy. 1.3 To be effectively implemented, public health policy on clinical nutrition should consider all patients including patients at nutritional risk, childbearing women and children, older adults and persons with non-communicable diseases as the target population. 1.4 Public health policy should consider nutritional care as part of the holistic approach for the patient, which aims to prevent and treat DRM and improve clinical outcomes.
Principle 2: Clinical nutrition education and research is a fundamental axis of the respect and the fulfillment of the right to nutritional care	2.1 Nutrition and human rights education is necessary for the training of all medical and healthcare professionals responsible for nutritional care, and should be mandatory in the curricula of universities and other academic training institutions. 2.2 During their medical, pharmacy, nursing and dietetic training all healthcare students should receive mandatory information about human nutrition in its three different domains, including basic nutrition, applied or public health nutrition, and clinical nutrition. 2.3 Considering that evidence-based decisions should be supported by good quality research as they impact on individual human rights to health as well-being and quality of life, it is of utmost importance to strive for high quality of research on nutritional therapy respecting the tenets of good science.
Principle 3: Ethical principles and values in clinical nutrition including justice and equity in nutritional care access are the basis for the right to nutritional care.	3.1 Prerequisites of artificially administered nutrition and hydration are: existing indication for a medical treatment, the definition of a therapeutic goal to be achieved, and respect for the will of the patient and his or her informed consent; 3.2 Health care professionals have the ethical duty to assure optimal and timely nutritional care within the boundaries of resources provided for them. This obligation must be exercised with due respect to a number of fundamental ethical values. 3.3 financial resources should be managed respecting the principle of distributive justice which requires that nutritional care be accessible to individuals according to need and within the context of resource availability. 3.4 The technological advances that have enabled the development of medical nutritional therapy, in particular enteral and parenteral nutrition, can pose dilemmas and ethical problems, which should be addressed from an ethical perspective, and respecting the internationally recognized principles of autonomy, beneficence, non-maleficence and justice. These principles are inter-related and have to be applied in the act of medical decision making. 3.5 The Human rights' FREDA principles (Fairness, Respect, Equality, Dignity, and Autonomy) are central to clinical nutrition practice. 3.6 The respect of patient dignity and equity in health care should be a central core of Clinical Practice Guidance development in clinical nutrition. 3.7 The cultural values, religious beliefs, ethnic background, country, region, and geographical considerations of patients and families need to be respected to the extent that they are consistent with the ethical principles and duties, and legal requirements.
Principle 4: Nutritional care requires an institutional culture that follows ethical principles and values and an interdisciplinary approach.	4.1 All nutritional care must include an after-hospital discharge plan, involving patients and caregivers, and be subject to an annual audit. 4.2 Interdisciplinarity is mandatory to provide the best treatment, since knowledge continues to enormously increase, so that contributions fromeach expert domain will ensure the best quality and safe treatment.
Principle 5: Patient empowerment is a key enabler to necessary action to optimize nutritional care	5.1 The World Health Organization has recognized patient empowerment as a necessary step to help improve healthcare, and it has defended this initiative based on the premise that when patients are engaged in their therapy and decision-making, they are more responsive to treatment and the latter is more efficient. 5.2 Empowerment means education, and education is equal to freedom. Empowering patients is to offer them the opportunity to be part of the disease process and treatment. It is not only a matter of gaining a voice, but patient empowerment is also sharing knowledge and responsibilities with them and the family. 5.3 Empowerment is both a process and an outcome. The process is based on the principle that by increasing education one also improves the ability to think critically and act autonomously, while the outcome is accomplished by the sense of self-efficacy, a result of the process. 5.4 The empowerment of patients and their families against DRM and its prevention or treatment represents a shift to help raise awareness against this condition, especially considering how information quickly spreads with the use of modern media technologies.

programs should focus and seek to promote national transformation (i.e; public health policy in nutrition, education programs etc.). To ensure that individual efforts are coherent, consistent and synergistic in reaching common goals (i.e., promoting access to nutritional care based on the HRBA), a common international normative framework should be also defined.

Importantly, the United Nations (UN) through the 2030 Agenda for Sustainable Development, the Second International Conference on Nutrition (ICN2) normative documents (the Rome Declaration and the Framework for Action) and the Decade of Action on Nutrition 2016–2025 (Nutrition Decade) [14–17] create a supportive environment for nutrition impact at the global level, by setting the standard and indicating long-term goals in terms of nutritional care at the country-level.

4.1. The 2030 Agenda for Sustainable Development

Improving nutrition is central to achieving the 2030 Agenda for Sustainable Development through the Sustainable Development Goals (SDG) [17]. The SDGs are a set of 17 global goals adopted in September 2015 by the UN, with specific targets aimed towards ending poverty, protecting the planet, and ensuring prosperity for all by 2030. The SDG #2 "Zero Hunger" recognizes the need for better nutrition. Through its targets, particularly target 2.2, it aims to end all forms of malnutrition by 2030. It is important to highlight, though, that the specific form of DRM is unfortunately not considered in this, or any other SDGs targets [see [5] for the difference between malnutrition in the community and DRM]. Clinical nutrition is consequently not considered by the international agenda on nutrition, and there is no international support for policy and program development at the national level. On the other hand, this is all the more unfortunate given the growing strong evidence of the impact of nutritional care interventions on patient outcomes as well as the economic burden of DRM Hence, through clinical nutrition interventions (screening, diagnosis, assessment and implementation of medical nutrition therapy and its monitoring) it is possible to positively impact the health system financial budget and most importantly to improve patient quality of life, morbidity and mortality, thus potentially strongly contributing to the global sustainable development goals. In other words, an improvement in the access to nutritional care and a reduction of DRM prevalence is essential to reach the SDG#2 target 2.2 to end *all* forms of malnutrition.

4.2. Second International Conference on Nutrition

The ICN2, held at Food and Agriculture Organization of the United Nations (FAO) Headquarters, in Rome, in November 2014, and jointly organized by FAO and the World Health Organization (WHO) was the first global intergovernmental conference to address the world's nutrition problems in the 2lst century. Its goal was to improve nutrition through national policies and effective international cooperation. The main results from this conference were two normative documents: the Rome Declaration on Nutrition, a political commitment document, and the Framework for Action (ICN2 FFA) [14,15], a flexible policy framework that established 60 recommendations. In these documents "A common vision for global action to end all forms of malnutrition" was set forward. The documents specifically committed to "eradicate hunger and prevent all forms of malnutrition worldwide, particularly undernourishment, stunting, wasting, underweight and overweight in children under five years of age; and anaemia in women and children among other micronutrient deficiencies; as well as to reverse the rising trends in overweight and obesity and reduce the burden of diet-related noncommunicable diseases in all age groups". As discussed above, DRM was unfortunately not directly addressed and discussed, thereby inherently limiting the official goal "to end all forms of malnutrition".

4.3. The UN decade of action in nutrition: an opportunity for a global network in clinical nutrition

The UN General Assembly proclaimed on April 2016 the Decade of Action on Nutrition 2016–2025 (Nutrition Decade) [16]. The program is co-led by the FAO and the World Health Organization (WHO). Its aim is to accelerate implementation of the commitments made at ICN2, achieve the global nutrition and diet-related non-communicable disease (NCD) targets by 2025, and contribute to implement the Sustainable Development Goals (SDGs) by 2030, while providing an enabling environment to respect, protect, and fulfil the right of everyone to have access to safe, sufficient, and nutritious food.

The Nutrition Decade is country-owned and country-driven, promotes alignment among actors and actions, and supports all countries to address all forms and causes of malnutrition. The program advocates that all relevant stakeholders join together to "consolidate, align and reinforce nutrition actions across different sectors; and recognizes and encourages the emergence of local, national, regional and global movements to end all forms of malnutrition." Thus, by providing an enabling environment to ensure that action is taken by governments and stakeholders to develop and implement inclusive policies aimed at ending all forms of malnutrition, this program appears to be an ideal framework to establish the implementation program of the Vienna Declaration.

More specifically, the Nutrition Decade provides "an umbrella for all relevant stakeholders working on food and nutrition-related programs and initiatives, to consolidate and align actions across different sectors, as well as facilitate policy processes across the areas identified in the two ICN2 outcome documents: the Rome Declaration on Nutrition and the FFA." The Work Program of the Nutrition Decade propose six action areas for devolvement of action, based on the 60 recommendations of the ICN2 FFA and relevant to related SDGs. The actions (i.e., policy and programs) should be framed and informed by a specific area, and can normally be linked to several areas at the same time. The six areas are:

1. Sustainable, resilient food systems for healthy diets;
2. Aligned health systems providing universal coverage of essential nutrition actions;
3. Social protection and nutrition education;
4. Trade and investment for improved nutrition;
5. Safe and supportive environments for nutrition at all ages;
6. Strengthened governance and accountability for nutrition

Actions in clinical nutrition can be part of area 2, as it aims to integrate all relevant nutrition actions in a health system framework, to support health workers at all levels to deliver nutrition actions, and to ensure the availability of the necessary resources, equipment and supplies. Furthermore, clinical nutrition actions may also be covered by area 3, as it aims to increase the number and quality of nutrition professionals, as well as action area 6, which aims to strengthen governance and accountability for nutrition.

There are mainly three strategies that are covered by the Nutrition Decade (Fig. 2). First, the establishment of specific, measurable, achievable, relevant, and time-bound (SMART) commitments for action. Second, encouraging the creation of action networks, i.e. informal coalitions of countries aiming at advocating for the establishment of policies and legislation, allowing the exchange of best practices, highlighting successes and providing mutual support to accelerate implementation. Finally, the convening of forums for

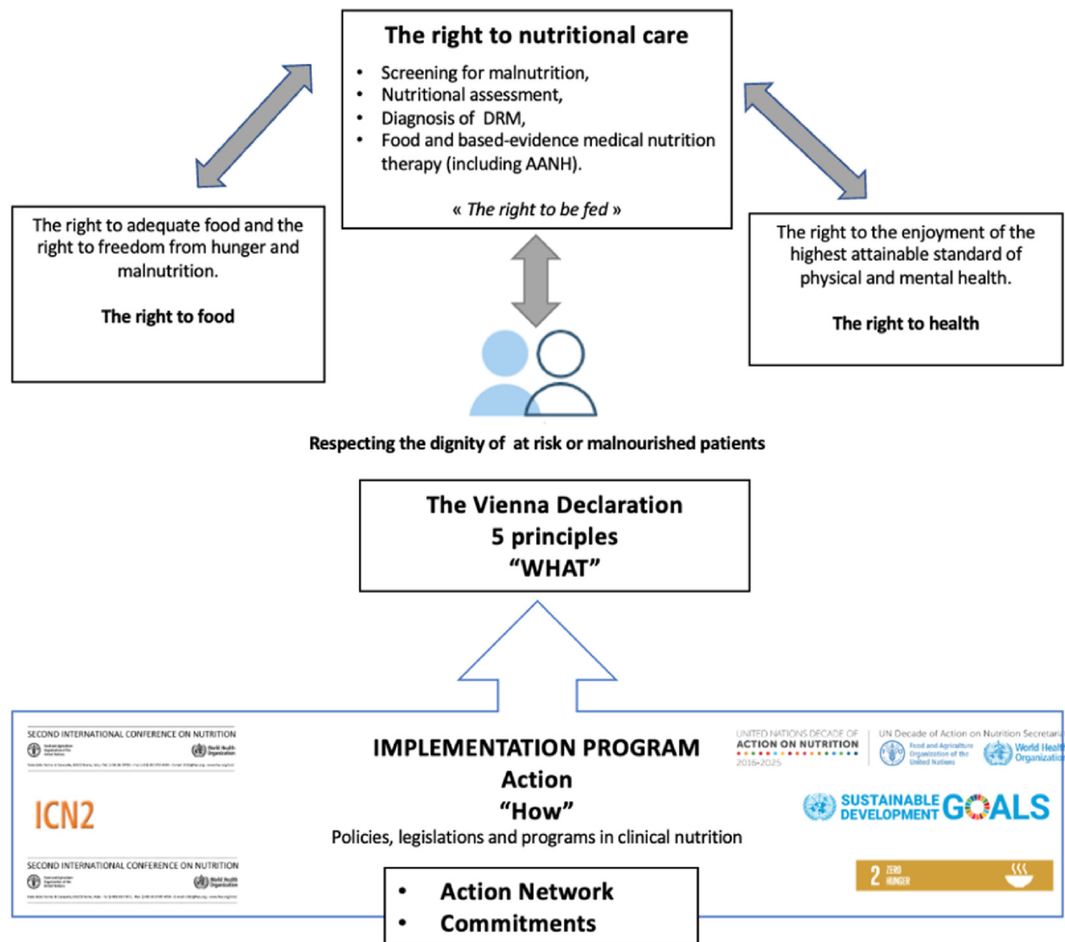

Fig. 2. Nutritional care as a human right and the normative framework for Implementation. The normative framework is composed of the Rome Declaration and the Framework for Action of the ICN2, the SDGs, and the Decade of Action on Nutrition 2016–2025 (Nutrition Decade) [15–18]. Action network and national commitments should be promoted by Clinical Nutrition Societies.

planning, sharing knowledge, recognizing success, voicing challenges and promoting collaboration.

Action Networks are "informal coalitions of Countries, with global or regional scope, aimed at accelerating and aligning efforts around specific topics linked to the Nutrition Decade's Work Program" allowing Countries to exchange knowledge and good practices, successes and challenges, and provide mutual support to accelerate progress with the final objective of improving food systems, diets and nutrition for all through individualized policies and legislation at national level.

Clinical nutrition societies can promote the generation of Action Networks to advocate for the establishment of policies and legislation (Vienna Declaration principle #1), educational programs (principle #2), ethics approach in clinical nutrition (principle #3), patient empowerment (principle #4) and institutional culture (Principle #5). The network should aim to share knowledge, recognize success, voice challenges and promote collaboration.

5. A work in progress

The main clinical nutrition societies ESPEN, ASPEN, PENSA, FELANPE, EFAD, and many other scientific societies committed to the principles of the Vienna Declaration have launched programs and action plans, which are presented below.

5.1. European actions

5.1.1. ESPEN action plan

ESPEN is an international clinical nutrition Society comprising 68 block-member national Societies from Europe and beyond, and it may therefore represent a template for providing a framework program that could be adapted to national needs in its member countries or elsewhere. ESPEN is fully committed to the Vienna Declaration and has recently launched an Implementation Action plan based on 5 activities that address each of the 5 principles. The activities include:

1. Preparation of a policy brief: to address the principle of cooperation and involvement of policymakers, ESPEN will prepare a specific document aiming at using understandable arguments and language to present the case of the key relevance of tackling DRM.
2. Research promotion and new NEMS educational material: to address the principle of promoting education and research, ESPEN will enhance efforts to promote its educational programs; in particular, ESPEN commits to expand educational material to promote nutrition education in medical schools, which is currently critically missing from regular programs worldwide, representing a critical unmet need.

3. Update of ESPEN ethics guidelines and program to create Clinical Nutrition Ethics Committees for the scientific societies: ESPEN has published a guideline document on ethics in clinical nutrition [18]. It is now committed to expand this material to include the new human right frame and principles.
4. Promotion of DRM screening and diagnosis, new interdisciplinary activities in the nutritionDay: to address the principle of promoting interdisciplinary institutional culture on the importance of implementing nutritional care, ESPEN will promote cooperation with non-nutrition healthcare professionals in a multidisciplinary approach, including existing simple tools for screening and diagnosis of malnutrition. ESPEN will further promote the development of nutritionDay, the benchmark initiative led by ESPEN and Vienna Medical University, with development and collection of additional questionnaires on specific areas and specialties in medical practice.
5. Nutritional care inclusion in patient Charter and bill of rights: to address the principle of involving patients and promoting their awareness on the importance of nutritional care, ESPEN will seek to expand already-existing collaborations and to create new ones to favor patient empowerment and include nutritional care in patient bills of rights.

The framework, as well as all existing and future material, is and will remain available for national initiatives, which ESPEN will be willing to support as appropriate.

5.1.2. The European Nutrition for Health Alliance

The European Nutrition for Health Alliance (ENHA) is a multi-stakeholder not-for-profit foundation that has been active since 2005 in translating clinical nutrition science into policy and practice across Europe [19]. ENHA comprises a wide span of member organizations, including professional societies such as ESPEN, EFAD and EUGMS as well as patient organizations (EPF, ECPC). With this basis, ENHA initiated a campaign at the highest political level of the European Union, now known as 'EU4Nutrition', to secure optimal nutritional care for all EU citizens by integrating nutrition in all EU programs and EU recommendations for national health policies. In 2014, to drive local implementation, ENHA launched the Optimal Nutritional Care for All (ONCA) campaign, now implemented in nineteen European countries and more to follow.

The ONCA campaign is a patient-centered campaign that empowers all stakeholders involved in nutrition care to transform the science and clinical knowledge developed and presented by the members of ENHA into policy at a national and regional level. These policies support changes to improve nutritional management in clinical practice on the floor where care is delivered. In this context, the International Declaration on the Human Right to Nutritional Care fits the work of ENHA and the aims of the ONCA campaign as a key message in strong support of our efforts to improve policies to drive better nutritional care.

5.1.3. European Federation of the Association of Dieticians

The EFAD, representing dietitians from 27 European Member States, held its annual General Meeting at October 21st 2022 in Budapest, Hungary. At the end of the assembly, which brought together national dietetic organisations, European dietitians issued a professional manifesto, the Budapest Resolution.

The Budapest Resolution stresses that everyone has the right to adequate food and to be free from hunger, in line with the Universal Declaration of Human Rights, and supports the International Declaration on the Human Right to Nutritional Care. The Resolution strongly recommends that dietetic care should be an integral part of nutritional care so that no one is left out.

Access to an optimal diet helps in preventing and reducing the risk of certain diseases, the length of hospital stays, improves the effectiveness of clinical treatment and the quality of life, and results in reduced healthcare costs. At the same time, food insecurity is associated with depression, reduced productivity, and increased healthcare costs, which can result in a disproportionate socioeconomic burden.

The Resolution states that dietitians are the healthcare professionals with the expertise to plan, conduct and control nutritional therapy for preventive purposes and for the treatment of nutritional disorders. However, their role extends beyond providing healthcare. In general, they improve the nutritional environment for everyone by collaborating with governments, industry, academia and research.

The Resolution underlines that nutrition therapy is a cost-effective investment and dietitians are more effective and efficient in providing evidence-based nutrition advice than any other healthcare professional. Dietitians can achieve effective, equitable and sustainable changes in a country's nutritional environment. https://www.efad.org/wp-content/uploads/2022/10/EFAD-Budapest-resolution_-FINAL_with-signatories-1.pdf

It is highly recommended that the dietetic service should be provided within the existing healthcare system of each country and integrated into public health. In addition to healthcare. For a healthier population, all European citizens should have access to nutritional and dietetic care. EFAD — as the voice of European dietitians representing national dietetic associations and academic institutions — is fully committed to improving nutritional health, promoting sustainable diets, and reducing health inequalities across Europe. It supports registered dietitians who can positively impact the nutritional intake and nutritional status of clients, patients and ultimately the whole population. EFAD is committed to improve the dietetic education and research conduction, as well as to raise the standards of lifelong learning and dietetic practice, given that dietitians are the ones who develop and implement nutrition and dietetic guidelines and nutritional care pathways. They contribute to the professional development of other healthcare professionals who need training in nutrition and dietetics. EFAD strongly believes nutritional care will benefit from interprofessional collaboration.

The goal of EFAD is fully aligned with ESPEN, i.e., working on a healthier population. All EFAD members endorse the Budapest Declaration and will bring this message at a country level in the European Union. To achieve our common goals, we must make nutrition and dietetic care accessible to all European citizens.

EFAD's stakeholders, e.g., WHO, EU, FAO, ENHA, EFP and many other organizations, received an announcement regarding the Budapest Resolution. Also, in EFAD's communication channels, the resolution has been reported.

5.1.4. Malnutrition in adults in the International Classification of Diseases — 11 (ICD-11)

The right to nutritional care implies that the patient has the right to benefit of the diagnosis of disease related malnutrition.

WHO and the International Classifications of Diseases (ICD) system provide the foundation for the identification of diseases and statistics globally. In coming years ICD-10 will be exchanged for ICD-11. The ICD-10, and the former ICD-9, terminology of malnutrition was influenced by experiences from recurrent famines in poorer parts of the world, with diagnostic foci on identifying deprivation and deficiencies of particular nutrients; i.e. food insecurity.

However, the clinical picture of malnutrition has changed, the awareness and the clinical settings for malnutrition have expanded, and the concept has become even more complex. Draught, flooding, poverty and war, with ensuing starvation-related malnutrition still

exist, but today malnutrition also prevails in individuals, often older, exposed to catabolic diseases and other stressors in wealthy countries with developed health and elderly care systems.

The ICD-11 terminology should adapt to this expanded understanding of malnutrition, and provide concepts and diagnosis codes that stand up to modern requirements [20]. The global clinical nutrition community, as manifested in the GLIM consortium on how to diagnose malnutrition, trust WHO to provide diagnosis codes that are based on combinations of the core malnutrition criteria; weight loss, underweight and reduced muscle mass (phenotypic criteria), and reduced food intake and high disease burden/inflammation (etiologic criteria).

6. Global leadership initiative on malnutrition (GLIM) and ICD-11

In 2019 four major global clinical nutrition societies; i.e. ASPEN (USA), ESPEN (Europe), FELANPE (South America) and PENSA (Asia), jointly presented the GLIM format for diagnosing malnutrition in adults [21]. Over the years many methods were introduced to screen and diagnose malnutrition: NRS-2002, MNA-SF, MUST, SGA, PG-SGA to name a few. All instruments use similar criteria for identification, whereas methodologies, grouping of criteria and cut-offs vary. For credibility and benchmarking reasons GLIM scrutinized existing approaches in a consensus process and introduced an umbrella concept for the malnutrition diagnostic procedure. This model is supposed to be applicable in all major clinical settings irrespective of technological standard. Five core criteria were identified and decided. Thus, three phenotypic criteria; weight loss, underweight and reduced muscle mass, and two etiologic criteria; reduced food intake/food assimilation and inflammation/high disease burden, should be assessed and combined.

GLIM advocates a 2-step procedure. Step 1 is screening by use of any well-validated screening tool. Individuals with risk of malnutrition should then in Step 2 be assessed by the five diagnostic criteria. When at least one of the phenotypic criteria combined with at least one of the etiologic criteria is aberrant from the suggested cut-offs, malnutrition is confirmed and diagnosed. Based on the degree of deviation from normal malnutrition is graded into moderate or severe. Moreover, based on the underlying etiology malnutrition is also categorized as related to chronic disease with inflammation, chronic disease with minimal or no perceived inflammation, acute disease or injury with severe inflammation, and related to starvation/food shortage due to socio-economic or environmental factors.

Since the launch of the GLIM format hundreds of validation and feasibility studies have been published, and the format compares well with existing instruments according to the capacity to identify malnutrition (criterion validity) and to predict negative outcomes (predictive validity) in most clinical settings [22].

7. American society of parenteral and Enteral Nutrition initiatives

ASPEN supports the belief that nutrition care is at the intersection of the right to food and the right to health, which was the premise of the Cartagena Declaration, signed in 2019 by FELANPE and witnessed by ASPEN. Supporting principle #13 of this declaration, which calls for an international action, ASPEN joined the International Human Rights Working Group (IHRWG) to give a global dimension to the proposed actions. The IHRWG, with 3 ASPEN representatives, subsequently drafted the Vienna Declaration, signed by ASPEN's president at the ESPEN congress on September 5, 2022.

Regarding public policy and advocacy, the first of the 5 principles of the VD, ASPEN's 2022−2025 strategic plan outlines tactics to maximize the society's aim to enhance its impact on nutrition care and patient outcomes through advocacy efforts. ASPEN supports legislation aimed at increasing access to medical nutrition therapy and clinical nutrition interventions including, but not limited to the Medical Nutrition Therapy, Medical Nutrition Equity, Safe Step, and Access to Medical Foods Acts. Additionally, ASPEN's submitted comments and feedback were incorporated into the Biden-Harris national Strategy on Hunger, Nutrition and Health in 2022.

After many years of hard work, in 2022, the Global Malnutrition Composite Score (GMCS) was approved, the first and only nutrition focused quality measure endorsed by the US National Quality Forum and included in any Centers for Medicare and Medicaid Services (CMS) payment program, the primary public funding agency for healthcare in the US. ASPEN has been an active promoter of this program since its inception and will continue to work to support its nationwide implementation. The score is based on four components reflecting inpatient malnutrition identification and care according to best practices and the components of nutrition care.

ASPEN's strategic plan also has a strong focus on clinical nutrition education and research, the second Vienna Declaration principle. ASPEN continues to disseminate education, in a variety of learning modalities, to current and future healthcare professionals in response to identified gaps in knowledge. Additionally, there is a need to increase the number of clinical nutrition and metabolism researchers who are actively seeking discoveries that will impact patient care. ASPEN's continued efforts with the National Institutes of Health, Office of Nutrition Research, provide the opportunity to make the funding needs of clinical nutrition researchers known.

Strongly aligned with the human rights-based approach to nutrition care is ASPEN's Malnutrition Awareness Week (MAW), its 2nd largest event annually. MAW's strategic pillars: educate, engage, expand, and advocate, are consistent with Vienna Declaration principles. Education increases knowledge and skills of healthcare teams to drive prevention, early identification, and intervention/treatment of DRM. By educating the public, in addition to healthcare professionals, on the negative consequences of malnutrition and the importance of nutrition to health awareness is raised and all individuals can advocate for the care they deserve and require. Engaging and collaborating with organizations worldwide to effectively deliver the key messages of MAW expands ASPEN's reach and advocacy for malnutrition awareness. MAW in 2022 reached over 230.5 million people from around the world, which included 158 ambassadors, of which 34% were international. The human rights theme has been incorporated into MAW for the past 3 years: Nutrition is a Human Right (2021), Nutrition is a Patient Right (2022) and Nutrition Care is a Patient Right (2023). A webinar on the topic of "Global Perspectives: Nutrition Care as a Human Right" was held in 2021 in cooperation with the Canadian Nutrition Society and the British Society for Parenteral and Enteral Nutrition. MAW's strong advocacy component highlights the issue of malnutrition and the right to nutrition care to legislators, accreditors, policy makers and payers via state declarations, senate briefings, and congressional resolutions. ASPEN actively participated in the planning and execution of the 2022 NIH Conference on Malnutrition, and the recommendations and opportunities identified will be presented in Las Vegas, at the 2023 ASPEN Nutrition Science and Practice conference.

It is through these activities, the ASPEN Nutrition Science and Practice conference, and joint activities with other professional societies (Academy of Nutrition and Dietetics, American Society of Nutrition, etc.), that ASPEN further supports and works to implement the principles of the Vienna Declaration. We will continue our broad work on these efforts, which is fully supported by ASPEN's strategic plan.

8. The Federación Latinoamericana de nutrición parenteral y enteral (FELANPE)

FELANPE one of the leading expert societies in raising awareness of the burden of malnutrition and its impact on the patient care [23] as well as highlighting the importance of the right to nutrition with the Cancun and Cartagena declarations has shared all the developed material related to the Vienna Declaration with its member societies and has stimulated each country to develop and tackle initiatives to promote and implement it. FELANPE has also sought the Organización Panamericana de Salud (OPAS) to raise awareness among its board of directors and enroll them in discussions regarding the topic at the 2023 congress. One of FELANPE member societies, Brazil, has, since December 2022, tackled a monthly plan of action covering the topic of nutrition and human rights, promoting educational material, videoconferences, webpage and social media updates, as well as organizing during its 2023 congress an activity with members of the government, OPAS and other stakeholders, such as patient non-governmental associations.

9. The Parenteral and Enteral Nutrition Society of Asia (PENSA)

PENSA is a professional organization that focuses on promoting clinical nutrition in Asia. PENSA recognizes that clinical nutrition is a human right, and it is committed to ensuring that patients have access to high-quality nutrition support. PENSA countries members advocate for policies and guidelines that support the provision of clinical nutrition to patients who need it.

PENSA is also dedicated to advancing the practice of clinical nutrition through education and research. The society provides training programs and conferences for healthcare professionals to improve their knowledge and skills in clinical nutrition. PENSA also supports research in the field of clinical nutrition to develop new and effective treatments for patients.

As an international organization, PENSA has taken several actions to endorse clinical nutrition as a human right.

Awareness: PENSA has been raising awareness about clinical nutrition as a human right through public campaigns, social media, and other communication channels. The society has been working to inform the public about the importance of clinical nutrition and the impact it has on patient health and well-being.

Advocacy: PENSA has been advocating for the inclusion of clinical nutrition as a human right in national and regional policies and guidelines. The society has been working closely with governments, international organizations, and other stakeholders to raise awareness about the importance of clinical nutrition in improving health outcomes and to ensure that patients have access to high-quality nutrition support.

Training programs: PENSA has been providing training programs and workshops for healthcare professionals to improve their knowledge and skills in clinical nutrition. The society has also been providing support to institutions to develop and implement clinical nutrition programs that meet international standards and guidelines to strength capacity building.

Research: PENSA has been promoting research in the field of clinical nutrition to develop evidence-based practices and guidelines. The society has been supporting research projects that focus on improving the provision of clinical nutrition to patients in Asia.

Collaboration: PENSA has been collaborating with other organizations and societies to promote clinical nutrition as a human right. The society has been working with the World Health Organization (WHO) and other regional nutrition societies to develop guidelines and policies that support the provision of clinical nutrition to patients in need.

10. CANADA- CAN DReaM – Create alliances nationally for policy to address disease related malnutrition

The Canadian Nutrition Society organized the Food for Health Workshop in May 2022 in Gatineau, Quebec to foster dialogue about DRM (https://conference2022.cns-scn.ca/pre-conference/food-for-health-workshop). The workshop provided an opportunity to bring stakeholders from across Canada and around the world to engage and discuss DRM in the context of the WHO/UN Decade of Action on Nutrition. The purpose of the workshop was to offer a broad perspective of DRM so that participants from diverse backgrounds, disciplines and geographies could learn about DRM as a medical, ethical and health system concern that impacts individual and system-level outcomes, including food insecurity. The workshop illuminated solutions to the problem of malnutrition both in Canada and abroad. An additional goal of the workshop was to solicit input from participants to inform the development of an approach to catalyze policy level action to address DRM.

Building upon the findings and feedback from the workshop, the Candian Nutrition Society (CNS) and its standing committee, the Canadian Malnutrition Task Force (CMTF) registered a commitment to the UN Decade of Action on Nutrition to Create a National Alliance to address DRM. The CNS/CMTF commitment represents the work and ability of civic organizations to support and effect policy change to address Nutrition Care as a human right. Five SMART goals have been articulatedand are presented in Table 3.

Preliminary work is focused on a scoping review of the grey and white literature in the area of health policy and DRM and using mixed methods including key informant interviews. This work will illuminate the actors, context, content and processes related to health policy in DRM.

This initiative is underscored by the need to mobilize knowledge about DRM to a wide range of stakeholders involved in the development and application of evidence based policy.

There are a lack of policy frameworks in Canada to address DRM which inhibits opportunities to support Canadians dealing with DRM through policy-level action. Current health policy is driven largely by conditions related to overnutrition, such as diabetes, obesity and coronary artery disease, and there is a dearth of health policy related to undernutrition and malnutrition in Canada. In addition, there is potential for overlap with Canada's Food Policy's vision of improved food-related health outcomes. This situation is not unique to Canada, and many countries across the globe struggle with the absence of frameworks and/or policies to address DRM. It

Table 3
CANDReaM committements DRM: Disease related malnutrition.

Over the next three years, under CAN DReaM, we are committed to achieving the following five goals:
Goal 1: Undertake a scoping review to identify gaps in existing policies related to DRM
Goal 2: Create a national alliance and set the foundation for a national coordination mechanism for improved DRM policy
Goal 3: Develop a policy framework and design a policy brief on DRM
Goal 4: Facilitate coordination/engagement for policies and practices to address DRM to happen on a multi-country scale
Goal 5: Advocate for national and provincial health policy (ies) to address DRM

is anticipated that by working within Canada with expert advisors from across the world this platform may support approaches across multiple countries.

11. Conclusion

Application of the human rights-based approach to the field of clinical nutrition can contribute to the construction of a political and legal focus to the concept of nutritional care. Through the Vienna Declaration, this approach can be the cornerstone to the rationale of political and legal instruments in the field of clinical nutrition. By endorsing and implementing the 5 principles of the Vienna Declaration, the global clinical nutrition network is deeply convinced of the need to appeal to other scientific medical societies, public authorities, international governmental and non-governmental organizations on the importance of the Human Right to optimal attainable nutritional care for all patients.

Authorship statement

Diana Cardenas: Conceptualization, Analysis and Writing- Original draft preparation; Maria Isabel Toulson Davisson Correia, Gil Hardy and Rocco Barazzoni: Analysis, Writing- Reviewing and Editing; Leah Gramlich, Tommy Cederholm, Annemieke Van Ginkel-Res, Wineke Remijnse, Albert Barrocas, Juan B Ochoa Gautier, Olle Ljungqvist and Winnai Ungpinitpong: Writing and Editing

Conflicts of interest

Diana Cardenas: Conflicts of interest/financial disclosures none. **M. Isabel T. D. Correia:** Lecturer for Abbott, Baxter, Danone, Fresenius, Nestle, Takeda; **Gil Hardy:** Conflicts of interest/financial disclosures none. **Leah Gramlich:** Conflicts of interest/financial disclosures none. **Tommy Cederholm:** Conflicts of interest/financial disclosures none. **Annemieke Van Ginkel-Res:** Conflicts of interest/financial disclosures none. **Wineke Remijnse:** Conflicts of interest/financial disclosures none. **Albert Barrocas:** Conflicts of interest/financial disclosures none. **Juan B Ochoa Gautier:** Lecturer for Nestle Health Science, Fresenius Kabi and a past Chief Medical Officer until July 1, 2018 - Nestle Health Science North America. **Olle Ljungqvist:** OL is a co-founder of the ERAS® Society, serves as its current chairman, and co-author of several of the guidelines from the ERAS® Society. He also held a patent for a pre-operative carbohydrate drink until 2013, and has received honoraria for speaking, travel and advice unrelated to the current work from Fresenius-Kabi, Nutricia, BBraun, Advanced Medical Nutrition. CG has received honoraria for speaking and travel from Abbott Nutrition and Nestle which is unrelated to the current work. **Winnai Ungpinitpong:** Conflicts of interest/financial disclosures none. **Rocco Barazzoni:** Conflicts of interest/financial disclosures none.

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