

Childhood Obesity and the Right to Health

KATHARINA Ó CATHAOIR

Abstract

Childhood obesity is now a global health epidemic, yet the obligations of states to prevent obesity through fulfillment of the right to health have received limited consideration. This article examines the childhood obesity recommendations of the UN Committee on the Rights of the Child (the committee on the CRC), the Special Rapporteur on the right to health, and the UN High Commissioner on Human Rights. It suggests how their engagement might be strengthened. It concludes that the final report of the World Health Organization's Commission on Ending Childhood Obesity could provide the committee on the CRC with a more systematic basis for advising and assessing preventive measures taken by states. Moreover, while the interim report envisages a central role for states in childhood obesity prevention, it pays inadequate attention to their obligations under international human rights law. It is hoped that this will be remedied in the final report through the adoption of a child-centered approach inspired by the rights to health and play, and the general principles of the Convention on the Rights of the Child (CRC).

KATHARINA Ó CATHAOIR, BCL, LL.M., is a PhD Fellow at the Faculty of Law, University of Copenhagen.

Please address correspondence to Katharina Ó Cathaoir, Faculty of Law, University of Copenhagen, Studiestraede 6, Copenhagen 1455, Denmark. Email: katharina.o.cathaoir@jur.ku.dk.

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Introduction

Childhood obesity rates have doubled (in some cases, tripled) in developed countries over the past 30 years.¹ The World Health Organization (WHO) estimates that there are approximately 42 million children with obesity, with rates rising fastest in middle-income countries.² However, obesity prevention has received little attention as a health concern triggering rights obligations.³ Obesity is considered to be primarily an issue of individual or parental responsibility with a nascent role for public health.⁴ Existing public health measures focus on informing individuals about healthy eating and exercise.⁵ Such measures are insufficient and benefit the middle classes disproportionately, conversely increasing inequality among immigrants and low-income families, who are already vulnerable to obesity.⁶

In light of this perceived gap, this paper analyzes the approach of the committee on the Convention on the Rights of the Child (CRC) toward childhood obesity from a right to health perspective. Child rights can add legal and moral impetus to public health measures.⁷ Furthermore, rights can reframe health as a shared responsibility of the state, parents, and child.⁸ Given the acknowledged role of human rights in HIV/AIDS prevention, and to a lesser extent in tobacco control, human rights norms should be explored as a framework for responding to childhood obesity.⁹

The paper introduces the CRC and its position under international human rights law in relation to the International Covenant on Economic, Social and Cultural Rights (ICESCR).¹⁰ It analyzes the right to health, through the work of the CRC and ICESCR committees and other UN bodies, to elucidate state obligations in relation to childhood obesity. Finally, recommendations are made for greater engagement of the committee on the CRC with childhood obesity through comprehensive fulfillment of the right to health, and increased emphasis on the right to play and the general principles of the CRC. Furthermore, the recent interim report of the WHO Commission on Ending Childhood Obesity (ECHO) is examined, and a child rights approach in line with the CRC is recommended.¹¹

Method

The approach is to analyze the current state of the art, while recommending measures to further obesity prevention through comprehensive fulfillment of the rights to health and play. The right to health is scrutinized because childhood obesity measures are always justified, at least in part, by the effect of obesity on the health of the child. Similarly, the right to play is examined because sedentary behavior and lack of physical exercise contribute to childhood obesity.¹² The primary emphasis is on the CRC, as it defines rights from a child-centered perspective.¹³ The article analyzes the committee on the CRC and CESCR non-binding interpretations of states' obligations under the treaties (General Comments). This paper also considers the specific recommendations of the committee on the CRC to European Union states in relation to childhood obesity. These findings are supplemented by reports of the Special Rapporteur on the right to health and the United Nations High Commissioner on Human Rights (High Commissioner). While important human rights protectors, states are not bound to follow their recommendations.

The paper focuses on the obligations of high income-states, as they experience the highest burden of non-communicable diseases.¹⁴ Furthermore, as state obligations to socioeconomic rights are resource-bound (discussed below), it appears from a plain reading of the treaties that obligations are weightier on developed states.¹⁵ Obesity measures are likely to fall outside the scope of the treaties' minimum core, and thus may carry more weight in countries with a high level of resources.

The Convention on the Rights of the Child

Children under the CRC are acknowledged as "fully fledged beneficiaries of human rights."¹⁶ However, their parents and guardians have the "primary responsibility for the upbringing and development of the child," and the state should respect parental rights and duties.¹⁷ For example, parents are principally obligated to secure an adequate standard of health, food, and opportunities to play for their children. Secondary to parental obligations, the

state must provide appropriate assistance to parents and legal guardians, as well as the development of “institutions, facilities and services for the care of the children.”¹⁸

The interplay of these obligations raises interesting questions in extreme cases of childhood obesity. For example, there have been a number of cases in the US and UK where a child with severe obesity was taken into protective custody.¹⁹ Parental rights are conditional, and are subject to limitations. Thus, the state must protect children from neglect or abuse, although children should only be separated from their parents where it is in their best interests.²⁰ The loose wording of the CRC does not detail the level of harm necessary to justify removing a child from his or her legal guardians. However, separation must be in the child’s best interests, as determined by a competent authority subject to judicial review, and in accordance with applicable law and procedures.²¹ In the case of childhood obesity, it has been suggested that criteria should include “(1) a high likelihood that serious imminent harm will occur; (2) a reasonable likelihood that coercive state intervention will result in effective treatment; and (3) the absence of alternative options for addressing the problem.”²² Factors such as unwillingness to engage with treatment, failing to bring the child to medical appointments, and ignoring dietary advice could indicate neglect.²³ On the other hand, it should be noted that there seems to be inadequate data to establish that children in protection lose weight.²⁴

Child rights contributes through emphasizing that children are rights holders who should only be removed from their families as a last resort, and that their views should be included in determining their best interests. Child protection authorities should, where necessary, work with families to address the causes of the child’s dangerous weight and to inform them on healthy meals and exercise. In the small amount of cases where it is in the child’s best interests to be removed from their family, the removal should be as temporary as possible, with support provided and the ultimate aim to reunite the family. Furthermore, as children’s capacities evolve, their autonomy increases, and as a result, so

does the state’s obligation to respect their health decisions. A child of sufficient age and maturity, like an adult, may adopt a lifestyle that is not optimal for his or her health and development. This should be subject to less intrusion from the state than for a very young child who is dependent on his or her parents, and has a lower capacity to make decisions about his or her health. Finally, as will now be explored, child rights allow that full responsibility should not be placed on parents; the state, schools, and media also have obligations in fulfilling the rights to health and play.

International legal obligations

The CRC is almost universally ratified; only the United States has failed to ratify it.²⁵ States parties are legally bound to “respect and ensure” the rights contained within.²⁶ While the International Covenants separate civil and political and socioeconomic rights into two treaties with different operative paragraphs, the CRC incorporates both “categories” of rights. Under Article 4 of the CRC, states parties accept the obligation to take “all appropriate legislative, administrative, and other measures for the implementation” of all rights. Although commentators acknowledge that it will take time for developing states to implement all rights, only in the case of socioeconomic rights is realization limited “to the maximum extent of their available resources.”²⁷ In comparison, under Article 2 of the ICESCR, states must *take steps*, to the maximum of their available resources, with a view to achieving progressively the full realization of socioeconomic rights. The drafting history of the CRC suggests that states wished to maintain the model whereby civil and political rights are immediately enforceable and socioeconomic rights are resource bound.²⁸ This position is supported by the committee on the CRC.²⁹ However, Nolan argues that references to progressive realization during the drafting of the CRC are “patchy” and received “limited attention.”³⁰ She suggests that the committee on the CRC needs to interpret the Convention on its own merits, rather than simply “copy and pasting” the approach of other supervisory bodies.³¹

Thus, it may convincingly be argued that state obligations to socioeconomic rights under the CRC are less flexible than those under the ICESCR, given the more emphatic wording of Article 4. This viewpoint is further supported by the vulnerabilities of children, who are often powerless to secure their rights. However, the expertise of the ICESCR committee should not be dismissed, particularly as the rights contained therein apply to both adults and children, and include some child-focused elements.³² Therefore, the ICESCR's provisions remain important when implementing the right to health under the CRC but should be considered in light of its guiding principles.

Child rights approach(es)

The best interests of the child as a primary consideration, the right to life, survival and development, non-discrimination and participation are considered the central building blocks when interpreting obligations in a child-rights approach.³³ The committee on the CRC advocates that the general principles should be implemented into law and reflected subsequently in laws and policies.³⁴ Although beginning as a didactic tool, the four principles are now endorsed by certain states, intergovernmental organizations, non-governmental organizations, and children's rights experts.³⁵ These principles can be applied to "analyse governmental progress toward implementation" of rights as they provide "the normative framework to guide the design, implementation and evaluation of health care and related policies by identifying the entitlements to which all children are eligible by virtue of their status as human beings."³⁶ Interdependence and indivisibility, accountability and universality have also been acknowledged as important principles to be considered when implementing a child-rights approach.³⁷

Council of Europe Member States have moreover committed to "child-friendly" health care guidelines, wherein states pledge to integrate child rights into a practical framework.³⁸ The Guidelines emphasize that children must give their consent to interventions. Where they do not have capacity,

their opinion must still be taken into account in line with age and maturity.³⁹ At a broader level, children should be informed and consulted on structural health care issues.⁴⁰ This echoes the committee on the CRC's General Comment on participation, wherein it highlights that states should introduce measures to enable children "to contribute their views and experiences to the planning and programming of services for their health and development."⁴¹ Children should have equitable access to health care (including prevention, promotion, and protection) and specific health care needs of vulnerable groups of children should be addressed.⁴² Where rights and interests conflict, the best interests of the child acts as a method of determination.⁴³ Thus, the Guidelines highlight that children's rights and needs must be at the center of health care responses, and that children should be empowered as active agents of change and people in their own right, not passive recipients of beneficence.⁴⁴

The right to health

Turning first to the ICESCR, under Article 12, states parties recognize "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." Under the CRC, states parties also recognize the right to "facilities for the treatment of illness and rehabilitation of health."⁴⁵ States must work toward all children having access to health care services.⁴⁶ They commit to a number of steps for the full realization of the right, including "the prevention, treatment and control of epidemic, endemic, occupational and other diseases." As with the ICESCR, the CRC requires states to strive toward a number of goals of particular import to children, including combating disease and malnutrition, encouraging breastfeeding, and ensuring all, including parents and children, receive information, education, and support with regard to child health and nutrition.⁴⁷ The goals have been criticized for providing too little guidance to states.⁴⁸ Similarly, health has been described as "a very broad and subjective concept influenced by a

variety of factors, including geographic, cultural and socioeconomic ones.⁴⁹ The wording of both treaties therefore requires greater analysis.

The ICESCR committee specified that the obligation to take steps requires that these are “deliberate, concrete and targeted as clearly as possible towards meeting the obligations recognized in the Covenant.”⁵⁰ Furthermore, states should move as “expeditiously and effectively” as possible toward full realization of the rights.⁵¹ This includes, but is not limited to, “all appropriate means,” such as “judicial or other remedies,” and “administrative, financial, educational, and social measures.”⁵² The CRC adds that “visible cross-sectorial coordination to recognize and realize children’s rights across government, between different levels of government and between government and civil society” is required.⁵³ It particularly highlights the role of legislative measures, such as enshrining the general principles in law, rendering the rights justiciable, assessing proposed legislation’s compliance with the CRC and impact on child rights, and the collection of disaggregated data on children.⁵⁴

The ICESCR committee holds that all rights impose “a minimum core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights.”⁵⁵ As noted above, the obligations toward children should be considered in light of the guiding principles and may leave less of a margin of appreciation to states. For example, the state should consider children’s best interests when making any decision that will impact on their health. The committee on the CRC agrees that “whatever their economic circumstances, States are required to undertake all possible measures towards the realization of the rights of the child, paying special attention to the most disadvantaged groups.” Therefore, although children must not be discriminated against, the state may legitimately target disadvantaged groups through positive measures.⁵⁶

While the status of socioeconomic rights has been subject to vigorous debate, it is now generally accepted by the committees, academics and advocates, that state obligations encompass duties to respect,

protect and fulfill.⁵⁷ Under the duty to respect, states should not interfere with individual rights. Under the obligation to protect, states must protect individuals from incursions by third parties, such as companies or private individuals. Finally, the responsibility to fulfill includes the duty to facilitate and provide where an individual or his guardian cannot or fails to do so.⁵⁸ This typology is complemented by a range of duties outlined by the committees.

The ICESCR and CRC committees issued General Comments on the right to health in 2000 and 2013 respectively, with the latter drawing attention to childhood obesity. In General Comment No. 14 (2000), the ICESCR committee interpreted the right to health as not a “right to be healthy,” but extending to the “underlying determinants of health,” among others “an adequate supply of safe food,” “nutrition,” and healthy occupational and environmental conditions.⁵⁹ Both committees consider the right to health underpinned by the principles of availability, accessibility, acceptability, and quality.⁶⁰ Availability requires functioning public health and health care facilities in sufficient quantity. Accessibility includes non-discrimination, and physical, economic, and information accessibility. Acceptability mandates that health services take full account of child needs and those of vulnerable groups. Finally, quality requires that the health system adequately meets the needs of the population it serves, in terms of facilities, treatment, drugs, and staff. Furthermore, the fulfillment of these criteria should be monitored.⁶¹

In its General Comment, the committee on the CRC interpreted health under Article 24 as not only including access to health services but also the right of children to grow and develop to “their full potential and live in conditions that enable them to attain the highest standard of health through the implementation of programs that address the underlying determinants of health.”⁶² Thus, both committees recognize that access to health care alone is insufficient and must be coupled with broader environment based public health measures. The state’s obligations under health are

complemented by the aims of education, which the committee on the CRC has highlighted should aid children in developing “life skills,” including the ability to make “well-balanced decisions” and “develop a healthy lifestyle.”⁶³

Obesity-specific recommendations

In its General Comment on the Right to Health, the committee on the CRC called on states to address obesity in children through limiting exposure to fast foods. The committee recommended the marketing of such foods be regulated and their availability in schools and child-specific places restricted.⁶⁴ Furthermore, in their latest Concluding Observations, the committee expressed concern and recommended state action to prevent obesity to eight European Union Member States.⁶⁵ In their latest report to the committee on the CRC, 16 EU Member States (out of a possible 27 at the time) referenced measures taken to combat obesity under their efforts to realize the right to health. This suggests that states consider that they have obligations to prevent obesity under the CRC.

In the case of Denmark, the committee on the CRC “remained concerned” and recommended the state strengthen its efforts, particularly through access to health advice, healthy food, and opportunities to take part in physical activity. It also recommended state engagement with the media and food industry.⁶⁶ As suggested by O’Flaherty, these non-prescriptive recommendations should be given consideration, but cannot be seen as strictly binding without a clearer and more analytical investigation.⁶⁷

The tentative interpretation is complemented by reports of other UN bodies that have explored human rights obligations of all states in relation to child obesity. In 2012, following a request to prepare a report on the right of the child to health, the High Commissioner drew attention to over-nutrition.⁶⁸ The High Commissioner focused on children’s access to adequate nutrition and physical exercise, with parental education, regulation of advertising, and the promotion of healthful foods recommended as strategies to limit exposure to unhealthful foods.⁶⁹ The High Commissioner’s approach reflect-

ed existing initiatives that focus on information provision and did not propose imaginative steps.

Interestingly, there was an acknowledgment of the stigmatization of children with obesity, although strategies to address this were not explored.⁷⁰ Furthermore, the report encouraged media organizations “to promote health and healthy lifestyles among children,” provide free advertising space for health promotion, and avoid health-related stigma.⁷¹ However, the High Commissioner did not explore the role of the state in guiding or regulating the media. In light of the best interests principle, states should engage with the media to ensure a balance between harmful stigma and necessary, beneficial information.

Finally, in April 2014, the Special Rapporteur on the right to health, Anand Grover, submitted a report to the Human Rights Council entitled “Unhealthy foods, non-communicable diseases and the right to health.”⁷² He emphasized the state’s obligation to ensure availability and accessibility of food in the necessary quantity and quality.⁷³ Grover recognized that while states must respect the right of individuals to make informed decisions about health, this must not be used to justify a “disengaged approach” to regulating the food industry.⁷⁴ Again, it was suggested that states ensure access to sufficient information through nutrition guidelines and labelling.⁷⁵

The Special Rapporteur went further than the High Commissioner, encouraging states to increase taxes on unhealthful foods and reduce prices of healthful foods.⁷⁶ The Special Rapporteur urged States strongly to “implement their obligations regarding children’s right to health” through measures such as “effective health education and awareness” aimed at children, provision of healthful food in child-centered institutions, limiting access to fast food and drinks, and regulating advertising and marketing of “unhealthy food and beverages.”⁷⁷ Furthermore, the Special Rapporteur recommended statutory regulation or collaboration between industry and government to address marketing of high-fat, sugar, and salt (HFSS) foods.⁷⁸

The Special Rapporteur stated that the food

industry also has an obligation to respect the right to health, although the primary obligation is on governments. Private industry was encouraged to adopt standards to improve nutrition quality and increase product labelling and information.⁷⁹ The Special Rapporteur highlighted the vulnerabilities of children and low-income groups.⁸⁰ Although the Special Rapporteur's reports are not legally binding, the Human Rights Council calls on states to give consideration to the recommendations.⁸¹

Recommendations

The role of the committee on the CRC

The text of the conventions, the analyses of the committees, the High Commissioner, and the Special Rapporteur suggest states should take measures to prevent childhood obesity in order to fulfill their obligations under the right to health. In its General Comment on the right to health, the committee on the CRC recognized that the obligation to combat disease includes taking action to prevent obesity.⁸² Furthermore, the High Commissioner has drawn attention to childhood obesity. However, neither has analyzed the material obligations that the right to health places on states in regard to childhood obesity. The Special Rapporteur has engaged the most concretely and recognizes the need for state support while avoiding disproportionate intrusion. All bodies have drawn particular attention to the regulation of marketing to children, although not consistently endorsing a regulatory approach, which is seemingly justified in the best interests of the child. While this is an important area, it is alone insufficient to significantly reduce obesity rates.⁸³

To date, the treaty body recommendations have provided limited leadership—mainly narrow or generally worded recommendations expressing “concern.” These cannot be considered strictly binding on states as they provide limited guidance on concrete obligations to ensure compliance with the treaty. As the interpretations are soft law, they require greater rigor to guide states, bearing in mind that states have a wide margin of appreciation in areas of policy.⁸⁴ The higher the quality of the

recommendations produced, the more regard and scrutiny they may be likely to receive.⁸⁵ However, given the responsibility to apply treaty obligations in good faith and that it is in the state's interest to tackle childhood obesity, the states in question should give active consideration to these recommendations.⁸⁶

According to Kaelin,

the principle of good faith suggests that States, at a minimum, take note of recommendations on policies and strategies to enhance human rights implementation, examine whether they want to implement them and provide the treaty body with some kind of reasoning during the follow-up procedure or the next reporting cycle if they decide not to do so.⁸⁷

The right to play and leisure

The right to play and leisure should also be considered in obesity prevention. This right has recently received more attention in the form of a General Comment by the committee on the CRC and a resolution of the Human Rights Council.⁸⁸ Under the CRC, play and leisure are rights in themselves, but also means by which children's health, development, and education can be secured.⁸⁹ In its General Comment, the committee distilled the main elements of Article 31 as the rights to rest, leisure time, non-compulsory play, voluntarily chosen recreational activities, cultural life and arts, participation (subject to best interests), and age-appropriate activities.⁹⁰ As with other rights, states should respect play and leisure through non-interference, protect children from violations by third parties, and take positive steps to secure access and opportunities to enjoy the rights.⁹¹ For example, the state should strive to provide parks and playgrounds and maintain them to a safe standard. In order to be fully realized, play requires support from the state, parents, teachers, and society at large.⁹² The committee on the CRC suggests that best interests and gathering children's views should be applied to decision making on risks.⁹³

In its General Comment, the committee noted that some groups of children are vulnerable and need extra support to secure their rights. Although not expressly mentioned, children with obesity

should be given adequate consideration. On the one hand, physical activity is beneficial for all children and obese children should not be singled out, in line with the state's obligation to avoid discrimination based on other status, including health status.⁹⁴ On the other hand, studies illustrate that children with obesity feel especially uncomfortable in physical activities as many have low body confidence or have been bullied due to their weight.⁹⁵ Suggested strategies include anti-bullying programs, appropriate PE clothing, private changing areas, training for PE teachers, and minimizing pressure in physical activity settings.⁹⁶ Children suggest more unstructured play and choice in games at school.⁹⁷ Finally, although the right to play and leisure has the potential to contribute to the prevention of obesity, the right should be fulfilled on its own merit and not solely as a means to an end.

The interim report of the commission on ending childhood obesity

WHO has appointed the ECHO to report on the interventions that are likely to be most effective in preventing and treating childhood and adolescent obesity around the world. The aim of its final report is to devise a comprehensive strategy of policy options and accountability.⁹⁸ Firstly, as it is outside the expertise and resources of the committee on the CRC to study childhood obesity policy in great detail, the report may provide the committee with a basis for recommendations on childhood obesity.⁹⁹ Therefore, it should make use of available resources and draw states' attention to WHO guidelines on childhood obesity. Secondly, as the commission is seeking input, this is an opportunity for collaboration between WHO and the committee on the CRC through mainstreaming the right to health and child rights generally.

In its interim report, the commission outlines a wide range of potential policy options. Many of the suggestions are in line with the right to health approach and the recommendations described above. Firstly, the recommendations are explicitly state centric—focusing on the state's responsibilities and central role.¹⁰⁰ Furthermore, it recognizes the need to include parents and caregivers in inter-

ventions.¹⁰¹ Secondly, the interim report supports a multi-sectorial response, including all areas of government, not simply the health department.¹⁰² Echoing the central focus of human rights, the ECHO highlights the need to focus on vulnerable groups that are excluded and marginalized and to include gender and equity perspectives.¹⁰³ There is also recognition of stigmatization, although the state's role in preventing this is not addressed.¹⁰⁴

Similar to the respect, protect, and fulfill typology, ECHO divides recommendations under the headings "inform," "enable," and "protect." It emphasizes the need for information and advice, complemented by positive action such as fiscal policies, marketing regulation, access to natural spaces, ensuring physical activity as part of the school curriculum, adequate facilities, and modifying the school environment.¹⁰⁵ ECHO suggests the reduction of unhealthy foods, including through the regulation of marketing, acknowledging that regulatory approaches are likely to be necessary.¹⁰⁶ It also suggests taxation measures, while noting the possible need to offset with subsidies the impact on low-income consumers.¹⁰⁷

Furthermore, the interim report underlines the importance of primary health care and health care worker training.¹⁰⁸ ECHO places particular emphasis on the built environment, echoing the responsibility to address the underlying determinants of health.¹⁰⁹ The interim report highlights that obesity is not the child's choice and must be tackled "independent from considerations of political philosophy."¹¹⁰ Finally, it emphasizes the need to develop accountability mechanisms, which will be further investigated by the Ad hoc Working Group on Implementation, Monitoring and Accountability for Ending Childhood Obesity.¹¹¹

While the interim report is far-reaching in the role it envisages for states in childhood obesity prevention and treatment, it fails to adequately incorporate state responsibilities under international human rights law. It refers briefly to rights in the context of the state's "moral responsibility," asserting that "tackling childhood obesity clearly resonates with the universal acceptance of the rights of children to a healthy life as well as the obligations

assumed by States Parties to the Convention on the Rights of the Child.¹¹² This sidesteps the binding legal obligations upon states to respect and ensure the rights to health and play, and suggests that rights are only moral obligations.

Furthermore, the interim report fails to incorporate the provisions and principles of the CRC. First, the interim report is not child-centered.¹¹³ A child-oriented plan should include the four principles of the CRC, that is, the child's best interests as a primary consideration, non-discrimination, participation, and the right to life and development.¹¹⁴ The interim report fails to incorporate the best interests test and child participation in particular. Children do not appear to have been consulted in drawing up the interim report, nor do the recommendations call upon states to do so. There is a growing body of research suggesting that children's participation strengthens health outcomes.¹¹⁵

Second, the committee on the CRC has emphasized "sufficient and reliable data collection, disaggregated to enable identification of discrimination and/or disparities in the realization of rights, is an essential part of implementation."¹¹⁶ Thus, data on childhood obesity should be segregated by, for example, race, color, sex, age, language, religion, geographical area, national or social origin, physical or mental disability, nationality, marital and family status, economic and social situation.¹¹⁷ Despite the links between social circumstances and obesity, the interim report does not suggest the gathering of disaggregated data. Furthermore, states should be encouraged to fix obesity targets. One methodology involves choosing indicators and setting benchmarks at the national level, followed by discussion between the committee and the state, and finally, conducting an assessment at the arranged time.¹¹⁸

Third, to ensure accountability, the impact of the policies proposed on the child should be evaluated from an epidemiological and rights standpoint. An assessment of access to health care, including financial and social barriers, should be conducted with children, keeping obesity specifically in mind. As outlined in the General Comments, children should have access to health care that is acceptable,

accessible, appropriate, and of sufficient quality. Furthermore, under the Council of Europe "Guidelines on Child-Friendly Health Care", Member States have pledged to uphold dignity, participation, equitable access to quality health care, and best interests of the child.¹¹⁹

Finally, the implementation of the right to health should be suggested as a means of accountability. On the one hand, through strategic litigation, rights could be used to, for example, argue for greater nutritional protection of food in public procurement. The new Optional Protocols of both the ICESCR and the CRC could also increase accountability at an international level. On the other hand, causality in health conditions such as obesity is notoriously difficult to prove.¹²⁰ Furthermore, justice for an individual may in some cases affect group rights.¹²¹ Therefore non-judicial mechanisms for oversight such as national human rights commissions must be explored. The committee on the CRC has highlighted the need for such mechanisms to be accessible and child friendly.¹²²

Conclusion

It has been argued that preventing childhood obesity will require greater awareness and analysis of the obligations under the rights to health and play. Its increasing prevalence in middle-income states adds moral justifications for high-income states' increased commitment. In light of the lack of clarity of state obligations, it is recommended that the committee on the CRC takes a leadership role in further elucidating and crystallizing the obligations of States Parties. A human rights framework provides for a minimum uniform response from states. Given the fluidity of borders and the prevalence of obesity, a common response in areas such as marketing to children may be most effective. A rights-based approach has its foundation in international law, not beneficence or political ideology. It can support public health by "providing additional tools to motivate governments to act to achieve public health goals" and reframe health concerns "into political claims, and a social movement that can press such claims."¹²³

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References

1. M. de Onis, M. Blössner and E. Borghi, “Global prevalence and trends of overweight and obesity among preschool children,” *The American Journal of Clinical Nutrition* (2010), pp. 1-8.
2. World Health Organization, *Global strategy on diet, physical activity and health*. Available at <http://www.who.int/dietphysicalactivity/childhood/en/>.
3. L. O’Hara and J. Gregg, “Human rights casualties from the ‘war on obesity’: Why focusing on body weight is inconsistent with a human rights approach to health,” *Fat Studies* 1/1 (2012), pp. 32-46.
4. European Commission, *European Union action plan on childhood obesity 2014-2020* (European Commission, 2014); World Health Organization, *Nutrition, physical activity and the prevention of obesity: Policy developments in the WHO European Region* (Copenhagen: WHO, 2007).
5. For example, Department of Health, *Healthy lives, healthy people: A call to action on obesity* (London: Department of Health (England), 2011).
6. Ibid.; L. McLaren, “Socioeconomic status and obesity,” *Epidemiologic Reviews* 29/(2007), pp. 29-48; A. Robertson, T. Lobstein and C. Knai, Obesity and socio-economic groups in Europe: Evidence review and implications for action (Brussels: European Commission, 2007).
7. S. Gruskin, L. Ferguson, D. Tarantola, et al., “Non-communicable diseases and human rights: A promising synergy,” *American Journal of Public Health* 104/5 (2014), pp. 773-775.
8. A. Rudiger and B.M. Meier, “A rights based approach to health care reform,” in E. Beracochea, C. Weinstein and D.P. Evans (eds), *Rights-based approaches to public health*, (New York: Springer, 2010), p. 69.
9. See further, UNHCHR and UNAIDS, *International guidelines on hiv/aids and human rights- consolidated version* (Geneva: UNHCHR and UNAIDS, 2006); See, for example, C. Dresler, H. Lando, N. Schneider, et al., “Human rights-based approach to tobacco control,” *Tobacco Control* 21/2 (2012), pp. 208-211.
10. International Covenant on Economic, Social and Cultural Rights (ICESCR), G.A. Res. 2200A (XXI), Art. Xx (1966). Available at <http://www2ohchr.org/english/law/cescr.htm>.
11. World Health Organization, *Interim report of the Commission on Ending Childhood Obesity* (Geneva: WHO, 2015).
12. For example, see note 5.
13. Convention on the Rights of the Child (CRC), G.A. Res. 44/25 (1989). Available at <https://www2.ohchr.org/english/law/crc.htm>.
14. World Health Organization, *Non communicable diseases*. Available at: <http://www.euro.who.int/en/health-topics/noncommunicable-diseases>.
15. M. Langford and J.A. King, “Committee on Economic, Social and Cultural Rights: Past, present and future” in M. Langford (ed), *Social rights jurisprudence: Emerging trends* (New York: Cambridge University Press, 2008), p. 495.
16. S. Detrick (ed), *The United Nations Convention on the Rights of the Child: A guide to the travaux préparatoires* (Leiden: Martinus Nijhoff Publishers, 1992), p. 27.
17. Article 18 CRC; Article 5 CRC (see note 13).
18. Ibid., Article 18.2.
19. *In re Brittany T.*, 48 A.D.3d; *In re G.C.*, 66 S.W.3d; “Obese children removed from families,” *The Telegraph* (February 28, 2014). Available at <http://www.telegraph.co.uk/foodanddrink/healthyating/10667066/Obese-children-removed-from-families.html>.
20. Article 19 CRC; Article 9.1 CRC (see note 13).
21. Ibid., Article 9.1.
22. T. Varness, D.B. Allen, A.L. Carrel, et al., “Childhood obesity and medical neglect,” *Pediatrics* 123/1 (2009), pp. 399-406.
23. R.M. Viner, E. Roche, S.A. Maguire, et al., “When does childhood obesity become a child protection issue?” *BMJ: British Medical Journal* 341/7769 (2010), pp. 375-377.
24. Ibid.
25. *United Nations treaty collection*. Available at https://treaties.un.org/Pages/ViewDetails.aspx?mtdsg_no=IV-11&chapter=4&lang=en.
26. Article 2.1 CRC (see note 13).
27. E. Riedel, “Economic, social and cultural rights,” in C. Krause and M. Scheinin (eds), *International protection of human rights: A textbook*, (Finland: Åbo Akademi University Institute for Human Rights, 2012), p. 140.
28. S. Detrick (ed) (see note 16), p. 102.
29. Committee on the Rights of the Child, General Comment No. 5, General Measures of Implementation of the Convention on the Rights of the Child (arts 4, 42 and 44, para. 6), UN Doc. No. CRC/GC/2003/5 (2003), para. 7.
30. A. Nolan, “Economic and Social Rights, Budgets and the Convention on the Rights of the Child,” *International Journal of Children’s Rights* 21/2 (2013), pp. 248-277.
31. Ibid., p. 271.
32. Articles 10 and 12(2)(a) ICESCR (see note 10).

33. Committee on the Rights of the Child, Report on the second session, UN Doc. No. CRC/C/10 (1992), para. 67.
34. General Comment No. 5 (see note 29), para. 22.
35. B. Abramson, *Article 2 the right of non-discrimination* (Leiden: Martinus Nijhoff Publishers, 2008), p. 65; see for example, The Ministry of Health and Social Affairs, *Strategy to strengthen the rights of the child in Sweden* (Sweden: Regeringskansliet, 2011); UNICEF, *The Convention on the Rights of the Child guiding principles: General requirements for all rights*. Available at: http://www.unicef.org/crc/files/Guiding_Principles.pdf; for example, CRIN, *Convention on the Rights of the Child*. Available at: <http://www.bettercarenetwork.org/resources/treaties/CRC.asp?legal&ID=6>; for example, Ursula Kilkelly, *Barriers to the realisation of children's rights in Ireland* (Commissioned by the Ombudsman for Children Ireland, 2007).
36. D. Tarantola and S. Gruskin, "Children confronting HIV/AIDS: Charting the confluence of rights and health," in S. Gruskin, M.A. Grodin, G.J. Annas and S.P. Marks (eds), *Perspectives on health and human rights* (New York/London: Routledge, 2005), p. 229; J. Tobin, "Beyond the supermarket shelf: Using a rights based approach to address children's health needs," *International Journal of Children's Rights* 14/3 (2006), p. 278.
37. *Ibid.*, p. 281-5.
38. Council of Europe, Guidelines on child-friendly health care (Adopted by the Committee of Ministers September 21, 2011), at para. 20.
39. *Ibid.*, para. 12(i).
40. *Ibid.*, para. 12(ii).
41. Committee on the Rights of the Child, General Comment No. 12, The Right of the Child to be heard, UN Doc. No. CRC/GC/2009/12 (2009), para. 104.
42. Council of Europe (see note 38), paras. 13-14.
43. *Ibid.*, para. 16
44. *Ibid.*, para. 25; T. Waterston and J. Goldhagen, "Why children's rights are central to international child health," *Archives of Disease in Childhood* 92/2 (2007), pp. 176-180.
45. Article 24 CRC (see note 13).
46. *Ibid.*, Article 24(1) CRC.
47. *Ibid.*, Article 24(2) CRC.
48. D. Fidler, *International law and infectious diseases* (Oxford: Clarendon Press Oxford, 1999), p. 14.
49. A. Eide, C. Krause, and A. Rosas, *Economic, social and cultural rights* (Leiden: Martinus Nijhoff, 2001), p. 174; O. de Schutter, *International human rights law* (Cambridge: CUP, 2014), pp. 30-31.
50. Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 3, The Nature of States Parties' Obligations (Art. 2, para. 1), UN Doc. No. E/1991/23 (1990), para. 2.
51. *Ibid.*, para. 9.
52. *Ibid.*, para. 7.
53. *Ibid.*, para. 27.
54. General Comment No. 5 (see note 29), paras. 12, 22 and 24.
55. *Ibid.*, para. 10.
56. *Ibid.*, para. 8.
57. O. de Schutter (see note 49), p. 243.
58. UNHCHR, *International Human Rights Law*. Available at <http://www.ohchr.org/EN/ProfessionalInterest/Pages/InternationalLaw.aspx>
59. Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 14, The Right to the Highest Attainable Standard of Health (Article 12), UN Doc. No. E/C.12/2000/4 (2000), paras. 8 & 11.
60. *Ibid.*, para. 12; Committee on the Rights of the Child (CRC), General Comment No. 15, The right of the child to the enjoyment of the highest attainable standard of health (Article 24), UN Doc. No. CRC/C/GC/1 (2013), paras. 112-117.
61. General Comment No. 15, *Ibid.*
62. *Ibid.*, para. 2.
63. Committee on the Rights of the Child, General Comment No. 1, The Aims of Education (Article 29(1)), UN Doc. No. CRC/GC/2001/1 (2001), para. 9.
64. *Ibid.*, para. 47.
65. Austria (2009 report), Denmark (2008 4th report), Finland (2008, the Committee expressed concern at a lack of marketing regulation), Italy (2009), Malta (2010), Spain (2008), Sweden (2012) & Belgium. Finland and Belgium had not mentioned obesity in their reports.
66. Committee on the Rights of the Child, Concluding Observations regarding Denmark, UN Doc. No. CRC/C/DNK/CO/4 (2011).
67. M. O'Flaherty, "The concluding observations of United Nations human rights treaty bodies," *Human Rights Law Review* 6/1 (2006), pp. 27-52.
68. UN Human Rights Council, Report of the United Nations High Commissioner for Human Rights on the right of the child to the enjoyment of the highest attainable standard of health, A/HRC/22/31 (2012), paras. 40-45.
69. *Ibid.*, para. 44.
70. *Ibid.*, para. 42.
71. *Ibid.*, para 108.
72. UN Human Rights Council, Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, A/HRC/26/31 (2014).
73. *Ibid.*, para. 12.
74. *Ibid.*, para. 14.
75. *Ibid.*, paras. 17-9.
76. *Ibid.*, paras. 19-21.
77. *Ibid.*, para. 38.
78. *Ibid.*, paras. 22-5.
79. *Ibid.*, paras. 28-32.
80. *Ibid.*, para. 33.
81. Right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Human

Rights Council Res. A/HRC/RES/15/22, para. 4(a).

82. General Comment No. 15 (see note 60), para. 47.

83. S.L. Gortmaker, B. Swinburn, D. Levy, et al., "Changing the future of obesity: Science, policy and action," *Lancet* 378/9793 (2011), pp. 838-847.

84. CESCR, An evaluation of the obligation to take steps to the maximum of available resource under the optional protocol to the covenant, UN Doc. No. E/C.12/2007/1 (2007), para. 11.

85. M. Sepúlveda Carmona, *Nature of the obligations under the International Covenant on Economic, Social and Cultural Rights* (Netherlands: Intersentia, 2003), p. 91.

86. According to WHO, 'Obesity is already responsible for 2-8% of health costs and 10-13% of deaths' in different parts of the WHO Europe Region World Health Organization, *Obesity*. Available at <http://www.euro.who.int/en/health-topics/noncommunicable-diseases/obesity/obesity>.

87. W. Kaelin, "Examination of states reports," in H. Keller and G. Ulfstein (eds), *UN human rights treaty bodies: Law and legitimacy* (UK: Cambridge University Press, 2012), p. 32.

88. C. Davey and L. Lundy, "Towards greater recognition of the right to play: An analysis of article 31 of the UNCRC," *Children & Society* 25/1 (2011), pp. 3-14.

89. Committee on the Rights of the Child, General Comment No. 17, The right of the child to rest, leisure, play, recreational activities, cultural life and the arts (Article 31), UN Doc. No. CRC/GC/17 (2013), para. 9.

90. *Ibid.*, para. 14.

91. *Ibid.*, para. 54.

92. *Ibid.*, para. 32.

93. *Ibid.*, para. 39.

94. Committee on the Rights of the Child, General Comment No. 4, Adolescent health and development in the context of the Convention on the Rights of the Child, CRC/GC/2003/4 (2003), para. 6.

95. M.F. Zabinski, B.E. Saelens, R.I. Stein, et al., "Overweight children's barriers to and support for physical activity," *Obesity Research* 11/2 (2003), pp. 238-46; W.N. Gray, D.M. Janicke, L.M. Ingerski, et al., "The impact of peer victimization, parent distress and child depression on barrier formation and physical activity in overweight youth," *Journal of Developmental and Behavioral Pediatrics* 29/1 (2008), pp. 26-33

96. I. Stankov, T. Olds and M. Cargo, "Overweight and obese adolescents: what turns them off physical activity?," *International Journal of Behavioral Nutrition and Physical Activity* 9/1 (2012); B. Deforche, L. Haerens and I. de Bourdeaudhuij, "How to make overweight children exercise and follow the recommendations," *International Journal of Pediatric Obesity* 6 Suppl 1/(2011), pp. 35-41.

97. G. Brunton, A. Harden, R. Rees, et al., *Children and physical activity: A systematic review of barriers and facilitators* (London: EPPI-Centre, University of London, 2003).

98. WHO (see note 11), para. 5.

99. P. Alston, *Effective functioning of bodies established pursuant to United Nations human rights instruments, Final report on enhancing the long-term effectiveness of the United Nations human rights treaty system*, UN Doc. No. E/CN.4/1997/74 (1996).

100. WHO (see note 11), para. 24.

101. *Ibid.*, para. 29.

102. *Ibid.*, para. 26

103. *Ibid.*, para. 28; p. 12.

104. *Ibid.*, para. 17.

105. *Ibid.*, p. 16, 17, 21.

106. *Ibid.*, paras. 34, 39.

107. *Ibid.*, para. 41.

108. *Ibid.*, para. 58.

109. *Ibid.*, para. 34.

110. *Ibid.*, para. 22.

111. *Ibid.*, para. 63.

112. *Ibid.*, para. 23.

113. This was advocated in relation to HIV/ AIDS, Committee on the Rights of the Child, General Comment No 3: HIV/AIDS and the rights of the child, CRC/GC/2003/3 (2003), para. 40.

114. Vienna Declaration and Programme of Action Adopted by the World Conference on Human Rights in Vienna on 25 June 1993, para. 47.

115. M. Donnelly and U. Kilkelly, "Child friendly health-care: Delivering on the right to be heard," *Medical Law Review* 19 (2011), pp. 27-54.

116. General Comment No. 5 (see note 29), para. 48.

117. Committee on the Rights of the Child, General Guidelines Regarding the Form and Contents of Periodic Reports to be Submitted under Article 44, Paragraph 1 (b) of the Convention on the Rights of the Child, UN Doc. No. CRC/C/58 (1996), para. 7.

118. E. Riedel, "The IBSA Procedure as a Tool of Human Rights Monitoring." Available at http://riedel.uni-mannheim.de/inhalt/unterdokumente/downloads/ibsa/ibsa2/2_the_ibsa_procedure_as_a_tool_of_human_rights_monitoring_1_1.pdf.

119. Council of Europe (note 38).

120. *Pelman v. McDonald's Corp.*, No. 02-7821 (U.S. Dist. Ct., S.D.N.Y., stipulation filed February 25, 2011).

121. M. Langford, "Judicial review in national courts," in E. Riedel, G. Giacca and C. Golay (eds), *Economic, social, and cultural rights in international law: Contemporary issues and challenges* (Oxford: Oxford University Press, 2014), pp. 417-447.

122. General Assembly, Report of the Committee on the Rights of the Child, Official Records, Fifty-seventh Session, Supplement No. 41 (A/57/41), para. 25.

123. D. Patterson and L. London, "International law, human rights and HIV/AIDS." *Bulletin of the World Health Organization* 80/12 (2002), pp. 964-969; L.P. Freedman, "Human rights and the politics of risk and blame," in S. Gruskin, M.A. Grodin, G.J. Annas, and S.P. Marks (eds), *Perspectives on health and human rights* (New York/Oxfordshire: Taylor and Francis Group, 2005), p. 531.

