2018

Childhood Obesity and Positive Obligations: A Child Rights-Based Approach

Benedetta Faedi Duramy
Golden Gate University School of Law, bfduramy@ggu.edu

Childhood Obesity and Positive Obligations: A Child Rights-Based Approach

Benedetta Faedi Duramy[*]

ABSTRACT

Childhood obesity is one of the most serious current public health challenges. Its prevalence has increased at an alarming rate. The World Health Organization estimated that in 2016 the global number of overweight children under the age of five was over 41 million. Although there is widespread concern about the rising rates of childhood obesity, there is not as much consensus on how to address the problem. Obesity has been mostly considered either a matter of personal responsibility or of parental responsibility when it concerns children. Inadequate attention has been given instead to the obligations borne by States to prevent and combat child obesity under international human rights law. This Article seeks to remedy such gap in the current research by discussing a comprehensive child rights-based approach that imposes positive obligations on States to prevent childhood obesity through the realization of children's rights to adequate food, health, and participation. This Article begins by exploring the causes of childhood obesity focusing on the multiple factors that influence weight, food preferences, and eating patterns in children. The Article proceeds by examining the international human rights law framework for States' positive obligations to fight obesity among children. It also discusses the child obesity-specific recommendations issued by the United Nations Committee on the Rights of the Child, the United Nations High Commissioner on Human Rights, the Special Rapporteur on the Right to Food, the Special Rapporteur on the Right to Health, and finally, the Special Rapporteur in the Field of

* Professor of Law & Associate Dean for Faculty Scholarship, Golden Gate University School of Law, JSD Stanford Law School, LLM London School of Economics, LLB University of Rome "La Sapienza" (*summa cum laude*). Special thanks for comments and suggestions to Humberto Cantu Rivera, Francisco Rivera Juaristi, Romola Adeola, John Anderson, Merryl Lawry-White and the other participants of the 3rd Annual Conference of the Business and Human Rights Scholars Association held at Santa Clara University on September 15th–16th, 2017. Many thanks also to Rachel Van Cleave, Marc Greenberg, Eric Christiansen, and Helen Kang for useful suggestions.

Cultural Rights who have further clarified the States' central role and responsibilities in the development and implementation of effective measures and strategies for child obesity prevention. The Article concludes that the right of children to participate in the decision-making processes related to their nutrition and health in accordance to the principles of the Convention of the Rights of the Child must also be at the core of governments' obligations to ensure the full realization of children's rights to adequate food and to health and the adoption of more effective solutions.

CONTENTS

INTRODUCTION

Childhood obesity is one of the most serious current public health challenges. Its prevalence has increased at an alarming rate. The World Health Organization estimated that in 2016 the global number of overweight children under the age of five was over 41 million.[1] A more

1. *See Global Strategy on Diet, Physical Activity & Health: Childhood Overweight and Obesity*, WHO, http://www.who.int/dietphysicalactivity/childhood/en/ [https://perma.cc/c2a6-rgd6]

recent study published by The New England Journal of Medicine found that there are approximately 108 million obese children worldwide, and in many countries, obesity rates among children are rising faster than among adults.[2] In the countries of the Organization for Economic Co-operation and Development (OECD), the number of children who are overweight or obese at the age of fifteen ranges from 10% in Denmark to 31% in the United States.[3] In particular, in the United States, the percentage of obese children has more than tripled since the 1970s;[4] one out of five children between the ages of six and nineteen are currently obese.[5] Once considered to be mostly prevalent in developed countries, the percentage of overweight and obese children is now dramatically on the rise in developing countries too, particularly in urban settings, where the rate of increase of childhood overweight and obesity has been more than 30% higher than that of developed countries.[6] Current estimates suggest that almost half of all overweight children under the age of five live in Asia and one quarter of them live in Africa.[7]

Obese and overweight children experience significant health problems. They have an increased risk of developing breathing difficulties, hypertension, and noncommunicable diseases, like diabetes and cardiovascular diseases, at a younger age.[8] Other health problems include gallstones, sleep apnea, bowed legs, back problems, hirsutism, and menstrual irregularities.[9] Longitudinal studies have shown that obese children are more likely to remain obese throughout their life, and those

---

[hereinafter WHO, *Global Strategy on Diet*]. Note, the Convention on the Rights of the Child defines a "child" as a person below the age of eighteen. G.A. Res. 44/25, art. 1 (Nov. 20, 1989).

2. GBD 2015 Obesity Collaborators, *Health Effects of Overweight and Obesity in 195 Countries over 25 Years*, 377 NEW ENG. J. MED. 13, 16 (2017); Matt Richtel, *More Than 10 Percent of World's Population Is Obese, Study Finds*, N.Y. TIMES (June 12, 2017), https://www.nytimes.com/2017/06/12/health/obesity-study-10-percent-globally.html?mcubz=0.

3. ORG. FOR ECON. CO-OPERATION & DEV., OBESITY UPDATE 2017 2 (2017), https://www.oecd.org/els/health-systems/Obesity-Update-2017.pdf [https://perma.cc/597N-CYT6].

4. CHERYL D. FRYAR, MARGARET D. CARROLL & CYNTHIA L. OGDEN, NAT'L CTR. FOR HEALTH STATISTICS, PREVALENCE OF OVERWEIGHT AND OBESITY AMONG CHILDREN AND ADOLESCENTS: UNITED STATES, 1963–1965 THROUGH 2013–2014 (2016), https://www.cdc.gov/nchs/data/hestat/obesity_child_13_14/obesity_child_13_14.pdf [https://perma.cc/ahm4-twzg].

5. Cynthia L. Ogden et al., *Trends in Obesity Prevalence Among Children and Adolescents in the United States, 1988–1994 Through 2013–2014,* 315 JAMA 2292 (2016).

6. WHO, OBESITY FACT SHEET NO. 311 (Aug. 2014), http://www.wpro.who.int/mediacentre/factsheets/obesity/en/.

7. WHO, *Global Strategy on Diet*, *supra* note 1.

8. *Id.*

9. A. Must & R.S. Strauss, *Risks and Consequences of Childhood and Adolescent Obesity*, 23 INT'L J. OBESITY & RELATED METABOLIC DISORDERS S2, S2–S5 (1999).

who are not obese as adults still have a higher mortality rate compared to their peers who were not obese as children.[10]

Obesity and high body mass indices are also associated with a higher risk of developing psychological problems, including depression, anxiety, and low self-esteem, which can persist into adolescence and adulthood.[11] Research has shown that the psychological well-being and quality of life of obese children is similar to those of children who have been diagnosed with a life-threatening disease like cancer.[12] Socially, obese children are more likely to be bullied, rejected, and discriminated against by their peers than children who experience bias due to race, age, or gender.[13] Studies report that obese children are socially excluded and stigmatized by their peers starting at nursery school, stereotyped as lazy, and often chosen last for teams in physical education classes.[14]

Overweight and obesity, as well as their related diseases, are largely preventable, especially in children. In theory, child obesity prevention should be a high priority for all States. Although traditionally considered an issue of individual and parental responsibilities, childhood obesity has become a serious public health concern.[15] In the United States, for

---

10. Aviva Must et al., *Long-Term Morbidity and Mortality of Overweight Adolescents—A Follow-Up of the Harvard Growth Study of 1922 to 1935*, 327 NEW ENG. J. MED. 1350, 1354 (1992).

11. *See generally* INST. OF MED., ACCELERATING PROGRESS IN OBESITY PREVENTION: SOLVING THE WEIGHT OF THE NATION (Dan Glickman et al. eds., 2012); M. van Geel, P. Vedder & J. Tanilon, *Are Overweight and Obese Youths More Often bullied by Their Peers? A Meta-Analysis on the Correlation Between Weight Status and Bullying*, 38 INT'L J. OBESITY 1263 (2014); Lucy J. Griffiths, Tessa J. Parsons & Andrew J. Hill, *Self-Esteem and Quality of Life in Obese Children and Adolescents: A Systematic Review*, 5 INT'L J. PEDIATRIC OBESITY 282 (2010); Christine L. Williams, Maria T. Gulli & Richard J. Deckelbaum, *Prevention and Treatment of Childhood Obesity*, 3 CURRENT ATHEROSCLEROSIS REP. 486 (2001).

12. *See generally* Jeffrey B. Schwimmer, Tasha. M. Burwinkle & James W. Varni, *Health-Related Quality of Life of Severely Obese Children and Adolescents*, 289 JAMA 181 (2003).

13. *See generally* ROBERTA R. FRIEDMAN & REBECCA M. PUHL, YALE RUDD CTR. FOR FOOD POLICY & OBESITY, WEIGHT BIAS: A SOCIAL JUSTICE ISSUE (2012), http://www.uconnruddcenter.org/files/Pdfs/Rudd_Policy_Brief_Weight_Bias.pdf [https://perma.cc/UEK8-DFBQ]; DEBORAH L. RHODE, THE BEAUTY BIAS: THE INJUSTICE OF APPEARANCE IN LIFE AND LAW 6, 15, 29, 41 (2010); William H. Dietz, *Health Consequences of Obesity in Youth: Childhood Predictors of Adult Disease*, 101 PEDIATRICS 518 (1998).

14. *See generally* SONDRA SOLOVAY, TIPPING THE SCALES OF JUSTICE: FIGHTING WEIGHT-BASED DISCRIMINATION (2000); Chad D. Jensen, Christopher C. Cushing & Allison R. Elledge, *Association Between Teasing, Quality of Life, and Physical Activity Among Preadolescent Children*, 39 J. PEDIATRIC PSYCHOL. 65 (2014); R. Puhl, *Obesity Stigma—Causes, Effects and Some Practical Solutions*, 54 DIABETES VOICE 25 (2009); Paul B. Rukavina & Weidong Li, *Adolescents' Perceptions of Controllability and Its Relationship to Explicit Obesity Bias*, 81 J. SCH. HEALTH 8 (2011).

15. *See generally* U.S. DEP'T OF HEALTH & HUMAN SERV., THE SURGEON GENERAL'S CALL TO ACTION TO PREVENT AND DECREASE OVERWEIGHT AND OBESITY (2001) [hereinafter CALL TO ACTION], https://www.cdc.gov/nccdphp/dnpa/pdf/calltoaction.pdf [https://perma.cc/FZD5-BRGU]; EUR. COMM'N, EU ACTION PLAN ON CHILDHOOD OBESITY 2014–2020 (2014), https://ec.europa.eu/health/sites/health/files/nutrition_physical_activity/docs/childhoodobesity_actionplan_2014_2020_en.pdf; Press Release, U.S. Dep't of Health & Human Serv., HHS Secretary and Surgeon General Join

instance, the Surgeon General and the U.S. Center for Disease, Control and Prevention pronounced obesity to be a national epidemic, and former First Lady Michelle Obama called it a public health crisis.[16] In the past decade, public health authorities around the world have primarily adopted a weight-centered approach encouraging healthy eating and exercise that has proven to affect low-income families and immigrant communities disproportionately.[17] Other interventions have ranged from imposing restrictions on the advertising of unhealthy foods directed at children to improving school meals, increasing taxes on unhealthy products to reduce their consumption, and subsiding local farming to increase intake of fruits and vegetables.[18] In many countries, the effective implementation of such measures and policies has often fallen short while obesity rates have risen sharply.[19]

On the contrary, the prevention of childhood obesity as a State obligation under international human rights law has received very limited consideration. A few studies have discussed it from the prospective of the right to health,[20] but no studies have looked at the issue through the intersection of the right to adequate food, the right to the highest attainable standard of health, and the right to participation under the Convention of the Rights of the Child. This Article attempts to remedy such gaps in the current research by proposing a comprehensive child rights-based approach assigning positive obligations to States to prevent obesity through the fulfillment of the rights of children to adequate nutrition, to health, and to participation in the decisions affecting their lives.

This Article examines the causes of childhood obesity by focusing on the multiple factors that influence weight, food preferences, and eating

---

First Lady to Announce Plans to Combat Overweight and Obesity and Support Healthy Choices (Jan. 28, 2010 1:29 PM), http://www.businesswire.com/news/home/20100128006371/en/HHS-Secretary-Surgeon-General-Join-Lady-Announce.

16. CALL TO ACTION, *supra* note 15.

17. *See* Lily O'Hara & Jane Gregg, *Human Rights Casualties from the War on Obesity: Why Focusing on Body Weight is Inconsistent with a Human Rights Approach to Health*, 1 FAT STUD. 32 (2012); *see also* Lily O'Hara & Jane Gregg, *Don't Diet: Adverse Effects of the Weight Centered Health Paradigm*, *in* MODERN DIETARY FAT INTAKES IN DISEASE PROMOTION 431(Fabien De Meester et al. eds., 2010); A. ROBERTSON, T. LOBSTEIN & C. KNAI, EUR. COMM'N, OBESITY AND SOCIO-ECONOMIC GROUPS IN EUROPE: EVIDENCE REVIEW AND IMPLICATIONS FOR ACTION (2007), http://ec.europa.eu/health/ph_determinants/life_style/nutrition/documents/ev20081028_rep_en.pdf; Lindsay McLaren, *Socioeconomic Status and Obesity*, 29 EPIDEMIOLOGIC REV. 29, 29–48 (2007).

18. *See* Corrina Hawkes et al., *Smart Food Policies for Obesity Prevention*, 385 LANCET 2410, 2410–21 (2015). *See generally* Deborah L. Rhode, *Obesity and Public Policy: A Roadmap for Reform*, 22 VA. J. SOC. POL'Y & L. 491 (2015).

19. *See generally* Christina A. Roberto et al., *Patchy Progress on Obesity Prevention: Emerging Examples, Entrenched Barriers, and New Thinking*, 385 LANCET 2400 (2015).

20. *See generally* Katharina Ó Cathaoir, *Child Obesity and the Right to Health*, 18 HEALTH HUM. RTS. 249 (2016).

patterns in children. It investigates the international human rights obligations that require States to respect, protect, and fulfill the rights of children to adequate food, to health, and to participation in the decision-making processes related to their nutrition, lifestyle, and wellbeing. This Article recommends a child rights-based approach that triggers positive obligations of States overarching the responsibilities of parents and any other stakeholders to prevent obesity in children, to support children's inclusion in the decisions related to their health and nutrition, and to ensure their best interest above all.

I. CHILDHOOD OBESITY

A. Causes of Childhood Obesity

Obesity is a multifactorial problem influenced by genetical, biological, behavioral, environmental, and cultural components. Studies identify genetic influences, sedentary lifestyle, changes in school curriculum, poor nutrition, city planning, technology, and food advertising as major contributors to obesity. The increased rate of childhood obesity is partly attributable to sedentary behaviors of children, such as television viewing, computer use, and video game playing. Longitudinal studies have consistently found that the more television children watch, the more likely they are to become overweight.[21] Television viewing in bedrooms has been associated with excess weight gain among preschool children and adolescents.[22] Research suggests that television viewing in childhood

21. Janne Boone et. al., *Screen Time and Physical Activity During Adolescence: Longitudinal Effects on Obesity in Young Adulthood*, 4 INT'L J. BEHAV., NUTRITION & PHYSICAL ACTIVITY 1, 1–10 (2007); Fred Danner, *A National Longitudinal Study of the Association Between Hours of TV Viewing and the Trajectory of BMI Growth Among US Children*, 33 J. PEDIATRIC PSYCHOL. 1100, 1100–07 (2008); Vani Henderson, *Longitudinal Associations Between Television Viewing and Body Mass Index Among White and Black Girls*, 41 J. ADOLESCENT HEALTH 544, 544–50 (2007); Marion O'Brien et. al., *The Ecology of Childhood Overweight: A 12-year Longitudinal Analysis*, 31 INT'L J. OBESITY 1469, 1469–78 (2007); Juan Pablo Rey-López et al., *Sedentary Behaviour and Obesity Development in Children and Adolescents*, 18 NUTRITION, METABOLISM & CARDIOVASCULAR DISEASES 242, 242–51 (2008).

22. *See generally* Christelle Delmas et. al., *Association Between Television in Bedroom and Adiposity Throughout Adolescence*, 15 OBESITY 2495 (2007); Barbra Dennison et. al., *Television Viewing and Television in Bedroom Associated with Overweight Risk Among Low-Income Preschool Children*, 109 PEDIATRICS 1028 (2002).

predicts future risk of obesity.[23] As noted by the Surgeon General of the United States, where childhood obesity has tripled in recent decades[24]:

> [The] widespread adoption of multiple technological innovations in the home, workplace, and schools has reduced our daily physical activity. Similarly, the car-dependent design of our communities has made it much harder for our children to walk to school—and much harder for us to shop and do other errands entirely on foot or by bicycle.[25]

This problem is not experienced by just the United States; fifteen year-old children living across Europe use the Internet for nearly two hours daily on weekdays and an extra half hour daily on weekends.[26] In the United Kingdom, a recent survey found that children aged seven to fifteen reported spending an average of three hours online daily, while those aged fifteen to sixteen reported nearly five hours daily.[27] The most frequently used devices to access the Internet content are smartphones and tablets: 67% of British children own a tablet, and tablet ownership is increasing very rapidly across central and eastern Europe.[28] In terms of Internet content, younger children between nine and eleven go online mainly to watch videos, whereas older children between the ages of thirteen and

---

23. C. Erik Landhuis et al., *Programming Obesity and Poor Fitness: The Long-Term Impact of Childhood Television*, 16 OBESITY 1457, 1457–59 (2008). *See generally* TJ Parsons, O. Manor & C. Power, *Television Viewing and Obesity: A Prospective Study in the 1958 British Birth Cohort*, 62 EUR. J. CLINICAL NUTRITION 1355 (2008).

24. *See generally* K.M. Flegal et al., *Prevalence and Trends in Obesity Among US Adults, 1999–2008*, 303 JAMA 235 (2010); K.M. Flegal et al., *Prevalence and Trends in Obesity Among US Adults, 1999–2000*, 288 JAMA 1723 (2002).

25. U.S. DEP'T OF HEALTH & HUM. SERV., THE SURGEON GENERAL'S VISION FOR A HEALTHY AND FIT NATION 2 (2010) [hereinafter SURGEON GENERAL'S VISION], https://www.ncbi.nlm.nih.gov/books/NBK44656/.

26. WHO, TACKLING FOOD MARKETING TO CHILDREN IN A DIGITAL WORLD 4 (2016), http://www.euro.who.int/__data/assets/pdf_file/0017/322226/Tackling-food-marketing-children-digital-world-trans-disciplinary-perspectives-en.pdf?ua=1 [https://perma.cc/UX2B-6PBD]; *see also* ORG. FOR ECON. CO-OPERATION AND DEV., STUDENTS, COMPUTING, AND LEARNING: MAKING THE CONNECTION 40 (2015), https://www.oecd-ilibrary.org/education/students-computers-and-learning_9789264239555-en.

27. OFCOM, CHILDREN AND PARENTS: MEDIA USE AND ATTITUDES REPORT (2015); Sean Coughlan, *Time Spent Online "Overtakes TV" Among Youngsters*, BBC (Jan. 26, 2016), http://www.bbc.com/news/education-35399658.

28. GIOVANNA MASCHERONI & KJARTAN ÓLAFSSON, NET CHILDREN GO MOBILE: RISKS AND OPPORTUNITIES 1, 28 (2014), http://eprints.lse.ac.uk/55798/1/Net_Children_Go_Mobile_Risks_and_Opportunities_Full_Findings_Report.pdf; Press Release, Childwise, Major Shift in UK Children's Behaviour as Time Online Overtakes Time Watching TV for First Time Ever, Reveals New Report 1 (2016), http://www.childwise.co.uk/uploads/3/1/6/5/31656353/childwise_press_release_-_monitor_2016.pdf; *Tablet Users in Central & Eastern Europe, by Country, 2014–2020*, EMARKETER (Mar. 29, 2016), http://www.emarketer.com/Chart/Tablet-Users-Central-Eastern-Europe-by-Country-2014-2020/188425.

seventeen spend most of their Internet time on social media.[29] In the United Kingdom, for instance, 78% of children aged ten to thirteen have a social media account (49% Facebook, 41% Instagram) and spend about one hundred minutes daily on social media.[30] In Denmark, adolescents reported that social media, such as Facebook, is essential for their social life and that they are an integral part of their identity.[31] Some studies have suggested that the use of computer, video game, and social media is associated with excess weight gain.[32]

The heavy use of television and social media not only contributes to inactivity but, as discussed later, it also increases the consumption by children of high calorie foods that are heavily advertised on television.[33] Lack of physical activity is further exacerbated by changes in school curriculum. In the United States, many schools have cut back or eliminated recess and physical education (PE) programs.[34] School administrators, teachers, unions, and policymakers argue that the change is necessary to increase instruction time.[35] However, keeping children in the classroom not only increases the likelihood of children's weight gain but also affects their general development and well-being.

Families' dietary choices also play an important role in children's risk of obesity as well as on their food preferences that can last well into

---

29. *See generally* SONIA LIVINGSTONE ET AL., RISKS AND SAFETY ON THE INTERNET: THE PERSPECTIVE OF EUROPEAN CHILDREN 42 (2011), http://www.lse.ac.uk/media%40lse/research/EUKidsOnline/EU%20Kids%20II%20(2009-11)/EUKidsOnlineIIReports/D4FullFindings.pdf; *see also* MARIA EUGENIA SOZIO ET AL., CHILDREN AND INTERNET USE: A COMPARATIVE ANALYSIS OF BRAZIL AND SEVEN EUROPEAN COUNTRIES 3 (2015), http://www2.fcsh.unl.pt/eukidsonline/docs/Brazil%20%20NCGM_COMPARATIVE%20REPORT.pdf.

30. LOGICALIS, THE AGE OF DIGITAL ENLIGHTENMENT: REALTIME GENERATION REPORT 2016 5 (2016), https://www.uk.logicalis.com/globalassets/united-kingdom/microsites/real-time-generation/realtime-generation-2016-report.pdf; Sean Coughlan, *Safer Internet Day: Young Ignore "Social Media Age Limit,"* BBC (Feb. 9, 2016), http://www.bbc.com/news/education-35524429.

31. *See generally* KAISER FAMILY FOUND., GENERATION M2: MEDIA IN THE LIVES OF 8- TO 18-YEAR-OLDS (2010), https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8010.pdf; G.H. Lapenta & R.F. Jørgensen, *Youth, Privacy and Online Media: Framing the Right to Privacy in Public Policy-Making*, 20 FIRST MONDAY (2015), http://firstmonday.org/ojs/index.php/fm/article/view/5568/4373.

32. *See generally* sources cited *supra* note 31.

33. Katharine A. Coon & Katharine L. Tucker, *Television and Children's Consumption Patterns: A Review of the Literature*, 53 MINERVA PEDIATRICA 1, 11–12 (2001); Robert W. Jeffrey & Simone A. French, *Epidemic Obesity in the United States: Are Fast Foods and Television Viewing Contributing?*, 88 AM. J. PUB. HEALTH 277, 278 (1998); M.H. Proctor et al., *Television Viewing and Change in Body Fat from Preschool to Early Adolescence: The Framingham Children's Study*, 27 INT'L J. OBESITY 827 (2003).

34. *See* RACHEL SINDELAR, EARLY CHILDHOOD AND PARENTING (ECAP) COLLABORATIVE, RECESS: IS IT NEEDED IN THE 21ST CENTURY? (2004), https://moorhead.learning.powerschool.com/meidsness/middleschooltaskforce2015/cms_file/show/59072394.pdf?t=1475157284.

35. Arthur L. Caplan & Lee H. Igel, *The Common Core Is Taking Away Kids' Recess—And That Makes No Sense*, FORBES (Jan. 15, 2015), https://www.forbes.com/sites/leeigel/2015/01/15/the-common-core-is-taking-away-kids-recess-and-that-makes-no-sense/#76a8de6d128d.

adulthood. The types of food that families buy and keep at home as well as the way family members eat their meals influence food intake in children. Recent studies have found that children eat more vegetables, fruits, and other healthy foods when they are available at home and when families eat their meals together.[36] Some studies have suggested a correlation between frequency of family meals and children's lower body weight status.[37] However, healthy foods, like vegetables, fruits and whole grains, are more expensive than less healthy options, like refined grains and sweets, and may be unaffordable for lower income families.[38]

Researchers have defined the current food environment as "toxic" given the increased consumption of cheap, tasty, and highly processed types of food, which are more likely to contribute to obesity and overweight.[39] Preparing healthy meals is not only expensive but also time consuming. Women's increased participation in the workforce means that more meals are pre-made, purchased, and consumed away from home.[40] Such meals tend to be less healthy than those homemade and shared among family members. In the United States, families spend about half of

---

36. *See generally* Amber J. Hammons & Barbara H. Fiese, *Is Frequency of Shared Family Meals Related to the Nutritional Health of Children and Adolescents?*, 127 PEDIATRICS e1565 (2011); Russell Jago et al., *Fruit and Vegetable Availability: A Micro Environmental Mediating Variable?*, 10 PUB. HEALTH NUTRITION 681 (2007); Nicole I. Larson et al., *Family Meals During Adolescence Are Associated with Higher Diet Quality and Healthful Meal Patterns During Young Adulthood*, 107 J. AM. DIET ASSOC. 1502 (2007); Cody C. Delistraty, *The Importance of Eating Together,* ATLANTIC (July 18, 2014), https://www.theatlantic.com/health/archive/2014/07/the-importance-of-eating-together/374256/.

37. *See generally* Sarah Gable, Yiting Chang & Jennifer Krull, *Television Watching and Frequency of Family Meals Are Predictive of Overweight Onset and Persistence in a National Sample of School-Aged Children*, 107 J. ACAD. NUTRITION & DIETETICS 53 (2007); Bisakha Sen, *Frequency of Family Dinner and Adolescent Body Weight Status: Evidence from the National Longitudinal Survey of Youth, 1997*, 14 OBESITY 2266 (2006); Elsie M. Taveras et al., *Family Dinner and Adolescent Overweight*, 13 OBESITY RES. 900 (2005).

38. *See generally* Nicole Darmon & Adam Drewnowski, *Does Social Class Predict Diet Quality?*, 87 AM. J. CLINICAL NUTRITION 1107 (2008); Gopal K Singh et al., *Dramatic Increases in Obesity and Overweight Prevalence and Body Mass Index Among Ethnic-Immigrant and Social Class Groups in the United States, 1976-2008*, 36 J. COMMUNITY HEALTH 94 (2010).

39. *Obesity Prevention Source: Toxic Food Environment*, Harv. Sch. of Pub. Health, https://www.hsph.harvard.edu/obesity-prevention-source/obesity-causes/food-environment-and-obesity/#references (last visited July 8, 2018); Andrew Jacobs & Matt Richtel, *How Big Business Got Brazil Hooked on Junk Food*, N.Y. TIMES (Sept. 16 2017), https://www.nytimes.com/interactive/2017/09/16/health/brazil-obesity-nestle.html (discussing the general transformation of the food system that is delivering Western-style cheap processed food and sugary drinks even to the most rural areas of Latin America, Africa, and Asia). *See generally* ZOLTAN J. ACS & ALAN LYLES, OBESITY, BUSINESS AND PUBLIC POLICY (2007); MICHAEL POLLAN, IN DEFENSE OF FOOD (2009).

40. *See* David N. Cutler et al., *Why Have Americans Become More Obese?*, 17 J. ECON. PERS. 93, 105–107 (2003). *See generally* Joanne F Guthrie et al., *Road of Food Prepared Away From Home in the American Diet, 1977–78 Versus 1994–96, Changes and Consequences*, 34 NUTRITION EDU. AND BEHAV. 140 (2002); Jennifer M. Poti & Barry M. Popkin, *Trends in Energy Intake Among U.S. Children By Eating Location and Food Source, 1997-2006*, 111 J. AM. DIETETIC ASSOC. 1156 (2011).

their food budget and consume one-third of their daily caloric intake on meals prepared away from home.[41] Low-income working families, especially single parents, may have even less time for meal preparation and may end up buying convenience foods or fast foods.[42] In the United States, it is estimated that since 1970 the amount spent on fast foods has increased from $6 billion to over $110 billion.[43]

Low-income families have four times more access to unhealthy food options than healthy ones.[44] They often live in neighborhoods with few supermarkets but with a high concentration of convenience stores and fast food restaurants, which has been associated with lower quality diets and increased risk of obesity.[45] Convenience stores and fast food restaurants are not only more likely to be located in poor neighborhoods but also in proximity of schools.[46] Studies have found that close proximity of fast food restaurants to schools is associated with an increased risk of obesity in schoolchildren.[47] Convenience store snacks and sweetened beverages are also available for purchase in schools and their consumption has been

---

41. *See generally* Michael A. McCann, *Economic Efficiency and Consumer Choice Theory in Nutritional Labeling*, 2004 WISC. L. REV. 1161 (2004).

42. *See generally* Nicole Darmon & Adam Drewnowski, *Does Social Class Predict Diet Quality?*, 87 AM. J. CLINICAL NUTRITION 1107 (2008); Tamara Dubowitz et al., *Lifecourse, Immigrant Status and Acculturation in Food Purchasing and Preparation among Low-Income Mothers*, 10 PUB. HEALTH NUTRITION 396 (2007).

43. ERIC SCHLOSSER, FAST FOOD NATION: THE DARK SIDE OF THE ALL-AMERICAN MEAL 3 (2001). *See generally* Robert Creighton, Commentary, *Cheeseburgers, Race, and Paternalism*, 30 J. LEGAL MED. 249 (2009); Michele M. Melli et al., *The McLawsuit: The Fast Food-Industry and Legal Accountability for Obesity*, 22 HEALTH AFF. 207, 207–09 (2003).

44. INST. OF MED., LEGAL STRATEGIES IN CHILDHOOD OBESITY PREVENTION: WORKSHOP SUMMARY 42 (2011).

45. *See generally* Gilbert C. Liu, et al., *Green Neighborhoods, Food Retail and Childhood Overweight: Differences by Population Density*, 21 AM. J. HEALTH PROMOTION 317, 317–25 (2007); Kimberly Morland et al., *Supermarkets, Other Food Stores, and Obesity: The Atherosclerosis Risk in Communities Study*, 30 AM. J. PREVENTIVE MED. 333, 333–39 (2006); Lisa M. Powell et al., *Associations Between Access to Food Stores and Adolescent Body Mass Index*, 33 AM. J. PREVENTIVE MED. S301, S301–07 (2007); Donald Rose & Rickelle Richards, *Food Store Access and Household Fruit and Vegetable Use Among Participants in the US Food Stamp Program*, 7 PUB. HEALTH NUTRITION 1081 (2004); Shannon N. Zenk et al., *Neighborhood Retail Food Environment and Fruit and Vegetable Intake in a Multiethnic Urban Population*, 23 AM. J. HEALTH PROMOTION 255, 255–64 (2009).

46. *See* Roland Sturm, *Disparities in the Food Environment Surrounding US Middle and High Schools*, 122 PUB. HEALTH 681, 681–90 (2008); Shannon N. Zenk & Lisa M. Powell, *US Secondary Schools and Food Outlets*, 14 HEALTH PLACE 336, 336–46 (2008).

47. *See* Brennan Davis & Christopher Carpenter, *Proximity of Fast-Food Restaurants to Schools and Adolescent Obesity*, 99 AM. J. PUB. HEALTH 505, 505–10 (2009); Austin SB et al., *Clustering of Fast-Food Restaurants Around Schools: A Novel Application of Spatial Statistics to the Study of Food Environments*, 95 AM. J. PUB. HEALTH 1575, 1575 (2005); Geeta Anand, *One Man's Stand Against Junk Food as Diabetes Climbs Across India*, N.Y. TIMES (Dec. 26, 2017), https://www.nytimes.com/2017/12/26/health/india-diabetes-junk-food.html (discussing the story of Mr. Verma, who filed a lawsuit before the Delhi High Court in 2010 seeking the ban on the sale of junk food and soft drinks in and around schools across India).

linked to an increased risk of obesity and diabetes.[48] In 2004–2005, approximately 40% of American students bought such types of food on a given school day.[49] Children's lack of physical activity, poor eating choices, and minimal access to healthy and nutritious food are important factors contributing to what authorities call a "major public health dilemma."[50]

B. Food Marketing and Childhood Obesity

Food marketing and advertisements also shape children's food choices and preferences. Identified as a key factor in the obesity crisis worldwide, food marketing targets children "on television, on the radio, on the Internet, in magazines, through product placement in movies and video games, in schools, on product packages, as toys, on clothing and other merchandise, and almost anywhere where a logo or product image can be shown."[51] Although there may be some disagreement on how much influence marketing has on children's diet and health, a joint study by the World Health Organization (WHO) and the Food and Agriculture Organization (FAO) of the United Nations concluded that heavy marketing of unhealthy foods and drinks is a "probable" causal factor in weight gain and obesity.[52]

In the United States, the Federal Trade Commission (FTC) reported that food and beverage companies spent $1.79 billion in 2009 to market their products to kids; 72% of this amount was spent to market just breakfast cereals, fast foods, and carbonated drinks.[53] Of the $1.79 billion, approximately $1 billion was directed to children between the ages of two and eleven, and $1 billion was directed to teenagers between the ages of twelve and seventeen.[54] However, the overall amount spent for food and

---

48. Daniel M. Finkelstein, Elaine L. Hill & Robert C. Whitaker, *School Food Environments and Policies in US Public Schools*, 122 PEDIATRICS 171, 251–59 (2008); Frank B. Hu & Vasanti S. Malik, *Sugar-Sweetened Beverages and Risk of Obesity and Type 2 Diabetes: Epidemiologic Evidence*, 100 PHYSIOLOGY & BEHAV. 47, 47–54 (2010); Nicole Larson & Mary Story, *Are 'Competitive Foods' Sold at School Making Our Children Fat?*, 29 HEALTH AFF. 430, 430–35 (2010).

49. Mary K. Fox, Anne Gordon, Renée Nogales & Ander Wilson, *Availability and Consumption of Competitive Foods in US Public Schools*, 109 J. AM. DIETETIC ASS'N S57, S57–66 (2009).

50. SURGEON GENERAL'S VISION, *supra* note 25.

51. CTR. FOR SCI. IN THE PUB. INT., FOOD MARKETING TO CHILDREN, https://cspinet.org/sites/default/files/attachment/food_marketing_to_children.pdf [https://perma.cc/HE5T-MZDU].

52. CORINNA HAWKES, MARKETING FOOD TO CHILDREN: THE GLOBAL REGULATORY ENVIRONMENT 1 (2004).

53. FED. TRADE COMM'N., A REVIEW OF FOOD MARKETING TO CHILDREN AND ADOLESCENTS, ES-2 (2012), https://www.ftc.gov/sites/default/files/documents/reports/review-food-marketing-children-and-adolescents-follow-report/121221foodmarketingreport.pdf [https://perma.cc/VZR3-K4ZB].

54. *Id.*

beverage promotional activities marketed to adults that were also marketed to children or teenagers reached about $9.65 billion.[55]

Television has been the predominant medium to reach children for decades. The FTC estimated that food companies spent approximately $375 million to reach children via television and $364 million to reach adolescents in 2009.[56] Fast food restaurants ($154 million) and breakfast cereals ($102 million) accounted for 68% of the child television expenditures; and fast food restaurants accounted for about 36%, or about $130 million, of the adolescent television expenditures.[57] Overall food companies spent $695 million on traditional forms of media, including television, radio, and print.[58] In 2007–2008, a survey across eleven countries evaluating 2,496 hours of television on the three channels most popular with children found that food advertisements accounted for 18% of the advertisements broadcasted; 67% of these were advertising food products high in fat, sodium, and energy.[59]

Across European countries, the leading categories of food being advertised on television are soft drinks, sweetened breakfast cereals, biscuits, candies, snack foods, ready meals, and fast food outlets.[60] Surveys conducted in 2007 across Europe found that over 50% of food advertisements on children's television programs were for food products high in fat, sugar, or salt, such as in Spain, Sweden, and the United Kingdom; this percentage was found to be over 60% in Greece and Italy, over 80% in Germany, and over 90% in Bulgaria.[61]

Studies conducted in the United Kingdom on the prevalence of food advertising broadcast with children's television programs found that food and drinks were the third most heavily advertised products and that most of such advertisements were promoting unhealthy food items and beverages during children's peak viewing times.[62] Even in a developing country like South Africa, where many children suffer from hunger and malnutrition, cheap, high-fat, high-sugar, high-salt, energy-dense, and

---

55. *Id.*

56. *Id.* at ES 3.

57. *Id.*

58. *Id.*

59. Bridget Kelly et al., *Television Food Advertising to Children: A Global Perspective*, 100 AM. J. PUB. HEALTH 1730, 1731 (2010).

60. WHO REG'L OFFICE FOR EUR., MARKETING OF FOODS HIGH IN FAT, SALT AND SUGAR TO CHILDREN: UPDATE 2012–2013 2 (2013), http://www.euro.who.int/__data/assets/pdf_file/0019/191125/e96859.pdf [https://perma.cc/U22Y-YDH3].

61. *Id.*

62. *See generally* Emma Boyland et al., *The Extent of Food Advertising to Children on UK Television in 2008*, 6 INT'L J. OF PEDIATRIC OBESITY 455 (2011); MK Lewis & AJ Hill, *Food Advertising on British Children's Television: A Content Analysis and Experiential Study With Nine Year Olds*, 22 INT'L J. OBESITY 206 (1998).

micronutrient-poor types of food are heavily promoted to children.[63] According to a report released from Statistics South Africa on the food and beverages industry, takeaway and fast food outlets spent R462 million on advertising in 2012 alone.[64]

In 2005, an Australian study evaluated 390 hours of advertisements and 346 hours of advertisements for sweets and fast food restaurants shown during children's viewing time over fifteen television stations.[65] The study concluded that 50% of the advertisements promoted food that was high in fat, sugar, or both fat and sugar. The study also found that sweets and fast food restaurants were, respectively, three times and two times more likely to be advertised during children's viewing times than during adult's viewing times and that fruits and vegetables were the least advertised food.[66]

Another Australian study, evaluating 645 hours of television food advertising, found that 81% of the advertisements promoted unhealthy types of food, including fast food, take away food, chocolate, and other sweets.[67] Similarly, in 2006 and 2007, a longitudinal analysis of the content of advertisements on three Australian commercial television stations showed that 61.3% of the food advertisements shown during children's peak viewing times were promoting fast food restaurants, chocolate, and other sweets.[68]

In the United States, about 80% of foods advertised on children's television programs promoted convenience foods, fast foods, and sweets.[69] A daily 2,000 calorie diet of such advertised foods would exceed the USDA recommended guidelines for sodium and provide nearly one cup of added sugar.[70] In the last decade, food companies have spent 50% more in marketing their products to children using new media, including the Internet, smartphones, and viral marketing.[71] Breakfast cereals ($22 million), fast foods ($19 million), and snack foods ($10 million) were the

---

63. Lize Mills, *Selling Happiness in a Meal: Serving the Best Interests of the Child at Breakfast, Lunch, and Supper*, 20 INT'L J. CHILDREN'S RTS. 624, 627 (2012).

64. STATISTICS S. AFR., REPORT NO. 64-20-01, FOOD AND BEVERAGES INDUSTRY (2012), http://www.statssa.gov.za/publications/Report-64-20-01/Report-64-20-012012.pdf [https://perma.cc/4LH6-52C6].

65. Leonie Neville et al., *Food Advertising on Australian Television: The Extent of Children's Exposure*, 20 HEALTH PROMOTION INT'L 105, 105 (2005).

66. *Id.* at 108–09.

67. Kathy Chapman et al., *How Much Food Advertising Is There on Australian Television?*, 21 HEALTH PROMOTION INT'L 172, 177 (2006).

68. *See generally* Bridget Kelly et al., *Persuasive Food Marketing to Children: Use of Cartoons and Competition in Australian Commercial Television Advertisements*, 23 HEALTH PROMOTION INT'L 337 (2008).

69. CTR. FOR SCI. IN THE PUB. INT., *supra* note 51.

70. *Id.*

71. FED. TRADE COMM'N., *supra* note 53, at 12.

top three categories for child-directed digital media expenditures. Carbonated beverages ($23 million), sweets ($12 million), and snack foods ($11 million) were the top three categories for adolescents.[72]

Food companies use a variety of promotional techniques to market their products to children and adolescents. Popular movies, television programs, and cartoon characters are used to promote fast food meals, cereal, fruit snacks, yogurt, sweets, and carbonated beverages. Foods and beverages are also cross-promoted with amusement parks, video games, and children's websites. Most food companies engage in online marketing, which is more appealing for children and far less expensive than television and other media. In 2009, about two million children between the ages of two and eleven and approximately three million between the ages of six and fourteen visited at least one of seventy-three food company websites per month.[73] Food companies' websites, Facebook pages, and Twitter accounts feature popular cartoon characters, video games, and sport and musical celebrities.[74]

Consumer research studies conducted by some food companies reported that the purchase of particular foods or the choice to eat at a specific fast food restaurant is often driven by a child's request.[75] In one company's study, 75% of the participants reported having purchased the product for the first time because their child suggested it.[76] Another study found that in-store advertising campaigns designed for children were far more effective than targeted in-store advertising for mothers.[77] Innovative product packaging formats and kids branding—reclassified by some researchers as "fun food"—are effective promotional techniques to target young people.[78] Online marketing, in particular, fosters brand loyalty and interactive participation by children and teenagers.

These results suggest that children play a key role in purchasing decisions for food and beverages, and that across the world and across multiple forms of media, foods high in fat and sugar are disproportionally advertised to them. In a recent study investigating the nutritional quality of foods advertised with popular children's characters, 72% of the

72. *Id.*

73. *Id.* at 18–19.

74. *See also* WHO REG'L OFFICE FOR EUR., *supra* note 60.

75. *See* THE EUR. HEART NETWORK, THE MARKETING OF UNHEALTHY FOOD TO CHILDREN IN EUROPE 10 (2005).

76. FED. TRADE COMM'N, *supra* note 53, at ES 11.

77. Charlene Elliott, *Marketing Fun Foods: A Profile and Analysis of Supermarket Food Messages Targeted at Children*, 34 CAN. PUB. POL'Y—ANALYSE DE POLITIQUES 259, 259 (2002).

78. *Id. See generally* Angela Groves, *Children's Food: Market Forces and Industry Responses*, 27 BRITISH NUTRITION FOUND. NUTRITION BULL. 187 (2002).

advertisements promoted foods of low nutritional value.[79] It is well-demonstrated by current literature that advertising of unhealthy and low-nutrient types of food correlates with the prevalence of childhood obesity. Recent studies have indeed found a direct link between children's exposure to food advertisements and their food preferences.[80] In a review of 123 studies, the Institute of Medicine concluded that "food and beverage marketing influences the preferences and purchase requests of children, influences consumption at least in the short term, is a likely contributor to less healthy diets, and may contribute to negative diet-related health outcomes and risks."[81]

Empirical evidence shows that young children have limited ability to process advertising content in an appropriate way. Between the ages of two and eleven, children start developing their consumer preferences and values; they begin to comprehend the different products, brands, and pricing and can express their purchase requests.[82] However, before eight years of age, children still lack the defenses and skills necessary to discern marketing's persuasive intent.[83] A study investigating children's ability to evaluate and respond to advertising messages concluded that 64.8% of six- and seven-year-old children reported "trusting all commercials" compared to 7.4% of ten- and eleven-year-old children.[84] These findings suggest that children have limited capacity to comprehend the nature and purpose of advertising; further, attractive messages and subtle selling techniques may impair their ability to resist the implicit persuasion of food marketing efforts.

II. INTERNATIONAL HUMAN RIGHTS FRAMEWORK

The main international legal instruments addressing children's right to adequate food and to health are the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the Convention on the Rights of the Child (CRC). This section of the Article first examines ICESCR provisions that generally impose obligations on States to achieve

79. Jessica Castonguay et al., *Healthy Characters? An Investigation of Marketing Practices in Children's Food Advertising*, 45 J. NUTRITION EDUC. & BEHAV. 571, 572 (2013).

80. *See generally* J. MICHAEL MCGINNIS ET AL., FOOD MARKETING TO CHILDREN AND YOUTH: THREAT OR OPPORTUNITY? 226–318 (2006).

81. *Id.* at 307.

82. GERARD HASTINGS ET AL., REVIEW OF RESEARCH ON THE EFFECTS OF FOOD PROMOTION TO CHILDREN 33–36 (2003).

83. *See* MCGINNIS ET AL., *supra* note 80, at 5; Sandra L. Calvert, *Children as Consumers: Advertising and Marketing*, 18 FUTURE CHILD 205, 218 (2008). *See generally* Deborah John, *Through the Eyes of a Child: Children's Knowledge and Understanding of Advertising*, *in* ADVERTISING TO CHILDREN—CONCEPTS AND CONTROVERSIES ch. 1 (M. Carole Macklin & L. Carlson eds., 1999).

84. Thomas S. Robertson & John R. Rossiter, *Children and Commercial Persuasion: An Attribution Theory Analysis*, 1 J. CONSUMER RES. 13, 17 (1974).

and protect the right to adequate food. The Article then proceeds by analyzing similar provisions under the CRC, which provides a more specific and robust basis for protecting the right of children to healthy food. The analysis also includes references to other legal instruments issued by international bodies that, although not binding, have addressed issues related to childhood obesity either under the right to food and adequate nutrition or under the right to the highest attainable standard of health.

A. International Covenant on Economic, Social and Cultural Rights

Under the ICESCR, which puts socioeconomic rights at the forefront, the right to adequate food is first mentioned in connection with the right to an adequate standard of living. Article 11 of the ICESCR assigns States Parties the obligation of taking appropriate measures to ensure the realization and protection of "the right of everyone to an adequate standard of living for himself and his family, including adequate food, clothing and housing, and to the continuous improvement of living conditions."[85] In practice, States Parties shall adopt all appropriate measures to "improve methods of production, conservation and distribution of food by making full use of technical and scientific knowledge, [and] by disseminating knowledge of the principles of nutrition."[86]

Further support for the interpretation that children have a right to adequate food comes from the Committee on Economic, Social, and Cultural Rights (ICESCR Committee).[87] The ICESCR Committee, in General Comment No. 12, clarifies that the right to adequate food is realized when "every man, woman, and child, alone or in community with others, have physical and economic access at all times to adequate food or means for its procurement."[88] The United Nations Special Rapporteur on the Right to Food further clarified that "the right to food cannot be reduced to a right not to starve," but rather, "it is an inclusive right to an adequate

85. International Covenant on Economic, Social and Cultural Rights, art. 12, Dec. 16, 1966, [hereinafter ICESCR], http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx [https://perma.cc/U6SE-6NGJ].

86. *Id.* art. 11(2)(a).

87. The ICESCR Committee is the treaty body comprised of independent experts that monitors the implementation of the ICESCR by its States Parties.

88. U.N. Econ. & Soc. Council, Substantive Issues Arising in the Implementation of Covenant of Economic, Social and Cultural Rights: General Comment 12, The Right to Adequate Food, ¶ 6, U.N. Doc. E/C.12.1999/5 (May 12, 1999) [hereinafter General Comment 12], http://tbinternet.ohchr.org/_layouts/treatybodyexternal/TBSearch.aspx?Lang=en&TreatyID=9&DocTypeID=11. General Comments are authoritative interpretation of the provisions under the ICESCR provided by the ICESCR Committee aimed at clarifying and in some cases expanding the content of the ICESCR.

diet providing all the nutritional elements an individual requires to live a healthy and active life, and the means to access them."[89]

The term adequate is not defined under the ICESCR. However, according to the ICESCR Committee, adequacy means that the food must be in a quantity and quality sufficient to satisfy dietary needs,[90] taking into consideration the individual's age, living conditions, health, occupation, sex, and so forth.[91] For example, unhealthy types of food that can contribute to obesity and other health problems constitute inadequate food. Similarly, food that does not contain the nutrients that are necessary for children's physical and mental development is not adequate.[92] Food must also be safe for human consumption and free from adverse substances, culturally acceptable, and economically and physically accessible to everyone, including the most vulnerable, such as infants and children.[93]

Human rights are often mutually related and dependent on each other; violating the right to adequate food may impair the enjoyment of other rights, like the right to education or the right to health. The dietary-needs requirement is fundamental to ensure the full realization of the right to education given that sufficient and adequate nourishment is necessary for children to attend and succeed at school. When children are denied access to nutritious food, both their right to adequate food and their right to health are violated as healthy nourishment is crucial to ensure their optimal health and development. Article 12 of the ICESCR provides that "States Parties recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health"[94] and that the measures to be adopted in order to "achieve the full realization of this right shall include those necessary for . . . the healthy development of the child."[95] Moreover, States must take "special measures . . . and assistance . . . on behalf of all children and young persons without any discrimination for reasons of parentage or other conditions."[96] These two provisions, which link the right to nondiscrimination and special protection for

89. Olivier De Schutter, *Rep. of the Special Rapporteur on the Right of Food*, ¶¶ 1–3, U.N. Doc. A/HRC/19/59, (Dec. 26, 2011), http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session19/A-HRC-19-59_en.pdf [https://perma.cc/57XN-SS3K]. The United Nations Rapporteur on the Right to Food is an independent expert appointed by the Human Rights Council to examine, monitor, advise, and report on the realization of the right to food.

90. General Comment 12, *supra* note 88.

91. OFFICE OF THE U.N. HIGH COMM'N FOR HUM. RIGHTS, THE RIGHT TO ADEQUATE FOOD FACT SHEET NO. 34, 3 (2010), http://www.ohchr.org/Documents/Publications/FactSheet34en.pdf [https://perma.cc/YX8Z-ZBK9].

92. *Id.*

93. *Id.*

94. ICESCR, *supra* note 85, art. 12.

95. *Id.* art. 12(2)(a).

96. *Id.* art. 10(3).

children to their right to the highest attainable standard to physical and mental health and, by inclusion, their right to nutritious food, should be interpreted in conjunction to one another because such rights are closely related. In order to ensure children's optimal growth and development, States Parties to the ICESCR are thus under the obligation to take positive measures to provide protection and access to healthy food for all children.

In General Comment No. 14, the ICESCR Committee also affirms that everyone is "entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity."[97] The full realization of the right to health closely correlates with the implementation of other rights, including the rights to food, education, human dignity, life, nondiscrimination, equality, and access to information, among others.[98] The ICESCR Committee further clarifies that the highest attainable standard of physical and mental health is not limited to the right to health care, but rather, it should be intended to embrace "a wide range of socioeconomic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition . . . ."[99] Thus, the ICESCR Committee interprets the right to health "as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to . . . adequate supply of safe food, nutrition . . . healthy occupational and environmental conditions, and access to health-related education and information . . . ."[100]

Interpreting the right to health as an inclusive right means that State obligations cannot be limited to building hospitals and ensuring availability to healthcare services for everyone.[101] Rather, positive measures must also be taken to secure access to the underlying determinants of health, including adequate nutrition and safe food, that are necessary to lead a healthy life.[102] Failure to ensure the full realization of the right to adequate nutritious food for children means that children's right to health is also violated. Providing access to healthcare facilities and services to obese children is not sufficient to fulfill children's right to health. Children's right to the highest attainable standard of physical and

97. U.N. Econ. & Soc. Council, Substantive Issues Arising in the Implementation of Covenant of Economic, Social and Cultural Rights: General Comment 14: The Right to the Highest Attainable Standard of Health, ¶ 1, U.N. Doc. E/C.12/2000/4, (Aug. 11, 2000), http://www.refworld.org/pdfid/4538838d0.pdf [https://perma.cc/3RRV-URZN].

98. *Id.* ¶ 3.

99. *Id.* ¶ 4.

100. *Id.* ¶ 11.

101. OFFICE OF THE U.N. HIGH COMM'N FOR HUM. RIGHTS, THE RIGHT TO HEALTH FACT SHEET NO. 31, 3–4 (2008), http://www.ohchr.org/Documents/Publications/Factsheet31.pdf [https://perma.cc/PQ9C-MX53].

102. *Id.*

mental health can only be achieved by ensuring the realization of the wide range of factors and conditions that protect and promote their healthy growth and development, such as adequate food.

The challenge for the implementation of the ICESCR and related rights lies in Article 2(1), which somewhat limits the responsibility of States Parties to adopt steps "to the maximum of . . . [their] available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means . . . ."[103] This wording undermines the effective implementation of rights under the ICESCR contrary to the immediate applicability of rights provided under the International Covenant on Civil and Political Rights.[104] The concept of progressive realization entails that the full implementation of all economic, social, and cultural rights might not be achieved by all States Parties immediately. As a matter of fact, this provision may allow States to slacken their efforts to comply by invoking lack of resources.

To remedy the unsatisfactory formulation of Article 2(1), the Limburg Principles, which clarify the nature and scope of the obligations under the ICESCR, provides that:

> The obligation "to achieve progressively the full realization of the rights" requires States parties to move as expeditiously as possible towards the realization of the rights. Under no circumstances shall this be interpreted as implying for States the right to deter indefinitely efforts to ensure full realization. On the contrary all States parties have the obligation to begin immediately to take steps to fulfill their obligations under the Covenant.[105]

Subsequently, the Maastricht Guidelines, which emanates from a further elaboration on the Limburg Principles, emphasizes that:

> The fact that the full realization of most economic, social and cultural rights can only be achieved progressively . . . does not alter the nature of the legal obligation of States which requires that certain steps be taken immediately and others as soon as possible. Therefore, the burden is on the State to demonstrate that it is making measurable progress toward the full realization of the rights in question. The State

---

103. *Id.* at 22.

104. *See generally* PHILIP ALSTON, THE BEST INTERESTS OF THE CHILD: RECONCILING CULTURE AND HUMAN RIGHTS (1994).

105. U.N., Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights, ¶ 21, U.N. Econ. & Soc. Council Official Records, U.N. Doc. E/CN.4/1987/17/Annes (Jan. 8, 1987), https://www.escr-net.org/resources/limburg-principles-implementation-international-covenant-economic-social-and-cultural [https://perma.cc/7LPL-FFSH].

> cannot use the "progressive realization" provisions in article 2 of the Covenant as a pretext for non-compliance.[106]

Although the Limburg Principles and the Maastricht Guidelines are not binding, they have been helpful for the interpretation of obligations under the ICESCR as well as to exhort States Parties to comply.

General Comment No. 3 on the Nature of States Parties' Obligations, adopted by the ICESCR Committee in 1990, clarifies that, under Article 2(1) of the ICESCR, States Parties are required to take steps that should be "deliberate, concrete and targeted as clearly as possible towards meeting the obligations recognized in the Covenant."[107] The undertaking to take appropriate steps must be satisfied by adopting "all appropriate means, including particularly . . . legislative measures," especially in the fields of health, the protection of children and mothers, and education.[108] Other appropriate means include judicial or other effective remedies,[109] and administrative, financial, educational, and social measures.[110] The ICESCR Committee stresses that the obligation under Article 2(1) to take steps "with a view to achieving progressively the full realization of the rights" under the ICESCR should be intended to urge States "to move as expeditiously and effectively as possible towards that goal."[111]

States must take all necessary steps, to the maximum of their available resources, to ensure the realization of the right to adequate food and the right to the highest attainable standard of physical and mental health. According to the ICESCR Committee, the concept of "to the maximum of its available resources" should not be limited to the resources existing within a country but also to those available from the international community through international cooperation and assistance.[112] The duty to use maximum available resources thus entails that States must invest not just their budgetary allocations but their full real resources to ensure the realization of the right to adequate food and the right to health.[113] Even when States may be able to demonstrate that their resources are inadequate to fulfill the realization of such rights, they are still under the obligation to endeavor to ensure the enjoyment of those rights as far as possible.

---

106. Int'l Comm'n of Jurists et al., *Maastricht Guidelines on Violations of Economic, Social and Cultural Rights* ¶ 8 (Jan. 26, 1997), http://www.refworld.org/docid/48abd5730.html.

107. U.N. Comm'n On Econ., Soc. & Cultural Rts., General Comment No. 3: The Nature of States Parties' Obligations, art. 2, U.N. Doc. E/1991/23 (Dec. 14, 1990), http://www.refworld.org/docid/4538838e10.html.

108. *Id.* ¶ 3.

109. *Id.* ¶ 5.

110. *Id.* ¶ 7.

111. *Id.* ¶ 9.

112. *Id.* ¶ 13.

113. *See generally* APPLYING AN INTERNATIONAL HUMAN RIGHTS FRAMEWORK TO STATE BUDGET ALLOCATIONS: RIGHTS AND RESOURCES (Rory O'Connell et al. eds., 2014).

B. Convention on the Rights of the Child

The CRC, which recognizes children as holders of their own rights and fundamental freedoms, encompasses both their civil and political rights as well as their economic, social, and cultural rights in a single document.[114] In particular, under the CRC, children's right to food is protected in the context of the rights to life, survival and development, the highest attainable standard of health, and an adequate standard of living. Article 6 of the CRC provides that "every child has the inherent right to life"[115] and requires that States ensure "to the maximum extent possible the survival and development of the child."[116] According to the Committee on the Rights of the Child (CRC Committee),[117] the notion of "development" must be interpreted in its broadest sense as a holistic concept, embracing the child's physical, mental, spiritual, moral, psychological, and social development.[118]

Thus, the right to adequate food can be broadly implied under such provision as sufficient, safe, and nutritious food is necessary for children to grow physically and mentally. Children are particularly vulnerable to undernutrition and malnutrition. Inadequate food affects them disproportionally, leading to death or other long-lasting health consequences, including mental and physical impairment, chronic illness, weak immune systems, and poor reproductive health.[119] Because children are largely dependent on their families or caregivers for food, their ability to enjoy their right to food is significantly affected by the choice and capacity of families and caregivers to provide adequate food.[120]

The right to adequate food can also be implied under Article 24 of the CRC, which recognizes "the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health."[121] As previously discussed, also under the CRC, the right to adequate food and the right to the highest attainable standard of health are interrelated and interdependent. For example, to

---

114. *See generally* Convention on the Rights of the Child, Nov. 20, 1989 [hereinafter CRC] (ratified by the General assembly as G.A. Res. 44/25 (Nov. 20, 1989)) http://www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx [https://perma.cc/27SS-X7J4].

115. *Id.* art. 6(1).

116. *Id.* art. 6(2).

117. The CRC Committee is the treaty body comprised of independent experts that monitors the implementation of the CRC by States Parties.

118. Comm. on the Rts. of the Child, General Comment No. 5 (2003): General Measures of Implementation of the Convention on the Rights of the Child, ¶ 4, U.N. Doc. CRC/GC/2003/5 (Nov. 27, 2003), https://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRC%2fGC%2f2003%2f5 [https://perma.cc/7UDZ-8ZBH].

119. OFFICE OF THE U.N. HIGH COMM'N FOR HUM. RIGHTS, *supra* note 91, at 16.

120. *See id.*

121. CRC, *supra* note 114, art. 24(1).

fulfill children's right to health, States must ensure equal access to health care services for all children affected by obesity.[122] Before they can do so, States must also strive to provide adequate and nutritious food to reduce the risk for children of becoming overweight and incurring related health problems. Under Article 24, the right to food is also directly mentioned when States Parties are required to take appropriate measures in order to "diminish infant and child mortality"[123] and to "combat disease and malnutrition, . . . through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods."[124]

In General Comment No. 15, The CRC Committee clarifies that children's right to health must be interpreted as an inclusive right extending not only to access to healthcare 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 by implementing programmes that address the underlying determinants of health."[125] The concept of "underlying determinants of health" encompasses a great range of socioeconomic factors, including food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment.[126] Children's right to health should be understood holistically and can only be fully realized in conjunction with other international human rights obligations, such as the right to adequate food.[127]

Finally, Article 27(1) of the CRC, providing for "the right of every child to a standard of living adequate for . . . [her or his] physical, mental, spiritual, moral and social development," can also be interpreted to include, by extension, the right to healthy and adequate food.[128] In fact, Article 27(3) requires "States Parties . . . [to] provide material assistance and support programmes, particularly with regard to nutrition."[129] The right to an adequate standard of living entitles children to enjoy the necessary subsistence rights, such as adequate food and nutrition, clothing, and housing. Lack of adequate food impairs children's ability to be full

122. *Id.*

123. *Id.* art. 24(2)(a).

124. *Id.* art. 24(2)(c).

125. Comm. on the Rts. of the Child, General Comment No. 15: The Right of the Child to the Enjoyment of the Highest Attainable Standard of Health, ¶ 2, U.N. Doc. CRC/C/GC/15 (Mar. 14, 2013), https://www.crin.org/en/docs/CRC-C-GC-15_en-1.pdf [https://perma.cc/H2ZV-Y4B4] (offering authoritative interpretation of the provisions under the CRC provided by the CRC Committee aimed at clarifying, and in some cases expanding, the content of the CRC).

126. Comm. on Econ., Soc. & Cultural Rts., General Comment No. 14: The Right to the Highest Attainable Standard of Health, ¶ 4, E/C.12/2000/4 (Aug. 11, 2000), http://undocs.org/E/C.12/2000/4.

127. Comm. of the Rts. of the Child, *supra* note 125, ¶ 2.

128. CRC, *supra* note 114, art. 27(1).

129. *Id.* art. 27(3).

participants in their everyday life and to reach their optimal physical, mental, spiritual, moral, and social development. Studies have shown that lack of adequate nutrition and poor eating habits affect children's cognitive functions and may lead to behavioral, emotional, and academic problems, as well as to obesity.[130] For instance, research conducted in 2013 across eight European countries found that children aged ten to twelve who skipped breakfast were 80% more likely to be obese.[131]

Under Article 4 of the CRC, States Parties "undertake all appropriate legislative, administrative, and other measures for the implementation of [all] rights."[132] In particular, "with regard to economic, social and cultural rights, States Parties shall undertake such measures to the maximum extent of their available resources and, where needed, within the framework of international co-operation."[133] Although the enjoyment of economic, social, and cultural rights is interdependent and intertwined with the enjoyment of civil and political rights, and States bear an overall obligation of implementation, this sentence recognizes that lack of resources can impede the full and immediate implementation of economic, social, and cultural rights in some countries.[134]

Thus, the CRC suffers from the same limitation of the ICESCR with regard to the immediate implementation of such rights. Indeed, both agreements contain wordings such as "to the maximum extent possible" and "to the maximum of . . . available resources," respectively, which subject the realization of the rights to food and health to the resources available and the priorities of the States. However, if both provisions are read in conjunction with Limburg Principle 21, States' obligation of intent to provide children with adequate food, the highest attainable standard of health, and an adequate standard of living and nutrition acquires a much stronger connotation.[135]

Similarly, the CRC Committee, in its General Comment No. 5, holds that the concept of "progressive realization" of rights under Article 4 of the CRC should impose an obligation on States to demonstrate that they have implemented economic, social, and cultural rights "to the maximum extent of their available resources," and where necessary, they have sought

---

130. *See* HENRY DIMBLEBY & JOHN VINCENT, THE SCHOOL FOOD PLAN 116–17 (2013), http://www.schoolfoodplan.com/wp-content/uploads/2013/07/School_Food_Plan_2013.pdf [https://perma.cc/LV9D-4K9T].

131. *Id.*

132. CRC, *supra* note 114, art. 4.

133. *Id.*

134. *See* Comm. on the Rts. of the Child, General Comment No. 5, *supra* note 118, ¶ 7.

135. U. Jonsson, *An Approach to Assess and Analyze the Health and Nutrition Situation of Children in the Perspective of the Convention on the Rights of the Child*, 5 INT'L J. CHILD. RTS. 367, 367–81 (1997).

international cooperation to implement these rights.[136] This means that States are expected to not only strive to ensure the implementation of such rights within their jurisdiction but also to contribute through international cooperation to the global implementation of economic, social, and cultural rights in those countries that may be lacking the necessary resources.

Even if States may have been able to demonstrate the inadequacy of their available resources, they are still bound to ensure the widest possible enjoyment of the relevant rights under the prevailing circumstances. The CRC Committee further clarifies 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."[137] In particular, despite resource constraints, legislative measures should be adopted to ensure that domestic laws consistently reflect the principles and standards of the CRC, especially in the fields of health, education, and justice, among others.[138]

III. CHILD RIGHTS-BASED APPROACH TO CHILDHOOD OBESITY

A. State Obligations

Under Article 2 of the ICESCR and the ICESCR Committee's General Comment No. 3, the principal positive obligation for States Parties is to take steps to achieve progressively, but as expeditiously as possible, the full realization of the right to adequate food.[139] To this end, each State must ensure for everyone access to food that is sufficient, nutritionally adequate, and safe. More specifically, the right to adequate food imposes three positive obligations on States: the obligations to respect, to protect, and to fulfill.[140]

The obligation to respect requires States to not take any measures that may result in preventing existing access to adequate food. States shall not pass legislation or develop policies that can interfere with anyone's existing enjoyment of the right to adequate food.[141]

The obligation to protect requires States to ensure third parties—including individuals, enterprises, and other entities—do not violate

136. Comm. on the Rts. of the Child, General Comment No. 5, *supra* note 118, ¶ 7.

137. *Id.* ¶ 8.

138. *Id.* ¶ 22.

139. *See* ICESCR, *supra* note 85, art. 2. *See generally* Comm. On Econ., Soc. & Cultural Rts., Substantive Issues Arising in the Implementation of Covenant of Economic, Social and Cultural Rights: General Comment No. 3: The Nature of States Parties' Obligations, U.N. Doc. E/1991/23 (Dec. 14, 1990).

140. Comm. on Econ., Soc. & Cultural Rts., Substantive Issues Arising in the Implementation of Covenant of Economic, Social and Cultural Rights: General Comment No. 12: The Right to Adequate Food, ¶ 15, U.N. Doc. E/C.12/1999/5 (May 12, 1999).

141. *Id.*

anyone's access to adequate food.[142] For example, States should ensure that food available on the market is safe and nutritious. They should also particularly protect children from the advertising and promotions of unhealthy food in order to support the efforts of parents and health professionals to encourage healthier food choices and eating habits.[143]

The obligation to fulfill the right to adequate food incorporates both the obligation to facilitate and the obligation to provide. To facilitate the full realization of the right to adequate food, a State must strive to strengthen everyone's access to resources and means necessary to ensure a livelihood, including food security.[144] States must also inform people, including children, of their right to adequate food and increase people's ability to participate in the development process of food and nutrition programs.

Finally, whenever persons are unable, for reasons beyond their control, to enjoy the right to adequate food by the means at their disposal, States have the obligation to provide adequate food directly, as in the case of the most deprived, often including children, or those who are victims of natural or other disasters.[145]

In addition to such progressive duties that can be realized over time, States also bear the following positive obligations of immediate effects: elimination of discrimination, prohibition of retrogressive measures, and protection of minimum essential level of the right to adequate food. Any discrimination in access to food on the basis of race, color, sex, language, or age, among others, should be immediately prohibited.[146] The concept of discrimination includes both direct and indirect forms of differential treatment. In General Comment No. 20 on non-discrimination in economic, social, and cultural rights, the ICESCR Committee clarifies that direct discrimination occurs when an individual is treated less favorably than another in a similar situation on prohibited grounds.[147] Indirect discrimination includes any legislation, policies, or practices that do not appear to be discriminatory at face value but have a disproportionate impact on the enjoyment of the right to adequate food by a particular

142. *Id.*

143. OFFICE OF THE U.N. HIGH COMM. FOR HUM. RTS., *supra* note 91, at 17.

144. *Id.*

145. *Id.* at 19.

146. Comm. on Econ., Soc. & Cultural Rts., Substantive Issues Arising in the Implementation of Covenant of Economic, Social and Cultural Rights: General Comment No. 12: The Right to Adequate Food, ¶ 18, U.N. Doc. E/C.12/1999/5 (May 12, 1999).

147. Comm. on Econ., Soc. & Cultural Rts., Substantive Issues Arising in the Implementation of Covenant of Economic, Social and Cultural Rights: General Comment No. 20: Non-Discrimination in Economic, Social and Cultural Rights, ¶ 10, U.N. Doc. E/C.12/GC/20 (July 2, 2009) (noting that prohibited grounds include race, color, sex, language, age, religion, political or other opinion, national or social origin, property, birth, or other status).

group.[148] Ensuring non-discrimination in access to adequate food means not only abolishing laws, policies, and programs that may treat individuals differently because of their gender, age, disability, race, or any other prohibited ground but also entails recognizing and providing for the specific needs of different groups, which may have different dietary needs, like children. For instance, in designing and implementing welfare measures, States must take into consideration the different dietary needs of children to ensure their access to adequate food.[149]

States are also prohibited from introducing any retrogressive measures that can degrade the existing enjoyment of the right to adequate food unless the State can demonstrate that it has carefully considered all the prevailing options, assessed the impact of such measures, and fully used the maximum available resources.[150] Also of immediate application is the core minimum obligation for States to satisfy: the minimum essential level of the right to food.[151] This means, for example, ensuring that everyone is free from hunger, even in times of natural or other disasters, or that access to adequate food is provided for those who are unable to secure it by themselves, as it may be the case for children. Whenever States may seek to justify failure to meet such minimum obligations due to resource constraints, they must demonstrate that every effort has been made to use all their available resources to satisfy, as a matter of priority, those core obligations.[152]

States' obligation to protect the right to adequate food includes ensuring that third parties, such as individuals, families, local communities, enterprises, and other entities, do not infringe upon the realization of such right. To what extent all members of society also have responsibilities with regard to the promotion and protection of human rights, including the right to adequate food, has been increasingly under debate. For example, the issue of obesity has been mostly approached as a matter of personal responsibility or, in the case of children, as a matter of parental responsibility. However, children have a limited ability to control their diets because they do not purchase their own food, they may not be able to prepare meals for their families, and they do not have a full understanding of the long-term health consequences of their actions and eating habits. By the same token, for all the reasons previously discussed in this Article, parents may also not be able to determine what will serve

148. *Id.*
149. OFFICE OF THE U.N. HIGH COMM. FOR HUM. RTS., *supra* note 91, at 20–21.
150. *Id.*
151. *Id.* at 22.
152. *Id.*

their children's best interest when it comes to food choices and eating patterns.

Although children are recognized as holders of their own rights under the CRC, parents have the primary responsibility for their upbringing and development.[153] The CRC holds that the family is the fundamental group of society and the natural environment for children's growth and well-being, and thus, should be accorded with the necessary protection and assistance to be able to fulfill its responsibilities within the community.[154] According to Article 5 of the CRC, "States Parties shall respect the responsibilities, rights and duties of parents . . . to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance" in children's exercise and enjoyment of the rights recognized under the CRC.[155] Parents bear the primary responsibility to provide their children with adequate nutritious food and health, among other obligations. Their primary responsibility is further stated under Article 14 of the CRC, on children's freedom of thought, conscience, and religion, providing that States Parties shall respect the rights and duties of the parents to provide direction to children's exercise and enjoyment of such right in a manner consistent with their evolving capacities.[156] In order to ensure the full realization of children's rights, States Parties must accord appropriate assistance to parents in performing their child-rearing responsibilities and must ensure the development and effective operation of institutions, facilities, and services for the care of children.[157]

Secondary to parental obligations, the State must afford children the protection and care necessary for their well-being, "taking into account the rights and duties of [their] parents . . . and, to this end, shall take all appropriate legislative and administrative measures."[158]In cases of child neglect or abuse, for example, Article 19 of the CRC requires States to "take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s) . . . ," thereby suggesting that parental rights may be conditional and subject to limitations whenever this may be in the child's best interest.[159] Despite the primary role of parents, and States' obligation to support them, the paramount principle under the CRC is that "in all actions concerning

153. CRC, *supra* note 114, art. 18(1).
154. *Id.* pmbl.
155. *Id.* art. 5.
156. *Id.* art. 14(2).
157. *Id.* art. 18(2).
158. *Id.* art. 3(2).
159. *Id.* art. 19(1).

children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interest of the child shall be a primary consideration."[160]

Ensuring their best interests means that the State has the positive obligation to intervene for the protection and care of children as a measure of last resort, whenever their health and wellbeing may be at serious risk, as determined by a competent authority. In multiple cases of severe obesity both in the United States and in the United Kingdom, for example, children have been removed from their families by social services because their excessive weight raised major concerns for their health.[161] Scholars have argued that childhood obesity may amount to medical neglect and may require intervention of child protection services should parents fail to follow recommended treatments and dietary guidelines, and if the following conditions are met: there is a high risk of serious imminent harm, there is a reasonable likelihood that State intervention will result in effective treatment, and all alternative options have been exhausted.[162]

Even in the United States, one of the only two countries that did not ratify the CRC and thus may not be bound by its obligations, governments are considered responsible for protecting children's best interest through the application of the *parens patriae* doctrine whenever parents or families

---

160. *Id.* art. 3(1); *see* MICHAEL FREEMAN, ARTICLE 3: THE BEST INTERESTS OF THE CHILD 53–56 (2007); John Tobin, *Beyond the Supermarket Shelf: Using a Rights-Based Approach to Address Children's Health Needs*, 14 INT'L J. CHILD. RTS. 275, 287 (2006); Mitchell Woolf, *Coming of Age?—The Principle of the "Best Interests of the Child,"* 2 EUR. HUM. RTS. L. REV. 205, 205–10 (2003).

161. *See In re* L.T., 494 N.W.2d 450 (Iowa Ct. App. 1992) (holding that a ten-year-old girl suffering from morbid obesity, depression, and a personality disorder following the divorce of her parents was properly adjudicated a "child in need of assistance" and that placement in a residential treatment foster care home was the least restrictive means available to address both her psychological and life-threatening physical problems); *In re* G.C., 66 S.W.3d 517 (Tex. App. 2002) (upholding the termination of parental rights for medical neglect of a morbidly obese four-year-old boy whose mother had failed to adhere to the recommended diet for him). See *In re Brittany T.*, 835 N.Y.S.2d 829 (N.Y. Fam. Ct. 2007), *rev'd*, 852 N.Y.S.2d 475 (N.Y. App. Div. 2008), in which the family court found the parents guilty of willfully violating court orders to, *inter alia*, keep the child on a diet, to get nutritional counseling, to enroll the child in a gym, and to take all actions necessary to ensure the child attended school more regularly. The court ordered the child to be removed to foster care. On appeal, the court reversed the family court's order because it determined that the Chemung County Department of Social Services had not proved "willful violation" of the family court orders by the parents and instead found that the parents had been trying to comply. *Brittany T.*, 852 N.Y.S.2d at 480. For a discussion of these cases, see generally Denise Cohen, *Childhood Obesity: Balancing the Nations' Interest with a Parent's Constitutional Right to Privacy*, 10 CARDOZO PUB. L. POL'Y & ETHICS J. 358 (2012); Lizet Dominguez, *Childhood Obesity as Child Abuse: Criminalizing Parents for Raising Obese Children*, 2 CHILD AND FAM. L. J. 105 (2014). Finally, see also *Obese Children Removed from Their Families*, THE TELEGRAPH (Feb. 28, 2014), https://www.telegraph.co.uk/foodanddrink/healthyeating/10667066/Obese-children-removed-from-families.html, which discusses children put into care in the UK because of their morbid obesity.

162. *See* Todd Varness et al., *Childhood Obesity and Medical Neglect*, 123 PEDIATRICS 399, 399–406 (2009); R.M. Viner et al., *When Does Childhood Obesity Become a Child Protection Issue?*, 341 BRITISH MED. J. 375, 375 (2010).

are failing to meet their primary obligations.[163] The *parens patriae* doctrine has its roots in English Common Law, when rights and duties were ultimately reserved to the King as parent of the country. Lately, its main application has been in the treatment of minors, the mentally handicapped, or otherwise incapacitated people who are legally unable to act for themselves. The government serves as their ultimate guardian to protect their best interest and their property. However, legal scholars have recently argued that "[the legislature's] paternalistic vigilance" should also be extended to secure adequate protection to all children from the "obesity epidemic."[164]

Adopting a rights-based approach to children's right to adequate food and to health entails that the prevention of childhood obesity is a matter of States' responsibility rather than being solely a matter of familial responsibility. The children's rights approach recognizes the crucial importance of the family as the natural social unit for children's optimal development and well-being, as well as its importance for the promotion and realization of children's right to adequate food. Such right is indeed "a source of parental responsibility, the discharge of which requires support from the state for good parenting practices."[165] However, "equally importantly, the existence of parental responsibility means that the children of parents with bad parenting practices should not be unduly disadvantaged by the inappropriate decisions of their parents."[166]

Adopting a children's rights-based approach to adequate food also means that the decision-making and implementation processes of the necessary measures must adhere to the human rights principles of participation, accountability, non-discrimination, transparency, human dignity, empowerment, and the rule of law, generally referred to as the PANTHER framework.[167] The principle of participation, as we will discuss further in the last section of this Article, entails that all actors,

---

163. Lauren Kaplin, *A National Strategy to Combat the Childhood Obesity Epidemic*, 15 U.C. DAVIS J. JUVENILE L. & POL'Y 347, 377, 400 (2011).

164. *Id.*; *see also* Mangini v. R.J. Reynolds Tobacco, 875 P.2d 73, 83 (Cal. 1994) (discussing how, when anti-smoking advocates brought suit against R.J. Reynolds challenging the Joe Camel advertising campaign targeting children in the 1990s, the California Supreme Court referred to the *parens patriae* doctrine in dismissing a summary judgment challenge).

165. Elizabeth Handsley, Christopher Nehmy, Kaye Mehta & John Coveney, *A Children's Rights Perspective on Food Advertising to Children*, 22 INT'L J. OF CHILD. RTS. 93, 119–20 (2014) (citing Richard Ingleby et al., *UNCROC and the Prevention of Childhood Obesity: The Right Not to Have Food Advertisements on Television*, 16 J. L. & MED. 56 (2008)).

166. *Id.*

167. Food and Agric. Org. of the U.N., The Right to Food: Making It Happen—Progress and Lessons Learned through Implementation 7 (2011), http://www.fao.org/docrep/014/i2250e/i2250e.pdf [https://perma.cc/Z7GZ-Y2EQ]; *see also* Food and Agric. Org. of the U.N., The Human Right to Adequate Food in the Global Strategic Framework for Food Security and Nutrition: A Global Consensus 14–15 (2013), http://www.fao.org/3/a-i3546e.pdf [https://perma.cc/CM66-EP6G].

including children, families, and communities whose right to adequate nutrition might be affected, should be included in the decision-making and implementation processes of relevant policies and programs. Accountability requires that States must be held accountable for violations of the right to adequate food and that effective remedies must be provided when violations have occurred. Non-discrimination requires States both to refrain from any form of discrimination on prohibited grounds and to adopt measures that can remove the conditions causing or perpetuating inequality and disparities.

Transparency means that the actors involved, including children, families, and communities, must receive all information related to decision-making processes about policies and programs that can impact the realization of their right to adequate food. The principle of human dignity requires States to provide access to food in a way that is consistent with children's dignity by ensuring, for instance, nutritional adequacy and cultural acceptability of food assistance. Empowerment means strengthening children's ability to effectively exercise and enjoy their right to adequate food by participating in decision-making and implementation processes of relevant policies and programs. Finally, the rule of law requires a state and its officials to obey to the laws of the country and to take actions that are consistent with human rights principles.

States' obligations to protect the right to adequate food also include ensuring that food companies do not infringe upon its realization, for instance, by assessing, monitoring, and regulating the impact of food advertising on childhood obesity. Complying with this obligation requires States to balance children's rights to adequate food and to health with children's right to freedom of expression.

Article 13 of the CRC provides that children's right to freedom of expression, which includes the freedom "to seek, receive and impart information and ideas of all kinds," may be subject to restrictions for public health reasons, among others.[168] Furthermore, Article 17 of the CRC imposes specific obligations on States Parties to ensure that children have "access to information and material from a diversity of national and international sources, especially those aimed at the promotion of [their] . . . social, spiritual and moral well-being and physical and mental health."[169] To this end, States must "encourage the development of appropriate guidelines for the protection of the child from information and material injurious to his or her well-being."[170]

168. CRC, *supra* note 114, art. 13(1)(2).

169. *Id.* art. 17.

170. *Id.* art. 17(e).

The CRC emphasizes the impact that information may have on children's health and thus requires States not only to provide adequate access to health care for children but also to provide information related to children's health and nutrition. This requirement implies that States have the obligation to ensure that food advertising is in compliance with children's freedom of expression, is in compliance with the restrictions under Article 17, and above all, is in accordance with the best interest of children. Under Article 32, the CRC recognizes States Parties' obligation to protect children from economic exploitation. Article 32 has been mostly interpreted as related to the exploitation of children in the workforce.[171] However, advertising might also be considered exploitative of children as consumers.[172]

B. Child Obesity-Specific Recommendations

States' human rights obligations related to childhood obesity have also been explored by reports and recommendations of United Nations bodies that, although not binding, can influence relevant legislations and policy making. In General Comment No. 15, the CRC Committee explicitly urges States to address obesity among children by limiting their exposure to fast foods "that are high in fat, sugar or salt, energy-dense and micronutrient-poor, and drinks containing high levels of caffeine."[173] Advertising of these products should be regulated and their availability in schools should be restricted.[174] To ensure that both children and parents are informed and supported in the use of basic knowledge of children's health and nutrition, the CRC Committee recommends that "information and life skills education should address a broad range of health issues including, inter alia, healthy eating and promotion of physical activity, sports, and recreation."[175]

In General Comment No. 16 on State obligations regarding the impact of the business sector on children's rights, the CRC Committee clarifies that the right to life, survival, and development under Article 6 of the CRC must be interpreted holistically to include children's physical, mental, spiritual, moral, psychological, and social development.[176] Therefore, food enterprises marketing unhealthy products to children can compromise children's rights to health and adequate food and can impact

171. CRC, *supra* note 114, art. 24.

172. Handsley, *supra* note 165, at 131.

173. Comm. of the Rts. of the Child, General Comment No. 15, *supra* note 125, ¶ 47.

174. *Id.*

175. *Id.* art. 59.

176. Comm. on the Rts. of the Child, General Comment No. 16 on State Obligations Regarding the Impact of the Business Sector on Children's Rights, ¶ 18, U.N. Doc. CRC/GC/16 (Apr. 17, 2013), https://undocs.org/CRC/C/GC/16.

the effective realization of children's right to life and their holistic development.[177] States have the responsibility to ensure that the media disseminates information and materials beneficial to the child, for instance regarding healthy lifestyles and eating.[178] In order to monitor, investigate, and provide remedies for abuses of children's rights to health, safety, and consumer rights, the CRC Committee suggests that regulatory agencies responsible for the oversight of advertising and marketing must strengthen their enforcement mechanisms.[179]

In its latest concluding observations, the CRC Committee has expressed serious concern for the growing rates of child obesity in several countries and has recommended prompt State actions. For instance, the CRC Committee encouraged Canada to promote a healthy lifestyle and physical activity among children and ensure greater regulation over the production and advertisement of fast food and other unhealthy foods, especially those targeted at children.[180] The CRC Committee has also recommended multiple European States increase their efforts to prevent and combat obesity among children.[181] In Finland, the CRC Committee shared its concern for the lack of regulation to restrict the marketing and advertising of unhealthy foods that affect child nutrition and contribute to childhood obesity and other negative health consequences.[182] In Denmark, the CRC Committee recommended the States Party engage with media and the food industry to ensure their contribution to healthy lifestyles and consumption patterns by children and adolescents.[183]

---

177. *Id.* ¶ 19.

178. *Id.* ¶ 58.

179. *Id.* ¶ 61(a).

180. Comm. on the Rts. of the Child, Concluding Observations on the Combined Third and Fourth Periodic Report of Canada (Sept. 17, 2012–Oct. 5, 2012), ¶ 64, U.N. Doc. CRC/C/CAN/CO/3-4 (Dec. 6, 2012).

181. *See generally* Comm. on the Rts. of the Child, Concluding Observations of the Committee on the Rights of the Child, Spain, U.N. Doc. CRC/C/ESP/CO/5-6 (2018); Comm. on the Rts. of the Child, Concluding Observations of the Committee on the Rights of the Child, United Kingdom of Greater Britain and Northern Ireland, U.N. Doc. CRC/C/GBR/CO/5 (2016); Comm. on the Rts. of the Child, Concluding Observations of the Committee on the Rights of the Child, Hungary, U.N. Doc. CRC/C/HUN/CO/3-5 (2014); Comm. on the Rts. of the Child, Concluding Observations of the Committee on the Rights of the Child, Iceland, U.N. Doc. CRC/C/ISL/CO/3-4 (2012); Comm. on the Rts. of the Child, Concluding Observations of the Committee on the Rights of the Child, Austria, U.N. Doc. CRC/C/AUT/CO/3-4 (2012); Comm. on the Rts. of the Child, Concluding Observations of the Committee on the Rights of the Child, Italy, U.N. Doc. CRC/C/ITA/CO/3-4 (2011); Comm. on the Rts. of the Child, Concluding Observations of the Committee on the Rights of the Child, Belgium, U.N. Doc. CRC/C/BEL/CO/3-4 (2010); Comm. on the Rts. of the Child, Concluding Observations of the Committee on the Rights of the Child, Sweden, U.N. Doc. CRC/C/15/Add.248 (2005).

182. Comm. on the Rts. of the Child, Concluding Observations of the Committee on the Rights of the Child, Finland, U.N. Doc. CRC/C/FIN/CO/4 (2011).

183. Comm. on the Rts. of the Child, Concluding Observations of the Committee on the Rights of the Child, Denmark, U.N. Doc. CRC/C/DNK/CO/4 (2011).

Although such recommendations are not legally binding, some States have been responsive to the observations of the CRC Committee related to childhood obesity. For instance, Spain reported that regulations have been amended to protect children from child-targeted advertising of toys, foods, and beverages with a view of preventing obesity and promoting healthy living.[184] Spain has adopted a strategic plan that includes measures aimed at controlling obesity among children to ensure the fullest realization of children's right to health.[185] Finally, an observation on nutrition and an assessment of the prevalence of child obesity in the country has been conducted to improve diets and life habits among children and raise awareness of the risk associated with childhood obesity.[186]

Denmark also provided a detailed plan and budget allocation for the implementation of multiple cross-sector initiatives to combat obesity among children for the period of 2013 to 2017.[187] The efforts included the publication of guidelines on early identification and intervention of obesity among children and adolescents; the dissemination of health prevention packages on nutrition, physical activity, and obesity to municipalities;[188] the implementation of a nationwide campaign to promote physical activity for children including commercials, advertisements, and a website;[189] the provision of healthy lunch meals in day-care centers;[190] the development of dietary guidelines for elementary schools; [191] the adoption by the food industry of a self-regulation code to limit the marketing of unhealthy products to children; the prohibition of vending machine in schools and pre-schools; and the introduction of mandatory physical exercise in any school day.[192]

Other countries have been more timid and generic in their responses. For instance, Canada's report only focused on specific initiatives

184. Comm. on the Rts. of the Child, Consideration of Reports Submitted by States Parties Under Article 44 of the Convention, Spain, ¶ 109, U.N. Doc. CRC/C/ESP/5-6 (May 13, 2017), https://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRC%2fC%2fESP%2f5-6.

185. *Id.* ¶ 200.

186. *Id.* ¶¶ 213–14.

187. Comm. on the Rts. of the Child, Consideration of Reports Submitted by States Parties Under Article 44 of the Convention, Denmark, ¶ 119, U.N. Doc. CRC/C/DNK/5 (Oct. 14, 2016), http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRC%2fC%2fDNK%2f5&Lang=en.

188. *Id.* ¶¶ 120, 122.

189. *Id.* ¶ 121.

190. *Id.* ¶ 124.

191. *Id.* ¶ 125.

192. *Id.*

addressing obesity among aboriginal children.[193] Finland generally mentioned the government's goal to enhance children's eating habits and achieve lifestyle changes that contribute to the prevention of obesity among children as part of the larger policy program on health promotion but failed to describe any imaginative steps.[194] In their latest reports, other countries—including Austria, Belgium, and Italy—have not discussed any measures taken to combat child obesity within their efforts to realize the right to adequate food and health.[195] Although compliance with recommendations of the CRC Committee can vary greatly among countries, reports for the most part show that States recognize bearing positive obligations to prevent obesity under the CRC.

In General Comment No. 14, the ICESCR Committee also provides that States must take measures to promote children's healthy development by ensuring the dissemination of appropriate information in relation to healthy lifestyle and nutrition in addition to supporting families and communities in implementing these practices.[196] Measures and polices adopted by States for the implementation of the right to health of children and adolescents must ensure that their best interest is the primary consideration.[197] In General Comment No. 24 on State obligations under the ICESCR in the context of business activities, the ICESCR Committee acknowledges that the realization of children's right to health and food, among others, is disproportionally impacted by the advertising of

193. Comm. on the Rts. of the Child, Consideration of Reports Submitted by States Parties Under Article 44 of the Convention, Canada, ¶¶ 283, 681, U.N. Doc. CRC/C/CAN/3-4 (Jan. 4, 2012), http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRC%2fC%2fCAN%2f3-4&Lang=en.

194. Comm. on the Rts. of the Child, Consideration of Reports Submitted by States Parties Under Article 44 of the Convention, Finland, U.N. Doc. CRC/C/FIN/4, ¶¶ 258, 267, (May 26, 2010), http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRC%2fC%2fFIN%2f4&Lang=en.

195. Comm. on the Rts. of the Child, Consideration of Reports Submitted by States Parties Under Article 44 of the Convention, Austria, U.N. Doc. CRC/C/AUT/3-4 (Nov. 16, 2011), http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRC%2fC%2fAUT%2f3-4&Lang=en; Comm. on the Rts. of the Child , Consideration of Reports Submitted by States Parties Under Article 44 of the Convention, Belgium, U.N. Doc. CRC/C/BEL/5-6 (July 20, 2017); Comm. on the Rts. of the Child, Consideration of Reports Submitted by States Parties Under Article 44 of the Convention, Italy, U.N. Doc. CRC/C/ITA/5-6 (Mar. 16, 2018), http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRC%2fC%2fITA%2f5-6&Lang=en.

196. Comm. on Econ., Soc. & Cultural Rts., Substantive Issues Arising in the Implementation of Covenant of Economic, Social and Cultural Rights: General Comment No. 14: Right to the Highest Attainable Standard of Health, art. 22, 37, U.N. Doc. E/C.12/2000/4 (2000), http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=4slQ6QSmlBEDzFEovLCuW1AVC1NkPsgUedPlF1vfPMJ2c7ey6PAz2qaojTzDJmC0y%2B9t%2BsAtGDNzdEqA6SuP2r0w%2F6sVBGTpvTSCbiOr4XVFTqhQY65auTFbQRPWNDxL [https://perma.cc/6LYH-8LDC].

197. *Id.* art. 24.

unhealthy foods and beverages.[198] To fulfill their obligation to protect, States should consider measures aimed at restricting the marketing and advertising of products that can be detrimental to public health, including the marketing of unhealthy foods and beverages to children.[199]

In 2012, the High Commissioner for Human Rights drew attention to overnutrition in its report to the Human Rights Council on the right of the child to enjoy the highest attainable standard of health.[200] The High Commissioner stressed that over-nutrition, due to lack of physical activity and unhealthy diets, and stigmatization of obese children represent serious concerns.[201] The measures proposed to address childhood obesity included the promotion of healthy eating habits and physical exercise, parental education, and regulation of advertising.[202] The High Commissioner also emphasized children's need for information and education on the importance of healthy eating and physical activity, which will enable them to realize their right to health, make informed choices in relation to lifestyle, and access health services.[203]

In particular, the High Commissioner recognized the essential role that schools can play in health promotion by including health-related information in the school curricula and fostering physical education programs.[204] The High Commissioner also advocated for imposing restrictions on the advertisement of food and beverage products that are detrimental to children's health and development [205] and for encouraging media to promote healthy eating habits and lifestyles among children and adolescents by providing free advertising space for health promotion and avoiding health-related stigma.[206] The approach adopted by the High Commissioner mostly reflected existing interventions focusing on information provision and did not suggest any innovative strategies to combat child obesity, nor did he propose any practical measures for States to guide and regulate food marketing and advertising.

---

198. Comm. on Econ., Soc. & Cultural Rts., Substantive Issues Arising in the Implementation of Covenant of Economic, Social and Cultural Rights: General Comment No. 24 on State Obligations Under the International Covenant on Economic Social and Cultural Rights in the Context of Business Activities, ¶¶ 2, 8, U.N. Doc. E/C.12/GC/24 (June 23, 2017), https://undocs.org/E/C.12/GC/24.

199. *Id.* ¶ 19.

200. Hum. Rts. Council, *Report of the U.N. High Commissioner for Human Rights on the Right of the Child to the Highest Attainable Standard of Health*, ¶¶ 40–45, U.N. Doc. A/HRC/22/31 (Dec. 4, 2012), http://undocs.org/A/HRC/22/31.

201. *Id.* ¶¶ 41–42.

202. *Id.* ¶ 44.

203. *Id.* ¶ 86.

204. *Id.* ¶ 87.

205. *Id.* ¶ 107.

206. *Id.* ¶ 108.

Conversely, in 2014, the Special Rapporteur on the Right to Health, Anand Grover, in his report to the Human Rights Council on Unhealthy Foods, Non-Communicable Diseases and the Right to Health, clarified the following:

> States [are required] to ensure the availability and accessibility of food in a quantity and quality to satisfy the individuals' dietary needs, and which contain a mix of nutrients for physical and mental growth, development and maintenance, and physical activity that are in compliance with human physiological needs at all stages of life.[207]

Like the High Commissioner, the Special Rapporteur recommended the formulation and dissemination of food and nutrition guidelines for a healthy diet for vulnerable groups, including children.[208] However, to reduce the consumption of unhealthy foods, the Special Rapporteur went further than the High Commissioner by encouraging States to increase taxes on unhealthy foods, like sugar-sweetened beverages, and reduce the prices of healthy foods.[209] The Special Rapporteur suggested the adoption of tax benefits and agricultural investments to incentivize the production of vegetables and fruits.[210] He also recommended the distribution of local and fresh produce to schools both to support localized farming and to encourage the consumption of healthy foods by school-children.[211] Finally, the Special Rapporteur urged States to implement their obligations regarding children's right to health through the adoption of further measures such as providing healthful food in child-centered institutions, limiting access to fast food and drinks, and teaching the benefits of a healthy diet within the school curriculum to influence children's food choices and preferences.[212]

The Special Rapporteur clarified that although States should refrain from interfering with people's enjoyment of their right to food and related decision-making processes, such obligation should not imply "a disengaged approach by States towards laws and policies concerning the food industry."[213] States bear the positive obligation to protect people from violations of their right to health caused by third parties, like food

---

207. Anand Grover (Special Rapporteur on the Right to Health), U.N. Hum. Rts. Council, *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, ¶ 12, U.N. Doc. A/HRC/26/31 (Apr. 1, 2014), http://undocs.org/A/HRC/26/31.

208. *Id.* ¶ 17.

209. *Id.*

210. *Id.*

211. *Id.* ¶¶ 18, 20; *see also* KEI OTSUKI & ALBERTO ARCE, BRAZIL: A DESK REVIEW OF THE NATIONAL SCHOOL FEEDING PROGRAMME (2007).

212. Grover, *supra* note 207, ¶ 18.

213. *Id.* ¶ 14.

companies, and to ensure that food advertising and marketing convey accurate information on products because advertising and marketing influence people's diet choices and impacts their right to health.[214] For children, States must implement their obligations regarding children's right to health by limiting their exposure to fast foods and drinks high in sugar and caffeine, and by regulating the marketing of such products and controlling their availability in schools and other places frequented by children.[215]

The Special Rapporteur included specific recommendations for States to adopt national policies to regulate advertising of unhealthy foods and legislative measures to reduce children's exposure to food and drink marketing.[216] It clarified that "the responsibility to protect the enjoyment of the right to health warrants State intervention in situations when third parties, such as food companies, use their position to influence dietary habits by directly or indirectly encouraging unhealthy diets, which negatively affect people's health."[217] This means that States have a positive duty to regulate unhealthy food advertising and the promotion strategies of food companies, especially those targeted at vulnerable groups, such as children.[218] Although reports issued by the Special Rapporteur are not legally binding, the Human Rights Council urged States to give full consideration to his recommendations.[219]

Similarly, the Special Rapporteur in the Field of Cultural Rights, Farida Shaheed, in her report to the Secretary General in 2014, noted that the rights of children, including the right to adequate food and to health, deserve particular attention.[220] The Special Rapporteur recalled that, under Principle 6 of the Children's Rights and Business Principles, corporations should refrain from advertising products that could have an adverse impact on children's rights and health, and they should use marketing that raises awareness of and promotes children's rights, positive self-esteem, and healthy lifestyle and eating habits.[221] The report acknowledges that food marketing and advertising of products with a high content of fat, sugar,

---

214. *Id.* ¶ 15.

215. *Id.* ¶ 38.

216. *Id.* ¶ 22.

217. *Id.* ¶ 25.

218. *Id.*

219. G.A. Res. 15/22, Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, ¶ 4(a), (Oct. 6, 2010), https://documents-dds-ny.un.org/doc/UNDOC/GEN/G10/167/05/PDF/G1016705.pdf?OpenElement.

220. Farida Shaheed (Special Rapporteur in the Field of Cultural Rights), *Report of the Special Rapporteur in the Field of Cultural Rights*, ¶ 8, U.N. Doc. A/69/286 (Aug. 8, 2014), https://undocs.org/A/69/286.

221. *Id.* ¶ 15.

and salt have contributed to changes in eating patterns and cooking practices into less healthy dietary habits.[222]

To reduce the risks related to childhood obesity and noncommunicable diseases, the report indicates that States have adopted different strategies. Some States have prohibited food companies from advertising junk food to young children or using toys to promote children's food;[223] other States have prohibited television advertising during certain hours or children's programs;[224] and some other States, like Brazil, Canada, Denmark, and Norway, have prohibited all forms of advertising to children younger than twelve.[225] The Special Rapporteur recommended that nutritional information should be more effectively provided by improving the content, form, and layout during advertising;[226] efforts should be made to regulate all forms of indirect advertising and sponsorship also in digital spaces; [227] and children should not be exposed to any marketing of unhealthy foods and beverages while at school or on playgrounds.[228]

C. Children's Participation

Finally, under a child rights-based approach, States must ensure the realization of children's right to participate in the decision-making processes affecting their adequate nutrition and health and include children's perspectives in the development and implementation of relevant measures. Under Article 12 of the CRC, children are entitled to express their views freely in all matters affecting them, and such views should be accorded due weight in consideration of the age and maturity of the child.[229] The CRC's General Comment No. 12 of 2009 defined participation as the children's ability to participate in "ongoing processes, which include information-sharing and dialogue between children and adults based on mutual respect, and in which children can learn how their views and those of adults are taken into account and shape the outcome of such processes."[230]

The Open-Ended Working Group established by the Commission on Human Rights, which drafted the text of the CRC, intentionally provided

222. *Id.* ¶ 50.
223. *Id.*
224. *Id.* ¶ 58.
225. *Id.*
226. *Id.* ¶ 51.
227. *Id.* ¶¶ 52–53.
228. *Id.* ¶ 66.
229. CRC, *supra* note 114, art. 12.
230. Comm. on the Rts. of the Child, General Comment No. 12: The Right of the Child to be Heard, ¶ 3, U.N. Doc. CRC/C/GC/12 (July 20, 2009), http://undocs.org/CRC/C/GC/12.

that the right to be heard should be applied broadly to all matters affecting children's lives, including their nutritional well-being. For practical implementation, Article 12 should be interpreted in connection with Article 3 of the CRC (primary consideration of the best interests of the child) when applied to children's best interest in relation to their nutritional health. To achieve children's participation in the decisions related to their nutritional needs and healthy diet, both Articles 12 and 3 should also be read in connection with Article 5 of the CRC (evolving capacities of the child and appropriate direction and guidance from parents) since it is crucial that parents acknowledge children's evolving capacities to participate in all matters affecting them.[231]

General Comment No. 12 of 2009 clarifies that the realization of the provisions of the CRC requires respect for children's right to participate in promoting their healthy development and well-being. Paragraph 98 states that this applies to individual health-care decisions in addition to children's involvement in the development of health policy and services.[232] By extension, children's right to participation should also be interpreted to apply to decisions related to children's healthy nutrition and eating habits, which are indeed a crucial component of their optimal development and well-being. Children's involvement in the development of nutrition policy and related measures is crucial to achieve effective programs and services that take into due consideration their perspectives and experiences and ensure their commitment as primary beneficiaries.

Under General Comment No. 12, States Parties are required to introduce legislation or regulations to ensure that children have access to confidential medical counseling and advice without parental consent, regardless of their age, whenever this may be necessary for their safety or well-being.[233] This requirement should be provided in case of conflicts between parents and children over access to health services, and by analogy, also whenever children's health and well-being may be at risk due to parental choices regarding children's nutritional needs or when conflicts arise between parents and children on such matters. Allowing children to seek support from experts and professionals whenever their current and future health may be compromised because of unhealthy eating habits and nutritional choices made by their parents should be intended as part of the right of children to participate in such crucial decisions affecting their long-term well-being and healthy relationship with food.

---

231. *Id.* ¶¶ 68–69.
232. *Id.* ¶ 98.
233. *Id.* ¶ 101.

Similarly, in General Comment No. 14, the ICESCR Committee provided that States must secure people's participation in the decision-making processes affecting their development and that such participation must be an integral component of any policy, program, or strategy developed for the realization of the right to the highest attainable standard of health.[234] For children and adolescents, States must provide a safe and supportive environment that fosters their ability "to participate in decisions affecting their health, to build life skills, to acquire appropriate information, to receive counselling and to negotiate the health-behaviour choices they make."[235] Only by adopting participatory and transparent processes that include children's perspectives in the development and implementation of steps and measures designed to prevent obesity can States effectively fulfill their positive obligations to the realization of the rights to adequate food and to health for all children.

As previously discussed, participation is among the human rights principles under the PANTHER framework, developed by FAO, that must be applied in the development and implementation of effective policies and programs related to adequate nutrition and food security. The practical application of such principle implies that all stakeholders, including children, who are among the vulnerable groups most affected by lack of adequate food must be given the choice to participate in the assessment, decision-making, implementation, and monitoring of measures, strategies, policies, and programs related to adequate nutrition. When it pertains to children, participatory processes must respect and take in due consideration their age and level of maturity to enable them to contribute to more effective outcomes.

In its 2012 report to the Human Rights Council, the High Commissioner stated that the full realization of children's right to the highest attainable standard of health requires States to make efforts to increase "interaction with children, and their participation at all stages of health system design and operation to improve the acceptability and, by extension, the uptake and use of services."[236] Beyond parents, schools, nutritionists, health professionals, and any other stakeholders, the High Commissioner thus recognized that only by according children with the opportunity to actively participate in the decision-making processes

234. Comm. on Econ., Soc. & Cultural Rts., Substantive Issues Arising in the Implementation of Covenant of Economic, Social and Cultural Rights: General Comment No 14: The Right to the Highest Attainable Standard of Health, ¶ 54, U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000), http://undocs.org/E/C.12/2000/4.

235. *Id.* ¶ 23.

236. Hum. Rts. Council, Rep. of the U.N. High Comm'r for Human Rts. on the Right of the Child to the Highest Attainable Standard of Health, ¶ 74, A/HRC/22/31 (Apr. 12, 2012), https://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/A-HRC-22-31_en.pdf

related to their adequate nutrition and health in a manner suitable to their age and level of maturity can the acceptability, understanding, and use of healthcare services by children themselves be improved. The High Commissioner also encouraged States to disseminate information on healthy eating and physical activity in a child-friendly manner to enable children to make informed choices in relation to their lifestyle, adequate nutrition, and access to healthcare services.[237] To ensure that such information related to health and adequate nutrition can effectively reach children and promote their healthy eating and physical activity, children must be given the opportunity to participate in designing relevant materials and social media campaigns in collaboration with adults.[238]

Finally, the Special Rapporteur on the Right to Food reaffirmed that the principle of participation requires beneficiaries of nutrition-based measures to partake in the development and implementation of the solutions that can benefit them.[239] This means that overweight and obese children should be included in designing nutrition, physical activity, and obesity prevention strategies and programs in collaboration with nutritionists and healthcare professionals. Participatory processes not only benefit children because their perspectives as primary beneficiaries enhance the effectiveness of measures and interventions adopted but also because children are empowered by the process and thus become committed in the success of the proposed solutions.

CONCLUSION

This Article has summarized the individual and societal costs connected to childhood obesity. It investigated the main causes of excessive weight gain in children and the consequences for their general health and development, as well as eating behaviors that can persist into adulthood. The Article explored the multiple contributing factors for child obesity, focusing on the complex relationship between sedentary lifestyle, extensive use of technology, advertising of unhealthy foods, poor nutrition, and families' food choices or necessities. In response to the general view that frames the obesity problem in children either as a personal issue or as a matter of parental responsibility, this Article proposes a child rights-based approach, positing that States bear an ultimate duty to prevent and combat childhood obesity.

To this end, the Article provides the first comprehensive analysis of the human rights obligations of States to respect, protect, and fulfill the rights of children to adequate food, the highest attainable standard of

237. *Id.* ¶ 86.
238. *Id.* ¶ 87.
239. De Schutter, *supra* note 89, ¶ 24.

health, and participation in the decision-making processes related to their nutrition, lifestyle, and well-being. Further, this Article analyzes the child obesity-specific recommendations issued by the United Nations Committee on the Rights of the Child, the United Nations High Commissioner on Human Rights, the Special Rapporteur on the Right to Food, the Special Rapporteur on the Right to Health, and the Special Rapporteur in the Field of Cultural Rights that, although not binding, have helped clarify States' responsibilities in child obesity prevention and suggested some strategies for action.

Adopting a child rights-based approach ultimately means that childhood obesity is a child rights issue and that the obligation to realize children's right to healthy food must be shared among parents, families, States, and any other relevant stakeholders. Following the principles of the CRC, this Article recognizes that parents and families are the first responsible entities to provide for their children's nutrition and health, and that governments are required to support them in implementing best practices for healthy lifestyle and dietary choices. However, whenever parents or families fail to fulfill their obligations—by choice, incapacity, or necessity—States must compensate for such loss and ensure the best interests of the child are valued above any other considerations. When it pertains to childhood obesity, States have an overarching responsibility to realize children's right to receive adequate nutrition, to enjoy the highest attainable standard of health possible, and to have their views included in the decision-making processes affecting their well-being. A child rights-based approach to child obesity further means that children must be recognized as active agents; holders of their own rights besides the rights and duties of parents, families, or the State. Children's interests, needs, and perspectives must be at the core of governments' strategies and solutions.