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*Analyzing the Laws, Regulations, and Policies
Affecting FDA-Regulated Products*

The World Health Organization's Global Strategy on Diet, Physical Activity, and Health: Turning Strategy Into Action

Emily Lee

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I. INTRODUCTION

The worldwide impact of diet- and inactivity-related diseases and health conditions such as heart disease, cancer, and obesity pose an increasing threat to international health and economic development, manifesting the modern interdependence of global public health conditions. The severity of the problem recently prompted governments and policymakers to shift their attentions to food regulations, including those concerning marketing and labeling, ingredient composition, fiscal measures, and agricultural policy, as possible mechanisms to combat this public health crisis. A notable example of this trend on the international front is the 2004 Global Strategy for Diet, Health, and Physical Activity (Global Strategy).¹ The World Health Organization² (WHO), a specialized body of the United Nations (UN), developed the Global Strategy after the World Health Assembly (WHA) authorized the WHO to address the prevention and control of noncommunicable diseases on a worldwide scale.³ Essentially, the Global Strategy is a nonbinding blueprint of policy mechanisms countries can use in fighting obesity and other diet- and inactivity-related diseases within their borders.⁴

While the ultimate success of the Global Strategy remains uncertain at this early stage, it is clear that the forces of globalization, international trade, and transnational marketing continue to undermine national laws and policies aimed at addressing the global epidemic. Partnerships that reach across national borders, and that affect all global stakeholders, are needed to resolve regulatory gaps to ensure best practices and improve enforcement. This article discusses the legal contribution that the WHO can make in that regard, and in other areas that would assist the global fight against diet- and inactivity-related diseases. The Global Strategy outlines the WHO's implementation role as primarily facilitative and technical.⁵ This limited role is questionable given the

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¹ See WHA57.17 (2004), available at http://www.who.int/entity/dietphysicalactivity/strategy/eb11344/strategy_english_web.pdf (last visited Nov. 24, 2005).

² The World Health Organization (WHO) was founded in 1946 as a specialized agency of the United Nations, and is the direct successor of pre-existing international health organizations. The Constitution of the WHO entered into force on April 7, 1948. See S.S. Fluss et al., *World Health Organization*, in INTERNATIONAL ENCYCLOPEDIA OF LAWS 11 (Herman Nys ed., 1998).

³ See WHA53.17 (2000), available at http://www.who.int/gb/EB_WHA/PDF/WHA53/Res_WHA53/17.pdf; WHA55.23 (2002), available at http://www.who.int/gb/ebwha/pdf_files/WHA55/ewha5523.pdf (last visited Nov. 24, 2005).

⁴ The Global Strategy addresses a variety of public policy initiatives such as consumer education, fiscal measures, and changes in agricultural policies to address public health problems related to diet and physical inactivity. This article focuses on three specific recommendations in the Global Strategy concerning food marketing, labeling, and composition.

⁵ Responsibilities for Action: WHO, WHA57.17, Annex (2004) states that:

WHO will provide support for implementation of programmes as requested by Member

organization's broad constitutional commitment to promote and attain the right to health for all, reinforced by human rights compacts and the WHO's own Corporate Strategy.⁶ Recently, the WHO has begun to pursue major international legal efforts in infectious disease and tobacco control in the face of pressures generated by the globalization of public health.⁷ Member Nations, in turn, generally have accepted the increased legal role of the WHO in such areas, and the need for international law to address global health problems.⁸ It would be useful, therefore, to establish the WHO's significant legal powers in the context of international food legislation that would assist the fight against obesity and other diet- and inactivity-related diseases.

The WHO's Constitution, various human rights compacts, and other sources of UN law contain the legal authority for the WHO to promulgate such requirements. As the leader in world health, the WHO should assume a more active, central role in implementing the Global Strategy. This article focuses mainly on defending the need for a centralized international instrument in addressing the increased prevalence of global obesity and diet- and inactivity-related diseases and on defining the ambit of the WHO's legislative powers in the area of food. The question of how the WHO should assume a more active role in global food regulation is an issue of considerable debate and significance that should be addressed separately, but this article offers some insight into the practical question of how binding and nonbinding international legal instruments could assist the worldwide fight against diet- and inactivity-related diseases.

Analyzing the WHO's legal jurisdiction in international food policy is an important starting point in using international supervisory institutions and international health law to address what has become one of the world's greatest health challenges in the twenty-first century. Parts II and III discuss the problem of global obesity and diet- and inactivity-related diseases and the background of the Global Strategy. Part IV discusses the mandate of the WHO in promoting international health through the constitutional and human rights perspective, its role as the leading international health institution, and its jurisdiction over food matters. Part V explores the possible frameworks through which the WHO could enact international legal instruments addressing food marketing, labeling, and other measures outlined in the Global Strategy. The WHO should recognize the need for more international norms to be established in this area and should

States; promote and support research in priority areas to facilitate programme implementation and evaluation; work with FAO [the Food and Agriculture Organization of the United Nations] and other organizations of the United Nations system, the World Bank, and research institutes on their evaluation of implications of the strategy for other sectors; establish networks for building capacity in research and training, mobilizing contributions from nongovernmental organizations and civil society, and facilitating coordinated, collaborative research as it pertains to the needs of developing countries in the implementation of this strategy.

⁶ The WHO's Constitution states that its objective is the attainment by all peoples of the world of the highest possible level of health. See CONSTITUTION OF THE WORLD HEALTH ORGANIZATION (July 22, 1946), 62 Stat. 2679, 14 U.N.T.S. 185, reprinted in WORLD HEALTH ORGANIZATION BASIC DOCUMENTS 1 (44th ed. 2004) [hereinafter WHO, BASIC DOCUMENTS]. The WHO's Corporate Strategy can be found in WHO Doc. EB105/3, available at http://ftp.who.int/gb/pdf_files/EB105/ee3.pdf (last visited Nov. 24, 2005).

⁷ See Allyn Taylor, *Global Health Governance and International Law*, 25 WHITTIER L. REV. 253, 261-62 (2003) (stating that the Framework Convention on Tobacco Control may signal a new era in international health cooperation and that "the WHO's unconventional consideration of the role of international law and institutions in promoting public health policies suggests an expansion of the organization's traditional scientific, technical approaches to public health, and perhaps, an evolution of its traditional culture.").

⁸ For example, the WHO's decision to invoke its treaty-making authority to address tobacco signifies an acknowledgement by its Member States of the gravity of the tobacco epidemic and their commitment to exploring innovative solutions. See discussion *infra* Part III.

consider such options as an alternative to relying on voluntary action by countries that are constrained from taking action by both domestic and global forces.⁹

II. OBESITY AND ITS GLOBAL IMPACT

A. *Global Prevalence of Obesity and Diet- and Inactivity-Related Health Conditions*

Major noncommunicable diseases (NCDs) (e.g., cardiovascular disease, diabetes, cancers, and obesity-related health conditions), now account for nearly sixty percent of global deaths and almost half (45.9%) of the global burden of disease.¹⁰ Without intervention, NCDs are expected to contribute to nearly seventy-five percent of all deaths by the year 2020.¹¹ Until recently, over nutrition, obesity, and the associated increased risk of NCDs generally were perceived as problems primarily in developed countries.¹² Sixty-six percent of the deaths attributed to NCDs occur in developing countries, however, where those affected, on average, are younger than those affected in developed countries.¹³ An escalating global epidemic of overweight and obesity paradoxically coexists with undernutrition in many parts of the world.¹⁴

The epidemic of overweight and obesity inflicts significant individual and societal costs through increased risk of disease and death; increased healthcare costs; and reduced social status, educational attainment, and employment opportunities.¹⁵ A recent study estimated annual medical spending for overweight and obesity to be as much as \$92.6 billion in the United States alone (9.1% of U.S. health expenditures).¹⁶ The economic development of developing nations also is jeopardized because NCDs impose a significant economic burden on already strained healthcare systems.¹⁷ In some countries (e.g., Brazil and Mexico), obesity and overweight is ceasing to be associated with relatively high economic status and is becoming a marker of poverty, as in developed countries.¹⁸

Responses to the epidemic must include prevention strategies that focus on reversing adverse dietary trends. The nutrition transition towards refined foods, foods of animal origin, and increased fats and added sugars, has played a major role in the global

⁹ While other factors in the obesity equation (e.g., decreased physical activity) are not addressed in this article, the author recognizes that policies encouraging exercise and increased movement also can contribute significantly to changes in the obesogenic environment.

¹⁰ Global Strategy on Diet, Physical Activity, and Health: Facts Related to Chronic Diseases, at <http://www.who.int/dietphysicalactivity/publications/facts/chronic/en/index.html> (last visited Nov. 24, 2005).

¹¹ WHO, DIET, NUTRITION, AND THE PREVENTION OF CHRONIC DISEASES: REPORT OF A JOINT FAO/WHO CONSULTATION 5 (2003) (Technical Rep. 916), available at http://www.who.int/nut/documents/trs_916.pdf (last visited Nov. 16, 2005) [hereinafter JOINT FAO/WHO CONSULTATION].

¹² Mickey Chopra, Sarah Galbraith & Ian Dartnon-Hill, *A Global Response to a Global Problem: The Epidemic of Overnutrition*, 80 BULL. WORLD HEALTH ORG. 952, 952-58 (2002).

¹³ See WHA57.17, *supra* note 1, at 1.

¹⁴ Levels of overweight and obesity among women in the Eastern Mediterranean Region and North Africa exceed those in the United States; and those in Eastern Europe and Latin America are similar to those in the United States. *Id.*

¹⁵ Chopra, Galbraith & Dartnon-Hill, *supra* note 12, at 953.

¹⁶ E.A. Finkelstein, I.C. Fiebelkorn & G. Wang, *National Medical Spending Attributable to Overweight and Obesity: How Much, and Who's Paying?*, HEALTH AFF., May 14, 2003, at http://www.healthaffairs.org/WebExclusives/Finkelstein_Web_Excl_051403.htm (subscription required).

¹⁷ WHO, MACROECONOMICS AND HEALTH: INVESTING IN HEALTH FOR ECONOMIC DEVELOPMENT (2001), available at <http://www.cid.harvard.edu/cidcmh/CMHReport.pdf> (last visited Nov. 24, 2005).

¹⁸ Chopra, Galbraith & Dartnon-Hill, *supra* note 12, at 953.

incidence of obesity, diabetes, and cardiovascular diseases.¹⁹ Intervention at this stage is one key to discouraging the further establishment of the negative aspects of the Western-type commercial diet being introduced and embedded into the eating cultures of developing countries. Much of the Western-type commercialization of the diet occurred without the guiding influence of public health policies, resulting in the Western-type processed-food diet being firmly embedded in the eating cultures of industrial countries.²⁰ Now that the availability and intake of foods that are risk factors for chronic diseases are increasing rapidly in all parts of the world, the present situation in the United States is doomed to repeat itself in countries such as China, Egypt, and South Africa.²¹

The global dimension of obesity and diet- and inactivity-related diseases limits the effectiveness of policies that countries may implement in an attempt to curb the spread of these diseases among their populations. Global forces that initially contributed to the problem maintain an international environment of health risks that contribute to obesity and related health problems. These factors include the increased availability of “Westernized” processed foods that are low in nutritional value and the rise of transnational corporations (TNCs) that use their significant market power and marketing techniques to influence the diets of a nation’s consumers.

B. Nature of the International Food Supply

The growth of the international food trade has increased the availability of highly processed, “value-added”²² foods that contribute to diet- and inactivity-related diseases. Chopra notes that the sheer pace and scale of change in food trade is unprecedented, with food now accounting for eleven percent of global trade, a proportion higher than that of fuel.²³ At \$3.2 trillion, processed food sales are a major component of global food markets and account for about three-fourths of total world food sales.²⁴ The consolidation of agricultural and food companies into large TNCs has enabled many food companies to become truly global in nature with offices, production plants, and stores around the world, and sales that impact the Gross Domestic Product (GDP) of

¹⁹ For an in-depth analysis of the nutrition transition, see Barry M. Popkin, *An Overview of the Nutrition Transition and Its Health Implications: The Bellagio Meeting*, 5(1A) PUB. HEALTH NUTRITION 93-103 (2002).

²⁰ See James E. Tillotson, *Multinational Food Companies & Development Nations’ Diets*, in WHO/WORLD BANK, *FOOD POLICY OPTIONS: PREVENTING AND CONTROLLING NUTRITION-RELATED NONCOMMUNICABLE DISEASES* (2003), available at <http://www.who.int/hpr/global.strategy.html> (last visited Nov. 16, 2005).

²¹ About 200 million Chinese are overweight, and the number of obese people in China doubled to 60 million between 1992 and 2002. *China Owes Growing Number of Diabetics to Obesity*, PEOPLE’S DAILY ONLINE, Nov. 15, 2004, at http://english.people.com.cn/200411/15/eng20041115_163910.html (last visited Nov. 16, 2005). In many Third World countries, obesity rates have risen dramatically—three-fold or more in some parts of Eastern Europe, the Middle East, Pacific Islands, Australia, and China since 1980. *Obesity: A Worldwide Issue* (Oct. 24, 2004), at <http://www.worldpress.org/Americas/1961.cfm> (last visited Nov. 16, 2005).

²² Processed foods and beverages often are referred to as “value added” products, in that some combination of labor, technology, and materials is applied to raw commodity inputs (e.g., wheat and yeast), and transformed into a product such as bread or pastry. For a full definition, see Value-added Agriculture, at <http://agriculture.house.gov/info/glossary/vw.htm> (last visited Nov. 16, 2005).

²³ See Mickey Chopra, *Globalization and Food: Implications for the Promotion of “Healthy Diets,”* in WHO, *GLOBALIZATION, DIETS, AND NONCOMMUNICABLE DISEASES* 37 (2002), available at <http://www.who.int/hpr/NPH/docs/globalization.diet.and.ncds.pdf> (last visited Nov. 16, 2005).

²⁴ Anita Regmi & Mark Gehlhar, *Processed Food Trade Pressured by Evolving Global Supply Chains*, in 3(1) ECONOMIC RESEARCH SERVICE/USDA, *AMBER WAVES: THE ECONOMICS OF FOOD, FARMING, NATURAL RESOURCES, AND RURAL AMERICA* (2005), at <http://www.ers.usda.gov/AmberWaves/February05/Features/ProcessedFood.htm> (last visited Nov. 16, 2005).

almost every country.²⁵ The influx of cheap, imported processed food, meanwhile, has shifted the food consumption habits of citizens away from traditional diets based on domestically-produced food products.²⁶

Given their success in introducing Western-type processed food and beverage products to developing countries, multinational food companies are expected to increasingly target those markets. Developing countries offer potentially huge new markets for multinational food companies facing no-growth in their home markets.²⁷ Multinational food corporations often purchase large, majority shareholdings in local food producers, wholesalers, or retailers.²⁸ Once established in local markets, these corporations can penetrate new markets easily and mold local tastes to their products.²⁹

C. Nature of Transnational Food Marketing

Along with the changes in food supply, the marketing of food also has negatively impacted dietary change. Corporate manufacturers of beverage and snack foods such as Coca-Cola, Nestle, and Kraft aggressively market foods of low nutritional quality in developing countries to make their products popular and profitable, and to enable further expansion in these countries.³⁰ The marketing goals of changing consumption patterns and creating demand negatively influences diets in populations undergoing the nutrition transition. As a result of these marketing techniques, multinational corporations have achieved global success after years of competition with other companies—concerns about health and nutrition have not played a role in this process.

The magnitude of food marketing by the world food industry poses a severe challenge to public health. Escalating investment into food advertising demonstrates the extent to which industry relies on marketing to influence consumer behavior. For every dollar the WHO spends on trying to improve the nutrition of the world's population, \$500 is spent by the food industry on promoting processed foods.³¹ The global food industry's advertising budget was estimated to be \$40 billion in 2001.³² Even companies that purport to be concerned about health issues and promote healthy eating habits downplay the impact of frequent consumption of products of low nutritional value. A common theme promoted by the food industry is that increased physical activity is the most important factor in addressing the epidemic of obesity and overweight.³³ Another

²⁵ Coca-Cola is produced in over 200 countries, Pepsi 190, McDonald's 121, and Yum! Brands (KFC and Pizza Hut) over 100. Seventy, 42, 51, and 35 percent of Coca-Cola's, Pepsi's, McDonald's, and Yum!'s sales, respectively, come from outside the United States. Corinna Hawkes, *Marketing Activities of Global Soft Drink and Fast Food Companies in Emerging Markets: A Review*, in WHO, GLOBALIZATION, DIETS, AND NONCOMMUNICABLE DISEASES, *supra* note 23, at 101.

²⁶ Tereso S. Tullao, *The Impact of Economic Globalization on Noncommunicable Diseases: Opportunities and Threats*, in WHO, GLOBALIZATION, DIETS, AND NONCOMMUNICABLE DISEASES, *supra* note 23, at 19.

²⁷ Tillotson, *supra* note 20, at 32.

²⁸ See Chopra, in WHO, GLOBALIZATION, DIETS, AND NONCOMMUNICABLE DISEASES, *supra* note 23, at 6.

²⁹ In China, for example, transnational corporations have invested significantly in local companies in order to produce, distribute, and retail both global and locally-adapted products. C. Handy, P. Kaufman & S. Martinez, *Direct Investment Is Primary Strategy to Access Foreign Markets*, FOOD REV., May-Aug. 1996, at 6-12.

³⁰ Global marketing and the systematic molding of taste by giant corporations is a central feature of the new globalization of the food industry. See Chopra, in WHO, GLOBALIZATION, DIETS, AND NONCOMMUNICABLE DISEASES, *supra* note 23, at 42. For a detailed report on how soft drink and fast food companies create demand and encourage excessive consumption of their products, see Hawkes, in WHO, GLOBALIZATION, DIETS, AND NONCOMMUNICABLE DISEASES, *supra* note 23, at 101.

³¹ See THE ATLAS OF FOOD: WHO EATS WHAT, WHERE AND WHY (Erik Millstone & Tim Lang eds., 2003).

³² *Id.*

³³ See INTERNATIONAL ASSOCIATION OF CONSUMER FOOD ORGANIZATIONS (IACFO), BROADCASTING BAD HEALTH: WHAT FOOD COMPANIES DO 18 (2003), at www.foodcomm.org.uk (last visited Apr. 25, 2005).

tactic is to “skew the science” through the activities of media-management companies acting on behalf of the food industry.³⁴

The problem is particularly acute when addressing the impact of food advertising on children. Marketers are interested in children and adolescents as consumers because this group spends billions of dollars annually, influences how billions more are spent through household food purchases, and are future adult consumers.³⁵ The Global Strategy acknowledges the power of food advertising in influencing dietary habits, stressing, “food and beverage advertisements should not exploit children’s inexperience or credibility.”³⁶ A Kaiser Foundation study found that children who spend more time with media are more likely to be overweight than children who do not,³⁷ and that “children’s exposure to billions of dollars worth of food advertising and cross-promotional marketing year after year” likely is a mechanism by which the media contributes to childhood obesity.³⁸ Similarly, the Food Standards Agency (FSA) of the United Kingdom concluded that a link exists between advertising and children’s diets.³⁹ Various professional organizations also have expressed concern about food advertising to children.⁴⁰

When countries do try to prohibit or control advertising directed to children, “crossborder” advertising limits the effectiveness of such policies. Sweden has banned advertising to children in the age group of twelve and under since 1991, but advertisements targeted at children broadcast on satellite channels are not covered by the ban.⁴¹ Similarly, a ban on advertising to children in Quebec, Canada does not prevent children from being exposed to crossborder advertising from other provinces, or from the United States.⁴² Without a more uniform global system where more countries are committed to stricter marketing laws, national regulations of food advertising to children continue to be undermined by external forces.

D. Global Trade Policies

Simultaneously, international trade policies that emphasize trade over public health concerns facilitate the introduction of foods and beverages of low nutritional value into

³⁴ In one example, The International Life Science Institute, co-founded by food companies Heinz, Coca-Cola, Pepsi, General Foods, Kraft, and Procter and Gamble, put out a publication stating that “intake of sugars is inversely associated with the prevalence of obesity” and comments on the need to research the positive role of glucose in “facilitating mental processes.” *See id.*

³⁵ Mary Story & Simone French, *Food Advertising and Marketing Directed at Children and Adolescents in the US*, 1 INT’L J. BEHAVIORAL NUTRITION & PHYSICAL ACTIVITY 3 (Feb. 10, 2004), at <http://www.ijbnpa.org/content/1/1/3> (last visited Nov. 16, 2005).

³⁶ WHA57.17, *supra* note 1, at 13.

³⁷ *See* KAISER FOUNDATION, THE ROLE OF MEDIA IN CHILDHOOD OBESITY 10 (Feb. 2004), available at <http://www.kff.org/entmedia/7030.cfm> (last visited Nov. 16, 2005).

³⁸ *Id.*

³⁹ The FSA conducted an independent review and concluded that television food advertising to children influences children’s food preferences, purchase behavior, and consumption at both the brand and food category levels. The FSA review also confirms that nearly all food products advertised directly to children can be classified as unhealthy (being high in fat, sugar and/or salt according to government guidelines). *See* FSA, REVIEW OF RESEARCH ON THE EFFECTS OF FOOD PROMOTION TO CHILDREN (Sept. 2003), at <http://www.food.gov.uk/healthiereating/promotion/readreview> (last visited Nov. 16, 2005).

⁴⁰ The American Psychological Association, for example, has called for regulation of television food advertising aimed at children, with mandatory equal time for pro-nutrition messages, and a ban on fast foods and soft drinks in schools. *See* <http://www.apap.org>; *see also Professional Concerns About Food Marketing in North America*, in BROADCASTING BAD HEALTH, *supra* note 33.

⁴¹ The European Court of Justice has made it clear that advertising originating in another Member State is permitted. *See* De Agostini v. Konsumentombudsmannen [1997] ECR I-3843. *See also* the decision by the European Free Trade Association Court in joined cases E-8/94 and E-9/94, June 16, 1995, available at <http://www.eftacourt.lu/default.asp?layout=article&id=28> (last visited Nov. 16, 2005).

⁴² *See What Other Countries Do*, 35 FOOD STANDARDS AGENCY NEWS 16 (Feb. 2004), available at <http://www.food.gov.uk/aboutus/publications/fsanews/fsanews2004/fsanews35> (last visited Nov. 24, 2005).

global markets. International trade agreements like those administered by the World Trade Organization (WTO) seek to liberalize trade by eliminating tariffs, quantitative trade restrictions, and nontariff trade barriers.⁴³ Limited exceptions are made in the interest of public health. Nations cannot easily justify restrictions on food imports, and measures such as nutritional labeling requirements may be attacked as being nontariff trade barriers. Both the 1994 General Agreement on Tariffs and Trade (GATT) and the Agreement on Technical Barriers to Trade (TBT) constrain domestic measures that might be taken to address health conditions caused by poor diet and over consumption of foods of low nutritional value.⁴⁴

The GATT broadly disallows quantitative restrictions⁴⁵ and imposes two types of nondiscrimination obligations. Article I on Most Favored-Nation (MFN) Treatment prohibits Member Nations from discriminating between trading partners, while Article III on National Treatment requires that Member Nations treat any given imported product no less favorably than a like domestic product. In theory, Member Nations can invoke Article XX(b) to make exceptions to the general requirements in the GATT for measures that are “necessary to protect human, animal or plant life or health,” subject to the requirement that such measures do not constitute “a means of arbitrary or unjustifiable discrimination” or a “disguised restriction on international trade.”⁴⁶ The exception under Article XX(b), as interpreted, however, has left Member Nations with little room to design and implement public health measures.⁴⁷ In the Thai Cigarette Case, a GATT panel ruled that Thailand’s import restrictions on cigarettes were not “necessary” within the meaning of the Article XX(b) exception, as less trade-restrictive alternatives were available to achieve the intended public health objectives.⁴⁸ The panel disregarded the various constraints, including institutional and fiscal, that the Thai government would have to face in order to implement the less restrictive alternatives.⁴⁹

Even if import restrictions and other domestic health measures pass muster under the GATT, they also must meet the additional obligations imposed by the TBT Agreement covering technical regulations (e.g., import bans, warning labels, and nutrition information panels). Under the TBT Agreement, all Members have the right to restrict trade for legitimate objectives, including the protection of human health or safety and the prevention of deceptive practices.⁵⁰ Unlike the measures allowed under the GATT, however, a TBT measure may be considered in violation of a WTO Member’s obligations even if it applies equally to domestic and imported products.⁵¹ Member Nations must

⁴³ In 1995, the WTO was established as the international organization to supervise the operation of the rules of trade between member nations.

⁴⁴ The Uruguay Round of Agreements established the WTO framework, which incorporated the previous GATT framework and also established new agreements such as the Agreement on Sanitary and Phytosanitary Measures (SPS) and the TBT Agreement. The SPS Agreement pertains mainly to food safety and contains obligations similar to the ones under the GATT and TBT Agreements. This article does not include a discussion of the SPS Agreement because human health risks such as nutrition concerns do not fall within the SPS category of protection of human or animal life. See SPS—Scope and Coverage, at http://www.wto.org/english/thewto_e/whatis_e/eol/e/wto03/wto3_24.htm#note1 (last visited Nov. 16, 2005).

⁴⁵ General Agreement on Tariffs and Trade, Oct. 30, 1947, 61 Stat. A-11, T.I.A.S. 1700, 55 U.N.T.S. 194, art. XI.1, available at http://www.wto.org/english/docs_e/legal_e/gatt47_e.pdf (last visited Nov. 16, 2005) [hereinafter GATT].

⁴⁶ GATT art. XX(b): General Exceptions, available at http://www.wto.org/english/docs_e/legal_e/gatt47_e.pdf (last visited Nov. 16, 2005).

⁴⁷ Carlos M. Correa, *Implementing National Public Health Policies in the Framework of WTO Agreements*, 34 J. WORLD TRADE 89, 96 (2000).

⁴⁸ Thailand-Restrictions on Importation of and Internal Taxes on Cigarettes, adopted Nov. 7, 1990, GATT Doc. DS10/R, BISD 37S/200, available at <http://docsonline.wto.org/DDFDocuments/t/JCR/PANELS/90CIGART.WPF> (last visited Nov. 16, 2005).

⁴⁹ *Id.*

⁵⁰ See TBT AGREEMENT, Annex 3.

⁵¹ *Id.*

not discriminate against imported like products and also must not adopt measures that are more trade-restrictive than necessary. The requirement that a measure “not be more trade-restrictive than necessary” leaves a measure open to attack as long as there are less trade-restrictive alternatives available. In the Pacific Islands, for example, the governments of Fiji and Tonga tried to halt the import of “mutton flaps,” or fat from sheep, in order to address the high levels of obesity and related chronic diseases suffered by their populations.⁵² Both governments then faced implied threats from other nations to use the WTO system to enforce continued importation.⁵³

Further, pressure for downward harmonization towards trade rules that are minimally protective of public health is built directly into the WTO agreements. The TBT Agreement encourages Members to base measures on international standards when available and appropriate.⁵⁴ To avoid the need to justify a stronger standard, and possibly defend it against a trade challenge, a country simply may adopt an established international standard, such as those set by the Codex Alimentarius Commission (Codex) or the International Standards Organization (ISO).⁵⁵ This is troublesome because the current system of setting international standards often is dominated by the participation of a few TNCs and governed by nonaccountable and sometimes secretive processes.⁵⁶ As a result, both Codex and ISO standards tend to be set at a minimally protective “floor” of international health and safety standards, which in practice acts as a “ceiling” to bar more protective domestic standards.⁵⁷ Under this rubric, national laws that exceed Codex, ISO, and other international standards, without justification deemed acceptable by the WTO, are prone to attack by other nations. European Union (EU) officials, for example, asserted in 1994 that the mandatory nutrition labeling required by the United States was a trade barrier⁵⁸ and violated the TBT Agreement, despite the fact that practically no members of the food industry supported the legislation when it was introduced in Congress.⁵⁹

Thus, while the WTO agreements could limit the trade-related provisions of international instruments in the service of public health, the inflexible obligations imposed by the agreements, and the heavy burden of justification for those health protection policies prevent countries from pursuing measures to improve consumer diet. The current governance of the food trade places a double burden on public health within countries by increasing the range of public health threats because of the international flow in goods, as discussed in Part I, and undermining the government’s ability to provide for the public’s health.

⁵² Mike Evans, Robert C. Sinclair, Caroline Fusimalohi et al., *Globalization, Diet and Health: An Example From Tonga*, 79 BULL. WORLD HEALTH ORGAN. 9, 856-62 (2001), available at <http://www.scielosp.org> (last visited Nov. 16, 2005).

⁵³ *Id.*

⁵⁴ TBT AGREEMENT art. 2.4.

⁵⁵ The International Standards Organization (ISO) is a worldwide federation of national standardization bodies. Many of the experts that form the ISO technical committees and working groups are strongly affiliated with corporations, especially TNCs. For more information on ISO, see www.iso.ch/iso/en/ISOOnline.frontpage. For a description of Codex and its specific problems, see discussion *infra* Part IV.

⁵⁶ See Lori M. Wallach, *Symposium: Globalization and Sovereignty: Accountable Governance in the Era of Globalization: The WTO, NAFTA, and International Harmonization of Standards*, 50 KAN. L. REV. 823, 832 (2002).

⁵⁷ *Id.* at 831.

⁵⁸ EUROPEAN COMMISSION, 15th ANNUAL REPORT ON UNITED STATES BARRIERS TO TRADE AND INVESTMENT 23 (1999), available at http://europa.eu.int/comm/external_relations/us/trade_barriers_report_99/usrbt99.pdf (last visited Nov. 24, 2005). The report states that U.S. nutrition labeling requirements differ from international labeling standards set by the Codex Alimentarius Commission and present “serious negative consequences on EU-U.S. trade in foodstuffs.”

⁵⁹ See CSPI Int’l, *The Impact of the TBT and SPS Agreements on Food Labeling and Safety Regulations*, at <http://www.cspinet.org/reports/codex/wtospst.htm> (last visited Nov. 16, 2005).

E. Weaknesses of Industry Self-Regulation

Industry self-regulation, which can take the form of the Children's Advertising Review Unit (CARU) Guidelines,⁶⁰ or the International Code of Advertising Practice,⁶¹ remains only theoretically promising as a form of regulation that minimizes the harm posed by liberal food trade policies and weak statutory controls. Self-regulation often is a tempting option for governments because it designates the complicated and expensive task of designing codes or guidelines of conduct to industry, leaves monitoring and enforcement costs to the regulated parties, and reduces, by its voluntary nature, industry resistance against regulatory intervention. Yet, these questionable benefits, even if realized, may come at the cost of allowing industry to subvert regulatory goals to its own business agenda while doing little to resolve the problem. Because the food and advertising industries continue to disclaim responsibility for escalating rates of obesity and other diet- and inactivity-related illnesses,⁶² it is difficult to see how these companies could construct, much less adhere to, self-imposed voluntary solutions. The measures that companies and trade organizations have taken thus far to address this health crisis fail to address the real harms at stake and seem designed, instead, to deflect the threat of government intervention.

Aside from the basic conflict of interest that underlies industry-designed and enforced solutions, numerous flaws weaken the effectiveness of self-regulatory systems. First, the private nature of self-regulation fails to give adequate attention to the needs of the public or the views of affected parties outside the industry. Most self-regulatory organizations have no consumer representation on their boards.⁶³ Second, enforcement and sanctions typically are limited or ineffective. There are no adequate incentives to comply because companies that do so will be placed at a competitive disadvantage. More importantly, when complaints are brought to the attention of the monitoring parties, complaints often are not adjudicated until the entire marketing campaign has finished, weakening the effect of sanctions and doing little to mitigate the harm that already has occurred.⁶⁴ Substantive weaknesses of the voluntary codes include their

⁶⁰ CARU, a division of the Council of Better Business Bureaus, is one of the primary self-governing authorities for the children's advertising industry in the United States and has published the Self-Regulatory Guidelines for Children's Advertising. The Guidelines are available at <http://www.caru.org/guidelines/index.asp> (last visited Nov. 16, 2005).

⁶¹ The International Code of Advertising Practice is issued by the International Chamber of Commerce (ICC). Notably, the Code does not prohibit the advertising of any specific product type; prohibit or control advertising aimed at any particular age group; control the frequency/volume of advertising; or control the time of advertisements in children's programming. See ICC, *ICC International Code of Advertising Practice* (Apr. 1973), at http://www.iccwbo.org/home/statements_rules/rules/1997/advercod.asp (last visited Nov. 16, 2005); see also *Self-Regulation, Can It Work?*, in BROADCASTING BAD HEALTH, *supra* note 33.

⁶² In one high-profile example, the sugar industry attacked the WHO for publishing advice that people should restrict sugar to 10% of total calories. See S. Boseley, *Sugar Industry Threatens to Scupper WHO*, THE GUARDIAN UNLIMITED, Apr. 2003, at <http://www.guardian.co.uk/international/story/0,3604,940287,00.html> (last visited Nov. 24, 2005). The advertising and food industries also went to great lengths to discredit the FSA's report concluding that television food advertising to children influences children's food preferences, purchase behavior, and consumption. See STAN PALIWODA & IAN CRAWFORD, AN ANALYSIS OF THE HASTINGS REVIEW: "THE EFFECTS OF FOOD PROMOTION ON CHILDREN" (Dec. 2003), available at http://www.fau.org.uk/hastings_review_analysis_dec03.pdf (last visited Nov. 24, 2005).

⁶³ CARU's efforts are hindered by guidelines that are too narrow, enforcement powers that are too weak, and the basic conflict that it is an industry group. There are no consumer group representatives on the 25-member board and some of the six academic board members have consulted for advertisers and major corporations. See Caroline E. Mayer, *Minding Nemo: Pitches to Kids Feed Debate About a Watchdog*, WASH. POST, Feb. 26, 2005, at F1.

⁶⁴ The Advertising Standards Authority (ASA) governs a voluntary code of practice for the advertising industry. ASA adjudications often last several years, during which time offending advertisements continue to be published. See RESPONSE TO CONSULTATION FROM SUSTAIN: THE ALLIANCE FOR BETTER FOOD AND FARMING (Jan. 2004), available at http://www.sustainweb.org/pdf/off28_01_04.pdf (last visited Nov. 24, 2005).

failure to address the cumulative impact of food advertising and to account for newer technologies of advertising, such as Internet marketing.⁶⁵

Some industry stakeholders recently have taken steps to create healthier products for children and to limit their own marketing efforts directed at children. These measures, while encouraging, are far from adequate and more can be done in light of the food and marketing industries' abilities to influence young audiences and populations' diets in general. Kraft Foods received wide media coverage when the company announced it would curb its advertising of many popular snack foods items to children under the age of twelve, but the actual change likely will be less significant than was widely anticipated.⁶⁶ Kraft Foods will not stop all promotions to young children, only those advertisements on television, radio, and in print publications aimed at audiences of six- to eleven-year-olds.⁶⁷ The Australian Association of National Advertisers has updated its code to include clauses stipulating that advertisements should neither encourage nor promote an inactive lifestyle or unhealthy eating. Very few of the current food advertisements would fall into either of these categories, however, and the clauses and definitions are a matter of open interpretation.⁶⁸

In sum, the effects of globalization make it difficult for governments and other stakeholders to address the growing threat of obesity and related health conditions without collective agreement to certain principles, and without the leadership, coordination, and expertise offered by the WHO—the international agency dedicated to achieving public health on a global level. This realization prompted Member Nations to formally endorse a comprehensive, multilateral approach to the problem of diet- and inactivity-related diseases.

III. THE GLOBAL STRATEGY ON DIET, PHYSICAL ACTIVITY, AND HEALTH

A. Overview

The WHO, in consultation with all concerned stakeholders, developed the Global Strategy on Diet, Physical Activity, and Health in response to a formal request from Member Nations to address the growing impact of noncommunicable diseases.⁶⁹ The Global Strategy offers a comprehensive public health program, providing countries with a range of global policy options to address two of the major risks responsible for the heavy and growing burden of NCDs: an unhealthy diet and physical inactivity. Rather than just focusing on consumer education and responsibility, the Global Strategy urges governments to consider using more affirmative measures such as limiting food advertising to children, using fiscal and pricing policies to promote the consumption of healthful foods, and examining the impact of agricultural policies on diet and health.⁷⁰ The Global Strategy specifically recommends limiting intake of sugars, fats, and salt in foods, and increasing the consumption of fruits, vegetables, legumes, whole grains, and nuts.⁷¹ The role of NCD prevention in health services, surveillance systems, and school policies as they affect food and physical activity choices, also is addressed.⁷² Private

⁶⁵ See *Targeting Children: New Technologies*, in BROADCASTING BAD HEALTH, *supra* note 33.

⁶⁶ Caroline E. Mayer, *Kraft to Curb Snack-Food Advertising*, WASH. POST, Jan. 12, 2005, at E1.

⁶⁷ *Id.*

⁶⁸ See Julian Lee, *Junk Food Code Is Lacking in Fibre*, SYDNEY MORNING HERALD, Aug. 19, 2004, at 22.

⁶⁹ See WHA55.23 (2002), available at http://www.who.int/gb/ebwha/pdf_files/WHA55/ewha5523.pdf (last visited Nov. 24, 2005).

⁷⁰ WHA57.17, ¶¶ 46, 47.

⁷¹ *Id.* ¶ 22.

⁷² *Id.* ¶¶ 31, 49.

sector, civil society, and nongovernmental organizations are further encouraged to promote healthy diets and physical activity in their respective capacities.⁷³

At the same time, the Global Strategy reflects the WHO's reluctance to offer more than technical and administrative support for its implementation. Designated responsibilities include developing and strengthening partnerships; supporting regional and national initiatives; setting up a monitoring system; and reporting on progress made in implementing the Global Strategy.⁷⁴ The one provision pertaining to the role of international norms and standards refers to those drawn up by the Codex Alimentarius Commission.⁷⁵ For the most part, it will be up to Member Nations, after they determine "which specific policy options are appropriate to their circumstances at the national level," to request the WHO's technical assistance for the implementation of programs.⁷⁶ Thus, the Global Strategy reflects the WHO's historical reluctance to use international law, and its preference for nonbinding commitments to promote public health.

Reluctance on the part of the WHO to enact more binding requirements on Member Nations and other stakeholders is understandable, given the organization's past neglect in using international legal strategies to promote its global public policies, and the political resistance that would inevitably arise from industry and from some Member Nations concerned about national sovereignty. The complexity of factors that contribute to diet-related diseases, along with the diverse social, economic, and cultural dimensions of diet in different populations, also make it desirable for the international system to have multiple approaches to this public health problem. The effectiveness of the Global Strategy is limited, however, by its primary allocation of legislative responsibilities to individual countries and by the absence of an intergovernmental body that will enforce and interpret health-promoting domestic policies in the global market.

B. *Limitations of the Global Strategy*

First, putting responsibility for enacting health-related legislation and programs solely in the hands of Member Nations ignores the fact that Member Nations traditionally have viewed the prevention of diet- and inactivity-related diseases as a low, nonurgent priority. The threat of chronic, noncommunicable diseases generally is viewed as a problem of less importance than other public health issues.⁷⁷ It is difficult, therefore, to rally the public support needed to spend sufficient funds on prevention, even if governments were inclined to do so. Moreover, while the United States and other wealthier nations maintain their own public health agencies, other smaller and developing countries with small public health infrastructures lack the resources to develop their own specific policies and implementation measures.⁷⁸ These nations traditionally have relied on the WHO to advocate and promote public health law on their behalf.⁷⁹

⁷³ *Id.* ¶¶ 60, 61.

⁷⁴ *Id.* ¶ 57.

⁷⁵ *Id.* ¶ 59.

⁷⁶ See WHO, Frequently Asked Questions About the WHO Global Strategy on Diet, Physical Activity, and Health, at <http://www.who.int/dietphysicalactivity/faq/en/print.html> (last visited Nov. 16, 2005).

⁷⁷ See Derek Yach & Robert Beaglehole, *Globalization of Risks for Chronic Diseases Demands Global Solutions*, 3 PERSP. ON GLOBAL DEV. & TECH. 1617 (2004) (stating that the response to the epidemics of chronic diseases, despite the threat they pose to health systems, has been grossly inadequate, and that donors and governments have been reluctant to invest in national institutions and infrastructure for chronic disease prevention).

⁷⁸ Developing countries often have neither the resources to make public health a national interest nor the political and economic clout to put their public health interests on the agenda of the international system. See DAVID P. FIDLER, *INTERNATIONAL LAW AND PUBLIC HEALTH* 72 (2000).

⁷⁹ Examples include the advocacy leading up to the International Code of Marketing of Breastmilk Substitutes (discussed in Part IV) and the WHO's provision of technical and financial support to Member Nations of the African and Western Pacific regions in implementing national food and nutrition policies and plans.

An additional limitation of the Global Strategy stems from its failure to require Member Nations to account for the global impact of their domestic policies, even when those policies might interfere with the ability of other countries to reduce and prevent the incidence of obesity and related health problems. The governments of both the United States and the European Union, for example, have undertaken some positive efforts to address the crisis within their respective populations,⁸⁰ but still continue to support domestic producers through policies that result in greater risks for diet-related diseases in developing countries.⁸¹ This is not surprising given that the U.S. government objected to the inclusion of provisions like controls on food marketing, questioned the scientific basis for the linking of increased consumption of certain foods to the risk of noncommunicable diseases and obesity, and stressed the idea of personal responsibility over government action during the drafting phase of the Global Strategy.⁸² The United States continues to be resistant to change at the global level, showing resistance to the role of Codex in promoting the Global Strategy at the latest meeting of Codex's Executive Committee.⁸³ At a minimum, the potential for national governments to pay lip service to the goals of the Global Strategy while undermining those goals in secret, unaccountable processes is a significant regulatory gap that should be addressed. In order for the Global Strategy to work, governments must be spurred to act beyond self-interest and must be truly committed to global obligations.

Finally, even if countries are willing to implement the recommendations outlined in the Global Strategy, the practical force of domestic rules or regulations is weak without the backing of an international body ready to enforce, interpret, and provoke Member Nations into following through with their commitments. To be effective, domestic regulations must be recognized as legally binding by other powerful actors and multilateral organizations in the global food market. As discussed in Part I, TNCs have enormous power in cultivating food policies that exert an adverse influence on health objectives, and the balance is tilted heavily in favor of favorable trade policies established by international organs like the WTO. The problem becomes more acute when international

⁸⁰ The U.S. Food and Drug Administration (FDA) has asked for public comment on food label changes to help make consumers make better-informed weight management decisions. See FDA, FDA Asking for Public Comment on Food Label Changes (Apr. 1, 2005), at <http://www.fda.gov/bbs/topics/news/2005/NEW01170.html> (last visited Nov. 16, 2005). The EU's food industry has been given a year to halt advertising of junk food to children and to improve labeling or face the threat of possible legislation. See Markos Kyprianou *Urges Food Industry to Combat Obesity*, HEALTH & CONSUMER VOICE: NEWSLETTER ON FOOD SAFETY, HEALTH AND CONSUMER POLICY, Feb. 2005, at 2, at http://europa.eu.int/comm/dgs/health_consumer/consumervoive/cv_22005_en.pdf (last visited Nov. 16, 2005).

⁸¹ Such policies include agricultural subsidies that limit competition from primary producers of fresh produce in developing countries and seriously reduce the income of the poor countries. In the related area of tobacco exportation, the European Union spends approximately \$1 billion on tobacco production subsidies. See Yach & Beaglehole, *supra* note 77, at 8.

⁸² In a letter to the WHO's Director-General, William Steiger, Special Assistant to the Secretary for International Affairs at the U.S. Department of Health and Human Services, said the WHO/FAO report was not credible, lacked "a high degree of transparency," and was not supported by "sufficient scientific evidence." Steiger criticized the WHO/FAO report for focusing on "good" and "bad" foods, writing that the U.S. government supports the idea that "all foods can be part of a healthy and balanced diet," and advocating that personal responsibility be a main tenet of dietary guidelines. The letter and comments to the draft Global Strategy can be viewed at <http://www.who.int/dietphysicalactivity/strategy/eb11344/en/index1.html>.

⁸³ The Member for North America (a representative of the U.S. Codex office) took the position that several recommendations of the Global Strategy were directed to Member countries and should be implemented at the national level but were not within the mandate of Codex, in particular as regards nutrition education and healthy life styles. See REPORT OF THE FIFTY-FIFTH SESSION OF THE EXECUTIVE COMMITTEE OF THE CODEX ALIMENTARIUS COMMISSION, ALINORM 05/28/3, at 15, para. 86 (Feb. 2005), available at http://www.codexalimentarius.net/download/report/629/al28_03e.pdf (last visited Nov. 24, 2005).

trade bodies have issued rules or interpreted public health exemptions in such a way as to marginalize public health issues in favor of trade.⁸⁴ At a minimum, there needs to be a powerful international body ready and willing to insert its weight and public health agendas into disputes that inevitably will arise between Member Nations.

The WHO has a central role in promoting and supervising the implementation of the Global Strategy through international legal instruments. The organization's duty in raising the expectations and standards of the international community is grounded in WHO's Constitution and is a product of its institutional place in the UN system. Moreover, the WHO has been pursuing a more deliberative legal strategy in promoting public health goals. In *Health for All in the 21st Century*, the WHO's former Director-General stated a strong commitment on the part of WHO "to ... develop international instruments that promote and protect health ... monitor their implementation, and ... encourage its Member States to apply their international laws related to health."⁸⁵ More recently, the shift to an international framework convention to regulate tobacco reflects the WHO's recognition that its traditional legal approach of encouraging its Member countries to adopt national laws and regulations has failed to address global health issues such as tobacco control.⁸⁶

Leading scholars have long called for the WHO to reconsider and rediscover its powers to build on the organization's comparative advantages in a globalizing world.⁸⁷ The Nordic UN project specifically recommended the strengthening of the traditional normative, research, and information roles of the major specialized agencies, including the WHO.⁸⁸ In 1995, the U.S. American Bar Association (ABA) recommended that the U.S. government support the WHO in exploring means of more effective implementation of public health improvements through increased standard setting and the development of elements of model legislation, regulations, and enforcement measures.⁸⁹ According to the ABA, the U.S. government should consider recommending the development of and adoption by the Health Assembly of the WHO regulations or conventions where: a) a major worldwide public health problem exists; b) there is consensus that regulation is required; c) there are international consequences across borders; and d) WHO regulations or conventions will raise the level of international public health significantly.⁹⁰ As established in Parts II and III, these conditions apply in the case of obesity and diet- and inactivity-related diseases.

Given the global forces and consequences at stake, the WHO should begin utilizing international law to promote and implement the Global Strategy. The practical difficulties in designing more effective, binding international regulatory schemes obviously are a consideration, but these objections should not dissuade governments and legal scholars from considering how the WHO can utilize its broad legal authority to more effectively address global health issues. The next section establishes the WHO's purpose in public health governance, describes the substantive legal provisions that the organiza-

⁸⁴ See discussion *supra* Part II.

⁸⁵ The former Director-General also noted "a strong system of global governance is necessary for implementation of existing international instruments on health and human rights as well as instruments having health implications." WHO Doc. A/51/5, ¶ 52.

⁸⁶ FIDLER, INTERNATIONAL LAW AND PUBLIC HEALTH, *supra* note 78, at 184.

⁸⁷ See, e.g., Gill Walt, *Globalisation of International Health*, 351 THE LANCET 434-37 (Feb. 7, 1998); Aude L'hironel & Derek Yach, *Develop and Strengthen Public Health Law*, 51 WORLD HEALTH ST. Q. 79 (1998).

⁸⁸ THE UNITED NATIONS: ISSUES AND OPTIONS: FIVE STUDIES ON THE ROLE OF THE UN IN THE ECONOMIC AND SOCIAL FIELDS 66-67 (Stockholm 1991).

⁸⁹ See *Section Recommendation and Reports of the American Bar Association*, 30 INT'L LAW 686 (1996).

⁹⁰ *Id.*

tion is granted under its Constitution, and identifies both the WHO's and Member Nations' obligations in other sources of international law.

IV. THE WHO'S LEGAL JURISDICTION OVER FOOD

A. *The WHO Constitution—Normative Visions*

Prior to the WHO's founding in 1946, public health governance was "Westphalian," meaning power was allocated horizontally with no superior authority to which national governments would answer, and each state was sovereign in reigning supreme over the people and activities within its territory.⁹¹ Uncoordinated "horizontal" agreements between national governments resulted in an incoherent regime of international sanitary conventions and agreements.⁹² The WHO was founded out of a commitment to a new, vertical reallocation of power in public health governance that would replace the sovereignty and noninterventionist principles of the Westphalian period of governance.⁹³

The WHO Constitution was an extraordinary undertaking in many ways, reflecting the far-reaching expectations of its founders. The Preamble appears to have been drafted expressly to reject Westphalian governance.⁹⁴ The WHO's founders embraced a broad, positive view of "health," eschewing the previous view of health as the mere absence of disease.⁹⁵ This vision is reflected in the two-page definition of health articulated in the WHO's Constitution. The Preamble proclaims "health is a state of complete physical, mental, and social well-being and not merely the absence of disease and infirmity."⁹⁶ Governments are responsible for the health of their people, which can be fulfilled only by the provision of "adequate health and social measures."⁹⁷

Drafters of the WHO's Constitution were remarkably prescient in their understanding of illness, disease, and disability in assigning a very significant jurisdictional importance to this definition.⁹⁸ According to one of the WHO's legal advisers, "language concerning health protection even in the absence of disease or infirmity has a very important jurisdictional effect because it allows WHO to research and implement protective measures regardless of whether people manifest illness and appear to be 'sick.'"⁹⁹ The definition also reflects the drafters' understanding of the notion of "latent" disease, whereby "a person may enjoy many years of seemingly 'good' health, while in fact the illness or disease is silently, slowly taking effect and will eventually overtake the body."¹⁰⁰

⁹¹ See David P. Fidler, *Constitutional Outlines of Public Health's "New World Order,"* 7 TEMP. L. REV. 247, 259-60 (2004) [hereinafter Fidler, *Constitutional Outlines*].

⁹² See Allyn L. Taylor, *Controlling the Spread of Infectious Diseases: Toward a Reinforced Role for the International Health Regulations*, 33 Hous. L. REV. 1327, 1342 (1997).

⁹³ See Fidler, *Constitutional Outlines*, *supra* note 91, at 260-61; see also G.L. BURCI & C.H. VIGNES, *THE WORLD HEALTH ORGANIZATION* 124 (Aspen Pub. 2004) (explaining that the WHO, being the single universal public health agency designed to replace the inconsistent earlier regime, was given extensive powers to set health-related standards and ensure their uniformity at the global level).

⁹⁴ The Preamble replaces the centrality of the state with an emphasis on individual rights and the transnational solidarity. It also replaces the Westphalian principle of nonintervention with principles that demand scrutiny of government behavior regarding the health of citizens and peoples of other nations. Fidler, *Constitutional Outlines*, *supra* note 91, at 260.

⁹⁵ Fluss et al., *supra* note 2, at 37-39.

⁹⁶ WHO CONST. Preamble, *reprinted in* WHO, BASIC DOCUMENTS, *supra* note 6.

⁹⁷ *Id.*

⁹⁸ See Ilise L. Feitshans, *Is There a Human Right to Reproductive Health?*, 8 TEX. J. WOMEN & L. 93, 98 (1998).

⁹⁹ *Id.* Ilise Feitshans is the Legal Advisor to the WHO and Russian Academy of Medical Sciences (RAMS) Committee of Experts on Reproductive Health at Work.

¹⁰⁰ *Id.*

Thus, the WHO's legal mandate should be understood to include diet- and inactivity-related illnesses like obesity, heart disease, and diabetes, and should grant the organization the ability to enact prophylactic measures of intervention in order to prevent such diseases from initially taking hold.

B. *The WHO's Functions and Legal Instruments*

More specific articles in the WHO Constitution uniformly express the international nature of public health and the need to harmonize national behavior through international standards. Article 2 lists a range of twenty-two functions to be fulfilled by the WHO in order to reach its objectives.¹⁰¹ These functions are supposed to guide the WHO in its mandate to attain the highest standard of health. Article 2(a), explaining that the WHO will "act as the directing and co-coordinating authority on international health work," has been characterized as the WHO's most important function.¹⁰² Article 2(k) establishes that the functions of the WHO are, *inter alia*, to "propose conventions, agreements and regulations, and make recommendations with respect to international health matters and to perform such duties as may be assigned thereby to the Organization and are consistent with its objectives."¹⁰³ Article 2(u) further states that the WHO should "develop, establish and promote international standards with respect to food, biological, pharmaceutical, and similar products."¹⁰⁴ Finally, Article 2(v) establishes that the WHO should "generally take all necessary action to attain the objective of the Organization."¹⁰⁵ These provisions clearly point to a central role for the WHO in enacting positive measures to implement the Global Strategy.

The text of the WHO Constitution and the debates that led to its drafting show that the WHO founders intended the adoption of conventions and regulations to be central instruments in the regulation and management of international health issues.¹⁰⁶ Article 19 empowers the WHA to adopt conventions and agreements with respect to "any matter within the competence of the Organization."¹⁰⁷ Indeed, the Global Strategy is an assertion, by the WHA, that chronic disease prevention is a specific priority area within the WHO's competence. In addition to the WHA having plenary authority to adopt conventions, Article 21 assigns to the WHA the authority to develop binding¹⁰⁸ regulations in five health-related areas: 1) sanitary and quarantine requirements; 2) nomenclatures on diseases, causes of death, and public health practices; 3) standards for diagnostic procedures for international use; 4) standards for the safety, purity, and potency of biological, pharmaceutical, and similar products moving into international use; and 5) advertising and labeling of biological, pharmaceutical, and similar products.¹⁰⁹ Article 21

¹⁰¹ WHO CONST. art. 2, in WHO, BASIC DOCUMENTS, *supra* note 6.

¹⁰² *Id.* See BURCI & VIGNES, *supra* note 93, at 119 (stating that this function appears to embody the essential task of the Organization).

¹⁰³ WHO CONST. art. 2, in WHO, BASIC DOCUMENTS, *supra* note 6.

¹⁰⁴ *Id.*

¹⁰⁵ *Id.*

¹⁰⁶ BURCI & VIGNES, *supra* note 93, at 153.

¹⁰⁷ WHO CONST. art. 19, in WHO, BASIC DOCUMENTS, *supra* note 6.

¹⁰⁸ In this article, the term "binding" is used to describe obligations in public international law that import a normative expectation of adherence, beyond a mere recommendation. Strictly speaking, however, most UN conventions are not truly "binding" in the way that domestic public statutes are because generally they are not enforceable by prosecutors and judges backed by the authority to order payment of monetary penalties or, ultimately, imprisonment. Deference to state sovereignty in international agreements usually, but not always, means that such agreements (except, for instance, trade agreements) do not confer on oversight bodies the authority to impose such penalties. For general background on public health and international law, see FIDLER, INTERNATIONAL LAW AND PUBLIC HEALTH, *supra* note 78.

¹⁰⁹ WHO CONST. art. 21, in WHO, BASIC DOCUMENTS, *supra* note 6.

has been called “an exceptional regulatory power” because regulations adopted by a simple majority of Member States are binding on the entire membership automatically, unless a Member notifies the WHO to the contrary.¹¹⁰ Under conventional treaty-making practice, a positive action is required by a national government in order to become bound by an international instrument.¹¹¹

There is an apparent inconsistency in the WHO Constitution between Article 21 and Article 2(u). The latter includes food together with biological, pharmaceutical, and similar products as items for which international standards may be developed, established, and promoted. The working papers provide no clear indication as to the background of the discussions that led to the noninclusion of food in Article 21(d) and (e).¹¹² One scholar speculates this may have been due to problems arising from the coordination of the work of two different committees of the Conference, or possibly a reluctance to see the WHO having express binding authority in the area of food, although this has not been proven conclusively.¹¹³ A structural, purposive, and pragmatic reading of Article 21 clearly supports the conclusion, however, that Article 21 does grant this power to the WHO.

First, an overview of the WHO’s Constitution reveals that the WHO has been given extensive responsibilities and concomitant authority in a range of areas that affect public health. This design flows from the plain meaning of paragraphs (k), (o), (s), (t), and (u) of Article 2 as well as Articles 19 to 23 concerning the functions of the WHA.¹¹⁴ The WHO’s founders would not have designated such important responsibilities to the WHO without granting its legislative body the legal powers to fulfill those objectives.¹¹⁵ In order to fulfill its broad mandate, the WHO must be able to exercise legal authority over food labeling, marketing, composition, and all other aspects of the Global Strategy. Thus, Article 21 should not be read, under a strict textual lens, to exclude the WHO from being able to regulate matters addressed by the Global Strategy. And, of course, a determination on this interpretive point does not diminish or affect in any way the plenary authority of the WHA to enter into conventions relating to subject matters within its competence.

The magnitude to which unhealthy food products have affected people’s dietary choices, resulting in obesity and diet- and inactivity-related diseases becoming one of the world’s greatest modern public health threats, was never contemplated by the WHO’s founders. “Food” was a much simpler category at the time of the WHO’s founding. Food remained largely in its natural state, and highly processed, packaged foods high in added sugars, salt, and fat were just beginning to emerge in the markets of industrialized nations.¹¹⁶ Since 1946, diet- and inactivity-related disease has become an epidemic, and mass marketing of food and inactivity-promoting products has become highly sophisticated, well financed, and ubiquitous in a media barely contemplated in the 1940s. More-

¹¹⁰ See BURCI & VIGNES, *supra* note 93, at 132.

¹¹¹ See FLUSS et al., *supra* note 2, at 13.

¹¹² *Id.* at 14.

¹¹³ *Id.*

¹¹⁴ A report to the 97th Session of the WHO’s Executive Board identifies paragraphs (k), (o), (s), (t), and (u) of Article 2 as establishing the WHO’s normative role. WHO Doc. EB97/9 (1995), available at http://policy.who.int/cgi-bin/om_isapi.dll?hitsperheading=on&infobase=ebdoc-en&jump=EB97%2f9&softpage=Browse_Frame_Pg42#JUMPDEST_EB97/9 (last visited Nov. 24, 2005). In addition, paragraphs (g), (i), (l), and (r) also comprise functions that are relevant to the implementation of the Global Strategy.

¹¹⁵ Article 21’s provisions with respect to biological, pharmaceutical, and similar products moving in international commerce were not introduced merely to simplify the regime of the previous international sanitary conventions. These innovative regulatory powers also were conceived as measures to protect the public health. See FLUSS et al., *supra* note 2, at 18.

¹¹⁶ For a brief introduction to the formative stages of the food industry leading to the rapid and extensive growth of modern “convenience” foods, see Tillotson, *supra* note 20.

over, workplace automation and computerization to an extent inconceivable in the 1940s has made work more sedentary and, as such, more disease promoting. Finally, progress in the treatment and prevention of communicable diseases in the second half of the twentieth century has revealed the heavy and unnecessary remaining burden posed by diet- and inactivity-related noncommunicable diseases.¹¹⁷

It also should be noted that the issue of the relationship of the functions of Article 21 to Article 2 functions was revisited when the WHA called on the WHO Executive Board to examine whether all of the parts of the WHO's Constitution remained appropriate and relevant.¹¹⁸ In 1997, a special group undertook extensive review of the WHO Constitution, including Articles 2 and 21, at the request of the Executive Board. The group proposed an alternative text of Article 21 in which there would be a clause explicitly permitting regulations to be adopted on any subject, as long as they fell "within the functions of the Organization as set forth in Article 2."¹¹⁹ The WHA never voted on whether the WHO's regulatory powers under Article 21 should be codified in this manner. The Executive Board noted, however, that Article 2, while not a perfect provision, had served the goals of the Organization well.¹²⁰ The Executive Board also noted that Article 2 would continue to include the reference to "food" in response to some suggestions by the South-East Asia regional consultation that "food" was a concern proper to other international agencies.¹²¹ The Executive Board's conclusion, although not an officially endorsed position of the WHA well, may be interpreted to indicate that Article 2's regulatory reach should be construed to cover new areas of international health challenges like obesity and diet- and inactivity-related diseases.¹²²

C. Human Rights Norms

Public international law prescribes specific safeguards for children, consumers, listeners (freedom of speech protects listeners as well as speakers), and natural persons (whose speech often is accorded more protection than corporate ones, and who are entitled to be healthy), as well as the right to adequate food. Much of this public international law creates broad expectations that "oblige" national governments—legally, politically, and/or morally—to sustain healthy environments and natural persons to be entitled to such safeguards. Taken together, several international human rights documents further delineate a role for the WHO in promoting the right to health through policies that will lead to an adequate supply of nutritious food and increase access to

¹¹⁷ For background and a discussion of these trends, see JOINT FAO/WHO CONSULTATION, *supra* note 11.

¹¹⁸ See WHA Res. 48.14, WHO Doc. WHA/1995/REC/1 (1995), available at http://policy.who.int/cgi-bin/om_isapi.dll?hitsperheading=on&infobase=wharec-e&record={4CC0}&softpage=Document42 (last visited Nov. 24, 2005).

¹¹⁹ REVIEW OF THE CONSTITUTION AND REGIONAL ARRANGEMENTS OF THE WORLD HEALTH ORGANIZATION: REPORT OF THE SPECIAL GROUP, WHO Doc. EB101/7 (1997), available at http://ftp.who.int/gb/pdf_files/EB101/pdfangl/eb1017.pdf (last visited Nov. 24, 2005).

¹²⁰ WHO EB, 103rd Sess., 9th mtg., WHO Doc. EB103/1999/REC/2 (1999), available at http://policy.who.int/cgi-bin/om_isapi.dll?hitsperheading=on&infobase=ebrec-en&record={28C4}&softpage=Document42 (last visited Nov. 24, 2005).

¹²¹ *Amendment to Article 2 of the Constitution*, WHO EB, 103rd Sess., Annex, at 1, WHO Doc. EB103/14 (1999), available at http://ftp.who.int/gb/pdf_files/EB103/ee14.pdf (last visited Nov. 24, 2005).

¹²² If it is truly necessary, the WHA still could vote to enlarge the ambit of the WHO's regulation-making authority in this manner—or by conferring a subject-limited delegation of powers—in aid of the latter's charge to implement the Global Strategy. If the WHA is committed to implementing the Global Strategy, which it has endorsed already, then specifically empowering the WHO to pass international health regulations to give effect to that Global Strategy should, in principle, be appealing to members. Certainly, it should be no less appealing than supporting a framework convention on food.

information that will aid consumers in making healthy dietary choices. In addition, UN documents designate children as a category of citizens who need special protection in terms of their health and development. Even though these documents place much of the responsibility for guaranteeing the right to health in Member Nations,¹²³ the legal obligations must be read in light of the WHO's affiliation within the UN system, which provides the foundation of the WHO's unique responsibility to implement the right to health. The structure of the relationship between the United Nations and the WHO is grounded in the UN Charter and, in particular, those sections that describe the objectives of the United Nations.¹²⁴

The WHO Constitution explicitly declares health to be a universal, fundamental human right and links the attainment of health to other human rights goals.¹²⁵ The WHA has reasserted this position formally on at least two occasions. In 1979, the WHA launched a "Global Strategy for Health for All by the Year 2000," which undertook to practically realize the right to health, giving people "a level of health that will permit them to lead socially and economically productive lives."¹²⁶ Similar human rights principles were expressed in the WHO's "Health for All in the Twenty-First Century" policy, in which Member Nations affirmed the "dignity and worth of every person, and the equal rights, equal duties and shared responsibilities of all for health."¹²⁷

Commentators also have credited the WHO with the responsibility for the health objectives of the International Covenant on Economic, Social, and Cultural Rights (ICESCR), which include a right to health.¹²⁸ Article 12 of the ICESCR clearly and deliberately espouses the "right of everyone to the enjoyment of the highest attainable standard of physical and mental health."¹²⁹ Steps to be taken by parties to achieve the full realization of this right include those necessary for the healthy development of the child, and the prevention, treatment, and control of epidemic, endemic, occupational,

¹²³ The Universal Declaration of Human Rights (UDHR) and the International Covenant on Economic, Social, and Cultural Rights (ICESCR) place much of the responsibility for guaranteeing the right to health in Member Nations. Legal obligations imposed by ICESCR focus on the duties of states and underscore that Member Nations have the primary duty to guarantee the right to health to their populations.

¹²⁴ Article 55 of the Charter describes the goals that the United Nations has pledged to promote among its Members, including "solutions of international economic, social, health, and related problems." U.N. CHARTER art. 55, available at <http://www.un.org/aboutun/charter> (last visited Nov. 16, 2005). See Allyn L. Taylor, *Making the World Health Organization Work: A Legal Framework for Universal Access to the Conditions for Health*, 18 AM. J.L. & MED. 301, 313 (1992) (stating that "as the specialized agency with the primary constitutional directive to act as the 'directing and coordinating authority on international health work,' the WHO has the cardinal responsibility to implement the aims of the Charter with respect to health").

¹²⁵ See WHO CONST., in WHO, BASIC DOCUMENTS, *supra* note 6, at 1.

¹²⁶ WHO, GLOBAL STRATEGY FOR HEALTH FOR ALL BY THE YEAR 2000 (1981), available at <http://whqlibdoc.who.int/publications/9241800038.pdf> (last visited Nov. 24, 2005). The Global Strategy was implemented by a plan of action in 1982 based on the Alma-Ata Declaration. WHO, DECLARATION OF ALMA-ATA, REPORT OF THE INTERNATIONAL CONFERENCE ON PRIMARY HEALTH CARE, ALMA-ATA (USSR 1978), available at http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf (last visited Nov. 24, 2005).

¹²⁷ *World Health Declaration*, WHA Res. 51.7, Annex, WHO Doc. WHA 51/1998/REC/1 (1998), available at http://policy.who.int/cgi-bin/om_isapi.dll?hitsperheading=on&infobase=wha&record={2A6}&softpage=Document42 (last visited Nov. 24, 2005); see *Health for All in the Twenty-First Century*, WHO Doc. A51/5 (1998), available at http://ftp.who.int/gb/pdf_files/WHA51/ea5.pdf (last visited Nov. 24, 2005).

¹²⁸ Renee D. Pietropaolo, *The Global Challenge of HIV/AIDS: The Future of World Health Law [Forum]*, 87 AM. SOC'Y INT'L L. PROC. 534, 536 (1993); see also Taylor, *supra* note 124, at 313.

¹²⁹ The International Covenant on Economic, Social and Cultural Rights, G.A. Res. 2200, U.N. GAOR, 21st Sess., Supp. No. 16, at 49, U.N. Doc. A/6316 (1966) [hereinafter *Covenant*] available at http://www.unhcr.ch/html/menu3/b/a_ceschr.htm (last visited Nov. 24, 2005).

and other diseases.¹³⁰ Article 11 of the ICESCR additionally includes the right to “adequate food,” recognizing 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.¹³¹

The UN Committee on Economic, Social, and Cultural Rights has issued General Comments that further define the scope of the rights to adequate food and health. General Comment 12 establishes that the availability of food in a quantity and quality sufficient to satisfy the dietary needs of individuals, free from adverse substances, is part of the “core content” of the right to adequate food.¹³² One could interpret adverse substances to include foods high in salt, added sugars, and saturated fat. The General Comment also stresses that measures may need to be taken to maintain, adapt, or strengthen dietary diversity and appropriate consumption and feeding patterns, while ensuring that changes in availability and access to the food supply do not adversely affect dietary composition and intake.¹³³ All members of society, including the private business sector, also are deemed to share the responsibility for the right to adequate food.¹³⁴ Thus, realization of the right to adequate food should be understood to include policies that address over-consumption of foods of low nutritional value, and other objectives outlined in the Global Strategy.

Furthermore, General Comment 14 describing the human right to health prescribes equally broad and inclusive duties.¹³⁵ Government obligations include disseminating appropriate information relating to healthy lifestyles and nutrition and supporting people in making informed choices about their health.¹³⁶ Violations of the right to health can occur through the “omission or failure” of governments to take necessary measures arising from legal obligations,¹³⁷ and through the direct action of governments or other entities “insufficiently regulated” by countries. In a related provision guaranteeing the “inherent right to life,” Article 6 of the International Covenant on Civil and Political Rights calls for nations to assume affirmative obligations in order to increase life expectancy, including measures to eliminate malnutrition and epidemics.¹³⁸ Obesity and other diet- and inactivity-related diseases, which have assumed the proportions of an epidemic, clearly require such measures. Inadequate responses by various national governments and intergovernmental bodies in implementing the Global Strategy cannot be justified in light of these provisions.

Although the right to health may not include a binding substantive obligation on the WHO or its Member States to achieve a perfect state of health for its citizens,¹³⁹ in the

¹³⁰ *Id.*

¹³¹ Covenant, *supra* note 129, art. 11.

¹³² ESCR Committee, General Comment No. 12, The Right to Adequate Food, 20th Sess., U.N. Doc. E/C.12/1999/5 (1999), available at <http://www.unhchr.ch/tbs/doc.nsf/0/3d02758c707031d58025677f003b73b9?OpenDocument> (last visited Nov. 24, 2005).

¹³³ *Id.* ¶ 9.

¹³⁴ *Id.* ¶ 20.

¹³⁵ ESCR Committee, General Comment No. 14, The Right to the Highest Attainable Standard of Health, 22nd Sess., U.N. Doc. E/C.12/2000/4 (2000), available at [http://www.unhchr.ch/tbs/doc.nsf/\(symbol\)/E.C.12.2000.4.En?OpenDocument](http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En?OpenDocument) (last visited Nov. 24, 2005).

¹³⁶ *Id.* ¶ 37.

¹³⁷ *Id.* ¶ 49.

¹³⁸ Human Rights Committee, General Comment No. 6, The Right to Life, 16th Sess., U.N. Doc. HRI/GEN/1/Rev.1 (1982), available at [http://www.unhchr.ch/tbs/doc.nsf/\(Symbol\)/84ab9690ccd81fc7c12563ed0046fae3?Opendocument](http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/84ab9690ccd81fc7c12563ed0046fae3?Opendocument) (last visited Nov. 24, 2005).

¹³⁹ See ESCR Committee, General Comment No. 14, *supra* note 135 (stating that “the right to health is not to be understood as a right to be healthy” and excluding “unhealthy or risky lifestyles” from protection under the right to health in Article 12 of the ICESCR); see also Taylor, *supra* note 124, at 310 (stating that “the right to health does not, however, constitute an entitlement to individual good health”).

context of food and nutrition, there is a sound basis for interpreting the “right to health” as embracing a right to be free from commercial influences that *may* erode health. And in fulfilling the right to health, national governments have a moral duty, to the extent that state resources permit, to provide opportunities for its citizens to achieve good health.¹⁴⁰ To that end, national governments must minimize the effects of adverse marketing, especially towards vulnerable classes of citizens like children, in order to correct any information imbalance that exists. In addition, because the consumption of less healthy foods and concomitant diet- and inactivity-related diseases disproportionately affect the poor,¹⁴¹ national governments would be achieving equality of opportunity for all citizens to attain the desired state of health if they intervened to correct this imbalance.

Other human rights documents emphasizing an individual right to adequate and accurate information provide normative support for the WHO and Member States to intervene, when necessary, in the area of food marketing and in other areas addressed by the Global Strategy. The UN General Assembly has adopted Guidelines for Consumer Protection (UNGCP), which impose an obligation on governments to prevent manufacturers, distributors, and others from utilizing practices that are “damaging to the economic interests of consumers,” and requiring the “provision of the information necessary to enable consumers to make informed and independent decisions.”¹⁴² According to Consumers International, an NGO working to encourage their national implementation, the UNGCP aim is to provide a framework for consumer protection, advice, and support, which would enable consumers to operate confidently and effectively in a market economy.¹⁴³ Interestingly, the original draft of the UNGCP included a provision that would have required regulation of the marketing of products inappropriate to the dietary requirements and habits of developing countries.¹⁴⁴ The factors that led to the exclusion of the clause in the final version of the guidelines are not evident, however, from the public record.¹⁴⁵

¹⁴⁰ For a comprehensive overview of health and human rights, see S. Gruskin & D. Tarantola, *Health and Human Rights*, in OXFORD TEXTBOOK ON PUBLIC HEALTH 311-36 (R. Detels & R. Beaglehole eds., 2001), available at http://www.oup.co.uk/pdf/0-19-263041-5_04-1.pdf (last visited Nov. 16, 2005).

¹⁴¹ See Annex to Resolution WHA57.17 of the 57th Session of the World Health Assembly Passed on May 22, 2004 Adopting the Global Strategy on Diet, Physical Activity, and Health, at para. 8, available at http://www.who.int/gb/ebwha/pdf_files/WHA57/A57_R17-en.pdf (last visited Nov. 16, 2005); see also JOINT FAO/WHO CONSULTATION, *supra* note 11, at 1-7.

¹⁴² UN Guidelines for Consumer Protection, G.A. Res. 248, U.N. GAOR, 2d Comm., 39th Sess., 106th mtg. at 179, U.N. Doc. A/RES/39/248 (1985):

14. Governments should intensify their efforts to prevent practices which are damaging to the economic interests of consumers through ensuring that manufacturers, distributors, and others involved in the provision of goods and services adhere to established laws and mandatory standards. Consumer organizations should be encouraged to monitor adverse practices, such as the adulteration of foods, false or misleading claims in marketing and service frauds.

20. Promotional marketing and sales practices should be guided by the principle of fair treatment of consumers and should meet legal requirements. This requires the provision of the information necessary to enable consumers to take informed and independent decisions, as well as measures to ensure that the information provided is accurate.

21. Governments should encourage all concerned to participate in the free flow of accurate information on all aspects of consumer products.

¹⁴³ CORINNA HAWKES, *MARKETING FOOD TO CHILDREN: THE GLOBAL REGULATORY ENVIRONMENT* 54 (WHO 2004); see J. Edwards, *The Implementation of the UN Guidelines for Consumer Protection: Speech to United Nations Conference on Trade and Development* (Feb. 2003), at <http://www.consumersinternational.org/Templates/News.asp?NodeID=89695&int1stParentNodeID=89645&int2ndParentNodeID=89645> (last visited Apr. 25, 2005).

¹⁴⁴ HAWKES, *supra* note 143, at 54.

¹⁴⁵ *Id.*

Article 19(2) of the International Covenant of Civil and Political Rights, protecting the freedom to seek, receive, and impart information and ideas of all kinds,¹⁴⁶ calls for governments to ensure that their citizens receive balanced information about the health risks of consuming certain foods. The UN Special Rapporteur on Freedom of Opinion and Expression has affirmed the obligation of private bodies to disclose information relating to crucial public interests, including health.¹⁴⁷ The food industry predictably would resist restrictions on marketing, labeling, and advertising on the notion that Article 19(2) protects its freedom of expression, but Article 19(3) further explains that the exercise of the rights covered by Article 19(2) carries “special duties and responsibilities,” including compliance with certain restrictions provided by law that are necessary for the protection of public health.¹⁴⁸ Legal scholars have construed Article 19(3) to embody the “general duty to present information truthfully, accurately, and impartially.”¹⁴⁹ To the extent that the food industry’s advertisements, labels, or marketing practices are misleading or deceptive,¹⁵⁰ restrictions on these activities would be consistent with Article 19(2).

Finally, the UN Convention on the Rights of the Child (UNCRC) offers special measures of protection for the world’s children.¹⁵¹ The UNCRC recognizes that by virtue of their age and maturity, children are vulnerable and require protection.¹⁵² Article 17 states that Parties shall: “Encourage the development of appropriate guidelines for the protection of the child from information and material injurious to his or her well-being.”¹⁵³ The UNCRC requires that Member States undertake administrative measures to implement the articles contained in the Convention.¹⁵⁴

Thus, the WHO’s legal authority to issue binding standards concerning food marketing, composition, and other measures advocated by the Global Strategy is supported in the WHO’s Constitution and given additional normative weight by expressions of governmental obligations articulated in various human rights compacts. Defining the WHO’s authority to issue regulations, and/or enter into conventions, codes, and agreements concerning diet- and inactivity-related disease is only the first step in analyzing how the WHO can address the weaknesses contained in the Global Strategy. As will be demonstrated in the last section, a WHO-based regulatory regime does not have to include the inflexible elements of traditional command-and-control regulation, nor does it necessarily infringe on consumer or national sovereignty. The underlying point is that some form of international regulation is necessary in light of the global nature of diet- and inactiv-

¹⁴⁶ International Covenant on Civil and Political Rights, art. 21, G.A. Res. 2200, U.N. GAOR, 21st Sess., Supp. No. 16, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171, 178, available at <http://daccess-ods.un.org/access.nsf/Get?Open&DS=E/CN.4/2000/63&Lang=E> (last visited Nov. 24, 2005).

¹⁴⁷ Report by the Special Rapporteur on the Promotion and Protection of the Right to Freedom of Opinion and Expression, U.N. ESCOR, 56th Sess., paras. 42, 44, U.N. Doc. E/CN.4/2000/63 (2000), available at [http://www.unhcr.ch/Huridocda/Huridoca.nsf/0/16583a84ba1b3ae5802568bd004e80f7/\\$FILE/G0010259.pdf](http://www.unhcr.ch/Huridocda/Huridoca.nsf/0/16583a84ba1b3ae5802568bd004e80f7/$FILE/G0010259.pdf) (last visited Nov. 24, 2005).

¹⁴⁸ International Covenant on Civil and Political Rights, *supra* note 146, art. 19, para. 3.

¹⁴⁹ Melissa E. Crow, *Smokescreens and State Responsibility: Using Human Rights Strategies to Promote Global Tobacco Control*, 29 YALE J. INT’L L. 209, 234 (2004); See MANFRED NOWAK, U.N. COVENANT ON CIVIL AND POLITICAL RIGHTS: CCPR COMMENTARY 351 (1993).

¹⁵⁰ See, e.g., Jon D. Hanson & Douglas A. Kysar, *Taking Behavioralism Seriously: Some Evidence of Market Manipulation*, 112 HARV. L. REV. 1420, 1451-57 (1999).

¹⁵¹ The UNCRC was adopted by the UN General Assembly in 1989 and came into force in 1990. Convention on the Rights of the Child, G.A. Res. 44/25, 44th Sess., U.N. GAOR, Supp. No. 49, annex, at 167, U.N. Doc. A/44/25 (1989), available at <http://www.unicef.org/crc/fulltext.htm> (last visited Nov. 24, 2005).

¹⁵² *Id.*; see also HAWKES, *supra* note 143, at 53.

¹⁵³ See Convention on the Rights of the Child, *supra* note 151, art. 17.

¹⁵⁴ HAWKES, *supra* note 143, at 53.

ity-related health problems, and the potential for existing rules to perpetuate and aggravate those problems. The WHO's structures and past experiences should be examined further in order to arrive at a workable legal model for strengthening national commitments, wielding more influence over the activities of TNCs, and balancing the interests of public health, international trade, and consumer sovereignty.

V. SPECIFIC APPROACHES FOR BINDING ACTION

The last section of this article examines different forms of WHO legal instruments and governance, focusing on the International Health Regulations, the Framework Convention on Tobacco Control, the Codex Alimentarius, and the International Code of Marketing of Breastmilk Substitutes as possible models to implement the Global Strategy. This discussion is limited to identifying the strengths and weaknesses of each model and to discussing tentative recommendations regarding future courses of action. The success of any WHO-centered framework will depend on its ability to foster increased transparency; to gain the confidence of Member Nations in the WHO's technical, surveillance, and response capabilities; and to improve coordination with other international bodies, especially the WTO. The effectiveness of each model also will depend on its adaptability to population- or country-specific needs, to the extent that will promote national acceptance of increased WHO intervention in this area or allay concerns about national sovereignty.

A. *Framework Convention Model*

Even though the WHA is empowered, under Article 19 of the Constitution, to adopt conventions or agreements "with respect to any matter within the competence of the Organization," the WHO typically has declined to utilize this regulatory function except for formal and administrative matters, preferring a technical or policy approach to global public health problems. That position changed dramatically in May of 2003 when the 56th WHA adopted the WHO Framework Convention on Tobacco Control (FCTC).¹⁵⁵ The WHO has long viewed the health burden of tobacco consumption as an epidemic of a communicated disease, and the tobacco industry and its commercial practices as the vector of that disease. The WHO's historical approach to tobacco regulation was to encourage countries to adopt national laws and regulations to control tobacco consumption. By 1994, it was evident that this approach had failed and that international regulation clearly was needed to address certain aspects of the global marketing and commercialization of tobacco products and their use in order to address their health impact.¹⁵⁶ The growing threat of global pandemics involving noncommunicable diseases caused by tobacco consumption produced enough political will for the WHO to propose an international framework convention for tobacco control.

The WHA's decision to adopt the framework convention-protocol model for tobacco resulted primarily from the political obstacles that could have prevented a global consensus on the more binding commitments embodied in a conventional treaty.¹⁵⁷ The predictable opposition of the tobacco industry also was expected to undermine support for a treaty. In light of these concerns and other political factors, the WHO's advisors

¹⁵⁵ WHA56.1 (2003). The FCTC entered into force in Feb. 2005.

¹⁵⁶ See VIGNES & BURCI, *supra* note 93, at 126.

¹⁵⁷ The perceived economic dependence of some 120 nations, including 90 developing countries, on tobacco production for employment and revenue made their governments especially unlikely to favor a treaty without assurances of an alternative source of income. See Crow, *supra* note 149, at 210.

recommended an incremental approach to setting international standards.¹⁵⁸ A framework convention is designed as a compromise solution between a purely recommendatory instrument and a single convention, so as to engage countries in an “incremental and flexible normative exercise” in a novel area.¹⁵⁹ Member Nations first adopt a framework convention that calls for international cooperation in realizing broadly stated goals, and, ideally, parties to the convention will conclude separate protocols containing specific measures designed to implement those goals. Multilateral environmental organizations have used this model to foster international agreement on pollution control measures and to overcome the resistance of powerful commercial interests.¹⁶⁰ The FCTC protocols will deal with tobacco advertising, promotion, and sponsorship; tobacco-product regulation; illicit trade in tobacco; and liability.¹⁶¹

The FCTC will be a major test of the WHO’s willingness and capacity to adopt future Article 19 legislation. On the one hand, the passage of the FCTC points to the effectiveness and potential for international lawmaking to regulate the activities of transnational food and beverage companies.¹⁶² In adopting the FCTC through the WHA, Member Nations were able to overcome heavy resistance from industry, collectively succeed where individual countries had failed, and create global norms of tobacco control.¹⁶³ At the same time, this does not necessarily mean that Member Nations will submit more willingly to WHO-based treaties in the future. Allyn Taylor, one of the WHO’s legal advisors, predicts that governments’ evaluations of the WHO are unlikely to depend on the substantive outcome of the FCTC.¹⁶⁴ Rather, the willingness of nations to use the WHO as a “platform, catalyst, and coordinator” for international health law negotiations in the near future may depend on governments’ final evaluations of the WHO’s effectiveness as manager of the FCTC negotiations and, potentially, the treaty regime.¹⁶⁵ In other words, governments may evaluate the WHO’s leadership capacity in the near future based on their perception of whether the WHO was able to serve as an “honest broker” in the process of negotiating the treaty.¹⁶⁶

Considering the parallels that exist between tobacco and food, the WHO should consider using the FCTC approach to carry out the objectives of the Global Strategy. Both tobacco and food require comprehensive multisector approaches at global and national levels. Increased consumption of foods high in sodium, sugar, and fat is a risk

¹⁵⁸ *Id.*

¹⁵⁹ VIGNES & BURCI, *supra* note 93, at 127. The framework convention model also can establish an organizational and procedural basis to develop new standards through deliberative processes, thereby providing a stronger basis for mutual trust.

¹⁶⁰ See FIDLER, INTERNATIONAL LAW AND PUBLIC HEALTH, *supra* note 78, at 189.

¹⁶¹ WHO *Framework Convention on Tobacco Control*, WHO Doc. A56/8, Annex. 8, available at http://www.who.int/entity/tobacco/framework/WHO_FCTC_english.pdf (last visited Nov. 24, 2005).

¹⁶² The WHO’s advisors point out that “the ability of international organizations to encourage and assist nations in overcoming powerful and organized industry resistance to regulation is evidence of the important role that international law-making could play in efforts to regulate the activities of transnational tobacco conglomerates.” See Allyn L. Taylor & Ruth Roemer, *International Strategy for Tobacco Control*, WHO Doc. WHO/PSA/96.6 (1996).

¹⁶³ For an analysis of the role of transnational tobacco corporations in attempting to influence the FCTC, see WHO, TOBACCO COMPANY STRATEGIES TO UNDERMINE TOBACCO CONTROL ACTIVITIES AT THE WORLD HEALTH ORGANIZATION (2000), available at http://www.who.int/entity/tobacco/en/who_inquiry.pdf (last visited Nov. 24, 2005).

¹⁶⁴ See Allyn L. Taylor, *Governing the Globalization of Public Health*, 32(3) J.L. MED. & ETHICS 506 (2004). Taylor explains the substantive outcome to include “whether the proposed convention and its protocols are relatively effective or ineffective in combating the epidemic, or even if the FCTC is ever adopted or entered into force.”

¹⁶⁵ “In other words, whether WHO provided the administrative coordination, public health expertise and legal skill necessary for complex, multilateral negotiations.” *Id.*

¹⁶⁶ *Id.*

factor for diet- and inactivity-related diseases, and marketing practices targeted toward increasing a nation's taste for and dependence on these products can be viewed equally as "vectors" of those diseases. The incremental standard-setting approach would enable the WHO to build increasing political support for binding international food regulation. In the meantime, the WHO could pursue targeted protocols, such as international cooperation on information sharing and data collection, and gradually build a comprehensive, technical body of knowledge on the effectiveness of different regulatory systems. Should the WHO choose to pursue other forms of legislation, such as labeling or marketing regulations under Article 21, or assert its diet-related health agenda into international trade governance, its expertise in these areas would heighten its bargaining power and its international reputation.

The initial stages of this model would be similar to the current Global Strategy in stating broad objectives, but at least would commit countries legally to future binding legal commitments of increased scope and generate greater national accountability. The WHO could mandate regular and institutionalized meetings of participating governments, drawing public attention to the issues and pressuring Member Nations to adhere to their commitments. To further minimize political resistance, the WHO could consider scaled-down framework conventions for singular issues (e.g., reducing the incidence of childhood obesity), and require countries to commit to even narrower objectives. Because the Global Strategy already is a recognition by Member Nations that obesity and diet- and inactivity- related disease is a matter entirely within the WHO's competence, there should be no legal ambiguity concerning the WHO's authority to adopt a convention for food marketing, labeling, and other aspects of the Global Strategy.

The drawbacks to using the FCTC model for food mainly stem from the practical difficulties and major time lag associated with adopting a convention. The convention-protocol approach calls for at least two rounds of international negotiation and national ratification. Adoption of an Article 19 convention requires a two-thirds majority vote from Member Nations, and the entry-into-force for each country also depends on its acceptance in accordance with its "constitutional process."¹⁶⁷ By the time a convention enters into force, it may have lost its relevance. In the worst case, using the FCTC model to implement the Global Strategy would allow governments to relieve public pressure for action without resolving to take concrete steps to adopt obesity reduction or preventive measures, would tie up WHO resources in highly politicized negotiations, and would undermine stakeholder confidence in the WHO's ability to tackle public health issues through international law. A framework convention model is worth consideration, however, as the WHO would be able to draw lessons from negotiating the current FCTC, and theoretically already has generated Member Nation commitment for the initial stages of such a convention through the Global Strategy.

B. International Health Regulation Model

The WHO has exercised its power to issue binding regulations under Article 21 only twice in its existence. The first of these were WHO Regulations No. 1 regarding nomenclature with respect to diseases and causes of death, which was adopted under Article 21(b). The second, the International Health Regulations (IHRs), were drafted in 1951 under Article 21(a) as an attempt to combat the global spread of communicable diseases by requiring countries to develop comprehensive surveillance and reporting programs, as well as to establish particular procedures in the event of an outbreak of a covered infectious disease.¹⁶⁸

¹⁶⁷ WHO CONST. art. 19.

¹⁶⁸ See VIGNES & BURCI, *supra* note 93, at 132-35.

Over the years, commentators have criticized the IHRs for being too narrowly focused and ineffective due to inadequate national surveillance capabilities and a reluctance of Members to report disease outbreaks for fear of economic repercussions.¹⁶⁹ Although Article 62 of the WHO Constitution requires that each Member must report annually on agreements, recommendations, and regulations,¹⁷⁰ the WHO traditionally has been circumscribed in its ability to challenge information submitted by nations, to compel the submission of additional information, or to publicly disseminate that information.¹⁷¹ In addition, despite the inclusion of a dispute resolution mechanism in its regulations, the WHO lacks the legislative and constitutional power necessary to sanction Member States for violations of the IHRs.¹⁷² As a result of these concerns, the WHA requested the WHO to revise the IHR, and recently approved a new set of IHRs.¹⁷³

Two aspects of the revised IHRs should be highlighted because of their potential to impact, at least indirectly, the possibility of using the IHRs model to address the analogous threat of noncommunicable diseases. One important provision in the new IHRs broadens Member Nation reporting obligations to reporting on any public health emergencies of international concern, which includes the danger arising from noninfectious risks (e.g., toxins and chemicals) that could spread to other countries through the transport of goods.¹⁷⁴ In terms of the Global Strategy, this model might be expanded to require Member Nations to submit data on diet and health, thus enabling the WHO to better gauge the effectiveness of diverse public health programs to promote better dietary practices. The WHO also could use this global reporting framework to monitor the food industry's marketing and advertising practices. The WHO could disseminate this information to Member Nations in its *International Digest of Health Legislation*.¹⁷⁵ As Member Nations increasingly partake in information sharing and surveillance in an open process, they may become more aware of the interconnectivity of public health conditions and more willing to implement global regulatory solutions.

Another significant aspect of the revised IHRs reflects the WHO's effort in making the IHRs more consistent with the WTO trade agreements, in order to establish a normative, conceptual, and operational approach that would respond to developing health threats and global trade trends. During the revision process, the WHO and the WTO considered synergizing the IHRs with the WTO Sanitary and Phytosanitary (SPS)¹⁷⁶ agreement by increasing the legal recognition of WHO directives in the SPS process.¹⁷⁷ While the new IHRs lack explicit provisions that attain this result, they do call upon Member Nations to recognize that the IHRs and other relevant international agreements should be interpreted so as to be compatible,¹⁷⁸ and to consider the risk of international

¹⁶⁹ The IHRs currently in force are limited to only three diseases (i.e., yellow fever, plague, and cholera).

¹⁷⁰ WHO CONST. art. 62.

¹⁷¹ 1 & 2 DAVID LEIVE, INTERNATIONAL REGULATORY REGIMES, at Introduction (1976).

¹⁷² There is no constitutional sanction in the event a Member Nation is charged by another Member with failure to enforce an international regulation. The principle "enforcement sanction" is the mutuality of interest of its Member Nations in the global observance of agreed minimum protective standards. See FIDLER, INTERNATIONAL LAW AND PUBLIC HEALTH, *supra* note 78, at 94.

¹⁷³ See WHA 58.3 (2005).

¹⁷⁴ See WHO, Frequently Asked Questions on the Proposed Revision of the International Health Regulations, at www.who.int/csr/ihr/howtheywork/faq/en/print.html (last visited Nov. 16, 2005).

¹⁷⁵ The WHO makes available texts and summaries of health legislation of the world in its unique *International Digest of Health Legislation*, published quarterly in English and French.

¹⁷⁶ The SPS Agreement allows Member Nations to exceed international standards when it is necessary to protect health. Overlap between the SPS Agreement and the IHRs occurs in the area of contaminated goods, chiefly food that could affect human health.

¹⁷⁷ See *Managing Urgent International Public Health Events With the Revised International Health Regulations*, G/SPS/GEN/179, para. 44.

¹⁷⁸ WHA 58.3, art. 57.

travel or trade restrictions in the process of determining whether events are public health emergencies of international concern.¹⁷⁹ The synergy of WHO and WTO Member State obligations in the area of food safety still might occur in the future. Given that possibility, it would not be inconceivable to apply the same synergistic approach, by analogy, to other food-related WHO regulations and WTO agreements. In terms of the Global Strategy, this collaborative model could be used to synergize Member Nation obligations under the TBT Agreement and any food composition, labeling, and related provisions issued under Articles 21(d) and (e).

Notwithstanding the result of the WHO's effort to deal with the threat of communicable diseases under the revised IHRs, uniform, automatically-binding regulations could serve as viable legal mechanisms to address obesity and other diet- and inactivity-related health threats. International standards in nutritional labeling or food packaging, issued under Article 21(d), would harmonize conflicting regulations on the basis of best practices, and would enable the world to distinguish which "technical" measures truly are trade barriers in disguise. Hopefully, this would reduce trade disputes and, more importantly, reverse the health-undermining effects of global trade compacts like the GATT and the TBT Agreement. The WHO also could use Article 21(e) to impose marketing restrictions on the advertising of unhealthy food items to children, minimizing the problem of crossborder interference with national advertising restrictions.¹⁸⁰ As Article 21 regulations would be automatically binding on Member Nations, theoretically this approach would avoid the compliance, delay, and ratification problems associated with Article 19 conventions and Article 23 recommendations.

Given the political resistance that would arise in response to an attempt to set binding standards, however, it could take years for the WHO to develop a set of international regulations. Even if the WHA was willing to approve such standards, Member Nations might refuse to comply as if they were not bound in the first place or might make excessive reservations under Article 22. The WHO still would lack the legal enforcement mechanisms necessary to sanction Member Nations who fail to comply with the regulations.¹⁸¹ Based on the WHO's experience in interpreting and administering the former IHRs, the end result may be that a formally binding legal regulation will have the same practical effect as a recommendation.¹⁸² The WHO's use of Article 21 as a means of legally adopting the Global Strategy's recommendations might best be reserved for a time when enforcement and sanction provisions have been incorporated into the WHO Constitution, or at least when the WHO has developed fully and has proven its capacity to address communicable diseases to Member Nations under the newly-revised IHRs.¹⁸³

¹⁷⁹ See *id.*, Annex 2.

¹⁸⁰ Commercial Alert has called for the WHO to ban the advertising of food items to children under age 12. See Statement on Junk Food Marketing to Children, at <http://www.commercialalert.org/junkfoodstatement.pdf> (last visited Apr. 25, 2005).

¹⁸¹ The WHO Constitution does not provide for any sanction against a member nation that fails to comply with a binding regulation enacted under Article 21. The old IHRs allowed any concerned Member Nation to refer IHRs-related disputes to the International Court of Justice (ICJ), but this procedure was seldom used. The new IHRs have replaced this procedure with the option to submit disputes to arbitration in accordance with the Permanent Court of Arbitration Optional Rules for Arbitrating Disputes Between States. See WHA 58.3, art. 56.

¹⁸² According to Leive,

[T]he approach currently employed by the WHO in the application and interpretation of its IHR is not to utilize every power or every measure of authority but to adopt a more modest, flexible and pragmatic approach. In dealing with noncompliance, for example, [the] WHO places principal emphasis upon persuasion and use of its good offices to resolve problems. In this sense, many legally binding Regulations tend to be treated in practice almost as recommendations.

LEIVE, *supra* note 171, at 46.

¹⁸³ Interestingly, during the 1998 review of the Constitution, a proposed amendment to Article 2 included an explicit role for the WHO in "monitoring" the health policies of Member States. See EB103/14 (1998), available at http://ftp.who.int/gb/pdf_files/EB103/ee14.pdf (last visited Nov. 24, 2005).

C. *The Codex Alimentarius Commission Model*

Another model for WHO-based reform comes from within the Codex Alimentarius Commission. Formed in 1961 by the Food and Agriculture Organization (FAO) and the WHO, the Codex Alimentarius Commission sets international food standards, with the twin aims of protecting consumer health and promoting fair trade practices. The Codex Alimentarius is an extensive code that addresses a broad range of food production issues including food additives, limits on pesticide residues, food labeling requirements, food composition, recommendations on food processing techniques, and suggested inspection procedures regarding food products and production.¹⁸⁴ Food standards are developed by subsidiary committees, then adopted by the Codex and promoted to nations for their acceptance. As a committee develops or modifies a standard, Member countries and properly credentialed nongovernment organizations (NGOs) can comment freely on the standard. Before 1995, Codex standards were mainly voluntary measures that governments might take into account. Following the Uruguay round of GATT negotiations, Codex's role changed to one with binding authority,¹⁸⁵ and the Commission was transformed from a little-known body with minimal impact to a body with the power to influence national law-making.¹⁸⁶

The linkage between Codex standards and the WTO has diverted the focus of the Commission from health to trade considerations. Codex statutes emphasize the advisory nature of the Commission's work with reference to its two co-sponsoring organizations, but this link has become progressively more tenuous over time. The submission of reports to the governing bodies of the FAO and the WHO, required under Article 5 of the statutes, for example, does not actually take place.¹⁸⁷ The standard-setting process seems to present a unique "democratic" setting in which industry representatives, government officials, and NGOs can negotiate and forge a unified position, but in practice, the distribution of influence is weighted heavily to reflect industry concerns.¹⁸⁸ The composition of national delegations in Codex meetings increasingly reflects the commercial importance of Codex decisions, as does the increasing difficulty in the negotiation of general principles for the elaboration of standards. Proceedings of the Commission often have turned into trade battlegrounds and forums for deregulation where decisions tend to reflect political compromises designed to promote international trade at the expense of human health. In one example, Codex approved, with the acquiescence of the United States, a maximum residue level for methyl parathion (and other

¹⁸⁴ Codex establishes international food standards through its 14 subsidiary committees and eight broader committees that deal with more general subjects, such as the Codex Committee on Food Additives and Contaminants.

¹⁸⁵ As discussed in Part II, the WTO Agreements establish an obligation on states to use relevant standards concerning food safety, packaging, and labeling developed by appropriate international organizations as a basis for national regulations affecting internationally-traded goods. This obligation converts standards developed by the Commission, which the organizations themselves do not regard as binding, into mandatory obligations for members of the WTO. See Fluss et al., *supra* note 2, pt. IV, chap. 2, Intergovernmental Organizations.

¹⁸⁶ See, e.g., Bruce A. Silverglade, *The Impact of International Trade Agreements on U.S. Food Safety and Labeling Standards*, 53 FOOD & DRUG L.J. 537, 537-41 (1998). The author argues, "the SPS Agreement, as it is being implemented, is resulting in 'downward harmonization' of health and safety standards in several areas." See *id.* at 539.

¹⁸⁷ VIGNES & BURCI, *supra* note 93, at 83.

¹⁸⁸ See Lucinda Sikes, *FDA's Consideration of Codex Alimentarius Standards in Light of International Trade Agreements*, 53 FOOD & DRUG L.J. 327, 328-32 (1998) (arguing that Codex's mandate to protect food safety conflicts with its goal of promoting trade, that countries with strict food safety laws can be out-voted at Codex, which makes some decisions by majority vote, and that public participation at Codex is poor).

pesticides) even though two months later the U.S. Environmental Protection Agency (as mandated under U.S. law) banned methyl parathion for fruits and vegetables because of its potential adverse effects on children.¹⁸⁹

Despite Codex's shift to resemble an industry-driven trade body, its relationship to its two parent organizations and its public health objectives mandate a significant role for Codex in terms of the Global Strategy. Codex's purpose to protect consumers from unsafe food and fraudulent practices also is tied to consumer protection values articulated in UN compacts.¹⁹⁰ The WHA's resolution endorsing the Global Strategy specifically calls on Codex to play a major role in advancing its objectives.¹⁹¹ The WHO commissioned a report to examine this possibility. The consultant's report recommended sweeping changes to the code as part of the fight against the global obesity epidemic, including setting maximum limits on fat and salt content; developing codes to limit food and drink commercials during children's television programs; and establishing a new Codex Task Force for Good Nutrition Practices.¹⁹² The WHO's official response to this report was requested at the February 2005 meeting of Codex's Executive Committee.¹⁹³ The Executive Committee also agreed to ask the WHO, in cooperation with the FAO, to prepare a document highlighting the action that could be taken by Codex, in the framework of its mandate, to facilitate the implementation of the Global Strategy.

Both substantive and procedural reforms can be used to integrate the Global Strategy's objectives into Codex governance, and into international trade law generally. The most direct approach would require the Commission to adopt new labeling, marketing, and/or composition standards in accordance with the recommendations of the Global Strategy. By virtue of Codex's significant role in the WTO framework, this would encourage Member Nations to apply higher standards and could reverse the downward trend of international harmonization. The disadvantages of this approach arise from the necessity of using Codex machinery to obtain this result. In advocating for higher Codex standards, the WHO would be mired in a lengthy, politically-charged controversy and would risk alienating Member Nations. As the campaign would require the WHO's

¹⁸⁹ See Bruce A. Silverglade, *The WTO Agreement on Sanitary and Phytosanitary Measures: Weakening Food Safety Regulations to Facilitate Trade?*, 55 FOOD & DRUG L.J. 517, 521 (2000). Similarly, Codex approved a maximum level for aflatoxin, a naturally-occurring carcinogen produced by a mold that grows on peanuts of 15mg/kg. That level was higher than the level sought by the European Union and represented a compromise with the United States, which permits greater amounts of aflatoxin in peanuts for further processing. See JOINT FAO/WHO CODEX ALIMENTARIUS COMMISSION, REPORT OF THE TWENTY-THIRD SESSION 102 (June 1999), available at <http://www.fao.org/docrep/meeting/005/X2630E/X2630E00.htm> (last visited Nov. 24, 2005).

¹⁹⁰ Codex can be seen as a response to the information asymmetries between buyers and sellers of food products for human consumption, such as the inability of a buyer to detect some health risks by visual inspection alone, compared with the seller's knowledge of the conditions of processing. See LEIVE, *supra* note 171, at 585.

¹⁹¹ WHA 57.17. The Global Strategy recommends the following areas of further development: labeling to allow better information about the benefits and contents of foods; measures to minimize the impact of marketing on unhealthy dietary patterns; and production and processing standards regarding the nutritional quality and safety of products.

¹⁹² See CODEX ALIMENTARIUS VIS-A-VIS THE WHO GLOBAL STRATEGY ON DIET, PHYSICAL ACTIVITY, AND HEALTH—FOOD STANDARDISATION TO SUPPORT THE REDUCTION OF CHRONIC DISEASES (2004), at <http://www.cspinet.org/reports/WHOGlobalStrategyCODEX.pdf> (last visited Nov. 16, 2005).

¹⁹³ The WHO Representative at this meeting informed the Committee that a report on the implementation of the Global Strategy in Codex had been prepared by a consultant to assist in the discussion within the WHO and currently was under consideration, but that it did not represent WHO policy. The Committee expressed its interest in being informed about the WHO position, when finalized, on the recommendations in the report. REPORT OF THE FIFTY-FIFTH SESSION OF THE EXECUTIVE COMMITTEE OF THE CODEX ALIMENTARIUS COMMISSION (Rome, Feb. 2005), available at http://www.codexalimentarius.net/download/report/629/al28_03e.pdf (last visited Nov. 24, 2005).

involvement in Codex's nontransparent, industry-dominated standard-setting procedures, the WHI will become vulnerable to accusations of interest group capture and secret political compromise from all sides.

Another option builds on the report's suggestion that an independent task force or committee be formed to focus specifically on nutrition issues. The WHO could go further and establish an Expert Panel that would issue official opinions in trade disputes involving public health laws conflicting with (i.e., exceeding) Codex standards. Such a committee would be familiar with the different regulatory options contained in the Global Strategy; would be attuned to current nutrition-based codes, practices, and laws; and would have working relationships with regional and national governmental health authorities. During the sixty-day consultation process of a trade dispute, the Expert Panel would issue a preliminary "health impact statement" assessing the impact of particular food standards on the health of national or local populations. If countries wished to continue their dispute before a formal WTO dispute panel, the Expert Panel's findings would be given deference as if it were a lower court opinion. The WTO's Understanding on Rules and Procedures Governing the Settlement of Disputes (Understanding) provides one possible entry point for introducing this procedure in WTO governance. WTO Dispute Settlement Panels may seek an advisory report from an expert review group with respect to any factual technical or scientific matter raised by a party to a dispute.¹⁹⁴ In Codex-related trade disagreements, the WHO Expert Panel might come to be recognized as *the* certified expert review group.

This "judicial" model would introduce the health objectives of the Global Strategy as factors for consideration in world trade disputes in a common-law like evolution process without requiring Member Nations to be bound to more health protective standards. Countries would have an easier time justifying their public health measures, which might foster more national implementation of the recommendations contained in the Global Strategy. The model also draws on the WHO's scientific and technical expertise, as the organization's regional infrastructure allows it to study health problems in local areas and to work closely with local governments. Much like the Framework Convention-Protocol approach, implementation of the Global Strategy would progress in an incremental fashion approximating political acceptance for the Global Strategy as more and more national governments passed stricter marketing or labeling laws conflicting with Codex standards.

At the same time, this mode of reform requires the Global Strategy's goals to be achieved in a slow, common-law like fashion and does not create incentives for Member Nations to adopt the Global Strategy's recommendations in the first place. Again, the WHO would find itself involved in nontransparent, closed processes, as both the consultation phases and the WTO Dispute Resolution Panels are not open to the public or to attendance by interested third parties.¹⁹⁵ The success of the model also is somewhat dependent on the WTO's view of the WHO's expertise in such matters, and the legal recognition that would be accorded to the Expert Panel's opinion. As the WHO and the WTO explore synergy in other areas of mutual cooperation (e.g., the joint effort to harmonize the IHRs with the SPS Agreement), this model may have more potential.

¹⁹⁴ Article 13 of the Understanding states that "panels may seek information from any relevant source and may consult experts to obtain their opinion on certain aspects of the matter. With respect to a factual issue concerning a scientific or other technical matter raised by a party to a dispute, a panel may request an advisory report in writing from an expert review group." See http://www.wto.org/english/docs_e/legal_e/legal_e.htm for the text of the Dispute Settlement Understanding (last visited Nov. 16, 2005).

¹⁹⁵ *Id.* art. 12.

D. Code of Practice Model

The WHO's setting of a wide variety of recommendations and other nonbinding standards generally is viewed as its most successful normative activity. Purely recommendatory documents have proved to be adaptable to very different national circumstances and have commanded compliance and adherence through their technical or political soundness. This may be one reason why the WHO favored nonbinding instruments even for issues that could have been the subject of regulations under the Constitution.¹⁹⁶ The WHA has explicitly placed its recommendations under Article 23 in only a few instances.¹⁹⁷ From a legal perspective, the invocation of Article 23, or lack thereof, does not change the recommendatory nature of the decision. The only legal difference is that, with regard to recommendations adopted explicitly under Article 23, countries would be under an obligation to report annually under Article 62 of the Constitution. Such a strict reporting requirement has never been enforced in practice, however, rendering the difference even more insubstantial.¹⁹⁸

The International Code of Marketing of Breastmilk Substitutes is the WHO's most controversial and significant recommendation for the purposes of this discussion. The Code arose out of concerns that breastmilk substitute marketing strategies were leading, directly and indirectly, to death, sickness, and severe malnutrition of infants in developing countries.¹⁹⁹ The Code contains guidelines for marketing products that, among other things, require warning labels, prohibit the use of infant pictures and the distribution of samples to pregnant or lactating mothers, and disallow gifts to hospitals and other healthcare personnel.²⁰⁰ The infant-food industry was particularly aggressive in its attempt to influence the WHO during the process of the Code's preparation, but the WHO was careful to not take sides in the controversies that prevailed at the time between the various interested parties.²⁰¹ Despite facing serious opposition from the infant-food industry in the form of a hostile media campaign, and from a U.S. government concerned with WHO intervention in an area of commercial importance, the WHO obtained significant support for the Code by the time it was presented for approval.²⁰²

The WHO's experience in adopting this recommendation in the form of a Code appears to be yet another missed opportunity to apply and develop its available legal instrumentalities. There have been many alleged violations of the Code on the part of manufacturers and distributors of breastmilk substitutes.²⁰³ Even though the Code could have been adopted under Article 21(e), the Board was concerned that the WHA would not accept a binding regulation. The WHO's legal adviser made it clear that breastmilk

¹⁹⁶ VIGNES & BURCI, *supra* note 93, at 141.

¹⁹⁷ *Id.* at 142.

¹⁹⁸ *Id.*

¹⁹⁹ The use of breastmilk substitutes denies the mother an emotional link with her baby, while depriving the infant of the immunity against diseases. Its unnecessary and improper use has caused health problems, has led to the death of thousands of infants in the developing world, and has caused great financial strain to families. SAMI SHUBBER, INTERNATIONAL CODE OF MARKETING OF BREAST-MILK SUBSTITUTES 1 (Kluwer Law Int'l 1998).

²⁰⁰ See INTERNATIONAL CODE OF MARKETING OF BREAST-MILK SUBSTITUTES, arts. 5, 6, 7, 9.

²⁰¹ SHUBBER, *supra* note 199, at 18-19.

²⁰² *Id.* at 39-40.

²⁰³ Advertising and promotion to the general public of products within the scope of the Code still continue in many parts of the world. See OVERVIEW OF BREAKING THE RULES, STRETCHING THE RULES 2004 (IBFAN 2004), available at <http://www.ibfan.org/english/pdfs/btr04summary.pdf> (last visited Nov. 16, 2005) (summarizing an International Baby Food Action Network (IBFAN) report analyzing the promotional practices of 16 transnational baby food companies and 14 bottle and teat companies between January 2002 and April 2004).

substitutes “fell precisely under Article 21 of the Constitution” because it was a “nutritional medicine.”²⁰⁴ Further, the Health Assembly itself had taken that position because in its resolution it had requested that a text be drafted either as a regulation in the sense of Articles 21 and 22 of the Constitution or as a recommendation.²⁰⁵

Perhaps realizing the inherent limitations of a voluntary code, the Board left the door open for the possibility of adopting the International Code as a regulation, some time later, if the Code was not effective in its operation as a recommendation. The WHO’s Director-General was requested to report to the 36th WHA on the status of compliance with and implementation of the International Code and to make proposals, if necessary, for revision of the text of the Code and for measures needed for its effective application.²⁰⁶ It seems that the Board intended the Code to move to a regulation if the recommendation format did not prove to be effective.²⁰⁷ The Director-General thought it was premature to propose any revision of the Code, however, and the position has not changed since that time.

The WHO should consider utilizing the Code of Practice model to address targeted issues like food marketing towards children or improved nutrition labeling requirements. The shortcomings of the Code in promoting compliance by manufacturers of breastmilk substitutes highlights the limitations of a nonbinding recommendation. Food corporations probably would have more interest in complying with a Global Strategy-directed Code than infant formula companies did following the adoption of the International Code on the Marketing of Breastmilk Substitutes. As a formal matter, Member Nations would have to implement the Code through domestic legislation and regulations before these companies could be bound legally, but industry compliance still could be generated through the Code’s public pressures. Public awareness of the obesity epidemic has generated extensive consumer awareness in making proper food choices. Unhealthy dietary trends have impacted the health of both developed and developing nations’ populations, at all age groups and income levels. Major international food and drink companies are beginning to take note of the limited legal actions already mounted against food companies. Investment analysts have gone so far as to advise food corporations that their shares are in danger of decline if they fail to address the public’s response to the obesity epidemic.²⁰⁸ Thus, food corporations might be willing to comply with a WHO-sponsored Code in order to distinguish their products from those of competing firms, and to guard against legal action.

The main limitations of the Code of Practice model stem from its voluntary nature, and its potential to disintegrate into a public relations tool for the food industry. Thus, the best course of action would be for the WHO to adopt the Code initially as a voluntary recommendation under Article 23, monitor its effectiveness in encouraging the food industry to adopt less harmful marketing practices, and then present the Code in the form of a binding regulation under Article 21 to the WHA in the event of low compliance. The lingering threat of binding regulations may spur food companies to make more efforts to comply with the Code, and to exert pressure on peer firms to comply. This scenario would allow the WHO to generate greater political acceptance and build a stronger case for a binding Code to the WHA. The model has the additional advantage of paralleling the recent approach

²⁰⁴ EB67/1981/REC/2, at 319.

²⁰⁵ WHA 33.32, ¶ 6(5).

²⁰⁶ See Resolution EB67.R12. See also WHA 34.22, ¶ 5(4).

²⁰⁷ See SHUBBER, *supra* note 199, at 33. One member of the Board stated that if the recommendation did not prove sufficiently effective, the Organization would have to move to a regulation.

²⁰⁸ See Jennifer Davies, *Food Industry Touts More Healthier Fare, But Is It?*, SAN DIEGO UNION TRIB., Feb. 13, 2005, at http://www.signonsandiego.com/uniontrib/20050213/news_1n13food.html (last visited Nov. 16, 2005).

taken by the European Union in regulating food marketing towards children.²⁰⁹ The action being undertaken by the European Union paves the way politically for a future, parallel international model and will serve as an important regional test case. Should the WHO choose to take this approach, the process of constructing the Code must take place in an open, deliberative, and neutral forum to guard against the charge of politicization and the industry tactics that occurred with the Breastmilk Substitute Marketing Code. Article 62's annual reporting requirement should be strictly enforced to assist the WHO in gauging the success or weakness of a voluntary code. This review process should assist the WHO in clarifying and strengthening the Code through new resolutions that keep pace with science and marketing.

V. CONCLUSION

Obesity and diet- and inactivity-related diseases threaten the health of populations in all parts of the world. No country can afford to ignore the burden of social and economic costs resulting from these diseases, nor can they deny shared responsibility in working towards improving the quality of diet in global populations. The Global Strategy on Diet, Physical Activity, and Health should be considered a groundbreaking—but not final—step in the mounting challenge posed by poor diets, inactivity, and obesity and overweight-related health conditions.

The WHO has classified the issue as a top priority but remains tentative in its perspective and unwilling to fulfill its legal responsibilities. The constitutional mandate of the organization includes a duty to address international health problems such as obesity through powerful legal instruments. The WHO and its constituent Member Nations also are obligated under human rights compacts and other sources of international law to achieve conditions that will lead to optimal health for their populations. The role of the WHO in this matter is of fundamental importance in light of its position as the authoritative international health agency within the UN system. An increased legal role for the WHO in this area is imminent in light of the need for an international organization to catalyze nonexistent national action, exert control over certain practices of transnational corporations, and advocate for domestic-health-promoting policies in international trade systems.

This article has outlined several options for the WHO to take in this regard. These models should not be viewed as mutually exclusive—it would be prudent for the WHO to explore a multipronged and flexible approach to address the complexity of diet- and inactivity-related diseases. The spectrum of regulation ranges from uniformly-imposed binding treaties to voluntary codes of practice, and includes familiar international law models as well as nontraditional solutions such as the use of the WHO as a judicial organ in international trade disputes. The probable success of each model depends on the outcome and evaluation of the Framework Convention on Tobacco Control and the revision of the IHRs because Member Nations will be more willing to accept the WHO's increased assertiveness in implementing the Global Strategy if the WHO is viewed as being neutral, technically competent, and responsive to changing conditions.

²⁰⁹ The food industry has been given a year to stop advertising junk food to children and improve product labeling or face possible legislation in the European Union. Markos Kyprianou, EU Health and Consumer Affairs Commissioner, hoped that the food industry would produce commitments by the end of 2005, or early 2006. *See Markos Kyprianou Urges Food Industry to Combat Obesity*, HEALTH & CONSUMER VOICE: NEWSLETTER ON FOOD SAFETY, HEALTH AND CONSUMER POLICY, Feb. 2005, at 2, available at http://europa.eu.int/comm/dgs/health_consumer/consumerveice/cv_22005_en.pdf (last visited Nov. 16, 2005).

Regardless of which legal strategy it decides to pursue, the WHO should begin to enforce Member Nation reporting requirements to obtain more information on the effects of current food marketing and labeling practices and to gauge the effectiveness of various national or regional regulatory policies. The WHO also should pursue narrower, targeted goals, such as increasing transparency and democratic participation in Codex proceedings, or clarifying the WHO's legal jurisdiction in international food regulations through a review of its Constitution. Progressive legal reform will move the WHO closer to the ideal envisioned by its founders—an organization dedicated to achieving the highest standard of health for all peoples.

