



International Association of
Consumer Food Organizations
(IACFO)

Association Internationale des
Organisations de Consommateurs
De Produits Alimentaires

Asociación Internacional de
Organizaciones de Alimentos
para el Consumidor

Internationaler Verband der
Nahrungsmittel Organisationen
für Verbraucher

Associazione Internazionale delle
Organizzazioni degli Alimentari
per il Consumatore

食品國際消費者機構

COMMENTS OF THE

INTERNATIONAL ASSOCIATION OF CONSUMER FOOD ORGANIZATIONS (IACFO)

ROUND-TABLE DISCUSSION ON THE *WHO GLOBAL STRATEGY ON DIET, PHYSICAL ACTIVITY, AND HEALTH*

GENEVA, SWITZERLAND

23 MARCH 2005

Good day. My name is Bill Jeffery. I am the Canadian national coordinator of the Centre for Science in the Public Interest. Today I am speaking on behalf of the International Association of Consumer Food Organizations, of which CSPI is a founding member. IACFO is a coalition of non-governmental organizations representing the consumer's interest in the United Kingdom, Japan, Singapore, the United States and my country. IACFO also works closely with NGOs representing consumers in developing countries. I am honoured to be invited here today to share our views.

IACFO congratulates the World Health Organization on the development of its *Global Strategy on Diet, Physical Activity, and Health* (the *Global Strategy*). The *Global Strategy* presents a blueprint for national public health authorities, food companies, and NGOs around the world who are committed to reducing the incidence of cardiovascular disease, cancer, diabetes, osteoporosis, obesity and other diet- and inactivity-related diseases. We agree that a multi-faceted approach involving all stakeholders is necessary to reduce the incidence of these diseases and make "the healthy choice the easy choice" for consumers.

The Government of Canada has been a staunch supporter of this WHO effort and just last month signed a bilateral agreement with the WHO committing technical and logistical collaboration in regards to the *Global Strategy*. A famous report of the Canadian government published nearly 25 years ago, called the *Lalonde Report* after the Minister of Health and Welfare of the day, the Honourable Marc Lalonde, is often credited with originating the notion of population health¹ and, of course, the *Global Strategy* cites

¹ Lalonde, Marc, *A New Perspective on the Health of Canadians*, (Ottawa: Supply and Services Canada, 1981).

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the *Ottawa Charter for Health Promotion*² as a conceptual pillar upon which the *Strategy* is based. As a Canadian, I am of course, encouraged by all of this, but it has been said that the Canadian government has been long on theory and short on practice when it comes to developing population health programs; it remains to be seen whether Canada will exceed the expectations associated with that dim view.

However, there are reasons to be optimistic. Last month, the Canadian federal government committed to spend \$210 million over five years on a chronic disease prevention strategy focussed on healthy eating, physical activity and health weights, and the federal government, working with the 13 provinces and territories (particularly British Columbia, Nova Scotia, Ontario, and Quebec) appears to have been working toward announcing a so-called “Pan-Canadian Healthy Living Strategy” in September 2005. We hope the Healthy Living Strategy will provide specific mechanisms for implementing many of the recommendations in the WHO’s Global Strategy.

I will now turn to the questions posed by the Director General.

1. How has IACFO progressed in the promotion of healthy lifestyles, better availability of healthy foods, and better possibilities for physical activity?

IACFO is an officially recognized observer at the Codex Alimentarius Commission and its committees. In that capacity, IACFO participates in a number of horizontal committees to help improve existing consumer health standards. This is especially important because the World Trade Organization (WTO) applies those standards in a manner that has significant implications for domestic food policies; national regulations that exceed Codex standards can be challenged as trade barriers and, thus, are discouraged under the WTO Agreement.

In particular, IACFO initiated a proposal in the Codex Committee on Food Labelling (CCFL) to expand standards governing percentage (quantitative) ingredient declarations on food labels to ensure, in part, that consumers are provided with useful information about the composition of processed foods containing fruits and vegetables and other ingredients identified in WHO *Technical Report 916* as having important causative or protective effects on chronic disease risks.

We are also urging the CCFL to develop standards for advertising food to children. And for a number of years, we have urged the Committee to consider setting a standard for nutrition labelling that permits national requirements for comprehensive mandatory nutrition labeling on all food packages (not just packages bearing nutrition claims). Since we became active in the Committee, a half dozen other countries have joined the United States in establishing mandatory nutrition labelling rules.

IACFO is also urging the Codex Committee on General Principles (CCGP) to help implement various recommendations in the *Global Strategy* by revising the *Code of Ethics for International Trade in*

² See Article 27 of the 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” (available on the Internet at: http://www.who.int/gb/ebwha/pdf_files/WHA57/A57_R17-en.pdf), hereinafter, the *Global Strategy*, and *Ottawa Charter for Health Promotion* and subsequent resolutions WHA51.2 (1998).

Food. We are also urging that committee to assume a leadership role in prompting a review of all Codex standards with a view to reforming them to facilitate national authorities' implementation of the *Global Strategy*.

IACFO's constituent-organizations have, collectively, more than one million members world-wide that have been informed about the initiatives advocated in the *Global Strategy*. Our members, in turn, mount national public policy campaigns aimed at all levels of government, coordinate the efforts of hundreds of other NGOs to support those campaigns, inform the media about the human and economic toll of chronic non-communicable disease and the public policy steps that must be taken to reduce that toll.

2. What further strategies or plans does IACFO have that coincide with or support the objectives of the WHO *Global Strategy on Diet, Physical Activity, and Health*?

The *Global Strategy* is a useful tool for marshalling support for public policy reform in our members' home countries. Our member organizations will continue to use it to advance our national efforts and we will continue to aide the WHO and the Codex Alimentarius Commission (and, resources permitting, other IGOs) to implement the *Strategy* through those fora. In Canada for example, Parliament is considering private member legislation that would require nutrition disclosures on menus of large chain restaurants. The recommendations in the WHO's *Global Strategy* play a significant role in helping advocate such measures at the national level.

3. How can the WHO form more effective partnerships across private and public sectors to support the implementation of the *Global Strategy on Diet, Physical Activity, and Health*?

(a) Engaging the assistance of other international governmental organizations

IACFO believes that national public health officials, the principal partners in WHO deliberations, must demonstrate leadership in coordinating national policy reforms in member countries by engaging other government ministries, health and scientific experts, civil society, and the food industry in pursuing the aims of the *Global Strategy*.³ The WHO can provide an impetus to mobilize those partners by exhorting other specialized agencies, institutes, commissions, programs, and departments within the United Nations system to redirect their resources, and their research and policy-making agendas toward pursuing aspects of the *Global Strategy* that are within their mandates. This is particularly true of the work of the Codex Alimentarius Commission which is itself, a subsidiary body of the WHO (jointly with the Food and Agriculture Organization (FAO)).

In particular, pursuant to recitals 3, 4, 5(4), 5(5) and 5(7) of resolution WHA57.17 of the Fifty-seventh World Health Assembly, and pursuant to the WHO's collaborative agreements already in place

³ See Article 44 of the 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" (available on the Internet at: http://www.who.int/gb/ebwaha/pdf_files/WHA57/A57_R17-en.pdf).

with many IGOs, we urge the Director General of the WHO to request the following activities be initiated by other institutions in the United Nations system to help achieve the objectives of the *Global Strategy*, with a view to reporting progress at least two months before the Fifty-ninth Session of the WHA:

- (i) **International Labour Organization (workplace occupational health research and standards):** Considering the enormous human and economic toll of diet- and inactivity-related disease, it is problematic that there is often limited access to nutritious foods, or food storage and cooking facilities at the workplace, and limited opportunities for physical activity. This is especially a problem where occupational requirements in mechanized, computerized, or hand-work preclude healthy disease-preventing human movement for extended periods during the work-day. “[P]rotection of the worker against sickness, disease... arising out of his [*sic*] employment” is one of the tasks assigned to the International Labour Organization (ILO) under its constitution,⁴ therefore that body has an important role to play in elaborating policy solutions to address these problems.

Accordingly, we urge the WHO to request, in accordance with Article 14(1) of the ILO Constitution, that the ILO prepare a discussion paper (with the assistance of the WHO) on the nature and extent of diet- and inactivity-related diseases associated with the workplace and recommendations for policy reforms to address this problem. We further urge the Director General of the WHO to request that the Director General of the ILO advise his Governing Body to consider initiating a process, at the earliest annual Conference practicable, to amend the *Occupational Safety and Health Convention, 19815* to help address the pressing global public health problems identified in the *Global Strategy*. To achieve that end, IACFO urges that the WHO signify its willingness to be invited to participate as a non-voting member in such deliberations pursuant to Article 12(2) of the Constitution of the ILO, and the collaborative agreement between the two specialized agencies.

- (ii) **Codex Alimentarius Commission (food standards review in relation to the *Global Strategy*):** Standard-setting by the Codex Alimentarius Commission is often guided by trade-facilitating aims rather than health-promotion. Instead, Codex standards should facilitate and encourage national authorities to be on the vanguard of health promotion and consumer protection.

Pursuant to the fourth recital of the *Global Strategy*, we urge the WHO to call on the Codex Alimentarius Commission and its constituent committees to undertake a review of Codex general and commodity-specific standards and guidelines to make recommendations for reforming those texts to help achieve, not undermine, the objectives set out in the *Global Strategy*. The WHO has already begun to explore such options.⁶

4 See the preamble to the Constitution of the ILO.

5 Pursuant to Article 28 of that *Convention*.

6 Alinorm 05/28/3, Report of the 55th Session of the Executive Committee of the Codex Alimentarius Commission, 9-11 February 2005, paragraphs 84 to 90. According to the Report of the 55th Session of the Executive Committee a report on the implementation of the *Global Strategy* by Codex had been prepared by a consultant to assist in the discussion within WHO, and was currently under consideration, although it had not been formally adopted as WHO policy. The consultant’s report is entitled: Rob Topp, *Codex Alimentarius vis a vis The WHO Global Strategy on*

For example, food-specific standards that require minimum amounts of salt or free sugars, or general standards that authorize mass marketing of breastmilk substitutes,⁷ ultimately impair the healthfulness of the food supply, and foster the consumption of nutrient-poor foods by infants.

- (iii) Codex Alimentarius Commission (WHO participation):** Furthermore, we urge that the WHO routinely send expert officials to pertinent Codex Commission and committee hearings and charge them with actively asserting the importance of health protection, health promotion and the *Global Strategy* in all applicable agenda item discussions. This step will require directing WHO staff to intervene more frequently in specific debates over particular standards at Codex meetings, rather than just making introductory remarks and observing the proceedings.
- (iv) UNICEF and the Office of the United Nations High Commissioner for Human Rights (rights and capacities of children in relation to commercial advertising):** The *Global Strategy* states that food and beverage advertisements should not “exploit children’s inexperience or credulity.”⁸ The United Kingdom Food Standards Agency commissioned a systematic review of peer-reviewed, published and gray literature examining the nature and effects of food advertising on children.⁹ However, according to a WHO report, the only three jurisdictions with legislated prohibitions on advertising directed at children (Sweden, Norway, and Quebec, Canada¹⁰) premise their legislation on the proposition that advertising directed at children is inherently misleading and unconscionable because children are incapable of interpreting commercial advertisements for *any* products.

Therefore, IACFO requests that the WHO ask these governmental bodies to prepare a discussion paper on the rights of children to be free from exposure to commercial advertising, most of which promotes foods of minimal nutritional value, and products and services that discourage active play. Most national governments already prohibit misleading commercial advertising; however, they do not take into account differing capacities of children to comprehend advertisements that may only appear non-misleading to adults. As such, IACFO further urges the WHO to direct these agencies to commission and publish an expert analysis of developmental psychology literature concerning the capacity of children to interpret commercial advertising.

- (v) UNICEF and UNESCO (school health):** IACFO urges the WHO to request UNICEF and UNESCO to prepare a discussion paper and model recommendations (perhaps in cooperation with the Codex Committee on Nutrition and Foods for Special Dietary Uses and the WHO) for school nutrition policies (A) establishing school nourishment programs and improving the

Diet, Physical Activity and Health – Food standardization to support the reduction of chronic diseases (food and diet for a healthy long life), prepared under contract for the World Health Organization, May 2004.

⁷ See, for instance, the *International Code of Marketing of Breastmilk Substitutes* and the subsequent WHA resolutions and recital 11 in the Annex to the *Global Strategy*.

⁸ Article 46(3) of Resolution WHA57.17.

⁹ Hastings G, et al., *Review of Research on the Effects of Food Promotion to Children*, (Glasgow, Scotland: Centre for Social Marketing, 2003).

¹⁰ See: Hawkes C, *Marketing Food to Children: The Global Regulatory Environment*, (Geneva: World Health Organization, 2004) at 14-16.

nutritional quality of existing programs; (B) including nutrition and physical activity in the school curriculum; and (C) setting minimum nutritional standards for foods used in school fundraising activities, or sold in school cafeterias, vending machines, or other food service operations and noting the fiscal consequences of such standards.

- (vi) **Food and Agriculture Organization, United Nations Institute for Social Development, the World Food Program, and the WHO Commission on Macroeconomics and Health (food subsidies):**¹¹ IACFO urges that, pursuant to Article 47(1) of the *Global Strategy*, the WHO request that the Food and Agriculture Organization, United Nations Institute for Social Development, the World Food Program, the Commission on Macroeconomics and Health (or any other international bodies the WHO deems appropriate) conduct a joint review of national agricultural and food subsidy programs with a view to encouraging the provision of subsidies for foods the sales of which support the dietary advice reflected in *Technical Report 916*,¹² the *Global Strategy*, or national dietary guidelines. Such subsidies would lower the price of more healthful foods, and make “the healthy choice the easy choice.”

These bodies should examine the possibility of countries obtaining subsidy reduction credits by shifting subsidies from foods of minimal nutritional value to foods with protective health effects such as vegetables, fruits, legumes, whole grains, and other such foods identified in *Technical Report 916*. The relevant bodies should produce a report on how such outcomes can be achieved within the parameters of existing international trade rules and identify how any necessary reforms to existing trade rules can be made to ensure that pursuit of effective national public health policies is not fettered by the WTO regime.

- (vii) **WHO, Codex, and FAO (salt and trans fat):** IACFO urges that, pursuant to Article 47(1) of the *Global Strategy*, the WHO strike a joint-agency expert committee (or committees) to develop model national policies to gradually reduce salt and added sugars in the food supply, and quickly reduce *trans* fatty acids in processed foods.

- (viii) **Solicit legal opinions when health-related standard-setting allegedly conflicts with commercial, trade law, or other non-health legal standards:** Too often, national and international policy reforms aimed at improving public health are stymied by unsubstantiated allegations that such measures violate intellectual property rights and/or international trade rules. For example, efforts to expand requirements for quantitative ingredient declarations (QUID) on food labels have been characterized by food industry opponents as violating internationally accepted norms of intellectual property law, even though at least some QUID is already mandatory in at least 18 countries.¹³ As such, IACFO urges the WHO to solicit a legal opinion

¹¹ See, for instance, *Macroeconomics and Health: Investing in Health for Economic Development*

¹² *The Report of the Joint WHO/FAO Expert Consultation on Diet, Nutrition and the Prevention of Chronic Diseases: Technical Report 916*, (Geneva: World Health Organization, 2003; available on the Internet at: http://www.who.int/nut/documents/trs_916.pdf).

¹³ QUID does not disclose production methods or manufacturing processes which *might* be subject to intellectual property protections in some cases. Nor does the QUID, as proposed, require disclosure of spices or seasonings that might be present in small amounts. National and international standard-setting bodies have a responsibility to ensure that their efforts are guided by well-considered legal opinions by qualified experts, not unsubstantiated assertions of

from the WHA's Commission on Intellectual Property Rights, Innovation and Public Health (CIPIH) as to the scope of intellectual property rights concerning QUID for food. Furthermore, IACFO urges the WHO to proactively seek to resolve such legal disputes by commissioning legal opinions from qualified independent legal experts on its own initiative whenever necessary.

(b) Commission and disseminate research related to the prevention of diet- and inactivity-related disease

While recognizing that measures designed to implement the *Global Strategy* should be based on the best *available* evidence¹⁴ (and need not await the arrival of the best *conceivable* evidence), the WHO can aid the work of the public health community by commissioning and disseminating research on topics that are relevant to the implementation of the *Global Strategy* by national authorities.¹⁵ In particular, the WHO should commission the following research to be published before the 59th session of the WHA:

- (i) **Shifting value-added taxes from nutritious foods to nutrient-poor foods:** Many jurisdictions currently apply point of sale taxes to foods in retail stores, markets, and restaurants. For the most part, those taxes are not applied to foods with any consideration for the nutritional value. In some cases, taxes may be applied to nutritious foods thereby discouraging their consumption in comparison to less healthful tax-exempt foods. We urge the WHO to commission research to assess the price elasticity of differential taxes on foods based on nutritional merit, estimate the impact on consumption of nutritious and nutrient-poor foods, and canvass factors influencing tax revenue losses or gains under various nutrition criteria scenarios. Some study has already been done on this issue in the United Kingdom.¹⁶
- (ii) **Evaluation evidence on the successful elements of publicly-funded mass media campaigns to promote physical activity and healthful eating:** Some governments (including, but not limited to, Canada and Australia) and NGOs have commissioned mass media advertising campaigns to promote physical activity and healthy eating. We urge the WHO to request member countries to provide research concerning the impact of those social marketing campaigns, and practical advice about developing and mounting such campaigns. We further urge the WHO to publish such materials on its web-site as it is provided so that such evidence can be readily accessed by all national authorities and public health advocates.
- (iii) **Urban and rural planning:** WHO should commission a literature review examining how urban and rural planning reduce physical activity in daily life and limits access to nutritious foods, and what can be done to address these problems.

legal rights, particularly when those assertions are advanced by organizations whose members have vested commercial interests in the matter.

¹⁴ See, for instance, Articles 27 (in "Principles for Action") and 65 (in "Conclusions") of the Annex to WHA57.17, (May 22, 2004).

¹⁵ See Article 38, 39, and the fourth bullet of Articles 37, in the Annex to Resolution 57.17 (May 22, 2004).

¹⁶ See, for instance, A. Leicester, F. Windmeijer, *Briefing Note No. 49: The 'Fat Tax': Economic Incentives to Reduce Obesity*, (London: The Institute for Fiscal Studies, 2004) (see: <http://www.ifs.org.uk/consume/bn49.pdf>)

(iv) Effectiveness of weight-loss programs: WHO should commission a survey of the published literature evaluating the long-term effectiveness of weight-loss and fitness programs and make recommendations for disclosure requirements in marketing materials.

(v) Statutory precedents: We urge the WHO to establish an Internet-based database of actual and model national statutory and regulatory reforms that help achieve the aims of the *Global Strategy*.

(c) Urge the United Nations to organize a global conference and/or special session of the General Assembly on policy reforms to increase life expectancy through diet and physical activity:

A substantial portion, and in some places most preventable loss of disability-free life-years can be averted by eating healthy and being physically active.¹⁷ Advancing the *Global Strategy* requires more dedication and both intergovernmental *and* intersectoral cooperation than can be readily achieved by health advocates and the WHO alone.

Accordingly, we urge the WHO to explore the possibility of the United Nations hosting a global conference, in 2007, on policy reforms designed to increase physical activity and promote better nutrition. Such a conference would occur five years after the United Nations held four conferences touching on key themes germane to the *Global Strategy*: the *General Assembly Special Session on Children* (New York, 2002), the *Second World Assembly on Ageing* (Madrid, 2002), the *International Conference on Financing for Development* (Monterrey, 2002), and the *World Food Summit: Five Years Later* (Rome, 2002). Indeed, 2007 is also five years after the publication of the *World Health Report* detailing the extent of loss due to diet- and inactivity-related disease.

A 2007 conference would provide an opportunity to assess progress toward achieving the goals set out in the *Global Strategy* and to begin exploring alternative instruments in public international law, if the *Global Strategy* does not then appear to be achieving the results sought using the voluntary approach and the persuasive authority of the WHO alone. (See Appendix 1.)

(d) Establish a timetable for invoking stronger international legal norms:

We urge the WHO to establish a timetable of intermediary measurable goals for success, and a contingency plan to begin elaborating a Framework Convention on Food Marketing, Diet, and Health at the proposed 2007 Global Conference, if voluntary efforts prompted by the 2004 WHA resolution prove ineffective.

¹⁷ World Health Organization, *World Health Report*, (Geneva: WHO, 2002) especially Table 4 in the annex which shows the loss in *healthy* life expectancy due to all risk factors at birth) http://www.who.int/whr/2002/en/whr2002_annex4.pdf And Table 10 which shows all risk-attributable Disability-Adjusted Life Years (DALYs) were lost due to "childhood and maternal undernutrition" plus "other diet-related risks and physical inactivity". (See: http://www.who.int/whr/2002/en/whr2002_annex9_10.pdf)

4. How can the WHO support IACFO's efforts?

In addition to taking the above-noted steps, the WHO could support IACFO's work by engaging our staff in your consultative processes and apprising us, at the earliest opportunity, of any future releases of relevant research papers, and announcements of events, conferences, or fora relevant to our common mandates. We hope that the WHO will be favorably disposed to continuing and enhancing our relations in this way.

In the future, IACFO and our constituent groups will continue to press national governments and international organizations, including the Codex Alimentarius Commission, to see that the recommendations of the WHO's *Global Strategy* implemented. WHO's support for these efforts is welcome.

Thank-you.

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Appendix I

Legal Analysis of WHO's Jurisdiction over Food Regulation

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This paper is an excerpt of a forthcoming article examining the constitutional and normative basis for legal action by the World Health Organization (WHO) and the World Health Assembly (WHA) to implement the Global Strategy on Diet, Physical Activity, and Health (“Global Strategy”).

Part I – The General Legal Authority of the WHO

A. 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 in its territory.¹⁸ Uncoordinated “horizontal” agreements between national governments resulted in an incoherent regime of international sanitary conventions and agreements.¹⁹ Thus, the WHO was founded out of a commitment to a new, vertical re-allocation of power in public health governance, that would replace the sovereignty and noninterventionist principles of the Westphalian period of governance.²⁰

¹⁸ See David P. Fidler, *Constitutional Outlines of Public Health's “New World Order,”* 7 TEMP. L. REV. 247, 259-60 (2004).

¹⁹ 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).

²⁰ See Fidler, *supra* note 1, at 260-261. See also G.L. BURCI and C.H. VIGNES, *THE WORLD HEALTH ORGANIZATION* 124 (Aspen Publishers 2004) (explaining that 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).

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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.²¹ The WHO's founders embraced a broad, positive view of "health," eschewing the previous view of health as the mere absence of disease.²² This vision is reflected in the two-page definition of health articulated in the WHO's Constitution. The Preamble to the Constitution proclaims that "health is a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity."²³ Governments are responsible for the health of their peoples which can be fulfilled only by the provision of "adequate health and social measures."²⁴

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.²⁵ 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.'"²⁶ 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."²⁷ Thus, the WHO's legal mandate should be understood to include diet-related illnesses like obesity and diabetes, and to grant

21 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, *supra* note 3, at 260.

22 S.S. Fluss, F. Gutteridge, J.K. Little, H. Harris, *World Health Organization*. INTERNATIONAL ENCYCLOPAEDIA OF LAWS 37-39 (Herman Nys. ed., Deventer, Boston 1998).

23 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]

24 *Id.*

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

26 *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.

27 *Id.*

the organization the ability to enact prophylactic measures of intervention in order to prevent such diseases from taking hold in the first place.

B. WHO's Functions and Legal Instruments

Article 2 lists a range of 22 functions to be fulfilled by the WHO in order to reach its objectives.²⁸ 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-ordinating authority on international health work,” has been characterized as the WHO’s most important function.²⁹ 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.”³⁰ Article 2(u) further states that the WHO should “develop, establish and promote international standards with respect to food, biological, pharmaceutical and similar products.”³¹ Finally, Article 2(v) establishes that the WHO should “generally take all necessary action to attain the objective of the Organization.”³² These provisions clearly point to a central role for the WHO in enacting positive measures to implement the Global Strategy.

The text of the Constitution and the debates that led to its drafting show that the founders of the WHO intended the adoption of conventions and regulations to be central instruments in the regulation and management of international health issues.³³ Article 19 empowers the WHA to adopt conventions and agreements with respect to any matter within the competence of the Organization.³⁴ Indeed, the

²⁸ WHO Const. art. 2, in WHO, Basic Documents, *supra* note 6.

²⁹ *Id.* See BURCI & VIGNES, *supra* note 3, at 119 (stating that this function appears to embody the essential task of the Organization).

³⁰ *Id.*

³¹ *Id.*

³² *Id.*

³³ BURCI & VIGNES, *supra* note 3, at 153.

³⁴ WHO Const. art. 19, in WHO, Basic Documents, *supra* note 6.

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 authority to develop binding³⁵ 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.³⁶ Article 21 has been called "an exceptional regulatory power" because regulations adopted by a simple majority of member states are automatically binding upon the entire membership, unless a member notifies the WHO to the contrary.³⁷ Under conventional treaty-making practice, a positive action is required by a national government in order to become bound by an international instrument.³⁸

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 non-inclusion of food in Article 21(d) and (e).³⁹ Some scholars speculate 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

³⁵ In this paper, the term "binding" is used to describe obligations in public international law which import a normative expectation of adherence, beyond a mere recommendation. However, strictly speaking, most UN conventions are not truly "binding" in the way that domestic public statutes are because they are not generally 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 DAVID P. FIDLER, *INTERNATIONAL LAW AND PUBLIC HEALTH* (2000).

³⁶ WHO Const., art. 21, in WHO, *Basic Documents*, *supra* note 6.

³⁷ See BURCI & VIGNES, *supra* note 3, at 132.

³⁸ See Fluss et al., *supra* note 5, at 13.

³⁹ *Id.* at 14.

see WHO having express binding authority in the area of food.⁴⁰ However, a structural, purposive, and pragmatic reading of Article 21 clearly supports the conclusion 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.⁴¹ 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.⁴² In order to fulfill its broad mandate, the organization must be able to exercise legal authority over food labeling, advertising, composition, and 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 in 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-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

⁴⁰ *Id.*

⁴¹ 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). In addition, paragraphs (g), (i), (l), and (r) also comprise functions that are relevant to the implementation of the Global Strategy.

⁴² 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 were also conceived as measures to protect the public health. *See* Fluss et al., *supra* note 5, at 18.

industrialized nations.⁴³ 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 media barely contemplated in the 1940s. Moreover, 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 non-communicable disease.⁴⁴

It should also be noted that the issue of Article 21's relationship to Article 2's functions was revisited when the WHA called on the Executive Board to examine whether all parts of the WHO's Constitution remained appropriate and relevant.⁴⁵ In 1997, a special group undertook extensive review of the Constitution, including Articles 2 and 21, at the request of the 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."⁴⁶ The WHA never voted on whether the WHO's regulatory powers under Article 21 should be codified in this manner. However, the Board noted that Article 2, while not a perfect provision, had served well the goals of the Organization.⁴⁷ The Board also noted that Article 2 would continue to include the reference to "food" in response to some suggestions by the South-East

43 For a brief introduction to the formative stages of the food industry leading to the rapid and extensive growth of modern "convenience" foods, see Dr. James E. Tillotson's report entitled "Multinational Food Companies and Developing Nations' Diets," available at www.who.int/hpr/global.strategy.html.

44 For background and discussion of these trends, see *Diet, Nutrition, and the Prevention of Chronic Diseases: Report of a Joint FAO/WHO Consultation* (World Health Organization, Geneva 2003), available at http://www.who.int/nut/documents/trs_916.pdf.

45 See WHA Res. 48.14, WHO Doc. WHA/1995/REC/1 (1995).

46 *Review of the Constitution and Regional Arrangements of the World Health Organization: Report of the Special Group*, WHO Doc. EB101/7 (1997).

47 WHO EB, 103rd Sess., 9th mtg., WHO Doc. EB103/1999/REC/2 (1999).

Asia regional consultation that “food” was a concern proper to other international agencies.⁴⁸ The Board’s conclusion, though not an officially endorsed position of the WHA, indicates that Article 2’s regulatory reach should be construed to cover new areas of international health challenges like obesity.⁴⁹

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 is often 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” – legally, politically and/or morally – national governments 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 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. Though these documents place much of the responsibility for guaranteeing the right to health in member nations,⁵⁰ the legal obligations must be read in light of the WHO’s affiliation within the UN system which provides the foundation of the

⁴⁸ *Amendment to Article 2 of the Constitution*, WHO EB, 103rd Sess., Annex, at 1, WHO Doc. EB103/14 (1999).

⁴⁹ If it is truly necessary, the WHA could still now 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 to which it has already endorsed, then specifically empowering the WHO to pass international health regulations to give effect to that Strategy should, in principle, be appealing to members. Certainly, it should be no less appealing than supporting a framework convention on food.

⁵⁰ 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 the International Covenant on Economic, Social, and Cultural Rights focus on the duties of states, and underscore that member nations have the primary duty to guarantee the right to health to their populations.

WHO's unique responsibility to implement the right to health. The structure of the relationship between the UN and the WHO is grounded in the UN Charter and, in particular, those sections that describe the objectives of the UN.⁵¹

The WHO's Constitution explicitly declares health to be a fundamental human right and links the attainment of health to other human rights goals.⁵² The WHA has formally reasserted this position 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."⁵³ 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."⁵⁴

Commentators have also 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.⁵⁵ 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."⁵⁶ Steps to be taken by

51 Article 55 of the Charter describes the goals that the UN has pledged to promote among its members, including "solutions of international economic, social, health, and related problems." U.N. CHARTER art. 55. 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 co-ordinating authority on international health work,' the WHO has the cardinal responsibility to implement the aims of the Charter with respect to health").

52 See WHO Const., in WHO, Basic Documents, *supra* note 6, at 1.

53 World Health Organization, *Global Strategy for Health for All by the Year 2000* (Geneva: World Health Organization, 1981). The Strategy was implemented by a plan of action in 1982 based on the Alma-Ata Declaration. World Health Organization, *Declaration of Alma-Ata, Report of the International Conference on Primary Health Care, Alma-Ata (USSR)* (Geneva: World Health Organization, 1978).

54 *World Health Declaration*, WHA Res. 51.7, Annex, WHO Doc. WHA 51/1998/REC/1 (1998); see *Health for All in the Twenty-First Century*, WHO Doc. A51/5 (1998).

55 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 35, at 313.

56 *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*].

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, and other diseases.⁵⁷ 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.⁵⁸

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, are part of the “core content” of the right to adequate food.⁵⁹ One could interpret adverse substances to include foods high in salt, added sugars, and saturated fat. The 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.⁶⁰ All members of society, including the private business sector, are also deemed to share responsibility for the right to adequate food.⁶¹ 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.⁶² Government obligations include disseminating appropriate information relating to healthy lifestyles and nutrition and supporting people in making informed choices about their

⁵⁷ *Id.*

⁵⁸ *Covenant*, *supra* note 40, at art. 11.

⁵⁹ ESCR Committee, *General Comment No. 12, The right to adequate food*, 20th Sess., U.N. Doc. E/C.12/1999/5 (1999).

⁶⁰ *Id.* at para. 9.

⁶¹ *Id.* at para. 20.

health.⁶³ Violations of the right to health can occur through the “omission or failure” of governments to take necessary measures arising from legal obligations,⁶⁴ 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 also calls for nations to assume affirmative obligations in order to increase life expectancy, including measures to eliminate malnutrition and epidemics.⁶⁵ Diet-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.

Though the right to health may not include a binding substantive obligation on the WHO, or member states, to achieve a perfect state of health for its citizens,⁶⁶ in the 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. 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-

⁶² 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).

⁶³ *Id.* at para. 37.

⁶⁴ *Id.* at para. 49.

⁶⁵ Human Rights Committee, *General Comment No. 6, The Right to Life*, 16th Sess., U.N. Doc. HRI\GEN\1\Rev.1 (1994).

⁶⁶ See General Comment No. 14, *supra* note 46 (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 35, at 310 (“The right to health does not, however, constitute an entitlement to individual good health.”).

related diseases disproportionately affect the poor,⁶⁷ national government 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 guidelines 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 other areas addressed by the Global Strategy. The UN General Assembly has adopted Guidelines for Consumer Protection (UNGCP) imposing 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.”⁶⁸ According to Consumers International, an NGO working to encourage their national implementation, the UNGCP aim to provide a framework for consumer protection, advice and support which would enable

⁶⁷ See para. 8 of the 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,” available at http://www.who.int/gb/ebwha/pdf_files/WHA57/A57_R17-en.pdf; see also *The Report of the Joint WHO/FAO Expert Consultation on Diet, Nutrition and the Prevention of Chronic Diseases: Technical Report 916*, supra note 28, at 1-7.

⁶⁸ *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.

consumers to operate confidently and effectively in a market economy.⁶⁹ 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.⁷⁰ The factors that led to the exclusion of the clause in the final version of the guidelines are, however, not evident from the public record.⁷¹

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,⁷² 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.⁷³ The food industry would predictably resist restrictions on marketing, labeling, and advertising on the notion that Article 19(2) protects their 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.⁷⁴ Legal scholars have construed Article 19(3) to embody the "general duty to present information truthfully, accurately, and impartially."⁷⁵ To the extent that the food industry's advertisements, labels, or marketing practices are misleading or deceptive, restrictions on these activities would be consistent with

69 Corinna Hawkes, *Marketing Food to Children: The Global Regulatory Environment* 54 (World Health Organization, 2004); see J. Edwards, *The implementation of the UN Guidelines for Consumer Protection: Speech to United Nations Conference on Trade and Development, February 2003*, at <http://www.consumersinternational.org>.

70 Hawkes, *supra* note 53, at 54.

71 *Id.*

72 *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.

73 *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).

74 *International Covenant on Civil and Political Rights*, *supra* note 56, art. 19, para. 3.

75 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).

Article 19(2).

Finally, the UN Convention on the Rights of the Child (UNCRC) offers special measures of protection for the world's children.⁷⁶ The convention recognizes that by virtue of their age and maturity, children are still vulnerable and require protection.⁷⁷ 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."⁷⁸ The UNCRC requires that Member States undertake administrative measures to implement the articles contained in the convention.⁷⁹

Thus, the WHO's legal authority to issue standards concerning food marketing, composition, and other measures advocated by the Global Strategy is supported in its Constitution and given additional normative weight by expressions of governmental obligations articulated in various human rights compacts. Defining sources of 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. Centering the Global Strategy on more binding legal mechanisms can serve important catalyzing and harmonizing functions. The WHO's structures and past experiences should be further examined in arriving at a workable legal model for elaborating public international legal norms in this area. Important legal developments regarding the revision of the WHO's International Health Regulations, the Framework Convention on Tobacco Control, and the Code of the Marketing of Breastmilk Substitutes provide useful foundations in an attempt to define an innovative legal solution to the regulatory gaps of the Global Strategy.

⁷⁶ 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).

⁷⁷ *Id.*; See also Hawkes, *supra* note 53, at 53.

⁷⁸ See *Convention on the Rights of the Child*, *supra* note 60, art. 17.

⁷⁹ Hawkes, *supra* note 53, at 53.