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SUPPLEMENT ARTICLE

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Identifying a human rights–based approach to obesity for States and civil society

David Patterson[1] | Kent Buse[2] | Roger Magnusson[3] | Brigit Toebes[4]

[1] Global Health Law Groningen Research Centre, Faculty of Law, University of Groningen, Netherlands

[2] UNAIDS, Geneva, Switzerland

[3] Sydney Law School, University of Sydney, Camperdown, NSW, Australia

[4] Faculty of Law, University of Groningen, Groningen, Netherlands

Correspondence
David Patterson, Prins Hendrikstraat 147, Den Haag 2518HN, Netherlands.
Email: dpatterson@healthlawdc.com

Summary

Obesity and its comorbidities pose daunting challenges to global health and development in the 21st century. This paper reviews some commonalities between obesity and another global health challenge, the pandemic of human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS). International human rights law was an important catalyst for civil society movements that helped to overcome inertia and generate political will for State action in response to HIV and AIDS. Drawing on the HIV experience, the authors propose a conceptual model for a human rights–based response to obesity founded on the twin pillars of State obligations and civil society engagement. Framing States' obligations to address the global obesity pandemic as a matter of international law, informed by the examples of the United Nations "International Guidelines on HIV/AIDS and Human Rights" and the General Comments of the United Nations human rights treaty bodies on HIV and AIDS, provides a normative framework to guide State actions and opportunities to engage the extensive accountability mechanisms of the United Nations international human rights system. In addition, it provides civil society organizations with the language and tools to demand State action on obesity. The authors call for similar authoritative guidance for States on the application of international human rights law to obesity.

KEYWORDS

civil society, HIV, human rights, law, obesity

1 | INTRODUCTION

The global obesity pandemic and its comorbidities, including diabetes mellitus, cardiovascular disease, cancer, osteoarthritis, and hypertension, pose risks to the life and health of individuals, the well-being of families, and economic development.[1-3] The risk factors for obesity arise at the level of genes, behaviours, and the environment. The main behavioural risk factors for obesity are excess consumption of foods and beverages including alcohol[4] that are energy-dense and high in sugar and/or fat, as well as insufficient physical activity due to changing modes of transportation, increasing urbanization, more screen time, and the increasingly sedentary nature of many forms of work. Changing food environments are a global phenomenon, driven by trade liberalization policies, increased global trade in food, and the rapid growth of supermarkets, large processed food companies, and fast food brands.[5,6] The result is a food environment characterized by cheap, palatable, heavily promoted, highly processed, energy-dense foods and drinks. While physical inactivity and increased energy intake both contribute to energy imbalance and to obesity, evidence suggests that increased energy intake plays the predominant role.[7]

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In 2012, the World Health Assembly endorsed a comprehensive implementation plan on maternal, infant, and young child nutrition.[8] The plan included a global target of no increase in child overweight by 2025. In 2013, the World Health Assembly adopted as a global target a zero increase in obesity and diabetes as one of eight voluntary global targets supporting the achievement of a 25% reduction in mortality from cardiovascular disease, cancer, diabetes, and chronic respiratory diseases by 2025.[9] In 2015, the United Nations General Assembly adopted the target of reducing premature mortality from non-communicable diseases (NCDs) by one third, as part of the 2030 Agenda for Sustainable Development.[10]

In 2018, in the Political Declaration of the third high-level meeting of the United Nations General Assembly on NCDs, Heads of State and Government committed, for the second time in the context of NCDs, to taking "the necessary measures to recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health across the life course …," and to respect human rights obligations in scaling up efforts to address NCDs.[11]

The modern concept of health as a human right dates from the 1946 Constitution of the World Health Organization and the 1948 United Nations Universal Declaration of Human Rights. The right to health first appeared in an international treaty in the United Nations International Covenant on Economic, Social and Cultural Rights (ICESCR), which was adopted by the United Nations General Assembly in 1966.[12,13]

In this paper, we describe some implications of a human rights–based approach to the obesity pandemic for actions by States and civil society. Unlike infectious agents such as the Ebola virus, risk factors for obesity are often framed as matters of personal responsibility rather than matters of urgent public concern warranting strong government intervention.[14,15] Yet obesity results from exposure to unhealthy environments as well as behavioural and biological responses to those environments. Responses to other global health challenges provide important lessons for the response to obesity. The extraordinary global movement that arose to tackle acquired immunodeficiency syndrome (AIDS) and successes in global tobacco control both demonstrate that international human rights law can be an important catalyst for the civil society movements that are needed to overcome inertia and generate the political will for State action.[16] International human rights law can help to transform data into moral and legal arguments[17] and to galvanize civil society organizations to "give the people who suffer most a face and a voice."[18-20]

We propose a conceptual framework for a human rights–based response to the leading obesity risk factors based on the twin pillars of State obligations and civil society engagement, and we offer recommendations for both States and civil society organizations. Our focus is the role of States and civil society; a discussion of private sector responsibilities to respect human rights in the context of obesity is beyond the scope of this paper.[21-24] Nonetheless, we recognize that action by the private sector is critical, in addition to action by civil society and States. Corporations are major contributors to the global obesity pandemic, including through the formulation and promotion of unhealthy foods and beverages, including alcohol.[25-28] A former United Nations Special Rapporteur on the Right to Health has noted that "the food industry plays a key role in the global food environment and is recognized as the primary driver of diet-related NCDs …"[29] Indeed, corporations, particularly trans-national food and beverage industries, are major "vectors" of obesity.[26,30,31]

Corporations are legal entities—created, regulated, and dissolved by domestic and international laws. Efforts to mitigate harm caused by exposure to harmful environments and by consumption of harmful products produced and marketed by corporations are therefore an appropriate focus for legal regulation by States, acting both individually and collectively. However, some States are heavily invested in vegetable oil and sugar production, and dependent on taxation and related revenue from large commercial interests, such as the palm oil, meat, and sugar industries. These investments, and their revenues, may also create conflicts of interest for States, including conflicts between health, finance, and agriculture ministries. High-level political leadership, and strong government engagement, combined with appropriate governance mechanisms to ensure effective communication channels within government, are all needed to effectively regulate these industries for the common good.[32,33]

2 | COMMONALITIES BETWEEN THE GLOBAL PANDEMICS OF OBESITY AND HUMAN IMMUNODEFICIENCY VIRUS

There are striking similarities between the global pandemics of obesity and human immunodeficiency virus (HIV). Once viewed as chronic diseases of aging populations, obesity and its comorbidities are increasingly affecting younger populations who are politically active, engaged in the workforce, and have dependants. As with HIV, there are complex linkages between low socio-economic status and NCDs and their risk factors, including obesity, in some countries.[34,35] In both cases, effective public policy responses risk becoming derailed by an excessive focus on individual behaviour and personal responsibility, rather than health systems that exclude large numbers of people, and health-harming and exploitative environments. There is no magic bullet in sight—an HIV vaccine and a cure for AIDS remain elusive, while treatments for diabetes mellitus, cardiovascular disease, cancer, osteoarthritis, hypertension, and stroke are often expensive and offer no promise of a lifetime cure.[36] In both cases, prevention is key but must be linked with access to treatment and protection from discrimination.[37]

With both HIV and obesity, there are powerful stakeholders opposed to change. Whether motivated by political values or by profit, organized resistance to evidence-informed policy is a central problem in tackling these public health threats. Although the legal issues vary, in both cases, punitive criminal laws can undermine prevention efforts[38-42]; trade and investment laws may be used to discourage countries from adopting legislation intended to correct dietary imbalances,[43,44] and laws on patent protection and data exclusivity may

create obstacles to affordable, accessible, generic medicines.[45,46] Trade and investment disputes, litigation under domestic laws, or threats of such action may have a chilling effect on government action, particularly in smaller, economically vulnerable countries where State capacity is limited.

Finally, with both HIV and obesity, prevention strategies should be based on a harm minimization approach—ie, the assumption that many people will continue to engage in risky behaviour including unsafe sex and injecting drug use, will not undertake adequate physical activity, and will continue to consume unhealthy food and beverages. A harm minimization approach aims to reduce the potential harms by, eg, promoting protected sex and safe drug use (in the context of HIV), and the reduction rather than elimination of free sugars in the diet (in the case of obesity). Prevention strategies should be evidence-informed—an effective strategy for one disease may not be appropriate for another.

Despite these similarities, there are also clear differences between the global pandemics of HIV and obesity. Most notably, products and markets play a major role in the commercial determinants of obesity, whereas this is not the case with HIV. The private food sector will continue to meet and stimulate demand for food and shape global food systems, subject to applicable national and international laws.[47]

3 | CONCEPTUAL MODEL FOR A RIGHTS–BASED RESPONSE TO OBESITY

Central to the human rights–based response to obesity is the legal obligation on States to respect, protect, and fulfil the right to the enjoyment of the highest attainable standard of physical and mental health, including through the fulfilment of a range of other rights.[48] Our approach places States' human rights obligations at the centre of the obesity response, with human rights informing these obligations (Fig. 1). In this analysis, international human rights law provides the foundation for the prevention and treatment of obesity—with individuals as rights holders and States as the corresponding duty bearers.[49]

The foundation for an explicit, human rights–based approach already exists in key policy documents on NCDs, including obesity. The World Health Organization (WHO) Global Action Plan for the Prevention and Control of NCDs 2013–2020 lists the "human rights approach" as one of its overarching principles.[50] Similarly, the WHO Report of the Commission on Ending Childhood Obesity notes that "Tackling childhood obesity resonates with the universal acceptance of the rights of the child to a healthy life as well as the obligations assumed by State Parties to the United Nations Convention on the Rights of the Child"[51,52] and cites the General Comment of the United Nations Committee on the Rights of the Child, which monitors the

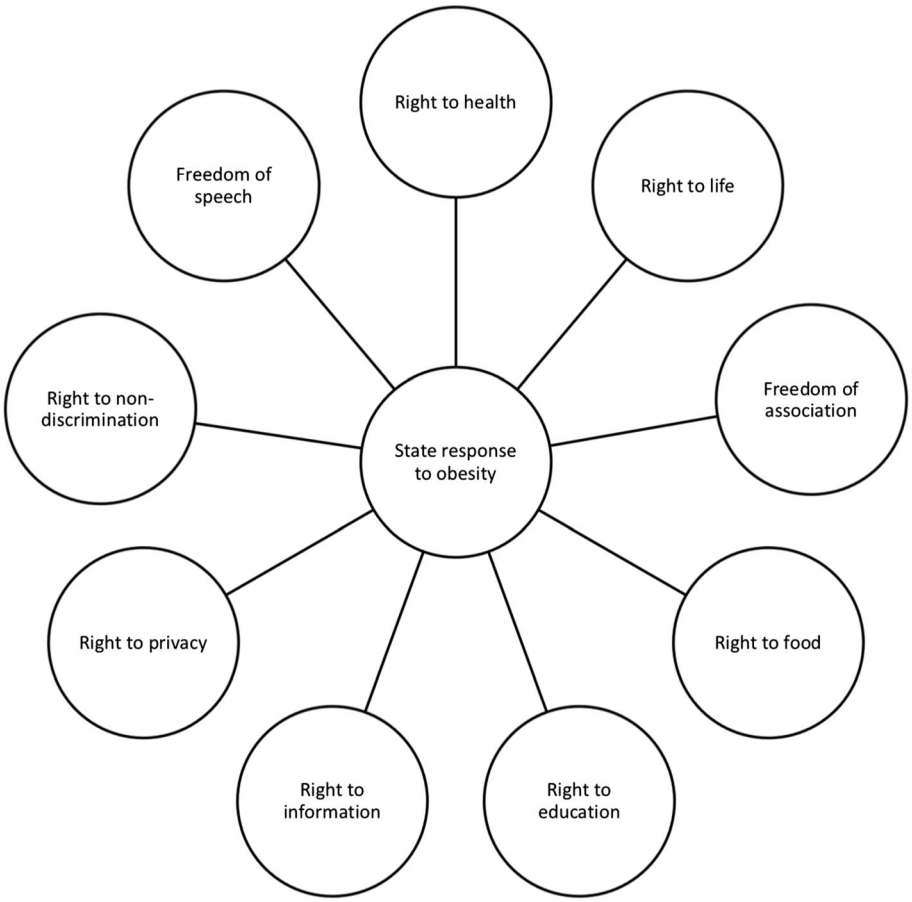

FIGURE 1 State human rights obligations at the centre of the obesity response (non-exhaustive list)

implementation of the Convention, on the right of the child to the enjoyment of the highest attainable standard of health.[53]

The United Nations Global Strategy for Women's, Children's and Adolescent Health, which includes health challenges posed by NCDs, such as obesity, is explicitly rights-based.[54] In 2017, the United Nations High-Level Working Group on the Health and Human Rights of Women, Children and Adolescents recommended that "All States should ensure that national accountability mechanisms (for example, courts, parliamentary oversight, patients' rights bodies, national human rights institutions, and health sector reviews) are appropriately mandated and resourced to uphold human rights to health and through health. Their findings should be regularly and publicly reported by States."[55] The terms of reference of the United Nations Interagency Task Force on the Prevention and Control of NCDs also affirm the right to health as a human right.[56] In 2018, the WHO Independent High-Level Commission on Noncommunicable Diseases recommended that "… all activities be framed within existing principles, including human rights- and equity-based approaches …"[33] Finally, as noted above, the 2018 United Nations General Assembly Political Declaration on NCDs also reaffirmed the right to health in the response to NCDs.[11]

Participation of affected communities is a central principle of human rights–based approaches to development.[57] As with HIV, civil society organizations, people living with NCDs, and affected communities must also be acknowledged as partners in the response to obesity, not merely as patients or beneficiaries of health interventions.[58,59] It is notable that civil society organizations are represented in the governance structures of the Joint United Nations Programme on HIV/AIDS (UNAIDS)[60,61] and the Global Fund to Fight AIDS, Tuberculosis and Malaria.[62] Similarly, civil society organizations were powerful advocates for the WHO Framework Convention on Tobacco Control, which acknowledges that the participation of civil society is essential to achieving the objectives of the Convention.[63,64]

The Global Coordination Mechanism on Prevention and Control of NCDs (GCM/NCD) was established by the World Health Assembly in 2013 and provides a platform for collaboration between WHO Member States, United Nations agencies, other inter-governmental partners, and non-state actors including civil society organizations.[9] However, governance reforms are needed to provide greater opportunities for a wider range of civil society organizations to engage beyond ministries of health and diplomatic missions based in Geneva, including opportunities to engage with national leaders at the highest level, in order to encourage multisectoral action.[65]

Piot et al have framed "AIDS activism" as a global public good, noting that investment in activism and civil society, "… and links with other groups, movements and academia that actively promote health, gender equality, development and human rights will help to build and sustain the political incentives that are needed to drive meaningful action …" on global health.[66] There is also an explicit commitment in the 2016 United Nations General Assembly Political Declaration on Ending AIDS to financial support for "social enablers," including advocacy, community and political mobilization, and community monitoring programmes.[67]

Figure 2 describes a simple theory of change that is based on the recognition that framing the response to obesity in terms of human rights will help to clarify State obligations while also invigorating civil society to press for meaningful actions and greater accountability from governments. In our conceptual model, civil society is positioned as a powerful driver of political change, both nationally and globally. By framing action on obesity in terms of human rights responsibilities, the political response to obesity becomes an issue of social justice and worthy of vigorous civic and political engagement.[68]

Buse and Sprague have identified lessons for NCDs from the global response to HIV and AIDS, including human rights.[69] Civil society organizations responding to NCDs, including obesity, are increasingly using the language of human rights to call for action on the social determinants of

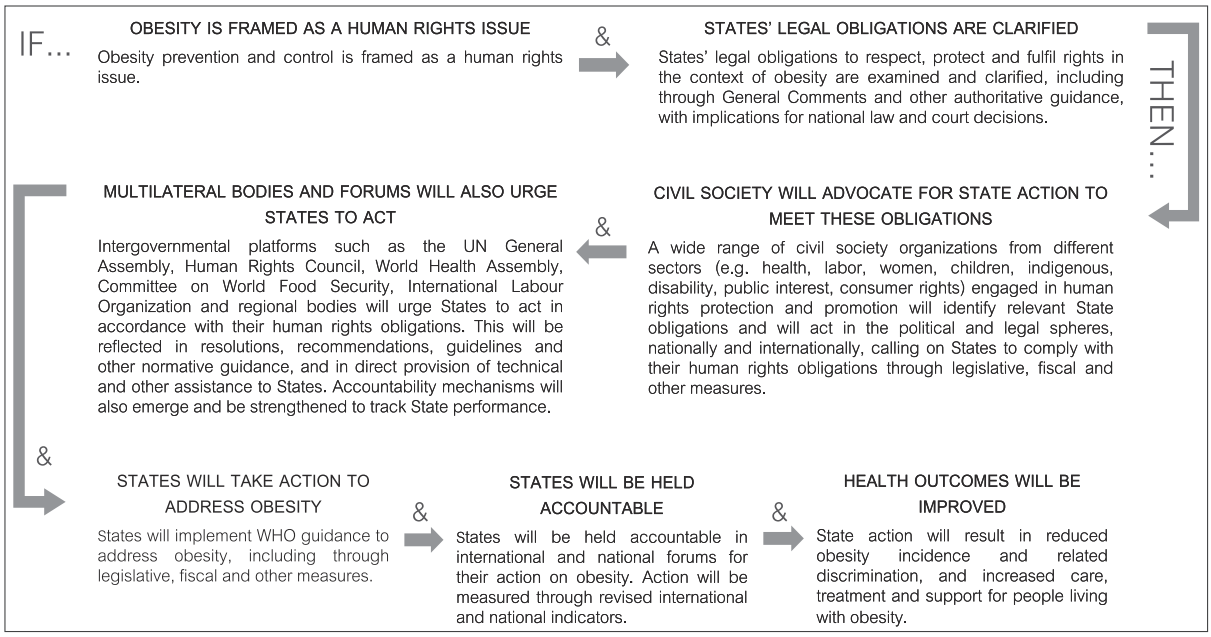

FIGURE 2 How a human rights–based approach can advance the obesity agenda

health.[70] However, the framing of obesity-related arguments and demands in terms of civil and political rights, such as the right to freedom of expression and the right to seek, receive, and impart information, is lagging. As with HIV, conceiving of obesity through the lens of both civil and political rights, as well as economic, social, and cultural rights, will encourage the engagement of a broader range of civil society organizations, including the labour movement, public interest and consumer rights groups, indigenous peoples, people with disabilities, and other minorities living with and affected by obesity.

For example, labour organizations will likely focus on healthy workplaces, non-discrimination against workers living with obesity, and the welfare of their families. Reflecting the experience with HIV, this could lead to an International Labour Organization (ILO) Code of Practice on obesity in the workplace, and an ILO Recommendation on obesity in the workplace.[71] Obesity also has a disproportionate impact on many indigenous and tribal peoples who live in contexts where environmental degradation, food insecurity, and reduction of dietary diversity have affected traditional lifestyles. Human rights provide a language through which their organizations can call attention to State obligations to protect and promote the rights to food, to health, and to the preservation of culture. In circumstances where governments or private sector organizations seek to interfere with evidence-informed advocacy for obesity prevention and control, civil society organizations may rely on constitutionally protected rights to information and freedom of expression, as demonstrated by an example from Colombia (Box 1).[72-75]

Box 1 Freedom of expression and the right to information about sugary drinks in Colombia

In 2016, a Colombian civil society organization, Educate Consumers (*Educar Consumidores*), launched a television and radio campaign that revealed the quantities of sugar in a number of sugary drinks. A Colombian sugary drink manufacturer initiated proceedings alleging "false advertising" with the Superintendency of Industry and Commerce, which ordered Educate Consumers and another civil society organization to cease the campaign in all media and to seek prior review by the Superintendency of any further material relating to sugary drinks.

The Colombian Constitution permits a person to petition any judge to protect his or her constitutional rights. Educate Consumers and another civil society organization filed a petition arguing that the Superintendency decision interfered with their rights to freedom of expression and to receive information about the health risks of sugary drinks. The Constitutional Court held that the freedom of expression guaranteed in the Constitution extended to giving consumers information about the food they consumed. The Court held that the announcements broadcast by Educate Consumers were information rather than advertising, and so could not be subject to prior restraint by the Superintendency. The Court also held that the Superintendency had violated consumers' rights both to receive information and to inform others.

Other lessons from HIV include the importance of gender-sensitive approaches, of advocacy for access to treatment alongside prevention, of combining legal action with social mobilization,[76] and of building global solidarity between people living with NCDs and affected communities in countries and regions at different stages of economic development.[77]

4 | GUIDANCE FOR STATES AND CIVIL SOCIETY ON THE HUMAN RIGHTS–BASED APPROACH TO OBESITY

Because the human rights–based approach is anchored in international treaties and conventions, it is much more than simply an assertion of the rights of marginalized and vulnerable populations. As illustrated by HIV, it can be used to develop legally based principles describing State obligations in response to social justice and human development challenges.[78] The roles of States and civil society are distinct but related: States have legal obligations to comply with international human rights law, whereas civil society is a partner in realizing human rights, and can advocate for State action to meet these obligations. A key role of civil society is holding governments to account.[79,80]

Although the right to health and other health-related rights found in international human rights treaties were not specifically created with obesity in mind, the principles that have emerged from authoritative interpretations of these rights provide helpful guidance in considering the application of human rights to new health challenges.[81] More recent legally binding standards, as well as non-binding, normative standards adopted by bodies such as the World Health Assembly, may also inform understanding of the content of human rights.

For example, the WHO Framework Convention on Tobacco Control (FCTC), which came into force in 2005, makes explicit reference to the right to health in its Preamble and establishes the minimum obligations of States with regard to the control of tobacco.[63] It therefore also provides a standard for evaluating States' compliance with their obligations under the right to health in international human rights treaties such as the ICESCR and the Convention on the Rights of the Child,[52] which both entered into force prior to the FCTC, in 1976 and 1990, respectively.[82,83]

The United Nations Committee on Economic, Social and Cultural Rights, which monitors implementation of the ICESCR, provides authoritative guidance on the obligations of States to *respect*, *protect*, and *fulfil* the right to health. Although not framed with obesity in mind, we see important implications for State actions to address the obesity epidemic. The obligation to *respect* the right to health requires the State itself to "to refrain from interfering directly or indirectly with the enjoyment of the right to health."[48] It therefore provides a language for civil society to enjoin governments from doing things that make the obesity epidemic worse; for example, by divesting state-owned corporations that manufacture obesogenic products, such as palm oil or sugary drinks, and by avoiding discrimination in the provision of State services, including health services, to people living with

obesity. Where they control pension or superannuation funds, governments can also respect the right to health by disinvesting in companies and industries that contribute unduly to nutritional risks and energy imbalance.

The obligation to *protect* the right to health requires the State to take actions to prevent third parties from interfering with the right to health. It therefore provides a language for civil society to call on governments to ensure appropriate legislative control over the risks posed by obesogenic environments, including obesogenic foods and beverages and the corporations that produce and sell them, and to protect vulnerable minorities from discrimination by third parties.

Finally, the obligation to *fulfil* the right to health addresses the problem of inaction by States, requiring them to "adopt appropriate legislative, administrative, budgetary, judicial, promotional, and other measures" towards full realization of the right to health. It therefore provides language and concepts for civil society to call on governments to address the determinants of obesity, including through legislation (including fiscal measures and urban planning controls, for example), as well as to improve the building blocks of the health system so that quality treatment is available, accessible, and acceptable for all who need it.

Authoritative guidance on international legal obligations in relation to obesity is already available.[48,53,84] United Nations human rights treaty bodies are increasingly commenting on State obligations to address risk factors for obesity under relevant treaties when considering States' periodic reports. For example, in 2018, the United Nations Committee on Economic, Social and Cultural Rights recommended that Argentina "… (a)dopt a regulatory framework that expressly recognizes the right to food and steers public policies that ensure access to healthy, nutritious and sufficient food, especially for disadvantaged groups …" The Committee also recommended that Argentina "… (t)ake effective measures to discourage the consumption of unhealthy foods and beverages, including an increase in the tax on sugary beverages, strengthening of regulations under the Argentine Food Code with regard to front-of-pack food labelling that includes information on sugar content, and restrictions on the advertising of unhealthy foods and beverages, especially those directed towards children."[85] United Nations human rights treaty bodies can make greater use of WHO and World Health Assembly normative standards and guidance in the context of dialogues with State delegations, and in concluding observations on States' periodic reports. States and civil society organizations can also raise concerns about action on obesity with States through the Human Rights Council's Universal Periodic Review process. For example, in the 2018 review of Tuvalu's report, Haiti noted that a recommendation on new food practices to address obesity had not been accepted and urged Tuvalu to improve the diets of its people.[86]

A former United Nations Special Rapporteur on the Right to Health has noted States' duties to regulate unhealthy food advertising.[29] Two former United Nations Special Rapporteurs on the Right to Food have noted that a State's obligation to regulate transnational corporations, which increasingly control the global food system, extends to situations occurring outside the State's national territory.[87,88] Scholars have identified how the rights of children under international law may be affected by food marketing, and the implications for States.[81,89] There have also been calls for new international treaties on healthy diets and obesity, global health, and alcohol.[79,90-92] In 2018, the United Nations circulated the first draft of a treaty on business and human rights, with implications for transnational tobacco, alcohol, food, and beverage corporations.[93,94]

In 1996, an expert committee convened by UNAIDS and the United Nations Office of the High Commissioner for Human Rights examined the application of international human rights law to HIV and AIDS and drafted guidance for States on steps to be taken to meet their legal obligation to respond to the HIV pandemic.[78] These twelve principles, the "International Guidelines on HIV/AIDS and Human Rights," were referred to repeatedly in subsequent resolutions of the (then) United Nations Commission on Human Rights, and later the Human Rights Council, substantially increasing their political impact.[95-101] For example, in 2011, the Council called on all States, UN bodies, and international and non-governmental organizations "to continue to take all necessary steps to ensure the respect, protection and fulfilment of human rights in the context of HIV/AIDS, as referred to in the Guidelines, as an essential part of efforts to achieve the goal of universal access to HIV prevention, treatment, care and support."[101] Appendix A provides a summary of the subject of each guideline.

The *International Guidelines on HIV/AIDS and Human Rights* provided a foundation for the 2003 General Comment by the United Nations Committee on the Rights of the Child on State obligations in the context of HIV and AIDS.[102] However, the *International Guidelines on HIV/AIDS and Human Rights* have also had a significant impact beyond the United Nations human rights system. For example, they informed the human rights language of the 2001 United Nations General Assembly "Declaration of Commitment on HIV/AIDS" and subsequent United Nations General Assembly resolutions on HIV and AIDS.[67,103,104] States report periodically to the General Assembly on steps taken to implement the commitments made in General Assembly resolutions on AIDS. The monitoring framework for these reports includes a "National Commitments and Policies Instrument" (NCPI).[105] The NCPI also captures the views of civil society organizations on State action on key policy and process indicators. Civil society organizations may also submit shadow reports to UNAIDS if there is inadequate consultation by States in the completion of the NCPI.[106] Moreover, the NCPI notes that shadow reports should be accepted "… if it is strongly felt that civil society was not adequately included in the national reporting process, if governments do not submit a report, or if the data provided by the government differ considerably from the data collected by civil society while monitoring government progress in delivering services."[107] Even though participation is voluntary, in 2015, 92% of United Nations Member States reported on their national AIDS responses using the NCPI.[108]

In 2010, UNAIDS mapped relevant national laws, highlighting discrepancies in rights-based approaches between United Nations Member States.[109] The rights-based approach informed the report of the United Nations Global Commission on HIV and the Law, published in 2012 and updated in 2018.[38,42] Since 2012, the Global Fund to Fight AIDS, Tuberculosis and Malaria has included human rights as one of its

strategic objectives.[110] The sharp decrease in the price of antiretroviral therapies to treat HIV, since 2000, is also consistent with the global discourse on access to medicines and the right to health.[111]

Much has been achieved in the global response to HIV and AIDS, and in explaining why, the strategic benefits of a human rights–based approach appear significant, and relevant to the global response to obesity. The approach frames government action in terms of entitlements (affected groups) and obligations (governments). It is supported by the United Nations human rights accountability mechanisms and normative frameworks. As with HIV, a human rights–based approach to obesity directs attention to obstacles to prevention and treatment and recognizes the existence of discrimination and socio-economic, regional, and other inequalities in obesity and its risk factors. Human rights have a high position in the hierarchy of norms—politically, ethically, and legally. The description of state obligations is also a powerful tool for civil society organizations to hold States accountable for their actions, even more so when children are involved.[79]

The rights-based approach is not a panacea however—the advocacy opportunities offered are not yet widely understood, more authoritative guidance on implementation is needed, quantification of impact remains a challenge, and there are wider challenges in the retreat by some States from such multilateral approaches.

5 | RECOMMENDATIONS

We recommend that States and civil society organizations urge the United Nations Human Rights Council to develop comprehensive technical guidance for States on the application of international human rights law to the global obesity pandemic. Drawing on the experience of the *International Guidelines on HIV/AIDS and Human Rights*, we propose the development of "International Guidelines on the Global Obesity Epidemic and Human Rights," under the auspices of the Office of the High Commissioner for Human Rights, with the following possible areas of focus for State action [Table 1.]

States and civil society organizations should also urge the United Nations human rights treaty bodies to hold relevant consultations and to develop or update General Comments or Recommendations, as appropriate, and other guidance in key areas that relate to obesity, for example, on children, food, women, and gender.

The United Nations human rights treaty bodies should make systematic use of WHO and World Health Assembly recommendations and other normative standards relating to obesity in dialogues with State delegations regarding their periodic reports. States and civil society organizations should also draw attention to action on obesity in States' reports through the Human Rights Council's Universal Periodic Review process.

States and civil society organizations should also advocate for inclusion of rights-based language in obesity-related resolutions of the United Nations General Assembly, Economic and Social Council, World Health Assembly, and other intergovernmental bodies.

TABLE 1 International guidelines on obesity and human rights—possible areas of focus for State action

1	Multisectoral national framework and platform established by central government with mechanisms for coordination, monitoring, accountability, and redress mechanisms across sectors.
2	Meaningful community engagement and consultation in the process of policy and standards development at the national level (and sub-national level where appropriate).
3	Recognition of the role of public health laws, for example, the regulation of production, promotion, marketing, and sales of unhealthy food and beverages, including front-of-pack labelling and use of claims and implied claims on food; safeguards from industry interference in the development of the guidance, standards, and reporting.
4	Protection of people living with obesity and obesity-related conditions from discrimination; develop the capacity of health care complaints units and human rights commissions to address complaints of discrimination.
5	Care, treatment, and support for people living with obesity, including safe and effective medication at an affordable price, and provision of disability benefits or social security for those disabled by obesity-related illness.
6	Supportive and enabling environments, including access to low salt, low sugar, nutritious food, and beverages, in State and non-State institutions (eg, workplaces, hospitals, schools, and prisons) and for vulnerable groups, including children and indigenous populations.
7	Reform of international trade and investment frameworks, where necessary, to enable governments to confidently implement effective policies for obesity prevention, consistent with international human rights obligations.
8	Recognition that the private sector remains accountable for taking actions to support obesity prevention, supported by codes of conduct (as appropriate), with transparent reporting and mechanisms to ensure compliance and independent review; effective management of conflicts of interest in the policy-making process; and appropriate regulation of the private sector, based on evidence-informed standards, with independent transparent reporting of performance and mechanisms for enforcement.
9	Support for creative education, training, and media programmes.
10	Support for transparently funded research on evidence-informed responses to obesity risk factors, noting the need for full transparency and to avoid conflicts of interest.
11	Monitoring and enforcement mechanisms to guarantee the protection of obesity-related rights.
12	International cooperation through the United Nations system to share knowledge and ensure effective mechanisms to respect, protect and fulfil human rights in the context of the global obesity pandemic.

WHO should further develop the Noncommunicable Diseases Progress Monitor reporting framework to include a comprehensive National Commitments and Policies Instrument with indicators to measure compliance with relevant human rights obligations in the context of obesity. States should consult civil society and international organizations in the drafting of the periodic monitoring reports.

Box 2 Summary of recommendations

1. The United Nations Human Rights Council should develop comprehensive technical guidance for States on the application of international human rights law to the global obesity epidemic.
2. The United Nations Office of the High Commissioner for Human Rights should develop and disseminate "International Guidelines on the Global Obesity Epidemic and Human Rights."
3. Human rights treaty monitoring bodies, including the Committee on the Rights of the Child, should develop General Comments and Recommendations, as appropriate, on obesity.
4. The United Nations human rights treaty bodies should consider action on obesity where relevant in the review of States' periodic reports.
5. States and civil society organizations should review States' action on obesity through the Human Rights Council's Universal Periodic Review process.
6. States and civil society organizations should advocate for human rights–based commitments in obesity-related resolutions of inter-governmental forums.
7. WHO should further develop the Noncommunicable Diseases Progress Monitor reporting framework to include indicators to measure compliance with relevant human rights obligations.
8. The United Nations General Assembly, the WHO, or other appropriate bodies should develop new international instruments, including treaties, regulating the activities of States and corporations on issues related to healthy diets, obesity, alcohol, and global health.
9. States and the donor community should invest in legal capacity building including legal literacy on international human rights law and implications for the obesity response, and provide resources for civil society empowerment to advocate for greater State action to address obesity.

The United Nations General Assembly, the WHO, or other appropriate bodies should develop new international instruments, including treaties, regulating the activities of States, and corporations on issues related to healthy diets, obesity, alcohol, and global health.

However, we note the need for urgent action and suggest that, in the interim, expanding and clarifying obligations under existing treaties should remain a priority for both States and civil society.

Finally, States and the donor community should invest in relevant legal capacity building including legal literacy on international human rights law and implications for the obesity response and provide resources for civil society empowerment to advocate for greater State action to address obesity.[112] These recommendations are summarized in [Box 2].

6 | CONCLUSION

Global action on HIV has unquestionably been strengthened through a human rights–based approach, since obligations owed by States under existing human rights instruments direct attention to important obstacles to prevention and treatment of HIV, and require protection from discrimination against people living with HIV.[113-115] We have argued that the human rights–based approach to HIV also offers guidance for invigorating the global response to obesity. Framing States' obligations to address the global obesity pandemic as a matter of international law, informed by the example of the United Nations *International Guidelines on HIV/AIDS and Human Rights* and General Comments of the human rights treaty monitoring bodies on the right to health in the ICESCR and other relevant treaties, provides a normative framework to guide State action. It also provides opportunities to engage the extensive accountability mechanisms of the United Nations international human rights system. Finally, it provides civil society organizations with the language and tools to demand State action on obesity and invites both human rights and public health advocates to make greater use of international human rights law to address other global health challenges.

DISCLAIMER

The views expressed in this article are those of the authors alone and do not necessarily reflect the positions of the institutions to which they are affiliated.

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ORCID

David Patterson https://orcid.org/0000-0001-8187-0777

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APPENDIX A

INTERNATIONAL GUIDELINES ON HIV/AIDS AND HUMAN RIGHTS (UNAIDS, OHCHR, 1998, REVISED 2006)—TOPIC SUMMARY ONLY

1	National framework established by central government
2	Community consultation in the process of policy development
3	Public health laws
4	Criminal laws and correctional systems
5	Anti-discrimination and protective laws
6	Regulation of goods, services, and information; availability of quality prevention measures and services; and safe and effective medication at an affordable price
7	Legal support services for affected populations also develop the capacity of non-judicial mechanisms such as health complaints units and human rights commissions
8	Promote a supportive and enabling environment for women, children, and other vulnerable groups
9	Support for creative education, training, and media programs
10	Government and private sector codes of conduct; with mechanisms to implement and enforce
11	Monitoring and enforcement mechanisms to guarantee the protection of related rights
12	International cooperation through the United Nations system to share knowledge and ensure effective mechanisms to protect human rights