LEGISLATIVE INTERVENTIONS TO PREVENT AND DECREASE OBESITY IN PACIFIC ISLAND COUNTRIES

David Clarke and Tim McKenzie, Allen & Clarke, Policy and Regulatory Specialists Limited

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Contents

EXECUTIVE SUMMARY

Obesity is a significant issue for Western Pacific nations. While awareness of the problem is widespread, responses to it vary, from extensive tax-funded health promotion programmes, to intermittent and occasional interventions.

Nonetheless, the range of initiatives being tried across the region suggests that Western Pacific countries can use legislation to coordinate sustainable efforts aimed at improving the nutritional balance of their people's diets. These efforts can feature a range of actions, including taxation, health promotion, increased physical activity and programmes in schools.

Evaluating interventions for their obesity-prevention value in the Pacific is difficult owing to the variable local conditions. The difficulty is compounded by the fact that obesity prevention programmes throughout the world are in their early stages. It is crucial therefore, that individual countries think through the kinds of intervention that could work to counteract obesity in their populations, as well as the different barriers presented by their culture, tradition and their legal systems to the use of specific interventions. A host of local contextual issues must be considered in determining which interventions are appropriate, and whether these are such as to make legislation necessary.

This report is intended as a resource to help countries work through these issues and assess which anti-obesity measures are likely to be most effective within their particular context.

Summary of Recommendations

In this report, we recommend, as appropriate to local conditions, the following:

- The introduction of low-level, domestic 'sin taxes' to fund health promotion programmes, similar to the system introduced in French Polynesia.

- Tax-funded health promotion foundations to coordinate health promotion activities, nutritional education, and promotion of physical activity.

- WPRO monitoring of the French Polynesian commission on food pricing, to consider whether proactive government intervention in food pricing and supply is applicable to other Western Pacific nations

- WPRO advice and assistance with the econometric analysis that will be necessary to design tax and price based mechanisms for obesity prevention

- WPRO advice, informed by measures introduced in Ghana, to countries who wish to restrict particular products (such as fatty meats)

- WPRO technical assistance to individual Pacific nations, to ensure that anti-obesity trade measures are consistent with PICTA and PACER

- Integration of health and trade policy, as recommended in the joint report of the WHO and WTO from 2000

- WPRO monitoring of the progress of simplified international food labelling initiatives

- WPRO assistance to Pacific countries concerned about the impact of advertising on consumption of high-fat and high-sugar products

- Programmes to promote healthy eating and physical exercise in schools.

- Closer cooperation between WPRO and the Forum Secretariat to explore opportunities to develop regional anti-obesity initiatives within the context of the Pacific plan.

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1. INTRODUCTION: OBESITY IN THE PACIFIC

1.1 Background

In line with global trends, the Pacific is experiencing increased obesity levels (Coyne, 2000, Hughes, 2003). Changes in food supply and lifestyle have led to increased risk of hypertension, heart disease and diabetes. As a result, combating obesity has become an important goal of collective Pacific health action. This is reflected in such initiatives as the Tonga Commitment, and in the actions of individual governments.

Legislation has an important part to play in strategies for preventing and overcoming obesity. This is recognised in the Pacific, as is evident in the background paper prepared for the 2002 FAO/SPC/WHO Consultation on Food Safety and Quality in the Pacific. This paper was published as *Using Domestic Law in the Fight Against Obesity: An Introductory Guide for the Pacific* (WPRO, 2003). The Guide outlines the issues Pacific countries face when using domestic law to address the obesity epidemic. In particular, it highlights the need for countries to consider the trade implications of any legislation they introduce.

1.2 Rationale and scope of the report

This report builds on the 2003 Guide by evaluating the legislative interventions available to Pacific countries in combating obesity. This report focuses on possible legislative interventions for obesity prevention and control. It involves a scan of international initiatives in the area, and a stock-take of existing Pacific interventions to identify how new legislation could be used to improve obesity control strategies. In the process, it considers the contextual issues that Pacific countries must consider if they wish to legislate to assist their obesity prevention measures. As well as local conditions, the relevant context includes consideration of WTO Agreements and domestic trade policies as factors that must influence Pacific law on the issue.

Our brief required us to consider 21 Pacific countries, the Cook Islands, Fiji, , French Polynesia, New Caledonia, Wallis and Futuna, Kiribati, the Republic of the Marshall Islands, the Federated States of Micronesia, Nauru, Tokelau, Niue, the Republic of Palau, Papua New Guinea, Samoa, the Solomon Islands, Tonga, Tuvalu, American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, and Vanuatu. Where possible, we examined both the legislation and the non-regulatory policies addressing obesity in these countries.

1.3 Links to related projects

The nutrition situation in Pacific countries has been the subject of several recent reports. This report should therefore be considered together with Rosalind Gibson's report on macronutrient deficiencies in the Pacific, Allen & Clarke's report on food fortification, and the reports by Bob Hughes and Jackie Knowles on various technical aspects of food fortification.

1.4 Methodology

This report builds on *Using Domestic Law* by examining a range of legislative strategies used to combat obesity internationally. Through consideration of relevant literature and legislation, and building on consultation with researchers and health officials with expertise in the problem of Pacific obesity, it evaluates the legislative interventions that might be implemented in Pacific jurisdictions. It also considers the trade obligations of Pacific countries, in order to recommend how anti-obesity policies can be implemented consistently with those trade obligations.

We used a number of methods to access the information required for the stock take. In the first instance, we developed a questionnaire for distribution to in-country contacts provided by WPRO. WPRO facilitated the distribution of this questionnaire.

We also contacted the countries involved by emails and phone to seek further information and to ensure that the questionnaire was received by the person with access to the relevant information required for the stock take.

The team conducted an internet search for relevant information which included a search of the following websites:

- the Pacific Islands Legal Information Institute (http://www.paclii.org/databases.html)
- the International Digest of Health Legislation (http://www.who.int/idhl/)
- the International Portal on Food Safety, Animal and Plant Health (http://www.ipfsaph.com)
- countries' own government websites
- the FAO's country profiles, located at http://www.fao.org/ag/agn/nutrition/profiles_en.stm
- WPRO's nutrition country profiles: http://www.wpro.who.int/sites/nut/data/

Based on this information the project team constructed country profiles outlining the nutritional status of various WPRO countries and current policies, legislation and trade agreements which impact on a country's nutritional status.

We also undertook internet searches for literature on obesity and nutrition using the internet search engine google, and the academic databases Medline and Web of Science.

1.5 Risks and limitations

This project identifies potential legislative interventions for addressing the obesity epidemic in the Pacific. It identifies these interventions in the context of a stocktake of other anti-obesity measures undertaken in the Pacific.

The stocktake was constrained by timeframes, distance, and available resources. Despite many attempts, we were unable to access all the information we desired. We had particular difficulty accessing current legislation and information about whether legislation was being complied with in practice. We therefore acknowledge that the information in this report cannot be considered complete.

In addition, measures to overcome obesity are in their infancy throughout the world. While there are lessons available from public health interventions in other areas, such as alcohol and tobacco control, obesity prevention is more complex than in either of those cases. It is thus too early to determine which prevention strategies will ultimately prove most effective against obesity.

Various technical issues arise in relation to some of the legislative measures proposed to prevent obesity. Implementing price controls, for example, would require econometric assessments of optimum taxation levels, as well as careful consideration of policy goals and dietary behaviour in each local economy. These assessments are beyond the scope of the present report, though they would be necessary if price controls were to be introduced in any given case.

Finally, while this project focuses primarily on regulatory options, the project team notes that obesity-prevention measures require a supportive policy environment if they are to reach their full potential. Regulation alone cannot address the complex issues involved. In researching these issues, we have been particularly impressed by the policy environment operative in French Polynesia over the past 5 years, and our recommendations are heavily influenced by the public health programme introduced there. It is disappointing to hear that these measures are under budgetary threats, since they include a comprehensive, thoroughgoing and innovative anti-obesity programme which have much to offer other Pacific countries.

2. LEGISLATIVE INTERVENTIONS TO PROMOTE HEALTHY FOOD CONSUMPTION

2.1 Obesity: an international issue

Concerns about obesity are found across the globe. Since obesity reduces the health of populations and incurs significant public health costs, many governments have introduced policy initiatives to address these issues.

Five main types of legislative intervention have been proposed or implemented in an effort to combat obesity. These are discussed in sections 2.2 to 2.6 below.

2.2 Price controls

Price controls are among the more direct obesity-prevention measures available to governments. Evidence, both internationally and in the Pacific, shows that price is an important factor in determining the foods which consumers purchase (Evans et al, 2001; Diabetes NZ, 2003; French, 2003). Since price is a particularly important consumption determinant among low-income groups, price controls have the potential to reduce health inequities in low income groups. Price controls can involve either increasing the prices of foods which contribute to an unbalanced diet and / or reducing the price of foods which would contribute to a more balanced nutritional intake.

A government seeking to introduce price controls could use various legal means:

- taxation on foods that contribute to obesity (such as foods high in fats and free sugars)
- reduced taxes on healthy foods
- subsidies on the production or cost of healthy foods (WHO, 2004).

2.2.1 Domestic taxes

To date, few jurisdictions have imposed taxes on unhealthy foods with the aim of dissuading customers from buying them. When proposed, 'fat taxes' or 'sin taxes' of this nature attract considerable pressure from the food industry. While, in the past, some significant taxes have been imposed specifically on snack foods in various states of the USA, they have tended to be quickly repealed under pressure from industry (Jacobson and Brownell, 2000, p. 856).

Nonetheless, many jurisdictions do impose taxes on soft drinks and snack foods at low rates. As many as 19 states in the USA currently levy taxes on soft drinks and snack foods, either through a general sales tax regime (where food is otherwise exempt from sales tax) or through specific taxation. In most cases, the revenue from these taxes is designated for general state funds. Various

commentators note considerable public support for the idea of using taxes on snack foods to directly fund health education programmes (Jacobson and Brownell, 2000; Strnad, 2003).

'Sin taxes' are used to fund health education in various jurisdictions. The Malaysia Health Promotion Foundation and the Thai Health Promotion Foundations are funded through taxation on alcohol and tobacco;[1] VicHealth in Victoria, Australia, was originally funded by a tobacco tax. As outlined below, French Polynesia also uses taxation to fund its health promotion foundation, while Tuvalu, Fiji, Tonga and Vanuatu are working towards such foundations. The value of these foundations is their ability to provide sustainable resources to engage in public health promotion work according to local needs.

The gains from taxes on foods high in fats or free sugars can be seen when considering global experience of tobacco taxes. In addition to the evidence from controlled studies on food prices (Evans et al, 2001; Diabetes NZ, 2003; French, 2003), tobacco taxation experience indicates that increased prices reduce the prevalence of tobacco use among adolescents and young adults (Wilson, 2003). Caution would be necessary, however, to determine optimal taxation levels. There is concern, for example, that taxes on processed foods of low nutrient value disproportionately impact on low-income families (Yach et al, 2004). Taxes also affect those consuming only moderate amounts of less healthy food (Strnad, 2003). Taxation policy must therefore consider its effect on the entire population.

2.2.2 Import Duties and tariffs

Many of the foodstuffs which contribute to the obesity epidemic in the Pacific are imported from outside the region. In theory, increasing tariffs and duties on them could reduce their intake in local populations. To date, no known country has imposed import duties with this express aim. Yet, the volume of high-fat foods imported into the Pacific region means that import duties could be useful in restricting consumption of foods contributing to obesity. However, import controls also present difficulties under trade agreements. These difficulties are discussed further below in section 4.

[1] http://www.healthpromo.gov.my/ ; http://www.thaihealth.or.th/en/

2.2.3 Subsidies for healthier foods

As with import controls, no known jurisdiction subsidises healthy foods in order to combat obesity. However, trials show that pricing strategies can have a significant impact on the purchase of healthy foods (French, 2003), so that subsidising healthier foods has the potential to shape diets in healthy ways. As an extension of this idea, taxes imposed on less healthy foods could be used to cross-subsidise healthier foods. Various commentators have made such proposals, although they have not been implemented in any known jurisdiction.

In isolation, subsidies are a simple and probably effective means of influencing food intake. However, they can attract difficulties under international trading agreements. As with import duties, subsidising the local production of healthy foods involves prima facie discrimination in favour of local goods. Thus, Callard et al (2001) suggest that Canadian government subsidies, encouraging farmers to grow crops other than tobacco during the 1980s, might be held contrary to WTO Agreements today. A fairer subsidisation regime would not differentiate between the source of subsidised foods.

2.3 Restrictions on Supply of Particular Foods

2.3.1 Product bans

Completely banning the sale or import of a particular food is the most direct method of restricting its supply. As discussed in section 3.2 below, this has largely failed in Fiji. Fiji's example suggests that banning particular foods is of limited effect in obesity control when multiple foods are available on the global market. One banned food high in fat can be replaced all too easily with another.

Nonetheless, Ghana has effectively engaged in product restriction by restricting imports of fatty meats. Rather than banning these meats outright, it has set composition standards which must be met before meat can be imported into the country. Beef must contain 25% or less fat, pork 42%, and mutton 35%. Turkey meat and turkey tails may not be imported unless the oil glands have been removed[2]. Ghana thus controls imports in a manner designed to protect public health and to be acceptable internationally from a trade perspective.

2.3.2 Restricting supply to youth

Globally, several key attempts to restrict the supply of unhealthy foods have targeted children and young persons. These attempts have been triggered by

[2] http://www.otal.com/ghana/ghanaimports.htm

concern that adult eating habits are formed in childhood. Further, recent research indicates that children's intake of some foods, such as sweetened drinks, contributes significantly to overweight and obesity in some populations (Striegel-Moore et al, 2006; Ebbeling et al, 2006.)

Food available in school

One method of improving children's diet is to control the nutritional quality of foods that they eat at school. The United States has used legislation to promote healthy eating through the Federal Meal Program. Under the programme, lunches must meet nutritional standards prescribed by the Secretary of Agriculture on the basis of tested nutritional research.[3] Further, at lunchtime in the food service areas of US schools, "foods of minimal nutritional value" (FMNV) must not be sold in competition with food provided under the Federal Meal Program. It should be noted that, US involvement in the Pacific means that some of these programmes are already operational there. The full Federal Child Nutrition Programme applies in Guam, while other free or reduced-cost meal programmes also apply in US territories in the Pacific. 100% of children in American Samoa, 75% in Palau, 67.9% in Guam, and 61% of children in the Marianas are on subsidised lunch programmes (National Center for Chronic Disease Prevention and Health Promotion, n.d.).[4]

Nutritious school lunch programmes also operate elsewhere. In England and Wales, Local Education Authorities are empowered to provide pupils with school meals, which must then meet mandatory nutritional standards.[5] These regulations are focused on enabling healthy eating options, and reducing consumption of foods cooked in oil and fat.

Food available in schools outside meal programmes

However, regulating the nutritional value of food available in schools cannot control children's entire diets. For example, school meals are not children's only source of food, even when they are at school. Consequently, some jurisdictions have attempted to control the quality of all the food available in schools. Hawkes (2004a) identifies 11 countries where restrictions on certain food products have been tried, including a large number of US States. (See also Wellever et al, 2004, pp. 25-26.) Various measures have been implemented in those States, which include directing schools to introduce healthy food choices for pupils, requiring

[3] The National School Lunch Act (42 USC 1758) as amended in 2004 by Public Law 108-265 (http://www.fns.usda.gov/cnd/Governance/Legislation/PL_108-265.pdf). The nutritional standards and the definition of FMNV are set out in §210.10 of the relevant regulations, available at http://www.fns.usda.gov/cnd/Governance/regulations/210_2006.pdf).

[4] In addition, the Federal Food and Nutrition Service supplies nutritious agricultural commodities to the Marshall Islands and the Federated States of Micronesia under the Food Donations Program (http://www.fsa.usda.gov/dam/bud/AppropAction/107116.pdf).

[5] Section 512 of the Education Act 1996; Education (Nutritional Standards for School Lunches) (England) Regulations 2000. See http://www.opsi.gov.uk/si/si2000/20001777.htm.

schools to make nutritional information available about the types of food sold, introducing additional physical activity, prescribing the food that may be sold during school mealtimes, prescribing the type of food that may be sold as snacks and the size of snack portions, restricting or banning vending machines, and working towards complete bans on carbonated drinks.

In France, measures to ban soft drinks and other sweet foods through vending machines in schools were introduced in September 2005. Similar measures seem imminent in the United Kingdom, through the work of the new School Food Trust. Various local governments in Belgium and Germany have also restricted the sale of soft drinks and confectionary in the vicinity of schools.

As with all anti-obesity measures, regulating the foods available in schools is an important part of any obesity-prevention strategy, both to educate children at an important time in their lives, and to improve their diet.

2.3.3 Restricting supply to youth at point of sale

An alternative method of restricting youth access to nutritionally unsafe foods would be to impose controls at point of sale, on the basis of age. Such controls would be similar to the age restrictions imposed by many countries on the sale of alcohol or tobacco products.

The experience of tobacco regulation suggests that, to work, age restrictions must be comprehensive and strictly enforced. In addition, restrictions on the supply of tobacco should form part of a wider strategy of control, education, and health promotion. Tobacco control experience also shows that controlling children's access to cigarettes requires comprehensive bans on the sale of single cigarettes, self-service, and vending machines, as well as vendor licensing and fines on vendors who violate the law (Woollery, Asma & Sharp, 2000).

Parallels with tobacco control are inexact, and attempting age restrictions on food supply would face many additional difficulties. Low-nutrition foods come in many different forms, so that imposing comprehensive and effective restrictions on *all* offending foods would be almost unworkable. Further, part of the Pacific nutrition problem stems from foods served at home. Thus limiting sales of soft drinks and snack foods to children can only contribute to an obesity solution.

2.4 Product information and labelling

Labels to indicate the composition of foods have become commonplace internationally, and have been made mandatory in several countries. This has become easier since the Codex Guidelines on Nutrition Labelling were

promulgated by the FAO in 1985.[6] Studies suggest that significant percentages of the public consult food labels where these exist, and that those who use food labels to guide their choices have a lower fat intake (Diabetes NZ & FOE, 2003).

Although uncertainties remain about the overall effectiveness of nutrition labelling in resisting obesity, it is being used internationally as an anti-obesity measure. In 2001, Brazil introduced mandatory nutrition labelling as a key part of its anti-obesity initiatives (Hawkes, 2004b, p. 16). Food sold in Brazil must list 7 specified nutrients and their percentage contribution to a healthy daily diet.

While nutritional content labelling is valuable, understanding it requires considerable knowledge about diet and food types. It is unlikely, therefore, to change food consumption patterns substantially across entire populations. In light of this, there are increasing calls for simple food labelling systems that simplify consumer choices so that consumers can choose healthier foods without comprehensive nutritional knowledge.

Several simple labelling systems operate throughout the world. The Heart Foundations in New Zealand and Australia maintain programmes of "heart tick" labelling for foods that are lower in fat, sodium, and added sugar than comparable foods. Similarly, Sweden's "green keyhole" system encourages consumers towards low-fat and enriched-fibre foods.[7] The Food Standards Agency (FSA) in the United Kingdom has been consulting on a government-sponsored but voluntary system for "signposting" various foods.[8] FSA proposals favour a "multiple traffic light" system of food labelling where foods are classified according to nutritional value, and marked with green, orange, or red traffic light symbols to indicate whether they contain low, medium, or high levels of total fat, saturated fat, salt, and sugar. These levels are linked to European Union criteria, and to guideline daily amounts.

All these simplified food-labelling systems are voluntary. While voluntary systems must be adopted by manufacturers and importers if they are to succeed, their voluntary nature minimises the chances that they present barriers to trade, since food producers and importers are free either to use or not use the labels. However, with due consideration of trade issues, such labels could be made mandatory.

An alternative to the kinds of simplified labelling discussed above would be warning labels, comparable to cigarette warning labels. Such labels could

[6] Available online at http://www.fao.org/documents/show_cdr.asp?url_file=/DOCREP/005/Y2770E/y2770e06.htm
[7] http://europa.eu.int/comm/enterprise/tris/pisa/cfcontent.cfm?vFile=120040493EN.DOC; www.slv.se.
[8] See http://www.eatwell.gov.uk/foodlabels/trafficlights/ ; http://www.food.gov.uk/multimedia/pdfs/signpostnov05app2.pdf.

feature negative symbols or messages that warn against too much consumption of particular foods (Diabetes New Zealand, 2003).

2.5 Advertising restrictions

Throughout the world, enormous amounts of money are spent annually on advertising, including food advertising. There is evidence to suggest that advertising on foods contributes to unbalanced diets (Diabetes New Zealand, 2003). Consequently, many countries have imposed or proposed restrictions on advertising, including food advertising, especially with a view to protecting children. The international measures regulating food advertising to children are summarised in a 2004 WHO report (Hawkes 2004a). Most advertising controls summarised there have been directed at television, and apply to all products, not just food. These controls vary between voluntary advertising standards codes, controls on the timing and content of advertisements, bans on advertising food to children, and bans on advertising all products to children.[9] Such measures have also influenced multinational food companies, some of whom have responded by issuing advertising guidelines. Outright bans on advertising all products to children have been implemented in at least three places: Sweden, Norway, and Quebec. The effect of these bans is unclear, although there are some suggestions that they have reduced consumption of unhealthy food products (Hawkes 2004a).

In addition, some countries have restrictions specifically on the advertising of food, imposed either through self-regulation or as legal requirements. Some of these restrictions are aimed at the whole population, and others specifically at children. Controls are aimed at a variety of issues including dental hygiene, unhealthy diets, and misleading statements about foods' nutritional value (Hawkes 2004a). As well as general restrictions on advertising, some countries, particularly in Europe, have implemented controls on food advertising and sponsorship in schools (Hawkes, 2004a). These have similar aims to the measures restricting the availability of certain foods in schools, discussed above at section 2.3.2.

While little work has been done to assess the effect of these advertising bans on populations' total diet, there are continued calls for further advertising restrictions on food. For example, various Bills have been debated in the British and Irish Parliaments,[10] proposing measures to ban the marketing of classes of food that are assessed as detrimental to children's health.

[9] The International Code of Advertising Practice, issued by the the International Chamber of Commerce, has been influential in this area. It contains little specific on food or health, but does contain provisions aimed at protecting children from harm to their health: http://www.iccwbo.org/policy/marketing/

[10] http://www.publications.parliament.uk/pa/cm200506/cmbills/023/06023.i-i.html; http://www.oireachtas.ie/documents/bills28/bills/2003/5403/b5403d.pdf

Restrictions on food advertising may form an important part of an obesity prevention strategy, although they need to form part of a broader strategy for intervention. Indeed, experience from the limits imposed on tobacco advertising suggests that advertising restrictions are effective only if they apply comprehensively to all media and all uses of brand names and logos. Moves to restrict food advertising would need to be similarly broad if they are to be effective. Indeed, there are indications that restricted food advertising leads to a proliferation of alternative marketing methods (Yach et al, 2004). Measures to limit advertising must, therefore, be comprehensive.

2.6 Promoting balanced diets and physical activity

Health promotion and dietary education are key in overcoming obesity. In many countries, health promotion is a basic function of the government agencies responsible for health, education, or sport. For example, in the United Kingdom, the Department of Health and the Department for Education and Skills have worked together on a Healthy Schools Programme to promote physical activity among school children[11]. In Cuba, participation in sport is encouraged among the whole population as a public health exercise.[12]

Nonetheless, some jurisdictions have enacted specific measures requiring education on nutrition and exercise. In the United States, several states have legislated to promote physical activity or nutrition education in schools. Such measures include expanding Physical Education programmes, requiring schools to report on the hours that pupils spend in physical activities, planning infrastructure in ways that build physical activity into school routines (Wellever et al, pp. 27-28)[13], and requiring or encouraging nutrition education in various forms.

In addition to school promotions, many states have used legislation to promote walking and cycling, by funding pedestrian access routes and cycleways (Wellever et al, p. 28). Some states have altered their public development and land use policies in order to encourage physical activity in adults. Federally, the United States Task Force on Community Preventive Services has recommended actions to increase physical activity, such as the construction of walking paths,

[11] http://www.publications.parliament.uk/pa/cm200304/cmselect/cmhealth/23/4031102.htm

[12] http://www.publications.parliament.uk/pa/cm200304/cmselect/cmhealth/23/4031102.htm

[13] Colorado Statutes, section 22-28-106 available online at http://198.187.128.12/colorado/lpext.dll?f=templates&fn=fs-main.htm&2.0 / www.leg.state.co.us/Clics2005a/csl.nsf/billcontainers/B22095692E95C60087256F4D006D5B5A/$FILE/081.enr – California, Education Code, §8990, §49435, §49433 available online at http://www.leginfo.ca.gov/calaw.html

encouraging physical activity in work places, and providing incentives to use gyms and other facilities (POD Report, p. 20).

3. CURRENT PACIFIC INTERVENTIONS

3.1 Contextual issues

A comparison between the obesity-prevention measures already introduced in the Pacific indicates the range of issues to be addressed, and the contextual differences between the countries. It is clear that the level of development of food-related legislation varies significantly, and that there are obvious gaps in the legislative frameworks of most countries.

Table 1 outlines the regulatory measures that have been introduced with the aim of controlling obesity. With the exception of French Polynesia, every country which has legislated against obesity has acted in a piecemeal fashion (as is the case with Fiji's ban on mutton flaps). There is also legislation in place which has implications for obesity prevention (such as sweetened beverage taxes), but which was not enacted specifically with obesity in mind.

With respect to food laws and standards, Pacific Island countries often have either no laws, or outdated laws and standards. In addition, many Pacific Island countries have yet to identify how they can be effective participants in the work of the Codex Alimentarius Commission. There are also varying standards of enforcement, education and training among different countries which contribute to inequity in levels of food safety across the region (WPRO,2003a). Import and export inspections are variable, and much food is traded without adequate controls.

The information in these tables has been gleaned from various sources. Allen & Clarke distributed a questionnaire to health officials throughout the Pacific, and much of the information has come from those completed questionnaires. In addition, the tables include information gathered for the DPAS meeting convened by the WHO, information published by the FAO ,information in the FAO/SPC/WHO consultation on food safety and quality in the Pacific (WPRO, 2003a), and information contained in the Annexes to the PICTA agreement.

Table 1: summary of legislative interventions relevant to obesity prevention in Pacific Island Countries.

	Obesity problem groups	Interventions:	Planned interventions?	Comment
American Samoa		- Taxation on beverages - US Federal law applies		
Cook Islands	Significant problem in several population groups	- Ministry of Health Act 1991: responsibility for health of Cook Islands people - Import Levy Act 1972 levies on food; not aimed at obesity but at protecting local industry	- sin tax proposed	
Federated States of Micronesia	Middle-aged urban women	- endorsing WHO breastfeeding guidelines in legislation - National Food Safety Act 1991 prohibits import or export of foods dangerous or injurious to health. - National Food Safety Act allows standards for composition and labelling of foods.	- price controls proposed under 2006-2010 draft NPAN	- desire to use Codex as basis for food standard setting
Fiji	Significant problem, especially among middle-aged urban, Fijian women	- mutton flap imports banned under Fair Trading Decree, which allows prohibitions of goods likely to adversely affect the health or wellbeing of any person - Food Act allows prohibition of certain foods, and controls on advertising and promoting of foods. - Food Act regulations may restrict substances having no or little nutritional value as food or ingredients - Excise Act 1986 duties on sugar, chocolate, margarine, instant noodles, sausages, edible oils, and snack foods, but aim to protect local industry not discourage import of high fat, salt and/or sugar foods. Duties to be phased out under PACER and PICTA - 10% tax on soft drinks from 2006		
French Polynesia	Increases with age. Highest levels among women and indigenous population	- tax on alcohol, soft drinks, ice cream, chocolate, and sweets for creation of Prevention Fund; raised 1.8 billion French Polynesian francs in first year of operation (2002); money allocated by E.P.A.P . (*Etablissement pour la prevention*) to extensive range of		Future of E.P.A.P. funding at risk following December 2005 budget

	Obesity problem groups	Interventions:	Planned interventions?	Comment
		health promotion projects, including obesity prevention.		
Guam	Middle aged, indigenous	- US Federal law applies		
Kiribati		- Consumer Protection Act 2001 requires goods to comply with prescribed standards. No controls on suspect foods - duties under Customs Act 1993 to be phased out under PICTA and PACER		
Mariana Islands	Indigenous population	- Taxation - legislation to construct walkway - Pure Food, Drug and Cosmetic Device Act 1998 requires food labelling, and compliance of imported food with prescribed standards. Standards can be made for preventing injury to consumer health. Regulations may be made about ingredients and food composition. - trade with USA		
Marshall Islands	Middle aged women	- trade relationship with USA	- taxation	
Nauru	No information provided.			
New Caledonia	No information provided.			
Niue	Middle-aged women		- funding mechanism?	
Palau	Young, working women	- trade relationship with USA		
Papua New Guinea	Urban problem	- Pure Food Act, not directed at obesity - Customs Tariff Act: tariffs on potato chips and French fries, sugar confectionary, some oils and fats etc; phasing out under PICTA and PACER by 2016		
Samoa	Middle-aged urban women	- Excise Tax Rate 1984 - 45% tax on imported sugar only - Value Added Goods and Services Tax 1992-93 zero-rates raw, unprocessed foodstuffs - duty on turkey tails, turkey wings, pigs' trotters, and beef	- taxation - funding mechanism	

Comment [t1]: See also http://www.worldlii.org/pg/legis/consol_act/cta1990178/ - there are tariffs on oils, fats etc

	Obesity problem groups	Interventions:	Planned interventions?	Comment
Solomon Islands	Middle-aged urban dwellers	Pure Food Act 1996 provides regulation-making powers on standards, additives and labelling, which could be used to regulate high fat, salt and sugar foods. Price Control Act 1982, aimed at securing food supply, imposes price controls on products. Goods Tax Act 1993 taxes sugar, biscuits, and brewed soft drinks at 5%. Both allow exemptions and could be used to promote healthy foods.		
Tokelau	Middle-aged and older women	Customs Regulations 1991 – levies at 6%, but PICTA and PACER will require phase-out		
Tonga	Middle-aged populations	- Consumer Protection Act 2000 - goods must comply with standards prescribed under regulation - Customs and Excise Act 1984; levies to be phased out under PICTA and PACER	- possible regulation	- import ban on fatty meats rejected
Tuvalu	Middle-aged women	Pure Food Act, and work of Price Control Committee Price Control Act 1990 controls prices of butter, sugar, edible oils and corned canned beef and mutton. Not directed at obesity, and PICTA and PACER will require removal.	- National Health Promotion Bill currently before Parliament	
Vanuatu	Middle-aged urban women	- Food Regulations - Food Control Act 1993 allows regulations for labelling and standards. Also establishes Vanuatu National Health and Food Safety Fund for preventing and reducing malnutrition; and improving nutritional status. Could be adapted for obesity. - Meat Supply Act 1977 regulates quality of domestically-produced meat; third grade (high fat) meat only for canning. - Price Control Act 1975 allows price controls. Import Goods (Control) Act 1984. Vanuatu is a signatory to PICTA and PACER	- considering Health Promotion Foundation	
Wallis & Futuna	No information provided.			

Table 2 outlines the non-regulatory measures directed at obesity control in the surveyed Pacific countries.

As can be seen, there is a wide range of measures in place. Most countries operate at least some form of health promotion or education, aimed at increasing public awareness of obesity risks. Education is directed both at providing nutritional information, and at encouraging physical activity and exercise. Many of these promotions occur in schools, though there are also more general, community-based promotions. There is also a good number of media campaigns aimed at promoting nutritional awareness and healthy eating, as well as local weight-loss campaigns, physical activity programmes, and screening programmes.

Many countries also have nutritional guidelines and action plans in operation, although some of these may exist more on paper than in action. Many were prepared as part of countries' National Plans of Action for Nutrition, formulated under the World Declaration and Plan of Action for Nutrition, rather than with the specific goal of combating obesity.

In general, the table indicates good awareness of the issues raised by obesity, but a slightly ad hoc approach to obesity prevention.

Table 2: summary of non-regulatory policies for obesity prevention in Pacific Island Countries.

	Non-regulatory Interventions:	Planned interventions?	Comment
American Samoa	- nutrition education in clinics and schools - 5+ a day fruit and vegetable promotion - school meal programmes - Prevention Block funded fitness classes in schools, government agencies, community groups, churches - NPAN		
Cook Islands	- school-based programmes and teacher training - media awareness campaign - national advocacy programmes - non-communicable disease plan - non-communicable disease guidelines - screening programme - weight education programme - health education in workplaces -Guidelines for the Prevention and Management of Hypertension, Diabetes and Obesity	- training of nutritionist - workplace programmes - promote physical activity and provide equipment - implement Green Prescription scheme - provide training in NCD nutrition	
Federated States of Micronesia	- community awareness and education - school based activities - weight control and physical activity groups - National Food Guide - National Nutrition Policy and Plan of Action - Fruit and vegetable promotion - physical activity promotion; organised sports -obesity screening	- school programme - support physical activity and provide equipment - weight control programme	- National and Nutriti Commissi intersector focus
Fiji	- Healthy canteen guidelines for schools, and school nutrition policy - Healthy workplace policy of physical activity - City Council initiatives in Suva - Move for Health Campaign and walkway - health staff training through one-day workshops - health promotion in schools, workplaces, churches through National Health Promotion Unit - media awareness - mini-STEPS evaluation for non-communicable diseases - patient education and counselling - National Dietary Guidelines	- training in physical activity and diet - social marketing programme - healthy food accreditation - Advocacy Agency - Healthy City initiatives - implement Green Prescription scheme	
French Polynesia	- E.P.A.P. health promotion foundation, funded by sugar tax; Territorial Programme for Healthy Life and Weight - Annual media campaigns - School programmes: nutrition education in curricula; health and nutrition teaching kits; health education guidelines; improved nutritional quality of school meals through HACCP analysis; replacement of vending machines by water dispensers; assistance for physical education programmes; health committees in schools; creation of Sports Schools; Walk for Health programme; Ministry of Sports promotion of sport and activity - Promotion of breastfeeding and child nutrition: training; awareness campaigns - Training of health professionals: alterations to nurse	- evaluation and targeting of media campaigns - evaluation of teaching methods - evaluation of health professionals' screening practices - good eating guide - spread and adapt grassroots activities - produce website - adapt school curricula - promote infant nutrition - train professionals and community workers - improve medical practices	Since 200 French Polynesia implement comprehe multi-secto programm interventio all levels o society. Resourced through th E.P.A.P. w funded by sugar prod

	Non-regulatory Interventions:	Planned interventions?	Comment
	training curriculum; creation of dietetic posts; guidelines on preventing obesity; training of sports educators, biology and P.E. teachers in nutrition, health, physical activity, and obesity prevention - Improved medical practices: establishment of reference centres and nutrition units for health in schools and childhood centres; creation of diabetic house; establishment of obesity screening programmes and recommendation sheets - Plans to improve quality of food supply: sugar tax; modifications to staple goods list; government commission to promote local agriculture; commission established to investigate quality-price-service ratio on food and non-food products (2005) - Tama'a Tano Noa Project promoting balanced diet in snack bars & vans through audits and proprietor training - Research into diet and obesity; diabetes and obesity	- promote balanced diets through a range of policies - improve quality of food in snack bars and food vans - improve school food - promote daily physical activity with families and individuals - continue research - Consultative commission investigating price controls to promote balanced diet - 2006 project to establish specifications for food sols in school snack bars and vans - 2006 intersectoral project, "Physical Activity for All" - 2006 survey into prevalence of diabetes and obesity	
Guam	- reducing obesity is a National Health Objective - Guam's Preventive Health & Health Services Block Grant funds Chronic Disease Prevention and Control Program which aims to reduce diabetes and obesity - diabetes screening programme; - Health Lifestyles for Healthy Generations; Lifestyle Nutrition Health Services Program - education programmes through faith communities and Care Givers Association - Guam Health Education and Promotion Program - Fruit and vegetable consumption promotion - Lifestyle Website (www.guamhealth.com) - Dietary Guidelines; Pacific Food Pyramid - interventions based on US Public Health Service's *Healthy People 2000*		
Kiribati	- Nutrition Policy/ National Plan of Action		
Mariana Islands	- community education and role modelling in schools, churches, workplaces - organised walks - Project Familia: training in portion control, shopping strategies, increasing activity levels etc		
Marshall Islands	- healthy stores campaign - school based programmes - advocacy and awareness programmes, media awareness - organised physical activity and demonstrations - National policy on agriculture, food and nutrition	- church, workplace, and family programmes - promote physical activity and provide equipment - weight control programme	
Nauru	No information provided.		
New Caledonia	No information provided.		

	Non-regulatory Interventions:	Planned interventions?	Comment
Niue	- SHEP (School Holiday Education Programme) - Primary school sports - National advocacy and awareness events - school curriculum development - dietary guidelines - Regional Nutrition Policy - physical activity and equipment promotion - fruit and vegetable promotion - implementation of clinical guidelines - screening programme	- school programmes - organised advocacy and activity programmes - curriculum development - food labeling - implement funding mechanism - involve community and improve environment	
Palau	- media awareness - organised advocacy programmes in workplaces and villages - non-communicable diseases strategic plan - support for physical activity - National Nutrition Plan and related NCD plan - weight loss programmes for health staff - obesity screening in schools - food service certification policy and food standards	-training in physical activity and diet - workplace programmes - build multi-sectoral partnerships	
Papua New Guinea	- awareness programmes - food standards and nutrition policies - Nutrition for PNG manual	- develop IEC materials - develop strategic NCD plan - develop supportive environment for physical activity - set up multi-sectoral taskforce	
Samoa	Involvement from Department of Health; Ministry of Agriculture, Forests, Fisheries and Meteorology; Department of Education; Ministry of Women's Affairs; Ministry of Youth, Sports and Culture in: - "Fruit Tree" promotion to promote fruit consumption - community education and training - advocacy events - mass media awareness - national physical activity events - workplace programmes; village programmes - National Dietary Guidelines, National Nutrition Policy, National Non-Communicable Diseases Policy, National Health and Physical Education Curriculum, National Sports Policy - provision of sports equipment - hospital health food promotions - obesity screening - patient counselling - cooking demonstrations - weight loss competition for health workers - promotion of local and home food production - Health Promoting Schools Committee to improve food in school canteens	- media campaign - training - school and workplace programmes - Healthy Food policy in schools - supportive environment for physical activity - healthy role models - screening - research - health worker training - individual counseling - clinical obesity guidelines	
Solomon Islands	- workplace programmes - weight loss programmes - community education - media awareness - clinical non-communicable disease guidelines - obesity screening		

	Non-regulatory Interventions:	Planned interventions?	Comment
	- weight-loss programme for health workers - National Food and Nutrition Policy and NPAN		
Tokelau	- community awareness and education - in-service training	- involve community - provide health role models - train health educators; National Plan for training health staff	
Tonga	- Workplace programmes - community awareness and education, church and workplace - Health promotion foundation - physical activity guidelines - weight-loss competitions; weight-loss classes - obesity screening - TV and radio promotions - capacity building in medical staff - National Food and Nutrition Policy; National Plan of Action - footpath construction	- community involvement - more weight loss competition - compulsory physical activity for health staff	
Tuvalu	- national physical activity programme - media awareness - community training and education - National Food and Nutrition Policy, NPAN - provision of equipment for physical activity - weight loss programme - patient education and counseling - home medical visits	- cooking training - weight reduction programme - clinical guideline on obesity - organised physical activity for health staff - obesity clinic	
Vanuatu	- community training and education - development of IEC materials for education and awareness - individual counseling -Walk for Life programme - Youth Gardens project - NPAN / National Food and Nutrition Policy - NCD plan - physical activity policy for workers - Clinical guidelines - screening - health information	- training on physical activity and diet - produce and disseminate IEC materials - establish supportive walkway - train educators	
Wallis & Futuna	- nutritional education		

Clearly, a diverse range of measures has been undertaken to improve nutrition and increase physical activity throughout the Pacific. In some Pacific countries, the legislative framework already allows for extensive health promotion activity. The Cook Islands Health Board, for example, exists "to promote, protect, and conserve the public health" of Cook Islanders (s. 5, Ministry of Health Act 1991). Legislation like this allows government departments to exercise their statutory powers to address obesity. In Fiji and Tonga, for example, notable obesity and nutrition education programmes are being pursued as an extension of existing government functions (WPRO, 2005, p. 4).

In what follows, we consider some particular legislative measures being pursued in the Pacific Islands.

3.2 Fiji - Product bans

Cheap, fatty meats, often imported from New Zealand and Australia, make a disturbing contribution to energy imbalances in several Pacific countries. The nutritional composition of products like mutton flaps makes them a significant public health hazard, apparent from the fact that they are not widely consumed in the exporting countries. While several countries have proposed bans on these, Fiji is the only country to have implemented one. This ban on mutton flaps was effected in 2000 through a prohibition order issued under section 102 of the Fair Trading Decree 1992.[14] At face value, the ban simply prohibits the supply of mutton flaps, but it is effectively an import ban, since the product comes from abroad. Certainly, New Zealand raised trade objections to the Fijian measure on this basis.

Thus, if mutton flaps are banned for health reasons, but not chicken parts or high-fat potato chips, a case can be made that the ban is an effective trade restriction. Thus, a ban on mutton flaps from New Zealand might lead to an increase in the purchase of turkey tails from the USA, say, which New Zealand could view as effective trade discrimination in favour of the USA. Those alleging discrimination would argue that products with a similar effect must be treated in the same way. (For discussion about overcoming these risks, see below, section 4).

As well as being in potential contravention of WTO Agreements, Fiji's ban has proved largely unworkable in practical terms. Although mutton flaps are no longer imported on their own, anecdotal evidence suggests that whole sheep carcasses are now imported to Fiji, so that mutton flaps can enter the market by another route. In addition, other fatty meats, to which the order does not apply, remain available on the Fijian market. These developments suggest that selective product bans are of limited value in restricting the consumption of

[14] Prohibition Order – Lamb Flaps – L/N 14/00.

products that contribute to obesity. Controls on high-fat products need to be implemented after consideration of the whole market, and of the likely consequences of any product ban.

The Fijian example has had repercussions elsewhere in the Pacific. In 2004, the Tongan cabinet considered a proposal to impose quotas on the importation of mutton flaps and turkey tails. Yet, concern over Fiji's experience, at a time when Tonga was acceding to the WTO agreements, meant that the proposal did not proceed.

3.3 Health Promotion Foundations

Several Pacific countries have proposed, or have introduced, health promotion foundations with a specific remit for obesity education. Thus, French Polynesia operates a comprehensive programme aimed at preventing obesity in its population. The programme is funded by E.P.A.P., an interdepartmental government organisation responsible for a range of public health programmes,[15] rather like I.N.P.E.S. in France. E.P.A.P's Prevention Fund is resourced through domestic taxation on a wide range of products, including soft drinks, alcohol, chocolate and ice cream. This collects over 1.5 billion FP francs per annum, which is largely used for public health purposes. In relation to obesity, the Fund is used for health education, preventive training, clinical education, and research. It also funds various interventions aimed at improving access to quality food and physical activity.

The French Polynesian prevention programme works at a local level, in a contextually appropriate manner. Its educational activities include six-monthly media campaigns, the production of nutrition teaching kits for schools, and community health projects for promoting physical activity. It has also produced clinical guides for treating and preventing obesity, and other clinical tools. In the field of health promotion, the programme strives to find strategies appropriate to local conditions. As well as efforts to improve the nutritional quality of school meals, there have been attempts (such as the Tama'a Tano Noa Project) to work with the proprietors of snack bars, soda shops, and food vans in order improve the quality of food available near schools.[16] The measures involved in these attempts have been primarily non-coercive. With education and promotion, parents, children, schools, and food sellers are encouraged to change their attitude and behaviours in relation to food.

Measures like these provide an excellent model for other Pacific countries. It is significant that some other countries, such as Fiji, Tonga, Tuvalu and Vanuatu, are presently considering tax-funded health promotion foundations.

[15] See http://www.gouvernement.gov.pf/articles.php?id=605 for details.
[16] International evidence suggests the importance of such measures, as foods banned from schools in some countries are often readily available from vendors nearby (Hawkes 2004a).

3.4 Taxes elsewhere

While French Polynesia's example is invaluable, other countries in the region also impose taxes on foods that contribute to the obesity epidemic. Among others, Fiji and American Samoa have taxes on soft drinks. Samoa levies duties on various meats, including turkey tails, tukey wings, and pigs' trotters. Under PICTA (the Pacific Islands Countries Trade Agreement), Papua New Guinea is allowed to impose tariffs on potato chips, french fries, sugar beet and other cane sugars. Kiribati, Niue and Tuvalu also impose tariffs on various oils. (It should also be noted that PICTA requires tariff elimination by 2016.)

Many of these taxes were introduced before obesity became the focus of public health concern in the Pacific. Nor, apart from those countries contemplating health promotion foundations, is the revenue from these taxes directed specifically to health promotion or obesity prevention. On their own, therefore, such low-level taxes and duties on soft drinks or fatty foods will have little impact on the prevention of obesity. Yet, with careful planning and assistance, they could be used to fund extensive and comprehensive health promotion activities.

The examples above show that there is a readiness in the Pacific to address obesity issues and a willingness to innovate in doing so. In particular, the comprehensive, multi-levelled approach employed in French Polynesia is commendable. With the necessary contextual adjustments, its example can serve as a model for other countries to follow.

4. INTERNATIONAL TRADE AND OBESITY CONTROL

4.1 Trade considerations

Because of the role imported foods play in the Pacific diet, any measures to influence the foods sold in Pacific countries must consider trade issues and be consistent with the country's international trade obligations. This is so whether the measures are implemented through tariffs, subsidies, taxes, or product bans.

As appropriate, the trade agreements involved are the WTO agreements, PICTA, PACER, the Cotonou Agreement, and the Compacts of Free Association with the United States.[17] This section of the paper summarises the key elements of these

[17] Fiji, Papua New Guinea, the Solomon Islands and Tonga are **WTO members**, while Samoa and Vanuatu are applying for membership. The Cook Islands, Federated States of Micronesia, Fiji, Kiribati, Nauru, Niue, Palau, Papua New Guinea, Samoa, Solomon Islands, Tonga and Vanuatu are **PICTA members** (see http://www.forumsec.org/), while those 12 countries, plus the Marshall Islands and Tuvalu are **PACER members** (http://www.forumsec.org/). The same 14

agreements and provides a general guide for countries as they consider the trade issues applicable when developing policy to control the consumption of foods contributing to obesity.

4.1.1 WTO obligations

The broad principles of the WTO Agreements are found in the General Agreement on Tariffs and Trade (GATT), established in 1948. The two key WTO principles are:

(i) non-discrimination between trading partners (known as the 'most-favoured-nation' principle), and
(ii) non-discrimination between imported and locally-produced goods (known as 'national treatment') (WHO and WTO, 2002).

In essence, these two principles require that all goods must be treated alike for the purposes of trade, irrespective of their origin. In general terms, WTO signatories must open their borders to products from all other countries, and not implement measures that have the effect (whether intended or not) of favouring domestic over imported products. Similar provisions are found in the Technical Barriers to Trade Agreement (the TBT Agreement), which prohibits governments from using technical standards or product regulations as a covert method of restricting trade.

In certain situations, the two non-discrimination principles do not apply. Special provisions have been adopted in relation to WTO members which are "developing countries" or "least developed countries", and in relation to regional trade agreements such as PICTA. These allow developing countries and least developed countries greater flexibility in implementing certain WTO rules. For example, under stated conditions, regional trade agreements like PICTA may grant more favourable trade conditions to the regional parties than to other WTO members, even where this departs from the guiding principle of non-discrimination.

There are also exceptions to the principles of non-discrimination which allow member countries to act in ways that protect the health of their populations. Under article XX(b) of the GATT, countries may adopt trade measures that are 'necessary to protect human, animal or plant life or health'. At face value, this provision would justify measures designed to prevent obesity. The burden of proving that a trade restrictive measure falls within this exception lies with the country that has implemented the regulatory intervention. To justify its measure, the country must meet a two-stage test:

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countries who are PACER members are also parties to the **Cotonou Agreement**. In addition, Palau, the Federated States of Micronesia and the Republic of the Marshall Islands have each entered into **Compacts of Free Association with the USA**.

1. It must show that the health measure is necessary – that is, that it is **effective** and that **no less restrictive trade measures were available** to achieve the same public health purpose; and

2. If the measure is proven to be necessary, the country must show under article XX that the proposed measure does not constitute a 'disguised restriction on international trade' or 'arbitrary or unjustifiable discrimination'.

The Agreement on Technical Barriers to Trade (TBT Agreement)

The TBT Agreement focuses on technical regulations, which can include matters such as product composition, labelling and packaging. This has obvious implications for anti-obesity measures like food labelling.

Under the TBT Agreement, WTO members should base domestic technical regulations and standards on international standards where these exist, unless to do so would be ineffective or inappropriate (article 2.4). This caveat allows countries to take into account differences and challenges in climate, geography and technology.

It is important to note that a technical regulation which complies with an international standard, for example a Codex standard, would be presumed not to cause an unnecessary barrier to trade (article 2.5). A country seeking to introduce technical regulations is also required to consider adopting technical standards from other countries to fulfil its 'legitimate objectives' (article 2.7). So, for example, a Pacific country may legitimately adopt or recognise standards on food-warning labels that are in place in the exporting country, if these requirements are consistent with the nutritional objectives of the Pacific country.

4.1.2 PICTA

PICTA is a trade agreement among the member countries of the Pacific Islands Forum, excluding Australia and New Zealand.

As a general principle, PICTA requires countries gradually to remove tariffs and barriers to trade among themselves, in order to work towards a free trade area among members. As part of this, goods from the region that are imported into the territory of one party from the territory of another party must be treated no less favourably than domestic products. The parties also commit to the elimination of tariffs on goods from the region by 2010, or in special cases, 2016. In addition, goods originating in the free trade area must be free of trade distorting measures, such as internal taxes and charges, and all requirements affecting sale,

distribution, transportation and use. PICTA signatories are therefore committed to abolishing any regulation on matters that could result in effective import restrictions, such as standards on product requirements, labelling, or manufacture.

Article 18 of PICTA also requires the parties to give consideration to harmonizing their laws, regulations and administrative practices in a way that will facilitate trade within the PICTA free trade area. This lends considerable weight to any proposal for adopting regional standards on nutrition issues.

Like the WTO agreements, PICTA also contains exceptions. The exception most relevant for obesity control is the right of a member country to claim that a trade restriction is necessary to protect human health (article 16(1)(b)).

4.1.3 PACER

PACER (Pacific Agreement on Closer Economic Relations) is an international treaty that was concluded on the same date as PICTA, and is open to signature and ratification by Australia and New Zealand as well as all parties to PICTA. Parties to PACER are obliged to establish programmes for developing, establishing and implementing trade facilitation, with a view towards the eventual establishment of a single regional market. The measures must, as far as practicable, be consistent with other regional and international trade facilitation agreements and initiatives. Effectively, PACER requires parties to work towards harmonisation of trade standards among members.

4.1.4 The Cotonou Agreement

The Cotonou Agreement between the Pacific Island countries and the European Union (EU) requires the Pacific Island countries, in their trade with EU countries, to grant the EU treatment “no less favourable than most-favoured-nation treatment” (Annex V, Chapter 1, Art 5(1)(a)). This obligation does not, however, require the Pacific Island countries to treat EU countries as favourably (in trade terms) as other developing countries or other States belonging to the African, Caribbean and Pacific (ACP) Group of States with whom the EU has entered into the Cotonou Agreement.

4.1.5 Compacts of Free Association with the USA

The Compacts with the Federated States of Micronesia and the Republic of the Marshall Islands require all products of the USA that are imported into the territories of these Pacific Island countries to receive “treatment no less favourable than that accorded like products of any foreign country with respect to

customs duties or charges of a similar nature and with respect to laws and regulations relating to importation, exportation, taxation, sale, distribution, storage or use" (Compacts Of Free Association, s. 244).

The Compacts with the Federated States of Micronesia and the Republic of the Marshall Islands also require the Pacific Island parties, prior to entering into consultations on, or concluding, a free trade agreement with any other government, to consult with the USA regarding "whether or how" the requirement to treat products from the USA no less favourably will be applied.

4.1.6 The application of trade agreements to obesity control

The application of trade agreements to health regulation is immensely complex, as evidenced by the fact that it was the subject of a joint WHO / WTO report in 2002. Despite the complexity, some broad implications for obesity control emerge from this brief examination of trade agreements.

First, measures to control the sale or import of foods that contribute to obesity must not be unnecessarily trade restrictive. That is, the measures must treat all goods alike. In particular, this means that a country must treat domestic goods in exactly the same way as it treats goods imported from a country with which it has a trade agreement. If, for example, a country wished to use article XX(b) of GATT to protect its population from an imported product that was dangerous to health, it would also need to be taking similar measures against equally dangerous local products. Likewise, a sin tax on carbonated beverages would have to be levied on local and imported products. Further, even where price controls appear to treat domestic and foreign industry alike, they may be held in de facto breach of trade agreements if they have the *effect* of creating competitive advantages for domestic companies, or competitive disadvantages for foreign companies.

Secondly, pricing measures designed to promote balanced nutritional intake, which are being justified on health grounds, must be consistently applied, so that they do not amount to effective discrimination, however unintentional, against an imported product. In other words, a tax on mutton flaps imposed for health reasons creates problems if equally fatty chicken parts are not taxed as well. The joint WTO/WHO report thus comments:

> Discrimination may be particularly difficult to justify on health grounds, as it should not matter where unsafe goods or services come from: for instance, meat containing a certain hazardous contaminant should be equally unwelcome irrespective of its origin (WTO & WHO, 2002, pp. 138-139)

If this thinking is translated into the obesity area, then it suggests that measures taken to restrict foods must be applied uniformly to both imported and locally-produced foods.

Thirdly, a country seeking to impose trade restrictions to combat obesity must think through the measures carefully, pointing to evidence and research which show that the measures are necessary and will be effective in addressing the problem identified, without being a disproportionate response to the problem.

Fourthly, as is the case under the TBT Agreement and in line with the intention of PACER, measures to control the sale or import of food can be justified if they meet international standards or equivalent technical regulations from other countries. This has implications for acceptable composition of foods, say, but also for labelling. Where sound technical warning requirements for food products exist under the Codex or other international standards, Pacific countries would be justified in adopting these standards if they adequately fulfil the anti-obesity objectives which the Pacific country is seeking to implement (compare Hawkes, 2004b, pp. 52-54)

Finally, the regional vision of PICTA and PACER mean that there is considerable merit in adopting Pacific regional approaches to nutrition issues. Standards applying across the Pacific would be entirely consistent with the vision of these agreements, and would minimise the possibility of trade difficulties.

5 THE WAY AHEAD IN PACIFIC OBESITY CONTROL: IMPLEMENTATION

5.1 Comprehensive interventions: a portfolio approach

While much can be learned from considering other countries' experiences, international evidence about the most effective interventions is still limited.[18] In addition, it is not always easy to obtain accurate information about the health needs of individual Pacific countries, so that tailoring effective regulatory intervention to a country's needs is difficult. Nonetheless, effective action will involve careful consideration of local conditions, existing legislation, and international obligations. It is also likely to involve a range of interventions, chosen to meet the local situation.[19]

This is in line with the model proposed by Swinburn et al (2005), who suggest a comprehensive approach to the obesity problem, involving a portfolio of interventions. Even if individual anti-obesity measures do not produce much

[18] Swinburn et al (2005) comment that "no country has yet developed and implemented a coherent programme of action to prevent further weight gain in the population".

[19] Evans et al (2001) argue that education alone is not enough to change behaviour. Tongans are well-educated on the risks of poor diet, but they 'nonetheless choose to consume less-healthy foods because of cost and availability'. Educational programmes must therefore be supported through other means.

impact on their own, if implemented as part of a collection of interventions they may have an important role in creating 'energy balance' in the target population. An interventions portfolio should thus mix interventions with a potentially high but uncertain impact alongside more proven but less dramatic interventions. These need to be selected according to the socio-economic conditions in each country.

The benefit of comprehensive interventions is also emphasised in the Ottawa Charter, developed during the first international conference on health promotion held by the WHO in 1986. The Charter sets out a framework for health promotion, based on the following principles:

- **Build healthy public policy** by putting health on the agenda of all policy-makers, so they are aware of the health consequences of their decisions. Here, this might include developing multi-agency, comprehensive policies aimed at promoting healthier diet options, and building physical activity into daily life.

- **Create supportive environments** that make a healthy lifestyle accessible to communities by preserving social structures and being responsive to changing needs. In Pacific countries, environments that support good nutrition would likely preserve and promote traditional diets.[20]

- **Strengthen community action** by empowering communities to identify priorities and implement initiatives that help them achieve better health. An example could be a programme that enables a community to identify lack of exercise as a growing problem, and then to choose and implement ways of integrating physical activity back into community life.

- **Develop personal skills** by providing information to increase the options available for individuals, families, and communities to improve their own health. Community-based programmes that teach families to grow traditional foods, low in saturated fats, are an example where enhanced personal skills lead to improved health.

- **Reorient health services,** so they focus on preventive efforts, rather than clinical services. This requires a collective change of attitude from policy makers, providers, and people who use services.

The Ottawa Charter thus encourages policy makers to be aware that choices made in many areas of life impact on health and weight. Increasing knowledge and supporting healthy nutrition choices of individuals, families and communities can help create an environment which recognises the importance of a balanced

[20] Hughes (2003) indicates that most traditional Pacific diets help to prevent and reduce obesity. Pollock, 1992, (cited in Curtis, p. 40), likewise states that "The value of local foods needs to be continually stated in order to raise people's consciousness of the good value of these foods". Programmes to this effect are occurring in various countries, as is evident in Table 2.

diet and regular physical exercise. Such comprehensive interventions are among the benefits of the French Polynesian obesity programme which, in its health promotion role, does more than simply inform the public about the benefits of exercise and nutrition. Among other things, it creates environments that encourage physical activity (such as playgrounds, fitness trails, heritage and hiking trails), recruits activity leaders for sports, recreation and youth clubs, and supports relevant community projects.

5.2 Evaluating interventions

Swinburn et al offer five criteria for evaluating possible measures for inclusion in a portfolio of public health actions:

- **Is it feasible?** (e.g. are there enough trained workers to implement it? Do the necessary networks, systems, and leaders exist? Has it been trialled successfully?)
- **Is it sustainable?** (e.g. will it survive political / economic / social changes? Is it likely that the behaviours etc required will be accepted as normal over time? Will it be funded on an ongoing basis?)
- **Does it impact the groups reporting as obese?** (i.e. will the intervention help reduce obesity among groups inequitably reporting as obese, such as groups defined by socioeconomic, ethnic, gender, or locality criteria?)
- **Does it have side-effects (whether positive or negative)?** (e.g. will the intervention have flow-on health consequences? Will it involve unacceptable stigmatisation of any group? Will it impact the environment? Will it lead to reduced traffic congestion? Will it have economic impacts? Will it increase household costs?)
- **Is it acceptable to stakeholders?** (e.g. will it be acceptable to parents and caregivers, teachers, health professionals, policy makers, private sector interests, government, the general community, the international community (WTO) etc?)
  (Adapted from Swinburn et al, 2005, p. 31).

These criteria can guide decisions about whether the interventions described in sections 2.2 to 2.6 above can usefully be introduced to Pacific countries.

5.2 Evaluating price and product controls

5.2.1 Taxes to fund health programmes

As indicated above, tax-funded health programmes have been implemented in French Polynesia, and are being considered elsewhere. As well as Vanuatu and Tuvalu, a 2005 WPRO report on the Tonga commitment identifies that several Pacific countries are contemplating taxes on cigarettes, alcohol, or unhealthy

imported food to fund programmes that promote healthy lifestyles. Such a tax fares well under the Swinburn criteria:

	Low level taxation to fund health promotion activity etc
Feasible?	- Yes: existing taxation regimes generally adaptable, and existing health promotion programmes would benefit from additional funds - Yes: idea familiar to Pacific countries (see report on implementation of Tonga Commitment (2005), Hone 2003, and example of French Polynesia) - Yes, if taxes levied in manner minimising need for technical analysis etc (e.g. levied on classes of product, rather than triggered by fat / sugar level), and to avoid discrimination against imported products
Sustainable?	- Yes: self-funding; can be levied on different products in each country - Yes: provided political will remains firm to apply funds to health promotion, rather than to redirect them to general Government funds. Disturbing reports indicate that the French Polynesian fund is becoming a victim of its own success, as Governments consider using it to fund interventions that are not health-related - sustainability may be more difficult in smaller nations where less revenue will be generated through taxation
Targeted impact?	- Low tax alone unlikely to change consumption patterns of specific population groups: targeted impact will depend on associated health promotions - Tax can increase awareness of obesity issues if publicised carefully
Side effects?	- Uncertain: will depend on foods taxed and rates of taxation. Econometric analysis necessary to ensure no adverse effects on consumption patterns - Could adversely affect poorer population groups if these remain dependent on taxed foods - Might encourage populations to grow / source own food
Acceptable?	- Opposition possible from manufacturers / importers / producers / sellers - otherwise likely to be accepted, provided taxation levels are not too high
SUMMARY:	**Low level taxes to fund health promotion activities, levied on products contributing to nutritional imbalance in each country, are a desirable and workable intervention, provided they are implemented with long-term political commitment and used to fund well-considered health programmes**

5.2.2 Taxes to change consumption patterns

No known jurisdiction imposes food taxes at levels designed primarily to reduce consumption of products contributing to obesity, though such arrangements are theoretically very attractive, since studies show a correlation between food prices and consumption levels (French, 2003; Diabetes NZ, 2003). Implementing such taxes, however, would require extensive analysis of local eating patterns, food markets, and economics, to ensure that there are no detrimental effects on local economies, and no unintended dietary consequences.

	High taxation aimed at altering consumption
Feasible?	- No legal barriers prevent high taxation per se, but targeting of particular products may cause international trade difficulties - As above: taxes should be levied in a manner avoiding need for compositional analysis, and in ways that prevent possible discrimination against imported products, including unintended discrimination
Sustainable?	- self-funding, but potential unpopularity of high taxes make them vulnerable to political change
Targeted impact?	- potential impact on nutritional intake of specific groups where data available on food consumed by those groups
Side effects?	- economic impact on households and possibly wider economy: econometric analysis necessary to set taxes at levels that minimise detrimental side-effects - risk that high tax may adversely affect low-income groups - may encourage people to grow or source own food
Acceptable?	- opposition likely from manufacturers / importers / producers / sellers - opposition likely from public, especially if no healthier, cheaper alternatives are available
SUMMARY:	**While high taxes are likely to alter consumption patterns, they should only be introduced after careful analysis of their likely impact on local eating patterns. They would also need careful implementation to avoid trade difficulties**

5.2.2 Cross-subsidisation to change consumption patterns

Some commentators have recommended that governments introduce cross-subsidisation arrangements, where taxes on high fat or sugar products are used to subsidise foods like fruit and vegetables. As with high taxes, such an arrangement is attractive, though untried. Interestingly, French Polynesia appointed a commission on staple goods in 2005 to examine the relationship between food quality and food price, and the commission's work may eventually lead to the implementation of obesity-directed price regulation. This pioneering move, if it is followed through, should be observed with interest by all Pacific countries, and by WPRO.

	Cross-subsidisation regimes aimed at altering consumption
Feasible?	- Unknown: idea attractive, though no international precedent. Would require considerable preliminary analysis and planning
Sustainable?	- Unknown: if workable subsidisation formulae reached, should prove sustainable. Difficulties likely to arise in devising appropriate formulae
Targeted impact?	- if adequate consumption data and technical expertise available, high potential to devise subsidisation regimes in manner that influences consumption patterns of particular groups

Side effects?	- detailed econometric analysis necessary to ensure no adverse consequences on population consumption patterns and on economy
Acceptable?	- Opposition possible from manufacturers / importers / producers / sellers - otherwise likely to be accepted, especially if healthy and desirable foods made affordable by subsidisation
SUMMARY:	**Extensive planning and analysis would be necessary to make a cross-subsidisation regime workable. While the idea is theoretically attractive, unknown variables suggest that other initiatives should be promoted ahead of cross-subsidisation at this stage**

5.2.3 Product restrictions

As the Tongan and Fijian experience shows, product bans are difficult to enforce, and have the potential to cause international trade difficulties. Nonetheless, the role of high-fat meat products in the Pacific obesity problem means that countries may wish to consider outright bans in any case. If so, we believe that WPRO must provide ongoing, and country specific advice to countries on their trade obligations, and on the way of working around these. This may include further research into the means by which Ghana restricts similar imports according to fat composition (see above, paragraph 2.3.1).

	Comprehensive product bans / restrictions
Feasible?	- feasible, especially for imported products which can be stopped at the border using existing customs procedures. - commitment to enforcement necessary to prevent proliferation of alternative products
Sustainable?	- sustainability depends on meeting trading objections, and ability to enforce bans adequately. - research is necessary to establish sound health reasons for ban, so that objections from trading partners can be met. - to be non-discriminatory under trade agreements, ban must be comprehensively applied to all products in local diet, imported or locally produced, that pose a similar health risk. - research into Ghanaian controls may assist discovery of sustainable method of enforcing ban.
Targeted impact?	- affects population indiscriminately: targets *products* contributing particularly to obesity, but research is necessary to ensure that ban impacts at-risk population groups.
Side effects?	- bans may direct consumers towards other unhealthy products. - analysis desirable to predict likely impact on overall diet.
Acceptable?	- objections likely from importers, retailers etc. - objections likely from public unless reasonably-priced substitute foods exist
SUMMARY:	**Where particular foods are manifestly contributing to obesity, a ban on**

	those foods could form a useful part of a regulatory portfolio. It would be necessary to show evidence that the banned products contributed significantly to adverse health risks. Further, as in Ghana, the ban would need to apply to all products posing similar risk in order to minimise the possibility that consumers would simply transfer their consumption to products as unhealthy as the banned ones.

5.3 Evaluating food labelling measures

Nutritional information panels, presented in a numerical fashion on food products, are becoming increasingly common throughout the world. While implementing mandatory numerical labelling could have some positive effects on Pacific diets, a food labelling system involving simplified warning labels (along the lines of the British traffic light labels currently under development by the FSA) is likely to be more easily understood, and so to have greater impact on health in the Pacific. It does, however, raise some difficulties under the Swinburn criteria.

	Product information and labelling requirements
Feasible?	- requiring numerical nutritional content labelling is feasible, due to increasing international use, Codex support, etc. - requiring simplified warning labels is less feasible for reasons of cost and resource, unless simplified systems begin to expand internationally or unless a regional standard is adopted for the Pacific
Sustainable?	- numerical content labelling is sustainable, especially on imported products, because numerical nutrition labelling is widely used internationally - However, introducing simplified labels specifically for Pacific countries would prove expensive and difficult to sustain at this stage. It might also pose trade difficulties if it was made mandatory
Targeted impact?	- requiring numerical information panels is unlikely to change behaviour of groups with limited nutritional knowledge, or with limited education. These are often the groups most likely to be at-risk. - culturally appropriate labelling systems could be introduced to target particular groups, but this would be expensive and could create trade difficulties unless the labelling was added and paid-for locally
Side effects?	- increased costs from product labelling
Acceptable?	- opposition possible from industry - warning system could create trade difficulties unless pinned to international standards
SUMMARY:	**Labelling standards can contribute to public awareness of nutritional issues. However, numerically-based nutrition labels are unlikely to target the most at-risk populations. A simplified warning system, such as "traffic light" labels, might be more effective in the Pacific, but considerations of cost and trade may prevent this intervention at this stage. If countries wish to introduce Pacific-specific labelling, they would be advised to act regionally to achieve this**

5.4 Evaluating restrictions on advertising

Further research is necessary to demonstrate links between advertising-restrictions and more balanced diets. However, where a country can demonstrate, through research, that product advertising is linked to obesity, advertising restrictions would appear desirable. The evidence must be clear enough, however, to justify the intervention in case of any trade challenges.

	Advertising restrictions
Feasible?	- tobacco control experience shows that restrictions may be feasible in Pacific, though the range of advertised products is much broader, which may lessen the feasibility of workable restrictions
Sustainable?	- probably yes, given tobacco experience - advertising restrictions may attract challenges under TBT Agreement unless the restrictions promote a "legitimate objective". Hence, research is needed in each case to prove that the measures are necessary to reduce obesity
Targeted impact?	- advertising restrictions affect whole population, not just targeted groups - impact depends on effect which advertising has on local consumption: research needed locally to establish that advertising increases consumption of less healthy foods
Side effects?	- Unclear. May have community impact, such as reducing sponsorship funds etc
Acceptable?	- opposition likely from advertisers
SUMMARY:	**Where demonstrable links exist between advertising and the consumption of products contributing to obesity, advertising restrictions make sense. However, restrictions may lead to trade challenges which must be met on legitimately researched grounds.**

5.5 Evaluating interventions for schools

Anti-obesity regulation aimed at schools includes measures to control the food served in and around schools, and measures to promote physical activity.

5.5.1 Food in school environments

Modelling good dietary behaviour for school-age children is likely to be useful in any ongoing obesity prevention strategy. Measures regulating the food served in schools therefore deserve close scrutiny. So too do measures, like those introduced in French Polynesia, to improve the nutritional quality of food served in the vicinity of schools.

	School interventions – nutritious food in schools
Feasible?	- Yes, where food is available in schools, nothing prevents the regulation of that food's quality and nutritive value, adapted for local conditions as appropriate - Regulating food sold in the vicinity of schools is more difficult: collaboration with retailers may be more effective than coercion, as in the Tama'a Tano Noa project operating in French Polynesia
Sustainable?	- Probably, where food is currently available in schools. - Regulating food quality near schools harder to sustain
Targeted impact?	- Where schools serve food, this effectively targets school children as a group
Side effects?	- may create backlash of unhealthy eating outside schools - alternatively, may increase community knowledge about dietary issues and create life-long, healthy eating habits
Acceptable?	- opposition possible from vendors etc, but opportunity available for public health education, as seen in French Polynesian experience with snack van proprietors.
SUMMARY:	**Where food is available in schools, regulating its nutritional quality, and restricting the availability of some products is likely to be an effective and helpful intervention. Improving the quality of food available to children near schools is harder to control, and may be best achieved through education and relationships.**

5.5.2 Physical activity in schools

Many Pacific countries encourage physical activity among school children as a method of preventing obesity. Legislative interventions can be used to enhance physical education curricula or mandate physical activity. Legislation may be used less prescriptively to fund sports equipment and programmes through 'sin-tax' mechanisms.

	School interventions – regulating physical activity
Feasible?	Yes – infrastructure and some programmes already exist, and these could be enhanced through legislative intervention, such as additional taxation funding
Sustainable?	Yes – interventions need not be expensive, and could be funded through taxation on less healthy products
Targeted impact?	Yes – targets children, with potential to instil a lifetime exercise habit
Side effects?	- other positive health benefits possible - potential to educate other community members
Acceptable?	- opposition difficult to foresee, though may be regarded as heavy-handed
SUMMARY:	**Physical activity programmes are already pursued in many Pacific schools, and form an important part of anti-obesity strategies. Coordinating these programmes by regulation and through providing additional resources may**

	be an effective means of maximising their impact on the obesity problem.

5.6 Health promotion

Most public health interventions require health education and promotion to maximise their benefit. Indeed, some public health interventions, such as food labelling, are only likely to be effective if combined with education. Appropriate health promotion strategies can be tailored to local conditions, and should therefore form part of every strategy directed at obesity prevention and control.

	Educational and promotional programmes for exercise and healthy diets
Feasible?	- Yes: health education programmes operate in most countries, and obesity can be included in these where this is not already so.
Sustainable?	- Yes, and sustainability can be enhanced if programmes are funded through 'sin-taxes'. Most existing programmes would benefit from the establishment of statutory Health Promotion Foundations, funded in this way.
Targeted impact?	- Can be designed for particular population groups, as well as whole populations
Side effects?	- intangible community benefits likely
Acceptable?	- difficult to foresee opposition
SUMMARY:	**Education is a vital part of any anti-obesity programme, and can be designed to maximise the effect of other anti-obesity interventions. Indeed, some interventions will only function properly with adequate educational support. Legislation will often be unnecessary to implement such programmes, though educational measures may usefully form part of anti-obesity legislative action (e.g. the implementation of a sin tax).**

6. SUMMARY AND RECOMMENDATIONS

Regulation alone cannot solve the obesity epidemic. However, it can have a vital role to play in focusing public health interventions. In particular, it can help to coordinate and cement the interventions already occurring, so that they remain truly comprehensive and sustainable.

In general, most Pacific countries lack the size and resources to implement sophisticated, technical responses to the epidemic. However, all Pacific countries can develop a sustainable financial base from which to organise comprehensive anti-obesity measures, involving the whole community, and targeted to local needs. Some measures, such as enhanced exercise and education programmes, are likely to be beneficial throughout the region.

To these ends, we recommend:

- That Pacific nations should contemplate low-level, domestic 'sin taxes' on foods that contribute particularly to obesity in their country. The revenue from such taxes should be dedicated to financing comprehensive anti-obesity measures, along the lines modelled by French Polynesia.

- That Pacific nations consider, as appropriate, establishing centralised, cross-government agencies (modelled on E.P.A.P. in French Polynesia) to administer the revenue from sin-taxes, by implementing comprehensive anti-obesity measures, coordinating health promotion activities, and resourcing programmes that promote physical activity.

- That WPRO should monitor the experience in French Polynesia of the recently established consultative commission on food pricing and food quality, to gauge whether other Pacific countries should act similarly.

- That WPRO facilitate access to econometric assistance that will be necessary to design tax and price based mechanisms for obesity prevention

- That WPRO should provide advice to countries wishing to control the import and sale of products causing particular concern (such as fatty meats) by means of Ghanaian style certification regimes

- That WPRO should provide technical assistance to Pacific nations, on a country-by-country basis, concerning their obligations under PICTA and PACER in relation to the removal of tariffs and domestic subsidies by 2016.

- That Pacific countries be encouraged to involve health officials in trade policy, as recommended in the joint report of the WHO and WTO from 2000,[21] so that international trade obligations can be implemented in a manner consistent with public health goals.

- That WPRO keep a watching brief on international food labelling initiatives with a view to recommending simplified food labelling systems in the Pacific as these become more feasible.

- That WPRO assist Pacific countries to undertake research into the role of advertising in encouraging consumption of high-fat and high-sugar products in their jurisdiction.

- That Pacific countries be encouraged to promote healthy eating and physical exercise among children by adopting measures to promote nutritious eating in schools, including, as appropriate, banning vending

[21] (WHO / WTO, 2002, pp. 138-142: such cooperation occurs in Thailand and Canada).

machines, promulgating nutrition standards for the food available in schools, serving meals in schools, and equipping physical activity programmes.

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